Our medical management programs include internal programs and those managed by vendor partners. You may be asked to collaborate with us and our vendor partners to help improve quality outcomes.

View all medical management programs on our provider website, **bridgespanhealth.com**: Programs>Medical Management.

Quality Program
Our Quality Program (QP) supports our commitment to evaluate and improve the quality, appropriateness and safety of medical care, behavioral health care and services provided to our members. We use industry standards and benchmarks to identify improvement opportunities and to measure, monitor and evaluate care, service and member experience. All QP goals and objectives align with the Quadruple Aim: the simultaneous pursuit of lowering the cost of care, improving the patient experience, improving the provider experience and improving the quality of care.

Participation in QP activities is a contractual requirement of our agreements with all physicians, other health care professionals and facilities.

Using Provider Data
Measuring and reporting health care quality is important. Network providers acknowledge and agree that the health plan may use the performance data collected through claims, medical records and surveys for quality improvement activities. The performance data collected includes, but is not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Data about coordination of care, information about patient-screening protocols and appointment access data is used to implement quality initiatives aimed at improving care and service, as well as providing members with information and tools to help them make more informed health care choices.

Medical Management
Program eligibility varies by the member's benefits and type of plan, such as a Medicare plan versus a self-funded employer group plan. Learn more about the following programs in the Programs section of our provider website.

Care Management
BridgeSpan care management supports the unique needs of members with acute, chronic and major illness episodes or severe illness conditions. The mission of care management program is to prioritize the needs of our members by providing personalized, equitable services that enhance their wellbeing.

We offer a single-nurse model dedicated to delivering personalized and holistic medical and behavioral health support to each member and their family. Case managers are experienced registered nurses and social workers. Our case managers work closely with providers to help our members improve their health and meet the goals of their providers' treatment plans.

Providers can refer their patients using the *Care Management Request Form* on our provider website: Programs>Medical Management>Care Management.

Members can also self-refer to our program. In addition, we proactively identify and outreach to those members most likely to benefit from additional support, education and collaboration with providers.

Kidney health management

Strive Health manages our kidney health program, which improves care and outcomes for eligible members with chronic kidney disease (CKD) and end-stage renal disease (ESRD). The program focuses on early detection, proper care and treatment choices as the most effective approaches to delay the disease's progression, enabling patients to live better, longer lives.

Personalized Care Support

The Personalized Care Support (PCS) program is a comprehensive set of benefits and supports available to members and their caregivers who are living with serious illness. Our vision is that every person living with serious illness will experience personalized care that is consistent with their values, goals and preference; caregivers will feel included, honored and supported.

The PCS program also helps to provide support to providers who are looking for ways to better address the needs of their patients living with serious illness and who may benefit from specialty palliative care.

Learn more on our provider website: Programs>Medical Management>Personalized Care Support.

Advice24

The BridgeSpan Advice24 nurse advice line gives members direct access to a registered nurse 24/7 who can provide:

- Critical advice and support for emerging health conditions before they become expensive, acute medical events.
- Assistance to members trying to navigate their health and health care system, ensuring the right access to the most appropriate and covered health care services.
- Quick and confidential medical advice and guidance for everyday health issues and questions which could otherwise lead to unnecessary doctor or emergency room visits.

BridgeSpan Bump2Baby*SM*

Bump2Baby is designed to improve the utilization of prenatal services and provide important support to mothers and families-to-be to improve pregnancy and birth outcomes. The program supports and reinforces your treatment plan.

All members receive:

- A welcome packet
- Quarterly newsletters
- Access to a 24-hour maternity nurse line staffed by skilled clinicians.

High-risk members are contacted and encouraged to engage with a nurse for education and support. Low-risk members receive educational newsletters with the option to opt in and work with a nurse to support them throughout their pregnancy.

Verify if your patients are eligible for Bump2Baby by calling 1 (888) 569-2229.

BridgeSpan Advantages
We offer our members discounts from a variety of health-related companies.

Utilization Management Programs
Pre-authorization
Our pre-authorization list is based on the latest medical evidence and reviewed at least annually to ensure the quality and accuracy. Our pre-authorization list is created with a primary focus on member safety, followed by efficacy and cost. Our pre-authorization list is available in available in the Pre-authorization section of our provider website.

Certain services and supplies are considered experimental or investigational and are, therefore, not covered by any of our plans. For a list of investigational services and supplies, please see the *Customized and Significant Clinical Edits* list located on our website: Claims and Payment>Claim Submission>Coding Toolkit.

All pre-authorization requests and post-service pre-payment reviews are first reviewed for member eligibility and benefits for the requested service and then for medical necessity. All participating providers are responsible for obtaining any required pre-authorization. Failure to pre-authorize services subject to pre-authorization requirements will result in an administrative denial, claim non-payment and provider and/or facility write-off. BridgeSpan members cannot be held liable for expenses incurred and cannot be balance billed.

We are fully compliant with all state and regulatory time frames and make utilization management decisions in a timely manner to ensure safe and effective care delivery. If a pre-authorization request is denied, members are notified of their right to appeal in the determination letter. Members can also receive their appeal rights from Customer Service, their Explanation of Benefits following claims processing or their benefit booklet. If a provider would like to discuss a denial, they can request a peer-to-peer review.

Peer-to-peer review
A peer-to-peer (P2P) discussion is a telephone conversation between a licensed BridgeSpan physician and the physician or other health care professional requesting authorization for coverage. A P2P is not an appeal, not specialty matched and not intended to overturn the denial. The purpose is to further understand the reason for the denial based on our medical policies.

P2P discussions may only happen before an appeal has been submitted and only for services which are denied for medical necessity or investigational reasons. A P2P discussion can only be requested for pre-service or concurrent denials, and post-service denials where the member has liability and we have issued a denial letter indicating a P2P is available.

To ensure that the provider has received the denial rational and has been informed of the criteria used for the review, a P2P discussion must be requested:

- After the provider has received the determination letter and
- Within 15 calendar days from the date of the determination letter

To request a P2P discussion, contact our Provider Contact Center. The Provider Contact Center phone number is located in the Contact Us section of our website.

No additional information will be accepted as part of the discussion. If the provider disagrees with our decision or has additional information to submit, they may submit an appeal following the process outlined in the denial letter and/or *Notice of Denial of Medical Coverage* form included with the determination letter.

Learn more about our appeals processes in the Appeals for providers section of our *Administrative Manual*.

Note: All medication-related calls will be routed to a BridgeSpan clinical pharmacist. If there are questions that the clinical pharmacist is unable to answer, the clinical pharmacist will schedule a call with a BridgeSpan medical director.

Post-Service Pre-Payment Reviews

We use a proprietary database logic and predictive models to identify claims that are probable for overpayment due to contract, reimbursement policy and medical policy noncompliance, as well as errors and duplicate charges. When such claims are identified, we perform a 360-degree review to ensure accuracy of payment.

The types of clinical reviews performed include:

- Line-by-line
- Readmission
- Correct coding
- Place of service
- Implantable devices
- Pre-admission testing
- Diagnostic-related group validation
- Hospital-acquired conditions (or HAC)

Providers are notified in writing when a clinical claim review is being performed. We will send the provider written, detailed notification if there are findings. These reviews are performed prior to the completion of claims processing.

For more information about pre-authorization, admissions notification and concurrent review, see the Facility Guidelines section of our *Administrative Manual*.

Physical Medicine program

We have partnered with eviCore to administer our Physical Medicine program. All BridgeSpan members are eligible for the Physical Medicine program. For a physical medicine service or procedure to be covered, providers are required to receive pre-authorization from eviCore for the following:

- Spinal surgeries
- Pain and joint management

Additionally, some joint surgeries performed in a hospital may require pre-authorization for the site of service.

Outpatient therapies providers can access eviCore's online tool from our provider website or via Availity Essentials at **availity.com**.

Radiology program
We partner with Carelon Medical Benefits Management (Carelon) to administer our radiology program.

Providers are required to request authorization in advance of performing specific elective imaging services in the outpatient setting including:

- Nuclear cardiology
- Nuclear medicine imaging
- Positron emission tomography (PET)
- Magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA)
- Computed tomography (CT)/computed tomographic angiography (CTA)
- Stress echocardiography (SE)/resting transthoracic echocardiography (TTE)/ transesophageal echocardiography (TEE)

Sleep Medicine program
We have partnered with Carelon, to administer our Sleep Medicine program. All BridgeSpan members are eligible for the Sleep Medicine program. For the service to be covered, providers must first receive pre-authorization from Carelon for the service to be covered. Providers can access Carelon from our provider website or via Availity Essentials.

The Sleep Medicine program includes:

- Titration studies
- Oral appliances for sleep therapy
- In-lab sleep studies (polysomnography [PSG])
- Initial treatment orders for automatic positive airway pressure (APAP), bi-level positive airway pressure (BiPAP) and continuous positive airway pressure (CPAP)
- Ongoing treatment orders for APAP, BiPAP and CPAP

Providers should contact Carelon to obtain an order number before scheduling or performing any elective outpatient home-based (unattended) diagnostic study or a facility-based diagnostic or titration study (free-standing or hospital), as well as for sleep treatment equipment and related supplies. Authorization for ongoing sleep therapy will be dependent on member compliance data provided to Carelon by the durable medical equipment (DME) vendor.

Notes:

- Supplies for APAP, BiPAP and CPAP do not require pre-authorization
- Compliance information for APAP, BiPAP and CPAP must only be submitted during the rent-to-purchase period. Once the equipment has been purchased, we do not require compliance information.

Cardiac program
We have partnered with Carelon to administer our cardiac program. Providers must first receive pre-authorization from Carelon for cardiac services to be covered. Providers can access Carelon from our provider website or via Availity Essentials.

Pharmacy pre-authorization
Pharmacy pre-authorization information and forms are located on our website: Programs>Pharmacy.

Dental management
We apply appropriate dental care management procedures and conduct retrospective data reviews to ensure that treatment provided:

- Is consistent with widely accepted standards of practice
- Could not have been omitted without adversely affecting the patient's condition or quality of care
- Is not primarily for the convenience of the patient, the participating dental provider or any other person

Polices
Learn more about the following policies and guidelines on our provider website: Library>Policies & Guidelines.

Clinical Practice Guidelines
We support the use of nationally recognized practice guidelines to assist in determinations of the clinical appropriateness of treatment services for medical and behavioral health.

Medical, reimbursement, medication and dental policy
Our policies are used as guidelines for coverage determinations in all health care insurance products, unless otherwise indicated. Benefit determinations are based on applicable member contract language. Plan language will be followed if there are any conflicts between these policies and the Plan.