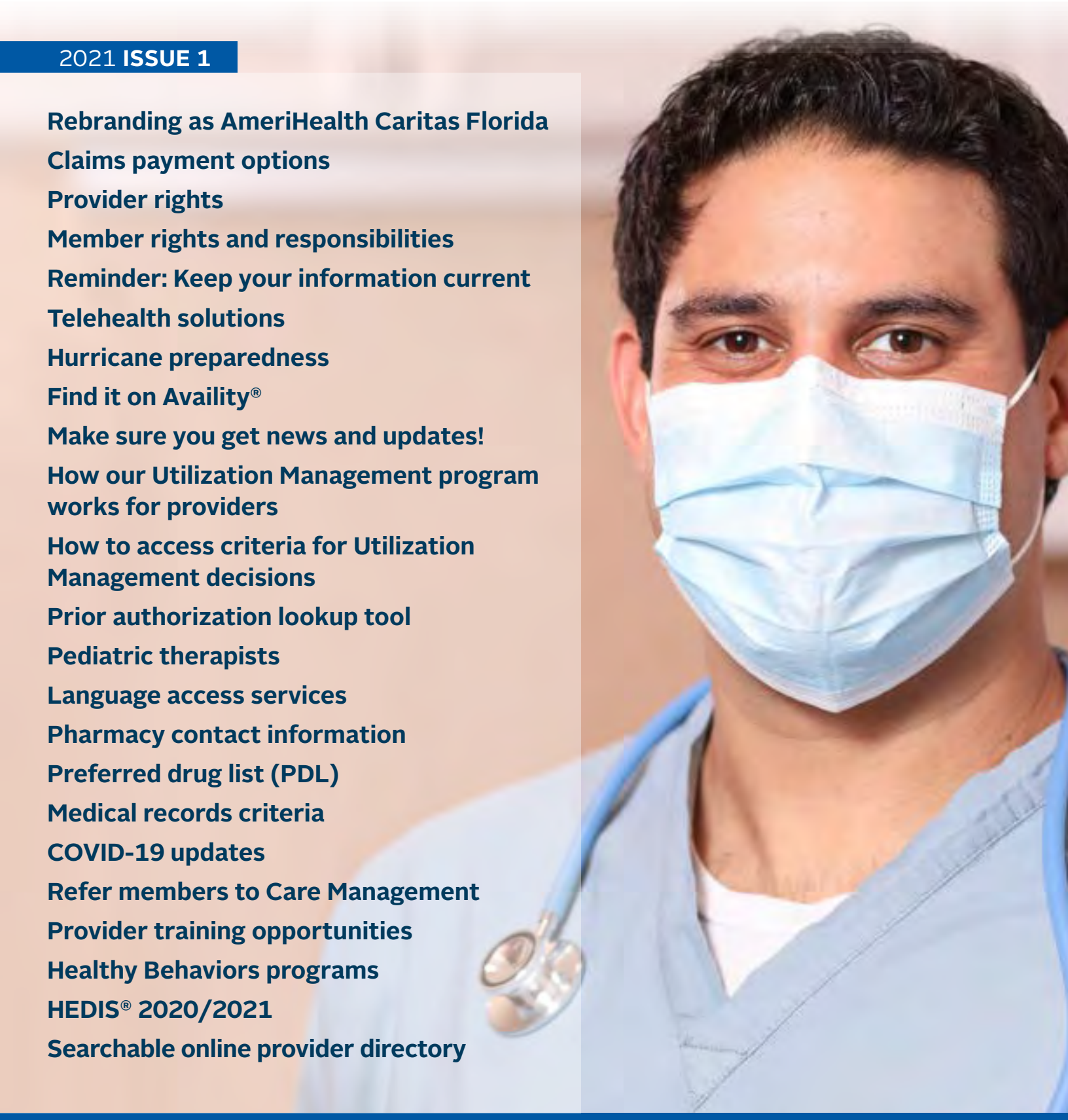
PROVIDER CONNECTIONS

Prestige HEALTH CHOICE®
Leading the Way to Quality Care

2021 **ISSUE 1**



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A Provider's Link to Prestige Health Choice

Rebranding as **AmeriHealth Caritas Florida**

On **July 1, 2021,** we will be changing our name from Prestige Health Choice to AmeriHealth Caritas Florida. This change will show our long-standing affiliation with the AmeriHealth Caritas Family of Companies. Our members have been notified of the change and will receive updated member ID cards reflecting the AmeriHealth Caritas Florida name.

Important highlights:

- Members will be issued new ID cards that will have the AmeriHealth Caritas Florida name and logo.
- No change will be made to Member ID numbers.
- No changes will be made to the Provider Services or Member Services phone number.
- No changes will be made to plan policy and procedures.
- No changes will be made to your current contract, other than the new legal name.
- The Prestige Health Choice website will change to **www.amerihealthcaritasfl.com**. Until July, please continue to visit us at **www.prestigehealthchoice.com**.

For medical and behavioral health providers:

- No change to your Provider ID number.
- No change to the EDI payer ID number.
- No change to Availity access.

We value your partnership and thank you for your continued commitment to the care of our members. If you have any questions about the name change, please call your Provider Account Executive or the Provider Services department at **1-800-617-5727**.

Claims payment options

Electronic claims payments. As of October 23, 2020, Prestige Health Choice is now offering more choice in payment methods. Electronic claims payments have the added benefit of reducing potential exposure risk associated with paper checks.

- **Virtual credit card (VCC) services**. VCC payment is your default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, your Explanation of Payment (EOP), and an instruction page for processing. Normal transaction fees apply based on your merchant acquirer relationship. To opt out of this VCC payment method, you can contact ECHO directly at **1-888-492-5579**.
- **Electronic fund transfer (EFT) payments**.
  - Payments appear on your bank statement from PNC and ECHO as "PNC – ECHO".
  - If you are using a practice management system, be sure your software reflects the new ECHO payer ID 58379 in addition to the Prestige Health Choice payer ID 77003 to receive Electronic Remittance Advices (ERAs).
  - All generated ERAs will also be accessible to download from the ECHO provider portal (**www.providerpayments.com**). Changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Enrollment team at **1-888-834-3511**.
- **Setting up EFT payments**. Setting up EFT is fast and straightforward. In addition to your banking account information, you will need to provide an ECHO payment draft number and payment amount as part of the enrollment authentication. Please note: Payments from Prestige Health Choice will appear on your bank statement from PNC and ECHO as "PNC– ECHO".
  - To sign up to receive EFT from Prestige Health Choice and any affiliated plans in the AmeriHealth Caritas Family of Companies, visit **https://enrollments.echohealthinc.com/efteradirect/enroll**. You only need to enroll once for all Prestige Health Choice affiliated plans and there is no fee.
  - To sign up for EFT from all payers you work with to process payments on the ECHO platform, visit **https://enrollments.echohealthinc.com/**. A fee for this service may apply.
- **MedPay**. If you are not enrolled with us to receive payments via EFT, and you opt out of VCC, and have enrolled for Medical Payment Exchange (MPX) with another payer, you will continue to receive your payments in your MPX portal account. Otherwise, you will receive a paper check via print and mail.

In addition, we want to make you aware that you will also be able to log into **www.providerpayments.com** to access a detailed EOP for each payment from Prestige Health Choice.

Provider rights

Prestige Health Choice is committed to complying with all applicable requirements under federal and state law and all regulations pertaining to provider rights. As a provider, you have the right to:

- Review information submitted to support your credentialing application. This includes any information you submit or any outside information obtained through primary source verification. The Credentialing department will share all information with you with the exception of references, recommendations, or protected peer review information.
- Correct erroneous information. You will be notified by phone or in writing of the discrepancy. You will be requested to return, within 10 business days, confirmation acknowledging communication of the discrepancy and will be required to submit a written explanation or provide an amended application. Submit corrections to the Credentialing department at **credentialingsupport@prestigehealthchoice.com.**
- Upon request, you may be informed of the status of your credentialing or recredentialing application. The Credentialing department will share all information with the provider with the exception of references, recommendations, or protected peer review information. Requests can be made via phone, email, or in writing. Our responses to you will be made via email or phone.

You have the right to appeal adverse credentialing determinations.

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

If Prestige Health Choice denies or terminates a provider during credentialing or recredentialing, a notification will be sent to the provider within the time frame 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., recredentialing), and time frames regarding response for a request to appeal the decision.

Member rights and responsibilities

Prestige Health Choice is committed to complying with all applicable requirements under federal and state law and regulations pertaining to member privacy and confidentiality rights. Member rights and responsibilities are available on our website at **www.prestigehealthchoice.com**. The PDF resource may be downloaded and printed. Please share this information with your Prestige Health Choice member patients, if asked.

Reminder: **Keep your information current**

The CAQH ProView® online application makes it quick and easy for you to stay current by allowing you to update only the information that needs to change. There's no need to resubmit information that should stay the same. Please remember to verify all contacts listed in CAQH ProView, including your credentialing contact information. Prestige Health Choice will reach out to the credentialing contact listed in CAQH ProView at the time of credentialing and recredentialing

Telehealth solutions

Prestige Health Choice readily embraces telehealth to better engage members in their care and improve outcomes. Prestige Health Choice can even assist members with technology barriers. Prestige offers a smartphone at no cost (one per household for members 18 and older). The member can call **1-877-631-2550** and use the promo code AMERIHEALTH to get registered.

Please visit our website to complete the telehealth attestation form **www.prestigehealthchoice.com** so that we can inform members of your telehealth service option. The completed form can be returned to: **PNM_Inquiries@prestigehealthchoice.com.**

Prestige Health Choice follows the relaxed guidelines enacted due to COVID-19 as endorsed by AHCA. Please continue to follow AHCA's requirements on telehealth.

Hurricane preparedness

Prestige Health Choice is committed to the health and safety of our members. With the approach of hurricane season, which officially runs from June 1 to November 30, now is the time to start preparing.

When an emergency does arise, perhaps the most important step is to be informed. Prestige Health Choice is committed to keeping you — our provider partners — updated on any changes to our coverage policies and procedures to ensure continuity of care for our members.

We encourage you to visit our website at **www.prestigehealthchoice.com** for important updates this hurricane season.

For state information on emergency planning, please visit **www.floridadisaster.org**.

Find it on Availity®

You can now find missing recommended services (care gaps) for your Prestige Health Choice members right on Availity. Care gap reports provide patient care information through Availity (e.g., immunizations for which the member is due) and Healthcare Effectiveness Data and Information Set (HEDIS®) care gap information when you need it.

You can also perform the following on Availity:

- Eligibility and benefits inquiry.
- Claim status inquiry.
- Authorization submission and inquiry.
- Report inquiry, including Panel Roster.

Go to Availity at **www.availity.com/providers/registration**-details/. Click the Register tab to begin the enrollment process.

Make sure you get news and updates!

At Prestige Health Choice, we are committed to delivering timely communication of health plan updates. Please be sure we have your correct fax and/or email contact information. You can update your information by contacting your Account Executive or Provider Services at **1-800-617-5727**.

Stay up to date on plan news and resources by visiting us at **www.prestigehealthchoice.com**.

How to access criteria for **Utilization Management decisions**

The Prestige Health Choice Utilization Management (UM) team bases coverage decisions only on the appropriateness of care and the service provided. Prestige Health Choice does not reward health care providers for denying, limiting, or delaying benefits or health care services. We also do not reward our staff for making decisions about the medical necessity of services or benefits that increase or decrease health care coverage and services.

All Prestige Health Choice providers and members may receive, at no cost, a copy of our criteria for UM determinations. Our provider and member handbooks, and UM determination letters, describe how to obtain a copy of the clinical criteria we use for UM determinations.

To receive a fax copy of these criteria, providers may contact the UM team at **1-855-371-8074**.

How our **Utilization Management program works** for providers

Our UM staff (i.e., nurses, Medical Directors, and pharmacists) regularly review the medical appropriateness of services for which authorization is requested. Approval or denial of coverage for requested services is based on medical necessity, eligibility for outpatient and inpatient services, and benefit guidelines. The medical necessity review is performed using:

- Nationally accepted medical guidelines.
- Medical information, including Medicaid benefits and supporting clinical information.

Prestige Health Choice does not reward health care providers for denying, limiting, or delaying benefits or health care services. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Prior authorization lookup tool

The Prestige Health Choice Prior Authorization Lookup Tool is a new, user-friendly resource which allows you to enter a CPT or a HCPCS code to verify the prior authorization requirements in real time, before the delivery of service. The tool is designed to be easy to use and offers general information on preauthorization for outpatient services performed by a participating provider. Please try the Prior Authorization Lookup Tool on our website at **www.prestigehealthchoice.com > provider > resources** to view all CPT and HCPCS codes and prior authorization requirements.

Just a reminder to continue to follow current prior authorization guidelines for all procedure codes that do require prior authorization. While prior authorization requests cannot be submitted through the Lookup tool, you can submit your requests electronically via Availity. Through your single login to Availity, you can request prior authorization and view authorization history. If you are not already an Availity user, visit **https://www.availity.com/provider-portal-registration** to sign up. If you have questions related to a procedure code or prior authorization, please call **1-855-371-8074**.

Pediatric therapists

If you need assistance finding a pediatric physical therapist, occupational therapist, speech therapist, or respiratory therapist, we can help! Please contact our Provider Network Manager at **PNM_Inquiries@prestigehealthchoice.com.**

Language access services

If your Prestige Health Choice patients need information about our services and benefits in a language other than English, please have them call Member Services at **1-855-355-9800** (**TTY 1-855-358-5856**). We are committed to serving all of our members and we have interpreters for many languages your patients may need. We can also provide your patients with written materials in other languages.

Pharmacy contact information

PerformRx℠ 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**, 24 hours a day, seven days a week.

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

Preferred drug list (PDL)

You can find additional information on the drug formularies by visiting **www.prestigehealthchoice.com** and/or **https://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/index.shtml**.

If you have questions, please contact your Provider Account Executive or the Provider Services department at **1-800-617-5727**.

COVID-19 updates

Prestige Health Choice has been closely monitoring the Centers for Disease Control and Prevention (CDC) for the latest information about COVID-19, and has been engaged in making the necessary plans based on guidance from the CDC. Prestige recommends that providers follow CDC, Centers for Medicare and Medicaid Services (CMS), and state-specific guidance with regard to COVID-19 evaluation, testing, diagnosis, treatment, and reporting. Please visit **www.prestigehealthchoice.com** for more information.

Medical records criteria

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 10 years according to legal, regulatory, and contractual rules of confidentiality and privacy. Prestige Health Choice 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 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 standards in the Provider Manual and the standards listed below:

- History and physicals.
- Allergies and adverse reactions.
- Problem list.
- Medications.
- Clinical findings.
- Evaluation of each visit.
- Preventive services/ risk screenings.

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

A member or authorized representative must sign and date a release form before any clinical or case records can be released to another party. Clinical or case record release must be 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 Florida Statute section 384.30(2).

Prestige Health Choice conducts record review audits to help ensure adherence with our medical record documentation standards and guidelines, and compliance with state and federal rules, laws, and contractual obligations.

Refer members to Care Management

Prestige Health Choice has Care Managers to help keep our members healthy. Our Care Management programs help with long-term illnesses, injuries, pregnancy, and mental health. We have health programs for asthma, pregnancy, heart problems, diabetes, COPD, and sickle cell anemia. These programs are offered to members at no cost to them. Please visit **www.prestigehealthchoice.com** for more information.

We welcome you to refer members for support from our clinical Care Managers. Our Care Managers are registered nurses who assist members with coordinating care and linking to services that best meet their needs.

If you have a member who is struggling to connect with Prestige Health Choice services or has special health care needs, please call our Rapid Response and Outreach Team at **1-855-371-8072**.

Provider training opportunities

Did you know that Prestige Health Choice offers provider training webinars? Visit the Providers Training and Education section of our website to register for an upcoming training at **www.prestigehealthchoice.com/provider/training-and-education/index.aspx**.

Healthy Behaviors programs

Prestige Health Choice offers Healthy Behaviors programs for eligible members to earn rewards for reaching certain health milestones. Members can earn up to a $50 reward per program. There is no limit on how many programs members can complete. For a complete list of Healthy Behaviors programs and associated forms, please visit **www.prestigehealthchoice.com**.

HEDIS® 2020/2021

At Prestige Health Choice, we are committed to offering quality preventive care and service to our members. HEDIS allows us to monitor how we are performing compared to other health plans and identify areas of opportunity for improvement.

As a network provider, HEDIS can help you:

- Monitor patients' health, prevent further complications, and identify future health care issues that could arise.
- Identify patients who have not received preventive screenings.
- Understand how you compare with other providers and the national average.

Visit the **Providers > Resources** section of our website for the HEDIS 2020/2021 Documentation and Coding Guidelines to help you increase your practice's HEDIS rates.

Fraud Tip Hotline: **1-866-833-9718**, 24 hours a day, seven days a week.

Secure and confidential.
You may remain anonymous.

Searchable online provider directory

Your practice demographic information is important. Please visit **www.prestigehealthchoice.com/provider/find-provider/index.aspx** to review and confirm that your information in our provider directory is accurate. If you notice any errors in the directory, please notify your Account Executive or Provider Services at **1-800-617-5727**.

Prestige HEALTH CHOICE®
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11631 Kew Gardens Avenue
Suite 200
Palm Beach Gardens, FL 33410

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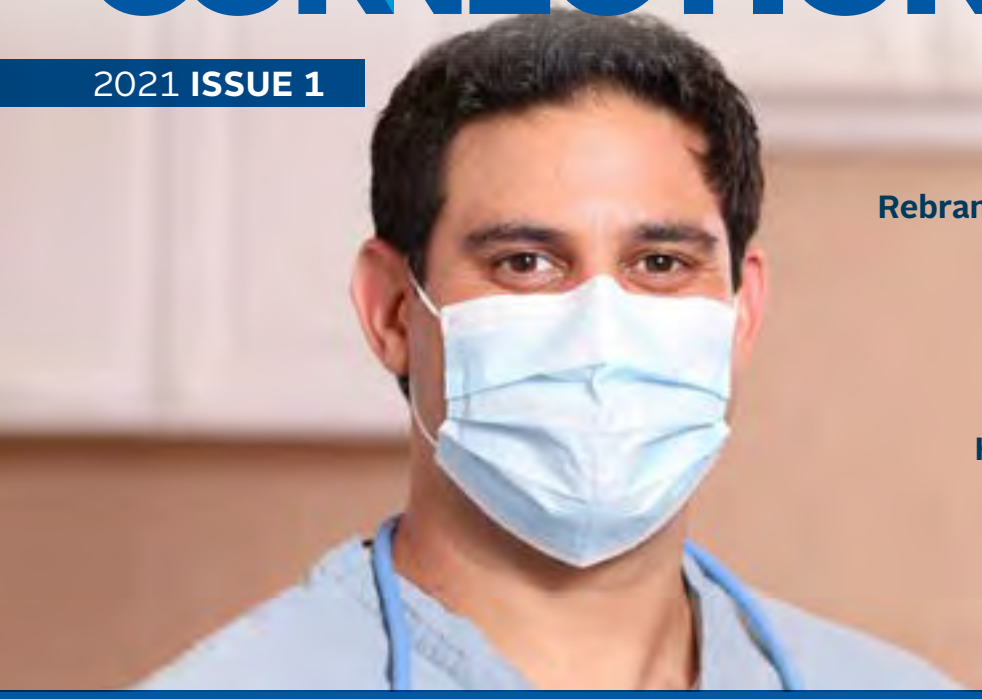

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