bravo HEALTH

Live life well.

2008 Provider Manual

Texas

BH-0133 Revised January 2008

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Dear Valued Provider and Staff:

I would like to extend a warm welcome and thank you for participating with Bravo Health's network of Participating Providers. We value our relationship with all of our Providers and are committed to working with you to meet the needs of your Bravo Health patients.

For more than ten years we have been focusing on serving the healthcare needs of people with Medicare. We will continue to serve the Medicare market and, in doing so, will continue to seek ways to bring the benefits and services our Members need to live life well.

Thank you for continued participation with Bravo Health.

Sincerely,

Pat Feyen
Senior Vice President and Executive Director
Bravo Health Texas, Inc.

QUICK REFERENCE GUIDE

ELIGIBILITY VERIFICATION

Member Services provides eligibility and co-payment information for plan members.
866-467-3126 Automated Eligibility

888-353-3789 Member Services
800-964-2561 TTY/TTD
866-464-0701 Liberty Private-Fee-For-Service
(available 24hrs/365days)

ANCILLARY SERVICES

The services shown below are provided by separate carriers.

OUTPATIENT LABORATORY SERVICES:
Clinical Pathology Laboratories
Quest Diagnostics

MENTAL HEALTH/SUBSTANCE ABUSE:
Corphealth: **866-671-4537**

DENTAL: Star Dent: **866-753-6319**

VISION: OptiCare: **866-258-4102**

TRANSPORTATION

Medicare/Medicaid Dual Eligible Members

Provided to and from participating provider appointments for Bravo Select members.

Transportation should be requested three days prior to appointment. Urgent transportation may be able to be accommodated. Provider or members may call to schedule.

Reservations: **866-853-6659**

FORMULARY/PART D

You may view Bravo Health's formulary online at:
www.bravohealth.com

Formulary Exceptions and Part D Authorizations:
877-813-5595

CLAIMS SUBMISSION

ELECTRONIC CLAIMS
Electronic claims may be submitted through
Availity/T.H.I.N, WebMD/Emdeon or Payer Path
Carrier code **#52192**

PAPER CLAIMS
Use original CMS 1500 or UB 04
Paper claims must be submitted within 180 days to:

Bravo Health, Inc.
c/o Texas Claims
PO Box 4432
Baltimore, MD 21223

Claims questions should be directed to our Member/Provider Services Department:
888-353-3789

CLAIMS RECONSIDERATIONS
Provider requests for claims reconsideration must be submitted within 60 days to:

Bravo Health, Inc.
c/o Claims Reconsiderations
PO Box 26038
Baltimore, MD 21223

APPEALS
Provider appeals must be submitted within 60 days to:

Bravo Health, Inc.
c/o Grievance and Appeals Unit
PO Box 4440
Baltimore, MD 21223

800-931-0149 (facsimile)

Appeal results are not available by telephone or by facsimile for 60 days following submission.

HEALTH SERVICES

1-888-454-0013

Inpatient Admission Notification
Extension: 336356 Fax: 866-234-7230

UR Concurrent Review/Discharge Planning
Extension: 336341 Fax: 866-234-7230

Prior Authorization – Outpatient Services
Prior Authorization – Elective Inpatient Admissions
Extension: 336336 Fax: 866-464-0707

Prior Authorization – DME
Extension: 336346 Fax: 866-464-0707

Skilled Nursing
Extension: 336923 Fax: 888-454-0024

Home Care
Extension: 336097 Fax: 800-931-0145

Case Management
Extension: 336351 Fax: 866-467-3134

After-Hours on Call Care Management/ Discharge Planning
Phone: 800-931-0154

BRAVO HEALTH IS AN OPEN ACCESS HMO.

NO REFERRALS REQUIRED.

CONTACT PROVIDER RELATIONS

El Paso	915-577-4183
Houston	713-454-8451
San Antonio	210-321-7766

PRIOR AUTHORIZATION REQUIRED

Elective admissions require prior authorization at least five days prior to the admission.

Urgent/emergent admissions require notification within 24 hours or next business day, whichever is later.

- Ambulance *(Non-Emergent)*
- Biofeedback
- Chemotherapy, outpatient
- Clinical Trials
- CT Scans
- Diagnostic Procedures *(Hospital-Based)*
- DME *(Any Item > $200)*
- Enhanced External Counter Pulsation
- Home Healthcare/Home IV
- Hyperbaric O2 Therapy
- IMRT
- Inpatient Admissions *(Acute, Sub-Acute, Skilled Nursing, Rehabilitation, Long-Term Acute, Hospice)*
- Mental Health and Substance Abuse *(See Corphealth)*
- MRI/MRA
- Neuropsychiatry Testing
- Nuclear Imaging
- Occupational Therapy*
- Outpatient Surgeries *(Hospital-Based)*
- Pain Management
- PET Scans
- Physical Therapy*
- Prosthetics *(Any Item > $200)*
- Radiation Therapy
- Speech Therapy*
- Sleep Studies
- Surgical Procedures *(Hospital-Based)*
- TMJ Treatment
- Transplants
- Wound Care

**Authorization only required when provided by a home health agency or visits greater than 12.*

NO AUTHORIZATION REQUIRED FOR THESE CODES

J0120	Tetracycline	J1670	Tetanus	90646	H-flu booster
J0170	Adrenalin/Epinephrine	J1700	Hydrocortisone Acetate	90647	H-flu (3 dose schedule)
J0280	Aminophyllin	J1710	Hydrocortisone Sodium	90648	H-flu
J0290	Ampicillin	J1885	Torodol	90658	Influenza
J0295	Ampicillin	J1940	Lasix	90660	Influenza - nasal
J0456	Azithromycin	J2300	Nubain	90665	Lyme
J0515	Cogentin	J2310	Narcan	90675	Rabies IM
J0530	Penicillin G	J2353	Sandostatin	90676	Rabies ID
J0540	Penicillin G	J2510	Penicillin G	90691	Typhoid IM
J0560	Penicillin G	J2550	Phenergan	90692	Typhoid SC/ID
J0570	Penicillin G	J3301	Kenalog	90698	Dtap-Hib-IPV IM
J0670	Carbocaine	J3302	Aristocort	90701	DTP
J0690	Ancef/Kefzol	J3420	Vitamin B12	90703	Tetanus IM
J0694	Mefoxin	J3430	Vitamin K	90704	Mumps
J0696	Rocephin	J9250	Folex	90705	Measles
J0698	Claforan	Q4093	Albuterol	90706	Rubella
J0702	Celestone	Q4094	Albuterol	90707	MMR
J0704	Betamethazone sodium			90708	MR SC
J0780	Compazine			90710	MMRV
J1020	Depo-Medrol			90713	IPV SC
J1030	Depo-Medrol			90718	DT
J1040	Depo-Medrol	90371	HBIG	90719	DT IM
J1094	Decadron	90375	RIG (Rabies)	90732	Pneumococcal Polysac
J1100	Decadron	90376	RIG (Rabies)	90733	Meningococcal Poly
J1200	Benadryl	90389	Tetanus	90740	Hep B Dialysis Pt (3)
J1600	Gold	90396	Varicella	90746	Hep B IM
J1610	Glucagon	90632	Hep A	90747	Hep B Dialysis Pt (4)
J1642	Heparin loc-flush	90636	Hep A&B	90748	Hep B-Hib
J1644	Heparin Sodium	90645	H-flu b vaccine		

MEMBER ELIGIBILITY

Anyone who meets the following criteria is eligible to enroll in one of Bravo Health's HMO Benefit Plans.

- Must be enrolled in Medicare, both Part A and Part B.
- Must reside in one of the following Counties:
    - Bexar
    - El Paso
    - Harris
- Must not have End Stage Renal Disease (ESRD) at time of enrollment.

To enroll in one of Bravo Health's Private Fee-For-Service (PFFS) Benefit Plans, the Member must

- Be enrolled in Medicare Part A and Part B
- Reside in one of the following Counties:
    - Atascosa
    - Bexar
    - Brazoria
    - Chambers
    - El Paso
    - Fort Bend
    - Galveston
    - Guadalupe
    - Harris
    - Jasper
    - Jefferson
    - Liberty
    - Medina
    - Montgomery
    - Orange

- Must not have End Stage Renal Disease (ESRD) at the time of enrollment

ELIGIBILITY VERIFICATION

All Participating Providers are responsible for verifying a Member's eligibility at each and every visit. Please note that Membership data is subject to change. CMS retroactively terminates Members for various reasons. When this occurs, the Bravo Health claim recovery unit will request a refund from the Provider. The Provider must then contact CMS eligibility to determine the Member's actual benefit coverage for the date of service in question.

You can verify HMO (Bravo Classic, Bravo Healthy Heart, Bravo Gold or Bravo Select) Member eligibility in three ways:

- Online through Emdeon or other office management software
- By calling Provider services at 1-888-353-3789
    - Through our Interactive Voice Response (IVR) System at 1-866-467-3126 The IVR System is available 24 hours a day, 7 days a week.

To verify Private-Fee-For-Service (Bravo Liberty) Member eligibility:

- Call 1-866-464-0701

MEMBER HOLD HARMLESS

Participating Providers are prohibited from balance billing Bravo Health Members including, but not limited to, situations involving non-payment by Bravo Health, insolvency of Bravo Health, or Bravo Health's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against Members or persons, other than Bravo Health, acting on behalf of Members for Covered Services provided pursuant to the contracted Provider's Agreement. The Provider is not, however, prohibited from collecting co-payments, co-insurances or deductibles for non-covered services in accordance with the terms of the applicable Member's Benefit Plan.

In the event a Provider refers a Member to a non-Participating Provider without pre-approval, or provides Excluded Services to Member, Provider must inform the Member in advance, in writing: (i) of the service(s) to be provided; (ii) that Bravo Health will not pay for or be liable for said services; and (iii) that Member will be financially liable for such services. In the event the Provider does not comply with the requirements of this section, Provider shall be required to hold the Member harmless as described above.

MEMBER CONFIDENTIALITY

At Bravo Health, we know Bravo Health Members' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our Member's personal information. Bravo Health does not give out any Member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued Provider to Bravo Health, we want you to know the steps we have taken to protect Bravo Health's Members' privacy. This includes how we gather and use their personal information. Bravo Health's privacy practices apply to all of Bravo Health's past, present and future Members.

When a Member joins a Bravo Health Medicare Advantage plan, the Member agrees to give Bravo Health access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care Provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium. Access to PHI allows Bravo Health to work with Providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the Members' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows Bravo Health to look at how care is delivered and carry out programs to improve the quality of care Bravo Health's Members receive. This information also helps Bravo Health manage the treatment of diseases to improve Bravo Health's Members' quality of life.

Bravo Health's Members have additional rights over their health information. They have the right to:

- Send Bravo Health a written request to see or get a copy of information that we have about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer Bravo Health's Member to the source, such as you.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.
- Receive an accounting of Bravo Health's disclosures of their medical information, except when those disclosures are for treatment, payment or health care operations, or the law otherwise restricts the accounting.

MEMBER RIGHTS AND RESPONSIBILITIES

Bravo Health Members have the following rights:

The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect, and fairness at all times. Bravo Health must obey laws against discrimination that protect Members from unfair treatment. These laws say that Bravo Health cannot discriminate against Members (treat Members unfairly) because of a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If Members need help with communication, such as help from a language interpreter, they should be directed to call Member Services. Member Services can also help Members in filing complaints about access (such as wheel chair access). Members can also call the Office of Civil rights **at 1-800-368-1019 or TTY/TDD 1-800-537-7697** or the Office for Civil Rights in their area.

The right to the privacy of medical records and personal health information

There are federal and state laws that protect the privacy of Member medical records and personal health information. Bravo Health keeps Members' personal health information private as protected under these laws. Any personal information that a Member gives Bravo Health when they enroll in our plans is protected. Bravo Health staff will make sure that unauthorized people do not see or change Member records. Generally, we will get written permission from the Member (or from someone the Member has given legal authority to make decisions on their behalf) before we can give Member health information to anyone who is not providing the Member's medical care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect Member privacy give them rights related to getting information and controlling how their health information is used. Bravo Health is required to provide Members with a notice that tells them about these rights and explains how Bravo Health protects the privacy of their health information. For example, Members have the right to look at their medical records, and to get copies of the records (there may be a fee charged for making copies). Members also have the right to ask plan Providers to make additions or corrections to their medical records (if Members ask plan Providers to do this, they will review Members request and figure out whether the changes are appropriate). Members have the right to know how their health information has been given out and used for non-routine purposes. If Members have questions or concerns about privacy of their personal information and medical records, they should be directed to call Member Services. Bravo Health will release a

Member's information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The right to see Participating Providers, get covered services, and get prescriptions filled within a reasonable period of time

Members will get most or all of their health care from Participating Providers, that is, from doctors and other health Providers who are part of Bravo Health. Members have the right to choose a Participating Provider (Bravo Health will tell Members which doctors are accepting new patients). Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their Providers and to see specialists when care from a specialist is needed. Members also have the right to timely access to their prescriptions at any network pharmacy. "Timely access" means that Members can get appointments and services within a reasonable amount of time. The Evidence of Coverage explains how Members access Participating Providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know treatment choices and participate in decisions about their health care

Members have the right to get full information from their Providers when they go for medical care, and the right to participate fully in treatment planning and decisions about their health care. Bravo Health Providers must explain things in a way that Members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition including all appropriate and medically necessary treatment options, no matter what they cost or whether they are covered by Bravo Health. This includes the right to know about the different Medication Management Treatment Programs Bravo Health offers and in which Members may participate. Members have the right to be told about any risks involved in their care. Members must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

Members have the right to receive a detailed explanation from Bravo Health if they believe that a plan Provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, Members must request an initial decision. "Initial decisions" are discussed in the Members' Evidence of Coverage.

Members have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This includes the right to stop taking their medication. If Members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to use advance directives (such as a living will or a power of attorney)

Members have the right to ask someone such as a family member or friend to help them with decisions about their health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If a Member wants to, he/she can use a special form to give someone they trust the legal authority to make decisions for them if they ever become unable to make decisions for themselves. Members also have the right to give their doctors written instructions about how they want them to handle their medical care if they become unable to make decisions for themselves. The legal documents that Members can use to give their directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If Members decide that they want to have an advance directive, there are several ways to get this type of legal form. Members can get a form from their lawyer, from a social worker, from Bravo Health, or from some office supply stores. Members can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where they get this form, keep in mind that it is a legal document. Members should consider having a lawyer help them prepare it. It is important to sign this form and keep a copy at home. Members should give a copy of the form to their doctor and to the person they name on the form as the one to make decisions for them if they can't. Members may want to give copies to close friends or family Members as well.

If Members know ahead of time that they are going to be hospitalized, and they have signed an advance directive, take should a copy with them to the hospital. If Members are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If Members have *not* signed an advance directive form, the hospital has forms available and will ask if the Member wants to sign one.

Remember, it is a *Member's choice* whether he/she wants to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If Members *have* signed an advance directive, and they believe that a doctor or hospital has not followed the instructions in it, Members may file a complaint with their State's Board of Medicine.

The right to make complaints

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two different types of complaints Members can make. If Members make a complaint, Bravo Health must treat them fairly, i.e., not discriminate against Members, because they made a complaint. Members have the right to get a summary of information about the appeals and grievances that have been filed with Bravo Health in the past. To get this information, Members should be directed to call Member Services.

The right to get information about their health care coverage and cost

The Evidence of Coverage tells Members what medical services are covered and what they have to pay. If they need more information, they should be directed to call Member Services. Members have the right to an explanation from Bravo Health about any bills they may get for services not covered by Bravo Health. Bravo Health must tell Members in writing why Bravo Health will not pay for or allow them to get a service, and how they can file an appeal to ask Bravo Health to change this decision. Staff should inform Members on how to file an appeal, if asked and should direct Members to review their Evidence of Coverage for more information about filing an appeal.

The right to get information about Bravo Health, plan Providers, drug coverage, and costs

Members have the right to get information from us about our plan and operations. This includes information about our financial condition, the services we provide, about our health care Providers and their qualifications, and about how Bravo Health compares to other health plans. Members have the right to find out from us how we pay our doctors. To get any of this information, Members should be directed to call Member Services. Members have the right to get information from us about their Part D prescription coverage. This includes information about our financial condition and about our network pharmacies. To get any of this information, staff should direct Members to call Member Services.

How to get more information about Members rights

Members have the right to receive information about their rights and responsibilities and if Members have questions or concerns about their rights and protections, they should be directed to call Member Services. Members can also get free help and information from their State Health Assistance Insurance Program (SHIP). In addition, the Medicare program has written a booklet called *Members Medicare Rights and Protections.* To get a free copy, Members should be directed to call **1-800-MEDICARE (1-800-633-4227). TTY is 1-877-486-2048**. Members can call 24 hours a day, 7 days a week. Or, Members can visit www.medicare.gov on the web to order this booklet or print it directly from their computer.

What can Members do if they think they have been treated unfairly or their rights are not being respected?

If Members think they have been treated unfairly or their rights have not been respected, there are options for what they can do.

- If Members think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, we must encourage them to let us know immediately. They can also call the Office for Civil Rights in their area.
- For any other kind of concerns or problem related to their Medicare rights and protections described in this section, Members should be encouraged to call Member Services. Members can also get help from their SHIP.

Bravo Health Members have the following responsibilities:

Along with rights Members have responsibilities by being a Member of Bravo Health. Members are responsible for the following:

a. To become familiar with their Bravo Health coverage and the rules they must follow to get care as a Member. Members can use their Bravo Health Evidence of Coverage and other information that we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. Members should always be encouraged to call Member Services if they have any questions or complaints.

b. To advise Bravo Health if the Member has other insurance coverage

c. To notify Providers when seeking care (unless it is an emergency) that Member is enrolled with Bravo Health and present their plan enrollment card to the Provider.

d. To give their doctors and other Providers the information they need to care for the Member, and to follow the treatment plans and instructions that they and their doctors agree upon. Members must be encouraged to ask their doctors and other Providers questions whenever they have them.

e. To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.

f. To pay their plan premiums and any co-payments they may have for the covered services they receive. Members must also meet their other financial responsibilities that are described in their Evidence of Coverage.

g. To let Bravo Health know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage and Bravo Health operations.

h. To notify Bravo Health Member Services and their Providers of any address and phone number changes as soon as possible.

i. To use their Bravo Health plan only to access services, medications and other benefits for themselves.

ADVANCE MEDICAL DIRECTIVES

All Providers, contracted directly or indirectly with Bravo Health, may be informed by the Member that Member has executed, changed or revoked an advance directive. At the time service is provided the Provider should ask the Member to provide a copy of the advance directive to be included in his/her medical record.

If the PCP and/or treating Provider, cannot, as a matter of conscience, fulfill the Member's written advance directive he/she must advise the Member and Bravo Health. Bravo Health and the PCP and/or treating Provider will arrange a transfer of care.

Participating Providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Patient Self-Determination Act precludes the right under state law of a Provider to refuse to comply with an advance directive as a matter of conscience.

BENEFITS AND SERVICES

All Bravo Health Members receive the benefits and services as defined in their Evidence of Coverage (EOC). Each month, Bravo Health sends Participating **Primary Care Physicians** a list of his/her active Members. The name of the Plan in which the Member enrolled will be listed on the roster. Recently terminated Members may appear on the list.

Bravo Health encourages its Members to call their Primary Care Physician to schedule appointments. However, if a Bravo Health Member calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the Member and explain to them your office policy regarding appointments. If this problem persists, please contact Bravo Health.

THE ROLE OF THE PRIMARY CARE PHYSICIAN ("PCP")

Each Bravo Health Member must select a Bravo Health Participating Primary Care Physician ("PCP") at the time of enrollment. The Primary Care Physician is responsible for managing all the health care needs of a Bravo Health Member as follows:

- Manage the health care needs of Bravo Health Members who have chosen them as their Primary Care Physician;
- Ensure that Member receives treatment as frequently as is necessary based on the Member's condition;
- Develop an Individual Treatment Plan for each Member;
- Submit accurately and timely encounter information for clinical care coordination;
- Comply with Bravo Health's pre-authorization procedures;
- Refer to Bravo Health Participating Providers;

- Comply with Bravo Health's Quality Management and Utilization Management programs;
- Use appropriate designated ancillary services;
- Comply with emergency care procedures;
- Comply with Bravo Health access and availability standards as outlined in this manual including after-hours care;
- Bill Bravo Health on the CMS 1500 claim form or electronically in accordance with Bravo Health billing procedures;
- When billing ensure that coding is specific enough to capture to acuity and complexity of a Member's condition and ensure that the codes submitted are supported by proper documentation in the medical record;
- Comply with Preventive Screening and Clinical Guidelines;
- Adhere to Bravo Health's medical record standards as outlined on page 49 of this manual.

THE ROLE OF THE SPECIALIST PHYSICIAN

- Provide specialty services;
- Collaborate with Bravo Health Primary Care Physician to enhance continuity of health care and appropriate treatment;
- Provide consultative and follow-up reports to the referring physician in a timely manner;
- Comply with access and availability standards as outlined in this manual including after-hours care;
- Comply with Bravo Health's pre-authorization process;
- Comply with Bravo Health's Quality Management and Utilization Management programs;
- Bill Bravo Health on the CMS 1500 claim form in accordance with Bravo Health's billing procedures;
- When billing ensure that coding is specific enough to capture to acuity and complexity of a Member's condition and ensure that the codes submitted are supported by proper documentation in the medical record;
- Refer to Bravo Health Participating Providers only;
- Submit encounter information to Bravo Health accurately and timely;
- Adhere to Bravo Health's medical record standards as outlined on page 49 of this manual.

COMMUNICATION BETWEEN PROVIDERS

- PCP should provide Specialist Physician with relevant clinical information regarding the Member's care.
- Specialist Physician must provide PCP with information about his/her visit with the Member in a timely manner.
- PCP must document in the Member's chart his/her review of any reports, labs or diagnostic tests received from a Specialist Physician.

PROVIDER MARKETING GUIDELINES

Bravo Health Participating Providers must adhere to the following guidelines with regard to any marketing activities:

- Ensure that any marketing activities are approved in advance by Bravo Health to ensure compliance with CMS guidelines;
- Ensure that any letters, events, health fairs, etc. are reported to and cleared in advance by Bravo Health;
- Ensure that any gifts or promotional items are cleared with Bravo Health in advance;

- Providers may make available and/or distribute Bravo Health marketing materials and display posters in accordance with and subject to Medicare Marketing Guidelines;
- Providers may not make available, accept or distribute plan enrollment applications or offer inducements to enroll in a specific plan; and
- Providers may not offer anything of value to induce a prospective Member to select them as their Provider.

PROVIDER CREDENTIALING AND PARTICIPATION

Providers must be credentialed by Bravo Health according to the following guidelines:

Provider	Status	Procedure
New to plan, not previously credentialed	Practicing in a solo practice	Requires a signed contract and initial credentialing which may include a site visit depending upon Provider's specialty*
New to plan, not previously credentialed	Joining a contracted group practice	Requires initial credentialing; however, a site visit is not be required regardless of specialty.
Already contracted and credentialed	Leaving a group practice to begin a solo practice	Does not require credentialing; however a new contract is required and a new office location may require a site visit depending upon Provider's Specialty*
Already contracted and credentialed	Leaving a group practice to join another contracted group practice	Does not require credentialing and no site visit is required regardless of specialty.
Already contracted and credentialed	Leaving a group practice to join a non-contracted group practice	The Provider's participation is terminated unless non-contracted group signs a contract with Bravo Health.

* Primary Care and OB/GYN offices require site visits

PROVIDER & ALLIED HEALTH PRACTITIONERS CREDENTIALING CRITERIA

REQUIRED INFORMATION

1) Completed Bravo Health, Texas Standard or CAQH application with a signed and dated Bravo Health Certification and Attestation form.

   a) If you answer yes to any of the questions, supply all additional information.

   b) If you answer yes to the malpractice history question, please supply for each case:

      1. Date of alleged malpractice
      2. A brief description of the nature of the case and alleged malpractice
      3. A statement describing your role in the case
      4. Current status of case, including any settlement amount

2) Current and complete professional liability information on the application and provide a copy of your current malpractice insurance face sheet.

3) Current and complete hospital affiliation information on the application and a copy of your current appointment or reappointment letter.

4) If no hospital privileges and your specialty warrants hospital privileges, a letter from you detailing your coverage arrangements and a letter from the physician who will admit for you.

5) Five years of work history (month/year format) documented on the application or on current curriculum vitae with any gaps of more than 6 months explained and gaps of one year or more explained in writing.

6) A signed and dated Provider Agreement. Upon acceptance, an executed copy will be returned to you for your files.

7) Completed and signed W-9 form.

8) Bravo Health conducts an office site visit at Primary Care and OB/GYN offices. This requirement is waived for new physicians joining an existing practice.

All applications for participation with Bravo Health will be reviewed by the designated Bravo Health Medical Director and Physician Advisory Credentialing Committee (PACC). Applications will be reviewed on an individual basis

The criteria stated below are the minimum standards, and meeting these criteria is not sufficient in and of itself for acceptance. Bravo Health maintains the right to limit the Provider network according to its needs. The credentials process is a vital part of the Bravo Health Quality Assessment program and is an essential tool to assure that the care delivered is of optimal quality using the resources available.

All information submitted to Bravo Health for both the initial credentialing and re-credentialing processes will be considered by the PACC prior to making a decision regarding acceptance, denial, or termination.

CREDENTIALS CRITERIA

1. Physicians must have obtained a Doctor of Medicine, Doctor of Osteopathy, Doctor of Medical Dentistry, or Doctor of Dental Surgery, degree from a medical school accredited by one of the following: the Liaison Committee on Medical Education (or have obtained a certificate from the Educational Council for Foreign Medical Graduates-ECFMG), the American Osteopathic Association (AOA) or the American Board of Oral and Maxillofacial Surgery (ABOMS). Allied Health Professionals must have graduated from an approved professional degree program for the specialty they are applying for participation.

2. Physicians must have completed a full residency training program accredited by one of the agencies listed below in the specialty designated as the individual's principal type of practice: American Osteopathic Association (AOA) or the American Dental Association Commission on Dental Accreditation or the American Medical Association (AMA).

3. Physicians and Allied Health Professionals must have and maintain a current and unrestricted license to practice medicine granted by each State where he or she has an office listing with Bravo Health. Any Provider whose license is in a probationary status is not eligible for Membership.

4. Physicians credentialed for participation with Bravo Health that are not board certified must have completed an approved residency training program with the following exception noted below.

   If not board certified, the credentialing staff will verify the physician's residency. Residencies will be verified through the AMA or AOA physician master profile for the specialty being requested or by writing the residency program itself. For podiatrists, the residency will be verified by writing the residency program itself. Board certification and residency verifications are completed within 180 days of being presented to the PACC.

   Exception: If a physician is not board certified but has completed internship/residency training prior to January 1, 1980 AND has ten year's of experience in his/her trained specialty, then the physician may be credentialed and listed in that designated specialty and is considered to be "***grandfathered.***"

5. For physician listings in Bravo Health provider directories:

   - Upon initial credentialing, if a physician is board certified in his/her primary specialty and has the appropriate fellowship training or board certification in his/her subspecialty, then the physician may be credentialed and listed in both the primary specialty and the subspecialty.

   - Upon initial credentialing, if a physician is not board certified in his/her primary specialty, then he/she may not be listed in his/her subspecialty. The physician will be credentialed and listed only in his/her primary specialty for which he/she has the appropriate residency training as outlined in # 4 above.

If the physician's designated specialty includes the provision of services in a hospital setting, then:

a. The physician must demonstrate active privileges at a state licensed acute-care hospital that is currently contracted with Bravo Health or part of the evolving network**; or**

b. The physician must provide to Bravo Health a written explanation as to why he/she does not have hospital privileges and an acceptable method of hospitalizing Members. Both the applicant and the Bravo Health contracted admitting physician must submit documentation of the arrangement; and

c. If the physician does not have hospital privileges due to any reason other than a strictly voluntary relinquishment by the physician, the physician's application will be reviewed by a Bravo Health Medical Director and forwarded for review to the PACC.

6. Primary care physicians must have coverage arrangements with a Bravo Health Participating physician to assure that services are available on a twenty-four-hour-a-day, seven-days-a-week basis.

7. Practitioners must disclose for Bravo Health Credentialing Committee review all claims or suits alleging malpractice that have been filed against him or her or appealed or settled by the physician or his or her insurance carrier in the past five (5) years.

8. Practitioners who currently or have ever been excluded from Medicare and/or Medicaid participation is not eligible for participation with Bravo Health. If a physician is accepted into Bravo Health and then is excluded from Medicare and/or Medicaid participation, that physician will be terminated.

9. Practitioners must hold and maintain a current federal narcotics license. It must include all DEA schedules that the physician prescribes. It is recommended that this license include all of the following DEA Schedules: 2, 2N, 3, 3N, 4, and 5. Pathologists and diagnostic radiologists may be exempted from this criterion.

10. Physicians must have and maintain malpractice insurance of at least $1,000,000 per incident and $3,000,000 aggregate, or minimum amounts according to community standards

11. Physicians must meet Bravo Health standards for medical office certification and medical record assessment (if applicable to their specialty).

12. Physicians must demonstrate professional growth and development through continuing education demonstrated by obtaining 50 hours of Category I AMA recognized Continuing Medical Education (CME) credits every two years. A current AMA Physician's Recognition Award will satisfy this criterion.

    This requirement will be waived:
    - In any year a physician becomes board certified or re-certified; or
    - If the physician is in his/her first year of practice.

13. Allied Health practitioners must demonstrate professional growth and development through continuing education units at the time of re-credentialing.

14. If any practitioner is indicted for a felony or a crime including moral turpitude, dishonesty or false statement or other acts, that practitioner will be suspended and may be terminated if the outcome is a conviction.

15. a. Physicians must exhibit understanding of and agree to Bravo Health policies relative to the provision of health care services, including ancillary services and adherence to the HMO's utilization, cost containment and quality assessment policies.

    b. Physicians must agree to cooperate with and/or respond to Bravo Health investigations of Member complaints, quality activities and/or satisfaction surveys or samplings.

    c. Physicians and Allied Health Professionals must agree to Bravo Health administrative protocols.

16. Physicians/Allied Health Practitioners must recognize that information from the National Practitioner Data Bank (NPDB) and confirmation of the validity of the practitioners board preparedness or certification, State License, Federal DEA Certificate and malpractice insurance information must be forthcoming and will be considered prior to credentialing.

ADDITIONAL REQUIREMENTS

If the applicant is accepted for participation in Bravo Health the following additional requirements will apply:

1. The physician or allied health professional must continually maintain and comply with all Bravo Health policies and procedures.

2. According to the Provider's Contract, physicians or oral surgeons must notify Bravo Health in writing within five (5) days of any changes in his or her status relative to the established credentials criteria or any other matter that could potentially affect a continued contractual relationship with Bravo Health, such as significant or prolonged illness, leave of absence, suspension or modification of privileges, any change in physical or mental health status that affects practitioner's ability to practice or any other action that materially changes the practitioner's ability to provide service to Members.

3. A physician or oral surgeon who maintains more than one office after acceptance must have all offices participate for the purpose of providing health care to patients.

4. If the relationship between the physician or oral surgeon and Bravo Health should be terminated at any point for any reason other than a voluntary termination, a one-year period will elapse prior to eligibility for reapplication. Upon reapplication, all the circumstances of the termination/resignation must be revealed and will be considered.

INITIAL CREDENTIALING OFFICE SITE REVIEWS

1. Provider Relations staff shall conduct initial credentialing office site reviews using the Office Site Evaluation Form.

2. The Office Site Evaluation Form is divided into the following sections:

    a. Physical Appearance and Accessibility
    b. Patient Safety and Risk Management
    c. Medical Record Keeping and Storage
    d. Appointment Availability

3. Each section of the Office Site Evaluation Form addresses a review topic with questions to be answered "YES", "NO", or N/A (not applicable). Each answer is scored and scores are added to generate an overall score for the office site.

4. Results of the office site review shall be reported directly to the reviewed office site. Objective findings and recommendations for improvement of deficiencies shall be included in the report.

5. Any office site scoring below 80% will be given thirty (30) days in which to submit and ninety (90) days to complete a corrective action plan for identified deficiencies. Upon completion of the corrective action plan, a repeat office site review will be performed.

6. The completed Office Site Evaluation Form will be placed in the practitioner's Credentialing file prior to review by the PACC.

Member Complaint or Quality of Care Concern

1. In response to a Member complaint and/or Quality Improvement office site or a quality of care concern relating to office site issues, Provider Relations staff shall conduct an office site review using the same Office Site Evaluation Form and procedures as at initial credentialing or a different data tool depending on the substance of the complaint.

2. Results of office site review will be evaluated, along with the complaint or quality of care concern, by the Provider Advisory Credentialing, Committee.

PROVIDER RE-CREDENTIALING

All Participating Providers must adhere to the re-credentialing requirements established by Bravo Health. The standard states that Providers must be formally re-credentialed every three (3) years. It is imperative that Providers complete the re-credentialing process in order remain in good standing and continue to treat Bravo Health Members. Non-compliance with the re-credentialing process in advance of the Provider's due date for re-credentialing will result in termination from the Bravo Health Provider network.

PRACTITIONER'S RIGHTS

The practitioner has the right to review information submitted to Bravo Health in support of his or her credentialing/re-credentialing application except for peer review information that is confidential, protected and restricted under State and Federal Peer Review Laws.

The practitioner will be notified in the event that information obtained from other sources varies substantially from that provided by the physician and he or she will be given the opportunity to clarify and/or correct this information prior to the finalization of the credentialing/re-credentialing process.

The practitioner has the right, upon request, to be informed of the status of their credentialing or re-credentialing application. The practitioner can contact their Provider Recruiter or the Bravo Health Credentialing Department at 866-442-7499 to make such a request.

Bravo Health Texas, Inc. conducts its credentialing and re-credentialing processes in a non-discriminatory manner and does not base its decisions for applicant participation solely on an applicant's race, ethnic/national identity, gender, age, and sexual orientation or the types of procedures or types of patients the practitioner specializes in. All decisions are based in the aforementioned criteria.

Bravo Health Texas, Inc., upon written request from a health care Provider that is applying to be credentialed or a physician who is already credentialed, shall disclose the relevant credentialing criteria outlined above.

Bravo Health Texas, Inc. will not exclude from credentialing or terminate a health care Provider who has a practice that includes a substantial number of patients with expensive medical conditions.

PROVIDERS DESIGNATED AS PRIMARY CARE PHYSICIANS (PCPs)

Bravo Health recognizes the following physician types as PCPs:

- Family Practice
- General Practice
- Geriatric Medicine
- Internal Medicine

Bravo Health also recognizes Infectious Disease physicians as a PCP for Members who may require a specialized physician to manage their specific healthcare needs.

CHANGES IN ADMINISTRATIVE, MEDICAL AND/OR REIMBURSEMENT POLICIES

From time to time, Bravo Health may amend, alter or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards and modification of Covered Services. Specific Bravo Health policies and procedures may be obtained by calling our Provider Services Department.

Bravo Health will communicate changes to the Provider Manual through the use of a variety of methods including but not limited to:

- Annual Provider Manual Updates
- Letter
- Facsimile
- E-Mail
- Provider Newsletters

Providers are responsible for the review and inclusion of policy updates in the Provider Manual and for complying with these changes upon receipt of these notices.

NOTIFICATION REQUIREMENTS FOR PROVIDERS

Participating Providers must provide written notice to Bravo Health 60 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

These changes should be communicated to the Bravo Health Provider Data Maintenance Department via facsimile at 1-866-234-9418 or by e-mail to PDM@BravoHealth.com.

The following is a list of changes that must be reported to Bravo Health:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliation
- Tax Identification Number
- Practice name
- Providers joining or leaving the practice (including retirement or death)
- Practice Mergers and/or acquisitions
- Adding or closing a practice location

CLOSING PATIENT PANELS

When a Participating Primary Care Physician elects to stop accepting new patients, the Provider's patient panel is considered closed.

If a Participating Primary Care Physician closes his or her patient panel, the decision to stop accepting new patients must apply to **all** patients regardless of insurance coverage. Providers may not discriminate against Bravo Health Members by closing the patient panels for Bravo Health Members only, nor may they discriminate among Bravo Health Members by closing their panel to certain product lines.

Providers who decide that they will no longer accept **any** new patients must notify Bravo Health's Network Management Department, in writing, at least 60 days before the date on which the patient panel will be closed.

PROVIDER ACCESS AND AVAILABILITY STANDARDS

A Primary Care Physician (PCP) must have their primary office open to receive Bravo Health Members **five (5) days and for at least 20 hours per week.** The PCP must ensure that coverage is available 24 hours a day, seven days a week. PCP offices must be able to schedule appointments for Bravo Health Members at least **two (2) months** in advance of the appointment. A PCP must arrange for coverage during absences with a Bravo Health Participating Provider in an appropriate specialty which is documented on the Provider Application and agreed upon in the Provider Agreement.

Primary Care Access Standards

Appointment Type	Access Standard
Urgent	Within 24 hours
Non-Urgent/Non-Emergent	Within 48 hours
Routine and Preventative	Within 4 weeks
On-Call Response (After Hours)	Within 30 minutes for emergency
Waiting Time in Office	30 minutes or less

Specialist Access Standards

Appointment Type	Access Standard
Urgent	Within 24 hours
Non-Urgent/Non-Emergent	Within 48 hours
Elective	Within 4 weeks
High Index of Suspicion of Malignancy	Less than one (1) week

After-hours Access Standards

All Participating Providers must return telephone calls related to medical issues. Emergency calls must be returned within 30 minutes of the receipt of the telephone call. Non-emergency calls should be returned within a 24 hour time period. A reliable 24 hours a day, 7 days a week answering service with a beeper or paging system and on-call coverage arranged with another Participating Provider of the same specialty is preferred.

Behavioral Health Access Standards

Appointment Type	Access Standard
Emergency	Within 6 hours of the referral
Urgent/Symptomatic	Within 48 hours of the referral

Routine	Within 4 weeks of the referral

Availability Standards

PCPs	OB/GYNs	Behavioral Health Providers
1 Provider for every 500 Members	1 Provider for every 2500 Members	1 Provider within 20 miles/minutes to Member
1 Provider within 20 miles to Member	1 Provider within 20 miles to Member	1 Provider within 30 miles/minutes to Member
1 Provider within 30 minutes to Member	1 Provider within 30 minutes to Member	

CLAIMS SUBMISSION

While Bravo Health prefers electronic submission of claims, both electronic and paper claims are accepted. Please see quick reference guide for details (page 3).

Bravo Health pays Clean Claims according to contractual requirements and CMS guidelines. A Clean Claim is defined as:

> A claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by Bravo Health or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term Clean Claim shall not include a claim from a Provider that is under investigation for fraud or abuse regarding that claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-Participating Providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Bravo Health, the claim is not considered clean.

The following standard CMS-required data elements must be present for a claim to be considered a Clean Claim. This applies to both electronic and paper claims:

Professional Claims

- Patient name
- Patient demographic information
- Member identification number
- Rendering Provider name
- Payee name and address
- Provider signature
- Explanation of Benefits from the primary carrier when Bravo Health is the secondary payor
- If the services were not rendered in an office or home setting, list the name and address of the facility where services were rendered in Box 32
- Provider federal tax identification number
- Date of service
- All appropriate diagnosis codes (ICD9-CM codes)
- Procedure code for each service rendered (CPT-4 or HCPCS Codes)
- All appropriate modifiers for each service rendered
- Amount billed for each procedure

- Place of service code
- NPI number
- Type of service
- Days and units
- Anesthesia time in minutes
- Include the following information for all injectible drugs:
    1. Average Wholesale Price (AWP) reimbursed Providers - the National Drug Code (NDC) Number and the NDC unit(s) associated with each drug.
    2. Average Sale Price (ASP) reimbursed Providers – the applicable HCPCS code and HCPCS unit(s).

Institutional Claims

- Bill type
- Revenue codes and HCPCS codes
- Patient status code
- DRG code
- All appropriate diagnostic codes
- All appropriate diagnosis codes (ICD9-CM codes)
- Detailed billing for all pharmacy related revenue codes. The detailed billing should include the name of the drug, the National Drug Code (NDC) number and the units associated with each drug.
- Skilled nursing facilities should include a description of charges, for example, bed level, blood glucose draw/stick, occupational/physical/speech therapy and radiology. Specific CPT-4 Codes are also required based on the services rendered.
- NPI Number

Claims must be submitted with all required information within 180 days of the date on which the service was rendered. All claims submitted after the 180-day period will be denied for untimely filing. For claims questions, please contact Provider Services at **1-888-353-3789**. A Provider Service Representative will be able to answer your questions concerning eligibility, benefits and claims. If a claim needs to be reprocessed for any reason, the Provider Service Representative will work with the Claims Department to handle these cases.

Providers who are being paid under capitation and expect no additional payments still must submit claims in order to capture encounter data as required per your Bravo Health Provider Agreement. This encounter data should be submitted to Bravo Health's Claims Department.

If a Provider provides services that require prior authorization, without obtaining prior authorization, the claim for those services will be denied.

If appropriate, Providers must include the following additional attachments to their claim submission:

- If Bravo Health is the secondary payer, the primary payer's Explanation of Payment
- For Institutional Claims a itemized bill for pharmacy charges or claims exceeding stop loss thresholds.

PARTICIPATING PROVIDER CLAIM RECONSIDERATION PROCESS

As a Participating Provider, you have the right to initiate a Claim Reconsideration Request and seek to have Bravo Health review its claim adjudication decisions. You have sixty (60) days from the date you received Bravo Health's claim denial or claim adjustment notice to request a review of our administrative decisions.

Your Claim Reconsideration Request must be in writing and include the following information:

1. The name of the Member, the Member's date of birth, and the Member's Bravo Health identification number;
2. Provider name and address;
3. A copy of the specific claim and our payment adjustment or denial notice;
4. An explanation of the specific service and dates of service for which payment was adjusted or denied and, using applicable Provider Agreement provisions, your rationale for requesting a reconsideration.

Your request should be sent to the following address:

Bravo Health
Claim Reconsideration Team
P. O. Box 26038
Baltimore, MD 21224

Bravo Health will review your request and respond within 60 days of receipt of the request. If our original claim adjudication decision is reversed, in whole or in part, the claim will be reprocessed and paid within 60 days. If our original claim adjudication decision is upheld, we will respond in writing and include a reason for the reconsideration denial. If you disagree with the outcome of the claim reconsideration process, or for any dispute other than claim reconsideration, you may pursue dispute resolution as described on page 67 of this Manual and in your Agreement with us.

You do have the right, in most instances, to file an appeal on behalf of a Bravo Health Member provided the Member has specifically authorized you to act on his/her behalf. A copy of the Member's written authorization must accompany the appeal.

Claim Adjustment Reason Codes-Texas		
Code	**Description**	**Denial Language**
3	SERVICE NOT AUTHORIZED	There is no authorization on file for these services.
7	SKILLED NURSING DAYS BENEFIT EXHAUSTED	This claim exceeds the maximum of 100 days per benefit period in a Medicare certified skilled nursing facility.
8	PREDATES ELIGIBILITY WITH PLAN	This service was rendered prior to the Member's effective date with Bravo Health.
9	POSTDATES ELIGIBILITY W/PLAN	This service was rendered after the Member's Bravo Health coverage ended.
14	PATIENT ENROLLED IN HOSPICE	Please submit this claim to Medicare. The patient is enrolled in Hospice.
15	DME RENTAL FOR 15 MOS. ONLY	Rental for durable medical equipment is capped at 15 months. No additional benefits are available for this equipment.
16	MEDICAL RECORDS REQUIRED	Please resubmit this claim with medical records.
17	INVALID PROCEDURE CODE	The procedure code billed is not valid. Please resubmit this claim with a valid code.
18	INVALID DIAGNOSIS CODE	Please resubmit this claim with a valid ICD9 diagnosis code.
19	INVALID PLACE OF SERVICE	Please resubmit this claim with a valid place of service e code.
21	CORRECTION TO PRIOR CLAIM	This claim represents a correction to a prior claim.
22	FILING TIME LIMIT EXPIRED	All claims for participating Providers must be submitted within 180 days of the date of service. This claim was submitted after the filing deadline.
25	AUTH EXPIRED	This service was rendered after the expiration date of the authorization.
32	SUBMITTED W/O NDC NUMBERS	Please resubmit this claim with National Drug Code number(s).
33	SUBMITTED W/O DETAIL	Please resubmit this claim with a detailed bill showing the charges and specific services for each date of service.
35	SUBMITTED W/O CPT CODES	Please resubmit with a valid CPT4 code.
36	INCLUDED IN PER DIEM	Reimbursement for this service is included in the per diem payment.
37	INCLUDED IN BASE RATE	Reimbursement for this service is included in the base rate.
38	SUBMITTED W/O HCPCS CODE	Please resubmit this claim with HCPCS codes.
39	MISSING DATE OF SERVICE	Please resubmit with dates of service.
60	ANESTHESIA TIME UNITS	This line item represents the payment of the anesthesia time units.
61	MISSING ANESTHESIA TIME UNITS	The claim was submitted without anesthesia time or anesthesia time units. Please resubmit the claim to indicate the length of time the patient was anesthetized.
63	DISCONTINUED PROCEDURE CODE	The procedure code billed has been discontinued. Please resubmit with a current procedure code.
72	SKILLED AT DIFFERENT LEVEL	The skill level billed is different than the skill level that was authorized. This claim has been processed according to the level authorized.
76	MISSING NUMBER OF UNITS	Please resubmit with the number of units specified.
82	INCORRECT PLACE OF SERVICE	Please resubmit with the correct place of service.
91	MISSING DIAGNOSIS	Please resubmit with appropriate diagnosis codes.
102	BILL WITH CPT ANESTHESIA CODES	Anesthesia claims must be submitted with ASA codes. Please resubmit this claim with ASA codes.
103	PREDATES AUTHORIZATION DATES	This service was rendered before the effective date of the authorization.

Claim Adjustment Reason Codes-Texas (cont.)		
104	PAID AT PER DIEM RATE	The payment for this service is included in the per diem rate.
105	PREVIOUSLY PAID	This claim has been previously processed. Please review your records and contact our Provider Service Team for assistance.
109	SUBMITTED W/O SERVICE UNITS	Please resubmit this claim with the units field completed.
110	MILEAGE INCLUDED IN BASE RATE	The mileage is included in the base rate and is not separately reimbursable.
114	POST DATES AUTHORIZATION DATES	This service was rendered after the expiration date of the authorization.
118	UR DENIED HOSPITAL DAYS	These hospital days have been denied by our Health Services Department.
120	PATIENT CONVENIENCE ITEM	Patient convenience items are not covered under this benefit plan.
123	DENTAL COPAY/PATIENT LIABILITY	This is a Member co-payment amount.
124	EXCEEDS AUTHORIZATION	This service exceeds the number of services authorized.
127	NOT ELIG ON DATE OF SERVICE	This patient was not a Bravo Health Member on the date of service.
128	SUBMIT TO SENIOR PARTNERS	Please resubmit this claim to Senior Partners because the service date is within their coverage period.
130	PROVIDE DETAIL SERVICE DATES	Please resubmit this claim with a detailed bill showing each separate date of service.
132	AUTH FOR DIFFERENT PROVIDER	The authorization on file for this service was issued to a different Provider.
134	ER VISIT W/IN 72 HRS OF ADMIT	Emergency Room visits within 72 hours of an inpatient admission cannot be billed and reimbursed separately.
135	ITEMIZED BILL REQUESTED	Please resubmit with an itemized bill.
136	SUBMITTED W/O MODIFIER	Please resubmit with appropriate modifier(s)
137	SUBMIT WITH NDC NUMBERS	Please resubmit with National Drug Code (NDC) numbers.
139	NO CHARGE BILLED	Please resubmit with billed charges for each service.
140	NOT COVERED SELF ADMIN RX	Self administered drugs are not covered services under this plan.
141	NOT COVERED EXPERIMENTAL	Experimental treatments are not covered services under this plan.
142	NOT COVERED ACUPUNCTURE	Acupuncture is not a covered service under this plan.
143	NOT COVERED COSMETIC	Cosmetic services are not covered services under this plan.
144	NOT COVERED CUSTODIAL CARE	Custodial services are not covered services under this plan.
145	NOT COVERED HOMEMAKER SVC	Homemaker services are not covered services under this plan.
147	NOT COVERED DELIVERED MEAL	Delivered meals are not covered services under this plan.
148	NOT COVERED NATUROPATH SVC	Naturopath services are not covered services under this plan.
149	NOT COVERED FULL TIME NURSING	Full time nursing services are not covered services under this plan.
150	NOT COVERED ORTHOPEDIC SHOES	Orthopedic shoes are not covered items under this plan.
151	NOT COVERED FOOT SUPPORT	Foot supports are not covered items under this plan.
153	NOT COVERED PRIVATE DUTY NURSE	Private Duty Nursing is not a covered service under this plan.
154	NOT COVERED PRIVATE ROOM	Private Room charges are not covered under this plan.
155	NOT COVERED CHARGE BY RELATIVE	Services rendered by a patient's relative are not covered services under this plan.
157	NOT COVERED SEX CHANGE	Services related to a sex change are not covered services under this plan.
158	NOT COVERED STERILIZ. REVERSAL	Services related to sterilization reversal are not covered services under this plan.
159	NOT COVERED NON RX CONTRACEPT	Non prescription contraceptives are not covered under this plan.

Claim Adjustment Reason Codes-Texas (cont.)		
160	NOT COVERED OBESITY	Services related to the treatment of obesity are not covered under this plan.
161	NOT COVERED RADIAL KERATOTOMY	Radial Keratotomy is not a covered service under this plan.
162	NOT COVERED LOW VISION AID/SVC	Services and equipment related to low vision aids are not covered services under this plan.
164	NOT COVERED ROUTINE CHIROPRACT	Routine chiropractic services are not covered services under this plan.
165	NOT COVERED ER FOR ROUTINE SVC	Emergency services are services needed immediately due to sudden illness or injury. Since the services received do not meet these requirements, the services are not covered under the Plan.
166	NOT COVERED HEALTH EDUCATION	Health Education services are not covered services under this plan.
167	NOT MEDICALLY NECESSARY	The service requested was reviewed by our Medical Director. The Medical documentation received does not support the need for this service.
168	PAID AT DRG RATE	This claim was paid at the DRG rate.
171	NOT COVERED BLOOD FIRST 3 UNIT	The first three units of blood are not covered services under this plan.
174	DUPLICATE OF CLAIM IN REVIEW	This claim is a duplicate of a claim that is currently in process.
175	PREVIOUSLY DENIED	This claim has been denied. Please review your records and contact our Provider Service Team for assistance.
176	SUBMITTED W/O ADA CODE	Please resubmit this claim with American Dental Association Codes.
177	MULTIPLE SURGERY DEDUCTION	Standard multiple surgery rules have been applied to this service.
180	INAPPROPRIATE MODIFIER	This modifier is not appropriate for this procedure code. Please resubmit this claim with appropriate codes.
181	MULT PROC BILLED W/O MODIFIER	Please resubmit with this claim with appropriate modifiers.
186	PREVIOUSLY APPLIED TO DEDUCTIBLE	The approved amount for this service was previously applied to the Member's deductible.
193	PREVIOUSLY APPLIED TO COPAYMENT	The approved amount for this service was previously applied to the Member's co-payment.
200	INCLUDED IN DRG RATE	Payment for this service is included in the DRG rate.
204	PAID AT CASE RATE	Reimbursement for this claim is made at the case rate.
205	INCLUDED IN CASE RATE	Payment for this service is included in the case rate.
206	INCLUDED IN ASC RATE	Payment for this service is included in the ASC rate.
216	SUBMIT CLAIM TO MENTAL HEALTH VENDOR	Please submit this claim to the Behavioral Health Vendor.
217	INVALID NDC NUMBER	Please resubmit with a valid National Drug Code (NDC) number. The number submitted is not valid.
221	PD AT STOPLOSS RATE	This claim was reimbursed according to the contracted stop-loss rate.
222	INCLUDED IN STOPLOSS RATE	Reimbursement for this service is included in the contracted stop-loss rate.
223	SUBMIT CLAIM WITH INVOICE	Please resubmit this claim with the appropriate invoice.
224	OVERTURNED APPEAL	This claim represents a change to a prior claim based on an appeal decision.
230	CUSTOMER SERVICE AUTH ISSUE	This claim was reprocessed as the result of a customer service case.
231	SUBMIT WITH CORRECT POS	Please resubmit this claim with a corrected place of service.
233	CUSTOMER SERVICE CLAIMS ISSUE	This claim was reprocessed as the result of a customer service case.
234	RETRO REVIEW IN PROCESS	Our Health Services Department has requested Medical Records on this admission. When the decision has been rendered, the claim will be processed in accordance with the decision.

Claim Adjustment Reason Codes-Texas (cont.)		
251	DN TO OBSERVATION RATE	This claim is processed as an observation stay.
252	RESUBMIT AS OBSERVATION	This stay was authorized as observation. Please resubmit this claims as an observation claim
255	IACD SERVICES - BILL MEDICARE	This claim is the responsibility of Original Medicare. Please bill this claim directly to Medicare with the appropriate codes.
256	REBILL WITH CPT CODES	Please resubmit this claim with CPT4 codes.
267	PRIMARY CARRIER PAYMENT	This amount represents the payment made by the primary carrier.
268	EOB REQUESTED	Please resubmit with an Explanation of Benefits from the primary insurance carrier.
270	INCORRECT BILL TYPE	Please resubmit with a corrected Bill Type.
275	MISSING DRG	Please resubmit this claim with the appropriate DRG code.
279	QUARTERLY MAXIMUM REACHED	The quarterly dental maximum has been met. No additional dental benefits are available for this quarter.
281	NON QUEST LAB PROVIDER	Laboratory services must be provided by Quest Laboratory unless the services have been pre authorized.
288	ITEMIZED BILL NOT= TO CHARGES	Please resubmit a corrected claim. The total on the itemized bill does not equal the total of the billed charges for these items.
302	UNLISTED PROCEDURE	Please resubmit this claim with medical records to support the unlisted procedure code.
305	DN GRADED TO SKILLED NURSING	This claim is processed as a skilled nursing claim.
306	DN GRADED TO TELEMETRY	This claim is processed as a telemetry stay.
308	NEED VALID ANESTHESIA CODE	Anesthesia claims must be submitted with ASA codes. Please resubmit this claim with ASA codes.
310	DN GRADED TO MED/SURG DAY	This claim is processed as a medical/surgical stay.
311	DN GRADED TO SUBACUTE	This claim is processed as a sub-acute stay.
312	INCLUDED IN INPATIENT PER DIEM	Reimbursement for this service is included in the inpatient per diem payment.
402	TRANSPORTATION MAXIMUM REACHED	The maximum benefit of 12 routine transportation roundtrips to plan-approved locations for covered health care services has been provided and no additional benefits are available.
404	MEDICAL NUTRITION THERAPY	Medical nutrition therapy must be approved in advance of the therapy.
405	SMOKING CESSATION PROGRAM	Smoking cessation counseling programs require prior authorization.
450	GLASSES ONE PAIR EVERY 2 YEARS	One pair of eye glasses is a covered benefit every two years. This pair of glasses exceeds the benefit maximum.
451	HEARING AID MAXIMUM REACHED	The maximum benefit for hearing aids has been provided and no additional benefits are available.
452	ROUTINE PODIATRY MAX REACHED	The maximum benefit for routine podiatry services of 4 visits every calendar year has been reached and no additional benefits are available.
505	BILL WITH SPECIFIC DATES	Please resubmit this claim with specific dates of service.
560	INCORRECT NUMBER OF UNITS	Please submit with the correct number of units.
574	UNIT COST < $1,000	The item billed is less than $1,000 and no separate reimbursement is due.
612	INCORRECT DISCHARGE DATE	This claim was submitted with an incorrect discharge date. Please resubmit with a correct date.
615	DRG GROUPER DISCREPANCY	The DRG listed on the claim does not match the DRG derived from the claim. Please resubmit with correct information.

Claim Adjustment Reason Codes-Texas (cont.)		
619	SUBMIT OPERATIVE NOTES	Please resubmit this claim with operative notes.
620	SUBMIT TO DAVIS VISION	Please submit this claim to Davis Vision.
620	SUBMIT TO DAVIS VISION	Please submit this claim to Davis Vision.
621	CONVERTED TO ASA CODE	The procedure code for this service was converted to an ASA code for pricing. Please submit all future claims with ASA codes.
624	NDC # DOES NOT MATCH RX NAME	This NDC number submitted with this claim is not valid for the drug name listed on the claim. Please resubmit with the correct code and name.
702	REBILL USING MEDICARE G CODES	Please resubmit with the appropriate HCPCS codes.
706	SUBMIT WITH CMG	This is an acute rehab admit. Please resubmit claim with the appropriate case mix group code.
707	PAID AT CMG	This claim was reimbursed according to the CMS case mix group.
708	INCLUDED IN CMG	Reimbursement for this service in included in the CMG
810	SUBMIT TO DENTAL HEALTH VENDOR	Please submit this claim to the Dental Health Vendor.
812	NON PAR PROVIDER TIMELY FILING	All claims for non participating Providers must be submitted by 12/31 of the year following the year of service, or by 12/31 of the second year for care rendered during the last 3 months of the year.
813	INPATIENT COPAYMENTS APPLY	The inpatient hospital co-pay applies to these inpatient hospital days.
814	INPATIENT DAYS EXHAUSTED	Inpatient hospital days have been exhausted.
855	CONTACT HEALTH SERVICES	Please contact our Health Services Department to discuss the Member's treatment.
877	NOT INCLUDED IN DENTAL BENEFIT	This service is not covered under the Member's dental benefit.
900	INCLUDED IN APC PRICE	Reimbursement for this service is included in the APC reimbursement.
999	ADJUSTMENT	This is an adjustment of a previously processed claim.
#C	SYSTEM-CAPITATED SERVICE	Reimbursement for this claim is included in the capitation payment.
C	CAPITATED SERVICE	Reimbursement for this claim is included in the capitation payment.
CG	CLAIMSGUARD ADJUSTMENT	This claim has been reimbursed according to Medicare and Correct Coding Initiative rules. If you disagree with this reimbursement, we will review the claim with additional supporting documentation.

NATIONAL PROVIDER IDENTIFIER (NPI)

Why the National Provider Identifier?

Providers utilize, in many situations, a different provider identification number for every health plan they are submitting claims to.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique identifier for health care providers called the National Provider Identifier.

The unique Health Identifier for Health Care Providers rule was published January 23, 2004, with an effective date of **May 23, 2008**.

The National Provider Identifier Number

The rule establishes a **standard** nationally assigned "non intelligent" Provider identifier required to be used in all electronic health care transactions.

This number will be a 10 digit numeric unique identifier, with an International Standard Organization (ISO) check digit in the 10th position.

This check digit acts the same way your checking account numbers allow banking institutions to verify your account number.

A Provider will have **one number only** and the Provider will use this number for every health plan they submit electronic transactions too. Once a Provider is enumerated with an NPI this number will not change ever. The NPI remains with the Provider regardless of job or location change.

Who will have responsibility of issuing the NPI?

The National Provider System (Fox Systems, Inc.) has the sole responsibility for issuing all NPI's to every provider in the country. This system is a comprehensive, uniform system for identifying and uniquely enumerating health care providers at the national level. The Department of Health and Human Services (DHHS) will have overall responsibility for oversight and management of the system.

How can a Provider apply for an NPI?

There are several methods that a Provider can apply for a NPI number;

1. **Phone: 1-800-465-3203**
   TTY: 1-800-692-2326

2. E-mail: customerservice@npienumerator.com

3. Mail: **NPI Enumerator**
   P.O. Box 6059
   Fargo. ND 58108-6059

NOTE: If a Provider wishes to obtain a copy of the NPI application form they must call to obtain an application form. No e-mail or mail requests for applications will be accepted.

Reminder to Providers: A Provider may apply for an NPI using only one of the ways described above. Make sure that the Provider has a correct Social Security Number (SSN) and Federal employee identification number when applying.

How do I bill with an NPI number?

The NPI number should be placed in the following boxes on the appropriate claim form:

CMS 1500
Place the NPI in Block 24J

UB92
Place the NPI in Block 56

Additional questions on how to bill an NPI number?

- Refer to: www.cms.gov

- Medicare Claims Processing Manual
  - Chapter 26
  - Completing and Processing Form CMS 1500 Data Set

THE IMPORTANCE OF HIERARCHICAL CONDITION CATEGORIES (HCC)

Effective January 1, 2004, CMS implemented a risk adjustment model in which reimbursement to Medicare Advantage organizations such as Bravo Health is based on hospital inpatient, hospital outpatient, and office-based Provider encounter data. This model predicts health cost expenditures by calculating the disease burden of the population. A Member's risk is measured by assessing the diagnostic characteristics (ICD-9) of the Member, rather than assessing what treatments (CPT) they have received.

Provider must document the Member's conditions and diseases accurately using ICD-9 codes and extend to the fifth digit where appropriate. This is particularly true for high-risk conditions where co-morbidities make a significant difference in risk scoring. Diabetes is a perfect example of where ICD-9 code 250 is not enough to establish the extent of diabetic complications such as neuropathy, blindness and vascular disease. Chronic conditions must be documented at least once a year to ensure correct risk stratification of the Member.

Ensure that all diagnosis codes are transferred to the CMS 1500 claim form when billing. For complicated cases, this may require additional CMS 1500 forms to document more than four diagnoses.

It is important that you document the diagnosis clearly and update the Member's problem list with each encounter. Even visits for minor conditions in patients with persistent conditions should be first coded with the conditions for which the patient is seen and second with accurate co-morbid codes for persistent conditions like diabetes and CHF. This will ensure that we capture accurate information on your patients annually. The Member's name should be recorded on each page of the medical record and the physician should sign and date each entry.

To meet CMS requirements and to initiate the risk adjustment chart and case management review process, Bravo Health requires your cooperation in providing access to office medical records. On a regular basis, you will receive written notification from Bravo Health requesting a chart audit. Please be assured that we will conduct these audits efficiently and professionally with minimal disruption to your office workflow. In addition, our certified coders or nurse coders will be glad to come to your office to work with you and/or your staff to resolve any coding issues that may arise.

Sample Explanation of Benefits Statement

Bravo Health Texas, Inc. P8790028002
7551 Callaghan Road, Suite 310 San Antonio, TX 78229
Forwarding Service Requested

TEST

1 0. 3840 SP 0.370
lllllllllllllllllllllllllllllllllllllllllllllllllllll
Get Well Medical Care, P.A.
PO BOX 3012
San Antonio, TX 78229-1234

Date: 06/29/2006
Vendor 9370
Voucher Number: 64687
Check ID: P6041
Check Number: 058522

Explanation of Payment

Member ID: 449999999 Option: BSEL Provider Acct. No. AB-458518
Member Name: SMITH, JOHN Claim Number: 205062201700120 Provider Name: William Physician

From Date of Service	To Date of Service	Service Code	Billed Amount	Allowed Amount	Copay Coinsurance	Deductible	Adjustment	Interest	Payment	Reason Code
05/13/2008	05/13/2008	99213	253.00	94.49	25.00	0.00	0.00	0.00	69.49	
Claims Totals			253.00	94.49	25.00	0.00	0.00	0.00	69.49	
Vendor Totals			253.00	94.49	25.00	0.00	0.00	0.00	69.49	

Remark Code Explanation

IF APPLICABLE IMPORTANT INFORMATION REGARDING APPEAL RIGHTS IS ATTACHED

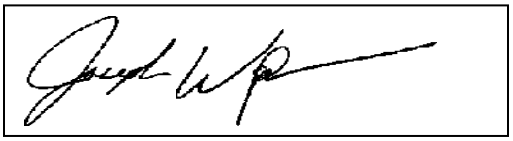
Sample Bravo Health Payment Check

Bravo Health Texas, Inc. **65-320** **CHECK NO.: 0058522**
7551 Callaghan Road, Suite 310
San Antonio, TX 78229

AMOUNT
*******69.49

PAY Sixty Nine & 49/100 dollars

TO THE ORDER OF **Get Well Medical Care, P.A.**
PO BOX 3012
San Antonio, TX 78229-1234



Wachovia Bank N.A.
Philadelphia, PA 19102

PRIOR AUTHORIZATION - GENERAL RULES

The following table outlines the general Bravo Health prior authorization and care direction procedures:

Ambulance (Place of Service 41)	
No Authorization Required for "911" ambulance service Only Medicare covered ambulance services. Routine Ambulance **NOT COVERED**	
Behavioral Health Inpatient & Outpatient	
Pennsylvania & Mid-Atlantic	Contact CompCare : 1-800-541-3647
Texas	Contact Corphealth : 1-866-671-4537
Chiropractic	
The only codes covered to chiropractic care are: 98940, 98941, 98942, 98943	
Clinical Trials	
Must Notify Plan (Original Medicare Plan pays for clinical trials with 20% coinsurance to the Member)	
Dental	
Pennsylvania & Mid-Atlantic	Contact Doral Dental : 1-800-341-8478
Texas	Contact StarDent : 1-866-753-6319
Laboratory	
Lab services provided by any lab other than those listed below require pre-authorization except for certain procedures that can be performed in outpatient settings. See appropriate place of service guide for a list of codes.	
Philadelphia & Mid-Atlantic	**MUST** use Quest Labs
Pittsburgh	Can use participating hospitals and Quest Labs
Texas	Can use Clinical Pathology Lab (CPL) or Quest Labs
Lab services performed at skilled nursing and long term care facilities do not require pre-authorization.	
Non-Participating Providers	
NON PARTICIPATING PROVIDERS	(All non-Participating providers require prior authorization except Chiropractor, Radiologist and Anesthesiologist, or ER)
Podiatry	
Routine	Refer to specific plan benefits
Non-Routine	Refer to Medicare Coverage Guidelines
Professional Services	
Modifier 26 professional component does not require an authorization for Participating or Non Participating Providers.	

Radiology Authorization	
Pennsylvania	**Bravo:** Contact NIA at 1-800-642-2804 for all procedures requiring authorization
	Senior Partners: Contact 215-606-6336
Mid-Atlantic & Texas	Contact: 1-888-454-0013
All Regions	Requests may be faxed to: 1-866-464-0707
Transportation	
Benefits vary according to plan. See Quick Reference Guide and Benefit Grid for details.	
Vision	
Pennsylvania	Contact Davis Vision : 1-800-584-3140
Texas	Contact OptiCare : 1-866-258-4102
Mid-Atlantic	Use Advantica Network – Contact Bravo Health for Customer Service

PRIOR AUTHORIZATION RULES BY PLACE OF SERVICE

The following tables list outlines the Bravo Health authorization procedures by place of service. Services listed in the tables require authorization as noted.

In Office (Place of Service 11,32,33)	
DURABLE MEDICAL EQUIPMENT	Diabetic Shoes
	Diabetic Supplies (initial set up only)
	DME **Purchase** (All Medicare Approved) >$200 Per Line Item
	All Prosthetics **except** mastectomy bras, colostomy supplies, indwelling Foley catheters
	Rentals (All)
	Repairs & Maintenance (All)
EDUCATION	Diabetic Education Training (**Except** Senior Partners)
	Dialysis Self Training
	Nutritional Education Classes (97802-97804) Diabetes and Renal
LABORATORY	Labs (ALL) **except** these labs performed in Physician's Office: 81000, 81002, 81003, 81007, 81025, 82010, 82270, 82272, 82570, 82947, 82962, 83026, 83036, 83721, 84478, 84520, 84703, 85013, 85014, 85108, 85610, 87449, 87804, 87880 Providers will be reimbursed for the lab draw (36415) for all other labs tests not listed above.

MEDICATIONS AND INJECTIBLES	Infusion Therapy (**except** exclusion list) *see pages 43-44
	Injectibles (except Flu, Pneumococcal, Tetanus and Hepatitis B) *see attachment pages 43-44
IMMUNIZATIONS (except Influenza, Tetanus, Hepatitis B and Pneumovax)	
	Immunizations for Travel
OUT-PATIENT SERVICES	Enhanced External Counter Pulsation (ECP) G0166 (limited to 35 visits per 12 month period)
	Hyperbaric Oxygen Therapy
	Interventional Radiology
	Thoracic Stress Echo
RADIOLOGY	CT Scans
	MRA
	MRI
	ALL Nuclear Medicine including Nuclear Cardiology
	PET Scans
	Stress Echo
RADIATION THERAPY	Intensity-Modulated Radiation Therapy (IMRT) - Prior authorization is required only for elective admission. A course of therapy occurring as part of an inpatient confinement that has met medical necessity criteria and been authorized does not require separate authorization.
THERAPY /REHABILITATION	Cardiac Rehabilitation
	Occupational Therapy (after 1st 12 visits)
	Physical Therapy (after 1st 12 visits)
	Pulmonary Rehabilitation
	Speech Therapy (except initial evaluation)

Inpatient (Place of Service 21,31,51,61)

Note: Emergency and urgent admissions **do not** require prior authorization. Medical necessity criteria will be applied after facility's notification to Bravo Health. Authorization for claims payment will **only** be granted to those meeting medical necessity criteria.

The following services **do** require authorization as outlined below:

DURABLE MEDICAL EQUIPMENT	Diabetic Supplies (initial set up only)
	DME **Purchase** (All Medicare Approved) >$200 Per Line Item
	All Prosthetics except mastectomy bras, colostomy supplies, indwelling Foley catheters
	Rentals (All)
	Repairs & Maintenance (All)

INPATIENT SERVICES	Acute Hospital Admissions (All)
	Acute Rehab Admissions (All)
	Behavioral Health Hospital Admissions (CompCare or Corphealth) *See Behavioral Health
	Elective Admissions (All)
	Long Term Acute Care Hospital Admissions (LTACH) (All)
	Skilled Nursing Admissions (All)
	Sub acute Admission (All)
RADIATION THERAPY	Intensity-Modulated Radiation Therapy (IMRT) - Prior authorization is required **only** for elective admission. A course of therapy occurring as part of an inpatient confinement that has met medical necessity criteria and been authorized does not require separate authorization.

Emergency Room/Urgent Care (Place of Service 20&23)

No Authorizations are required

Outpatient Hospital (Place of Service 22)

EDUCATION	Diabetic Education Training (**Except** Senior Partners)
	Dialysis Self Training
	Nutritional Education Classes (97802-97804) Diabetes and Renal
LABORATORY	Labs (ALL) **except** these labs that may be performed in Physician's Office: 85018, 82947, 82962, 81000, 81002, 81003, 81005, 86308, 86403-86406
MEDICATIONS AND INJECTIBLES	Infusion Therapy (**except** exclusion list) *see pages 43-44
	Injectibles (**except Influenza**, Pneumococcal, Tetanus and Hepatitis B) *see attachment
IMMUNIZATIONS (except Influenza, Tetanus, Hepatitis B and Pneumovax)	Immunizations for Travel
OUTPATIENT SERVICES	Allergy Testing (95004-95199)
	Audiologic Function Test (92551-92597)
	Blood Transfusions
	Bronchoscopy
	Cardiac Catheterization
	Chemotherapy (includes all IM, SQ, and IV injections)
	Colonoscopy, Diagnostic
	Enhanced External Counter Pulsation (ECP) G0166 (limited to 35 visits per 12 month period)
	Electroencephalogram (EEG) w/ video monitoring 48 hrs

	Endoscopy Procedures
	Gastroenterology (91000-91299)
	Hyperbaric Oxygen Therapy
	Interventional Radiology
	Intracardiac Electrophysiological Procedures (93600-93668)
	Neurological Testing (95812-96120)
	Out-Patient Therapy ***see therapy for auth rule**
	Pain Management Epidural 64400-64530 (ASC approval after 3rd inject) *Performed by Anesthesiologist
	Pulmonary Testing (94010-94799)
	Regulated Space (Maryland only)
	Sleep Studies
	Surgery
	Thoracic Stress Echo
	Vestibular Function Test (92531-92548)
	Wound Management
PROFESSIONAL SERVICES	Hearing Exams
	Non-Participating Providers except Anesthesiologists *Refer to Pain Management
	Non-Participating except chiropractors
RADIOLOGY	CT Scans
	MRA
	MRI
	ALL Nuclear Medicine including Nuclear Cardiology
	PET Scans
	Stress Echo
RADIATION THERAPY	Intensity-Modulated Radiation Therapy (IMRT) - Prior authorization is required only for elective admission. A course of therapy occurring as part of an inpatient confinement that has met medical necessity criteria and been authorized does not require separate authorization.
THERAPY /REHABILITATION	Cardiac Rehabilitation
	Occupational Therapy (after 1st 12 visits)
	Physical Therapy (after 1st 12 visits)
	Pulmonary Rehabilitation
	Speech Therapy (except evaluation)

Ambulatory Surgery Center (Place of Service 24)	
OUTPATIENT SERVICES	Interventional Radiology
	Pain Management Epidural 64400-64530 (ASC approval after 3rd inject) ***Performed by Anesthesiologist**
RADIATION THERAPY	Intensity-Modulated Radiation Therapy (IMRT) - Prior authorization is required only for elective admission. A course of therapy occurring as part of an inpatient confinement that has met medical necessity criteria and been authorized does not require separate authorization.
Home Health Services (Place of Service 12)	
DURABLE MEDICAL EQUIPMENT	Diabetic Shoes
	Diabetic Supplies (initial set up only required)
	purchase (Medicare Approved) >$200 Per Line Item
	Prosthetics **except** mastectomy bras, colostomy supplies, indwelling Foley catheters
	Rentals
	Repairs & Maintenance
EDUCATION	Diabetic Education Training
	Dialysis Self Training
	Nutritional Education Classes (97802-97804) Diabetes and Renal
HOME HEALTH SERVICES **Primary Care Physicians (PCPs) may see Members in their home without prior authorization**	Aide
	Dialysis in Home
	Infusion
	Nurse
	Occupational Therapy
	Physical Therapy
	Specialist Physician Home Visits (except Podiatry)
	Speech Therapy
	Wound Management

PREVENTIVE CARE

The following Preventive Health Care Services **DO NOT** require authorization:

<table>
<tr><th colspan="2">Preventive Care</th></tr>
<tr><td>Abdominal Aortic Aneurysm Ultrasound: A one-time screening ultrasound for people at risk (like people who have smoked).</td><td>Influenza Vaccine (once a year in fall winter)</td></tr>
<tr><td>Bone Mass Measurements [Dexascan]:
Every 24 months; more often if medically necessary</td><td>Glaucoma Test: once every 12 months)
indicated for those at high risk for glaucoma</td></tr>
<tr><td>Cardiovascular Testing: Electrocardiogram and cardiovascular blood screenings to check cholesterol and other blood fat (lipid) levels</td><td>Hepatitis B Vaccine: Three shots are needed for complete protection. Indicated for those at medium to high risk for Hepatitis B.</td></tr>
<tr><td rowspan="3">Colorectal Screening: Fecal Occult Blood Test once every 12 months if age 50 or older.
OR
Flexible sigmoidoscopy generally, once every 48 months if age 50 or older, for those not at high risk, 120 months after a previous screening colonoscopy
OR
Screening Colonoscopy generally once every 120 months (high risk every 24 months), 48 months after a previous flexible sigmoidoscopy. No minimum age.</td><td>Medical Nutrition Therapy Services: For Members with diabetes or kidney disease and your doctor refers you for the service</td></tr>
<tr><td>Mammogram: once every 12 months for Members 40 years and older)</td></tr>
<tr><td>Pap & Pelvic Exams: Once every 24 months for women at low risk, and once every 12 months for women at high risk and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past three years</td></tr>
<tr><td>Colorectal Screening: Barium Enema - once every 48 months if age 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy.</td><td>Pneumococcal Vaccine: Generally once per lifetime</td></tr>
<tr><td>Diabetes Screening (Fasting Plasma Glucose Test): Member may be eligible for up to two screenings each year
*see definition for coverage</td><td>Prostate Cancer Screening: Digital Rectal Examination once every 12 months;
Prostate Specific Antigen (PSA) Test once every 12 months</td></tr>
<tr><td></td><td>Routine Physical Exams</td></tr>
</table>

Health & Wellness	
ForEver Fit	Texas
Health Education Mailings	
Smoking Cessation. Includes counseling for two cessation attempts within a 12-month period for Members diagnosed with smoking-related illness or are taking medicines that may be affected by stop smoking tobacco. Counseling for each cessation attempt includes up to four face-to-face visits.	

PRIOR AUTHORIZATION – MEDICINES AND INJECTIBLES

The following list of drugs **requires authorization** under the Medicare Part B Benefit:

HCPCS Code	Short Description	HCPCS Code	Short Description	HCPCS Code	Short Description	HCPCS Code	Short Description
J0129	Abatacept, inj	J0735	Clonidine hydrochloride	Q2009	Fosphenytoin, 50 mg	J9230	Mechlorethamine hcl inj
J0130	Abciximab injection	J0770	Colistimethate sodium inj	J1458	Galsulfase, inj	J7669	Metaproterenol non-comp unit dose
J7608	Acetylcysteine inh sol u	J0800	Corticotropin injection	J1560	Gamma globulin > 10 CC inj	J7674	Methacholine chloride, neb
J0132	Acetylcysteine injection	J7631	Cromolyn sodium inh sol u d	J1460	Gamma globulin 1 CC inj	J7505	Monoclonal antibodies
J0135	Adalimumab injection	J7330	Cultured chondrocytes implnt	J1550	Gamma globulin 10 CC inj	Q4079	Natalizumab injection
J0180	Agalsidase beta injection	J9100	Cytarabine hcl 100 MG inj	J1470	Gamma globulin 2 CC inj	J9261	Nelarabine injection
Q4093	Albuterol inh non-comp con (Initial auth only)	J9110	Cytarabine hcl 500 MG inj	J1480	Gamma globulin 3 CC inj	Q4087	Octagam Injection
Q4094	Albuterol inh non-comp u d (Initial auth only)	J9098	Cytarabine liposome	J1490	Gamma globulin 4 CC inj	J2357	Omalizumab injection
J7620	Albuterol ipratrop non-comp	J0850	Cytomegalovirus imm IV /vial	J1500	Gamma globulin 5 CC inj	J2355	Oprelvekin injection
J9015	Aldesleukin/single use vial	J9130	Dacarbazine 100 mg inj	J1510	Gamma globulin 6 CC inj	Q4086	Orthovisc, inj
J0215	Alefacept	J9140	Dacarbazine 200 MG inj	J1520	Gamma globulin 7 CC inj	J9263	Oxaliplatin
J9010	Alemtuzumab injection	J7513	Daclizumab, parenteral	J1530	Gamma globulin 8 CC inj	J9265	Paclitaxel injection
J0205	Alglucerase injection	J9120	Dactinomycin actinomycin d	J1540	Gamma globulin 9 CC inj	J9264	Paclitaxel protein bound
J0256	Alpha 1 proteinase inhibitor	J1645	Dalteparin sodium	Q4088	Gammagard Liquid injection	J2425	Palifermin injection
J0270	Alprostadil for injection	J0882	Darbepoetin alfa, esrd use	Q4092	Gamunex injection	J2469	Palonosetron HCl
J0275	Alprostadil urethral suppos	J0881	Darbepoetin alfa, non-esrd	J7310	Ganciclovir long act implant	J2430	Pamidronate disodium /30 MG
J2997	Alteplase recombinant	J9150	Daunorubicin	J9201	Gemcitabine HCl	J2504	Pegademase bovine, 25 iu
J0207	Amifostine	J9151	Daunorubicin citrate liposom	J9300	Gemtuzumab ozogamicin	J2503	Pegaptanib sodium injection
J0288	Ampho b cholesteryl sulfate	J0894	Decitabine, inj	J9202	Goserelin acetate implant	J9266	Pegaspargase/singl dose vial
J0285	Amphotericin B	J0895	Deferoxamine mesylate inj	Q4090	HepaGam B IM Injection	J9305	Pemetrexed injection
J0287	Amphotericin b lipid complex	J9160	Denileukin diftitox, 300 mcg	J9225	Histrelin implant	J9268	Pentostatin injection
J0289	Amphotericin b liposome inj	J1190	Dexrazoxane HCl injection	Q4083	Hyalgan or Supartz, inj	J9600	Porfimer sodium
J0348	Anadulafungin injection	J1162	Digoxin immune fab (ovine)	J3470	Hyaluronidase injection	J2783	Rasburicase

Continued on next page

J7198	Anti-inhibitor	J0470	Dimecaprol injection	J3473	Hyaluronidase, recombinant, inj	Q4095	Reclast injection
J7197	Antithrombin iii injection	J1212	Dimethyl sulfoxide 50% 50 ML	J1740	Ibandronate sodium, inj	J2993	Reteplase injection
J7511	Antithymocyte globuln rabbit	J9170	Docetaxel	J1742	Ibutilide fumarate injection	Q4089	Rhophylac injection
J0364	Apomorphine hcl, inj	J7639	Dornase alpha inhal sol u d	J9211	Idarubicin hcl injection	J2794	Risperidone, long acting
J0365	Aprotonin, 10,000 kiu	J9001	Doxorubicin hcl liposome inj	Q4080	Iloprost inhalation solution	J9310	Rituximab cancer treatment
J9017	Arsenic trioxide	J0600	Edetate calcium disodium inj	J1566	Immune globulin, powder	J2820	Sargramostim injection
J9020	Asparaginase injection	J0886	Epoetin alfa, esrd on dialysis	J1745	Infliximab injection	J2941	Somatropin injection
J0475	Baclofen 10 MG injection	Q4081	Epoetin alfa, for ESRD on dialysis	J9065	Inj cladribine per 1 MG	J9320	Streptozocin injection
J0476	Baclofen intrathecal trial	J0885	Epoetin alfa, non-esrd	J0835	Inj cosyntropin per 0.25 MG	J3030	Sumatriptan succinate / 6 MG
J0480	Basiliximab	J1325	Epoprostenol injection	J1650	Inj enoxaparin sodium	Q4084	Synvisc, inj
J9031	Bcg live intravesical vac	J1327	Eptifibatide injection	J9245	Inj melphalan hydrochl 50 MG	J7525	Tacrolimus injection
J9035	Bevacizumab injection	J1438	Etanercept injection	J2260	Inj milrinone lactate / 5 MG	J7507	Tacrolimus oral per 1 MG
J0583	Bivalirudin	J1430	Ethanolamine oleate 100 mg	J2850	Inj secretin synthetic human	J3100	Tenecteplase injection
J9040	Bleomycin sulfate injection	J9181	Etoposide 10 MG inj	J3305	Inj trimetrexate glucoronate	Q2017	Teniposide, 50 mg
J9041	Bortezomib injection	J9182	Etoposide 100 MG inj	J7187	Inj Vonwillebrand factor IU	J9340	Thiotepa injection
J0585	Botulinum toxin a per unit	Q4085	Euflexxa, inj	J9178	Inj, epirubicin hcl, 2 mg	J3240	Thyrotropin injection
J0587	Botulinum toxin type B	J7194	Factor ix complex	J1595	Injection glatiramer acetate	J1655	Tinzaparin sodium injection
J7626	Budesonide non-comp unit dose	J7193	Factor IX non-recombinant	J2505	Injection, pegfilgrastim 6mg	J7682	Tobramycin non-comp unit dose
J0594	Busulfan, inj	J7195	Factor IX recombinant	J1817	Insulin for insulin pump use	J9350	Topotecan
J9045	Carboplatin injection	J7189	Factor viia	J1830	Interferon beta-1b / .25 MG	J9355	Trastuzumab
J9050	Carmus bischl nitro inj	J7190	Factor viii	J7644	Ipratropium bromide non-comp	J3285	Treprostinil injection
J0637	Caspofungin acetate	J7192	Factor viii recombinant	J9206	Irinotecan injection	J3315	Triptorelin pamoate
J9055	Cetuximab injection	J1440	Filgrastim 300 mcg injection	J1945	Lepirudin	J3355	Urofollitropin, 75 iu
J0725	Chorionic gonadotropin/1000u	J1441	Filgrastim 480 mcg injection	J1950	Leuprolide acetate /3.75 MG	J3365	Urokinase 250,000 IU inj
J0740	Cidofovir injection	Q4091	Flebogamma injection	J9219	Leuprolide acetate implant	J3370	Vancomycin hcl injection
J0743	Cilastatin sodium injection	J9200	Floxuridine injection	J9218	Leuprolide acetate injeciton	J3396	Verteporfin injection
J9060	Cisplatin 10 MG injection	J9185	Fludarabine phosphate inj	J9217	Leuprolide acetate suspnsion	J1562	Vivaglobulin, injection
J9062	Cisplatin 50 MG injection	J7311	Fluocinolone acetonide implt	J2020	Linezolid injection	J3487	Zoledronic acid
J9027	Clofarabine injection	J1652	Fondaparinux sodium	J7504	Lymphocyte immune globulin		

Prior Authorization Request

Please fax to: 1-866-464-0707
Or call 1-888-454-0013, extension 336336

TX ☐ Bexar ☐ Harris ☐ El Paso ☐

Type of Request ☐ Elective ☐ Expedited Date/Time Rec'd

Member Name ID# DOB:

PCP/Requesting Provider Office Contact Person

Phone#: Fax# e-mail:

Referring To: Specialty/Facility:

Service Requested ☐ ASC ☐ Out-Patient Hospital ☐ In -Patient ☐ Office Procedure

☐ DME ☐ Home Health ☐ PT/OT/ST ☐ Medications

Type of Service ☐ Medical ☐ Surgical

Service Description

Procedure Description

Date of Procedure:

☐ **Participating Provider/Facility:**

☐ **Non-Participating Provider/Facility:**

Reason if requesting non par facility/Provider:

Diagnosis Codes: Procedure Codes:

Suppporting Clinical Information Attached? Yes ☐ No ☐

(If no, was additional Information requested ?) Yes ☐ No ☐ Date Requested:

Comments:

For Office Use

Pre Cert Specialist

Medical Director Determination: ☐ Certified ☐ Not Certified

Medical Director Date

QUALITY IMPROVEMENT PROGRAM

Bravo Health is committed to providing access to quality healthcare for all Members in all product lines through the continuous study, implementation and improvement of care to our Members. Quality Improvement (QI) assumes that there is no permanent threshold for good performance. Our Members expect and should be provided a comprehensive and therapeutic health care delivery system that is always evolving and improving.

The Quality Improvement Department accomplishes this by integrating, analyzing, and reporting on data from across the Plan as well as other data sources. The QI Department prioritizes quality initiatives based on relevance to the Plan. QI works with internal Bravo Health departments to manage plan resources in the most cost effective manner to maximize patient health outcomes. The following is a brief overview of the QI Department's functions.

The QI Department works on internal and external reporting of quality of care and risk management concerns. Substantial QI/Risk Management is presented to the Quality Improvement Committee (QIC) to formulate corrective action plans and monitor the results.

The QI Department assists Senior Management and the Medical Director in the coordination of the Quality Improvement activities. The QIC is charged with providing oversight (identification, prioritization, and coordination) of all quality improvement activities related to the care and service of our Members.

The QI Department coordinates with various internal departments on mandatory Centers for Medicare and Medicaid Services (CMS) audits such as Healthcare Plan Effectiveness Data and Information Set (HEDIS) and The Health Outcomes Survey (HOS). QI also contributes to Bravo Health's annual CMS site visit and quality reviews by the Pennsylvania Department of Health.

The QI department works to maintain optimal health outcomes for our Members through annual review of best practice standards. Preventive standards are derived from The United States Preventive Services Task Force Standards (USPSTF), which are derived from the American Diabetes Association, the American Cancer Society as well as other nationally recognized organizations. Guidelines are revised and modified to reflect the latest in preventive best practices.

If you have any questions about Bravo Health's Quality Improvement Program, or would like a comprehensive description of The QI Program, QI Program Annual Goals, or a list of activities towards achieving those goals, please feel free to contact Bravo Health's Quality Improvement Department at:

Bravo Health, Inc.
3601 O'Donnell Street
Baltimore, MD 21224

Information will be provided upon request.

QUALITY IMPROVEMENT PROGRAM

A. Goals

- Coordinate all quality management audits and quality improvement activities through the QIC;
- Monitor and evaluate the quality of clinical healthcare, service quality, process improvement, Member and Provider satisfaction, complaint/grievance resolution and Provider network credentialing/re-credentialing;
- Monitor and evaluate Provider practice patterns, develop improvement plans as needed, and review performance to assess whether improvements have occurred;
- Promote and monitor preventive health services;
- Identify educational needs of Members, Providers, customers, and staff, and develop resources to meet those needs;
- Maintain accurate data to ensure QI Program integrity;
- Ensure compliance with applicable accreditation and regulatory requirements;
- Conduct an annual review of all QI actions, assessing the improvement achieved through the initiatives of the QI Work Plan, and revising the Work Plan when necessary;
- Document and share improvements in healthcare delivery as a result of QI initiatives.

B. Quality Improvement Committee ("QIC")

The QIC is responsible for the overall design and implementation of quality improvement activities for the organization, as well as for the oversight of QI activities carried out by other committees and reports these activities to the Board of Directors. The QIC ensures that all quality improvement tasks and functions are a reflection of Membership involvement, the participation of Participating Providers, and the compliance with all applicable regulatory and accreditation mandates.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® (a standardized data set) is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS® measurements enable comparison of performance across plans. The sources of HEDIS® data include administrative data (claims/encounters) and medical record review. HEDIS® measurements include measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Glaucoma Screening for Older Adults, Controlling High Blood Pressure, and Breast Cancer Screening.

Plan-wide HEDIS® measures are reported annually and is a mandated activity for Health Plans contracting with The Centers for Medicare and Medicaid Services (CMS).

All records are handled in accordance with Bravo Health's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS® initiative, will be requested. HEDIS® is considered a quality related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Bravo Health HEDIS® results are available upon request. Contact the Health Plan's Quality Improvement Department.

ON-SITE ASSESSMENTS

On-site facility assessments are performed to assess the quality of care and services provided by prospective or Participating Providers. Structural elements of quality care and services are evaluated. On-site evaluations must be performed for all **PCPs, OB/GYNs, and high volume Behavioral Health Providers** prior to initial credentialing and re-credentialing.

Components assessed during an on-site evaluation include, but are not limited to, the following:

Office Standards

1. Facility appearance, cleanliness
2. Access to services
3. Administrative/organizational structure
4. Policy and procedure manuals
5. Personnel
6. Confidentiality
7. Fire/safety/emergency
8. Patient care services
9. Ancillary services
10. Medical records organization and maintenance according to CMS and NCQA Medical record documentation standards.
11. Safety and emergency procedures
12. Member-oriented educational material
13. Advance Directives and Treatment Planning

Medical Record Review

Confidentiality of Records: Participating Providers and Bravo Health agree that all Members' medical records shall be treated as confidential to comply with state and federal laws regarding confidentiality of medical records. However, nothing shall limit timely dissemination of such records to authorized Providers and consulting physicians, to governmental agencies as required and permitted by law, to accrediting bodies, to committees of Provider and Plan concerned with the quality of care and utilization and to Plan for purposes of administration. To the extent permitted by law, Plan shall have the right to inspect at all reasonable times any medical records maintained by Provider pertaining to Plan's Members. Provider agrees to maintain all patient records pertaining to treatment of Members for a period of ten (10) years.

Medical Records shall not be removed or transferred from Provider except in accordance with general Provider policies, rules and regulations. Providers agree to furnish Members timely access to their own records.

Bravo Health may audit a Provider's medical records, for Bravo Health Members, as a component of Bravo Health's quality improvement, credentialing and re-credentialing processes. In accordance with AMA guidance and NCQA guidelines, medical records must be legible with current details organized and comprehensive in order to facilitate the assessment of the appropriateness of care rendered.

Documentation audits are performed to assure that Primary Care Physicians maintain a medical record system that permits prompt retrieval of information. They are also performed to assure that medical records are legible, contain accurate and comprehensive information and are readily accessible to health care Providers. Medical record review also provides a mechanism for assessing the appropriateness and continuity of health care services. Applicable regulations mandate medical record review by Bravo Health.

Criteria (indicators) to be evaluated must include, but are not limited to, the following:

1. Demographic/personal data are noted in the record, complete patient name, date of birth, home address and phone number, sex, marital status, insurance, and Member identification number
2. An emergency contact person's name, address, and phone number, or that there is no contact person is noted in the medical record
3. Each page of the medical record contains patient's name or Bravo Health identification number
4. All entries are legible, signed and dated
5. Significant illness, medical and psychological conditions are indicated on the medical list
6. Prescribed medications, including dosage, date of initial and/or refill prescriptions are listed
7. Allergies and adverse reactions to medications are prominently noted in the record
8. Appropriate past medical history in the medical record
9. History and physical are included in the record
10. The working diagnosis are consistent with the findings
11. Treatment plans are consistent with the diagnosis and is noted on every visit note
12. There is documentation that the Member participated in the formulation of the treatment plan
13. All diagnostic and therapeutic services for which a Member was referred for are in the medical record and there is evidence that the practitioner reviewed these reports
14. There is explicit notation in the medical record of follow-up plans related to consultation, abnormal laboratory, and imagining study results
15. Chronic or unresolved problems from previous visits are addressed in subsequent visits
16. There is no evidence that the patient is placed at risk by a diagnostic or therapeutic procedure
17. There is evidence of patient/significant other teaching
18. There is evidence that medical care is offered in accordance to Bravo Health clinical care guidelines
19. The medical record contains appropriate notation concerning use of alcohol, cigarettes and substance abuse
20. There is notation regarding follow-up care, calls or visits
21. The specific time of return is noted in days, weeks, months, or as needed
22. There is a separate medical record for each patient
23. The documentation is consistent with ICD-9 codes
24. Only authorized staff have access to medical records
25. Medical records are easily located and retrieved
26. Forms used for documentation are consistent in all records
27. There is a completed immunization record in accordance with the organization's adult preventive guidelines
28. Chart is orderly
29. Preventive screenings/services are recommended
30. There is documentation of a discussion of a living will or advance directives for patients 65 years of age or older/or patients with life threatening conditions
31. Clinical findings/evaluations are documented

Provider must meet these requirements for medical record keeping. If opportunities for quality improvement are identified, Bravo Health will present these opportunities and implement interventions.

HEALTH SERVICES

Bravo Health utilization management staff base their utilization-related decisions on the clinical needs of its Members, the Member's Benefit Plan, the appropriateness of care, Medicare National Coverage Guidelines, objective, scientifically-based clinical criteria and treatment guidelines, in the context of Provider and/or Member supplied clinical information and other such relevant information.

Bravo Health in no way rewards or offers incentives, either financially or otherwise, practitioners, utilization reviewers, clinical care managers, physician advisers or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

If you have any further questions or comments, please feel free to contact our Provider Services Department at **1-888-353-3789.**

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the Member's health plan benefits.
- To monitor utilization practice patterns of Bravo Health's Contracted Physicians, Contracted Hospitals, and Contracted ancillary services,
- To provide a system to identify high-risk Members and ensure that appropriate care is accessed.
- To provide utilization management data for use in the process of re-credentialing Providers.
- To educate patients, physicians, contracting hospitals, ancillary services, and specialty Providers about the company's goals for providing quality, value enhanced managed health care.
- To improve utilization of Bravo Health's resources by identifying patterns of over and under utilization that can be improved upon.

Clinical Review Guidelines

Bravo Health has approved the following guidelines to be used for determining medical necessity and the appropriateness of care:

- InterQual™ Criteria Guidelines, (ISP, ISX, ISD and SAC)
- Utilization Management Policies and Procedures
- Technology Assessment
- Medicare National Coverage Decision Guidelines
- ASAM for Chemical Dependency and current literature and regulatory requirements for Mental Health Services (MHN)
- Evidence of Coverage, consistent with the contract definition of Medical Necessity.

Utilization Review decisions approving or denying payment of a service shall be based on the medical necessity and appropriateness of requested service, the Member's individual circumstances, and the appropriate contract language concerning benefits and exclusion.

All criteria utilized are available to any healthcare Provider upon written or verbal request.

Bravo Health and delegated utilization review entities will involve actively practicing Providers in its development of criteria and in the development and review of procedures in applying the criteria. Clinical criteria will be reviewed regularly and shall be modified as required to reflect current medical standards.

PROSPECTIVE REVIEW PROCESS

Bravo Health requires prospective review of non-urgent/non-emergent procedures that require the use of a facility other than the office. InterQual™, internally developed clinical guidelines, CMS guidelines, National Decision Coverage Guidelines and Health Plan benefits/contract and coverage guidelines are used to help make medical necessity determinations.

Decision Time Frames

Prospective review decisions on outpatient and inpatient elective procedures will be determined and communicated electronically or in writing to Bravo Health , the Member and the healthcare Provider within 14 days of receipt of the request. Bravo Health or the Member may extend this period an additional 14 days if the delay is in the best interest of the Member. If the service requested can adversely affect the Member's life or function, an expedited determination may be made within 3 days of the request, or as soon as required by the health status of the Member.

Prospective Utilization Review decisions shall be communicated via telephone and/or in writing to the requesting Provider and Member in accordance with the Standard Maximum Time Frames identified below:

- Emergent – Authorization not required using prudent layperson standards
- Urgent – within 48 hours or as soon as the Member's health requires
- Expedited – within 72 hours or as soon as the Member's health requires
- Routine – within 14 days

Authorization and/or denial or alternative treatment is the end result of prospective review.

While prospective review is preferable and must occur prior to planned care (e.g., elective admissions), situations will exist when a prospective process is not feasible (e.g., emergency admissions) and/or does not occur.

The Provider is responsible for the prior authorization of all scheduled admissions or services. The Provider shall obtain prior authorization for admissions/services on a prospective basis, when possible, and in a timely manner that ensures Member's access to medically appropriate care.

Bravo Health's Utilization Management (UM) Department is responsible for the prospective review of admissions/services; the authorization ensures that the Member receives the proposed treatment in the appropriate type of facility/location. The prospective review process shall occur only after the authorization for proposed treatment is obtained by the Provider, when indicated by the Provider Agreement . Without the Provider's approval, an authorization number will not be issued.

1. The clinical information regarding the Member, the severity of the Member's illness and the proposed plan of care are assessed and evaluated by UM. The guidelines listed above are utilized for screening medical and surgical care for the first level review. Examples of information needed include, but are not limited to:

a. Member name and identification number
b. Location of service, e.g., hospital or ambulatory surgery setting
c. Primary Care Physician name
d. Attending physician
e. Date of service
f. Diagnosis
g. Surgery, if applicable, with CPT code
h. Clinical information supporting the need for the service to be rendered

2. If the information regarding the Member, the severity of the Member's illness, and proposed plan of care meet the criteria for the establishment of medical necessity for inpatient care, outpatient procedure or surgery, or other required services needing prior authorization a length of stay is assigned. This information is entered into the Electronic Data Record and approval is communicated to the Provider and the hospital within 2 days of the determination either via facsimile or in writing if denied.

3. If the information regarding the Member, the severity of the Member's illness and the proposed plan of care do not meet the criteria for the establishment of medical necessity; the attending Provider is advised that the case will be referred to the Medical Director for review. UM Staff will advise the Provider that he/she can contact the Medical Director for further discussion regarding the case. The Provider will also be advised that the Medical Director will also attempt to contact him or her. If the case is approved by the Medical Director, UM will notify the attending Provider of the authorization.

4. In the case of adverse determinations for the Member, UM will:

- Notify the PCP and/or attending Provider, Bravo Health and enrollee of the denial and the Appeal process including time frames and methods for filing an Appeal.

- Generate a notice of adverse determination to the attending Provider and the Member within two (2) business days of the determination or within 14 days of receipt of the request, whichever is less either via facsimile or in writing.

5. If the prospective review does not occur prior to the procedure (e.g., the procedure was performed on an urgent basis) a review will be conducted within twenty-four (24) hours of notification of the procedure.

6. Prospective or pre pre-service authorization is valid for ninety (90) days from the date of issuance. All prospectively reviewed treatment, which is not begun within ninety (90) days from the date of issuance, will require another pre-service review.

7. Pre-service review procedures will include provisions for the identification of Members with special circumstances who may require flexibility in the application of screening criteria and for those for whom case management services would be appropriate.

8. The information regarding the medical necessity for an approval of a prospective review request will be accepted from any source including, but not limited to, phone, facsimile, and/or written correspondence and can be initiated by any of the following entities: Provider, Member or authorized representative of the Member.

CONCURRENT REVIEW

1. Concurrent Review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to ensure Covered Services are being provided at the appropriate level of care. These reviews are conducted telephonically. Bravo Health is responsible for final authorization.

2. The Concurrent Review process is performed telephonically by a licensed nurse. The Bravo Health nurse confers with the attending Provider or other hospital staff (Case Managers, Social Workers, Discharge Planners, etc.) regarding the acute stay and any discharge planning needs; and where appropriate, speaking with the patient and/or family.

3. A Medical Director reviews any in-patient days that do not meet medical necessity criteria and issues a determination. All days which do not meet medical necessity criteria, are discussed with the facility utilization staff and attending Provider and/or PCP when appropriate or available. In those instances where the admitting Provider does not agree with the determination, the attending is encouraged to contact Bravo Health's Medical Director to discuss the appropriateness of the continued hospitalization. The Medical Director then makes a determination to approve or deny the admission or days in question.

The Hospital's Utilization Review Department will be notified via facsimile of the daily log and/or verbally regarding the status of the case and all denials. All determinations to deny or down grade a stay will be followed up with a formal letter. Only a Medical Director is authorized to deny or downgrade days during an acute stay.

RETROSPECTIVE REVIEW

Retrospective reviews are performed on all admissions to non-Participating facilities where the Member has been admitted and discharged prior to Bravo Health's notification. What about Participating facilities?

a. Bravo Health allows 14 days after notification for facility to provide a verbal, written or facsimile clinical review. Bravo Health will issue a determination within 14 days of the notification based on the clinical information provided Clinical information submitted is reviewed according to criteria for medical necessity, and are subject to Member eligibility at the time services are rendered.

b. Retrospective review may occur for pre-authorized services in order to facilitate claims payment.

Referrals to Non-Contracted Providers

Referrals to non-Contracting Providers are approved only when the non-Contracting Providers provide services that are not available within the network. All referrals to non-Contracting Providers must be reviewed and authorized by Bravo Health before services are performed. There must be verification that the Provider of service is Medicare certified. The Medical Director must review all referrals to non-Contracted Providers. The Director of Health Services may approve non-Contracting Providers when deemed necessary by the Medical Director.

Ambulatory Services

a. The PCP is responsible for obtaining pre-authorization for services requiring pre-authorization and for any referral made out of network.

b. The Provider may make their requests via facsimile, phone or letter for pre-authorization before scheduling the service.

c. The Medical Director reviews any request that does not meet Bravo Health's criteria.

d. All Member requests for second opinions and recommendations for second opinions will be provided within the network whenever the opportunity exists. Bravo Health does not require second opinions for procedures.

e. Except for eligibility and benefit coverage denials, all denial determinations are made at the Medical Director level.

f. Member eligibility is noted. Benefit level(s), indication of other insurance, and limitations/exclusions are noted.

g. Prior authorization guidelines/clinical practice guidelines/medical necessity criteria are utilized as part of the review. Guidelines will be provided to physician upon request.

h. A written description identifying the information that is collected to support decision-making is maintained.

i. An appropriate licensed medical professional supervises all the review decisions.

j. Physician consultants from the appropriate specialty areas of medicine and surgery are utilized if the reviewing Medical Director deems necessary.

k. Each request will be approved, denied or an alternative Covered Service may be suggested.

l. A request may be pended, in order for additional information to be obtained as requested. In these cases, the requesting Provider will be contacted by phone or facsimile within twenty-four (24) hours by Bravo Health to obtain the required information. If the addition al information is not received within 14 days Bravo Health will issue a determination based on the clinical information submitted.

Discharge Planning

Discharge Planning is a critical component of the process that begins with an assessment of the patient's potential discharge care needs to facilitate the transition from the acute setting to the next level of care. It includes preparation of the patient and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services needed after acute care discharge. Bravo Health's Utilization Staff will coordinate with the acute care discharge planning team to assist in establishing a safe and effective discharge plan. The Bravo Health Utilization Review nurse will provide all needed discharge authorizations for services, equipment and skilled needs.

Case Management

Case Management is the focused arrangement of the sequence of services and resources necessary to respond to the patient's overall care requirements in catastrophic or complicated cases.

Case Management uses a team approach, which includes the Primary Care Physician, Specialist, Home Health Agencies, Social Workers, family and others as appropriate. A collaborative approach is used to assist in meeting the health care needs and community service needs of the Member on a short or long term basis. The Primary Care Physician's involvement in care of Members in case management is essential to support improved Member outcomes.

The Case Management program strives to deliver access to quality care in the most cost effective manner through appropriate utilization of all available health care resources. Members that can be referred to Case Management include, but are not limited to, the following:

- Members discharged home from acute/sub-acute/skilled settings with specific ambulatory-sensitive diagnosis such as DM, CHF, angina without procedure, and COPD
- Members with frequent readmissions
- Members in disease management programs to include, but not limited to, diagnosis of CHF or Diabetes Mellitus
- Members enrolled in Special Needs Plans for Hypertension and Hyperlipidemia
- Members receiving intensive level of home health care

If you would like to refer a Bravo Health Member for Case Management services, please call 1-888-454-0013, extension 336940.

Skilled Nursing Care

Bravo Health follows Medicare guidelines for skilled nursing care needs. All Members will be reviewed and notified within two (2) days prior to the last covered approved day. Only the Medical Director can deny skilled care based on medical necessity. If additional skilled services are denied, the facility will be instructed to provide the Member and/or the authorized representative with notification of the termination of skilled benefits.

Emergency Services

Bravo Health covers emergency services necessary to screen and stabilize Members without preauthorization in accordance with applicable law. Bravo Health covers emergency services if a PCP or other authorized representative acting on behalf of Bravo Health has directed the Member to the Emergency Room.

In an emergency situation, Members sometimes self-refer without the knowledge of the Primary Care Physician or Bravo Health. In such cases, the medical records will be reviewed retroactively. Final determination regarding whether an emergency situation existed will be subject to review and will be determined in accordance with applicable law.

The review is primarily used to promote high quality care, assess whether there is access to Primary Care Physicians who are contractually obligated to provide care 24 hours a day, 7 days a week is adequate, and increase awareness of appropriate use of costly emergency care resources.

Decision Time Frames

Utilization review determinations are made in a timely manner and in compliance with applicable law.

- Emergent - authorization not required in accordance with applicable law
- Urgent - within 48 hours or next business day
- Expedited – with 72 hours or as required by the health status of the Member
- Routine - within 14 days of the receipt of the request

Bravo Health recognizes the need for prompt handling of all referrals and will communicate directly with the requesting Provider's office all rendered decisions via telephone communication and/or facsimile.

Denials

Efforts are made to obtain all necessary information, including pertinent clinical information from the treating Provider to allow the Medical Director to make coverage determinations. The Medical Director is available by telephone to the Provider to discuss determinations based on medical necessity. A denial may occur:

a. At the time of prospective pre-service review. The process for discussion of such denials between Bravo Health's Medical Director and the Provider of care will be documented by the UM department staff and processed according to the adverse decisions policy.

b. At the time of concurrent review, the health plan will notify the acute facility via facsimile or verbally within 24 hours after receipt of all clinical information needed to render a determination. Denial notification is sent to the facility and patient (only when in a non-Contracting facility) in writing at the end of the admission stay. A copy of the letter is also sent by mail to the attending Provider notifying him/her of any downgrade or denied determination.

c. At the time of a request for authorization for a non-Covered service.

Rendering Denials

a. The Utilization Management staff can make the decision for an administrative denial based on Covered Services, eligibility, etc.

b. Only the Medical Director makes the decision for denial based on medical necessity but he/she can also make a decision on administrative guidelines. The Medical Director, in making the initial decision, may elect to suggest an alternative Covered Service to the requesting Provider. A denial notice is issued documenting the original request that was denied and the alternative service and the process for appeal. If the Provider agrees, he/she notifies the Member.

Notification of Denials

a. The reason for each denial, including the specific utilization review criteria or benefits provision used in the determination of the denial are included in the written notification and sent to Members and Providers.

b. The criteria used to determine the coverage is available to the Provider and Member upon request.

C. All denials for retrospective review are sent to Providers within five working days of making the decision

CONTINUITY OF CARE

Bravo Health's policy is to provide for continuity of and coordination of care among medical practitioners treating the same patient, coordination between medical and behavioral care and to minimize potential continuity problems caused when a practitioner leaves a network and has patients in active treatment.

Any Member who is currently undergoing treatment upon the termination of a Provider for reasons other than those associated with quality of care or a Member who is new to Bravo Health may be allowed to continue care with their current Provider for up to 90 days from the date the enrollee is notified by the plan of the termination or pending termination of a Contracting Provider. Members undergoing active treatment for a chronic or acute medical condition will have access to such discontinued Provider through the current period of active treatment for up to 90 calendar days, whichever is shorter. Members in their second or third trimester of pregnancy have access to their discontinued practitioner through the postpartum period. If Bravo Health terminates a Contracting Provider for cause, Bravo Health will not be responsible for the health care services provided by the terminated Provider to the enrollee following the date of termination.

Members with previously scheduled treatments or procedures and Members in the middle of an episode of care may be allowed to continue care with their current Provider for up to 90 days from the date the Member is notified by Bravo Health of the termination or pending termination of a healthcare Provider.

CLINICAL PRACTICE GUIDELINES

OUTPATIENT MANAGEMENT OF CONGESTIVE HEART FAILURE IN ADULTS	
GOALS FOR DIAGNOSTIC EVALUATION	▪ Establish Ejection Fraction and document the Left without resulting Ventricular Dysfunction ▪ Determine underlying cause of heart failure ▪ Identify precipitating or aggravating correctable factors ▪ Develop Management and Treatment Plan ▪ Provide baseline information to monitor effects of treatment ▪ Establish baseline NYHA classification
INITIAL EVALUATION OF HEART FAILURE DIAGNOSTIC TESTING	▪ Complete History and Physical Examination ▪ Clinical Testing ▪ Chest X-Ray, 12-lead Electrocardiogram ▪ Assessment of Ventricular Function ▪ Transthoracic Doppler 2-D Echocardiography ▪ Radionuclide ventriculography ▪ Evaluation testing for ischemia (Stress, Nuclear Test ▪ OR Stress Echocardiography OR Cardiac ▪ Catheterization) Complete Blood Count, Urinalysis ▪ Fasting Lipid Panel, (Cholesterol Triglyceride, HDL Cholesterol, LDL and LDL: HDL Ratio) ▪ Blood Chemistry: Electrolytes, BUN, creatinine, ▪ Glucose, Liver function test and TSH level
ADDITIONAL DIAGNOSTIC TESTING	Consider additional diagnostic testing for evaluation of other cardiac or non-cardiac related causes in the absence of ischemia or Valvular Heart Disease, Serum Iron and Ferritin, Endomyocardial Biopsy, Phosphorus, Magnesium, Calcium and Albumin levels
SPECIALTY REFERRALS	▪ Cardiac Educator – As indicated ▪ Nutritional Counseling – As indicated ▪ Cardiology Consult – Consider consultation during the initial evaluation and anytime during the ongoing management of CHF as appropriate ▪ Home Health Care – Consider home health care for outpatient monitoring ▪ Cardiac Rehabilitation Programs – Consider rehabilitation programs to maximize functional capacity
MANAGEMENT PLAN, EDUCATION & FAMILY COUNSELING	
PATIENT AND FAMILY EDUCATION AND COUNSELING	▪ Nature of heart disease-Drug Adherence Regimens ▪ Symptoms of worsening CHF-What to do if symptoms occur ▪ Mechanisms for complicated medical regimens-Coping ▪ Presentation measures for further progression of the disease *Accurate information concerning prognosis should be discussed in order for patients to make decisions and plans for the future. Discuss the planning of advance directives with patients and family in the context of heart failure management*
LIFESTYLE CHANGES/HABITS	▪ Physical Activity – Recreation, leisure and work activity as tolerated ▪ Exercise – Establish a regular exercise program consistent with individual patient's capabilities and clinical status. Program should be dynamic (walking, cycling) not isometric to pervert or reserve physical including drug doses. ▪ Sexual Activity – Discuss sexual difficulties and coping mechanisms if they occur ▪ Smoking Cessation – Emphasis on the importance of not smoking: medications of financial assistance determine the willingness to stop smoking and strategies for smoking cessation should be tailored to each individual ▪ Alcohol Usage – Discourage alcohol use
DIETARY MEASURES	▪ Sodium restriction –Define and quantify the amount of salt that is allowed in the daily diet, 3 grams or less. (Personal food preferences, culture, income and family support should be considered) ▪ Management of Cachexia/Management of Obesity
FLUID MANAGEMENT	▪ Establish baseline weight ▪ Encourage daily weights on the same scale at the same time each day ▪ Report weight gains of $\geq$ of 5+ lbs. in a week ▪ Establish/monitor daily fluid intake limits; avoid excessive fluid intake ▪ Instruct on fluid restriction if indicated
MEDICATION EDUCATION	▪ Develop a patient medication schedule including drug doses ▪ Review effects of medications on quality of life and survival ▪ Discuss probability of side effects and what to do if they occur ▪ Discuss availability of lower cost medications or financial assistance
IMMUNIZATIONS	▪ Influenza (flu) –vaccine annually ▪ Pneumococcal vaccine –initially/repeat as per CDC recommendations

**Utilization Management Committee will review Guidelines for new scientific evidence or national standard changes prior to distribution to Providers annually.

CHF PHARMACOLOGICAL TREATMENT OPTIONS - RECOMMENDATIONS

ACE Inhibitors (Angiotension Coverting Enzyme) Need to change font to match others	▪ ACE Inhibitors should be prescribed for patients with left-ventricular systolic dysfunction with EV < 40 unless contraindicated or not tolerated. ▪ ACE Inhibitors should be continued indefinitely. ▪ The recommended dose of ACE Inhibitors for heart failure are the larger doses used in the clinical trials demonstrating improvement in survival. ▪ Contradictions to ACE Inhibitors include shock, angioneurotic edema, significant hyperkalemia (scrum potassium >5.5mEq/1)**, symptomatic hypotension, severe renal artery stenosis, severe aortic stenosis and pregnancy
Alternative Treatment to ACE Inhibitors	▪ Consider Angiotension Receptor Blockers (ARB) as alternative therapy only in ACE inhibitor – intolerant patients due to persistent cough shock or angineurotic edema(or add to ACE if beta-blocker contraindicated) ▪ Consider hydralazine/isosorbide dinitrate combination therapy if renal insufficiency precludes ACE/ARB therapy.
Beta - Blockers	▪ Data supports long acting metoprolol, carvedilol, or bisoporlol indicated for clinically stable patients with left ventricular systolic dysfunction and mild to moderate heart failure symptoms that are on standard therapy (which typically includes ACE Inhibitors, diuretics as needed to control fluid retention and digoxin). ▪ Start with low doses and gradually increase. ▪ If tolerated, beta-blockers are also indicated in the treatment of high-risk patients after an acute myocardial infarction.
Diuretics	▪ Consider diuretic drugs for patients with fluid overload and edema. ▪ Patients with symptomatic heart failure should be treated with a diuretic drug, even when rendered free of edema. Diuretic drugs should be used in conjunction with an ACE inhibitor. The dose and type of diuretic drug may change according to fluid status, but generally will be needed indefinitely.
Digoxin	▪ Consider digoxin in patients with symptomatic evidence of heart failure, elevated filling pressures, a third heart sound, ventricular dilatation or depressed ejection fraction. ▪ Useful drug in heart failure patients with atrial fibrillation with rapid ventricular rates.
Anti-Coagulants (Warfarin)	▪ Patients with heart failure and atrial fibrillation should be treated with Warfarin, unless contraindicated in present systematic embolization. ▪ Anticoagulation with Warfarin should be considered in patients with severely impaired systolic function and high risk thromboemboli.
Aldosterone Antagonist Spironolactone	▪ Considered administration of spironolactone at low dose (12.5mg to 25mg daily) for patients receiving standard therapy who have severe heart failure caused by left ventricular dysfunction. ▪ Patients should have a normal serum potassium level and adequate renal function. ***Monitor serum K + levels at regular intervals and after any change in dosage.*
Antiarrhythmics	▪ Not routinely recommended, but indicated in atrial fibrillation. ▪ Due to its low incidence of proarrhythmic effects in general, amiodarone is the preferred drug when antiarrhythmic therapy is indicated in patients with heart failure for supraventricular tachycardia not controlled by Digoxin or beta-blocker or patients with life threatening ventricular arrhythmia that are not candidates for implantable cardiac defibrillators. ▪ Use of antiarrhythmic agents should not be used for the suppression of ventricular premature beats or non-sustained ventricular tachycardia, which is either asymptomatic or perceived as palpations.
Other	Use of most calcium channel blockers is not recommended unless needed for hypertension or rapid response of atrial fibrillation.

**Monitor Serum K+ levels on a regular basis; Consider low potassium duet and avoid foods high in potassium

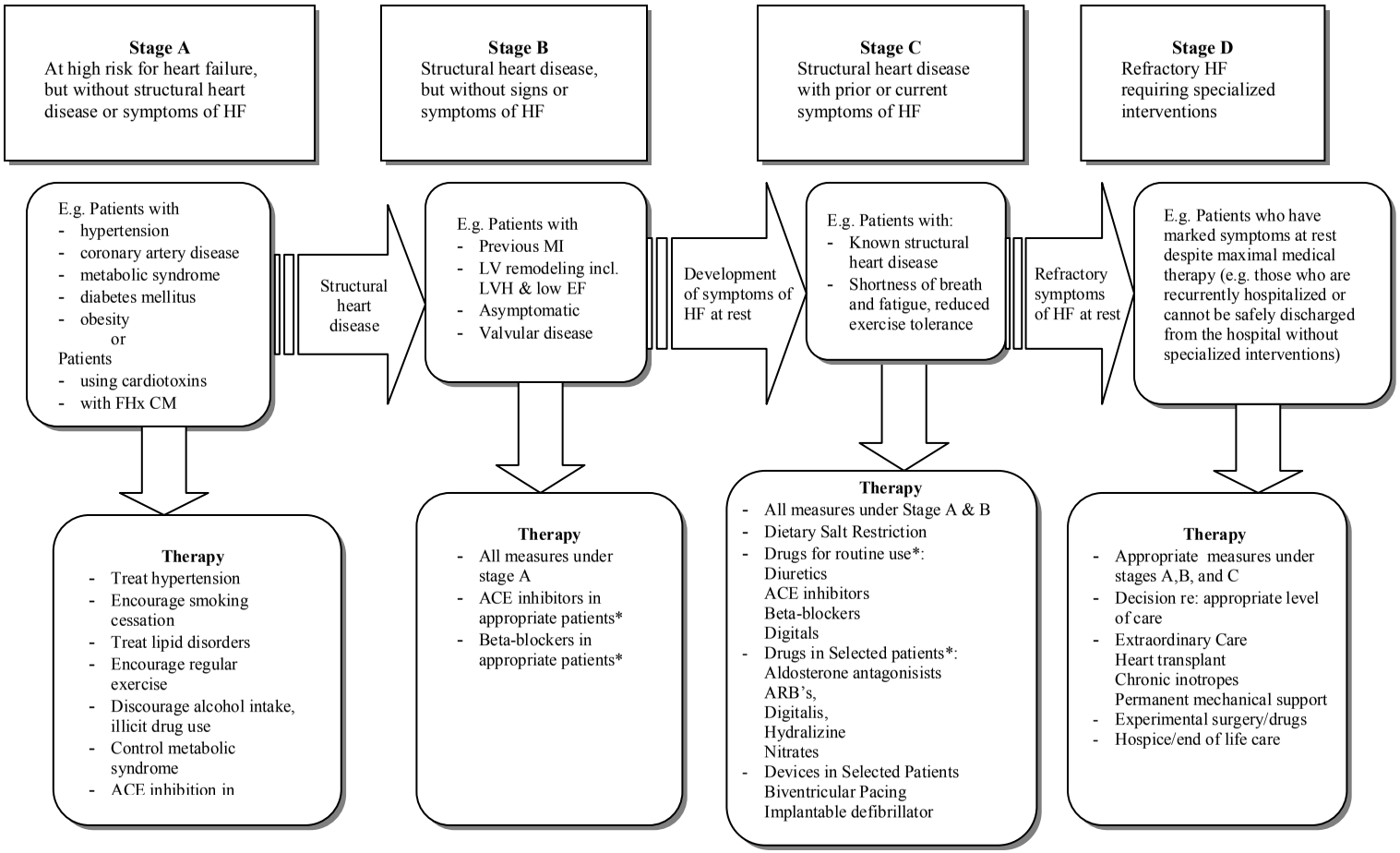
Complied From:

1. Guidelines for the Evaluation and Management of Heart Failure. Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Evaluation and Management of Heart Failure). Circulation 1995; 92: 2764-84, **reviewed 2005.**
2. US Department of Health and Human Services. Agency for Health Care Policy and Research. Heart failure: evaluation and care of patients with left ventricular systolic dysfunction. Rockville, The Agency 1994 (Clinical Practice Guideline No. 1) (AHCPR Publication No. 94-0612.)
3. Heart Failure Society Guidelines: A Model of Consensus and Excellence. Pharmacotherapy 20(5) 495-522, 2000
4. Institute for Clinical Systems Improvement, Inc. Health Care Guidelines; Congestive Heart Failure in Adults. November, 2000

**Utilization Management Committee will review Guidelines for new scientific evidence or national standard changes prior to distribution to Providers annually.

NEW YORK HEART ASSOCIATION HEART FAILURE DISEASE CLASSIFICATION:

Class I Asymptomatic (Patients with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undo fatigue, palpitations, dyspnea, or anginal pain)
Class II Mildly symptomatic (Patients with cardiac disease resulting in slight limitation of physical activity. Comfortable at rest, ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain)
Class III Moderately symptomatic (Patients with cardiac disease resulting in marked limitation of physical activity. Comfortable at rest, less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain)
Class IV Severe symptoms at rest (Patients with cardiac disease resulting in an inability on any physical activity)



This table of suggested guidelines has been developed from the ***ACC/AHA 2005 Chronic Heart Failure Guideline Update***. It is intended to provide guidance to practitioners to reduce risks associated with CHF, increase awareness of CHF, and to optimize disease management. It contains guidelines only and should never supersede clinical judgment. The practitioner, in conjunction with the patient or responsible party, should decide whether these or other recommended services should be performed more frequently, less frequently, or not at all. As with all services provided to Bravo Health Members, the clinical judgment and the discussion around it should be documented in the medical record. *ACC/AHA full text guideline available at; http://circ.ahajournals.org/cgi/reprint/112/12/e154

OUTPATIENT MANAGEMENT OF DIABETES

Aspect of Care	Monitor	Frequency	Target Outcome	Recommendations
Glycemic Control Fix font so they all match	HbA1c	Quarterly or Semi-Annual	<7%	Target hemoglobin A1c (A1C) should be individualized. A reasonable goal for A1C in relatively healthy adults with good functional status is 7% or lower. For frail, older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent treatment goal may be appropriate. Obtain A1C test quarterly in persons whose therapy has changed or who are not meeting glycemic goals. Obtain A1C test at least twice yearly if at goal and who have stable glycemic control. Use of Point of Care Testing for A1C allows for timely decisions on therapy changes when needed.
Lipids	LDL	Annual	<100 mg/dl	Lifestyle modification focusing on the reduction of fat and cholesterol intake, weight loss (if indicated), and increased physical activity has been shown to improve the lipid profile in persons with diabetes. In persons without overt CVD over the age of 40 years, statin therapy to achieve an LDL reduction of 30-40% regardless of baseline LDL is recommended. In persons with overt CVD, all persons should receive statin therapy to achieve an LDL reduction of 30-40%.
Retinopathy	Dilated-eye examination by an Eye-Care Specialist	Annual		Adults with type 1 diabetes should have an initial dilated and comprehensive eye exam performed by an eye care specialist within three to five years after the onset of diabetes. Persons with type 2 diabetes should have an initial dilated and comprehensive eye exam shortly after the diagnosis of diabetes. Subsequent dilated comprehensive eye examinations for persons with type 1 and type 2 diabetes should be performed annually.
Nephropathy	Micro-albumin Serum Creatinine	Annual		Perform an annual test for the presence of microalbuminuria in persons with type 1 diabetes with diabetes duration of ≥ 5 years and in all persons with type 2 diabetes starting at diagnosis. In persons with any degree of CKD, protein intake should be limited to RDA (0.8g/kg) to reduce the risk of nephropathy. Serum Creatinine should be measured at least annually for the estimation of glomerular filtration rate in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine alone should not be used as a measure of kidney function but instead used to estimate GFR and stage the level of CKD.
Hypertension	Blood Pressure	Each visit	.	If patient has hypertension, then the target blood pressure should be less than 130/80 if it is tolerated. Because older adults may have reduced tolerance for blood pressure reduction, hypertension should be treated gradually to avoid complications.
Foot Care	Foot exam	Annual		All persons with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity. Persons with neuropathy should have a visual inspection of their feet every office visit by a health care professional.

This table of suggested guidelines has been developed from the American Diabetes Association: 2007 Standards of Medical Care in Diabetes:
Diabetes Care 29: S4-S42, 2006. It is intended to provide guidance to practitioners to reduce risks associated with diabetes, increase awareness of diabetes, and to optimize disease management. It contains guidelines only and should never supersede clinical judgment. The practitioner in conjunction with the patient should decide whether these or other recommended services should be performed more or less frequently. Clinical judgment and discussion should be documented in the medical record

Utilization Management Committee will review Guidelines for new scientific evidence or national standard changes prior to distribution to Providers annually. 9/27/2007

OUTPATIENT MANAGEMENT OF CORONARY AND OTHER VASCULAR DISEASE

Antiplatelet Agents/ Anticoagulants	▪ Start aspirin 75 to 162 mg/d and continue indefinitely in all patients unless contraindicated. ▪ Gastrointestinal side effects are dose-dependent. Since the benefits of aspirin have been measured at doses as low as 81 mg. enteric-coated 81 mg tablets are reasonable and almost always tolerated. ▪ For patients undergoing CABG, aspirin should be started with in 48 hours after surgery to reduce saphenous vein graft closure. Dosing regimens ranging from 100 to 325 mg/d appear to be efficacious. Doses higher than 162 mg/d can be continued for up to 1 year. ▪ Start and continue clopidogrel 75mg/d in combination with aspirin for up to 12 months in patients after acute coronary syndrome or percutaneous coronary intervention with stent placement (≥1 month for bare metal stent, ≥3 months for sirolimus-eluting stent, and ≥6 months for paclitaxel-eluting stent). ▪ Patients who have undergone percutaneous coronary intervention with stent placement should initially receive higher-dose aspirin at 325mg/d for 1 month for bare metal stent, 3 months for sirolimus-eluting stent, and 6 months for paclitaxel-eluting stent ▪ Manage Warfarin to international normalized ratio= 2.0to 3.0 for paroxysmal or chronic atrial fibrillation or flutter, and in post myocardial infarction patients when clinically indicated (e.g., atrial fibrillation, left ventricular thrombus). ▪ *Use of Warfarin in conjunction with aspirin and/or clopidogrel is associated with increased risk of bleeding and should be monitored closely.* ▪ *Patients with true aspirin allergy (laryngospasm, anaphylaxis) should receive Clopidogrel.*
Renin-Angiotensin-Aldosterone System Blockers	***ACE Inhibitors*** ▪ Start and continue indefinitely in all patients with left ventricular ejection fraction ≤40% and in those with hypertension, diabetes, or chronic kidney disease, unless contraindicated. ▪ Among lower-risk patients with normal left ventricular ejection fraction in whom cardiovascular risk factors are well controlled and revascularization has been performed, use of ACE inhibitors may be considered optional. ***Angiotensin receptor blockers*** • Use in patients who are intolerant of ACE inhibitors and have heart failure or have had a myocardial infarction with left ventricular ejection fraction ≤40%. • Consider in other patients who are ACE inhibitor intolerant. ***Aldosterone Blockade*** ▪ Use in post-myocardial infarction patients, without significant renal dysfunction (creatinine <2.5mg/dl in men, <2.0mg/dl in women) or hyperkalemia (Potassium should be <5.0MEq/L), who are already receiving therapeutic doses of an ACE inhibitor and Beta-Blocker, have a left ventricular ejection fraction ≤40%, and have either diabetes or heart failure. ▪ Refer to the *Clinical Practice Guideline for the Outpatient Management of CHF in Adults.*
B-blockers Goal: All patients post MI	▪ Start and continue indefinitely in all patients who have had myocardial infarction, acute coronary syndrome, or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated. ▪ Consider chronic therapy for all other patients with coronary or other vascular disease or diabetes unless contraindicated.
Blood Pressure Goal: <140/90 mm Hg or <130/80 mm Hg if Diabetes or Renal Insufficiency	▪ Identify and treat reversible causes. ▪ Accurate BP measurements with appropriate size cuff at every visit. ▪ Advocate & monitor lifestyle changes *(weight control, physical activity, alcohol moderation, if moderate sodium restriction, emphases on fruits/vegetables and low-fat dairy products)* ▪ Pharmacological management goals. All patients on optimal dose of drug therapy for insufficiency adequate hypertension control. *(see Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7).*
Cigarette Smoking Goal: Complete Cessation	▪ **ASK** – Identify use of all tobacco products at every visit. ▪ **ADVISE** – Strongly urge and educate users on the importance of quitting at every visit. ▪ **ASSESS** – Determine the patient's willingness to quit. ▪ **ASSIST** – Counsel the patient and help to develop quit plan and set quit date. Prescribe pharmacotherapies found to be effective (unless contraindicated); Combination treatment with sustained release bupropin and nicotine withdrawal products has been shown to be the most effective. ▪ **ARRANGE** – Follow up soon after quit date. **AVOIDANCE--** of exposure to environmental tobacco smoke at work and home.

<table>
<tr><td>Cholesterol

Primary Goal:
LDL-C<100 mg/dL

If triglycerides are ≥200 mg/dL, non – HDL-C should be <130 mg/dL</td><td>▪ Intensive cholesterol-lowering therapy can significantly reduce the risk of major coronary events, strokes and total mortality.
▪ LDL-C should be <100mg/dL
▪ Further reduction of LDL-C to <70 mg/dL is reasonable.
▪ If baseline LDL-C is ≥100/dL, initiate LDL-lowering drug therapy.
▪ If on-treatment LDL-C is >100 mg/dL, intensify LDL-lowering therapy (may LDL-lowering drug combination).
▪ If triglycerides are >200 mg/dL, non-HDL-C should be <130mg/dL and further reduction of non-HDL-C to <100mg/dL is reasonable.
▪ If triglycerides are ≥500mg/dL, therapeutic options to prevent pancreatitis are fibrate or niacin before LDL-lowering therapy; and treat LDL-C to goal after triglyceride-lowering therapy.
▪ Refer to NCEP III guidelines for details</td><td>The treatment of elevated LDL-C involves therapeutic lifestyle changes (TLC) and Drug therapy.

Essential features of TLC are:
▪ Reduced intake of saturated fats (<7% of total calories) and cholesterol (<200 mg/day)
▪ Increased intake of soluble fiber
▪ >10g/day and plant stanols/sterols (2g/day)
▪ Increase consumption of omega-3 fatty acids in the form of fish or in caspsule form (1g/d).
▪ Weight reduction/management
▪ Increased physical activity
▪ HMG CoA reductase inhibitors (statins)</td></tr>
<tr><td>Diabetes

Goal:
HbA1c <7%</td><td colspan="2">▪ Screen all CAD patients for diabetes: type 1 DM increases CAD risk three-to-ten fold
▪ Type 2 DM increases CAD risk two fold in men and four in women.
▪ Initiate lifestyle and pharmacotherapy to achieve near-normal HbA1c.
▪ Begin vigorous modification of other risk factors (e.g., physical activity, weight management, blood pressure control, and cholesterol management as recommended above).
▪ Coordinate diabetic care with patient's primary care physician or endocrinologist.
▪ Refer to the Clinical Practice Guideline for Diabetes Care.</td></tr>
<tr><td>Physical Activity

Goal:
At least 30 minutes
7days/week
(minimum 5 days)</td><td colspan="2">▪ Exercise training improves exercise tolerance, symptoms, psychological well-being, lipid profiles and cardiac outcomes.
▪ To guide exercise prescription, assess risk preferable with exercise tolerance test.
▪ For all patient , encourage of 30-60 minutes of moderate-intensity aerobic activity, such as brisk walking, supplemented by an increase in daily lifestyle activities (household work, gardening).
▪ Encourage resistance training 2 days per week
▪ For moderate-to high risk patients, recommend medically supervised "Cardiac Rehab" programs.
▪ Physicians and patients are sometimes concerned about the safety of exercise training in patients with CAD although there is clearly a very low rate of serious cardiac events during cardiac rehabilitation.</td></tr>
<tr><td>Weight Management
Goal:
BMI 18.5 to 24.9kg/m2

Waist circumference:
Men <40 inches
Women < 35 inches</td><td colspan="2">▪ Assess body mass index and/or waist circumference on each visit and consistently encourage weight maintenance/reduction through an appropriate balance of physical activity, caloric intake, and formal behavioral programs when indicated to maintain/achieve a body mass index between 18.5 and 24.9 kg/m2.
▪ If waist circumference is ≥35 inches in women and ≥40 inches in men, initiated lifestyle changes and consider treatment strategies for metabolic syndrome as indicated.
▪ The initial goal of weight loss therapy should be to reduce body weight by approximately 10% from baseline. With success, further weight loss can bet attempted if indicated through further assessment. gardening).</td></tr>
<tr><td>Influenza Vaccine</td><td colspan="2">Patients with cardiovascular disease should have an influenza vaccination annually.</td></tr>
<tr><td>Education

Goal:
Improve patient
Knowledge &
Enhanced outcome</td><td>• Assess patients' baseline understanding.
▪ Elicit their desire for information.
▪ Use ancillary personal and professional patient education programs.
▪ Involve family Members.
▪ Invest time to improve functional capacity and survival.
▪ Incorporate patient specific information including prognosis, treatment plan, physical activity including limitations, resumption of occupation and sexual activities.
▪ Emphasize risk factor reductions.
▪ Discuss accessing the emergency medical system.
▪ Develop action plans for aspirin and sublingual nitroglycerin including any contraindications.</td><td>Category I risk factors
▪ Identify and treat aggressively
▪ Hypertension
▪ Smoking
▪ Diabetes
▪ Sedentary lifestyle
▪ Hyperlipidemia
▪ Obesity

Category II risk factors
▪ Menopausal complications
▪ Obesity
▪ Stress
▪ Depression</td></tr>
</table>

This table of suggested guidelines has been developed from the **AHA/ACC Secondary Prevention for Patients with Coronary and Other Vascular Disease revised 2005 clinical guidelines**. It is intended to provide guidance to practitioners to reduce risks associated with CAD, increase awareness of CAD and to optimize disease management. It contains guidelines only and should never supersede clinical judgment. The practitioner, in conjunction with the patient or responsible party, should decide whether these or other recommended services should be performed more frequently, less frequently, or not at all. As with all services provided to Bravo Health Members, the clinical judgment and the discussion around it should be documented in the medical record.

OUTPATIENT MANAGEMENT OF COPD

ASPECT OF CARE	MONITOR	RECOMMENDATIONS
Screening	It is important to obtain a thorough history to screen for risk factors especially cigarette smoking, occupational exposure, and outdoor/indoor pollution. The most important risk factor for COPD is cigarette smoking.	At initial assessment and periodically determine risk factors and causes of exacerbations. Initiate and monitor cigarette and smoking cessation
Diagnosis Symptoms: Chronic cough throughout the day Any pattern of sputum production Dyspnea that is progressive, persistent, worse on exercise, worse during respiratory infections Repeated episodes of acute bronchitis History of exposure to tobacco smoke , occupational dusts and chemicals Smoke from home cooking and heating fuel	The diagnosis should be confirmed by spirometry if patient has symptoms.	At initial assessment and annually. According to the GOLD standards, spirometry can be used to monitor disease progression but to be reliable the intervals between measurements must be at least 12 months apart. Additional tests for the assessment of a patient with Stages II-IV: Bronchodilator Reversibility Testing, CXR, ABG
Classification by Severity: **Stage 0: At Risk**	Chronic cough and sputum production Lung function is normal	Avoidance of risk factors Annual Influenza Vaccine
Stage 1 Mild COPD	FEV_1>=80% FEV_1/FVC<70% Mild airflow limitation, and usually, but not always, chronic cough and sputum production.	Short Acting Bronchodilator when needed **Albuterol, terbutaline, metaproterenol, ipratropium (Tier 1)** **Proventil HFA, Ventolin HFA, Atrovent HFA (Tier 2)**
Stage 2 Moderate COPD	$FEV_1/FVC < 70\%$ 50%<=FEV_1<80% predicted Worsening airflow limitation, and usually the progression of symptoms, with shortness of breath, developing on exertion.	Continue short acting Bronchodilators as needed Add treatment with one or more long acting bronchodilators **Servent, Spiriva (Tier 2)** Pulmonary Rehabilitation
Stage 3 Severe COPD	$FEV_1/FVC < 70\%$ 30%<=FEV_1<50% predicted Further worsening of airflow limitation, increased shortness of breath, and repeated exacerbations which have an impact on patients' quality of life.	Short and long acting bronchodilators Pulmonary Rehabilitation Inhaled Glucocorticosteroids if repeated exacerbations **Asmanex, Flovent HFA, Pulmicort (Tier 2)** **Combo w/ long-acting bronchodilator: Advair (Tier 2)**
Stage 4 Very Severe COPD	$FEV_1/FVC < 70\%$ FEV_1<30% predicted or FEV_1<50% predicted plus chronic respiratory failure Severe airflow limitation, quality of life is very appreciably impaired, and exacerbations may be life threatening	Add long term care oxygen Initiate oxygen therapy for patients with Stage IV: Very Severe COPD if: 1. PaO_2 is < or = 55mm Hg or SaO_2 is < or = 88% with or without hypercapnia or 2. PaO_2 is between 55mm Hg and 60 mm Hg or SaO_2 is 89%, if there is evidence of pulmonary hypertension, peripheral edema, suggesting CHF or polycythemia
Patient Education/Prevention of Complications	Patient education is an effective way to accomplish smoking cessation, improve knowledge of disease and associated signs and symptoms, and improve responses to acute exacerbations. How to assess severity of an exacerbation: PaO_2 < 60mmHg and/or SaO_2 < 90% with or without $PaCO_2$ >50mmHg when breathing room air indicates respiratory failure PaO_2 < 50 and $PaCO_2$ >70 and pH<7.30 suggest a life threatening episode that needs close monitoring or critical management:	Smoking cessation (all stages COPD) Yearly Influenza vaccination (all stages COPD) Pneumococcal Vaccine: ***One dose for persons under 65 who have chronic disorders of the pulmonary systems.*** One dose for unvaccinated persons age 65 and older. One dose revaccination for persons age 65 and older if they received the vaccine greater than or equal to 5 years previously and were less than 65 years at time of primary vaccination. Increase bronchodilator therapy Consider antibiotic therapy for bacterial infection Consider corticosteroids if no improvement in symptoms; Administer O_2 as needed;, Increase social support; Improve exercise tolerance Indications for Hospital Admissions: Insufficient home support; newly occurring arrhythmias; significant co-morbidities; onset of new physical signs (cyanosis, peripheral edema); failure of exacerbation to respond to initial medical treatment; severe background COPD; marked increase in intensity of symptoms such as development of resting dyspnea

This table of suggested guidelines has been developed from the American Diabetes Association: 2007 Standards of Medical Care in Diabetes: Diabetes Care 29: S4-S42, 2006. It is intended to provide guidance to practitioners to reduce risks associated with diabetes, increase awareness of diabetes, and to optimize disease management. It contains guidelines only and should never supersede clinical judgment. The practitioner in conjunction with the patient should decide whether these or other recommended services should be performed more or less frequently. Clinical judgment and discussion should be documented in the medical record **Utilization Management Committee will review Guidelines for new scientific evidence or national standard changes prior to distribution to Providers annually.

PHARMACEUTICAL MANAGEMENT

Bravo Health provides a pharmacy benefit to all of our Members. This benefit consists of a three-tier formulary with a fourth tier for specialty injectible medications. All prescriptions require the Member to pay a co-payment based on the medication's formulary status. Our formulary can be found on line at www.bravohealth.com. Click on Providers, then Provider Forms and Information. You may also request a printed copy of the formulary by contacting our Provider Services Department at 1-888-353-3789.

Bravo Health's formulary requires that some medications require prior authorization before they can be dispensed. Please call 1-800-753-2851 for prior authorization. The formulary lists these medications with the designation 'PA.' If you would like a copy of the criteria that Bravo Health uses to determine coverage status for these medications, please visit our website. You may also request a printed copy of these criteria by contacting our Provider Services Department.

Step Therapy

Bravo Health requires step therapy on the following 2 classes: Proton Pump Inhibitors and Lipid lowering agents. The first line therapy for the proton pump inhibitor class will be either generic Omeprazole or Zegerid. If you require any other medications for your Members in this class, prior authorization will be required. For the lipid lowering class, first line medications are; Lovastatin, Simvastatin, and Pravastatin. If you require any other medications in this class for your patients, they will require prior authorization.

As always, remember to prescribe generics to our Members. Generic medications offer the lowest co-payments and don't require you to fill out any paperwork or receive callbacks from the retail pharmacies asking you to switch to a formulary medication. If you do prescribe a brand name drug that has a generic equivalent, the pharmacy will automatically switch the drug to the generic medication. If the Member requires the brand name drug due to a medical failure or allergic reactions to a generic medication, you must contact Bravo Health to seek prior authorization for the brand name medication.

PART D PHARMACY PRIOR AUTHORIZATION

The following drugs **DO NOT** require prior authorization under the Part D benefit:

Accuneb	**Cellcept**	**Fosamax 40mg**	**Myobloc**	**Rebetol**	**Testoderm**
Actimmune	**Cerezyme Inj**	**Foscarnet Inj**	**Nebupent**	**Rebetron**	**Testred**
Actiq	**Ciprofloxacin Inj**	**Gabitril**	**Neoral**	**Rebif**	**Thalomid**
Actonel 30mg	**Cis Platin Inj**	**Gammar**	**Nicotine Patch**	**Regranex**	**Tobi**
Acyclovir inj	**Cladribine Inj**	**Gammimune N**	**Nicotrol**	**Relenza**	**Tracleer**
Adderall/Adderrall XR	**Cognex**	**Gangiclovir Inj**	**Nitroglycerin Inj**	**Remicaid**	**Triseonx Inj**
Alupent Nebulizer	**Concerta**	**Genotropin**	**Norditropin**	**Reminyl**	**Ultracet**
Amevive	**Copaxone**	**Gleevec**	**Ofloxacin Inj**	**Restatis**	**Ultram**
Amphotericin B Inj	**Copegus**	**Halotestin**	**Orthoclone**	**Retin A**	**Venoglobulin**
Anabolic Steroids	**Delatestryl**	**Hepsera**	**Oxandrin**	**Ribavirin**	**Vfend**
Anadrol	**Depo Testosterone**	**Humatrope**	**Oxycodone SR**	**Ritalin/SR/LA**	**Vfend Inj**
Androgel	**Desoxyn**	**Humira**	**Panretin**	**Roferon**	**Vidaza**
Anzemet	**Dexedrine**	**Infergen**	**Pegasys**	**Saizen**	**Vitraset**
Apokyn	**Diflucan 150mg Tab**	**Intron A**	**Peg-Intron**	**Sandimmune**	**Winstrol**
Arava	**Dobutamine Inj**	**Iressa**	**Penlac**	**Sandoglobulin**	**Xifaxin**
Atrovent Amp	**Dopamine Inj**	**Kepivance**	**Pentamidine Inj**	**Sensipar**	**Xolair**
Avastin	**Doxycycline Inj**	**Kineret**	**Prograf**	**Skelid 200mg**	**Xoponex**
Avelox Inj	**DuoNeb**	**Kytril**	**Prolastine Inj**	**Somavert**	**Zavesca**
Avonex	**Elidel**	**Lotrenox**	**Protonix Inj**	**Stadol NS**	**Zelnorm**
Balcofen Inj	**Emend**	**Lunesta**	**Protopic**	**Straterra**	**Zenapax**
BCG Vaccine	**Enbrel**	**Metadate CD**	**Protropin**	**Symlin**	**Zithromax Inj**
Betaseron	**Erbitux**	**Methotrexate (MTX)**	**Provigil**	**Tamiflu**	**Zofran**
Botox	**Farbazyme Inj**	**Methylin ER**	**Pulmicort Resp.**	**Tarceva**	**Zyvox**
Brethine Amp	**Fludarabine Inj**	**Metronidazole Inj**	**Pulmozyme**	**Targretin Gel**	
Byetta	**Focalin**	**Mucomyst**	**Rapamune**	**Tazorac Cream**	
Camptosar Inj	**Forteo**	**Myfortic**	**Raptiva**	**Testim**	

ALTERNATIVE DISPUTE RESOLUTION

1. Binding Arbitration.

Except as otherwise provided in the Agreement, the Parties agree that any controversy or claim including, but not limited to, any alleged class actions, arising out of or relating to the Agreement or the breach thereof, whether involving a claim in tort, contract or otherwise, that cannot be resolved by informal means, shall be settled by final and binding arbitration as its exclusive remedy. A party aggrieved by the alleged failure, neglect, or refusal of another to arbitrate under the Agreement for arbitration may petition the applicable United States District Court of Texas for an order directing that such arbitration proceed in the manner provided for in the Agreement. The Parties expressly agree, however, that the right of either party to terminate the Agreement pursuant to the Agreement and Bravo Health's right to withdraw from a service area is absolute and shall not be subject to arbitration. All arbitration proceedings shall take place in the applicable State in which Provider is to provide Covered Services under the Agreement.

2. Rules for Arbitration.

The Parties agree to adopt the Rules of Procedure for Arbitration ("Rules") and the Code of Ethics for Arbitrators ("Code") of the American Health Lawyers Association Alternative Dispute Resolution Service (collectively referred to as "AHLA"). The AHLA Rules and Code for Arbitration shall apply to any arbitration under the Agreement unless otherwise specifically stated or supplemented in the Agreement. In the event of any conflict between the AHLA Rules and Code for Arbitration and the Agreement, the provisions of this language and the Agreement shall control.

3. Demands for Arbitration and Selection of Arbitrators.

The demand for arbitration shall be in writing and shall be served in the manner prescribed in Section 7.9 of the Agreement. The demand for arbitration shall set forth a detailed statement of the issue and facts supporting the arbitration demand, shall specify the matters to be arbitrated, including identification of the Section or Article of the Agreement in dispute, and shall identify the name and address of the Arbitrator chosen by the Party making such demand. The other Party to the dispute shall appoint an Arbitrator, shall give written notice of such appointment in accordance with Section 7.9 to the other Party, and shall specify the name and address of such Arbitrator within forty-five (45) calendar days after receipt of the demand,. If such Party fails to appoint an Arbitrator and notify the other Party as herein provided within such forty-five (45) calendar day period, the Party making the arbitration demand shall have the right to apply to the Chief Judge of the United States District Court of Texas for the appointment of an Arbitrator. Each Arbitrator must have a minimum of ten (10) years of legal experience or professional experience in the healthcare industry.

4. Procedure for Selection of Third Arbitrator.

The two (2) Arbitrators appointed or selected as set forth in Section 6.4 shall appoint a third Arbitrator as soon as practicable, or if they do not do so within forty-five (45) calendar days after notice is given to the Parties of the appointment of the second Arbitrator, any Party may apply to the Chief Judge of the United States District Court of Texas for the appointment of an Arbitrator. After the appointment of the third Arbitrator, the Arbitrators shall hold a preliminary conference with the Parties within thirty (30) days to define and narrow the issues and claims to be arbitrated. The arbitrator may, at the preliminary conference, establish the extent of and schedule for the production of documents and other information, identify the form of evidence to be presented, and limit discovery.

5. **Scheduling and Timing of Arbitration**.
The arbitrators must begin the formal arbitration hearing within one hundred-twenty (120) days of the date the last arbitrator is appointed. The arbitration hearing must be completed within sixty (60) days following the close of discovery. The parties and arbitrators shall use their best efforts to ensure that the arbitration hearing proceeds in a timely fashion without unnecessary delay ("unnecessary delay" is defined as a period of time that exceeds five (5) consecutive business days). The Parties must ascertain the ability of each arbitrator to comply with this scheduling requirement as a condition of his/her selection as an arbitrator. If the arbitration hearing is not begun within this period, either Party shall have the right to file suit, a motion, a petition, or otherwise commence a legal proceeding in the United States District Court of Texas and shall have the right to refuse to participate further in any arbitration proceeding related to the same dispute.

6. **Discovery.**
In any such arbitration proceeding, each Party thereto shall have access to the relevant books and records of the other Party and the power to call any employee, agent or officer of any other Party for testimony and shall have all other rights to discovery afforded under the Federal Rules of Civil Procedure, as well as the rules or laws applicable to the Federal District Court proceedings in Texas, all of which shall be fully enforceable by the arbitrators or, if they fail to effect such enforcement, by the United States District Court of Texas. Any discovery by the Parties to the arbitration shall be performed within a discovery period to be defined and limited by the arbitrators, but in no event shall such discovery period exceed ninety (90) calendar days following the preliminary conference, unless an extension is mutually agreed upon in writing by the Parties.

The parties agree that each will be limited to a maximum of twenty-five (25) (including subparts) written interrogatories and/or written document requests and/or written requests for admissions. Responses to written discovery are due within thirty (30) days of service. Upon motion by the aggrieved party, the arbitrators may enter any appropriate orders for non-compliance with discovery requests against the other party up to, and including, preclusion of the presentation of certain evidence not produced in a timely fashion. The parties may agree to reasonable extensions to respond to the other's discovery requests so long as the extension does not extend the overall discovery period beyond ninety (90) calendar days following the preliminary conference.

Each party will be limited to no more than five (5) party opponent depositions and the parties agree to make requested employees available for deposition within forty-five (45) days of such a request. If either party believes a deposition has been requested in bad faith or for the purposes of harassment, delay or otherwise, either party may move for an appropriate protective order and the arbitrators shall rule on such protective order. Either party may also move for additional depositions or deponents should the issues reasonably require and the arbitrators shall rule on such request.

The arbitrators shall strictly enforce these discovery limits. With respect to any motions to extend or expand discovery, the arbitrators shall not agree to do so unless, the requesting party has shown good cause as to why the additional or expanded discovery is necessary.

On motion by either Party and for good cause shown, the arbitrators shall have the power to enter and impose any appropriate protective orders limiting use and disclosure of any information submitted during, or related to, the arbitration. In addition, the arbitrators shall abide by any protective orders agreed upon by the Parties.

7. **Evidence**.
Any arbitration pursuant to this Section shall be conducted by the Arbitrators under the guidance of the Federal Rules of Evidence. The Arbitrators, however, shall not be required to conform strictly to such Rules in conducting any such arbitration. The Arbitrators shall conduct such evidentiary or other hearings as they deem necessary or appropriate and thereafter shall make their determination within ten (10) days of any evidentiary hearing or motion.

The parties may offer such non-duplicative evidence as is relevant and material to the dispute and shall produce such evidence as the arbitrators may deem necessary to an understanding and determination of the dispute. An arbitrator or other person authorized by law to subpoena witnesses or documents may do so upon the request of a Party or upon the arbitrators' own motion.

The arbitrators shall be the judges for the duplicative nature, relevance and materiality of the evidence offered and, as noted above, the Federal Rules of Evidence shall serve as guidance; however, strict conformity is not necessary. The arbitrators should refuse to allow the introduction of any evidence that the arbitrators believe would result in the disclosure of confidential information which is privileged under any applicable statute or under applicable law, including, but not limited to, information subject to: (a) a peer review privilege; (b) a patient-physician privilege; (c) an attorney-client privilege; or (d) any business proprietary or trade secret privilege. All evidence shall be taken in the presence of the arbitrators and all of the Parties and the Parties' counsel and other authorized representatives, except where a Party is absent after due notice has been given or has waived the right to be present.

8. **Judgment and Award of Arbitrators**.
The arbitrators shall render their decision and award upon the concurrence of at least two (2) of their number. Such decision and award shall be in writing and shall be signed by all three (3) arbitrators. Thereafter, counterpart copies thereof shall be delivered to each of the Parties simultaneously. In rendering such decision and award, the arbitrators shall not add to, subtract from, or otherwise modify the provisions of the Agreement or any agreement entered into pursuant hereto. The arbitrators shall have the power to grant and award only legal remedies in the form of monetary damages as provided by Texas law, except that the arbitrators shall not have the power to award punitive or exemplary damages. As used herein, punitive or exemplary damages include, but are not limited to, multiple damage awards and any award of attorneys' fees, regardless of whether these types of damages are based on statute or common law. Notwithstanding the above, in the event that either Party wishes to obtain injunctive relief, such as a permanent or temporary restraining order, such Party may initiate an action for such relief in a court of competent jurisdiction in the State of Texas. The decision of the court with respect to the requested injunctive relief shall be subject to appeal only as allowed under applicable state or federal law. However, the courts shall not have the authority to review or grant any requests or demands for damages.

The judgment and award of the arbitrators shall be accompanied by detailed written findings of fact and conclusions of law. At any time within one year after the award is made, any party to the arbitration may apply to the United States District Court of Texas for an order confirming the award.

9. **Confidentiality of Arbitration**.
Except in connection with the enforcement of such award or as otherwise may be required by law, all aspects of such arbitration proceeding will be held in strict confidence by the Parties and arbitrators and shall not be disclosed to any third party without the prior written consent of the disclosing Party. The parties agree that a breach of the terms of this confidentiality requirement will cause immediate and irreparable harm to the disclosing party. As such, in addition to any other rights or remedies available at law or in equity, the disclosing party is entitled to injunctive relief to restrain or enjoin such breach without the need to prove actual damages.

Within sixty (60) days of the date of the decision and award of the arbitrators, the Parties agree to return and/or destroy and provide certification of destruction of any confidential materials provided by the other party during arbitration process. The arbitrators will also return and/or destroy and provide certification of destruction of any confidential materials provided to them by the Parties during the arbitration process. The Parties and their respective counsel are permitted to keep their own confidential materials along with any attorney client privileged communications or attorney work products.

10. **Fees and Transcript of Arbitration**.
The fees and expenses of each arbitrator and all other costs and expenses incurred in the arbitration, including reasonable attorneys' fees shall become due as specified in the arbitration award. The arbitration award shall not include any punitive, exemplary, or other non-economic damage component. A full and complete record and transcript of the arbitration proceeding shall be maintained. If either Party desires a copy of the record and transcript, that Party shall bear the fees and expenses for the record and transcript. If both Parties desire a copy then such fees and expenses will be equally shared between the Parties.

11. **Limitation of Other Proceedings**.
Each Party agrees that it will not file, nor will it cause any other individual or entity to file, any suit, motion, and petition or otherwise commence any legal proceeding which must be submitted to arbitration pursuant to the Agreement. Upon the entry of an order dismissing or staying any such action or proceeding in a court, the Party that filed such action or proceeding shall promptly pay to the other Party the attorney's fees, costs, and expenses incurred by such other Party prior to the entry of such order.

Bravo Health Adult Prevention and Screening Guidelines - 2008

This chart of suggested services has been adapted from the U.S. Preventive Services Task Force Recommendations, American Diabetes Association, and American Medical Association by Bravo Health Clinicians. It is intended to provide guidance to practitioners in selecting appropriate prevention and screening services for Bravo Health Members. It contains guidelines only and should never supersede clinical judgment. The practitioner in conjunction with the patient or responsible party should decide whether these or other recommended services should be performed more frequently, less frequently, or not at all. As with all services provided to Bravo Health Members, the clinical judgment and the discussion around it should be documented in the medical record. (March 17, 2006)

Health Maintenance	**Frequency**
Physical Assessment	Within 30 days of enrollment & yearly
Height & Weight	Yearly
Blood Pressure	Each visit and at least yearly
Lipid Profile	Initial assessment & periodically
Thyroid screening	Initial assessment & periodically
Diabetes screening	Initial assessment & every 3 years. Earlier for high risk patients at the discretion of the physician
Obesity screening (BMI)	Initial assessment & yearly
Screening for Depression	Periodically according to patient's needs
Hearing screening	Periodically according to patient's needs
Vision screening	Periodically according to patient's needs
Glaucoma screening	Periodically according to patient's needs
Colon Cancer screening • Colonoscopy • Fecal Occult Blood	Every 10 years Yearly
Aspirin use for the prevention of cardiovascular events	Discuss with adults who are at increased risk for cardiovascular disease (men>40 years and post-menopausal women). Discussions should address both the potential benefits and harms of aspirin therapy
PPD	Periodically according to patient's needs

Discussion and Counseling (All Members)	**Frequency**
Diet	Initial assessment and yearly for obese adults (BMI>=30)
Exercise	Initial assessment and periodically
Physical Activity	At least yearly
Tobacco Use	At least yearly
Alcohol use	At least yearly
Dental health	At least yearly
Fall Prevention	At least yearly
Vehicle Safety	At least yearly
Safe Sexual Practice	At least yearly
Immunization	**Frequency**
Influenza	Yearly
Pneumococcal vaccine	One dose for persons under 65 who have chronic disorders of cardiovascular or pulmonary systems, diabetes, renal dysfunction, or immunosuppression. One dose for nursing home residents One dose for person age 65 and older One dose revaccination for persons age 65 and older if 5 years or more have past since the last dose
Tetanus-diphtheria booster	Every 10 years

Females Only		**Males Only**	
Health Maintenance	**Frequency**	**Health Maintenance**	**Frequency**
Pelvic exam and pap smear	At least every three years up to age 70.	Prostate Cancer screening • Digital rectal screening • PSA	Case – by - Case basis Case – by - Case basis
Breast examination	Yearly	Abdominal Aortic Aneurysm • Abdominal ultrasonography	Screening for men aged 65-75 years who have ever smoked
Mammography	Every 1-2 for women age 40 and older Yearly for women age 50 and older		
Osteoporosis	Routine screening beginning at age 65. Screening for women with increased risk for osteoporotic fractures beginning at age 60		

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