

Bravo Health
Private Fee-for-Service
Provider Reference Guide



Bravo Health Contact Information

Member Services

To check claim status, update facility or practice data, or appeal submission process, please call: [1-800-291-0396](tel:1-800-291-0396).

Available Monday through Friday, 8 am – 8 pm.

Eligibility Verification

Member Services provides eligibility and copayment information for plan members. Please call:

Phone: [1-800-291-0396](tel:1-800-291-0396)

TTY/TTD: [1-800-964-2561](tel:1-800-964-2561)

PFFS Provider Relations Department

Phone: [443-573-8881](tel:443-573-8881)

Fax: [410-537-8936](tel:410-537-8936)

Available Monday through Friday, 8 am – 5 pm.

Formulary/Pharmacy

For a copy of a Bravo Health Formulary or Pharmacy Directory, please visit Bravo Health's website at www.bravohealth.com.

For Formulary Exceptions, please call: [1-877-813-5595](tel:1-877-813-5595).

Health Services

To obtain an advance determination of coverage, please call or fax:

Phone: [1-888-454-0013](tel:1-888-454-0013)

Fax: [1-866-464-0707](tel:1-866-464-0707)

Payment Dispute Process

Submit disputes in writing to pffsinq@bravohealth.com or fax your disputes to [410-537-8936](tel:410-537-8936) within 120 days of the date payment is received by the provider.

Online Services

You may obtain Bravo Health's Terms and Conditions of Payment, Reimbursement Grid, and/or additional PFFS materials via:

Internet: www.bravohealth.com

Phone: [443-573-8881](tel:443-573-8881)

E-mail: pffsinq@bravohealth.com

Claims

Electronic claims may be submitted through Emdeon (WebMd) or Availity (T.H.I.N) using Carrier Code #52192.

Paper claims must be submitted within 180 days to:

Bravo Health – Bravo Liberty Claims
P.O. Box 981706
El Paso, TX 79998-1706

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Overview of Bravo Health’s Private Fee-for-Service Plans

Bravo Liberty Private Fee-for-Service (PFFS) plans are Medicare Advantage plans offered by Bravo Health. The plans are available in various counties in the Mid-Atlantic region, Texas, and Pennsylvania. A detailed list of states and counties in our service area can be found under the heading *Bravo Health Private Fee-for-Service Plans*.

Bravo Liberty plans are PFFS plans that offer members flexible plan premiums and benefit options often at a lower cost than Original Medicare. These plans are also available with or without Medicare Part D Prescription Drug coverage.

Bravo Liberty plans allow members the freedom to visit any doctor, hospital, or health care professional that accepts Bravo Health’s Terms and Conditions of Payment. Members enrolled in a Bravo Liberty plan retain the same rights as a beneficiary enrolled in Original Medicare. Bravo Liberty members receive the same or better benefits than Original Medicare, including the following:

- ▶ Plans with \$0 copayments for generic prescriptions
- ▶ Flexible benefit plans that offer varying levels of copayments and premiums
- ▶ Generally lower out-of-pocket costs (copayments) than Original Medicare
- ▶ No annual deductibles or out-of-pocket maximums
- ▶ Coverage of Medicare Part A (inpatient hospital), Part B (outpatient care and doctor visits), and, in some cases, Part D (prescription drugs) through one carrier

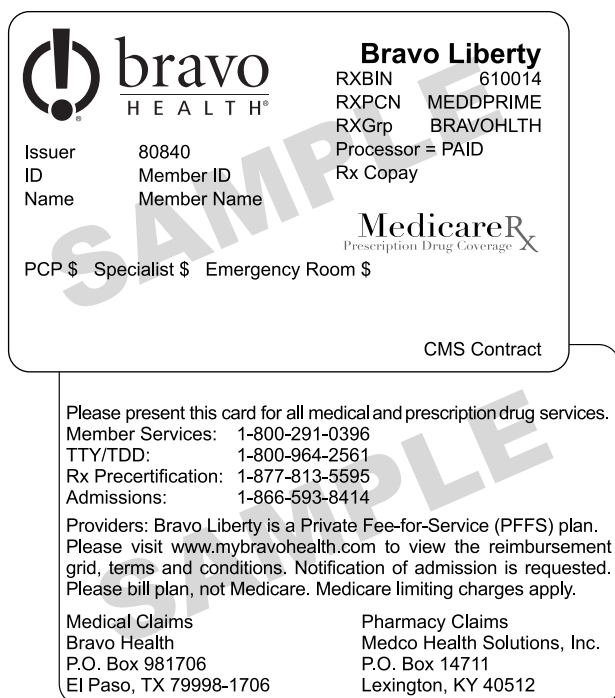
Bravo Liberty Member ID Cards

How does a provider know that a Medicare beneficiary is enrolled in a Bravo Liberty plan rather than Original Medicare?

A Bravo Liberty member should inform the provider before receiving a service that they are enrolled in a Bravo Liberty plan. The member will show the provider their Bravo Health identification card identifying him or her as a member of a Bravo Liberty plan. In addition, the identification card will specify a toll-free phone number and website where the provider may obtain Bravo Health’s Terms and Conditions of Payment. (Providers should be sure to use the telephone number(s) and address(es) noted on each particular member’s Bravo Liberty ID card.)

Bear in mind that possession of a Bravo Health identification card does not guarantee eligibility, and providers should verify eligibility through the Bravo Health eligibility verification process by calling [1-800-291-0396](tel:1-800-291-0396).

Bravo Liberty Member ID Card Sample



Bravo Health Private Fee-for-Service Plans

Bravo Liberty Plan Types

Medicare Advantage-Only plans without Prescription Drug Coverage include:

- ▶ Bravo Liberty Silver
- ▶ Bravo Liberty I
- ▶ Bravo Liberty II

Medicare Advantage plans with Prescription Drug Coverage include:

- ▶ Bravo Liberty II Rx
- ▶ Bravo Liberty Bell

Marketed Mid-Atlantic Service Areas

Delaware

Kent, New Castle, Sussex Counties

District of Columbia

Washington, DC

Maryland

Anne Arundel, Calvert, Charles, Dorchester, Garrett, Harford, Howard, Prince George’s, Washington Counties

Marketed Pennsylvania Service Areas

Adams, Carbon, Cumberland, Dauphin, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Northampton, Perry, York Counties

Marketed Texas Service Areas

Atascosa, Bexar, Brazoria, Chambers, Collin, Dallas, Denton, El Paso, Ellis, Fort Bend, Galveston, Guadalupe, Harris, Johnson, Liberty, Medina, Montgomery, Parker, Rockwall Counties

To learn more about Bravo Health’s Private Fee-for-Service plans, please visit our website at www.bravohealth.com.

Who is eligible to enroll in a Bravo Liberty plan?

Members who are eligible for Original Medicare Parts A and B.

How do members access health care professionals?

Member can choose any physician or health care professional that accepts Bravo Health's Terms and Condition of Payment.

Does a primary care physician have to make a referral to a specialist?

No. A referral is not needed.

Is the treating physician required to notify Bravo Health for care coordination or authorization?

No. But, they have an option to request an Advanced Determination of Coverage to confirm medical necessity.

Advanced Determination

How do I know if a service a patient needs is medically necessary?

Medicare Private Fee-for-Service plans must use Medicare's coverage rules in determining what services are medically necessary. That means if a service is medically necessary under the Original Medicare plan, then the Medicare Private Fee-for-Service plan must cover the service. You can also request a written Advance Determination of Coverage decision from Bravo Health to make sure the service is medically necessary and will be covered. Visit Bravo Health's website at www.bravohealth.com to obtain or complete an Advanced Determination of Coverage Form.

About Bravo Liberty Plans

Background Information

How does a Bravo Liberty plan work?

Bravo Liberty operates similar to Original Medicare. Provider participation is voluntary, and providers who accept Medicare are eligible to become deemed providers. Providers will treat Bravo Liberty members as they would if the member had Original Medicare while following all Medicare regulations.

What advantages does a Bravo Liberty plan offer providers?

Bravo Health offers the following benefits for providers:

- ▶ Ease of administration
 - *No authorizations or referrals required*
 - *No network or contract requirements between Bravo Health and providers*
 - *Resources to check eligibility, copayments, and status of payments*
- ▶ Provider payment at current Medicare rates, which follow Medicare guidelines
- ▶ Bravo Health Provider Relations Department available to assist providers and their staff

Does each Bravo Liberty plan cover everything Original Medicare covers?

Yes. By law, all Bravo Liberty plans must provide members with at least the same benefits they would receive under Original Medicare. However, Bravo Liberty may offer extra benefits in addition to those provided by Original Medicare. Any extra benefits offered by the plan will be specified in Bravo Health's Terms and Conditions of Payment.

Bravo Health's Terms and Conditions of Payment

What are the Terms and Conditions of Payment?

The Terms and Conditions of Payment establish the rules providers must follow if they choose to render services to a Bravo Liberty member. At a minimum, the Terms and Conditions of Payment will specify:

- ▶ The amount Bravo Health will pay for all plan-covered services;
- ▶ The appropriate provider billing procedures; and
- ▶ The amount the provider is permitted to collect from a Bravo Liberty member and whether the provider must obtain prior authorization from Bravo Health before rendering a particular service.

If the provider renders a service to a Bravo Liberty member that is not covered by Bravo Health, Bravo Health is not required to pay for the service. Bravo Health is, however, required to make its Terms and Conditions of Payment available to providers who have the potential to treat Bravo Liberty members. Providers may access Bravo Health's Terms and Conditions of Payment at www.bravohealth.com, or by calling Bravo Health's Member Services Department at 1-800-291-0396.

Provider Requirements

What steps do providers need to take prior to treating Bravo Liberty plan members?

Providers do not need to sign any contracts or notify Bravo Health prior to treating Bravo Liberty members. Rather, providers need to verify the member's eligibility with Bravo Health, review and accept Bravo Health's Terms and Conditions

of Payment prior to rendering services, and submit all claims directly to Bravo Health.

What qualifications must providers have to render services to Bravo Liberty plan members?

Physicians must be licensed in the state where they will provide care, have a Medicare billing number (or be eligible to obtain one), and participate in Original Medicare in order to provide services to Bravo Liberty plan members.

Institutional providers, such as hospitals and skilled nursing facilities, must be certified to treat Medicare members.

Does a provider have to be credentialed?

No. Credentialing paperwork is not required to become a deemed provider for Bravo Liberty members.

What does it mean for a provider to be "deemed" by Bravo Health for Bravo Liberty plans?

A provider is considered a "deemed" provider if the following conditions are met:

- a) In advance of rendering services, the provider must know that a patient is enrolled in a Bravo Liberty plan;
- b) The provider possesses and has access to Bravo Health's Terms and Conditions of Payment; and
- c) The provider adheres to Bravo Health's Terms and Conditions of Payment.

It is important to note that a provider is not required to render health care services to a Bravo Liberty member. When a provider chooses to provide services to a Bravo Liberty member and the above deeming conditions have been met, the provider automatically becomes a deemed provider (for that member) and must follow Bravo Health's Terms and Conditions of Payment.

However, every Bravo Liberty member has the right to obtain emergency care when and where they need it without any prior approval from their PFFS plan. If the member's health is in serious danger (i.e., severe pain, serious injury, sudden illness, or illness that is quickly getting much worse), the member can obtain emergency care anywhere in the United States and from any provider.

How does the deeming process work?

Once the provider is aware that the member is enrolled in a Bravo Liberty plan, it is up to the provider to access Bravo Health's Terms and Conditions of Payment. Accordingly, if the provider renders services to the member, the provider will automatically be considered a deemed provider who is bound by Bravo Health's Terms and Conditions of Payment.

What happens if a provider renders services to a Bravo Liberty member, but the deeming conditions have not been met?

If a provider renders services to a Bravo Liberty member and the deeming conditions have not been met, the provider is considered to be a non-deemed provider. The first time a provider renders services to a Bravo Liberty member, the provider will be paid as a non-deemed provider. If the deeming conditions continue to remain unmet and the provider decides to again treat a Bravo Liberty member, the provider will be paid as a deemed provider.

It is important to note that a provider can choose whether or not they will furnish services to a member enrolled in a Bravo Liberty plan, but if a provider furnishes services, the provider cannot choose whether they are classified as a deemed or a non-deemed provider. If a provider is aware that the person is enrolled in a Bravo Liberty plan in advance of providing care, and the provider either possesses or has access to Bravo Health's Terms and Conditions of Payment, the provider is automatically a deemed provider.

Is a provider who already accepts Medicare assignment required to provide care to a Bravo Liberty member?

No. Providers are not required to see a Bravo Liberty member. Providers may choose whether to provide routine care to a Bravo Liberty member on a per-member basis. If a provider renders care to a Bravo Liberty member and the deeming process has been fulfilled, the provider is then bound by Bravo Health's Terms and Conditions of Payment.

Any provider may provide emergency care to Bravo Liberty members. Those providers who have not accepted Bravo Health's Terms and Conditions of Payment will be treated as non-deemed providers and paid at Original Medicare rates.

Claims and Billing

In accordance with the contract Bravo Health maintains with CMS, Bravo Health must follow prescribed Medicare Advantage guidelines with respect to prompt payment requirements to providers. Under these guidelines, Bravo Health must pay 95% of clean claims within 30 days of receipt for services rendered under deemed or written contracts. Bravo Health must pay interest on all clean claims that are not paid within 30 days. All other claims must be approved or denied within 60 days of receipt for services rendered.

Can a deemed provider independently bill a member for services?

No. If a provider chooses to treat a Bravo Liberty member as a deemed provider, they may only bill the member for applicable cost-sharing. The provider must bill Bravo Health for the member's covered health care services. The member is required to pay only the applicable copayment or coinsurance amount for their plan for the service the member receives.

Can a provider bill the beneficiary if Bravo Health will not pay?

No. Any provider who renders care to a Bravo Liberty member can only collect from the beneficiary the amount allowed under Bravo Health's Terms and Conditions of Payment. Thus, the provider collects the appropriate cost-sharing from the member, and Bravo Health pays the remainder of the amount due for the services rendered. Bravo Health is accountable for any other amounts owed to the provider for the covered care. If the care provided is not covered under the plan, the provider can collect from the beneficiary only for the non-covered care. For example, if the member's Bravo Liberty plan does not cover routine hearing exams, but a provider performs a routine hearing exam for the member, the provider may collect payment from the member for that service.

Does Bravo Health allow balance billing?

No. If they accept assignment from Original Medicare, a provider must agree **not** to balance bill members and can collect from members **only** the members' applicable cost-share amounts. Other than the cost-share amount, the provider will receive payment from Bravo Health as outlined in Bravo Health's Terms and Conditions of Payment. For additional information relative to how much a provider is paid, see the section entitled *Provider Payment* later in this guide.

If a provider does not agree to Bravo Health's Terms and Conditions of Payment, the provider should not provide services to a Bravo Liberty member, except in the case of an emergency. If the provider chooses to treat a Bravo Liberty member anyway without accepting Bravo Health's Terms and Conditions of Payment, the provider still cannot bill the Bravo Liberty member for services. The provider must bill Bravo Health for all covered health care services.

If a provider bills Original Medicare for Bravo Liberty claims, will the claims be denied?

Yes. Claims for services provided to members of a Bravo Liberty plan will not be paid by Original Medicare and will be rejected. Providers must submit all Bravo Liberty claims to Bravo Health.

Do you follow Medicare coding, billing, and bundling guidelines?

Yes. Bravo Liberty claims are paid just as if the member was enrolled in Original Medicare.

Does the provider use the same forms and coding as Original Medicare?

Bravo Health's Terms and Conditions of Payment will specify the form and content of the claim the provider must submit to Bravo Health.

What is the claims submission process?

Please use original CMS-1500 or UB92/UB04. All claims must be submitted within 180 days of service.

Providers must submit claims directly to Bravo Health through Bravo Health's claims system. Bravo Health accepts both paper and electronic submission.

Paper Claims

Where should a provider send paper claims?

Bravo Health - Bravo Liberty Claims
P.O. Box 981706
El Paso, TX 79998-1706

Electronic Claims

What online tools does Bravo Health have to assist providers in filing accurate electronic claims?

Bravo Health provides electronic claim submission capabilities with Emdeon (formerly

WebMD) users, as well as easy to use IVR capabilities to check eligibility status.

Electronic claims may be submitted through Emdeon (formerly WebMD) using Carrier Code #52192.

Clearinghouses

What clearinghouses does Bravo Health use for administering claims?

- ▶ Availity T.H.I.N.
- ▶ Emdeon
- ▶ Payer Path

National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) required issuance of a unique National Provider Identifier (NPI) to each physician, supplier, and other health care providers who conduct HIPAA standard electronic transactions. Please use your NPI when submitting claims for payment. If a claim is submitted with a tax ID number, it will not be processed for payment.

Provider Payment

How does a provider receive payment from Bravo Health?

To be reimbursed by Bravo Health, the provider must submit claims to the mailing address or electronic address provided in Bravo Health's Terms and Conditions of Payment. Section 4 of the Terms and Conditions of Payment establishes how much the provider is compensated by Bravo Health for a given service.

What payment amount will providers receive from Bravo Health?

Bravo Health pays providers at Medicare rates, minus the member's cost-sharing responsibility.

Providers can find additional information regarding payment amounts in Bravo Health's Terms and Conditions of Payment located on our website at www.bravohealth.com, or by calling the Member Services Department at 1-800-291-0396.

How is a non-deemed provider reimbursed by Bravo Health?

If a provider has furnished services to a Bravo Liberty enrollee and the deeming conditions were not met, then the provider is a non-deemed provider. Non-deemed providers are entitled to receive what they would have received under Original Medicare for furnishing a given service. The amount the provider is paid includes the amount the plan allows the provider to collect from the enrollee and the amount the plan pays the provider directly. If the total amount received by the provider (including cost-sharing from the enrollee) is less than the provider would have been paid under Original Medicare, Bravo Health must pay the provider the difference.

What is an estimated Medicare payment amount?

An estimated Medicare payment amount is an estimate of the dollar amount that Original Medicare would have paid for certain Medicare covered services. In many cases, providers are entitled to receive the same dollar amount they would have been paid by Original Medicare for a given service. A provider will be paid an estimated Medicare payment amount for those services where Original Medicare lacks a fee schedule or prospective payment amount that could readily be used by Bravo Health to pay providers.

Bravo Health's Terms and Conditions of Payment will inform providers if they are entitled to receive a payment amount equal to what they would have received under Original Medicare.

Will providers still receive the same Health Professional Shortage Area (HPSA) bonus that Original Medicare pays every quarter?

Yes. If you treat Bravo Liberty members in a recognized HPSA zip code/service area, Bravo Health will pay the HPSA bonus at the same time we pay the member's claim – no waiting up to three months to receive your bonus!

How long will it take for Bravo Health to pay a provider?

Let us emphasize again, Bravo Health is required by law to process all error-free claims (known as “clean claims”) within 30 days of receipt.

To aid in even faster claim processing, providers can pre-register with Bravo Health to facilitate timely and accurate adjudication by contacting Bravo Health's Member Services Department at [1-800-291-0396](tel:1-800-291-0396). To learn more about the adjudication process, please visit Bravo Health's website at www.bravohealth.com.

What happens if Bravo Health pays a deemed provider less than what the provider believes they are entitled to receive?

If a provider is deemed and provides services to a Bravo Liberty member, the total amount of payment they are entitled to receive, including any beneficiary cost-sharing and the amount the plan will pay, will be specified in Bravo Health's Terms and Conditions of Payment. The provider is responsible for collecting the allowable cost-sharing from the member. Bravo Health must pay providers the amount specified by the Terms and Conditions of Payment.

Payment Disputes

As a physician or other health care provider rendering covered services to a Bravo Liberty member, you have the right to file a dispute if you disagree with the payment made to you for services provided by calling Bravo Health's Member Services at [1-800-291-0396](tel:1-800-291-0396). If you wish to submit a dispute in writing, please include supporting documentation with your request, and submit your dispute via one of the following methods:

- ▶ Secure e-mail: pffsinq@bravohealth.com
- ▶ Fax: [410-537-8936](tel:410-537-8936)
- ▶ Mail: Bravo Health
Attn: PFFS Provider Relations Department
3601 O'Donnell Street
Baltimore, MD 21224

Appeals

What if a provider disagrees with the payment issued by Bravo Health?

Providers may appeal any claim they feel was incorrectly paid by Bravo Health.

Providers have rights regarding appeals and grievances with Bravo Health in accordance with the guidelines issued by CMS.

Providers have the right to initiate a Provider Appeal and seek to have Bravo Health review and/or change plan decisions. When appealing payment decisions, the patient must be or have been an enrolled member of a Bravo Liberty plan at the time services are/were rendered.

If the payment amount a provider receives from Bravo Health (including the enrollee cost-sharing collected) is less than what the provider would have received under Original Medicare for the service, the provider can appeal that payment amount to Bravo Health. To appeal the payment

amount, the provider must provide reasonable documentation to the plan of the Original Medicare payment amount that applies to the service. If it is determined that the provider is paid less than the amount they are entitled to receive, Bravo Health must pay the provider the difference.

What is the time frame for filing a provider appeal?

Providers have sixty (60) days from the date they are notified in writing by Bravo Health of its intent to deny payment or deny authorization for services to file a Provider Appeal.

What must the appeal include?

The request must be in writing and include the following information:

- a) Member's name, date of birth, and Bravo Health Member Identification Number;
- b) Provider name and address; and
- c) Explanation of the specific service and dates of service for which coverage was provided or denied, and the rationale for requesting an appeal.

Can a provider make an appeal on behalf of a Bravo Liberty member?

Providers do have the right to file an appeal on behalf of a Bravo Health member, provided that the member has specifically authorized the provider to act on his/her behalf. A copy of the member's written authorization must accompany the appeal.

Where should a provider appeal be sent?

The appeal should be sent to the following address:

Bravo Liberty
Attn: Appeals and Grievances Unit
P.O. Box 4440
Baltimore, MD 21223

More information about the appeals and grievances procedures and applicable policies is available upon request by contacting Bravo Health's Member Services Department at [1-800-291-0396](tel:1-800-291-0396).

For More Information

The provider must contact Bravo Health to obtain more information about the member's specific Bravo Liberty plan. The Centers for Medicare & Medicaid Services (CMS) is responsible for the oversight of all Medicare Advantage PFFS plans and can provide information about the operation of those plans as well.

For specific contact information, please refer to the Bravo Health Contact Information at the beginning of this manual.



More information about Bravo Health may be found by calling 1-800-235-9188 or on our website at www.bravohealth.com.

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