



## ***Introduction***

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### **Advantage by Bridgeway Health Solutions HMO SNP**

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While much of the information in the beginning chapters of this manual focused on our Medicaid resources and references, this chapter is a reference guide for providers and their staff providing services to members who participate in our Medicare Advantage Special Needs Plan, Advantage by Bridgeway Health Solutions HMO SNP (Bridgeway). In this chapter, we will highlight areas unique to Medicare.

### **Overview**

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Bridgeway is a licensed health maintenance organization (HMO) contracted with the Centers for Medicare and Medicaid Services (CMS) to provide medical and behavioral health services to the dual eligible members in the following Arizona counties:

- Maricopa
- Pima
- Santa Cruz

Bridgeway is designed to achieve four main objectives:

- Full partnership between member and case manager
- Integrated case management (medical, social, behavioral health, pharmacy)
- Improved provider and member satisfaction
- Quality of life and healthy outcomes

All of our programs, policies and procedures are designed with these objectives in mind. These objectives mirror and support the objective of the CMS and state guidelines to provide covered healthcare services to low-income, elderly and physically disabled members.

Bridgeway takes the privacy and confidentiality of our member's health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations.

The services provided by the contracted Bridgeway network providers are a critical component of our system in terms of meeting the objectives above.

Our goal is to reinforce the relationship between our members and their primary care physician (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted hospitals and specialists. The PCP is responsible for coordinating our member's health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the member about their health status, medical treatment options, which include the benefits, consequences of treatment or non-

treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

If a PCP is unable to provide treatment to a member, including counseling and referral services, because of religious or moral reasons, they should contact our Provider Services number at (866) 475-3129.

Bridgeway appreciates your partnership in achieving our objectives.

## **How To Contact Advantage By Bridgeway**

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**Bridgeway Health Solutions:** [www.Bridgewayhs.com](http://www.Bridgewayhs.com)

**Advantage by Bridgeway Health Solutions:** <http://advantage.bridgewayhs.com/>

**Plan Address:** **Bridgeway Health Solutions  
1501 W. Fountainhead Parkway  
Suite 295  
Tempe, AZ 85282**

**Administrative Office:** (866) 475-3129  
TTY (877) 613-2076

**Provider Services:** (866) 475-3129  
TTY (877) 613-2076  
Fax: (866) 687-0514

**Claims Submission Address:** **Bridgeway Health Solutions  
P. O. Box 3060  
Farmington, MO 63640-3814**

**Claims Call Center:** (866) 518-6843

**Part D Prescription Drug Formulary  
Directory:** <http://advantage.bridgewayhs.com/>

**Medical Management and Prior  
Authorization:** [www.Bridgewayhs.com](http://www.Bridgewayhs.com)  
(866) 295-9729  
Fax: (866) 638-6126

# ***Provider Relations***

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## **Primary Care Provider**

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The Primary Care Provider (“PCP”) is the cornerstone of Bridgeway’s delivery model. The PCP serves as the “medical home” for the member. The “medical home” concept should assist in establishing a patient-provider relationship and ultimately better health outcomes. The PCP is responsible for providing all primary care services for Bridgeway’s members including but not limited to:

- Supervision, coordination, and provision of care to each assigned member
- Initiation of referrals for medically necessary specialty care
- Maintaining continuity of care for each assigned member
- Maintaining the member’s medical record, including documentation for all services provided to the member by PCP, as well as any specialists, behavioral health or other referral services
- Screening for behavioral health needs and when appropriate, initiate a behavioral health referral.

Our Case Managers partner with the PCP not only to ensure the member receives any necessary care but to also assist the PCP in providing a “medical home” for the patient.

All PCP’s may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member’s choice, Bridgeway does not guarantee a PCP will receive a set number of patients. A PCP must contact their Provider Relations Specialist if they choose to change their panel size or close their panel and only accept established patients. However, if a PCP closes their panel to Bridgeway, they must also close their panel to all other plans. If Bridgeway determines a PCP fails to maintain quality, accessible care, then Bridgeway reserves the right to close their panel and if necessary, re-assign members to a new PCP.

## **Specialty Care Physician**

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The Specialty Care Physician or Specialist agrees to partner with the member’s PCP and Case Manager to deliver care. A key component of the specialist’s responsibility is to maintain ongoing communication with the member’s PCP. Most visits to specialists do not require a prior authorization. Most specialists will require a written referral from the member’s PCP, however, the referral is not required for the claim to be reimbursed by Bridgeway. Specialists can elect to limit their practice to established patients only upon request to their Provider Relations Specialist.

Female members can self-refer to an OB/GYN for their annual well-woman check up.

Specialty Care Physicians include, but are not limited to:

- Cardiology
- Gynecology and Women’s Services
- Endocrinology
- Gastroenterology

- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Urology

## **Hospitals**

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Bridgeway has contracted with hospitals in the counties we serve; however, any facility may be used in the case of an emergency. We also contract with other facilities such as rehabilitation facilities and ambulatory surgery centers to assist our members. It is important that our contracted providers have privileges at a contracted facility or have an agreement with a hospitalist group to care for their member when hospitalized. Please see the Provider/Pharmacy Directory for a list of contracted hospitals in each county.

## **Ancillary Providers**

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Ancillary providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (Physical, Occupational, Speech)

## **Appointment Availability**

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Consistent with the CMS requirements, Appointment Availability Standards are listed below. Bridgeway's PCPs and Specialists must have adequate office hours in order to accommodate appointments for members.

PCPs are required to be accessible to members 24 hours a day, seven days a week as follows:

- Office phone is answered during normal business hours
- After hours, a provider must have an arrangement for:
  - Access to covering physician, or
  - Answering service, or
  - Triage service, or
  - A voice message that provides a second phone number that is answered

## Member Information

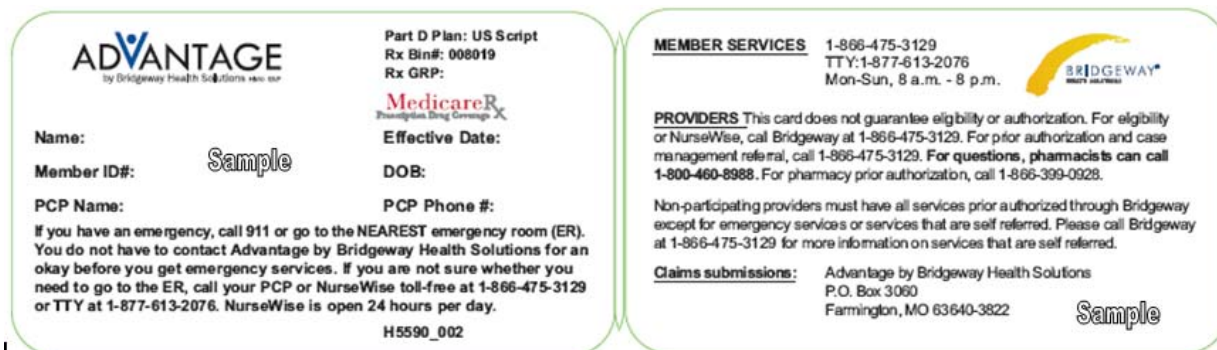
Bridgeway's Member Services Department is able to assist you in verifying eligibility, member education, and assisting with any other questions you may have about Bridgeway members. Member Services can be reached at (866) 475-3129.

### Verification Of Member Eligibility

Eligibility requirements for Medicare are determined by CMS and compliance is essential. To enroll, a completed enrollment application must be submitted to our Plan for processing. Each applicant must be enrolled in the Arizona Health Care Cost Containment System (AHCCCS) Medicaid program, have Medicare Part A and B coverage, and reside within one of the service areas approved by CMS, in order to enroll in Bridgeway. Persons interested in applying for the Bridgeway Medicare program should contact Bridgeway Medicare Member Services at (866) 475-3129.

Providers should always verify member eligibility prior to delivering services. It is very important to ask the member for a copy of the health plan ID card and some other form of identification, such as a driver's license or photo ID.

The Bridgeway Medicare ID card replaces the member's original red, white, and blue Medicare card and looks like this:



**To verify Medicare enrollment call Bridgeway Member Services at (866) 475-3129.**

Bridgeway Medicare members obtain member **Medicaid** services through the Arizona Health Care Cost Containment System (AHCCCS), so they will have an AHCCCS ID card, in addition to their Bridgeway Medicare ID card.

Members who have enrolled in this program are issued a card from AHCCCS. You will need this card to bill Medicaid for the Part B cost sharing amount (or any applicable deductibles or co-insurance which may be payable by Medicaid). For example, for most Part B Medicare services, Medicare will pay 80% and Medicaid will pay the member's 20% cost sharing amount, if the provider is a Medicaid provider, the member is in the Medicaid program, and the provider bills

Medicaid for the cost sharing amount. You cannot bill the member for Medicare Part A or B deductibles or coinsurance, for members who are eligible for Medicaid.

## **Member Orientation**

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Once the enrollment application is processed, each new member receives a letter stating the effective date of coverage and a packet of information about our program.

The following documents are provided to the new members:

- Welcome letter
- Evidence of Coverage
- Member ID card
- Provider/ Pharmacy Directory
- Abridged formulary

Members are encouraged to select a health plan contracted PCP. For all members in case management, a case management team works with the member's PCP or facility personnel to address the needs of the member, coordinate needed healthcare and services and ensure the member accesses their preferred health service benefits.

Members receive various pieces of information from Bridgeway through mailings and face-to-face contact. Many of these materials are printed in English and Spanish. These materials include:

- Provider/Pharmacy Directory
- NurseWise Information
- Emergency Room Information
- Member Evidence of Coverage which includes:
  - Benefit information, including pharmacy network information, out of pocket cost information, and
  - Member rights and responsibilities

Providers interested in receiving these materials may contact the Provider Services Department at (866) 475-3129.

## **American With Disabilities Act (ADA)**

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Under Title III of the ADA, requirements for public accommodations, such as a physician's office, mandate that they must be accessible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

## **Disenrollment**

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A member may disenroll from Bridgeway at any time. Any disenrollment requests received in writing will be effective the first day of the following month. CMS regulatory guidelines may, in certain circumstances, permit Bridgeway to terminate a member's coverage. This termination is considered involuntary disenrollment. These involuntary disenrollments may occur, for example, if:

- Member permanently moves out of the geographic service area
- Loss of entitlement to Medicare benefits
- For cause or fraud and abuse as defined by Medicare regulations
- Disruptive behavior as defined by Medicare regulations
- Plan termination or service area reduction
- Death

Bridgeway may disenroll a member if the individual's behavior is documented to be disruptive, unruly or uncooperative to the extent that his or her continued membership does not allow us to furnish services to them or other members. CMS must approve all involuntary disenrollments. If the service provider encounters any instance of this behavior, please notify us by calling the provider services department at (866) 475-3129.

Bridgeway will notify the member of their involuntary disenrollment. This includes providing the member with a written notice within the timelines determined by CMS. We will notify CMS when the member is disenrolled, so that Medicare benefits assignments can be transferred back.

## **Voluntary Disenrollment**

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A member may terminate their participation in the Bridgeway. If on the date of disenrollment, the member is confined as an inpatient in a hospital, Bridgeway continues to cover the enrollee benefits. Coverage continues until the enrollee is discharged from the hospital.

## **Benefits**

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Bridgeway covers all Medicare covered services as well as additional and supplemental benefits. Our health plan also includes the Medicare Part D Prescription Drug program. All services must be provided in a manner consistent with professionally recognized standards of healthcare.

A general list of covered services is included in the plan's Evidence of Coverage. For a detailed listing of services covered, contact Provider Services at (866) 475-3129 or visit <http://medicare.bridgewayhs.com/>.

## **Exclusions**

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Certain services may be excluded from coverage under Bridgeway. The coverage of services list outlines many of the excluded services. In addition to specific excluded services, Bridgeway may deny coverage if:

- The service is not medically necessary or
- The service is not a Medicare covered benefit.

See the Bridgeway Medicare EOC for a comprehensive list of excluded services or visit our website at <http://advantage.bridgewayhs.com/>.

## **Self Referral**

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A Bridgeway Member may self-refer (does not require PCP approval) for the following:

- Emergency
- Routine gynecological well woman visits
- Mammography
- Influenza vaccination

## **Dialysis Services**

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Bridgeway provides coverage for dialysis services received in the plan's specific service area by a participating provider. In addition, Bridgeway provides coverage for dialysis services received while the member is temporarily outside of the plan's service area for up to 6 months.

## **Post- Stabilization, Emergency And Urgently Needed Services**

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Inpatient and outpatient emergency health services are covered inside or outside of the specific Bridgeway service area at the preferred benefit level. In the event of an emergency, the enrollee should seek immediate care, or call 911 for assistance. Prior authorization is not required, and Bridgeway may not deny payment if a Bridgeway contracted physician or healthcare provider instructs an enrollee to seek emergency services.

Bridgeway plan provides coverage for the treatment of an emergency medical condition, which is defined as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Bridgeway plans include coverage for post-stabilization care. Post-stabilization care is defined as a non-emergency services needed to ensure that the enrollee remains stabilized after an emergency. The attending physician or healthcare provider determines when the condition is no longer an emergency and the enrollee is considered stabilized for discharge or transfer. Continuation of care after the condition is no longer an emergency will require coordination with Bridgeway.

Prior authorization of post-stabilization services:

- Prior authorization is automatically approved if Bridgeway does not respond to the request by the physician or healthcare provider within one hour after Bridgeway was asked to approve post-stabilization care, or
- Automatically approved because Bridgeway could not be reached for prior authorization despite reasonable efforts.

Such automatic approval of post-stabilization care continues to be covered until Bridgeway has responded to the request and arranged for discharge or transfer.

## **Termination Of Provider**

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Providers and Bridgeway must provide the other at least 90 days written notice if electing to terminate our agreement without cause, or as described in the Provider participation agreement, if longer than 90 days. Please refer to your provider agreement or contact us at (866) 475-3129.

## **Data Collection**

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Bridgeway is required to maintain a health information system that collects, analyzes and integrates all data necessary to aggregate, evaluate and report certain statistical data related to cost, utilization, quality and other data requested by CMS. As a Bridgeway provider, you are required to submit all data necessary to fulfill these requirements in a timely manner. You are required to certify, in writing, that the data submission to Bridgeway is complete and accurate, and truthful. This includes all data, including encounter data, medical records, or other information required by CMS. CMS requires that you maintain complete member records for a minimum of 10 years.

## **Health Risk Assessment**

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Understanding the health status of Bridgeway members is critical to effective case management. We take an active role in determining the health status of all members, including the identification of all conditions, especially those that are complex and serious. All members receive an initial health risk assessment and appropriate interventions within 90 days of enrollment. The provider must work with the health plan to assure this assessment is completed in the 90 day initial period. Member HRAs are also conducted annually or whenever there is a change in health condition.

## **Member Surveys**

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CMS requires all Medicare contractors to participate in a member satisfaction survey and submit the results. Bridgeway surveys the members or their legal representative at least annually. This survey includes the level of member satisfaction with their PCP, their primary care team, customer service, sales and marketing, and written information provided to the members.

Upon request, Bridgeway will make the data available to the member, their physician or other healthcare providers.

## ***Medical Services***

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Bridgeway's Medical Services department encompasses all clinical functions, including Utilization Management, Case Management, Prior Authorization, and Quality Management. This structure ensures a cohesive, communicative approach to service delivery and guarantees quality services to our providers and members.

### **Bridgeway Case Management Services**

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Bridgeway is required to ensure that every Advantage member has an individual care plan. Bridgeway Case Managers are responsible for the development and review of the individual care plan. Bridgeway offers a case management system that incorporates three unique strengths. It is fully integrated, through a team approach that involves a nurse, behavioral health clinician, social worker, pharmacy coordinator and non-clinical Case Managers. This ensures continuity and comprehensive service planning for members transitioning from one setting to another. Medical case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Care coordination/management is a Member-centered, goal-oriented, culturally relevant and logically managed process to help ensure a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

For members that need behavioral health services, our behavioral health Case Managers can assist you in finding the appropriate behavioral health provider to see the member. You can reach Behavioral Health Case Management at (866) 475-3129. If you know the member is currently in treatment with a behavioral health specialist, call the health plan. We will be happy to work with them to retain their behavioral health specialist. You may refer to the Behavioral Health chapter of this manual for further information.

Bridgeway's Case Managers support the physician by tracking compliance with the case management plan, and facilitating communication between the PCP, member, and the case management team. The Case Manager also facilitates referrals and linkages to community providers, such as local health departments. The managing physician maintains responsibility for the patient's ongoing care needs. The Bridgeway Case Manager contacts the PCP and/or managing physician if the Member is not following the plan of care or requires additional services.

The Bridgeway Case Manager works with all involved providers to coordinate care, provide referral assistance and other care coordination as required.

### **Case Management Process**

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Bridgeway's case management for our members contains the following key elements:

- Notifying the member and their PCP of the member's assignment to a Bridgeway Case Manager
- Completing a Health Risk Assessment

- Developing and implementing a care plan that accommodates the specific cultural and linguistic needs of the member
- Establishing treatment objectives and monitoring of outcomes
- Referring and assisting the member to ensure timely access to Providers
- Coordinating medical, residential, social and other support services
- Monitoring care/services
- Revising the care plan as necessary and
- Tracking care plan outcomes.

Bridgeway’s Case Management Department can be reached at:

Phone (866) 475-3129  
 TTY (877) 613-2076

## **Prior Authorization**

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Bridgeway is committed to allowing our providers to decide which medically necessary services are needed in order to care for the member. Therefore, Bridgeway developed an “open access” health plan for contracted providers. Members should consult with their PCP prior to seeing a specialist. However, a referral is not required for the claim to be reimbursed by Bridgeway. Our prior authorization list (below) is for procedures and services where review can favorably influence the quality of care. If a service is performed and prior authorization is required but not obtained, payment for the claim may be denied.

Prior-authorization is required for certain services/procedures/diagnostic tests frequently over or under utilized, costly services, or where there is a need for case management.

Standard Service Authorization (Routine) – Prior authorization decisions for Part A and B non-urgent services shall be made within fourteen (14) calendar days of receipt of the request, and within seventy-two (72) hours for standard Part D drug benefit coverage determinations. An extension may be requested if all appropriate medical documentation is not received with request.

Expedited Service Authorization (Urgent) – Urgent/emergent prior authorization decisions for Part A and B services shall be made within seventy-two (72) hours of the request as long as all appropriate medical documentation is received with the request, or within twenty-four (24) hours of receiving the request for expedited Part D drug benefit coverage determinations.

\*Timeframes may be shorter, depending on the member’s condition.

Bridgeway will make every attempt to follow the guidelines, and will ensure that the CMS guidelines for prior authorization requests are always met.

The Bridgeway Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. For prior-authorizations during business hours, the Utilization Management Department may be contacted at:

Phone (866) 295-9729  
 Fax (866) 638-6126

Prior authorization requests after business hours and on weekends and holidays may be faxed to (866) 638-6126.

***Failure to obtain authorization may result in payment denials.***

Information needed for authorization includes but is not limited to:

- Member's Name and **Medicare** ID Number
- Referring Physician's name and telephone number
- Service being requested
- Date of service
- Referred to Provider (Provider Name or Facility Name)
- If admission:
  - Hospital Name
  - Reason for admission; primary diagnosis, surgical procedures, surgery date
  - Relevant clinical information; past/proposed treatment plan, surgical procedure, diagnostic procedures to support the appropriateness and level of service proposed
  - Admission date or proposed date of surgery
  - For obstetrical admissions, the date and method of delivery and information related to the newborn or neonate
  - If more information is required, the Prior Authorization staff will notify the provider of the specific information needed to complete the authorization process

***The following services require prior authorization:***

Experimental or Investigative Services

Any experimental or investigative procedure, service or drug protocol

Non Participating Providers

Prior authorization is required for services provided by a non participating provider

Inpatient Facility Admissions

All inpatient admissions:

- Acute care hospitals and medical centers
- Rehabilitation
- Skilled nursing
- Hospice

Outpatient Facility Services

- Observation services (Includes those that result in admission).
- Outpatient surgery or ambulatory surgery services (excludes tubals and vasectomies)
- Dialysis
- Nutritional therapy
- Wound therapy
- Physical, occupational and speech therapy (Excludes initial evaluation)
- Cardiac rehabilitation (Excludes initial evaluation)
- Pulmonary rehabilitation (Excludes initial evaluation)
- Pain management services
- Diagnostic tests:

- MRI, MRA and PET scans
- Cardiac nuclear imaging
- Sleep Study

#### Home Health Care Services

- Home nursing visits
- Home health aid
- Infusion therapy
- Occupational therapy
- Physical therapy
- Respiratory Therapy
- Speech Therapy
- Social worker
- Includes supplies for home healthcare

#### DME, Orthotics and Prosthetics\*

- All durable medical equipment (rental or purchase)
- Prosthetic and orthotic devices.

*\*Excludes those provided in a physicians office and less than \$500 in total billed charges.*

#### Specialist Referrals

- Podiatry
- Chiropractic
- Pain Management

#### Transportation

Scheduled Air ambulance

#### Pharmacy

See the Formulary for complete details

#### Pregnancy Notification

Fax (866) 638-6126

**For complete prior authorization requirements, see the listing on our website found at <http://advantage.bridgewayhs.com/>.**

## **Medical Necessity**

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A Prior Authorization Nurse in conjunction with the Bridgeway Medical Director will complete the medical necessity screening.

Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These services are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of the recommended treatment could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital

There must be no other effective, more conservative or substantially less costly treatment, service and setting available.

## Referral Process

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The PCP is responsible for coordinating healthcare services. When medically necessary, PCP's should refer members to services beyond their scope of practice. Most visits to specialists do not require a prior authorization. Most specialists will require a written referral from the member's PCP, however, the referral is not required for the claim to be reimbursed by Bridgeway. Services that require prior authorization by Bridgeway are listed under the Prior Authorization section.

Bridgeway encourages specialists to communicate to the PCP the 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 specialist being referred is a participating provider within the Bridgeway network.

For access to out-of-network providers or facilities, the network provider must call Bridgeway for a prior authorization for any service.

## Inpatient Notification Process

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Inpatient facilities are required to notify Bridgeway for emergent and urgent admissions **within one business day following the admission**, per CMS requirements effective April 1, 2009. The authorization is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. All inpatient admissions require authorization.

## To Care

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Bridgeway provides direct access to preventative healthcare services. Members may access, without a referral, any of the following services:

Woman's health services – All female members may seek care directly from women's health specialists, such as gynecologists and certified nurse midwives within the physician or provider network for their routine and preventative healthcare services. This includes self referrals for mammography. Preventative health services are defined as breast exams, mammograms, pap smears and pelvic exams. Institutionalized members may choose their own providers or request to have these services provided by their primary care providers.

Influenza Vaccine - Bridgeway members may receive an influenza vaccination from any qualified provider, including the licensed medical professionals employed by a skilled nursing facility. Members are not required to obtain a referral or prior authorization in order to receive the influenza vaccination. There is no member cost sharing payment for this vaccine, or for a pneumococcal vaccine.

## ***General Billing Guidelines***

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Please make sure to use the Medicare member ID number and your Medicare provider number when submitting claims.

### **Claims Mailing Instructions**

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Submit paper claims to Medicare Advantage at the following address:

Advantage by Bridgeway Health Solutions HMO SNP  
Claim Processing Department  
P. O. Box 3060  
Farmington, MO 63640-3822

### **Appeals**

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In accordance with the Medicare Managed Care Manual Chapter 13 contracted providers do not have Medicare appeal rights; however, Bridgeway has an adjustment and reconsideration process for review of any contracted provider claim issues. Requests for reconsiderations from contracted providers must be received by Bridgeway within 60 days of the date of the Explanation of Payment (EOP). A copy of the EOP and supporting justification or documentation (such as medical record) must accompany any request for reconsideration.

Requests sent to the wrong address will be returned to the submitter.

Please mail claim adjustment/ reconsideration requests (e.g., error in processing) to:

Advantage by Bridgeway Health Solutions HMO SNP  
Claims Reconsideration  
P. O. Box 3060  
Farmington, MO 63640-3822

## ***Compliance***

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The Bridgeway Medicare Compliance Officer has overall responsibility and authority for carrying out the provisions of the compliance program.

Bridgeway is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Bridgeway provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at Bridgeway or the subcontractor's own expense.

## **Waste Abuse And Fraud (WAF) System**

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Bridgeway prohibits fraud, waste, or abuse and is committed to respond appropriately in the event— potential or suspected – fraud, waste, or abuse is committed by its employees, vendors, subcontractors, contracted providers, or business associates.

The Bridgeway FWA Compliance Program is organized to follow in sequence the core elements of a compliance plan in accordance with the Office of the Inspector General's (OIG) Guidelines.

**Health care fraud is a serious and costly reality. It places patients at risk and increases the cost of health care for all of us. The following are highlights of our FWA Program:**

1. The purpose of the Fraud, Waste and Abuse policy is to articulate our commitment to doing the right thing when it comes to fraud, waste, and abuse.
2. We are committed to compliance with all government requirements associated with fraud, waste and abuse.
3. We are working to prevent fraud, waste and abuse through awareness training and communication just like this.
4. We develop our FWA infrastructure to assess risk, monitor and audit its systems to detect signs of fraud, waste, or abuse.
5. Allegations of fraud, waste, or abuse are investigated and, where appropriate, corrective action is taken. Corrective action can include operational or policy changes, disciplinary action up to and including termination, and legal action.

The bottom line is that health care fraud is a serious problem that concerns everyone in our health care system and it is a reality that we can not afford to ignore.

### **REPORTING POTENTIAL FRAUD WASTE AND ABUSE**

**Medicare Fraud Hotline of the HHS Office Inspector General**  
800.447.8477

**Centene Anonymous Compliance Hotline**  
(866) 685-8664

**Bridgeway Compliance Officer**  
Compliance Officer  
1501 W. Fountainhead Pkwy Suite 295  
Tempe, AZ 85282  
(866) 475-3129 ext. 26818

**There is no tolerance for retaliation against any employee, physician, vendor, or contractor for making a good faith report of possible wrongdoing. Retaliation is against the law, and it is a violation of Plan policy. If you wish, you may call the Hotline anonymously.**

## Member Grievances

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A grievance is any member complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal.

Examples of member grievances are:

- Problems with the quality of medical care.
- Being encouraged to leave (disenroll from) the Plan.
- Problems with having to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when needed or waiting too long for them.
- Waiting too long for prescriptions to be filled.
- Rude behavior by doctors, nurses, receptionists, network pharmacists or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.

Members must file the grievance no later than 60 days after the event of incident. Bridgeway must address the grievance as quickly as the case requires based on the member's health status, but no later than 30 days after receiving the complaint. Bridgeway may extend the time frame by up to 14 days if the member asks for the extension, or if we justify a need for additional information and the delay is in the member's best interest.

A member or member's authorized representative may file a grievance either orally or in writing. Members or their authorized representative may file a grievance by contacting Member Services at (866) 475-3129 or by submitting written notification to:

**Advantage by Bridgeway Health Solutions HMO SNP**  
**Advantage Appeals Department**  
**1501 W. Fountainhead Parkway Suite 295**  
**Tempe, AZ 85282**

## Member Appeals

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If we deny any part of a request for a service or payment of a service, the member or their representative may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration/ redetermination." Appeals must be filed within 60 days of notification of the organization determination.

For a standard decision about medical care:

After we receive the appeal, we have 30 days (7 days for decisions related to Part D services) to decide, but will decide sooner if the member's health condition warrants it. However, if an extension is requested by the member, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not make our decision within 30 days (7 days for Part D services), or by the end of the extended time period, the request will automatically go to Appeal Level 2.

For an expedited decision about medical care:

After we receive the appeal, we have 72 hours to decide, but will decide sooner if the member's health warrants it. However, if an extension is requested by the member, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide

within 72 hours (or by the end of the extended time period), the request will automatically go to Appeal Level 2.

Members or their authorized representative must file an appeal by writing to:

**Advantage by Bridgeway Health Solutions HMO SNP  
Advantage Appeals Department  
1501 W. Fountainhead Parkway Suite 295  
Tempe, AZ 85282**

If we deny an appeal in whole or in part, we will forward the appeal file to the CMS contracted independent review entity (IRE), Maximus Federal Services Inc. (Maximus) to conduct a review of the plan's determination. The member or their representative will be notified when the case has been forwarded to Maximus.

### **Appointment of Representative**

An enrollee may designate any person as their representative. CMS requires that Bridgeway document proof of the validity of the enrollee's representative. If the party requesting the reconsideration is not the enrollee (and the special circumstances listed below do not apply), the party must submit appropriate documentation of representation. Appropriate documentation may include, but is not limited to, durable power of attorney, a health care proxy, appointment of guardianship or other legally recognized forms of appointment. The representative may also complete and submit a CMS Appointment of Representative Form (AOR) located on our website: <http://advantage.bridgewayhs.com/>.

Any physician may request an **expedited** reconsideration on behalf of an enrollee without serving as the beneficiary's representative.

Any physician may request a **standard** reconsideration on behalf of an enrollee but is required to provide notice to the beneficiary prior to filing the reconsideration request.

### **Special Conditions for Appointment of Representative**

If a member is incapacitated or incompetent and cannot sign an appointment of representative document, Arizona laws regarding legal representation of incapacitated or incompetent persons will be applied.

## **Assistance With Member Grievances And Appeals**

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Bridgeway's Member Services Department is available to assist members who need help in filing a grievance or appeal, or who need assistance in completing any element in the grievance or appeal process. Members may seek assistance by calling (866) 475-3129.

## **Medicare Regulatory Requirements**

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As a Medicare contracted provider, you are required to follow a number of Medicare regulations and requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- You may not discriminate against Medicare members in any way based on health status.
- You must ensure that members have adequate access to covered health services.
- You may not impose cost sharing on members for influenza vaccination or pneumococcal vaccination.
- You must allow members to directly access screening mammography and influenza vaccinations.
- You must provide female members with direct access to women's health specialists for routine and preventative healthcare.
- You must comply with the plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Bridgeway will provide you with at least 90 days written notice of termination if electing to terminate our agreement without cause, or as described in your participation agreement if greater than 90 days. You agree to notify the health plan according to the terms outlined in your provider agreement.
- You will ensure that your hours of operations are convenient to the member and do not discriminate against the member for any reason. You will insure necessary services are available to members 24 hours per day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Medicare members without CMS approval of the materials or forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- You will work with plan procedures to inform our members of healthcare needs that require follow up and provide necessary training in self care.
- You will document in a prominent part of the member's medical record, whether the member has executed an advance directive.
- You must provide services in a manner consistent with professionally recognized standards of care.
- You must cooperate with Bridgeway to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- You must cooperate with the health plan in notifying members of provider contract terminations.

- You must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- You must comply with any plan medical policies, Quality Improvement (QI) programs and medical management procedures.
- You will cooperate with the health plan in disclosing quality and performance indicators to CMS.
- You must cooperate with the health plan procedures for handling grievance appeals, and expedited appeals.
- You must fully disclose to all members before providing a service, if you feel the service may not be covered by the plan. The member must sign an agreement of this understanding. If they do not, the claim may be denied and the provider will be liable of the cost of the service.

## **References**

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Centers for Medicare & Medicaid Services (CMS) Managed Care Manual Chapter 13  
<http://www.cms.gov/manuals/downloads/mc86c13.pdf>

CMS Prescription Drug Benefit Manual Chapter 18  
[http://www.cms.gov/MedPrescriptDrugApplGriev/01\\_Overview.asp](http://www.cms.gov/MedPrescriptDrugApplGriev/01_Overview.asp)

CMS Prescription Drug Benefit Manual Chapter 9  
[http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual\\_Chapter9\\_FWA.pdf](http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf)

Maximus Federal Services, Inc. Medicare Health Plan Reconsideration Process Manual: Medicare Managed Care Reconsideration Project.  
<http://www.medicareappeal.com/Page.asp?Script=8>

Maximus Federal Services Inc. Part D Appeals Manual  
<http://www.medicarepartdappeals.com/>

Medicare Claims Processing Manual  
<http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10>