Prestige HEALTH CHOICE
Leading the Way to Quality Care

In the Know

A Provider's Supplement to Our Quarterly Connections Newsletter November 2016

Year-End Provider Incentive Program to Improve Member Health Outcomes

Prestige Health Choice (Prestige) invites you to participate in the 2016 Year-End Provider Incentive Program to Improve Member Health Outcomes, which includes a supplemental payment opportunity for each eligible service provided from October 1, 2016 through December 31, 2016.

How do I participate?

1. Identify Prestige members on your panel who require one or more of the eligible services in this program. Eligible members may be identified via Availity reporting by following the steps on our **Availity Care Gap Reports** instructions.
2. Schedule appointments with the identified members and provide the required eligible service(s) from October 1, 2016, through December 31, 2016.
3. Submit a claim for the encounter. Submit the eligible service(s) you provided by including the appropriate CPT codes and following your normal claim submission procedures.

Supplemental payments of $10 are available for each measure below:

- Childhood immunization combo 3 (CIS).
- Immunization for adolescents combo 1 (IMA).
- Lead screening in children (LSC).
- Breast cancer screening (BCS).
- Cervical cancer screening (CCS).
- Adults' access to preventive/ambulatory health services (AAP).
- Children and adolescents' access to primary care practitioners (CAP).
- Adult dental visit (ADV).

For additional information on this program, including the **Availity Care Gap Reports** instructions, visit our website at **www.prestigehealthchoice.com/pdf/provider/itn/communications/letters/2016/1016-year-end-incentive.pdf**. To access Availity, visit their homepage at **www.availity.com**. If you have questions about this program, please contact your Provider Network Management account executive or Provider Services at **1-800-617-5727**. Thank you for your participation in the Prestige provider network, and for your continued commitment to our members.

Agency for Health Care Administration (AHCA) consent forms

Prestige would like to remind OB/GYN providers that the following AHCA consent forms are required to be submitted for the associated services:

- **State of Florida Abortion Certification Form (AHCA-MedServ Form 001):** This form is the physician's responsibility and should be submitted with the claim. The patient does not sign this form .
- **State of Florida Exception to Hysterectomy Acknowledgment Requirement — Physician's Certification Statement (ETA-5001):** This form is filled out by the physician and should be submitted with the claim.
- **State of Florida Hysterectomy Acknowledgment Form (HAF-5000):** This form is filled out by both physician and patient, and should be submitted with the claim.
- **Consent for Sterilization Form (HHS-687):** This form is filled out by the physician and patient 30 days prior to sterilization and should be submitted with the claim. If the patient does not sign this form 30 days prior to sterilization, the claim will be denied.

All claims submitted for these services without the required forms will be denied with instructions to resubmit the claims with the appropriate forms. Paper claims should be submitted so the signed forms can be attached. Claims with incomplete forms, or submissions that do not adhere to the directions outlined above, will also be denied. These consent forms can be located on AHCA's website at **ahca.myflorida.com/medicaid/review/forms.shtml**. If you or your staff has any questions, please contact Prestige Provider Services at **1-800-617-5727**.

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Fraud Tip Hotline 1-866-833-9718 24 hours a day, seven days a week. Secure and confidential. You may remain anonymous.

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Durable medical equipment (DME), home health, and home infusion and injectables

Authorization requests for DME and home care services, which include home health, home infusion and injectables, wound care supplies, and enteral nutrition are handled by our Coordinated Care Unit (CCU). Please reference the list below when submitting your requests.

- Complete orders should use the appropriate request form, and include the following:
  - Date when orders were written.
  - Member name.
  - Diagnosis.
  - Service requested and length of need of service.
  - Requesting provider signature and NPI.
  - Member demographic information.
  - Clinical documentation to support the need of the service(s) being requested.
- CCU fax numbers (DME, home health, and home infusion therapy):
  - Routine requests can be faxed to **1-855-398-5610.**
  - Discharge requests can be faxed to **1-844-412-7885.**
- The CCU provider forms below can be located at **www.prestigehealthchoice.com**, under Provider Resources/Forms:
  - DME prior authorization request form.
  - Home care services prior authorization request form.
  - Hospital discharge prior authorization request form.
  - Notice of patient non-admit form.
  - Notification request form.

Members requiring assistance on discharge, or with home care services, can be directed to the CCU Rapid Response and Outreach Team at **1-855-371-3960**.

Rules for procedures billed with modifier 50 and modifier 51

Effective January 1, 2017, Prestige will be utilizing the Centers for Medicare & Medicaid Services (CMS) rules for bilateral procedures billed with a modifier 50 and for multiple surgical reduction for surgical procedures billed with a modifier of 51.

Modifier 50

- Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. Correct bilateral billing will ensure timely and accurate processing of these claims.
- Modifier 50 is used as a payment modifier, rather than an informational modifier. The addition of this modifier may affect payment, depending on the procedure code and the BILAT SURG indicator.

Modifier 51

- Multiple surgeries performed on the same day, during the same surgical session.
- The addition of this modifier may affect payment, depending on the procedure code and the MULT SURG indicator.

For further information regarding the CMS rules, please see **www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx**.

Prestige offers non-emergency transportation options for members

Prestige offers non-emergency transportation for members who need assistance visiting provider offices for their scheduled appointments.

Providers are encouraged to refer members requiring transportation services to our transportation vendor to ensure they do not miss their scheduled regular checkups or fall behind with any ongoing treatment. Transportation should be scheduled at least 24 hours prior to the appointment, with 48 hours prior preferred, to ensure promptness and availability. Additionally, passes for public transportation may be available for members with regular ongoing visits. The passes eliminate the need for members to schedule a ride ahead of each visit. The transportation vendor will inform the member about their options.

Please contact our transportation vendor at **1-855-371-3968**. For questions about non-emergency transportation, please contact Member Services at **1-800-355-9800**.

Medicaid provider bulletin updates

Please take time to read the Fall 2016 Medicaid Bulletin articles on the Florida Medicaid Administrative Rule Update and Medicaid Provider Enrollment Application Common Errors.

The Medicaid Bulletin can be found on AHCA's website at **ahca.myflorida.com/medicaid/Program_Coordination/provider_bulletins/docs/Fall_2016_Provider_Bulletin_Draft_2016-10-24.pdf**.

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Impact HEDIS® scores and improve members' health

What is HEDIS®?
The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The plans are measured in effectiveness of care, access and availability of care, experience of care, and utilization and relative resource use.

Why is HEDIS important?
HEDIS measures are important to Prestige. HEDIS scores measure preventive care, treatment of chronic diseases and member utilization and satisfaction. Satisfactory measures ensure health plans offer quality preventive care and services to our members.

Why is HEDIS valuable to physicians?
HEDIS helps you effectively monitor and evaluate the care your patients receive. HEDIS can help you identify non-compliant patients who are eligible for care. By doing so, health care costs are reduced and patients receive timely quality care.

Why is HEDIS valuable to your patients?
HEDIS ensures your patients/our members receive preventive and quality care. It gives patients the ability to stay actively engaged in their health and receive the care they need. Here are some benefits:

- Assists in providing appropriate care to patients.
- Encourages patients to receive preventive services in a timely manner.
- Ensures patient medical records are accurate, legible, and complete.

Become familiar with HEDIS to understand what is required of health plans and providers. If you have any questions, contact the Prestige Quality department at **phcqidepartment@prestigehealthchoice.com**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
www.ncqa.org/hedis-quality-measurement

Healthy Behaviors Program is expanded

Prestige offers Healthy Behaviors programs to its members to promote wellness and enhance coordinated efforts to provide quality care. As a trusted provider, your efforts and experience are vital to increase members' understanding of the programs offered. In addition to the weight loss, smoking cessation, and substance or alcohol use recovery programs, we are pleased to offer five additional programs.

Members expressing interest in joining one or more of the five additional programs will need to submit a Completion Form, signed by you, as evidence they have completed the necessary actions. The Completion Form can be found on our website at **www.prestigehealthchoice.com**. You can fax the signed form to **1-855-236-9281** or mail it to Prestige Health Choice, P.O. Box 7181, London, KY 40742.

- **Dental visit**
  This program rewards members ages 2 – 20 who complete at least one dental visit during the calendar year.

- **Well-child visits**
  This program rewards members who complete six or more well-child visits from 31 days – 15 months of age.

- **Behavioral health follow up**
  This program rewards members ages 6 and older who were hospitalized in an acute inpatient setting with a principal diagnosis of mental illness, and who had two follow-up visits with a mental health provider — one within seven days of discharge and another within 30 days of discharge.

- **Diabetes care**
  This program rewards members with diabetes who are ages 18 to 75 and who complete the diabetic testing series, including an annual diabetes eye exam.

- **Maternity**
  This program rewards pregnant members who complete a minimum of 10 out of 13 prenatal visits, as well as a postpartum visit 21 – 42 days after birth.

If you would like more information about each program, please visit our website. You can also call your provider account executive or Provider Services at **1-800-617-5727**.

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Updating demographics and the provider directory

Prestige asks providers to give advance notice of any changes to office addresses, phone numbers, or panel status. Updating demographics is vital to ensure both our members and our staff have the most up-to-date information. Prestige relies on its providers to notify us of these demographic changes to ensure our provider directory remains current. Please notify your account executive immediately if there have been, or will be, any changes to your demographic information, including, but not limited to, address, phone or fax numbers, office hours, and whether you are accepting new Prestige members.

If you see any errors in our provider directory, please notify us in writing, on practice letterhead, and fax the correct information to Provider Services at **1-855-358-5849**.

Improving communication with members

Poor communication can damage a member's confidence in the health care team, cause medical errors, and may ultimately lead to litigation. Members may feel strongly that they have been wronged. They may complain about poor clinical care, a billing issue, a health care employee's display of rude behavior, a breach of confidentiality, or lost or damaged property. The seriousness of the member's complaint will ultimately determine how providers respond. A minor complaint, such as a delayed appointment or rude personnel, can often be remedied on the spot. A serious complaint, such as an error in care or a privacy breach, may require a formal investigation.

The key to good health communication is establishing goals prior to engaging in conversations with members. Goals should include learning to listen in order to discover the truth, making sure the member and his or her family feel heard, and strengthening the patient-provider relationship. Avoid barriers and poor communication habits that may prevent you from attaining your communication goals, such as the need to be proven right, defending your staff when they are in the wrong, or wanting to save face. When an issue occurs, provide the patient with a full and honest disclosure, and apologize for the experience. The *BMJ Quality & Safety* journal published a survey of more than 700 patients and caregivers about medical mistakes. The survey concluded that patients wanted honesty and an apology. Apologizing also has been shown to prevent litigation and salvage the patient-provider relationship. Apologizing is not only about reducing costs associated with litigation. The method also trains providers to take a closer look at preventable adverse events and adjust the processes that caused them.

Here are a few strategies for communicating with dissatisfied members:

- Apologize showing empathy or remorse. An expression of empathy is advisable when a patient is harmed, impacted, or inconvenienced but no error or system failure has occurred. The apology of remorse is appropriate when a provider, through a clear error or system failure, caused an injury to the patient that was preventable.
- Listen actively and take notes. Remember the commitment to finding the truth.
- It is important to maintain good eye contact and body language, so that you appear to be open and not defensive.
- Be professional, concerned, and avoid arguments.
- Ask open-ended questions and show respect for the patient's perspective.
- Follow up with any issues that were not resolved before communication ended.

Pharmacy benefit management and prior authorization

Effective December 1, 2016, PerformRx℠ will be providing pharmacy benefit management services to Prestige. Updated PerformRx prior authorization forms will be available on our website beginning on that date. Providers are responsible for obtaining prior authorization when required. Providers may not bill members for a service if that service requires prior authorization and their claim is denied because authorization was not obtained.

- Specialty and non-specialty pharmacy prior authorization forms and drug criteria can be found on our website at **www.prestigehealthchoice.com/provider/itn/find-provider/index.aspx**.
- Fax a request for prior authorization to PerformRx at **1-855-825-2717**.
- You can call PerformRx at **1-855-371-3963** for assistance.
- For prompt service, upon approval of a specialty authorization, you may fax the corresponding prescription to PerformSpecialty® pharmacy at **1-844-489-9565** or call them at **1-855-287-7888**.

For pharmacy questions, call the Pharmacy Help Desk at **1-855-371-3963, option 3**, available 24 hours a day, seven days a week.

Zika virus travel and testing recommendations update

On October 13, 2016, Florida health officials announced a new area of active Zika transmission in Miami-Dade County. In response to the continued spread of the Zika virus in Miami-Dade County, on October 19, the Centers for Disease Control and Prevention (CDC) expanded its travel and testing guidance to apply its recommendations to all of Miami-Dade County.

For more information about the Zika virus, visit the CDC's Zika virus information page at **www.cdc.gov/zika**.
For the CDC's travel and testing guidance recommendations, as well as other Zika updates specific to Florida, visit the CDC's Florida update page at **www.cdc.gov/zika/intheus/florida-update.html** for the latest news.