Provider Manual

www.prestigehealthchoice.com
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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 Florida's Statewide Medicaid Managed Care (SMMC) program. As a Florida-based company, Prestige Health Choice is dedicated to serving the needs of Floridians enrolled in the SMMC program.

Florida Medicaid and the Statewide Medicaid Managed Care (SMMC) 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. The SMMC program has three components, the Long-Term Care (LTC) program, the Managed Medical Assistance (MMA) program, and the Dental Program. 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.
Please visit our website at www.prestigehealthchoice.com to learn more about Prestige Health Choice, including the following:

- Provider forms
- Provider directories (online searchable and printable)
- Claims and billing information including billing guide
- Clinical guidelines
- Online training
- Provider updates and newsletters

Create your secure online 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, 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 can contact:
  - Change Healthcare Provider Support Line at 1-877-363-3666
  - Prestige Health Choice Provider Services Department at 1-800-617-5727
  - Prestige Health Choice Website: www.prestigehealthchoice.com
- Prestige Health Choice EDI Payer ID: 77003

**Population Health Management.**

Our population health 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 www.availity.com.

To reach Prestige Utilization Management, 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. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 C.F.R. §447.45.

**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 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 of electronic claims against 837 edits at Change Healthcare.
- 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 in the Florida Medicaid program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by Prestige.
- 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 statutes.

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 90 days from the date of the primary payer’s final determination.

• For Medicare coordination of benefit claims the time filing limit is 36 months from the date of service or 90 days from the date of the primary payer’s final determination, 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 Health Choice 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 SMMC 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.

**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 with 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 Prestige Provider Services at 1-800-617-5727 for assistance.

**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, as well as 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) alphanumeric digits. 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 for processing. If a plan provider ID is sent using the G2 qualifier, it is used as the provider on the claim.

**Inpatient Claim Submission**

Prestige Health Choice validates that only properly billed claims are paid. As such, all inpatient Diagnosis Related Grouper (DRG) facility claims that will pay greater than $50,000, if paid as billed, and are billed with cost outliers of $2,500 or more, will be subject to a prepayment review. This prepayment review service will be conducted by an external vendor (currently Equian LLC) to review the cost outlier portion of the inpatient claim for billing inconsistencies and variances from industry billing practices.

To help ensure timely processing of inpatient claims, Prestige Health Choice requires that you submit an itemized bill with each inpatient DRG facility claim that will pay greater than $50,000, if paid as billed. **Inpatient claims meeting this criteria must be submitted with an itemized bill to avoid an upfront denial.** If you receive an upfront denial, please follow the instructions provided on the remittance advice to ensure proper and timely submission of the itemized bill.

Please note that the level of monetary criteria for review as noted above is subject to change.

For more detailed information on how to comply with this requirement, please refer to the Provider alert titled **Inpatient claims update** which can be found under the “Newsletters and updates” section on the Provider page of the Prestige Health Choice website at [http://www.prestigehealthchoice.com/pdf/provider/newsletters-and-updates/06-11-19-inpatient-claims-update.pdf](http://www.prestigehealthchoice.com/pdf/provider/newsletters-and-updates/06-11-19-inpatient-claims-update.pdf).
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 Prestige, but rather a requirement of the mandated HIPAA Version 5010 Implementation Guide.
- Each unique claim number can only be corrected one time. If you have already filed a corrected claim, and need to correct it a second time, please utilize the most recent claim number in the Payer Claim Control Number. 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 Prestige claim number must be in Field 22.
  - On an institutional UB-04 Claim, bill type should end in “7” or “8” in Form Locator 4 and the Prestige 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 a Prestige Health Choice claim number.

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

Please submit corrected claims using the appropriate Paper Claim Submission or EDI Claim Submission guidelines above.

Claims Payments

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

- EDI – nursing facility and hospice clean claims – 10 business 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 should return improper or overpaid funds to Prestige by:

   a. Use page two of the form or attach your own spreadsheet with the pertinent fields from the form, as needed, to list multiple claims connected to the return payment.
2. 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:** Well child services are identified using 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.

- **EP modifier:** used with procedure code 99385 and 99395 to identify children 18 through 39 years of age
- **FP modifier:** 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 Family Planning services (99383-99385 with modifier FP, or 99393-99395 with modifier FP). Family Planning services do not require a well child referral code.

**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
- 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 (AANNNNNA) 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.
- **CLIA Number Missing or Invalid** - Providers that perform laboratory testing are required to indicate their CLIA ID number when submitting claims. Ensure that the CLIA certificate is active on the date of service and that the procedure is covered under the CLIA certification type.
- **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 (EOB) from Primary Insurers Missing or Incomplete** – a copy of the explanation of benefit from all third-party insurers must be submitted with the original claim form. Please ensure that the EOB is complete, and includes processing/payment 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** – handwritten claims are not acceptable on resubmitted claims and will be rejected.

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

• **Valid Florida Medicaid ID** – Ensure that the billing, servicing, and ROPA* providers have a valid Medicaid ID with the State of Florida.

*See the ROPA section below for additional information*

**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 (CMS), 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.

**ROPA (Referring, Ordering, Prescribing, or Attending) providers.** All providers who order or refer services in conjunction with the provision of services to Florida Medicaid recipients must be enrolled with the Florida Medicaid program.

The Florida Medicaid provider enrollment online application features a fully automated process through which licensed ordering and referring providers can enroll as ROPA providers. The automated application allows providers to obtain a Florida Medicaid ID, which must be included on certain claims for services.

If you are billing for services that were referred, ordered, or prescribed, you should always include appropriate ROPA identifiers on your Prestige Health Choice claim to avoid a potential claim denial. ROPA information should be billed as follows:

**Referring provider:**
- Box 17 = Qualifier DN and Name of Referring Provider.
- Box 17a = Qualifier ZZ and Taxonomy Code or Qualifier 1D and Referring Provider Florida Medicaid ID.
- Box 17b = Referring Provider NPI.

**Ordering provider:**
- Box 17 = Qualifier DK and Name of Ordering Provider.
- Box 17a = Qualifier ZZ and Taxonomy Code or Qualifier 1D and Ordering Provider Florida Medicaid ID.
- Box 17b = Ordering Provider NPI.

Please note that if a provider referring or ordering services for you does not have a valid Medicaid ID issued by Florida Medicaid, your claim could be denied.

To learn more about the ROPA provider enrollment initiative, please review one of the following ROPA Quick Reference Guides:

**ROPA Provider Enrollment Overview Quick Reference Guide**
http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/PUBLIC%20MISC%20FILES/ROPA%20Enrollment%20Overview_QRG.pdf
Program Integrity
The Program Integrity Department utilizes internal and external resources to help ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from Prestige Health Choice or, on behalf of Prestige Health Choice, regarding payment or recovery of potential overpayments. You may be asked to provide supporting documentation including, but not limited to, medical records, itemized bills or other supporting documentation to support the review of the claim(s). In addition, you may be informed that your claim submission patterns vary from industry standards; if this were to occur you would be notified and additional action may be required on your behalf. Should you have any questions regarding the communication received relating to these requests, please use the contact information provided in the communication to expedite a response to your question or concerns. Authorization of services is not a guarantee of payment and Prestige Health Choice reserves the right to adjust any payment made following the review of the medical record, itemized bill and determination of the medical necessity of the services provided.

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 records or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member’s eligibility changes between when the authorization was issued and the service was provided.
Chapter 2: Provider Complaint Process

Overview
Prestige Health Choice maintains a provider complaint 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. Complaints are reviewed and resolved by the Provider Complaints Department.

Should a provider disagree with a claims decision, the provider may participate in the provider complaint process. Some examples could include:

- 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 Complaint
1. Download the Provider Complaint Form at www.prestigehealthchoice.com and complete in its entirety.
2. Submit the provider complaint to the following:
   - Mail: Prestige Provider Complaints Dept.
     PO Box 7366
     London, KY 40742
   - Fax: 1-855-358-5853
3. Please include all relevant information to support your provider complaint, including but not limited to:
   - Fee schedules
   - Copy of contract
   - Remittance advice
   - Calculation of expected reimbursement
   - Other information to support the request
4. A provider has ninety (90) days from the claims payment date to submit a provider complaint. All provider complaints past that date will be administratively upheld.
5. Prestige will send an acknowledgement letter within three (3) business days to inform you that we have received your provider complaint.
6. Prestige will utilize relevant statutory timelines in reviewing complaints relating to coordination of benefits issues.
7. Prestige will send a status update after fifteen (15) days of receipt if the provider complaint is not resolved and we will provide written notice of the status every fifteen (15) days until it is resolved.
8. Prestige will resolve all provider complaints within sixty (60) days.
9. 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.
10. 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.
11. If the provider is still not in agreement with the original denial, the provider may appeal the decision by utilizing 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 healthcare providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the provider to the plan and
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 member services 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 Prestige employee, failure to respect an enrollee’s rights, or an enrollee dispute of an extension of time proposed by the health plan to make an authorization decision. The member can file a grievance at any time by calling Member Services at 1-855-355-9800 (TTY/TDD at 1-855-358-5856) twenty-four hours a day, seven days a week.

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 can call Member Services at 1-855-355-9800 (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.

Standard Appeal
A standard appeal can be submitted by a provider on behalf of the member. The provider, with member’s consent, can call Member Services at 1-855-355-9800 (TTY/TDD at 1-855-358-5856) or fax appeal request to 1-855-358-5847.

Providers can file an appeal orally or in writing on behalf of the member within 60 calendar days of the member’s receipt of the Notice of Adverse Benefit Determination and, except when expedited resolution is required, must be followed with a written consent within ten calendar days of the oral filing.

Expedited Appeal
A member or his/her authorized representative, with the member’s written consent, can request an expedited appeal if 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 healthcare services, not denied claims. To ask for an expedited appeal, the member or his/her authorized representative can call Member Grievances and Appeals at 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  
Medicaid Hearing Unit  
P.O Box 60127  
Ft. Myers, FL 33906  
(Toll-free) Phone: 1-877-254-1055  Fax: 1-239-338-2642 MedicaidHearingUnit@ahca.myflorida.com


**Continuation of Benefits**

The member may continue to receive services while waiting for Prestige’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, Prestige 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, Prestige will issue an authorization for the services to restart as soon as possible and Prestige will pay for the services.

**OR**

The member can continue to receive services while waiting for Prestige’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: Population Health

Utilization Management (UM)
UM activities are designed to assist our providers with the organization and delivery of appropriate healthcare 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 population health nurse in discharge planning discussions and meetings.
- Providing a plan of treatment, progress notes and other clinical documentation as required.

Providers can reach Prestige - Utilization Management - by calling 1-855-371-8074 Monday through Friday from 8:00a.m. to 5:00p.m. After hours staff are available to assist with urgent or discharge needs at the same number after 5:00p.m., on holidays, or weekends.

Members needing assistance with UM issues can call 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:

- By fax
  - For outpatient or planned inpatient services, please complete the prior authorization request form and fax to 1-855-236-9285.
  - For inpatient, Skilled Nursing Facility and Rehabilitation requests, clinical documentation and admission notifications, fax to 1-855-236-9293.
- Call the Prestige Utilization Management Department at 1-855-371-8074.
- Durable medical equipment/home health requests – contact Coastal Care Services at 1-855-481-0505.
- For Behavioral Health call 1-855-371-3967.
- For transplant requests call 1-855-355-9800.

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 SMMC 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.

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, or a covered service/benefit.

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.
Prestige uses 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 but not limited to:

- **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 for post discharge support.
  - 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 Prestige Utilization Management at 1-855-371-8074.

Prestige does not reward healthcare providers for denying, limiting, or delaying benefits or healthcare services, give incentives to staff or providers for making decisions about medically necessary services, or give rewards to provide less healthcare 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 primary care physician, treating provider, 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 not a guarantee of payment for the service authorized. Prestige reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the
medical necessity of the services provided. Additionally, payment may also be adjusted if the member’s eligibility changes between when the authorization was issued and the service was provided.

Prior authorizations are processed by Prestige Utilization Management. The most up-to-date listing of services requiring prior authorization or notification is maintained on the Prestige website at www.prestigehealthchoice.com. You can also request a listing by contacting Provider Services at 1-800-617-5727. Providers can request prior authorization by:

- Submitting the request online via our secure provider portal at www.availity.com. (preferred method)
- Completing an authorization request form and securely sending a fax request to 1-855-236-9285. All forms are located on the Prestige website, www.prestigehealthchoice.com. (Incomplete forms will not be processed and will be returned to the requesting provider.)
- Calling Utilization Management at 1-855-371-8074.

If prior authorization is not granted, associated claims will not be paid.

When requesting prior authorization:
- The prior authorization request should include the member’s information, diagnosis to be treated and all CPT and/or HCPCS code(s) needed for 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 durable medical equipment (DME), home health and home infusion services provided in the home (billed with place of service 12) 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 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:
  - Please contact Bright Start® at 1-855-371-8076.
- Orthotics/prosthetics.
- Vision, hearing, and speech pathology services (HCPCS codes in the "V" series).

To request prior authorization from Coastal Care Services, please call 1-855-481-0505 or fax to 1-855-481-0606.

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 frame could endanger the member. 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.

**Prior Authorization Specific to Pregnancy-Related Services**

All obstetric care requires a pregnancy notification form in order for proper and expedient payment to be made to obstetric providers. Once approved, this authorization includes three (3) obstetric 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](http://www.prestigehealthchoice.com) and can be faxed to the Prestige Bright Start® Department at 1-855-358-5852 or submitted online via the secure provider portal at [www.availity.com](http://www.availity.com).

Providers can also review the status of an existing authorization request by utilizing our secure portal [www.availity.com](http://www.availity.com).

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 obstetric services enables Prestige to identify members for inclusion into the Healthy Behaviors Prenatal Program and for reporting pregnancies to the Florida Department of Children and Families.

**Inpatient Concurrent Review and Discharge Planning**

Inpatient facilities must notify the Utilization Management Department within one (1) business day after the date of admission.

Concurrent review determinations will be made within 1 business day 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 Utilization Management 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; these services may require prior authorization.

**Denials Based on Lack of Medical Necessity**

If you receive an adverse benefit determination (denial) from Prestige, you have three (3) business days from the verbal, online 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 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 a decision to uphold a denial 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 within sixty (60) days of notification of the upheld denial decision. The appeal will require the member’s written consent.

**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 healthcare 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 healthcare 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 providers’ 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.

**Population Health Management**

Prestige Health Choice (PHC) Population Health Management (PHM) strategy uses a population health framework to strive to match Medicaid members to the level of support they need to address their medical, behavioral health and social needs. The PHM strategy utilizes a person-centered approach that listens to and respects Member and family choices, including cultural, spiritual, and linguistic preferences. It provides customized, integrated, person-centered care comprehensively addressing member wellness. The strategy delivers and coordinates services in a way that blends advanced data-driven stratification and analyses with appropriate levels of individual engagement such as advocacy, communication, problem-solving, collaboration, and empowerment. These services focus on proactive medical care coordination, support and assistance to members with medical, behavioral and social issues that affect their quality of life and their health outcomes.

The PHM approach includes nurses, behavioral health clinicians, non-clinical care connectors and community health navigators, clinical pharmacists, PHC medical and behavioral health directors, primary care physicians (PCPs), specialists, and community agencies. This multi-disciplinary approach works with members, caregivers, and parents/guardians to meet our members’ needs at all levels in a proactive manner; a process designed to maximize health outcomes and quality of life.

The overall objective of the PHM strategy is to proactively identify and intervene with PHC members with potential avoidable health care needs and to empower at-risk members to regain optimum health or improved functional capability.
The PHM strategy consists of core components that are focused on the member’s level of need, including: Complex Care Management (CCM), Care Coordination, Bright Start Maternity Management, Pediatric/Adolescent Preventive Health Care, Disease Management, and Health and Wellness activities. Each component is designed around a holistic approach that addresses physical health, behavioral health and social determinants of health.

1) Keeping Members Healthy (Low Risk): Members in subsets assigned to this domain are mostly healthy. They need reminders for preventive health services and education for health promotion-related activities, including well child visits and other preventive health services, along with access to health services to address needs as they arise.

2) Managing Emerging Risk (Moderate Risk): Members in subsets assigned to this domain have short term needs related to a chronic condition, social determinant of health or challenges navigating the health care delivery system. These members benefit from care coordination including education on their condition, reminders for health monitoring and medication refills, connections to community resources and assistance coordinating treatment and follow-up care.

3) Managing Multiple Chronic Illnesses and/or Disabilities (High Risk): Members in subsets assigned to this domain have multiple co-morbid conditions, unstable support systems, social instability and/or need ongoing assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). They often require ongoing care management support and education to strengthen their self-management skills and achieve their individual goals. These members also need assistance to navigate and connect with needed health care services and available community supports.

4) Member Safety (All Risk): Interventions to promote member safety are implemented across the populations in the above domains. Member safety activities include management of care transitions and medication safety.

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 neonatal intensive care unit 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 inter-pregnancy 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, claims data, information from the initial health assessment, referrals from internal departments, the use of member newsletters, 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 who works closely with the member, ensuring 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 care managers separate pregnant members into low and high intensity risk categories:

• Low risk pregnancy management - members receive care coordination from care connectors and receive pregnancy-related educational materials and outreach phone calls to encourage good prenatal care.
• 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.
• In-home services are available and include an obstetrical registered nurse to perform in-home assessments, pre-term labor education and progesterone injections on a weekly basis. Prior authorization is required for Makena and/or progesterone administration.

All pregnant members have access to a 24-hour toll free registered nurse call line at **1-855-398-5615**. 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 Population Health Management model is the Rapid Response & Outreach Team (RROT). This team 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 through the RROT:

• Inbound call service – members and providers can request support by calling the RROT at **1-855-371-8072** Monday through Friday from 8:00a.m. to 5:00p.m. Providers can call the RROT for assistance in coordinating office-based care for members; to request assistance for members who need community resources or to refer a member to any care management service.
• Outreach services – outreach activities include telephonic outreach such as completion of health risk assessments and support of special projects and quality initiatives. These include those related to Healthcare Effectiveness Data and Information Set (HEDIS) and EPSDT/well child campaigns. RROT employees also initiate continuity of care calls to chronically ill members during hospital stays, to those recently discharged from the hospital and to members who have used the nurse call line within the past 24 hours.
• 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 for 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 addresses the urgent needs of our members and supports providers and their staff. This team works to assist members in overcoming barriers to healthcare goals and ensuring continuity of care. They are here to support you. Call them at **1-855-371-8072** from 8:00 a.m. to 5:00 p.m. Monday-Friday. After hours and on weekends and holidays, please call our 24-hour nurse call line at **1-855-398-5615**.

2. **Fax** a member intervention request form to **1-855-236-9281**. This form can be found at [www.prestigehealthchoice.com](http://www.prestigehealthchoice.com).

3. **Refer a patient to the Complex Case Management Program:** complex case management is a voluntary program that focuses on prevention, education, lifestyle choices and adherence to treatment plans. It is designed to support your plan of care for patients with chronic diseases such as asthma, diabetes, and 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.
- Well Child Visits – please refer to the Medicaid Well Child Visits 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 up to 4 years of age.
- Immunizations – please refer to the immunization 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 children and adolescents aged 18 years or younger, 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).
- Providers are encouraged to provide the Department of Children and Families with complete immunization records as part of the Temporary Cash Assistance application process if asked by a Prestige member.

Prestige has adopted the following recommended immunization schedules for members under the age of twenty-one (21).

Immunization Schedules (childhood, adolescent and adult)

For the recommended vaccines and immunization schedules, please visit [www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html](http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html) for children and adolescents and [www.cdc.gov/vaccines/schedules/hcp/adult.html](http://www.cdc.gov/vaccines/schedules/hcp/adult.html) for adults.

Visit [www.uspreventiveservicestaskforce.org/usptopics.htm](http://www.uspreventiveservicestaskforce.org/usptopics.htm) for the Guide to Clinical Preventive Services for recommendations made by the U.S. Preventive Services Task Force for clinical preventive services.

Vaccines for Children Program (VFC)

The Vaccines for Children Program 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 Centers for Disease Control and Prevention purchases vaccines at a discount and distributes them to grantees, e.g., state health departments and certain local and territorial public health agencies, that then distributes 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 VFC supply and bill Prestige for the administrative fee only.
• MediKids are not covered under the VFC program.
• Members nineteen (19) through twenty (20) years of age should receive their vaccinations from their primary care physician. 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:
  o The non-participating provider contacts Prestige at the time of service delivery; and
  o 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
• Well child visits include preventive and comprehensive services for eligible children birth through twenty (20) years of age and enrolled in the Medicaid program. Prestige’s well child visit coverage directs participating providers to adhere to the following: Conduct a comprehensive health screening evaluation that includes a past medical history, developmental history and behavioral assessment. The screening evaluation should also include:
  o A nutritional assessment
  o Comprehensive unclothed physical exam
  o Developmental assessment
  o Growth measurements
  o Appropriate immunizations based on the Recommended Childhood Immunization Schedule for the United States
  o Laboratory testing (including blood lead testing as outlined below)
  o Health education (including anticipatory guidance)
  o Dental screening (including a direct referral to a dentist for members beginning at age three (3) or earlier as indicated)
  o Vision screening (including objective testing as required)
  o Hearing screening (including objective testing as required)
  o Diagnosis and treatment
  o Referral and follow-up as appropriate
  o 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 provided on the AHCA website at: [https://ahca.myflorida.com/medicaid/childhealthservices/chc-up/index.shtml](https://ahca.myflorida.com/medicaid/childhealthservices/chc-up/index.shtml).
• Prestige does not require authorization for a member to be seen by a participating specialist when determined that it is needed by a primary care physician.
• Primary care physicians are 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.

Well Child Visit 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 can 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 can 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 AHCA 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 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 or 1 set of eye glasses per year.</td>
<td>Yes, if done by a private practitioner</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 at a Community Mental Health Center.</td>
</tr>
<tr>
<td></td>
<td>Daytime treatment for behavioral health</td>
<td>Unlimited; must be active in case management.</td>
<td>No</td>
</tr>
</tbody>
</table>

For Vision services please contact Premier Eye Care.
<table>
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<tbody>
<tr>
<td>Behavioral Health Day Services/Day Treatment</td>
<td>Needs about everyday living. Day care services, adult.</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>No</td>
</tr>
<tr>
<td>Behavioral Health Screening Services</td>
<td>Assessments and screening services for mental health and substance use issues.</td>
<td></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 use needs.</td>
<td></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 use issues with medication.</td>
<td></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></td>
<td>No</td>
</tr>
<tr>
<td>Cellular Phone Service</td>
<td>This benefit can help members stay in touch with Prestige or their providers.</td>
<td>One cellphone. 1000 minutes, unlimited text messages, and 1 GB of data per month. Unlimited calls to Prestige Health Choice Member Services.</td>
<td>No</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Services and treatment provided by a chiropractic provider.</td>
<td>Expanded benefit covers 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, the member’s family, or one-to-one sessions with a mental health professional while the member has a physical illness.</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Health and behavior intervention; family (without the patient present).</td>
<td></td>
<td>No</td>
</tr>
<tr>
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<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>Meals delivered at home if provider believes this is a high risk pregnant member.</td>
<td>Up to two 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>Home Delivered Meals – Post-Discharge</td>
<td>Meals delivered to members’ home after leaving a medical facility.</td>
<td>Up to two 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 with activities of daily living like bathing, getting dressed and eating.</td>
<td>Provide up to an additional 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>Assistance with locating community resources that support housing options and alternatives for all members; provides 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</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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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></td>
</tr>
<tr>
<td>Meals - Non-emergency Transportation</td>
<td>Reimbursement for the cost of meals when traveling 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>Prior authorization required for physical therapist. No prior authorization needed for chiropractor.</td>
</tr>
<tr>
<td>Day-Trips</td>
<td></td>
<td>Limited to $50 per day with annual maximum of $250.</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>Some service limits apply. Call Coastal Care Services at 1-855-481-0505 for more information.</td>
<td>Yes</td>
</tr>
<tr>
<td>Incontinence products</td>
<td>Maximum of 200 products per month; any combo of applicable codes can be billed. Some service limits apply.</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Medically Related Home Care Services</td>
<td>One carpet cleaning service to help adults control their asthma. Once per year, up to $100.</td>
<td></td>
<td>Yes – needs case management referral</td>
</tr>
<tr>
<td>Medication Assisted Treatment</td>
<td>A licensed program that gives medication to lessen withdrawal symptoms from drugs or alcohol, along with supportive counseling.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Newborn Circumcision</td>
<td>An elective surgery for baby boys.</td>
<td>Available during initial hospital stay and in physician’s office for 90 days after birth.</td>
<td>Yes, if discharged from the hospital and within 90 days after birth</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Provides you with information about</td>
<td>Unlimited</td>
<td>No</td>
</tr>
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</tr>
<tr>
<td>Occupational Therapy</td>
<td>Adult occupational therapy services.</td>
<td>One initial evaluation and re-evaluation per year; up to seven 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 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 products.</td>
<td>No</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Adult physical therapy services.</td>
<td>One evaluation and re-evaluation visit per year; up to seven 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 Adults)</td>
<td>Visits with your PCP.</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Adult respiratory therapy services.</td>
<td>One evaluation and re-evaluation per year; respiratory therapy visits one per day.</td>
<td>No</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Adult speech therapy services.</td>
<td>One initial evaluation and one re-evaluation visit per year, up to seven 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 from 6 months to 12 years of age. Up to $200 per enrollee will be paid to a plan approved agency or certified instructor.</td>
<td>Yes, will require plan referral.</td>
</tr>
<tr>
<td>Therapy (Art)</td>
<td>Art uses creative activities, such as drawing and painting as part of treatment.</td>
<td>Up to seven sessions per year on outpatient basis.</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy (Equine)</td>
<td>Uses horseback riding with a behavioral health</td>
<td>Up to three sessions per year for enrollees with a substance use disorder or chronic condition</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
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</tr>
<tr>
<td>Therapy (group)</td>
<td>Therapy for a group of people with a mental health professional.</td>
<td>You may have to pay for the services if you go to a provider that is not in the Prestige network under care management, on an outpatient basis.</td>
<td>No</td>
</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>Volunteers and their pets to help with treatment or therapy.</td>
<td>Up to three 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 vaccine per pregnancy.</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine – Influenza</td>
<td>A vaccine to help reduce the chance of getting the flu.</td>
<td>One 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 getting shingles.</td>
<td>Adult enrollees who have had chickenpox and as medically advised.</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
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</tr>
<tr>
<td>Vaccine - Pneumonia (pneumococcal)</td>
<td>A vaccine that helps reduce the chance of getting pneumonia.</td>
<td>Two 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 year apart.</td>
<td>No</td>
</tr>
<tr>
<td>Waived Copayments</td>
<td>Member will not have any copayments on any 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>
Chapter 6: Credentialing

Credentialing Requirements
Prestige Health Choice operates in compliance with the standards set forth by the National Committee for Quality Assurance, the Agency for Health Care Administration 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 agreement other than Limited or Fully Enrolled 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 2 background check pursuant to s. 409.907, F.S.

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

If the provider is currently suspended or terminated from Florida Medicaid whether by contract or sanction, other than for purposes of inactivity, that provider is not considered eligible to participate as a Prestige 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 a provider’s 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 Quality 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 license (when applicable).
- Professional liability insurance or proof of meeting other state requirements.
- Clinical Laboratory Improvement Amendments number (when applicable).
- A current group W9 form (not older than 12 months).
• A correct and active Practitioner and Group National Provider Identifier.
• At least five years of employment history by 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 a 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:
• An attestation of the correctness and completeness of the information supplied.
• Current copy of state license for each address (when applicable).
• Copy of certificate of accreditation (when applicable).
• Copy of Clinical Laboratory Improvement Amendments license (when applicable).
• Copy of Drug Enforcement Administration license (when applicable).
• A current W9 form (not older than 12 months).
• Evidence of Medicaid eligibility.
• Active Medicaid Number/Enrollment/Certification.
• Current copy of the general and malpractice liability insurance. This document must indicate the current facility name and address.
• Documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid Sanctions, or loss, limitation, or cancellation of professional liability insurance.
• Ownership Disclosure Form.
• If the organizational provider does not have accreditation or a CMS State Survey or letter from CMS, or if the most recent survey is older than 3 years old, a Plan Site Visit must be performed.

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:
  o Limited or loss of license;
  o Change in Medicaid status;
  o Loss of sufficient liability coverage;
  o Fraud or felony investigation; and/or
  o 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 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 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 Prestige’s Risk Management Department by the 5th of each month.

Primary Care Providers (PCP)

A Primary Care Provider is a 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.

Our PCPs are 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, 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 principles which includes the following characteristics: a primary care provider adopting a “whole person” orientation; coordinated and/or integrated care based on physical and behavioral health needs; taking into account members’ socioeconomic conditions and cultural norms; quality and safety; and enhanced access to care. 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. This includes 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, 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 well child visit).
• High cost specialty/injectable drugs, as listed on the prior authorization list, require a prior authorization and must be obtained from Prestige Health Choice 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, and immunizations according to the Advisory Committee on Immunization Practices 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, body mass index, 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 could benefit from Prestige Health Choice’s 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 (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 Prestige.

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 for maintaining 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.

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.

**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. 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 the Special Supplemental Nutrition Program for Women, Infants, and Children) 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 Prestige 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.

PCPs coordinate member 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 www.prestigehealthchoice.com under Provider Resources. Authorization
requests for services requiring an authorization can be submitted online at www.aviality.com or via Prestige Health
Choice 24-Hour Nurse Call Line at 1-855-398-5615.

For additional information please contact Utilization Management at 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 Rapid Response and Outreach Team at 855-371-8072 Monday through Friday from 8:00a.m. to
5:00p.m.

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.
• GYN services, including those of a certified nurse midwife.
• Women’s health services provided by a Federally Qualified Health Center 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.
• 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 Prestige Health Choice Provider Services 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 should notify Prestige in advance of making any addition or change to your office locations, as referenced in your contract. The standard notification timeframe is at least sixty (60) days prior to making any addition or change to office locations.

**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 in-patient and selected out-patient 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 with AHCA provider requirements and public health initiatives.
- Immediately report knowledge of 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 is mandated to report abuse, neglect and exploitation and has received appropriate training in reporting abuse, neglect and exploitation.
- Participate in any other training as mandated by regulatory authorities and/or Prestige Heath Choice.
- Follow Prestige Health Choice’s medical records 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 Prestige Health Choice.
• Follow Prestige Health Choice’s medical documentation policy.
• Follow Prestige Health Choice’s QI and UM programs.
• 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 in-patient 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 in-patient and selected out-patient 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 Prestige’s UM staff access to the hospital’s electronic medical record system when applicable.
• Participating hospitals should refer to their contract for complete information regarding the hospital’s 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.
• Hospital warrants and represents that staff is mandated to report abuse, neglect, and exploitation and has received appropriate training in reporting abuse, neglect and exploitation.
• Provider agrees to participate in any other training as mandated by regulatory authorities and/or Prestige Health Choice.
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 healthcare 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 non-compliance, 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 Prestige 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;
- Include 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 enrolls and their children (including referrals to the Florida Special Supplemental Nutrition Program for Women, Infants, and Children, 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; and
• Documentation of the express written and informed consent of the enrollee’s authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, anti-anxiety 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:
   
   (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 authorization 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 conducts record review audits to help ensure adherence with Prestige’s medical record documentation standards and guidelines, and compliance with State and Federal rules, laws and contractual obligations. Included in the records review audits, Prestige confirms that the records are well documented to facilitate communication, coordination, continuity of care, and promote efficient and effective treatment. Standardized tools along with an established scorecard are utilized to assess compliance with medical record standards and practice guidelines. The audits are conducted as a monitoring activity of provider sites. Additionally, a random sample of newborn and prenatal records are audited annually. Medical records are reviewed to verify they accurately reflect all services provided directly by the provider, including all ancillary services, and all the diagnostic and therapeutic services for which the provider referred the member. Enrollee records will be treated as confidential information and be accessible only to authorized persons.
**Advance Directives**

Prestige Health Choice is committed to ensuring 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 Prestige Member Welcome Kit).
- Member services 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 Quality Improvement will monitor compliance with this provision during medical record reviews and as scheduled thereafter.

**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 U.S. 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 -- provides 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 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.

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 member 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 healthcare 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.
- Increased complaints.

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 emergency rooms, 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

Prestige Health Choice expects compliance with federal and state requirements, including, but not limited to those set forth in accordance with/by: Medicaid, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, the Office of Inspector General (HHS-OIG) compliance program elements and privacy requirements, including the Health Insurance Portability Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) and the Omnibus Rule. As such, Prestige has outlined its expectations of staff, subcontractors, vendors, and providers in their ongoing compliance with federal and state requirements in the Prestige Compliance Plan. The elements related to provider compliance include Fraud Waste and Abuse, Risk Management, Education and Training.
Fraud, Waste and Abuse (FWA)

Prestige has a designated Compliance Officer who is primarily responsible for Prestige Compliance and Special Investigations Unit (SIU) activities, and is qualified to oversee the Fraud and Abuse program to help ensure program integrity. Designed in accordance with applicable state and federal rules and regulations, Prestige’s Anti-Fraud Plan addresses the detection and prevention of potential overpayments, abuse, and fraud related to the provision of, and payment for, Medicaid services. The Anti-Fraud Plan includes FWA policies and procedures designed to help prevent, reduce, detect, investigate, correct, and report known or suspected fraud, waste, and abuse activities, and to implement corrective action. For more information on reporting fraud, waste and abuse visit our website at www.prestigehealthchoice.com.

Definitions

Fraud

“Fraud” is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person (FS 409.913 “Fraud Definition” Section 2 paragraph “C”). The term includes any act that constitutes fraud under applicable federal or state law. (Fla. Stat. §409.913(2)(c)(defining fraud)). As applied to the federal health care programs (including the Medicaid program), health care fraud generally involves a person or entity’s intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a federal health care program. Some examples of fraud include:

- Billing for services not furnished
- Soliciting, offering or receiving a kickback, bribe or rebate
- Violations of the provider self-referral prohibition

Waste

“Waste” is the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

Abuse

“Abuse” is defined as provider practices that are inconsistent with generally accepted business or medical practice that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or, as recipient practices that result in unnecessary cost to the Medicaid program (Fla. Stat. §409.913(1)(a)(defining abuse)). In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicaid program. Some examples of abuse include:

- Charging in excess for services or supplies unintentionally
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards

Overpayment

“Overpayment”, defined in accordance with Fla. Stat. §409.913(1)(e), includes any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

False Claims Act

The Florida False Claims Act (the Florida FCA) is a broad-reaching statute defined in Florida Statutes 68.081 through 68.092, designed to address an array of wrongdoing from health care fraud to fraud involving any type of government contract or business relationship involving state or local money. Health care entities that violate the Federal FCA can be subject to civil monetary penalties ranging from $5,000 to $11,000 for each false claim submitted to the United States government or its contractors, including state Medicaid agencies. Fla. Stat. §68.082(1)(g) The Federal FCA
contains a “qui tam” or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

Effective in 2007, the Deficit Reduction Act of 2005 (DRA) increased states’ obligations to fight fraud, waste, and abuse activities within their state Medicaid plans and introduced incentives for the states to enact their own False Claims Acts. Florida has a False Claims Act, codified at Fla.Stat.§68.081, et seq. The purpose of the Florida FCA is to deter persons from knowingly causing or assisting in causing state government to pay claims that are false or fraudulent, and to provide remedies for obtaining treble damages and civil penalties for state government when money is obtained from state government by reason of a false or fraudulent claim. Fla.Stat.§68.081 No proof of intent to defraud is required for liability to attach, but an innocent mistake may be a defense to an action under the Florida FCA. Florida’s FCA includes provisions similar to the federal FCA, allowing for qui tam actions by relators; the Florida Department of Legal Affairs may also bring an action under the Florida FCA. A portion of the amount recovered from prosecuting Medicaid false claims in Florida is deposited to the Medicaid Operating Trust Fund in order to fund rewards for persons who report and provide information relating to Medicaid fraud.

Anti-Kickback Statute
A criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. Fla. Stat. § 456.054

Stark Law
Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. Fla. Stat. § 458.331(1)(i) and 459.015(1)(j)

Provider Responsibilities Related to Fraud, Waste and Abuse
Prestige’s providers must all comply with the False Claims Act to the extent applicable and assist in the detection and prevention of fraud, waste, and abuse in connection with the provision of services in their provider agreements and the State Contract. Providers are also responsible for including the above mentioned provisions in their compliance programs.

All suspected or confirmed instances of fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Prestige employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under state and/or federal law, must be reported to Medicaid Program Integrity (MPI) within five (5) calendar days of detection. To report suspected Medicaid fraud, contact the MPI hotline at 1-888-419-3456 or complete a complaint form online at https://apps.ahca.myflorida.com/mpi-complaintform/. Upon request, and as required by state and/or federal law, providers shall adhere to the following:

Reporting and Preventing Fraud, Waste and Abuse
Compliance with state and federal laws and regulations is mandated. Providers and members may anonymously report suspected fraud, waste, or abuse to the SIU. Please provide as much information as possible or available using one of the following methods:

- Via telephone by calling the Fraud Tip Line at 1-866-833-9718
- By sending an email to FraudTip@amerihealthcaritas.com
• Via postal service
• Online using the Fraud Tip form at http://home.kmhp.com/index.asp?go=/fraud/.
• Directly to the state oversight agency:

Medicaid Program Integrity Bureau (MPI), Office of the AHCA Inspector General

Mail:
Kelly Bennett, Chief
2727 Mahan Drive, MS#6
Tallahassee, FL 32308
Email: MPIComplaints@ahca.myflorida.com
Online Form: https://apps.ahca.myflorida.com/mpicomplaintform/
Website: https://ahca.myflorida.com/MCHQ/MPI/
Hotline: 1-888-419-3456
Phone: (850) 412-4600
Fax: (850) 410-1972

Medicaid Fraud Control Unit of Florida, Office of the Attorney General

Mail:
PL–01 The Capitol
Tallahassee, FL 32399-1050
Hotline: 1-866-966-7226
Phone: 850-414-3990/ 850-414-3300

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program at 1-850-414-3990. The reward may be up to twenty-five (25) percent of the amount recovered, or a maximum of $500,000 per case as set forth in Fla. Stat. §409.9203. You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Below are examples of information that will assist Prestige with an investigation:

• Contact information (i.e., name of individual making the allegation, address, phone number)
• Type of item or service involved in the allegation(s)
• Place of service
• Nature of the allegation(s)
• Timeframe of the allegation(s). As situations warrant, Prestige may make referrals to appropriate law enforcement and/or the Medical Education Development in Communities (MEDIC)

Risk Management
Prestige Health Choice recognizes the importance of minimizing risk to enrollees during the provision of healthcare services. For this reason, Prestige Health Choice utilizes a formal risk management program to promote the delivery of optimal and safe healthcare for enrollees. The program allows objective monitoring, evaluation and correction of situations that may occur in the administration and delivery of healthcare services.
Provisions of the Risk Management Program

The Risk Management Program has developed processes in compliance with contractual reporting requirements. The Risk Manager or designee educates 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 incident 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, the Risk Management Department 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 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 our website at www.prestigehealthchoice.com.

Procedures for Adverse Incident Reporting

Providers and subcontractors must report adverse incidents or injuries affecting Prestige Health Choice 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 Health Choice Risk Management at 1-305-436-7485 or phcriskmanagement@prestigehealthchoice.com. The incident report should be maintained in a secure confidential file.

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

1. Are associated in whole or in part with service provision rather than the condition for which such service provision occurred;
2. Are not consistent with or expected to be a consequence of service provision;
3. Occur as a result of service provision to which the patient has not given his informed consent; or
4. Occur 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 our AHCA contract an injury is defined as:

a. Death.
b. Brain damage.
c. Spinal damage.
d. Permanent disfigurement.
e. Fracture or dislocation of bones or joints.
f. 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.
g. Any condition requiring surgical intervention to correct or control.
h. Any condition resulting in the transfer of a 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 healthcare 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.

**Reporting Abuse, Neglect, Exploitation and Human Trafficking**
In accordance with 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 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/)

**Definitions**

**Adult Abuse**
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. Fla. Stat. §415.102 (1)

**Child Abuse**
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 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. Fla. Stat. 39.01(2)

**Adult Neglect**
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. Fla. Stat. 415.102(16)

Child Neglect
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:

- Eliminate the requirement that such a case be reported to the department;
- Prevent the department from investigating such a case; or
- 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. Fla. Stat. 39.01(35)(4)(f)

Adult Exploitation
A person who 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. Fla. Stat. 415.102 (8)(a).

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. Fla. Stat. 787.06 (7)(d).

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 are committed to preventing human trafficking. 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
  o Bruising
  o Burns
  o Cuts or wounds
  o Blunt force trauma
  o Fractures
  o Broken teeth
  o Signs of torture
• Neurological conditions
  o Traumatic brain injury
  o Headaches or migraines
  o Unexplained memory loss
  o Vertigo of unknown etiology
  o Insomnia
  o Difficulty concentrating
• Cardiovascular/respiratory conditions that appear to be caused or worsened by stress, such as:
  o Arrhythmia
  o High blood pressure
  o Acute Respiratory Distress
• Gastrointestinal conditions that appear to be caused or worsened by stress, such as:
  o Constipation
  o Irritable bowel syndrome
• Dietary health issues
  o Severe weight loss
  o Malnutrition
  o 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
  o Effects of prolonged exposure to extreme temperatures
  o Effects of prolonged exposure to industrial or agricultural chemicals
  o 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
  o Lack of or difficulty in engaging in social interactions
  o Signs of withdrawal, fear, sadness, or irritability
• Depersonalization or derealization
  o Feeling like an outside observer of themselves, as if watching themselves in a movie
  o Emotional or physical numbness of senses
  o Feeling alienated from or unfamiliar with their surroundings
  o Distortions in perception of time
• Dissociation disorders
  o Memory loss
  o A sense of being detached from themselves
  o A lack of a sense of self-identity, or switching between alternate identities
  o 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 www.traffickingresourcecenter.org. For additional resources, please contact the National Human Trafficking Resource Center at 1-888-373-7888 or email at nhtrc@polarisproject.org.

Compliance Education and Training
Prestige Health Choice provides compliance-related trainings to new and existing participating providers. Compliance training covers the following topics:

- Ethics and legal compliance issues
- Fraud, waste, abuse, and overpayments
- Health Insurance Portability Accountability Act (HIPAA)
- Risk Management

At least annually, Prestige will conduct a live webinar for providers including the topics listed above. Information about training and educational opportunities can be found on the Prestige Health Choice website at www.prestigehealthchoice.com.
Chapter 8: Enrollee Rights and Responsibilities

In accordance with 42 CFR 438.100, Florida law requires that healthcare 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 healthcare provider. Florida law requires that a patient’s healthcare provider or health care facility recognize those rights while the patient is receiving medical care and that the patient respect the healthcare provider’s or healthcare 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 healthcare provider or health care facility. A summary of patients’ rights and responsibilities are as 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 healthcare 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 healthcare 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.
- Request a second opinion from another provider.
- Request a copy of medical records and ask to have information added or corrected record, if needed.
- Have medical records kept private and shared only when required by law or with patient approval.
- Designate someone to make medical decisions on the patient’s behalf (advanced directive).
- To file a grievance about any matter other than a Plan’s decision about services.
- To appeal a Plan’s decision about services.
- Receive services from an out-of-network provider if we cannot locate a provider that is part of our Plan.

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.
• Treating health care staff with respect.
• Reporting problems with any health care staff.
• Using the emergency room only for real emergencies.
• Advising of any informational updates (address, phone number, etc.).
• Having a plan for emergencies and access this plan if necessary.
• Report fraud, abuse and overpayment.
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 can 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 can 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 that 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 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 https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.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); and
- 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 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. Hemophilia drugs are an excluded service from the health plans benefit package. They are covered through the fee-for-service Statewide Medicaid Comprehensive Hemophilia Disease Management Program. Though not a covered benefit through the Statewide Medicaid Managed Care Program, health plans are required to coordinate the care of their enrollees who require services covered outside of the managed care delivery system.

CVS Caremark is responsible for the Statewide Medicaid Comprehensive Hemophilia Management Program. CVS Caremark’s contract, combines the provision of pharmaceutical products, pharmaceutical management, and disease management (e.g., treatment and prevention of bleeding episodes, medical consultation, home infusion education, training, twenty-four hours per day, seven days a week access to a registered nurse and a licensed pharmacist) for the Florida Medicaid recipients diagnosed with hemophilia or Von Willebrand disease.

CVS Caremark can be reached Monday- Friday at 1-888-826-5621, option 4 for claims questions associated with hemophilia medications. You can also find additional information on the Agency for Healthcare Administration’s website at [https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/fee-for-service/hemophilia.shtml](https://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 for psychotropic medications, 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 under the age of eighteen (18) years.

For consent forms and resources visit https://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 Preferred Drug List (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. For more information and a list of available OTC products, visit our website at www.prestigehealthchoice.com.

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.

Pharmacy Prior Authorization
Providers are responsible for obtaining prior authorization. A prior authorization is a requirement for physicians to approve medication requests from the health insurance plan. Providers may not bill members for services that require prior authorization for which authorization was not obtained. Authorization is not a guarantee of payment. Other limitations or requirements may apply.

Please refer to the links below for the most up-to-date Preferred Drug List (PDL). The links define the AHCA preferred medications and those requiring prior authorization.

For the PDL visit https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

For prior authorization criteria visit https://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria.shtml

1. Submit authorization requests to the PerformRx℠ Prior Authorization team by fax at 1-855-825-2717.

Mailing Address:
2. To submit requests for medication with Healthcare Common Procedure Coding System (HCPCS) codes that require authorization, include the HCPCS code that corresponds to the medication in the request. If the HCPCS code is a miscellaneous code, the National Drug Code (NDC) number must also be included on the request.

Please refer to the Prestige website at www.prestigehealthchoice.com for the most current information.
Chapter 10: Quality Improvement Program

Overview
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.

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 healthcare needs. These include family practitioners, internal medicine specialists, pediatricians and general practice physicians. 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 (Board) has ultimate authority and accountability for the oversight of the quality of care and services provided to our members. The Board oversees and supports the Quality Improvement Program and provides strategic guidance to the QI program.

Operational responsibility for the development, implementation, monitoring and evaluation of the QI program is delegated by the Board to Prestige’s market president and Quality Improvement Committee. The Prestige leadership group meets with the Board on a monthly basis. Information is then cascaded as needed to the directors of various departments.

Every year, the Director of Quality and Community Outreach engages 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
Prestige’s Quality Improvement Program facilitates the following:

- The effective collection, analysis and reporting of data for a variety of programs.
- The management and reporting of process improvement plans mandated by AHCA.
- Addressing the clinical, psychosocial and function needs of health plan members.
- Reviewing utilization trends including over/under utilization.
- Establishing performance targets for both member and provider satisfaction.
- Works to minimize fragmentation and/or duplication of services through the integration of quality improvement activities across functional areas.
- Maintains compliance with preventive and clinical practice guideline.
- Maintains compliance with all applicable regulatory requirements and accreditation standards.
- Monitors member quality of care and access to care.
- Reducing healthcare disparities by collecting race, ethnicity and language data to monitor and ensure the delivery of culturally competent healthcare.
• Reporting of and incorporation of social determinants of care outcomes, assist in planning for interventions to improve quality of life for our members.
• Establishing and maintaining all continuous quality improvement functionality at Prestige.
• Reviewing quality of care and health outcomes.
• Providing clinical and service improvement initiatives and recommendations for our members/populations.
• Provides oversight of delegation and credentialing-re-credentialing processes.
• Maintaining a system for measuring performance across the organization and networks.
• Working with members, providers and community resources to improve quality of care.
• Utilizing the provider outreach team to provide quality improvement information to network providers.
• Conducting quality of care reviews relative to patient safety.
• Monitoring and ensuring the delivery of culturally competent healthcare.
• Monitoring complaints and grievances.
• Monitoring and reporting on preventive care rendered to our members.

Health Effectiveness Data and Information Set (HEDIS)

HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. 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). HEDIS reporting is required under our AHCA contract and consists of 6 major measure groupings:

1) Well child visits
2) Other preventative
3) Prenatal/perinatal care
4) Comprehensive diabetes care
5) Other chronic and acute care
6) 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 connects members to health-related, community-based services for children’s programs, domestic violence prevention programs, pregnancy prevention programs, prenatal/postpartum pregnancy programs, and behavioral health programs. A complete list and additional details on these quality enhancements is available online at 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 Population Health 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, breastfeeding, immunizations, well child visits, 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 web site.
  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. During the visit, the community health navigator 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 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.
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 Programs
- Adolescent Well-Care visits
- Adult Access to Preventive or Ambulatory 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 Member Services at 1-855-355-9800/ as (TTY/TDD at 1-855-358-5856).
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 use 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**. There are many helpful resources for members on Optum’s Live and Work Well website at [https://www.liveandworkwell.com/content/en/member.html](https://www.liveandworkwell.com/content/en/member.html). You can also access the behavioral health online provider directory from the Live and Work Well page.

**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 use 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 [https://www.providerexpress.com/](https://www.providerexpress.com/).

**Online behavioral health resources.** As a practitioner, Prestige Health Choice’s website has many helpful resources for you. The Behavioral Health & Substance Abuse webpage 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 use medications. Both of these pages can be located in the provider resources section of our website at [www.prestigehealthchoice.com](http://www.prestigehealthchoice.com).

**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 Provider Services 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.
- Providing 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.
- Screening 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.
- Identifying and reporting to applicable authorities any suspected abuse or neglect.
- Assisting in the collection and verification of race/ethnicity and primary language data.
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 Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Hour Nurse Call Line</td>
<td>855-398-5615</td>
<td></td>
</tr>
<tr>
<td>Bright Start® Maternity Program</td>
<td>855-371-8076</td>
<td>855-358-5852</td>
</tr>
<tr>
<td>Claim Status</td>
<td>800-617-5727</td>
<td></td>
</tr>
<tr>
<td>Fraud, Waste &amp; Abuse</td>
<td>866-833-9718</td>
<td></td>
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<tr>
<td>Healthy Behaviors Program</td>
<td>855-236-9281</td>
<td></td>
</tr>
<tr>
<td>Integrated Health Care Management</td>
<td>855-371-8072</td>
<td>855-358-5851</td>
</tr>
<tr>
<td>Member Complaints</td>
<td>855-355-9800</td>
<td></td>
</tr>
<tr>
<td>Member Grievances &amp; Appeals</td>
<td>855-371-8078</td>
<td>855-358-5847</td>
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<tr>
<td>Member Services</td>
<td>855-355-9800</td>
<td>TTY: 855-358-5856</td>
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<td>Provider Complaints</td>
<td>800-617-5727</td>
<td>855-358-5853</td>
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<tr>
<td>Provider Services</td>
<td>800-617-5727</td>
<td>855-358-5849</td>
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<tr>
<td>Quality Improvement</td>
<td>855-358-5854</td>
<td></td>
</tr>
<tr>
<td>Rapid Response &amp; Outreach</td>
<td>855-371-8072</td>
<td>855-236-9281</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>855-371-8074</td>
<td>Inpatient 855-236-9293</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior Authorization 855-236-9285</td>
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## Appendix B: Subcontractor and Vendor 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>Optum</td>
<td>855-371-3967</td>
</tr>
<tr>
<td>Electronic Claims Submission</td>
<td>Change Healthcare</td>
<td>877-363-3666</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>Non-Emergency Medical Transportation</td>
<td>MTM</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>
<tr>
<td>Payment Integrity</td>
<td>Equian</td>
<td>800-304-5649</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>PerformRx</td>
<td>855-371-3963</td>
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