



**ADVANTAGE BY BRIDGEWAY HEALTH SOLUTIONS (HMO SNP)
PROVIDER QUICK REFERENCE GUIDE**

Revised: December 2011

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CONTACT US

Department	Phone	Fax
Case Management- Maricopa County	(866) 475-3129	(866) 687-0509
Case Management- Pima County	(866) 475-3129	(866) 614-4952
Claim Liaisons	(866) 518-6843	(866) 472-4568
Claim Disputes and Appeals	(866) 475-3129	(866) 687-0518
Disease Management	(866) 475-3129	(866)687-0509
Hospital/ SNF Admission Notification	(866) 295-9729	(866) 638-6126
Member Services	(866) 475-3129	(866)687-0519
Prior Authorization Medical	(866) 295-9729	(866)638-6126
Prior Authorization Dental	(866)327-4462	(866)653-5544
Prior Authorization Pharmacy	(800) 460-8988	(866) 399-0929
Provider Network Operations	(866)475-3129	(866) 687-0514

SERVICE AREAS

Advantage by Bridgeway Health Solutions HMO SNP (Bridgeway) is a Medicare Advantage Special Needs Plan (SNP) with a Medicare contract.

Bridgeway is a Full Dual Eligible SNP contracted to serve the following service areas:

- Maricopa County
- Pima/ Santa Cruz Counties

MEMBER ELIGIBILITY

Providers are responsible for verifying all member eligibility prior to rendering services. You can verify eligibility by using one of the following methods:

Member Services: (866) 475-3129.

You should obtain a copy of the Advantage member ID card.

CLAIMS & REIMBURSEMENT

Claims Customer Service

Bridgeway Claims Liaisons are able to assist you during the following business hours:



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Monday- Friday 8:00 AM to 5:00 PM
(866) 518-6843

EDI@centene.com

Timely Filing Guidelines

When Bridgeway is the primary insurance, the initial claim submission must be received within 12 months from the date of service.

Secondary claim submissions should include a copy of the primary payor's EOB and be received within 60 days of the date of the primary payor EOB, or 12 months from the date of service, whichever is greater.

Resubmissions must be received within 365 days from the date of service for consideration.

Claim Submissions

Network providers are encouraged to participate in Bridgeway's Electronic Claim Filing Program through Centene. For more information on electronic filing contact:

Bridgeway Health Solutions
c/o Centene EDI Department
(800) 225-2573 ext. 25525

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

All claims with the exception of those services categorized as "carve outs" (e.g. routine dental services, vision services, etc.) should be submitted to:

Bridgeway Health Solutions
PO Box 3060
Farmington, MO 63640-3822
Attention: Claims Department

Claim Forms

The Centers for Medicare & Medicaid Services (CMS) requires providers to submit claims on the newest version of each claim form. The claim forms incorporate the required National Provider Identification (NPI) fields.

The most recent forms include:



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- Practitioners: CMS 1500 (08/05)
- Facilitates: UB-04
- Dental: J400 (ADA 2006 version)

Scanning Tips

All paper claims are inputted using a process called “data lifting”. The following are tips for ensuring quality scans:

- Laser printers create the best character quality
- Use black ink for claims submissions
- Ensure that clean character formation occurs when printing paper claims (e.g. one side of a letter is not lighter or darker than the other side)
- Refrain from red stamps when possible as the ink may be removed during the scanning process.
- Use an original claim form
- Use a standard claim form

Multiple Page Claims

When a claim is greater than 1 page, place the grand total dollar amount for the claim on the bottom of the last page.

Multiple Services

All services for the same date of service (less than 6 lines on a CMS 1500) are submitted on a single form.

When multiple units are performed for the same service and date of service, the service is submitted on 1 line with the appropriate number of units.

Duplicate Claims

To avoid duplicate claims, Bridgeway recommends allowing 60 days prior to resubmission of a claim. In an effort to reduce duplicate claim billings and duplicate denials, we recommend that you verify claim status prior to resubmitting a claim.

National Provider Identification (NPI) Number

Bridgeway requires all providers to submit the rendering/ servicing provider NPI on each claim.

Bridgeway requires that, when applicable, the prescribing, referring, attending and operation provider NPIs also be including on the claim submission.

Claims that do not include the appropriate NPIs will be denied.



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To apply for a NPI online, please go to www.nppes.com.hhs.gov or call (800) 465-3203 to request a paper application.

Please fax a copy of your NPI to Bridgeway Provider Relations Department at (866) 687-0514

Please contact your Provider Relations Specialists if you need any additional information or assistance.

Refunds

When submitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payor's remittance advice (if applicable).

If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

PRIOR AUTHORIZATIONS

Authorization Forms

Prior authorizations for medical services (including in-office injectables) are requested using the Request for Authorization form.

The form is available on our website:

<http://advantage.bridgewayhs.com/home/provider-information>

Exceptions to the formulary are submitted using the Pharmacy Exception Request form also located on our website:

<http://advantage.bridgewayhs.com/home/prescription-drug-part-d-benefit-information/exceptions/>

Urgent/ Expedited Authorization Requests

Per CMS requirements, you must provide a supporting statement indicating why you believe applying the standard review process would jeopardize the member's health to have the request automatically expedited. Requests not containing a supporting statement will be reviewed for medical necessity of an expedited review.

Urgent/ expedited requests are responded to in 72 hours. Please include all pertinent records, lab reports and other information in the request to avoid any unnecessary delays in review.



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Routine/ Standard Authorization Requests

Routine/ standard requests are responded to within 14 calendar days. Please include all pertinent records, lab reports and other information in the request to avoid any unnecessary delays in review.

CLAIM DISPUTES & APPEALS

Medicare guidelines stipulate that contracted providers do not have appeal rights related to claim payment issues. Bridgeway encourages contracted providers to contact our Claim Liaisons for assistance with any questions or issues related to claim payments.

Appealing a Service Denial on Behalf of a Member

If Bridgeway denies a prior authorization requests for services in whole, or in part, you may file an appeal on behalf of the member. The appeal must be filed within 60 calendar days of the original denial notice. You will have the same rights and responsibilities of a member in obtaining an organizational determination or managing the levels of the appeal process.

BEHAVIORAL HEALTH

You can contact the Bridgeway Prior Authorization Department for assistance with coordinating behavioral health care for an Advantage member.

If there is any indication that a member is currently a danger to themselves or to others, please contact 911.

If the situation is not imminently dangerous, you can call the Maricopa Crisis Line at (602) 222-9444 or (800) 631-1314. TTY users can call (602) 274-3360.

CASE MANAGEMENT

Each Advantage Bridgeway member has a personal care plan. Case Management services are available to all members who have complex medical conditions. Bridgeway partners with providers, community programs and family members for a holistic approach to health care with optimal outcomes.

Our Case Management goals include:

- Decreasing unnecessary hospital admissions
- Decreasing unnecessary emergency room utilization
- Improvement in quality of life through community resources
- Greater understanding of the Bridgeway Advantage benefits and services available



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Please contact our Case Management Departments for more information on the case management program available to members at (866) 475-3129.

DISEASE MANAGEMENT

Bridgeway partners with Nurtur to provide Disease Management services.

Nurtur is a health and wellness Company that helps people transform their lives and well-being through best-in-class life and health coaching. Focus areas include back pain, depression, diabetes, heart disease and respiratory disease.

Bridgeway encourages provider participation in the member's care. For more information and assistance, please contact (866) 475-3129.

PHARMACY SERVICES

The Bridgeway formulary is located on our website:

<http://advantage.bridgewayhs.com/home/prescription-drug-part-d-benefit-information/formulary/>

If you have any questions, or do not have internet access and would like a hard copy of our formulary,

pharmacy prior authorization information or quantity limit information; please contact your Provider Relations Specialist.

Please ensure that your office is prescribing the medications listed on our formulary. Please consider all formulary options prior to submitting an exception request for non-formulary medication.

Prior authorization and exception requests can be faxed to (866) 399-0929.

US Script is our Pharmacy Benefit Manager (PBM). US Script manages our prescription drug transactions and pharmacy network.

DURABLE MEDICAL EQUIPMENT & HOME CARE

Durable Medical Equipment (DME) and Medical Supplies

Covered DME and medical supplies must be medically necessary and may require prior authorization

Skilled Nursing Facility (SNF) and Home Therapy

SNF and Home Therapy services require prior authorization.



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Infusion

Infusion services require prior authorization

Diabetic Supplies

The following diabetic supplies can be filled at network pharmacies under the Medicare Part B benefit:

- Glucose monitoring strips
- Lancets
- Lancet devices
- Glucose blood strips

DENTAL SERVICES

Bridgeway currently covers:

- Up to 1 oral exams every year
- Up to 2 cleanings every year
- Up to 1 fluoride treatments every year
- Up to 1 dental x-ray every year

Bridgeway also offers a \$1200 comprehensive dental benefit for the year.

Note: prior authorization requirements may apply. In additions, it is recommended that providers contact

Avesis prior to any treatments to verify the comprehensive benefit availability at the time of service

Please contact the Bridgeway Member Services Department for more information on the dental benefit.

Bridgeway contracts with Avesis to provide dental care for Advantage members. Avesis can be reached at (800) 327-4462.

Dental Claims:
AVESIS 3rd Party
PO Box 7777
Phoenix, AZ 85011-7777

MEDICARE WEBSITE REFERENCES

Commonly used Medicare links for billing are available on the Bridgeway website.

VISION SERVICES

Bridgeway covers the following vision benefits:

- 1 Routine eye exam
- The cost of the exam to diagnose and treat diseases and conditions of the eye
- 1 pair of glasses or contacts every year



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- 1 pair of glasses or contacts after cataract surgery

Glasses and contacts are limited to \$150.

Bridgeway contracts with OptiCare for vision services. OptiCare can be reached at (800) 334-3937.

HEARING SERVICES

Bridgeway covers the cost for Medicare-covered diagnostic hearing exams. Please note prior authorization requirements may apply.

Other hearing services are not currently covered by Advantage by Bridgeway Health Solutions (HMO).

CULTURAL COMPETENCY

Bridgeway has a diverse membership and makes every effort to provide cultural competent services taking into consideration race, ethnic background, language, age and religion.

Bridgeway provides all member materials in Spanish and other languages and formats when requested.

Translation & Sign Language Interpretation Services

Bridgeway can assist with providing translation and interpretation services. Bridgeway provides these services to members and providers at no cost.

If you need account information please contact your Provider Relations Specialist.

ADVANCE DIRECTIVES

The Patient Self-Determination Act was passed by Congress in 1991. The Act requires that all health care providers educate patients on the issues related to Advance Directives.

The ACT requires all Medicare providers to provide timely information so that member's have the opportunity to express their wishes regarding the refusal of medical care.

Bridgeway requests your assistance in complying with the requirement. Please document in the medical record whether or not an Advantage member has completed an Advance Directive.

For more information on health care directives, please see the following resources:

American Medical Association
www.azmedassn.org



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Arizona Hospital & Healthcare Association
www.azhha.org

Arizona Aging and Adult Administration
www.azdes.gov/aaa

American Academy of Family Physicians
www.familydoctor.org

American Association of Retired Persons
www.aarp.org

American Hospital Association
www.puttinwriting.org

FRAUD WASTE AND ABUSE

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.



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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.

PROVIDER DIRECTORIES

Provider directories are available on our website:

<http://advantage.bridgewayhs.com/home/find-a-provider-or-pharmacy/>

If you have any questions, or do not have internet access and would like a hard copy of our directories, please contact your Provider Relations Specialist.

PROVIDER MANUAL

The Provider Manual is available on our website:

<http://advantage.bridgewayhs.com/home/provider-information/>

If you have any questions, or do not have internet access and would like a hard copy of our provider manual, please contact your Provider Relations Specialist.