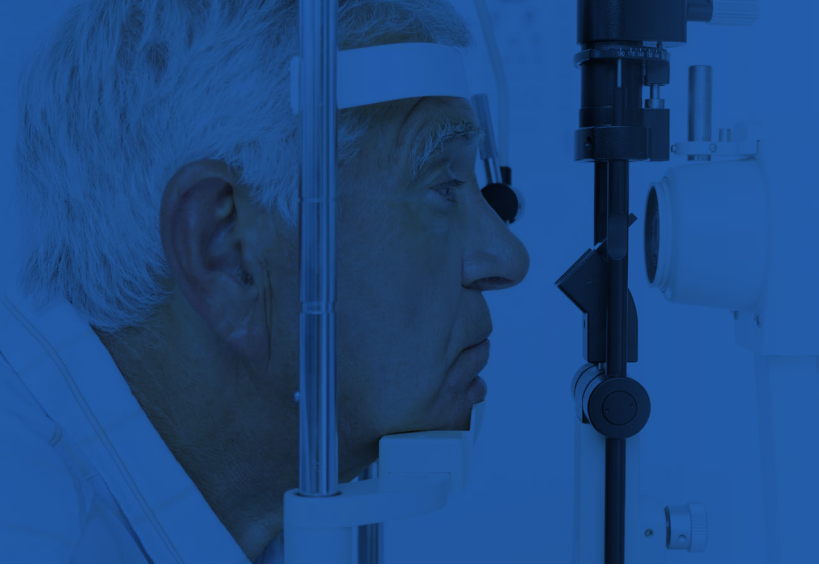


Provider Newsletter

Availity™

Have you signed up with Availity?

Availity is Florida Blues' trusted information exchange partner enabling the movement of business and clinical information in real-time. By signing up with an account you will be able to verify eligibility, benefits, and more – all online and at your fingertips. For more information, including online demonstrations or to register, please visit Availity's website at www.availity.com or call (800) AVAILITY (282-4548).

myBlue— Florida Blue New Product

You will begin seeing a new card with the name "myBlue", this is a new Marketplace Exchange product that is managed by Eye Management. Please do not turn away any patients with this new card

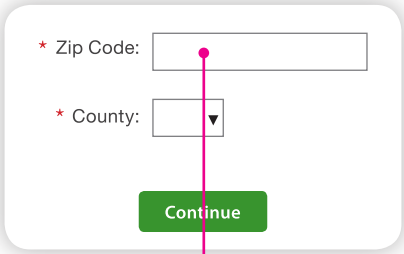
2016 Member Plans & Benefits—At A Glance

Please use the following steps to view all the 2016 Medicare Advantage plans by using link: BlueMedicare Solutions and the click on see plans.

Step 1

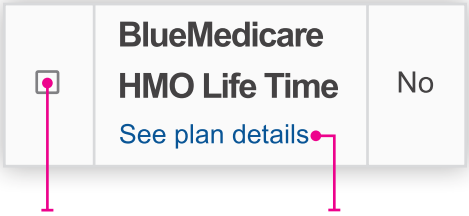
Select "See the Plans"

Step 2



Enter the zip code and press continue

Step 3



Check the BlueMedicare HMO box.

Click on "See plan details" Towards the bottom of the page you will see all the plan documents and summary of benefits for all counties.

Law Against Health Care Fraud: Exclusion Provisions

Although most health care providers work hard to deliver quality care and submit correct claims for payment, some providers seek to exploit government health care programs for illegal personal gain. Health care fraud remains a serious problem for these programs. The U.S. Government Accountability Office has designated Medicaid as a program that is at high risk for improper payments. Improper payments "include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided." There are a number of Federal and State laws to deter and punish those who fraudulently seek to obtain improper payments from Medicaid. Federal laws include, but are not limited to, the following:

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal health care programs, including Medicaid, for various reasons. Exclusions can be mandatory, meaning the HHS-OIG has no choice about whether to exclude, or discretionary, which means the HHS-OIG does have a choice. Exclusion is mandatory for convictions of program-related crimes, convictions relating to patient abuse, felony convictions relating to health care fraud, and felony convictions relating to controlled substances. Exclusion is discretionary for loss of license due to professional competence or financial integrity, convictions relating to fraud, convictions relating to obstruction of an investigation or audit, misdemeanor convictions relating to controlled substances, and participation in prohibited conduct such as kickbacks and false statements.

As a Federal health care program, Medicaid will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity. If someone on a provider's staff has been excluded from participation in a Federal health care program, the provider should not bill any Federal health care programs for any items or services furnished, ordered, or prescribed by the excluded individual. "Furnished" is a key word that refers to items or services provided or supplied, directly or indirectly, by an excluded individual or entity.

It is in the best interest of providers to screen potential employees and contractors prior to employment or contracting to ensure they are not excluded from participating in Federal health care programs. In addition, providers should regularly check the exclusions database to ensure that none of the practice's employees or contractors have been excluded.

CMS has issued guidance to State Medicaid agencies that they should require providers to screen their employees and contractors for exclusions by checking the database on a monthly basis. The guidance further advises States to require all providers to immediately report any exclusion information discovered. The List of Excluded Individuals/ Entities (LEIE) database is available at http://exclusions.oig.hhs.gov/ on the HHS-OIG website. Both licensed and unlicensed individuals may be excluded, so it is best to check for both. In addition to checking the LEIE, providers should check the Exclusions Extract, which can be accessed by visiting https://www.sam.gov/ on the System for Award Management website.

Medicare Part D Prescriber Enrollment… Time is Running Out

Beginning June 1, 2016, prescribers who write prescriptions for Part D drugs must be enrolled in an approved status or have a valid opt-out affidavit on file with Medicare in order for their prescriptions to be covered under Medicare Part D. Before opting out of Medicare, you should consider the following impacts:

- You will not be able to participate in a Medicare Advantage plan, which means that you will no longer be able to continue your participation in our Network and
- Your opt-out status lasts for two years and cannot be terminated unless within 90 days of your opt out designation

You can also contact the Medicare Administrative Contractor that services our area:

Florida First Coast Service Options
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021
888-845-8614
http://medicare.fcso.com/
http://medicareespanol.fcso.com/

To learn more about the options available to you, refer to the following chart:
http://healthnetworkone.com/partd-decision-chart

For more information on the prescriber enrollment requirements, visit:
http://healthnetworkone.com/partd-prescriber-enrollment

CREDENTIALING NEWS

If you have any questions or concerns, you may contact the Credentialing Director, Amy Long, at (305) 614-0361.

Expiration of Documents

As credentialing documents expire, you will receive requests to submit copies of your current licenses, DEA's and Malpractice Insurance. To be proactive, you can fax them to (305) 614-5055 as soon as you receive the new documents and we can update our records accordingly. If you participate with CAQH, you can upload these documents to your profile and we can obtain them directly from the Pro View site.

Recredentialing Process

In order for your initial or recredentialing process to run smoothly, here are some helpful tips:

- Submit the credentialing applications timely
- Sign and Date the Consent & Release and Attestation pages
- Include all of the requested supporting documents (ie: License, DEA, CV, Malpractice Insurance, Accreditations, etc.)
- Ensure that supporting documents have been uploaded to CAQH, if applicable.
- Ensure that you have authorized HS1 Medical Management, Inc. or have CAQH set to "Global" so that we have access your information
- Ensure that your CAQH attestation is current

We're Just A Phone Call Or Click Away

If you have any changes to your practice, including demographic or provider additions/ terminations, please notify your EMI Provider Relations Representative.

Marjorie Auguste
Provider Relations Representative

305-614-0100 x4536
800-595-9631 x4536
Fax: 305-614-0171
augustem@healthnetworkone.com

Authorizations

800-595-9631 Option 1
Fax: 305-614-0165
Fax: 866-646-1772

Claims

305-614-0133 Option 3
954-335-8130 Option 3

To report suspected Fraud, Waste, and Abuse, or any Compliance issue:

1-866-321-5550

Annual Quality Improvement Documents

Annually the Quality Improvement (QI) Department develops Quality documents that include a QI Evaluation, Program Description, and Work Plan. The development of the Quality documents satisfies Health Plan and NCQA Accrediting body requirements. The QI Evaluation analyze the QI department's previous year quality indicators, key accomplishments, identify any areas needing improvement, and develop action plans to improve results.

The Program Description and Work Plan establish objectives, goals, QI activities, and the QI Program Structure for the current year.

Copies of the annual QI documents are available by contacting the QI department at the address below.

2001 South Andrews Avenue
Fort Lauderdale, FL 33316
Phone: (800) 422-3672 Ext. 4701
Fax: (305) 614-0364

Eye Notes from the Medical Director

Dear Doctor:

As you know, an annual Diabetic Retinal Exam (DRE) should be part of every diabetic patient's preventive care regimen. In addition, the DRE is a measurement tool used by the National Committee for Quality Assurance (NCQA) to determine if a managed care organization is meeting the health care needs of their member population.

Florida Blue is working closely with their Primary Care Physicians and with their members to ensure that they are receiving the preventive services with an eye care professional.

When your patient is in the office we ask that you perform a complete eye exam and document appropriate retinal eye examinations. Please also ensure that you submit a HIPAA 5010 Compliant Claim when billing for these services.

It is also extremely important that you document the results of your findings in the patient's chart including No evidence of diabetic retinopathy. We have added this as a separate "diagnosis" (#37) on the Report of Ophthalmic Consultation.

In addition, a report of your findings should be communicated with the member's Primary Care Physician. EMI has a simple template "Report of Ophthalmic Consultation" that you may use. If you need a copy of this form or if you have any questions regarding this information, please contact your Provider Relations Representative, Marjorie Auguste, at (800) 595-9631 x 4536.