Provider Manual

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Welcome to Prestige Health Choice

We are pleased to have you participating in our network. Our Provider Manual has been designed to provide important information on processes, programs and the delivery of care to Prestige members.

Prestige Health Choice is contracted with the Agency for Health Care Administration (AHCA) as a participant in the Florida Statewide Medicaid Managed Care program. As a Florida-based company, Prestige Health Choice is dedicated to serving the needs of Floridians enrolled in the Medicaid program.

Florida Medicaid and the Statewide Medicaid Managed Care Program. Florida has offered Medicaid services since 1970. Medicaid provides healthcare coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7170, creating Part IV of Chapter 409, F.S.to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services including long term care services. This program is referred to as the Statewide Medicaid Managed Care Program (SMMC) and includes two programs: one for Managed Medical Assistance (MMA) and one for Long-Term Care (LTC).

Our model of care provides an integrated approach to person-centered care for all aspects of a members’ well-being. Prestige Health Choice has a long history of advancing excellence in delivering quality health care to members. Key to our success is the long standing collaborative relationships we enjoy with network practitioners and providers.

Thank you for your participation and commitment to care for our members.

Your Quick Reference Guide

Prestige Health Choice offers healthcare coverage to Floridians enrolled in the Statewide Medicaid Managed Care Program. Please visit our website to learn more about Prestige Health Choice, including the following:

- Provider manual
- Provider forms
- Provider directories
- Billing guide
- Clinical guidelines
- Online training
- Provider newsletters
- Online searchable provider database
- Claims and billing information
- Forms

Create your secure account today. Register for access to the Prestige secure provider portal to manage your Prestige transactions online: https://www.availity.com/resources/support/provider-portal-registration. If you prefer, we can help you set up your account. Call Provider Services at 1-800-617-5727. You can perform the following tasks online through your secure account:

- Confirm member eligibility
- Check the status of your claims
• Determine which services require a prior authorization
• Request and view your prior authorizations
• Run and review clinical reports
• Review panel and capitation rosters

We’re ready to help you get started. Call us at 1-800-617-5727 to learn more about:
• Becoming a participating provider
• Checking on member eligibility or verification
• Learning about practice tools and services available to you
• Getting questions about a claim status answered

Electronic claims transactions.
• In order to send claims electronically to Prestige Health Choice, all EDI claims must first be forwarded to Change Healthcare. This can be completed via a direct submission or through another EDI clearinghouse or vendor.
• If you are a provider interested in submitting claims electronically to Prestige Health Choice, but do not currently have Change Healthcare EDI capabilities, you may contact:
  o Change Healthcare Provider Support Line at 1-877-363-3666
  o Prestige Health Choice Provider Services Department at 1-800-617-5727
  o Prestige Health Choice Website: https://www.prestigehealthchoice.com/provider/claims-and-billing/claims-submission-process.aspx
• Prestige Health Choice EDI Payer ID: 77003

Medical management. Our medical management team oversees utilization management, case management and care coordination for members. Prior authorization is required for both elective and scheduled services. Please use the Prestige Health Choice online prior authorization tool at https://www.availity.com/.

To reach the Medical Management Department, please call 1-855-371-8074.
Chapter 1: Claims and Billing

Definitions

**Clean claim** -- a claim received in a nationally-accepted format, in compliance with standard coding guidelines, that can be processed by Prestige Health Choice without obtaining additional information from the provider of the service or from a third party.

**Non-clean claim** -- a claim requiring additional information from the provider of the service, or from a third party. Non-clean claims contain errors/omissions of data or require submission of additional medical records. In addition, non-clean claims may involve issues regarding medical necessity or those not submitted within the filing deadlines.

**Encounter vs. claim** -- *Encounter data* is used to evaluate quality and utilization management. Prestige Health Choice requires capitated providers to submit an encounter (also called a "proxy claim") or a claim for each service that you render to a health plan member. The information for each member visit must be submitted on a standard CMS-1500 or UB-04 form and completed with a dollar value. This is a requirement of the Centers for Medicare and Medicaid Services (CMS) and the state of Florida. A *claim* is a request for reimbursement either electronically or by paper for any medical service. Claims must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, a Remittance Advice (RA) will be mailed to the provider who submitted the original claim.

Procedures for Claim Submission

Prestige Health Choice is required by state and federal regulations to capture specific data regarding services rendered to members. As such, we ask that network providers adhere to all billing requirements in order to ensure timely processing of claims.

When required data elements are missing or are invalid, claims will be rejected for correction and re-submission.

Claims for billable and capitated services provided to Prestige Health Choice members must be submitted by the provider who performed the services. All claims are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits at Change Healthcare™ (formerly Emdeon).
- Verification of member eligibility for services under Prestige Health Choice during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the “out of plan” provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Florida Medicaid program at the time of service.
• Verification that an authorization has been given for services that require prior authorization by the Plan.
• Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that Prestige is the “payer of last resort” on all claims to Prestige.

Claim Filing Deadlines
Original invoices must be submitted to Prestige Health Choice as set forth in your provider contract, or as otherwise permitted by law, from the date services were rendered or compensable items were provided. Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within the allowed time frame listed in your participating provider’s contract, or as otherwise permitted by law, or as outlined in federal/state statues.

Claims with explanation of benefits from primary insurers must be submitted within the following timeframes:
• For third-party liability or coordination of benefits claims, the time filing limit is 6 months from the primary insurance explanation of benefits, or 12 months from date of service for secondary claim submission, whichever is greater.
• For Medicare coordination of benefit claims the time filing limit is 36 months from the date of service or 12 months from the Medicare explanation of benefits, whichever is greater. Medicare crossover claims shall not be denied solely based on the date span between date of service and the date a clean claim was received, unless this period exceeds three years.

Paper Claim Submission
Paper claims should be submitted to Prestige at the following address:

Prestige Health Choice  
Attn: Claim Processing Department  
P.O. Box 7367  
London, KY 40742

We encourage all providers to submit claims electronically. Please call your EDI software vendor or the Change Healthcare Provider Support Line at 1-877-363-3666 to arrange transmission.

Prestige Health Choice is authorized to take whatever steps are necessary to ensure that as a network provider, you are recognized by the Statewide Medicaid Managed Care program -- including its choice counseling/enrollment broker contractor(s) -- as a participating provider of Prestige Health Choice, and that your submission of encounter data is accepted by the Florida Medicaid Management Information System (FLMMIS).

Electronic Claim Submission
The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

**Prestige Health Choice EDI Payer ID.** The Prestige Health Choice EDI Payer ID is 77003.
**Hardware/software requirements.** There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

**Contracting with Change Healthcare and other electronic vendors.** If you are a provider interested in submitting claims electronically to Prestige, but do not currently have Change Healthcare EDI capabilities, you can contact Provider Services at 1-800-617-5727 and we will assist you. Or if you prefer, you can contract another EDI clearinghouse or vendor who already has Change Healthcare capabilities. If you are interested in electronic claims submissions and would like to contact the EDI Technical Support Group, please call Provider Services at 1-800-617-5727 for assistance.

**Specific data record requirements.** Claims transmitted electronically must contain all the same data elements identified within the EDI Claim Filing sections of this provider manual. EDI guidance for Professional Medical Services claims can be found at the beginning of this claims section. EDI guidance for facility claims can be found at the beginning of this claims section. Change Healthcare or any other EDI clearing-house or vendor may require additional data record requirements.

**Electronic claim flow description.** In order to send claims electronically to Prestige Health Choice, all EDI claims must first be forwarded to Change Healthcare. Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and Prestige Health Choice’s payer edits. Claims not meeting requirements will be rejected and returned electronically via a Change Healthcare error report. The name of this report can vary based upon your contract with your EDI vendor or Change Healthcare.

Accepted claims are passed along to Prestige Health Choice for processing. Change Healthcare returns an acceptance report to the sender immediately.

Claims forwarded to Prestige Health Choice by Change Healthcare are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to Change Healthcare, which also forwards this rejection to its trading partner – the EDI vendor or provider. Claims passing eligibility requirements are then forwarded to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

As a network provider, you are responsible for the verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from Change Healthcare, or other contracted EDI software vendors. It is your responsibility to review and validate against transmittal records daily.

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to Prestige Health Choice.

For assistance in resolving submission issues, contact Change Healthcare Provider Support directly at 1-877-363-3666.
Plan specific electronic edit requirements. Prestige Health Choice has specific edits for professional and institutional claims sent electronically. They are as follows:

- 837P – 005010X098A1 – Provider ID Payer Edit states the ID must be less than thirteen (13) alphanumeric digits.
- 837I – 005010X096A1 – Provider ID Payer Edit states the ID must be less than thirteen (13) alphanumeric digits.
- Member Number must be less than seventeen (17) AN. Date submitted must not be earlier than date of service. Plan Provider ID is strongly encouraged.

National Provider Identification (NPI) processing. Prestige Health Choice provider numbers are created from individual NPI numbers using any of the following criteria:

- Prestige Health Choice’s ID, Tax ID and NPI numbers;
- Service location’s ZIP code;
- Billing address; or
- Taxonomy.

If no single match is found, the claim is sent to the Invalid Provider queue (IPQ) for processing. If a plan provider ID is sent using the G2 qualifier, it is used as the provider on the claim.

Corrected, Replacement, and Voided Claim Submission
Corrected, replacement and voided claims should be sent electronically or on paper and should be submitted to Prestige Health Choice in accordance with the following guidelines:

- If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) must contain the value ‘7’ for the Replacement (correction) of a prior claim or ‘8’ for the Void of a prior claim.
- In addition, you must also provide the original claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the Plan but rather a requirement of the mandated HIPAA Version 5010 Implementation Guide.
- If the corrected claim is submitted on paper, the claim must have the following in order to be processed:
  - On a Professional CMS 1500 Claim, the resubmission code of “7” or “8” and the Plan’s original claim number must be in Field 22.
  - On an Institutional UB04 Claim, bill type should end in “7” or “8” in Form Locator 4 and the Plan’s original claim number must be in Form Locator 64A (Document Control Number).
- You can only resubmit as a corrected or replacement claim when you have received an original Prestige Health Choice claim number.

Please do not utilize the corrected claim process if the claim was rejected by Prestige Health Choice.

Claims Payments
Clean claims will be adjudicated (finalized as paid or denied) within the following timeframes:

- EDI – Nursing Facility and Hospice clean claims – 10 days from date of receipt
- EDI – Non-Nursing Facility and non-Hospice clean claims – 15 days from date of receipt
- Paper – 20 days from date of receipt
Submitting a Refund

Prestige encourages providers to conduct regular self-audits to ensure receipt of accurate payment(s) from Prestige. Medicaid program funds must be returned when identified as improperly paid or overpaid.

If a plan provider identifies improper payment or overpayment of claims from Prestige, the improperly paid or overpaid funds must be returned to Prestige within 60 days from the date of discovery of the overpayment. Providers may return improper or overpaid funds to Prestige by:

2. Using page two of the form or attaching your own spreadsheet with the pertinent fields from the form, as needed, to list multiple claims connected to the return payment.
3. Submitting the completed form, attachments and refund check by mail to the claims processing department:
   
   Prestige Health Choice  
   Attn: Provider Refund Unit  
   PO Box 7367  
   London, KY 40742

We aspire to provide an exceptional service experience. In order to expedite the processing of refunds, providers are encouraged to submit individual refunds (one claim per check). This will allow for automated processing and provide a faster turnaround time for the refund to be applied.

Additional Claim Submission Guidelines

Medicaid Well Child Visits - Child Health Check-Up Program (CHCUP). CHCUP services are the CPT Preventive Medicine Services Codes. In some cases, one or two modifiers are required to uniquely identify the service provided. Both the procedure code and modifiers listed must be completed on the claim to facilitate proper reimbursement. No modifiers other than the ones listed below are allowed when billing these services.

*Note: The EP modifier must be used with Procedure Code 99385 and 99395 to identify children 18 through 39 years of age.

*Note: The FP modifier must be used with Procedure Code 99383-99385 or 99393-99395 when the appropriate diagnosis is billed for Family Planning services.

Each Preventive Medicine Service code billed will be required to have a referral code with the exception of Modifier FP for codes 99383-99385 or 99393-99395. No referral code is required.

Code Description:

- 99381 New Patient Under One Year
- 99382 New Patient Ages 1-4 years
- 99383 New Patient Ages 5-11 Years
- 99384 New Patient Ages 12-17 Years
- 99385 EP New Patient Ages 18-39 Years
• 99391 Established Patient Under One Year
• 99392 Established Patient Ages 1-4 years
• 99393 Established Patient Ages 5-11 Years
• 99394 Established Patient Ages 12-17 Years
• 99395 EP Established Patient Ages 18-39 Years

Common Causes of Claim Processing Delays, Rejections or Denials:

• **Authorization or Referral Number Invalid or Missing** - A valid authorization number must be included on the claim form for all services requiring prior authorization.

• **Attending Provider ID Missing or Invalid** – Inpatient claims must include the name of the provider who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (Attending Provider ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as two (2) alpha, six (6) numeric, and one (1) alpha character (AANNNNNNNA) OR two (2) alpha and six (6) numeric characters (AANNNNNN).

• **Billed Charges Missing or Incomplete** – A billed charge amount must be included for each service/procedure/supply on the claim form.

• **Diagnosis, Procedure or Modifier Codes Invalid or Missing** - Coding from the most current coding manuals (ICD-10, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

• **Explanation of Benefits from Primary Insurers Missing or Incomplete** – A copy of the EOB from all third-party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages.

• **External Cause of Injury Codes** – External Cause of Injury “E” diagnosis codes should not be billed as primary and/or admitting diagnosis.

• **Future Claim Dates** – Claims submitted for medical supplies or services with future claim dates will be denied, for example, a claim submitted on October 1st for bandages that are delivered for October 1st through October 31st will deny for all days except October 1st.

• **Handwritten Claims** – Non-legible Legible handwritten claims are acceptable on resubmitted claims. Illegible handwritten claims will be rejected (See Illegible Claim Information).

• **Illegible Claim Information** – Information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed or printed in black ink, data is lined up correctly in appropriate fields, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate. Handwritten information often causes delays or inaccuracies due to reduced clarity.
• **Member Plan Identification Number Missing or Invalid** – Prestige’s assigned identification number must be included on the claim form or electronic claim submitted for payment.

• **Member Date of Birth Does Not Match Member ID Submitted** – a newborn claim submitted with the mother’s ID number will be pended for manual processing causing delay in prompt payment.

• **Newborn Claim Information Missing or Invalid** – Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert “Baby Girl” or “Baby Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.

• **Payer or Other Insurer Information Missing or Incomplete** – Include the name, address and policy number for all insurers covering the Prestige member.

• **Primary EOB Required** – The member has other insurance as primary and the primary explanation of benefits was not submitted with the claim.

**Prospective claims editing policy.** Our claim payment policies, and the resulting edits, are based on guidelines from established industry sources. These include the Centers for Medicare and Medicaid Services, the American Medical Association, state regulatory agencies and medical specialty professional societies.

In making claim payment determinations, Prestige Health Choice uses coding terminology and methodologies that are based on accepted industry standards. These include the Healthcare Common Procedure Coding System manual, the Current Procedural Terminology codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code.

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policies. These factors may include but are not limited to: legislative or regulatory mandates, a provider’s contract, and/or a member’s eligibility to receive covered healthcare services.

**Billing forms.** Please submit claims using standardized claim forms whether filing on paper or electronically. Refer to the appropriate provider handbook, issued by AHCA at [http://ahca.myflorida.com/medicaid/review/index.shtml](http://ahca.myflorida.com/medicaid/review/index.shtml), to determine which claim form is appropriate for each type of service.

**Third party liability.** Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the healthcare expenses of the member. Please verify recipient eligibility prior to serving the recipient and verify third party sources prior to billing Prestige Health Choice.
**CMS crossover claims.** In accordance with guidance from CMS, providers only need to submit claims for dual eligible members once to CMS for processing and are no longer required to submit secondary claims to Prestige Health Choice. This means that CMS will automatically forward claims to Prestige Health Choice for members who are dually eligible for both Medicare and Medicaid coverage.

**Please note:** If a provider submits a claim for a dually eligible member that CMS has already forwarded to Prestige Health Choice, we will deny the provider-submitted claim as a duplicate claim.

**Billing the enrollee.** Providers may *not* bill an enrollee for Medicaid-covered services for which a claim has been submitted, regardless of whether the claim has been paid or denied.
Chapter 2: Provider Appeal Process

Overview
Prestige Health Choice maintains a provider appeals system that allows the provider to dispute Prestige’s policies, procedures, or any aspect of our administrative functions, including proposed actions, claims, billing disputes, and authorizations. Appeals are reviewed and resolved by the Provider Appeals department.

Should a provider disagree with an authorization or claims decision, the provider may participate in the Provider Appeal process. Some examples could include:

- I submitted an authorization request that was denied, had my Peer to Peer review denied, and would like to appeal that decision
- I had a claim denied due to lack of authorization
- I had a claim denied for reasons other than authorization or I disagree with the payment amount. These include, but are not limited to the following:
  - Untimely filing
  - Billing edits
  - Benefit limitations
  - Unlisted procedure codes/non-covered codes
  - Fee schedule/reimbursement rates
  - Provider contract questions/concerns

Steps for Submitting a Provider Appeal
1. Download the Provider Appeals Form at www.prestigehealthchoice.com and complete in its entirety.
2. Submit appeal to the following:
   - Mail: Prestige Provider Appeals Dept.
     PO Box 7366
     London, KY 40742
   - Fax: 1-855-358-5853
   If you have already submitted a provider appeal, you may call us for a status update at 1-561-839-2550.
3. If the appeal is of clinical nature, provide supporting documentation including medical records and additional information to support the clinical decision. Please only attach the relevant additional medical records required to support your case. Medical records submissions must be limited to 300 pages.
4. If the appeal is of a claims nature, please include all relevant information to support your appeal, including but not limited to:
   - Fee schedules
   - Copy of contract
   - Remittance Advice
   - Calculations
   - Other information to support the request
5. A Provider has 180 days from the clinical decision or claims payment date to submit an appeal. All appeals past that date will be administratively upheld.
6. Prestige will send an acknowledgement letter within three (3) business days to inform you that we have received your appeal.

7. Prestige will utilize relevant statutory timelines in reviewing an appeal relating to COB issues.

8. If the appeal is of an administrative nature, you will receive a status update after fifteen (15) days of receipt if the appeal is not resolved and we will provide written notice of the status every fifteen (15) days until the appeal is resolved.

9. Prestige will resolve all provider appeals within 60 days.

10. If the decision is to overturn the original denial, Prestige will send either a Remittance Advice, a Remittance Advice with payment, or written notification within three (3) business days of the decision.

11. If the decision is to uphold the original denial, this decision will be communicated to the provider via written notification within three (3) business days of the decision.

12. If the Provider is still not in agreement with the original denial, the Provider may appeal the decision by submitting to the MAXIMUS Dispute Process.

**MAXIMUS – Florida Statewide Provider and Health Plan Claim Dispute Resolution Program**

MAXIMUS is an independent dispute resolution organization that provides assistance to health care providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the Provider to the Plan and they must have been denied in full or in part or where presumed to have been underpaid or overpaid. Disputes regarding late payments will not be considered by MAXIMUS.
Chapter 3: Member Complaints, Grievances, and Appeals

Member Complaints
Complaints allow Prestige to resolve a problem without it becoming a formal grievance. If a member has a concern or question regarding care or coverage under Prestige, he/she should contact Member Services at the toll-free number on the back of his/her ID card. A member services representative will answer questions and/or concerns. The representative will try to resolve the problem. If the member services representative does not resolve the problem to the member’s satisfaction, he/she has the right to file a grievance. A complaint that is not resolved by close of business the day following its receipt is automatically moved into the Prestige Grievance System.

Grievance Process
A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee, failure to respect an enrollee’s rights, or an enrollee dispute of an extension of time proposed by the Managed Care Plan to make an authorization decision. The enrollee can file a grievance orally or by phone at any time. A grievance may be filed about such things as the quality of the care the member receives from Prestige or a provider, rude behavior from a Prestige employee or a provider’s employee, a lack of respect for their rights by Prestige or a provider, or anything else with which the member may be dissatisfied.

To file a grievance, the member may call Member Services at 1-855-355-9800 or TTY/TDD at 1-855-358-5856. Hours of operation are twenty-four hours a day, seven days a week (24/7).

Or write to:
Prestige Health Choice
P.O. Box 7368
London, KY 40742

If the member needs assistance in completing forms and following the procedure for filing his/her grievance or needs the help of an interpreter, the member may call Member Services at 1-855-355-9800 or TTY/TDD at 1-855-358-5856. The interpreter services are free of charge to the member.

Prestige will send the member an acknowledgement letter within five (5) business days of receiving the grievance. Prestige will send a decision letter within ninety (90) days of receiving the request. In some cases, Prestige or the member may need more information. If the member needs more time to get information, he/she may request up to fourteen (14) additional days. If Prestige needs more time, the member will be informed of the reason for the extension, in writing, within two (2) calendar days.
**Providers Appealing on Behalf of Member**

A standard appeal may be submitted by a Provider on behalf of the member. The Provider, with member’s consent, may call Member Services at 1-855-355-5856 or fax appeal request to 855-358-5847.

Provider may file an appeal orally or in writing within sixty (60) calendar days of the member’s receipt of the Notice of Adverse Benefit Determination (NABD), and except when expedited resolution is required, must be followed with a written notice within ten (10) calendar days of the oral filing. The date of oral notice shall constitute the date of receipt.

Hours of operation are twenty-four hours a day, seven days a week (24/7).

**Standard Appeal**

A standard appeal may be submitted by a Provider on behalf of the member. The Provider, with member’s consent, may call Member Services at 1-855-355-5856 or fax appeal request to 855-358-5847.

Provider may file an appeal orally or in writing within sixty (60) calendar days of the member’s receipt of the Notice of Adverse Benefit Determination (NABD), and except when expedited resolution is required, must be followed with a written notice within ten (10) calendar days of the oral filing. The date of oral notice shall constitute the date of receipt.

Hours of operation are twenty-four hours a day, seven days a week (24/7).

**Expedited Appeal**

A member or his/her authorized representative, with the member’s written consent, can request an expedited appeal when taking the time for a standard resolution could jeopardize the member’s life, health or ability to attain, maintain or regain function. Expedited appeals are for health care services, not denied claims. To ask for an expedited appeal, the member or his/her authorized representative may call 1-855-371-8078.

If Prestige denies a request for an expedited resolution of an Appeal, Prestige shall provide oral notice by close of business on the day of disposition, and written notice within two (2) calendar days after the disposition. The appeal will immediately be moved into the standard appeal timeframe, if it does not meet the criteria for an expedited appeal.

Prestige shall resolve each expedited appeal and provide notice to the member as quickly as the member’s health condition requires, within state established time frames, not to exceed forty-eight (48) hours after the request for expedited appeal is received. Prestige also shall provide oral notice by close of business on the day of disposition, and written notice within two (2) calendar days of the disposition.

**Medicaid Fair Hearing**

A Provider may seek a Medicaid Fair Hearing on behalf of the member, if signed express consent has been provided by member granting permission to do so, and only after exhausting the plan’s
internal appeal process within one hundred twenty (120) days of the Notice of Adverse Benefit Determination (NABD). The Provider addresses requests for a Medicaid Fair Hearing to:

Agency for Health Care Administration of Medicaid Hearing Unit  
P.O. BOX 60127, Ft. Myers, Florida 33906  
Medicaid Hearing Unit  
P.O Box 60127  
Ft. Myers, FL 33906  
(Toll-free 1-877) -254-1055 (toll-free) Fax: 1-239-338-2642 (fax)  
MedicaidHearingUnit@ahca.myflorida.com


**Continuation of Benefits**

The member may continue to receive services while waiting for Plan’s decision. The member may have to pay for the continued services if the final decision from the Medicaid Fair Hearing is against them.

If the Medicaid Fair Hearing Officer agrees with the member, Plan will pay for the services received while waiting for the decision.

If the Medicaid Fair Hearing decision agrees with the member and he/she did not continue to get the services while waiting for the decision, Plan will issue an authorization for the services to restart as soon as possible and Plan will pay for the services.

**OR**

The member may continue to receive services while waiting for Plan’s decision if all of the following apply:

- The appeal is filed within ten (10) days after the notice of the adverse action is mailed.
- The appeal is filed within ten (10) days after the intended effective date of the action.
- The appeal is related to reduction, suspension or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization has not ended.
- The member requested the services to continue.

The member’s services may continue until one (1) of the following happens:

- The member decides not to continue the appeal.
- Ten (10) days have passed from the date of the notice of resolution unless the member has requested a Medicaid Fair Hearing with continuation of services within those ten (10) days.
- The time covered by the authorization has ended or the limitations on the services are met.
- The Medicaid Fair Hearing office issues a hearing decision adverse to the member.
Chapter 4: Medical Management

Utilization Management (UM)
Utilization Management activities are designed to assist our providers with the organization and delivery of appropriate health care services to members within the structure of the member benefit plan.

Under their participating provider agreements with Prestige, providers are required to comply fully with medical management programs administered by Prestige and its agents, including:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Including Prestige’s medical management nurse in discharge planning discussions and meetings.
- Providing a plan of treatment, progress notes and other clinical documentation as required.

Providers can reach the UM department by calling 1-855-371-8074 during normal business hours Monday through Friday from 8:30am to 6:00pm (Eastern). After hours staff is available to assist with urgent or discharge needs at the same number after 6pm, on holidays, or weekends.

If a Prestige associate needs to reach out to a provider for information on a request, they will identify themselves by name, title, and plan they are calling from.

Members needing assistance with UM issues are referred to Member Services at 1-855-355-9800 (TTY/TDD 1-855-358-5856). Interpretation services are also available through Member Services, as needed.

Submitting an Authorization request:

- For Outpatient Services complete the Prior Authorization Request form and fax to 1-855-236-9285
- For IP Authorizations fax notification and clinical to 1-855-236-9286
- Call Prestige UM Department at 1-855-371-8074
- Online via our secure provider portal at www.availity.com
- DME/Home Health Requests – Contact Coastal Care Services

Medical Necessity Standards
Medically Necessary or Medical Necessity is defined as meeting the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs.
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational.
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide.
• Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Prestige uses McKesson InterQual and the American Society of Addiction Medicine (ASAM) Patient Placement Criteria as screening tools for UM determinations related to Medical Necessity. When applying UM Medical Necessity criteria, UM staff also considers the individual member factors and the characteristics of the local health delivery system, including:

- Member Considerations.
  - Age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment.
- Local Delivery System.
  - Availability of sub-acute care facilities or home care in the Prestige service area for post discharge support.
  - Prestige benefits for sub-acute care facilities or home care where needed.
  - Ability of local hospitals to provide all recommended services within the estimated length of stay.

Any decision to deny or reduce in amount, duration or scope a request for covered services will be made by clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice. In no instance will Prestige Health Choice impose limitation or exclusions more stringent than outlined within the AHCA Contract.

Providers can request a copy of the UM criteria used in any determination by contacting the UM Department at 1-855-371-8074.

Prestige does not reward health care providers for denying, limiting, or delaying benefits or health care services, give incentives to staff or providers for making decisions about medically necessary services, or give rewards to provide less health care coverage and services.

Prestige Health Choice has processes in place for the authorization of any medically necessary service to enrollees under the age of twenty-one (21), in accordance with Section 1905(a) of the Social Security Act, when:

- The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule, or is not a covered service of the plan; or
- The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.
Prior Authorizations

Prior authorization is the process of obtaining approval in advance of a planned inpatient admission or outpatient service Prestige Health Choice will make an authorization decision based on the clinical information provided in the request.

Prior authorization allows for efficient use of coordinated services and ensures that members receive the most appropriate level of care, within the most appropriate place of service. Prior authorization may be obtained by the member’s PCP, treating specialist or facility.

Reasons for requiring prior authorization may include:
- Review for medical necessity;
- Ensure services are coordinated with appropriate provider;
- Appropriateness of place of service; and/or
- Case and disease management considerations.

Prior authorization is processed through Prestige’s UM Department. The most up-to-date listing of services requiring prior authorization or notification will be maintained on the Prestige website at www.prestigehealthchoice.com. You may also request a listing by contacting Provider Services at 1-800-617-5727. Providers may request prior authorization by sending a fax request for authorization to 1-855-236-9285 or online via our secure provider portal at www.availity.com.

Prior authorization is not a guarantee of payment for the service authorized. Prestige Health Choice reserves the right to adjust any payment made following a review of the medical record and determination of the medical necessity of the services provided.

Services Requiring Prior Authorization or Notification

Prior authorization is required for select elective or non-emergency services as designated by Prestige. Certain services may also require notification even if authorization is not required. Guidelines for prior authorization and/or notification requirements by service type may be found in the Prior Authorization Reference Guide at www.prestigehealthchoice.com, under Provider resources.

Some prior authorization guidelines to note are:
- The prior authorization request should include the diagnosis to be treated and the CPT and HCPCS code describing the anticipated procedure or service. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not typically required. If an adjustment is needed following delivery of the service, please contact Utilization Management on the next business day at 1-855-371-8074.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

Emergency room admission and related services do not require prior authorization.

Coastal Care Services manages all of Prestige Health Choice's DME, home health, and home infusion services provided in the home with the exception of those listed below. When rendered in place of service 12 (home), these specific excluded services should be authorized by and billed to Prestige Health Choice:
• Communication boards.
• All contraceptive medications and supplies.
• Cranial helmets.
• All end-stage renal disease (ESRD) services rendered in the home.
• Implantable device supplies (examples include supplies related to cochlear implants, permanent birth control, and urogynecologic surgical mesh implants).
• Inhalation solution (solution/drug should be obtained through member's pharmacy benefit).
• OB/GYN home health services (provided by Optum Women and Children).
  o Please contact Optum directly by phone at 1-800-999-0025 or via fax at 1-678-355-4711 prior to providing these services.
• Orthotics/prosthetics.
• Vision, hearing, and speech pathology services (HCPCS codes in the "V" series).

All services not rendered in place of service 12 (home) should be billed to Prestige Health Choice.

Prior Authorization Specific to Pregnancy-Related Services
All OB care requires a Pregnancy Notification Form in order for proper and expedient payment to be made to OB providers. Once approved, this authorization includes three (3) OB ultrasounds, all regularly scheduled pre-natal visits, and four (4) post-delivery follow up appointments. In addition, for high risk pregnancies, unlimited ultrasounds are allowed if provided by network Maternal/Fetal Medicine specialists.
For the member, this authorization initiates Prestige Care Management follow up from a team who works closely with pregnant members.

The Pregnancy Notification Form is located at www.prestigehealthchoice.com and can be faxed to the Prestige Bright Start® Department at 1-855-358-5852 or submitted on-line via the secure provider portal at www.availity.com.

Exceptions to Prior Authorization
For a list of services that do not require prior authorization review, please refer to the Prior Authorization Reference Guide at www.prestigehealthchoice.com, under Provider Resources.

Standard Authorization Decisions
Prestige will:
• Provide notice as expeditiously as the member’s health condition requires.
• Provide notice within no more than seven (7) calendar days following receipt of the request for service.

The time frame can be extended up to four (4) additional calendar days if:
• The provider or the member requests an extension; or
• Prestige justifies the need for additional information and how the extension is in the member’s interest.

Expedited Authorization Decisions
Prestige will expedite authorization decisions when a provider indicates, or Prestige determines, that following the standard timeline could seriously jeopardize the member’s life, health or ability to attain, maintain, or regain maximum function. Expedited requests must include a physician’s order which indicates waiting for a decision under the standard time framed could endanger the member’s
life, health, or ability to regain maximum functionality, or would cause serious pain. Requests that do not meet this definition or that are incomplete will be moved to the standard authorization process and worked under the timeframes outlined above.

- An expedited decision must be made no later than two (2) calendar days after receipt of the request for service.
- Prestige may extend this time by an additional one (1) calendar day for expedited requests, if the member requests an extension or if Prestige justifies the need for additional information and how the extension is in the member’s interest.

**Authorization Request Forms**

Prestige Health Choice requests providers use our standardized request forms and include supporting clinical information to ensure a timely response to your request, all forms are located on the Prestige website, [www.prestigehealthchoice.com](http://www.prestigehealthchoice.com), under Provider Forms.

Incomplete forms will not be processed and will be returned to the requesting provider. If prior authorization is not granted, all associated claims will not be paid.

Providers must immediately notify Prestige of a member’s pregnancy. A Prenatal Notification Form should be completed by the OB/GYN or Primary Care provider during the first visit and faxed to Prestige as soon as possible after the initial visit. Notification of OB services enables Prestige to identify members for inclusion into the Healthy Behaviors Prenatal Program and for reporting pregnancies to DCF.

All forms should be submitted via fax to the number listed on the form. Providers may also request authorization, attach clinical information, and review the status of an existing authorization request by utilizing our secure portal at [www.availity.com](http://www.availity.com).

**Inpatient Concurrent Review and Discharge Planning**

Inpatient facilities must notify the UM department within one (1) business day after the date of admission. Concurrent review determinations will be made within 24 hours of receipt of a request for authorization with clinical information.

If medical necessity is established, an authorization will be issued to the facility for the days where medical necessity is met. In order to expedite our review, clinical information must be received with the request for authorization. Please note that a finding of lack of medical necessity for the inpatient stay or any part thereof will result in claims denials for both the facility and admitting provider.

Discharge planning activities are expected to be initiated upon admission. Prestige’s UM department will coordinate discharge planning efforts with the hospital’s discharge planners to ensure the member receives appropriate post discharge care. Coastal Care Services will assist in arranging post discharge needs related to home care, home infusion and most Durable Medical Equipment (DME); these services require prior authorization.

**For Authorization Request Denials Based on Lack of Medical Necessity**

If you receive an adverse benefit determination from Prestige, you have three (3) business days from the verbal or faxed notice of adverse determination to request a Peer-to-Peer discussion with a Prestige Medical Director. You may request a Peer-to-Peer discussion by contacting Prestige
Utilization Management at 1-855-371-8074. Be prepared to provide a convenient time to receive a call from the Prestige Medical Director.

If you still disagree with our decision after the Peer-to-Peer discussion, you have the right to file an appeal. If the adverse benefit determination was related to a pre-service authorization request you can file an appeal on behalf of the member. You may file the appeal on the member’s behalf within sixty (60) days of notification of the upheld denial decision. The appeal will require the member’s written consent. If the adverse benefit determination was related to a post-service authorization request you can file a provider appeal; please see the Provider Appeal Process.

**Second Medical Opinion**
A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team, a member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.
The second opinion must be provided at no cost to the member by a qualified health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

In accordance with Florida Statute 641.51, the member may elect to have a second opinion provided by a non-contracted provider located in the same geographical service area of Prestige. Prestige may require that any tests deemed necessary by a non-contracted provider be conducted by a participating Prestige provider.

Prestige’s provider’s professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization.

**Integrated Health Care Management**
Prestige Health Choice Integrated Health Care Management (IHCM) program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This means that Complex Case Management and Disease Management is a fully integrated model that allows members to move seamlessly from one component to another, depending on their unique needs.

Several services overlap all five components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and members with chronic conditions. There are five core components to our Integrated Care Management (ICM) program: Pediatric Preventive Health Care, Episodic Care Management, Bright Start (Maternity Management), Complex Care Management (CCM), and Rapid Response & Outreach Team. Each of these is summarized below.

**Pediatric Preventive Health Care**
The Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members under age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and
Treatment (EPSDT) program guidelines. We accomplish this by identifying and coordinating preventive services for these members.

**Episodic Care Management**
The Episodic Care Management (ECM) program coordinates services for members with short-term and/or intermittent needs who have single problem issues and/or co-morbidities. The Care Manager supports members in the resolution of pharmacy, DME and/or dental access issues, transportation needs, identification of and access to specialists, and coordination with behavioral health providers or other community resources. Care Managers perform comprehensive assessments, address short-term and long-term goals, and develop a plan of care with input from the member and the physician(s). The ECM team has RN Care Managers.

**Complex Case Management**
Members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments, and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member/caregiver and the physician(s). These programs include Diabetes, COPD, Asthma, Sickle Cell, Obesity, HIV/AIDS, Hepatitis C and Cardiovascular Disease and Cancer. The CCM process includes performing an initial assessment, reassessing and adjusting the care plan and its goals as needed. Care Managers coordinate care and address various issues including but not limited to: pharmacy, DME and/or dental access, assistance with transportation, identification of and access to specialists and coordination with behavioral health providers or other community resources. The Complex Care Management team contains both nurse and social worker Care Managers. Using Motivational Interviewing Skills, the Care Managers develop a rapport with engaging members in care management programs for a timeframe based on their individual needs.

PCP’s should coordinate case management services including, but not limited to, performing screening and assessment, developing a plan of care to address risks and medical needs and basic behavioral health services such as screening, prevention, early intervention, and medication management.

Prestige Health Plans Integrated Health Care Management include Special Needs and Care Management Programs that contact members with the following chronic conditions, including but not limited to:
- Asthma
- Diabetes
- COPD
- Heart Failure
- Cancer

**Bright Start Program for Pregnant Members**
Prestige Health Choice has developed a comprehensive prenatal risk reduction program in an effort to decrease poor obstetrical outcomes of our pregnant population, which were evidenced by the following:
• High percentage of low birth-weight infants
• High NICU length of stay
• Infant readmission rates
• Rising preterm births
• Increased incidents of maternal complication requiring extended hospitalizations

The goals of the Bright Start Program are:
• Early identification of pregnant members
• Early and continued intervention throughout pregnancy
• Education and follow-up to promote recommended infant care
• Introduction and Education on Interpregnancy Care

Prestige Health Choice utilizes several means to identify members as early in their pregnancy as possible. These include but are not limited to SMMC State Files, claim data analysis, information from the initial health assessment, referrals from internal departments, the use of member newsletters and referral networks, and physician referrals. Members who agree to participate in the Bright Start Program are paired with a Prestige Health Choice Bright Start Care Manager. The Bright Start Care Manager works closely with the member, assuring that she has the means necessary to receive prenatal care and instruction and respond to various social and medical needs. Bright Start Care Managers offer the following types of special services to our Bright Start members:
• Motivational Interviewing
• Health Coaching
• Counseling
• Health Education
• Connection to social support services

Bright Start separates pregnant members into low and high intensity risk categories:
• Low Risk Pregnancy Management - Members receive Care Coordination from Care Connectors, pregnancy-related educational materials encouraging good prenatal care and regular outreach calls
• High Risk Pregnancy Management - Pregnant members identified at risk for preterm labor and/or other pregnancy complications are assigned a Nurse Care Manager to provide ongoing supervision and education concerning pregnancy. A letter is sent to the member's physician to notify him/her of the member's enrollment in the program with a summary of the initial assessment
• Prior Authorization is required for Makena and/or Progesterone administration, In Home Services are offered for in home administration. This service also includes an obstetrical registered nurse to perform an in home assessment, pre-term labor education and progesterone injection on a weekly basis.

All pregnant members have access to a 24-hour toll free registered nurse call line at 1-855-398-5615 for the Nurse Line needed. All pregnant members are encouraged to select a pediatrician prior to delivery. For more information or to refer members to the Bright Start
Program call 1-855-371-8076.

**Rapid Response and Outreach Team**

An important component of the ICM model, the Rapid Response & Outreach Team (RROT) was developed to address the urgent needs of our members and to support our providers and their staff. The RROT team consists of registered nurses and non-clinical Care Connectors.

There are three key service functions performed in the Rapid Response unit:

- **Inbound Call Service** – Members and providers may request RROT support via a direct toll-free Rapid Response line. Providers can call the Rapid Response team for assistance coordinating care for members in their office; to request assistance for members who need community resources or to refer a member for any care management service.

- **Outreach Service** – Outreach activities include telephonic survey such as the Health Risk Assessment completion and support of special projects or quality initiatives including those related to Healthcare Effectiveness Data and Information Set (HEDIS) and EPSDT/well child campaigns. RROT employees also initiate calls to chronically ill members currently hospitalized and follow-up calls to members recently discharged from the hospital under the Transition of Care program to ensure smooth transition between settings and continuity of care. They also follow up on members who contacted the 24- hour Nurse Call Line (NCL) the previous day.

- **Care Management Support** – Care Connectors support Care Managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and reminders, transportation and interpreter support, member educational mailings, and other administrative tasks assigned by Care Managers.

Several services overlap all five core components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and members with chronic conditions.

**Let Us Know** is a program designed to partner Prestige Health Choice with the provider community by collaborating in the engagement and management of our chronically ill members. We have support teams and tools available to assist in the identification, outreach, and education of these members, as well as clinical resources providers in their care management.

There are three ways to let us know about chronically ill members:

1. **Contact our Rapid Response and Outreach Team:** The Rapid Response and Outreach Team address the urgent needs of our members and supports providers and their staff. The RROT consists of Registered Nurses and Care Connectors who are trained to assist members in investigating and overcoming the barriers to achieving their health care goals. They are here to support you, call them at 1-855-371-8072 from 8:00 a.m. until 5: 00 p.m. Monday-Friday. After hours, weekends and holiday coverage by our 24 hour/NCL.

2. **FAX a Member Intervention Request form to 1-855-236-9281. This form can be found at www.prestigehealthchoice.com.**

3. **Refer a patient to the Complex Case Management Program:** Complex Case Management is a voluntary program focused on prevention, education, lifestyle choices and adherence to treatment plan and is designed to support your plan of care for patients with chronic diseases, such as asthma, diabetes, or coronary artery disease. Members receive educational materials
and, if identified as high risk, will be assigned to a Care Manager for one-on-one education and follow up. For more information, or to refer a patient to the Complex Case Management program, call 1-855-371-8072.
Chapter 5: Benefits

Routine Services
Prestige Health Choice provides coverage for the following routine services:

- **Primary care visits** – Prestige Health Choice provides coverage for unlimited primary care visits
- **Child Health Check-Up (CHCUP)** – Please refer to the Child Health Check-Up section below for additional information
- **Cancer screenings**
  - Breast cancer
  - Cervical cancer
  - Colon cancer
- **Family planning services and supplies**
- **Fluoride varnish** – Prestige Health Choice provides coverage for the application of fluoride varnish by a physician for members aged 0 to 4
- **Immunizations** – Please refer to the Immunizations section below for additional information

Immunizations
Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer immunizations in accordance with the Recommended Childhood Immunization Schedule for age birth through eighteen (18) years for the United States, or when medically necessary for the member’s health.
- All vaccines for which a member is eligible at the time of each visit should be administered simultaneously.
- Providers are required to participate in the Vaccines for Children Program (VFC).
- PCPs are encouraged to provide immunization information about members requesting Temporary Cash Assistance program (TCA) from DCF, upon request by DCF and receipt of the member’s written permission. This information is necessary in order to document that the member has met the immunization requirements for members receiving temporary cash assistance.

Prestige has adopted the recommended immunization schedules for age birth up to twenty-one (21) years for immunization for children and adults that is published by the Advisory Committee on Immunization Practices (ACIP) from the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP).

Immunization Schedules (Childhood, Adolescent and Adult)
For the recommended vaccines and immunization schedules, please visit
Visit [www.uspreventiveservicestaskforce.org/uspstopics.htm](http://www.uspreventiveservicestaskforce.org/uspstopics.htm) for the Guide to Clinical Preventive Services for recommendations made by the U.S. Preventive Services Task Force (USPSTF) for clinical preventive services.

**Vaccines for Children Program (VFC)**
The Vaccines for Children Program (VFC) is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to pay. The CDC buys vaccines at a discount and distributes them to grantees, e.g., state health departments and certain local and territorial public health agencies, that then distribute them at no charge to those private providers' offices and public health clinics registered as VFC providers. Children who are eligible for VFC vaccines are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices. For more information visit [www.cdc.gov/vaccines/programs/vfc/index.html](http://www.cdc.gov/vaccines/programs/vfc/index.html).

- Florida Medicaid requires vaccines for Medicaid children from birth through eighteen (18) years of age. Providers for Medicaid members must use his/her Vaccines for Children Program (VFC) supply and bill Prestige for the administrative fee only. The VFC program covers children from birth through eighteen (18) years of age.
- MediKids are not covered under the VFC program.
- Members nineteen (19) through twenty-one (21) years of age should receive their vaccinations from their PCP. Prestige will provide reimbursement for these members to the participating provider for immunizations covered by Medicaid but not provided through VFC.
- Providers are expected to plan for a sufficient supply of vaccines.
- Prestige will pay the immunization administration fee for continuation of care services at no less than the Medicaid rate from non-participating providers as follows:
  - The non-participating provider contacts Prestige at the time of service delivery; and
  - The non-participating provider submits a claim for the administration of immunization services and provides medical records documenting the immunization to Prestige.

**Medicaid Well Child Visits - Child Health Check-Up Program (CHCUP)**
The State of Florida’s CHCUP is a program for Medicaid members under the age of twenty-one (21). Prestige coverage includes CHCUP, and participating providers are required to adhere to the following CHCUP service standards:

- Conduct a comprehensive health screening evaluation that includes a past medical history, developmental history and behavioral assessment. The screening evaluation should also include:
  - A nutritional assessment
  - Comprehensive unclothed physical exams
  - Developmental assessment
  - Growth measurements
  - Appropriate immunizations based on the Recommended Childhood Immunization Schedule for the United States
Laboratory testing (including blood lead testing as outlined below)
Health education (including anticipatory guidance)
Dental screening (including a direct referral to a dentist for members beginning at age three (3) or earlier as indicated)
Vision screening (including objective testing as required)
Hearing screening (including objective testing as required)
Diagnosis and treatment
Referral and follow-up as appropriate
Blood lead testing:
- All providers are required to screen all enrolled children for lead poisoning at the age of twelve (12) months and twenty-four (24) months.
- Children between the ages of twelve (12) months and seventy-two (72) months must receive a screening blood lead test if there is no record of a previous test.
- Prestige will provide additional diagnostic and treatment services determined to be medically necessary to a child/adolescent diagnosed with an elevated blood lead level.
- If children or adolescents are identified as having abnormal levels of lead through blood lead screenings, Prestige will provide case management follow-up services.

- Providers are required to inform members when tests or screenings are due based on the periodicity schedule in the CHCUP Handbook.
- Prestige does not require authorization for a member to be seen by a participating specialist when determined that it is needed by the PCP.
- PCP is to refer to the appropriate provider within four (4) weeks of these examinations for further assessment and treatment of conditions found during the initial examination.
- Providers are expected to cooperate with Prestige to accommodate new member appointments within 30 days of the member’s enrollment with Prestige.
- Provide assistance with scheduling for members to ensure they keep medical appointments.
- Provide or coordinate other important health care diagnostic services and treatment including necessary referrals as they relate to physical and mental illnesses and/or conditions discovered through screening services in accordance with EPSDT contractual requirements.

**CHCUP Schedule for Exams**
- Birth or neonatal examination;
- 3-5 days for newborns discharged in less than 48 hours after delivery;
- By 1 month, and at 2, 4, 6, 9, 12, 15, 18 months, 24 months and 30 months; and
- Once per year for 3-year-olds through 20-year-olds.

Urgent and Emergency Services

Prestige is available for emergency services and care inquiries twenty-four hours a day, seven days a week (24/7) for members and caregivers. You may contact our 24-Hour Nurse Call Line at 1-855-398-5615.

Prestige does not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, Prestige does not deny payment for treatment obtained when a representative of Prestige instructs the member to seek emergency services and care in accordance with s. 743.064, F.S. Prestige provides emergency services and care without any specified dollar limitations.

Emergency services and care under Prestige will not:

- Require prior authorization for a member to receive pre-hospital transport or treatment for emergency services or care.
- Specify or imply that emergency services and care are covered by Prestige only if secured within a certain period of time.
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.
- Deny payment based on a failure by the member or the hospital to notify Prestige before, or within a certain period of time after, emergency services and care were given.

Prestige covers pre-hospital and hospital-based trauma services and emergency services and care to members. When a member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists is to be made, for the purposes of treatment, by a provider of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital provider.

- The provider or the appropriate personnel must indicate on the member's chart the results of all screenings, examinations and evaluations.
- Prestige covers all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member's condition is an emergency medical condition.
- If the provider determines that an emergency medical condition does not exist, Prestige is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.

If the provider determines that an emergency medical condition exists, and the member notifies the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a member of the Plan, the hospital must make a reasonable attempt to notify:

- The member's PCP, if known; or
- Prestige, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, do not know the member's PCP, or have been unable to contact the PCP, the hospital must:
• Notify Prestige as soon as possible before discharging the member from the emergency care area; or
• Notify Prestige within twenty-four (24) hours or on the next business day after the member’s inpatient admission.

Prestige will cover any medically necessary duration of stay in a non-contracted facility which results from a medical emergency until such time as Prestige can arrange to safely transport the member to a participating facility. Prestige may transfer the member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the member's emergency medical condition.

Notwithstanding any other state law, a hospital may request and collect from a member any insurance or financial information necessary to determine if the patient is a member of Prestige, in accordance with federal law, so long as emergency services and care are not delayed by the process.

**Prestige Expanded Benefits**

Expanded Benefits are Agency approved services that are additional benefits specified in the AHCA Contract. These expanded benefits may be subject to medical necessity and prior authorization.

The following expanded benefits are available to Prestige members:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>A treatment that is used to treat your pain.</td>
<td>Annual maximum of 12 visits for members with acute and chronic pain.</td>
<td>No</td>
</tr>
<tr>
<td>Adult Hearing Services</td>
<td>Adult hearing services including hearing aids.</td>
<td>1 hearing aid and evaluation every 2 years.</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Vision Services</td>
<td>Adult vision services including eye glasses and contact lens.</td>
<td>1 eye exam per year; 6 month supply contact lens with prescription; 1 set of eye glasses per year.</td>
<td>Yes, if done by a private practitioner. No if done at a Community Mental Health Center</td>
</tr>
<tr>
<td>Assessment Services</td>
<td>In-depth assessment for substance use issues.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Psychological testing to identify behavioral health problems.</td>
<td>Unlimited</td>
<td>Yes, if done by a private practitioner. No if done at a Community Mental Health Center</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Daytime</td>
<td>Unlimited; must be active in</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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</tr>
<tr>
<td>Health Day Services/Day Treatment</td>
<td>treatment for behavioral health needs about everyday living.</td>
<td>You may have to pay for the services if you go to a provider that is not in the Prestige network</td>
<td></td>
</tr>
<tr>
<td>Day care services, adult.</td>
<td></td>
<td>case management.</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Screening Services</td>
<td>Assessments and screening services for mental health and substance abuse issues.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Verbal Interaction)</td>
<td>Talking with a medical professional about your mental health and/or substance abuse needs.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Medication Management)</td>
<td>Services with a medical professional who can treat mental health and substance abuse issues with medication.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Drug Screening)</td>
<td>Alcohol and other drug screening with urine samples.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Cellular Phone Service</td>
<td>This benefit can help you stay in touch with Prestige or your medical providers so that you can stay healthy.</td>
<td>1 cellphone; 350 minutes; unlimited text messages; 1 GB. Unlimited calls to Prestige.</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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</tr>
<tr>
<td>Chiropractic</td>
<td>Services and treatment provided by a chiropractic provider.</td>
<td>24 additional visits for a total of 48 visits per year.</td>
<td>No</td>
</tr>
<tr>
<td>Computerized Cognitive Behavioral Analysis</td>
<td>Health and behavior services, including assessments and therapy with a group, your family, or one-to-one sessions with a mental health professional while you have a physical illness.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Doula Services</td>
<td>Pregnancy services done by providers who are trained in childbirth and give support and education to pregnant members.</td>
<td>Unlimited visits for pregnant members.</td>
<td>No, but requires a referral from plan’s Bright Start maternity program</td>
</tr>
<tr>
<td>Home Delivered Meals for High Risk Pregnant Members</td>
<td>You can have meals delivered to you at home if your doctor believes you are a high risk pregnant mom.</td>
<td>Provide up to 2 meals per day for 30 days; limited to high risk pregnant members who meet Plan guidelines for medical necessity.</td>
<td>Yes – needs case management referral</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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</tr>
<tr>
<td>Home Delivered Meals – Post-Discharge</td>
<td>You can have meals delivered to your home after leaving a medical facility.</td>
<td>Up to 2 meals per day for up to 7 days for enrollees that have been recently discharged from the hospital with specific medical conditions. Extension of services may be granted with Medical Director approval.</td>
<td>No – will require case management referral</td>
</tr>
<tr>
<td>Home Health Nursing/Aide Services</td>
<td>Services that can help you with activities of daily living like bathing, getting dressed and eating.</td>
<td>Provide up to 48 visits per pregnancy for home health aide; limited to high risk pregnant members who meet plan guidelines for medical necessity; requires a physician order.</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Visit by a Clinical Social Worker</td>
<td>Services to provide support and education that will help to improve the quality of life for high risk pregnant moms.</td>
<td>Limited to 24 visits per year for high risk pregnant members; requires physician order.</td>
<td>Yes – needs case management referral</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>Provide help to high risk pregnant members in finding community resources to help with housing.</td>
<td>Provide assistance with locating community resources that support housing options and alternatives for all members; provide up to $500 per lifetime max for transitional housing alternatives; financial assistance is limited to high risk pregnant members who are homeless.</td>
<td>Yes – needs case management referral</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>Outpatient treatment services in a program for substance abuse that meets three</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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<tr>
<td>Massage Therapy</td>
<td>Therapy that is used for the treatment of pain. Commonly, massage is applied with a therapist’s hands and fingers.</td>
<td>You may have to pay for the services if you go to a provider that is not in the Prestige network</td>
<td>Prior authorization required for physical therapist. No prior authorization for chiropractor.</td>
</tr>
<tr>
<td>Meals - Non-emergency Transportaion Day-Trips</td>
<td>Provides you reimbursement for the cost of meals when you have to travel away from home for a medical appointment.</td>
<td>Annual maximum of 12 visits for medical massage provided by a participating physical therapy or chiropractic provider.</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Medical supplies are items meant for one-time use and then thrown away.</td>
<td>You may have to pay for the services if you go to a provider that is not in the Prestige network</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Incontinence products.</td>
<td>Limited to $50 per day with annual maximum of $250.</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Care Services</td>
<td>1 carpet cleaning service that will help adults keep their asthma under control.</td>
<td>Some service limits apply. Call Coastal Care Services at 1-855-481-0505 for more information.</td>
<td>Yes – needs case management referral</td>
</tr>
<tr>
<td>Medication Assisted Treatment</td>
<td>A licensed program gives medication to lessen the withdrawal symptoms from drugs or alcohol, along with supportive</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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<tr>
<td>Newborn Circumcision</td>
<td>An elective surgery for your baby boy.</td>
<td>Available during initial hospital stay and in physician’s office for 90 days after birth.</td>
<td>Yes, only if older than 90 days</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Provides you with information about what foods are good for you and your health condition. These services can also help you with food shopping and ways to prepare these foods at home.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Adult occupational therapy services.</td>
<td>1 initial evaluation and re-evaluation per year; up to 7 therapy treatment units per week.</td>
<td>Yes – only for treatments. Not needed for evaluation.</td>
</tr>
<tr>
<td>Over-The-Counter Medication/Supplies</td>
<td>Provides you with a benefit to get health supplies and items such as aspirin, vitamins, first aid items, and cough medicine.</td>
<td>$25 per household per month; purchases limited to approved number of products.</td>
<td>No</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Adult physical therapy services.</td>
<td>1 evaluation and re-evaluation visit per year; up to 7 therapy treatments per week.</td>
<td>Yes, for treatments only. Not needed for evaluation.</td>
</tr>
<tr>
<td>Prenatal/Perinatal Visits</td>
<td>Pregnancy visits before and after giving birth and breast pump.</td>
<td>Limited to 14 visits for low-risk pregnancies, and 18 visits for high-risk pregnancies.</td>
<td>Yes. For authorization for hospital grade breast pumps provided in your home, please contact Coastal Care Services at 1-855-481-0505</td>
</tr>
<tr>
<td>Primary Care Visits (Non-Pregnant)</td>
<td>Visits with your PCP.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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<tr>
<td>Adults)</td>
<td></td>
<td>You may have to pay for the services if you go to a provider that is not in the Prestige network</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Adult respiratory therapy services.</td>
<td>1 evaluation and re-evaluation per year; respiratory therapy visits 1 per day.</td>
<td>No</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Adult speech therapy services.</td>
<td>1 initial evaluation and one reevaluation visit per year, up to 7 visits per week.</td>
<td>Yes, only for visits. Not needed for evaluation or reevaluation</td>
</tr>
<tr>
<td>Swimming Lessons (drowning prevention)</td>
<td>Provides swimming and water safety lessons for children to keep them safe around water.</td>
<td>Each April, there will be an open enrollment for up to 1,000 children. Open enrollment period will be documented in member handbook, plan website and promotional mailing. Up to $200 per child will be paid at a plan approved agency and/or certified instructor.</td>
<td>Yes, will require case management referral.</td>
</tr>
<tr>
<td>Therapy – Art</td>
<td>Art uses creative activities, such as drawing and painting as part of your treatment.</td>
<td>Up to 7 sessions per year on outpatient basis.</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy -- Equine</td>
<td>Uses horseback riding with a behavioral health professional as part of your treatment.</td>
<td>Up to 3 sessions per year for enrollees with a substance use disorder or chronic condition under care management, on an outpatient basis.</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy (group)</td>
<td>Therapy for a group of people with a mental health professional.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
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</tr>
<tr>
<td>Therapy (individual/family)</td>
<td>Training and educational services about how to care for the member’s disabling mental health problems.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Therapy – Pet</td>
<td>Uses volunteers and their pets to help you with your treatment or therapy.</td>
<td>Up to 3 sessions per year for members under care management for a chronic condition; inpatient care only while member is in an acute care hospital for treatment.</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapeutic Behavioral On-Site Services</td>
<td>Services provided by a team to support behavioral health issues and keep you from being placed in a hospital or other facility.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>Help with getting health care and behavioral health services.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine -- TDaP</td>
<td>A vaccine to help keep pregnant moms healthy during their pregnancy.</td>
<td>One (1) vaccine per pregnancy.</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine – Influenza</td>
<td>A vaccine to help reduce the chance of you getting the flu.</td>
<td>One (1) vaccine per year, per enrollee.</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine -- Shingles (Varicella – Zoster)</td>
<td>A vaccine to help reduce the chance of you getting shingles.</td>
<td>Adult enrollees who have had chickenpox and as medically advised.</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
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</tr>
<tr>
<td>Vaccine - Pneumonia (pneumococcal)</td>
<td>A vaccine to help reduce the chance of you getting pneumonia.</td>
<td>Two (2) vaccines for all adults aged 65 and older and enrollees ages 21 - 64 with specific medical conditions in accordance with current CDC Immunization Schedule; vaccines must be given at least one (1) year apart.</td>
<td>No</td>
</tr>
<tr>
<td>Waived Copayments</td>
<td>You will not have any copayments on any of your health plan services.</td>
<td>All services that have a copayment requirement in accordance with Rule 59G-1.056, FAC.</td>
<td>No</td>
</tr>
</tbody>
</table>

**In Lieu of Services**
The following in lieu of services are available to Prestige members:

PLACEHOLDER – will be completed upon final approval from the Agency
Chapter 6: Credentialing

Credentialing Requirements
Prestige Health Choice operates in compliance with the standards set forth by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Healthcare (AAAHC), Florida’s Agency for Health Care Administration (AHCA) and federal and state regulations. Our credentialing standards mandate that we credential providers before they join the Prestige Health Choice provider network and prior to offering healthcare services to Prestige Health Choice members, and no later than 36 months thereafter.

Per Florida requirements, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time services are rendered. Any entity that bills Medicaid for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider. This includes solo practitioners practicing under a corporation.

Any provider and/or billing entity with a Medicaid other than Limited or Fully Enrolled agreement with the Agency may be subject to additional credentialing requirements such as Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106); and level II background check pursuant to s. 409.907, F.S.

To enroll in Medicaid visit: https://portal.flmmsis.com/Flpublic/Provider_ProviderServices/Provider_Enrollment/Provider_EnrollmentApplication/tabid/67/desktopdefault/+/Default.aspx

If the provider is currently suspended or terminated from the Florida Medicaid number whether by contract or sanction, other than for purposes of inactivity, that provider is not considered eligible to participate as a Medicaid provider.

Criteria and verification methodology used by Prestige Health Choice is designed to credential and re-credential in a non-discriminatory manner, with no attention to the practitioners’ race, creed, religion, ethnicity, national origin, gender, age, disability, sexual orientation, political affiliation or beliefs, or specialty and procedures performed.

To initiate credentialing or re-credentialing, the process starts with one of the options below:

Practitioners:

Council for Affordable Healthcare (CAQH) providers:
- If you participate with CAQH, you will need to grant Prestige Health Choice access to your application. Please make sure the information on your application is current.
- In addition to the CAQH application, AHCA requires health plans to collect additional information included in the Prestige Health Choice supplemental form for CAQH applicants.
To request the supplemental application, please contact us by e-mail credentialingsupport@prestigehealthchoice.com or fax to 1-866-930-4632.

Non-CAQH providers:
- If you do not participate with CAQH, you must register by calling the CAQH Provider help desk at 1-888-599-1771 or at https://proview.caqh.org/. Once you have registered with CAQH, you will need to grant Prestige Health Choice access to your application.

Your CAQH application must be current at the time of credentialing and have these documents:
- Medical License.
- Copy of Drug Enforcement Administration (DEA) license (when applicable).
- Professional liability insurance or proof of meeting other state requirements.
- Clinical Laboratory Improvement Amendments (CLIA) number (when applicable).
- A current group W9 form (not older than 12 months).
- Practitioner and Group NPI is correct and active.
- At least five years of employment history is included with month and year, as well as an explanation for any gaps of employment six months or greater.
- For any question answer “YES” on section #8 of the CAQH application, include a written explanation of the event indicated. This explanation should include dates, description of events, outcomes and any settlements or payments made by the provider or on his/her behalf.
- A site visit is required for all practitioners. Credentialing cannot start until a site visit is conducted. Contact your account executive to schedule a site visit evaluation.

Organizational providers: i.e., facility/ancillary providers:
- Complete an Prestige Health Choice application
- Any answers marked “Yes” on the Disclosure Questionnaire of the application must be accompanied by a written description of the event indicated. This explanation should include dates, description of events, outcomes, and any settlements or payments made by the provider or on its behalf.

Your application must be sent with a copy of these documents:
- Current copy of state license for each address (when applicable).
- Copy of certificate of accreditation (when applicable).
- Copy of Clinical Laboratory Improvement Amendments (CLIA) license (when applicable).
- Copy of Drug Enforcement Administration (DEA) license (when applicable).
- A current W9 form (not older than 12 months).
- Current copy of the general and malpractice liability insurance. This document must indicate the current facility name and address.
- Any ancillary/facility that does not have an accreditation or Medicare certified or has an AHCA certificate needs to schedule a site inspection evaluation conducted by a Prestige Health Choice Network account executive.

Credentialing Committee
The Prestige Health Choice Credentialing Committee uses a peer review process to evaluate practitioner and organizational provider applications, and credentials to determine appropriateness for participation in the Prestige Health Choice network. The Committee includes representation
from a range of participating practitioners representing primary care providers, specialists, and allied health practitioners in Prestige Health Choice’s network.

The Credentialing Committee may make one of the following determinations:

- Credentialing application approved, with or without restriction
- Credentialing application denied may include, but not be limited to:
  - Limited or loss of license;
  - Change in Medicaid status;
  - Loss of sufficient liability coverage;
  - Fraud or felony investigation; and/or
  - Adverse information related to quality of care or service concerns.

Notification of the Credentialing Committee’s decision is sent to the provider within sixty (60) calendar days of the decision. In the case of a denial or terminations, the notification is sent within the timeframe required by contract, state regulation or accreditation body.

**Re-credentialing**

Prestige Health Choice network providers are re-credentialed every 36 months. The Credentialing Department will start the re-credentialing processes prior to the provider’s re-credentialing due date. Re-credentialing requirements are the same as during the initial credentialing as noted above. Verification of network provider’s education, training and work history are not required elements for collection at the time of re-credentialing.

A new site inspection evaluation conducted by a Prestige Health Choice Network Account Executive will be required for any ancillary/facility that does not have an accreditation or is not Medicare certified or does not have an AHCA certificate. Re-credentialing cannot start until the site inspection evaluation is conducted. Contact your account executive to schedule a site inspection. For all other providers, Prestige Health Choice may repeat the site visit as deemed necessary.

If Prestige Health Choice cannot re-credential a provider within the 36-month time frame due to active military assignment, maternity leave or a sabbatical, but the contract between Prestige Health Choice and the provider remains in place, we may re-credential the provider upon his or her return. The provider must provide documentation for the reason(s) of the delay.

**Right to Review and Correct Information**

The provider has the following rights:

- The right to review information submitted to support their credentialing application. This includes any information submitted by the Provider or any outside information obtained through primary source verification, with the exception of references, recommendations, or other peer-review protected information.
- The right to correct erroneous information.
- The right, upon request, to be informed of the status of their credentialing or re-credentialing application.

**Right to appeal adverse credentialing determinations**

If a provider or organizational provider’s application is terminated from participation during the re-credentialing process, the practitioner or organizational provider may appeal or dispute the
termination. Denial of participation into the Prestige Health Choice network during initial credentialing does not have appeal rights.

In the case Prestige Health Choice denies or terminates a provider’s during credentialing or re-credentialing, a notification will be sent to the provider within the timeframe required by contract, state regulation or accreditation body. The notification will include the reason for the decision, notification of the right to appeal the action (when applicable, i.e. re-credentialing), and, time frames regarding response for a request to appeal the decision.
Chapter 7: Provider Responsibilities

In accordance with Attachment B, Section IX.G.1.a-f, and Exhibit B-1, Section IX.G.1.a-c of the AHCA Contract, s. 641.55, Florida Statutes, and s. 59A-12.012, Florida Administrative Code, providers and subcontractors are required to report adverse incidents or injuries affecting enrollees to Prestige immediately upon the incident occurrence, and no later than forty-eight (48) hours of detection or notification.

Prestige Health Choice subcontractors are also required to complete an Adverse Incident Summary Report for the previous month’s incidents, involving Prestige Health Choice enrollees. The report shall be submitted to the Prestige Risk Management by the 5th of each month.

Primary Care Providers (PCP)

A Primary Care Provider is a Managed Care Plan staff or participating provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

The Primary Care Provider (PCP) is the foundation of Prestige Health Choice. The PCP serves as the “medical home” for the member. The member is allowed to change their PCP as frequently as desired. The “medical home” concept assists in establishing a member provider relationship, supports continuity of care (COC), leads to elimination of redundant services and ultimately more cost effective care and better health outcomes.

Prestige Health Choice’s Patient-Centered Medical Home (PCMH) is built upon the joint principles of the Patient-Centered Medical Home which includes the following characteristics: a personal physician in a physician directed medical practice, whole person orientation; coordinated and/or integrated care assessing physical and behavioral health and taking into account members’ socioeconomic conditions and cultural norms; quality and safety; enhanced access; and payment. Prestige Health Choice accepts PCMH recognition from Association for Ambulatory Health Care (AAAHC). If a practice is interested in becoming a PCMH they can contact Provider Services at 1-800-617-5727.

Covered PCP Services

The PCP is required to adhere to the responsibilities outlined as follows:

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and/or initiating referrals for specialty care (both in and out of network), maintaining continuity of each member’s healthcare and maintaining the member’s Medical Record, including documentation of all services provided by the PCP, any specialty services, and screening for behavioral health or substance abuse conditions. The PCP shall arrange for other participating physicians to provide members with covered physician services as stipulated in their contract, and communicate with those treating providers. Each participating PCP provides all covered physician services in accordance with generally accepted clinical, legal, and ethical standards in a manner consistent with practitioner licensure, qualifications, training, and experience. These standards of practice for quality care are generally recognized within the medical community in which the PCP practices.

Covered services include:
• Professional medical services, both inpatient and outpatient, provided by the PCP, nurses, and other personnel employed by the PCP. These services include the administration of immunizations, but not the cost of biologicals.
• Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with AHCA’s, Prestige Health Choice’s preventive guidelines, and other nationally recognized standards recommended for the age and sex of the covered person).
• Vision screening, hearing screenings, and dental assessment (as part of CHCUP visit).
• High cost specialty/injectable drugs, as listed on the prior-authorization list, require a prior authorization and must be obtained from Prestige Health to ensure payment. Please call the Prestige Health Choice Pharmacy Department at 1-855-371-3963 to obtain more detailed information on these drugs.
• All tests routinely performed in the PCP’s office during an office visit.
• The collection of laboratory specimens.
• Voluntary family planning services such as examinations, counseling, and pregnancy testing.
• Well-child care and periodic health appraisal examinations, including all routine tests performed customarily in a PCP’s office. Well-child exams performed according to the EPSDT periodicity schedule, Prestige Health Choice’s preventive guidelines, and recommendations of the American Academy of Pediatrics (AAP), and immunizations according to the Advisory Committee on Immunization Practices (ACIP) guidelines, and in keeping with procedures outlined in this Provider Manual.
• Referral to specialty care physicians and other health providers with coordination of care, follow-up after referral.
• Oversight of a member’s entire drug regimen, including those prescribed by another provider, inclusive of behavioral health providers.
• PCP’s supervision of home care/home infusion regimens involving ancillary health professionals provided by licensed nursing agencies.
• Any other outpatient services and routine office supplies normally within the scope of the PCP’s practice.
• A treatment plan developed collaboratively with member, member’s parent or legal guardian, or other member authorized person and other treating specialists, as appropriate. This includes members seen for routine care or monitoring and those who need an extended or complex course of treatment.
• Health Risk Assessments will include screening for tobacco use, proving cessation counseling, BMI, nutrition, exercise or other lifestyle risks. In addition, anticipatory guidance based on age of member – normal growth and development, seat belt use, drug or alcohol use.
• Assessments for gaps in preventive health screenings or visits along with the evidence based treatment of chronic conditions.
• Identification and referral of members who may benefit from Prestige Health Choice case management, health management, or lifestyle coaching programs.
• Provider shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE). Provider warrants and represents that staff mandated to report abuse, neglect and exploitation have received appropriate
training in reporting abuse, neglect and exploitation. Provider agrees to participate in any other training as mandated by regulatory authorities and/or Health Plan.

PCP Availability
Availability is defined as the extent to which Prestige Health Choice contracts with the appropriate type and number of PCPs necessary to meet the needs of its members within defined geographical areas. Prestige Health Choice has implemented several processes to monitor its network for sufficient types and distribution of PCPs.

PCP availability is analyzed annually by Prestige Health Choice. Prestige Health Choice computes the percentage of PCPs with panels open for new members versus those PCPs accepting only members who are already existing patients in their practice. The Member Services Department analyzes member surveys and member complaint data to address AHCA and federal requirements regarding the cultural, ethnic, racial, and linguistic needs of the membership. The Quality Improvement Department tracks and trends member and provider complaints quarterly and monitors other data (such as appointment availability audits, after hours use of the member hotline and member and provider satisfaction surveys) that may indicate the need to increase network capacity. Practice specific data is shared with the Credentialing Committee bi-annually as part of ongoing monitoring.

Summary information is reported to the Quality Improvement Committee for review and recommendation and is incorporated into Prestige Health Choice’s annual assessment of quality improvement activities. The Quality Improvement Committee will review the information for opportunities for improvement.

PCP Accessibility
Accessibility is the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. Prestige Health Choice monitors access to services by performing access audits, tracking applicable results of the Consumer Assessment of Healthcare Provider Systems Survey (CAHPS), analyzing member complaints regarding access, and reviewing telephone access.

24-Hour Access
Each PCP is responsible to maintain sufficient facilities and personnel to provide covered physician services and shall ensure that such services are available as needed 24 hours a day, 365 days a year. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means. The chosen method of 24 hour coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after hour coverage must be accessible using the medical office’s daytime telephone number. The PCP or covering medical professional must return the call within 30 minutes of the initial contact.
Prestige Health Choice will monitor physicians’ offices through phone calls and scheduled and unscheduled visits.

**PCP Coverage**
The PCP shall arrange for coverage with a physician who has executed a PCP Services Agreement with Prestige Health Choice. If the participating physician is capitated for primary care services, compensation for the covering physician is considered to be included in the capitation payment. If the participating physician is paid a fee-for-service by Prestige Health Choice, the covering physician is compensated in accordance with the contracted fee schedule.

Prestige PCPs must provide, or arrange for coverage of services, consultation or approval for referrals twenty-four hours a day, seven days a week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage will consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office’s daytime phone number.

The PCP is responsible for arranging coverage of primary care services during absences due to vacation, illness or other situations that render the PCP unable to provide services. A Medicaid-eligible PCP must provide coverage.

**Appointment Access Standards**
Prestige monitors the following access standards on an annual basis per Medicaid Managed Care guidelines.

<table>
<thead>
<tr>
<th>General Appointment Scheduling for PCPs and Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent examination</td>
</tr>
<tr>
<td>Routine sick patient care</td>
</tr>
<tr>
<td>Well-care visit</td>
</tr>
<tr>
<td>Postpartum exam</td>
</tr>
</tbody>
</table>

Emergency services must be provided immediately upon presentation, twenty-four hours a day, seven days a week (24/7).

**Missed Appointment Tracking**
If a member misses an appointment with a provider, the provider must document the missed appointment in the member’s medical record. Providers must make at least three (3) documented attempts to contact the member and determine the reason. The medical record should reflect any reasons for delays in performing the examination and should also include any refusals by the member.
Access to After-Hours Care

Prestige members will have access to quality, comprehensive health care services twenty-four hours a day, seven days a week (24/7). PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider, or instruct the member that the provider will contact the member within thirty (30) minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office’s daytime phone number.

For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room. Prestige will monitor access to after-hours care by conducting a survey of PCP offices after normal business hours.

Monitoring Appointment Access and After-Hours Access

Prestige monitors appointment waiting times using various mechanisms, including:

- Reviews conducted by Account Executives during routine visits
- Reviewing provider records during the initial and triennial facility site review.
- Monitoring administrative complaints and grievances.
- Conducting an annual Access to Care survey to assess member access to daytime appointments and after-hours care.
- Non-compliant providers will be subject to corrective action and/or termination from the network.
- A non-compliance letter will be sent to the provider.

Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the member’s telephone inquiries on a timely basis.
- Response time for telephone call-back waiting times:
  - After hours telephone care within 30 minutes.
  - Same day for non-symptomatic concerns.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling cancelled and no-show appointments.
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, or for non-compliant individuals or those people with cognitive impairments).
- Scheduling continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours, Protocols shall be in place to provide coverage in the event of a provider’s absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other satisfactory method, and then transferred to the member’s medical record.
Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

Referrals
Case Managers determine the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting (to include referral to WIC) with assistance, as needed, by the area Medicaid office.

Prestige Health Choice ensures that case managers are required to provide community referral information on available services and resources to meet the needs of enrollees.

If a service is closed because the Managed Care Plan has determined that it is no longer medically necessary, the enrollee must be given a written Notice of Action regarding the intent to discontinue the service that contains information about his/her rights with regards to that decision.

PCP coordinates healthcare services. Members are allowed to self-refer for certain services (see below). PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of the PCP. This includes referral to behavioral health providers. Those referrals do not require authorization. For out of network referrals see information described herein. Providers are required to notify Prestige Health Choice immediately when they are rendering prenatal care services. All teen pregnant members are considered high risk and assigned to a Prestige Bright Start Care Manager.

PCPs are not required to issue a paper referral for in-network specialty services. PCPs must ensure communication with all specialty providers to discuss ongoing and follow-up care. There are some services that require Prior Authorization, which can be found on prestigehealthchoice.com under Provider Resources. Authorization Requests for services requiring an authorization can be submitted online via Availity.com or via Prestige Health Choice 24-Hour Nurse Call Line at 1-855-398-5615.

For Additional Information you may contact Utilization Management at telephone number 1-855-371-8074 or fax 1-855-236-9285.

The Behavioral Health telephone number is 1-855-371-3967.

Prestige Health Choice requires specialists to communicate their findings to the PCP and notify if there is a need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate their members’ care, and to make sure the referred specialist is a participating provider with Prestige Health Choice.

Prestige Health Choice does not use paper referrals. Should a provider desire a standing referral, or access to a specialty care center for a life threatening condition or certain prolonged conditions, the provider must contact the Prestige Health Choice Case Management Department.

Providers are prohibited from making referrals for designated health services to healthcare entities in which the provider or a member of the provider’s family has a financial relationship.
**Self-Referrals**

The following services do not require PCP authorization or referral:

- Prescription drugs, including certain prescribed over-the-counter drugs
- Emergency services including emergency ambulance transportation.
- OB services, including those of a Certified Nurse Midwife (CNM)
- GYN services, including those of a Certified Nurse Midwife (CNM)
- Women’s health services provided by a Federally Qualified Health Center (FQHC) or certified Nurse Practitioner (CNP).
- Initial visit for mental health and chemical dependency/substance abuse services.
- Family Planning Services and supplies from a qualified Medicaid family planning provider
- Routine eye care
- Dental care
- Except for emergency and family planning services, the above services must be obtained through network providers or prior authorized out-of-network providers

**Member Panel Capacity**

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Prestige Health Choice **DOES NOT** guarantee that any provider will receive a set number of members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact the Prestige Health Choice Provider Services Department at **1-800-617-5727**. A PCP shall not refuse to accept new members as long as the physician has not reached their requested panel size.

Providers shall notify Prestige Health Choice at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under Prestige Health Choice agreements. Prestige Health Choice prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

**Provider Termination**

Providers should refer to their Prestige Health Choice contract for specific information about terminating from Prestige Health Choice.

**Provider Maintenance Obligation to Report**

Providers shall notify Prestige Health Choice of any demographic changes to his or her practice no more than 60 days from said change.

**Other PCP Responsibilities**

- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide culturally competent care
- Maintain confidentiality of medical information
- Obtain authorizations for all inpatient and selected outpatient services listed on the current Prior Authorization List, except for emergency services up to the point of stabilization.
- Provide preventative and chronic care screenings, well care and referrals to community health departments and other agencies in accordance to AHCA provider requirements and public health initiatives.

- Report immediately knowledge or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult, to the Florida Abuse Hotline on the statewide toll free number: 1-800-962-2873. Ensure that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation.

- Participate in any other training as mandated by regulatory authorities and/or Prestige Health Choice

- Follow Prestige Health Choice’s medical record documentation policy.

- Follow Prestige Health Choice’s QI and UM program.

- Participate in any other training as mandated by regulatory authorities and/or Prestige Health Choice.

Prestige Health Choice providers should refer to their contract for complete information regarding their PCP obligations and reimbursement.

**Specialist Responsibilities**

Selected specialty services require a formal referral from the PCP. The specialist may order diagnostic tests without PCP involvement by following Prestige Health Choice’s referral guidelines. The specialist must abide by the prior authorization requirements when ordering diagnostic tests. However, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation. All non-emergency inpatient admissions require prior authorization from Prestige Health Choice.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain referral or authorization from the member’s PCP and/or Prestige Health Choice’s Utilization Management Department as needed before providing services.
- Coordinate the member’s care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five business days of seeing the member.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information
- Provider shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-962-2873).
- Provider agrees to participate in any other training as mandated by regulatory authorities and/or Health Plan.
- Follow Prestige Health Choice’s medical documentation policy.
- Follow Prestige Health Choice’s QI and UM program
- For hospice and nursing home providers the bed-hold days will comport with Medicaid fee-for-service applicable policies and procedures.
Prestige Health Choice providers should refer to their contract for complete information regarding providers’ obligations and mode of reimbursement.

**Hospital Responsibilities**

Prestige Health Choice utilizes a network of hospitals to provide services to Prestige Health Choice members.

Hospitals must:

- Cooperate and comply with Prestige Health Choice’s policies and procedures.
- Notify the PCP immediately or no later than the close of the next business day after the member’s appearance in the emergency department.
- Obtain authorizations for all inpatient emergent or urgent admissions through Prestige Health Choice’s secure, on-line portal within two business days after the date of admission.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current Prior Authorization List, except for emergency stabilization services.
- Notify Prestige Health Choice’s Utilization Management Department of all maternity admits upon admission and all other admissions by close of the next business day.
- Notify Prestige Health Choice’s Utilization Management Department of all newborn deliveries on the same day as the delivery.
- Assist Prestige Health Choice with identifying members at high risk for readmission and coordination of discharge planning which includes scheduling, prior to discharge, a post discharge follow up appointment with the member’s PCP or treating specialist.
- Support a consistent effort to effectively communicate to Prestige Health Choice the clinical status of members to assist with the discharge planning.
- Provide the health plan’s utilization management staff access to the Hospital’s electronic medical record system when applicable.
- Prestige Health Choice’s hospitals should refer to their contract for complete information regarding the hospitals’ obligations and reimbursement.
- Provider shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-962-2873). Provider warrants and represents that staff mandated to report abuse, neglect, and exploitation have received appropriate training in reporting abuse, neglect and exploitation.
- Provider agrees to participate in any other training as mandated by regulatory authorities and/or Health Plan.

**Provider-Initiated Request to Terminate a Member**

A Prestige provider shall not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based upon the member’s race, national origin, religion, medical condition, amount or variety of care required, or source of payment, in accordance with F. S. 381.026 (4)(d)(1).

A health care provider may terminate a patient relationship at any time; however, the provider may not abandon a patient. Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should have three (3) documented attempts in the member’s medical record to support his/her efforts to develop and
maintain a satisfactory provider and member relationship.

If a satisfactory relationship cannot be established or maintained due to member noncompliance, abuse, violence, or the threatened violence, the provider shall continue to provide medical care for the Prestige member until such time that verbal or written notice is received by the member. The Florida Board of Medicine, Florida Medical Association, and American Medical Association’s Council on Ethical and Judicial Affairs recommends providers remain available to the patient for at least 30 days to provide emergency services, referrals, prescriptions, and assistance in locating another practitioner for the patient to ensure the continuation of care. (F. S. 381.026) Assistance may include referring the member to the Plan to locate an in-network provider.

Medical Records
Prestige Health Choice providers must keep medical records in a secure location to ensure the member’s privacy. All medical records, Medicaid-related member cards, and communications are to be maintained for a period of ten (10) years according to legal, regulatory, and contractual rules of confidentiality and privacy. Prestige providers must maintain a medical records system that is consistent with professional standards. Providers are to deliver prompt access to records for review, survey or study if needed.

Medical Records Required Information
Medical records should reflect all services and referrals supplied directly by all providers. This includes all ancillary services and diagnostic tests ordered by the provider, and the diagnostic and therapeutic services for which the provider referred the member. Members’ medical records must be treated as confidential information and be accessible only to authorized persons.

Medical records must be in accordance with the following standards:
- Include the enrollee’s identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any);
- Include information relating to the enrollee’s use of tobacco, alcohol, and drug/substances;
- Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
- Reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
- Identify enrollees needing communication assistance in the delivery of health care services;
- Include copies of any completed consent or attestation form (s) used by Prestige Health Choice or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13) years;
- A copy of the completed screening instrument in the enrollee record and provides a copy to the enrollee.
- Documentation of preterm delivery risk assessment in the enrollee record by week twenty-eight (28) of pregnancy.
- Documentation of nutritional assessment and counseling to all pregnant enrollees and postpartum enrollee and their children (including referrals to WIC and Healthy Start and other social services)
• Referral to all enrollees under the age of five (5), and pregnancy, breast feeding, and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075)
• Documentation of referral services in the enrollee record, including reports resulting from the referral.
• Documentation of emergency care encounters in the enrollee record with appropriate medically indicated follow-up.
• Documentation of the express written and informed consent of the enrollee’s authorized representative prescriptions for psychotropic mediation) i.e, antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) YEARS. In accordance with S.409.912 (16), F.S., Prestige health Choice shall ensure the following requirements are met:
  1. The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription
  2. The prescriber must ensure completion of an appropriate attestation form. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.html
     (a) The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.
     (b) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
     (c) Every new prescription will require a new informed consent form.
     (d) The informed consent forms do not replace prior authorizations requirements for non-PDL medications or prior authorized antipsychotics for children and adolescent under the age of eighteen (18) years.

Medical Records Release
Providers are required to adhere to the requirements in safeguarding the confidentiality of member medical records. In addition, ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

A member or authorized representative shall sign and date a release form before any clinical or case records can be released to another party. Clinical/Case record release shall occur consistent with state and federal law.

Providers are also required to comply with the privacy and security provisions of HIPAA; and are further required to maintain the confidentiality of a minor’s consultation, examination and treatment for a sexually-transmitted disease, in accordance with s. 384.30(2) F.S.

Medical Records Audit
Prestige Health Choice conducts medical record audits to assess the provision and documentation of high quality primary care according to established standards. The medical records review will be focused on poor quality HEDIS outcome, Home Health Agencies with a pattern of quality of care complaints/referrals and a random selection of prenatal and newborn medical records. The medical
records review is conducted at least annually of a random selection per provider.

**Advance Directives**

Prestige Health Choice is committed to ensure that its members know of, and are able to avail themselves of, their rights to execute advance directives. Prestige Health Choice is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and any providers delivering care to Prestige Health Choice members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record. All records must contain documentation that the member was provided written information concerning the member’s rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive.

Prestige recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP’s office should ask if the member has executed an advance directive; the member’s response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP’s office and document this request in the member’s medical record.
- An advance directive should be included as a part of the member’s medical record, including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives.
- If the member requests further information, member advance directive education/information should be provided (form available on our plan website and in the Member Handbook).
- Member Services and CONNECTIONS representatives will assist members with questions regarding advance directives; however, no employee of Prestige Health Choice may serve as witness to an advance directive, or as a member’s designated agent or representative.

Prestige Health Choice’s Quality Improvement Department will monitor compliance with this provision during medical record reviews and as scheduled thereafter. If you have any questions regarding advance directives, contact: Quality Improvement Department Telephone: 1-866-796-0530

**Cultural Competency: Overview**

Prestige Health Choice’s Cultural Competency Program addresses deep-rooted disparities found in today’s healthcare industry and recognizes the need to more effectively connect with multicultural
patient populations. Our Cultural Competency program is designed to improve health outcomes among underserved individuals and families in partnership with network providers.

This Program utilizes the 15 national Culturally and Linguistically Appropriate Services (CLAS) Standards, developed by the US Department of Health and Human Services’ Office of Minority Health, as the guide and baseline of our standards. These standards fall into the following classifications:

- Principal standard: provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement and Accountability

**Cultural Competency: Provider Training**

Prestige Health Choice provides access to training and evaluation for our network providers to assist them in developing culturally competent practices. Our providers are trained in a variety of areas including advancing health equity, improving quality and helping to eliminate health disparities, by providing culturally and linguistically appropriate care.

There are an estimated 2,107,585 Floridians who speak a language other than English at home. Prestige and our providers have access to medical interpreters, signers and TDD/TYY services to facilitate communication without cost to the member.

We also train our providers on collecting race, ethnicity and language data to have a better understanding of the CLAS needs of their member panel. Treatment plans need to be respectful of the members’ race, ethnicity, native language, age, gender, and other characteristics that may result in a disparity in decision making. Written materials need to be respectful of language barriers experienced by our members.

Members of our provider network management team meet with our providers and their staffs on a regular basis and provide training in cultural competency on a yearly basis.

**Impact of Cultural Competence**

Cultural competence is an ongoing process and starts immediately when the member enters the physician office and/or has interaction with health care delivery in some way. For those taking care of our members, Prestige is dedicated to assisting our providers and staff to explore their own self-awareness and become much more aware of cultural and linguistically competent practice. This can avoid:

- Misdiagnosis due to lack of sufficient information
- Misunderstanding of the treatment plan by the member
- Non-compliance with the treatment plan due to cultural sensitivity
- Missed appointments
Health Disparities
The cost of health disparities can be felt by our members in a variety of ways:

- Lost wages
- Premature death
- Barriers to timely care
- Less likely to receive prenatal care, resulting in lower birth weight babies and have higher infant and maternal mortality
- More frequent utilization of the ED, long wait times, and members leaving without being seen
- Low income minority children are less likely to receive childhood immunizations
- Higher medical costs as a result of non-compliance due to language deficits, cultural differences, and other barriers

Compliance and Risk Management: Overview
Prestige recognizes the importance of minimizing risks to enrollees during the provision of health care services. In order to achieve this goal, Prestige utilizes a formal risk management program. The purpose is to promote the delivery of optimal and safe health care for enrollees. The program allows objective monitoring, evaluation and correction of situations that may occur in the administration and delivery of health care services.

Procedures for Adverse Incident Reporting
Providers and subcontractors must report adverse incidents or injuries affecting Prestige enrollees using the AHCA approved Provider Adverse Incident Form. Providers must complete this report immediately upon the incident occurrence, and no later than forty-eight (48) hours of detection or notification. Reporting will include information such as the member’s identity, description of the incident, and outcomes including current status of the member. After completion, the form must be submitted to Prestige Risk Management at 305-436-7485 or phcriskmanagement@prestigehealthchoice.com. The incident report should be maintained in a secure confidential file.

For reporting purposes, the State of Florida defines an injury of an enrollee occurring during delivery of Prestige’s covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider
Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents. In accordance with the AHCA contract an injury is defined as:

- Death.
- Brain damage.
- Spinal damage.
- Permanent disfigurement.
- Fracture or dislocation of bones or joints.
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient’s case or patient’s preexisting physical condition.
- Any condition requiring surgical intervention to correct or control.
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care.

**Examples of reportable events:**

- Example A – The performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the Prestige enrollee’s diagnosis or medical condition.
- Example B – A procedure to remove unplanned foreign objects remaining from a surgical procedure.

Provider submission of adverse incident forms from the following providers: health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.S.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S. are not contractually required.

**Provisions of the Risk Management Program**

The Risk Management Program has developed processes in compliance with contractual reporting requirements. The Risk Manager or designee education the providers and subcontractors on adverse and critical incidents, abuse, neglect, exploitation, and human trafficking awareness as well as training regarding incident reporting and timeliness requirements.

All incidents reports are reviewed in collaboration with the Quality Improvement Department for potential quality of care, quality of service, adverse incidents, and safety issues. Data collected during the investigative process will be analyzed to identify potential trends. When appropriate, Risk Management will collaborate with providers and subcontractors to determine the best actions for preventing events from reoccurring. Adverse trends will be reviewed internally by the Quality Improvement Committee and Compliance Committee. The Risk Manager will prepare a monthly
Adverse and Critical Incident Summary Report, which includes identified adverse and critical incidents, for submission to AHCA.

Suspected abuse, neglect or exploitation of a child and/or vulnerable adult shall be reported immediately online or by phone to the Department of Children and Families (DCF) Central Abuse Hotline. The Risk Management Department will keep separate, confidential electronic files and/or paper records of investigations involving abuse, neglect, and exploitation of Prestige enrollees.

The Provider Adverse Incident Report Form can be found on the Plan’s website at www.prestigehealthchoice.com.

**Provider ResponsibilitiesRelated to Reporting Abuse, Neglect, Exploitation and Human Trafficking**

In Accordance with the AHCA Contract, sections 39.201 and 415 of the Florida Statutes all providers with knowledge or suspicions of abuse, neglect, abandonment, exploitation, or human trafficking of a child or vulnerable adult are required to make a report online or by phone to the Florida Central Abuse Hotline.

- **Report online** at [https://reportabuse.dcf.state.fl.us/](https://reportabuse.dcf.state.fl.us/)
- **Report by phone:** 1-800-962-2873

If you have information regarding suspected Human Trafficking of an adult anywhere in the United States or of a child **outside of Florida**, please contact the National Human Trafficking Resource Center:

- **Report by phone:** 1-888-373-7888
- **Report online** at [https://humantraffickinghotline.org/](https://humantraffickinghotline.org/)

**Abuse:**
- **Adult:** Any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult’s physical, mental, or emotional health. Abuse includes acts and omissions.
- **Child:** Any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child’s physical, mental, or emotional health to be significantly impaired. Abuse of a child includes the birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

**Neglect:**
• **Adult:** The failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term “neglect” also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. “Neglect” is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

• **Child:** Neglects the child. Within the context of the definition of “harm,” the term “neglects the child” means that the parent or other person responsible for the child’s welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so. However, a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone, but such an exception does not:
  o Eliminate the requirement that such a case be reported to the department;
  o Prevent the department from investigating such a case; or
  o Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician, as defined in this section, or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization.

**Exploitation:** A person who:
1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult’s funds, assets, or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

**Human Trafficking:** Under both federal and Florida law, it is defined as the transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport; for the purposes of forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion.

**Identifying Victims of Human Trafficking**
The Office on Trafficking in Persons, Administration for Children and Families, and U.S. Department of Health and Human Services (HHS) are committed to preventing human trafficking and ensuring that victims of all forms of human trafficking have access to the services they need. Healthcare providers may come into contact with victims of human trafficking and have a unique
opportunity to connect them with much needed support and services. Anyone in a medical position
including clerical staff, lab technicians, nursing staff, security personnel, case managers, and
physicians may be in a position to identify human trafficking.

The National Human Trafficking Resource Center provides the following list of potential red flags
and indicators. Patients who are potential victims of human trafficking may exhibit the behaviors
listed below. Please note that this list is not exhaustive. Each indicator taken individually may not
imply a trafficking situation and not all victims of human trafficking will exhibit these signs.
However, the recognition of several indicators may point to the need for referrals and further
assessment.

**General Indicators of Human Trafficking**

- Shares a scripted or inconsistent history
- Is unwilling or hesitant to answer questions about the injury or illness
- Is accompanied by an individual who does not let the patient speak for themselves, refuses to
  let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a
  family member, romantic partner, or employer)
- Demonstrates fearful or nervous behavior or avoids eye contact
- Is resistant to assistance or demonstrates hostile behavior
- Is unable to provide his/her address
- Is not aware of his/her location, the current date, or time
- Is not in possession of his/her identification documents
- Is not in control of his or her own money
- Is not being paid or wages are withheld

**Labor Trafficking Indicators**

- Has been abused at work or threatened with harm by an employer or supervisor
- Is not allowed to take adequate breaks, food, or water while at work
- Is not provided with adequate personal protective equipment for hazardous work
- Was recruited for different work than he/she is currently doing
- Is required to live in housing provided by employer
- Has a debt to employer or recruiter that he/she cannot pay off

**Sex Trafficking Indicators**

- Patient is under the age of 18 and is involved in the commercial sex industry
- Has tattoos or other forms of branding, such as tattoos that say, “Daddy,” “Property of…,”
  “For sale,” etc.
- Reports an unusually high numbers of sexual partners
- Does not have appropriate clothing for the weather or venue
- Uses language common in the commercial sex industry
Physical Health Indicators

- Signs of physical abuse or unexplained injuries
  - Bruising
  - Burns
  - Cuts or wounds
  - Blunt force trauma
  - Fractures
  - Broken teeth
  - Signs of torture

- Neurological conditions
  - Traumatic brain injury
  - Headaches or migraines
  - Unexplained memory loss
  - Vertigo of unknown etiology
  - Insomnia
  - Difficulty concentrating

- Cardiovascular/respiratory conditions that appear to be caused or worsened by stress, such as:
  - Arrhythmia
  - High blood pressure
  - Acute Respiratory Distress

- Gastrointestinal conditions that appear to be caused or worsened by stress, such as:
  - Constipation
  - Irritable bowel syndrome

- Dietary health issues
  - Severe weight loss
  - Malnutrition
  - Loss of appetite

- Reproductive issues
  - Sexually-transmitted infections
  - Genitourinary issues
  - Repeated unwanted pregnancies
  - Forced or pressured abortions
  - Genital trauma
  - Sexual dysfunction
  - Retained foreign body

- Substance use disorders

- Other health issues
  - Effects of prolonged exposure to extreme temperatures
  - Effects of prolonged exposure to industrial or agricultural chemicals
  - Somatic complaints
Mental Health Indicators
- Depression
- Suicidal ideation
- Self-harming behaviors
- Anxiety
- Post-traumatic stress disorder
- Nightmares
- Flashbacks
- Lack of emotional responsiveness
- Feelings of shame or guilt
- Hyper-vigilance
- Hostility
- Attachment disorders
  - Lack of or difficulty in engaging in social interactions
  - Signs of withdrawal, fear, sadness, or irritability
- Depersonalization or derealization
  - Feeling like an outside observer of themselves, as if watching themselves in a movie
  - Emotional or physical numbness of senses
  - Feeling alienated from or unfamiliar with their surroundings
  - Distortions in perception of time
- Dissociation disorders
  - Memory loss
  - A sense of being detached from themselves
  - A lack of a sense of self-identity, or switching between alternate identities
  - A perception of the people and things around them as distorted or unreal

Social or Developmental Indicators
- Increased engagement in high risk behaviors, such as running away or early sexual initiation if a minor
- Trauma bonding with trafficker or other victims (e.g. Stockholm syndrome)
- Difficulty establishing or maintaining healthy relationships
- Delayed physical or cognitive development
- Impaired social skills

The information provided above may be located on the National Human Trafficking Resource Center website at [http://www.traffickingresourcecenter.org](http://www.traffickingresourcecenter.org). For additional resources, please contact the National Human Trafficking Resource Center via phone: 1-888-373-7888 or email: nhtrc@polarisproject.org.
Chapter 8: Enrollee Rights and Responsibilities

In accordance with 42 CFR 438.100, Florida law requires that health care providers and facilities recognize member rights. Providers must post a copy of the summary of Florida’s Patient’s Bill of Rights and Responsibilities. Members have the right to request and receive from their health care provider, a complete copy of the Florida Patient’s Bill of Rights and Responsibilities.

Patient’s Bill of Rights and Responsibilities

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well-being of patients and to promote better communication between the patient and the health care provider. Florida law requires that a patient's health care provider or health care facility recognize those rights while the patient is receiving medical care and that the patient respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. Patients may request a copy of the full text of this law from their health care provider or health care facility. A summary of patients’ rights and responsibilities follows.

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct. Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
- Express complaints regarding any violation of his or her rights.
A patient is responsible for:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider’s instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.
Chapter 9: Pharmacy

Pharmaceutical management is a critical component of Prestige’s success. Prescription services are one of the largest service and expenditure areas under the Florida Medicaid program. The Plan’s goal is to manage pharmacy costs while effectively maintaining optimal health outcomes for our members.

The pharmacy benefit is administered by the Pharmacy Benefit Manager (PBM). There are certain medications on the AHCA Preferred Drug List that require prior authorization. Various clinical edits including Prior Authorization and Age Limits are included on the posted formulary for specific medications. Prior authorization forms and criteria can be accessed from our website at www.prestigehealthchoice.com. It is important to remember that plans may be less stringent than the posted criteria for certain medications or classes. As part of the prior authorization process, providers must complete a Prior Authorization Request form. The form must be 100% completed and submitted along with all appropriate documentation (medical history, previous therapies tried, additional rationale, etc.) which may help us process the request. Incomplete forms or missing documentation may delay or prevent a request from being processed. The current prior authorization forms may be downloaded by visiting www.prestigehealthchoice.com.

PerformRxSM provides pharmacy benefit management services to Prestige Health Choice.
- You may fax prior authorization requests to PerformRx at 1-855-825-2717.
- You may call Provider Services at 1-800-617-5727 for assistance.

For pharmacy questions, call the Pharmacy Help Desk at 1-855-371-3963, available 24 hours a day, seven days a week.

Upon approval of a specialty authorization, you may forward the corresponding prescription to PerformSpecialty® via fax at 1-844-489-9565 for prompt service. You can contact them by phone at 1-855-287-7888.

AHCA Preferred Drug List (PDL)

Prestige has adopted the AHCA PDL and provides all prescription drugs and dosage forms in congruence with the Agency’s direction. The PDL is a clinical reference of medications that are selected by the AHCA Pharmacy and Therapeutics Committee (P&T Committee). We encourage our providers to prescribe generic medications when the generic is preferred by AHCA and to adhere to the PDL.

A comprehensive list of Prestige’s formulary may be accessed from our website. The formulary may be accessed and reviewed by clicking on the “Preferred Drug List (formulary)” link. This link will direct the user to the searchable PDL on AHCA’s website. This searchable version will provide details regarding age limits, prior authorization and other coverage requirements. There is also a link labeled “Summary of drug limitations” which provides all quantity limits and age limits for applicable drugs.
When a non-PDL (non-preferred) agent or an agent which has an associated edit is inadvertently prescribed, prescribers and pharmacists are encouraged to work together to convert to a preferred formulary agent when appropriate.

**Formulary Changes**
The Agency for Health Care Administration (AHCA) Preferred Drug List and Changes Summary Report, which lists changes made to the preferred drug list as a result of the last AHCA Pharmaceutical and Therapeutics Committee meeting, may be accessed from the same Prestige web page referenced above or on AHCA's website at [http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fnpdl.shtml](http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fnpdl.shtml).

In the event that there is a formulary change, various types of communications may be utilized depending on the type of change. Communication strategies may include letters, fax blasts, web documents, provider alerts, etc. Any necessary communication will be completed as early as possible, prior to the implementation of a change. Most direct communications will be the result of a negative formulary change such as removal of a medication from the formulary or the addition of a clinical edit.

**Coverage Limitations**
Prestige covers the medication categories that are listed on the PDL. Excluded items are as follows:

- Anti-hemophilia products
  - Factor products are distributed through the Comprehensive Hemophilia Disease Management Program
- Cough and cold medications for members age twenty-one (21) and over
- Drug Efficacy Study Implementation (DESI) ineffective drugs as designated by AHCA
- Drugs used to treat infertility
- Experimental/Investigational pharmaceuticals or products
- Erectile dysfunction products prescribed to treat impotence
- Hair growth restorers and other drugs used for cosmetic purposes
- Prostheses, appliances and devices (except products for diabetes and products used for contraception)
- Nutritional supplements
- Oral vitamins and minerals (except those listed in the PDL)
- Over-the-counter (OTC) drugs (except those listed in the PDL)
- Weight loss/gain medications

Additionally, Prestige does not reimburse for early prescription refills, duplicate therapy, or medication dosages that exceed the Food and Drug Administration (FDA) maximum dose under the Agency’s direction.

**Carve-Out Medications**
A portion of the pharmacy benefit for Medicaid beneficiaries is “Carved-out” by the State of Florida. Medications such as anti-hemophilic factors, Spinraza and Exondys 51 are covered under
the Fee-for-Service portion of the benefit. Instead of billing Prestige for the medications, the pharmacy must bill Fee-for-Service Medicaid (Magellan Rx Management). Pharmacies will be alerted in a reject message if they submit a claim to Prestige for a Carve-out medication.

The Magellan Rx Management Clinical Call Center can be reached at 1-800-603-1714 for claims questions associated with these medications. You can also find additional information on the Agency for Healthcare Administration’s website at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/fee-for-service/hemophilia.shtml.

Generic Substitution
Prestige requires that brand medications be substituted for generic medications when an equivalent generic is available and when the formulary allows for coverage of the generic. There are some medications for which the brand medication is preferred by AHCA.

Informed Consent for Psychotropic Medications
Prestige requires that prescriptions for psychotropic medications prescribed for a member under the age of thirteen (13) be accompanied by the express written and informed consent of the member’s parent or legal guardian. Psychotropic (psychotherapeutic) medications include antipsychotics, antidepressants, antianxiety medications, and mood stabilizers. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time.

The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription. The prescriber must ensure completion of an appropriate attestation form.

The completed form must be filed with the prescription (hardcopy or scanned) in the pharmacy and held for audit purposes for a minimum of six (6) years. Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form. Every new prescription will require a new consent form. The consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents from birth through age seventeen (17).

For consent forms and resources visit http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml.

Injectables
Prestige covers limited self-administered, injectable medications (e.g. Epinephrine). For a complete list, please reference the PDL. Most other injectable medications will require prior authorization.

Over-the-Counter (OTC) Medications
Prestige covers several OTC products. Our members receive an OTC benefit of $25 per household per month. A list covering OTC products can be found at http://www.prestigehealthchoice.com/pdf/member/eng/common-otc-medications.pdf.
**Specialty Medications**
Several specialty and injectable medications are listed on the PDL. Additionally, Prestige also adheres to the AHCA medication criteria for specialty, injectable and other medications requiring prior authorization. The majority of the specialty and injectable medications listed on the PDL will require a prior authorization. Please call the Prestige Pharmacy Benefit Manager at **1-855-371-3963** to obtain more detailed information about these medications.

**Working with our Specialty Pharmacy Provider**
Prestige utilizes an exclusive specialty pharmacy, PerformSpecialty to fill most specialty and some injectable medications. Most of these medications require a prior authorization. Please call PerformSpecialty at 1-855-287-7888 or fax the prescription request or prior authorization form to 1-844-489-9565.

Once approved PerformSpecialty will call the member for delivery confirmation. If you prefer the medication be delivered to your office instead please note that in your request. More information can be found at www.performspecialty.com.

**Prior Authorization**
Please refer to the links below for the most up-to-date PDL. The links define the AHCA preferred medications and those requiring prior authorization.


Prior Authorization Fax: **1-855-825-2717**
Prior Authorization Phone: **1-800-617-5727**

Mailing Address:
PerformRx
PO Box 516
Essington, PA 19029

Please refer to the provider website for the most current information.
Chapter 10: Quality Improvement Program

Overview
Prestige Health Choice is a managed care plan that provides Medicaid managed care services to Floridians most in need. The plan’s mission is to provide quality, affordable service to the underserved in the communities it serves, reflecting the owners’ commitment to helping members achieve optimal health.

Prestige is continuously working to improve and support its whole person, member centric model. The Prestige Quality Improvement (QI) program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided the Prestige members and providers.

The Prestige model of care centers on the individual member with a direct connection to a primary care provider. Primary care providers are defined as individual practitioners who provide primary care services and manage routine health care needs; including family practice, internal medicine, pediatrics and general practice. Primary care physician relationships are critical to sustained, comprehensive, and coordinated medical care. Vendor partners manage certain aspects of plan administration and member benefits through delegated contractual agreements.

Organizational Structure, Governing Bodies, and Committee Structure
The Prestige Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to our members. The BOD oversees and supports the Quality Improvement Program as well as providing strategic direction to the QI program. Operational responsibility for the development, implementation, monitoring and evaluation of the QI program is delegated by the BOD to the Plan President and Quality Improvement Committee. The Prestige leadership group, including the plan President, Operational lead, Chief Medical Officer and Chief Financial Officer meet with the BOD on a monthly basis. Information is then cascaded as needed to the Directors of various departments as needed. Annually, the Director of Quality and Community Outreach engage directly with the BOD for a quality summit. The Quality Improvement Committee (QIC) is managed through the Quality department with oversight by the Director of Quality and Community Outreach, with the Chief Medical Officer as the Chair of the QIC.

The committee structure is comprised of the Quality Improvement Committee, which has three sub-committees including the Clinical Quality Improvement Committee, the Quality of Service Committee, and the Credentialing Committee. The Quality of Service Committee has two sub-committees including the Delegation Oversight Subcommittee and the Cultural Competency and Service Quality Subcommittee. The Peer Review Committee is a sub-committee of the Credentialing Committee and meets on an ad hoc basis.
Goals and Objectives of the Quality Improvement Program

The goals of the Quality Improvement Program at Prestige include but are not limited to the following:

- Effective collection, analysis and reporting of data for a variety of programs
- Management and reporting of process improvement plans mandated by the Agency
- Addresses clinical, psychosocial and function needs of the membership
- Reviewing utilization trends including over/under utilization
- Member and provider satisfaction will meet established performance targets
- Minimize fragmentation and/or duplication of services through integration of quality improvement activities across functional areas
- Preventative and clinical practice guideline compliance
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained
- Monitor quality and access to care provided to members
- Reduce health care disparities and collects REL data to monitor and assure delivery of culturally competent health care
- Reporting of and incorporation of social determinants of care outcomes, assist in planning for interventions to improve quality of life for our members
- Establish and maintain all health plan functions that promotes continuous quality improvement
- Review of quality of care and health outcomes, and provide clinical and service improvement initiatives and recommendations for our members/populations
- Oversight of delegation and credentialing/re-credentialing
- Maintain a system for measuring performance across the organization and networks
- Work with members, providers and community resources to improve quality of care
- Utilize provider outreach team to provide quality improvement information to network providers
- Quality of care reviews related to patient safety
- Monitor and assure delivery of culturally competent health care
- Monitor complaints and grievances
- Monitor and report on preventative care rendered to our members

Health Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool used by more than 90% of America’s health plans to measure performance on important dimensions of care and service. Health plans are measured in the following areas:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and relative resource use
HEDIS was developed by the National Committee for Quality Assurance (NCQA), which allows comparisons across health plans. This gives purchasers and consumers of health care the ability to distinguish between health plans based on comparative quality. HEDIS reporting is required under the AHCA contract and consists of 6 major measure groupings:

- Well child
- Other preventative
- Prenatal/perinatal care
- Comprehensive diabetes care
- Other chronic and acute care
- Mental health and substance use

HEDIS rates are calculated based on two types of data: administrative data and hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member records to abstract data for services rendered but not reported through claims/encounter data. This typically happens sometime between March and May each year.

Improving HEDIS scores depends on accurate documentation and billing for each claim/encounter for services rendered to members. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will reduce the number of medical record reviews that need to be done in the hybrid season.

Quality Enhancements

Prestige coordinates access for members to certain health-related, community-based services for children’s programs, domestic violence, pregnancy prevention, prenatal/postpartum pregnancy programs and behavioral health programs. A complete list and additional detail on these quality enhancements are available by visiting www.prestigehealthchoice.com.

The following services are available to our members and may be accessed by providers:

- Prestige Health Choice offers Quality Enhancements (QE) in community settings and as components of established programs. Prestige will make a good faith effort to work with the following agencies and community organizations to coordinate access to already established QE services:
  1. Healthy Start Coalitions
  2. County Health Departments
  3. Early Intervention Programs
  4. Local domestic violence agencies
  5. United Way
  6. Community Hospitals
  7. Federally Qualified Health Centers
- QE referrals (made by Integrated Health Care Management case managers/care connectors or other staff such as member service staff) and follow-up related to the services received
are documented in Prestige Health Choice’s Medical Management system. Providers are notified through the provider handbook that QE referrals and follow up on the members’ receipt of services must be documented in members’ medical records.

- Prestige Health Choice offers the following QEs:
  1. Community based educational sessions for the mothers of infants and children addressing self-care for common childhood illnesses. Alternatively, Prestige Health Choice may involve or refer members in existing community children’s programs.
  2. Health Fairs – The Health Plan participates in local community health fairs to promote general wellness programs, prevention and early-intervention services for children.
  3. Provider Education Offerings – Provider education programs to promote proper nutrition, breast-feeding, immunizations, child health check-up (CHCUP), wellness, prevention, early intervention services, domestic violence screening.
  4. Domestic Violence – In addition to the provider education offerings mentioned above, Prestige Health Choice’s care managers/care connectors educate female members on available community resources and support for victims of domestic violence. In addition, members receive information regarding domestic violence in the member handbook and member website.
  5. Pregnancy Prevention – Prestige Health Choice partners with the Abstinence Education Program to promote program attendance to members. Alternatively, Prestige Health Choice may involve members in existing community pregnancy prevention programs.
  6. Prenatal and post-partum pregnancy programs – Prestige Health Choice care managers/care connectors will utilize local community based services to support a woman and her baby during her pregnancy and the post-partum period. Prestige Health Choice shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with Prestige Health Choice’s prenatal and postpartum programs. Our New Mom and Baby Program provides home visits to post-partum enrollees, conducted by a Community Health Navigator (CHN). During the visit, the CHN obtains pertinent information relating to the pregnancy such as delivery date and post-partum medical appointments and provides educational materials and care gap counseling.
  7. Behavioral Health Programs – Prestige has various departments that identify the need for a member referral to our behavioral health provider. A Behavioral Health (BH) intake coordinator receives each referral and assigns it to a care coordinator/manager.

Prestige provides information regarding the availability of these services to members through documentation in the Member Handbook, on Prestige’s website at www.prestigehealthchoice.com, and through the provision of educational materials. Members also have access to this information by calling Prestige Member Services at 1-855-355-9800, where a Member Service Representative will be available to provide the information and answer any questions the member may have. Prestige Health Choice offers substance use screening training to all of its providers on an annual basis.
Chapter 11: Healthy Behaviors

Prestige Health Choice takes a proactive role in engaging members to make healthy decisions and positive lifestyle changes. Members who participate in our Healthy Behaviors Program earn gift cards for up to $50 when they complete any of the following:

- Smoking Cessation Care Management Program
- Weight Loss Care Management Program
- Alcohol or Substance Use Care Management Program
- Behavioral Health Follow Up Visits
- Diabetes Screenings
- Diabetes Eye Exams
- Maternity Visits
- Postpartum Visits
- Well-Child Program
- Adolescent Well-Care visits
- Adult Preventive Care Visit
- Lead Screening
- Breast Cancer Screening
- Cervical Cancer Screening

These programs are offered at no cost to members. If you have Prestige patients who could benefit from participating in a Healthy Behaviors Program, please instruct the Prestige member to call our Member Services Department: **1-855-355-9800/TTY: 711.**
Chapter 12: Telemedicine Solutions

Prestige Health Choice readily embraces telehealth to better engage members in their care and improve outcomes. When treating Prestige Health Choice members, please remember to include the following items in your documentation for services provided through telehealth:

1. A brief explanation of the use of telehealth in each progress note;
2. Documentation of telehealth equipment used for the particular covered services provided; and
3. A signed statement from the patient or his/her authorized representative indicating their choice to receive services through telehealth. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

Prestige Health Choice and our network providers routinely use telehealth applications to conduct the following:

- **Remote patient monitoring**, including the collection and transmission of patient health data to monitoring stations (i.e. electrocardiogram, glucose levels, blood pressure readings, etc.).
- **Medical education and mentoring** of healthcare practitioners on special topics or procedures.
- **Consumer medical and health information** which can assist in improving life style changes for improved health.
Chapter 13: Behavioral Health

Prestige Health Choice has partnered with Optum Behavioral Health to manage the behavioral health and substance abuse benefits for our members. Optum has a sophisticated algorithm used for predictive modeling to identify care gaps earlier. We have focused on building a high level of integration, especially with our clinical teams who have shared system access for real time referrals and care coordination. Optum also has a network of providers who offer outpatient treatment via telehealth to increase the accessibility of services for our members.

Members seeking behavioral health services. Optum helps our member identify what services would be helpful, and then finds the right provider to meet their needs. Prestige Health Choice members do not need a referral from their PCP for any behavioral health service. For emergency behavioral health services, contact 911 or have the member go to the nearest emergency room.

Optum can be contacted at the number on the back of the member’s ID card for Behavioral Health, 1-855-371-3967. You can also access the Behavioral Health Provider Directory online. There are many helpful resources for members on Optum’s LiveAndWorkWell website.

Covered services. Prestige Health Choice members have access to a full range of medically necessary behavioral health services from outpatient to acute inpatient treatment for mental health and substance abuse issues. The Medical Necessity Criteria (MNC) and service-specific coverage requirements, along with prior authorization information, for behavioral health services are available on Optum’s website at www.ProviderExpress.com.

Online behavioral health resources. As a practitioner, Prestige Health Choice’s website has many helpful resources for you. When you click on “Behavioral Health & Substance Abuse” it lists our Behavioral Health Toolkit, Opioid Treatment Resources, and Centers for Disease Control and Prevention guidelines. You will also find in the Forms Section, the Pharmacy Prior Authorization forms for various behavioral health/substance abuse medications.

Screening, Brief Intervention and Referral to Treatment (SBIRT). We are working diligently to address alcohol and drug use through early identification and prevention. As a network provider, you play an important role in identifying at-risk members. We support a program called SBIRT: Raise the Topic, which engages members ages 12 through 20 for early substance use disorder screening, brief intervention and referral to treatment (SBIRT) using an evidence-based approach that is widely recommended. We have developed a robust program to support your staff with the tools and resources essential to integrating SBIRT into your practice. The training includes live and webinar options to meet your needs, and ongoing support to insure your success. If you would like to learn more, contact your Prestige Health Choice Provider Network Management Account Executive, or call Network Development at 1-800-617-5727.
Chapter 14: Provider Assistance with Public Health Services

Prestige Health Choice is required to coordinate with public health entities regarding the provision of public health services. Providers must assist Prestige Health Choice in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Referring to the local public health entity for tuberculosis contact investigation, evaluation and the preventive treatment of persons with whom the member has come into contact.
- Referring members to the local public health entity for STD/HIV contact investigation, evaluation and preventive treatment of persons whom the member has come into contact.
- Provide all women of childbearing age HIV counseling and offer them HIV testing at the initial prenatal care visit, and again at 28 to 32 weeks. All women who are infected with HIV are counseled about and offered the latest antiretroviral regimen.
- Screen all pregnant members for the Hepatitis B surface antigen and ensure that infants born to HBsAg-positive members receive Hepatitis B Immune Globulin and Hepatitis B vaccine once they are stable and ongoing testing for HBsAg.
- Referring members for WIC services and information sharing as appropriate.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Identify and report to applicable authorities any suspected abuse or neglect.
- Assisting in the collection and verification of race/ethnicity and primary language data.
Chapter 15: Marketing Activities

Prestige Health Choice maintains compliance with all Agency guidelines regarding marketing activities. As such, providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in Prestige Health Choice based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Prestige Health Choice.
- Offer anything of value to persuade potential enrollees to select them as their provider or to enroll in Prestige Health Choice.
- Accept compensation directly or indirectly from Prestige Health Choice for marketing activities.
## Appendix A: Prestige Health Choice Department Contact Information

<table>
<thead>
<tr>
<th>Department</th>
<th>Phone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Hour Nurse Call Line</td>
<td>855-398-5615</td>
</tr>
<tr>
<td>Bright Start® Maternity Program</td>
<td>855-371-8076/855-358-5852</td>
</tr>
<tr>
<td>Claims Status</td>
<td>800-617-5727</td>
</tr>
<tr>
<td>Enrollment</td>
<td>855-358-5845</td>
</tr>
<tr>
<td>Fraud, Waste &amp; Abuse</td>
<td>866-833-9718</td>
</tr>
<tr>
<td>Healthy Behaviors Program</td>
<td>855-236-9281</td>
</tr>
<tr>
<td>Integrated Health Care Management</td>
<td>855-371-8072/855-358-5851</td>
</tr>
<tr>
<td>Member Complaints</td>
<td>855-355-9800</td>
</tr>
<tr>
<td>Member Grievances &amp; Appeals</td>
<td>855-371-8078/855-358-5847</td>
</tr>
<tr>
<td>Member Services</td>
<td>855-355-9800/855-358-5856</td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>800-617-5727/855-358-5853</td>
</tr>
<tr>
<td>Provider Services</td>
<td>800-617-5727/855-358-5849</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>855-358-5854</td>
</tr>
<tr>
<td>Rapid Response &amp; Outreach</td>
<td>855-371-8072/855-236-9281</td>
</tr>
<tr>
<td>UM Inpatient Concurrent Review/Right Fax</td>
<td>855-236-9286</td>
</tr>
<tr>
<td>UM Prior Authorization/Right Fax</td>
<td>855-236-9285</td>
</tr>
<tr>
<td>Utilization Management Prior Authorization</td>
<td>855-371-8074</td>
</tr>
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</table>
## Appendix B: Subcontractor Contact Information

<table>
<thead>
<tr>
<th>Services</th>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>HearUSA Distribution, LLC</td>
<td>800-731-3277</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>United Behavioral Health dba Optum</td>
<td>855-371-3967</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Coastal Care Services</td>
<td>855-481-0505</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Quest Diagnostics</td>
<td>866-697-8378</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Perform Rx</td>
<td>855-371-3963</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation</td>
<td>Access2Care</td>
<td>855-371-3968</td>
</tr>
<tr>
<td>Optometry &amp; Ophthalmology</td>
<td>Premier Eye Care of Florida</td>
<td>855-371-3961</td>
</tr>
<tr>
<td>Orthotics &amp; Prosthetics</td>
<td>Hanger, Inc.</td>
<td>877-754-6542</td>
</tr>
</tbody>
</table>
Appendix C: Forms

Please visit our website at http://www.prestigehealthchoice.com/provider/resources/forms.aspx to view and download available forms.