Bridgeview COMPANY

BlueCross BlueShield Minnesota

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Bridgeview Care Coordination User Guide

The intent of the Bridgeview web tool is to provide a data entry tool for Care Coordinators and support staff to assign care coordinators, retrieve enrollment reports and enter Assessments and Service Agreements for Blue Plus MSHO and MSC+ members.

Updated May 11, 2023

*Recent changes in Red

Table of Contents

GETTING STARTED

Contacts

Resource	Questions

BCBS Help Desk
 	
1-800-333-1758
	• For webtool login username assistance
	• For password assistance
	  ◦ Reset password
	  ◦ Unlock Bridgeview account

Bridgeview.bluecrossmn.com	Bridgeview Company home page for providers ◦ Includes Bridgeview Care Coordinator Web Tool log in link

Bridgeview.service.agreements@bluecrossmn.com
 	
1(800) 584-9488
 	
Monday – Friday 8:00 a.m. - 4:30pm
	• Return completed Bridgeview Care Coordinator Web Tool Access Request form
	  ◦ Add
	  ◦ Remove
	  ◦ Report changes
	• Status of Bridgeview access requests
	• Role access issues
	• Cannot see enrollment reports
	• Any Bridgeview webtool issues (service agreement, LTCC & Case Mix, etc.)

Care Coordination Website - Bridgeview tab	See this page for the following Bridgeview resources:
	• Communiques related to Bridgeview
	• Links to:
	  ◦ Service Agreement Provider & Member Reason Codes
	  ◦ Bridgeview Care Coordination Web Tool Access Request Form
	  ◦ Bridgeview Care Coordination User Guide
	  ◦ Member360 Manual
	  ◦ T2029 Guide for Care Coordinators
	  ◦ DME Payor Determination Checklist
	  ◦ Bridgeview Company home page for providers
	  ◦ EW Transportation information

EWBusPasses@bluecrossmn.com	Used for all non-medical bus pass inquiries/questions, except for lost or stolen bus passes requests in the metro (see below) Request Metro Transit replacement bus pass card for lost or stolen cards (metro only). Include “Replacement

Resource	Questions
	card needed" in the subject line.
EWProviders@bluecrossmn.com 1 (800) 584-9488 Monday – Friday 8:00 a.m. - 4:30 p.m.	Refer Elderly Waiver Providers to these resources to contact Bridgeview related to: • EW Provider registration • Elderly waiver service agreement questions • Elderly waiver claims/billing questions or concerns
Partner.Relations@bluecrossmn.com	Sent completed Bridgeview Care Coordinator Web Tool Access Request form to both Bridgeview and Partner Relations Team (add, remove or changes)
Secureblue.Enrollment@bluecrossmn.com	• Bridgeview HRA audit questions • Enrollment questions • Incorrect delegate assignment(s) • Report discrepancies

Roles/Definitions

Delegate Representative /Support Staff	Full access to Delegate agency dashboard reports and data entry abilities (includes entering HRA info, creating service agreements, submit edit requests and update care coordination assignments). *Support Staff access has been eliminated and has been combined to this role.
Care Coordinators	Access for Care Coordinator to enter their own assessments, service agreement information.

Access

Every individual using Bridgeview Company's web tool will use their email address for log in. The Care Coordination Delegate Representative/Supervisor must complete the Care Coordinator Web Tool User ID Request Form to have a user account created/removed. This form can be found at the Care Coordination website, Bridgeview page.

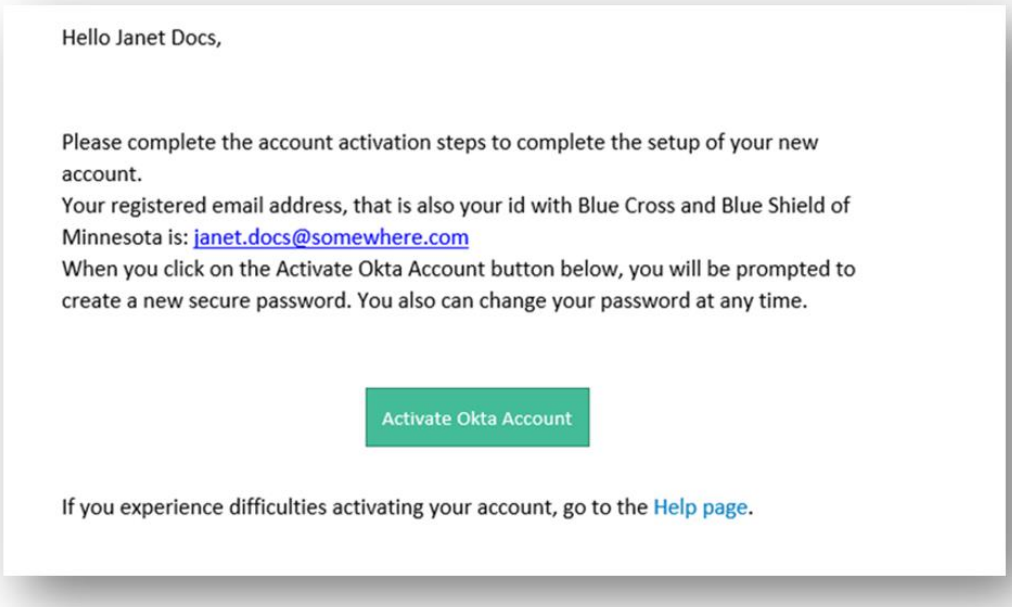
CC Website-Bridgeview page

Completing the Care Coordinator Web Tool User ID Request Form

1. This form should be completed by the Care Coordination Delegate Representative/Supervisor to request or remove access.
2. Select the level of access needed (refer to Roles/Definitions above).
3. Complete the effective date that the Care Coordinator needs access/removal.

4. Bridgeview requires all Care Coordinators to have a DHS assigned UMPI number.
5. If you provide nursing home only care coordination type in “nursing home only” in the UMPI number field and a number will be assigned by Bridgeview staff.
6. If the Care Coordinator does not already have an UMPI number, then they must apply for a permanent DHS Type 27 (MCO) UMPI number with DHS.
7. The Care Coordinator Web Tool User ID Request Form can be submitted through Bridgeview while a request for a DHS UMPI number is being processed.
8. While waiting for the permanent DHS UMPI number, Bridgeview will assign a temporary, unique Bridgeview ID number.
9. Indicate on the Care Coordinator Web Tool User ID Request Form that the permanent UMPI number is pending if submitting the form prior to receiving an UMPI number from DHS.
10. For Delegate Representative/Support Staff are not required to have an UMPI number (leave this field blank on the form).
11. Once an UMPI number is received from DHS, the Delegate/Care Coordinator must update Bridgeview with the UMPI number via email to Bridgeview.service.agreements@bluecrossmn.com.

Once the request has been submitted and processed, the user requesting access will receive an email from carecoordinator.noreply@bluecrossmn.com providing the link to activate their secure Okta account (Screenshot of the e-mail the new user will receive below). Registration will take 10 business days, if you have any questions contact Bridgeview at Bridgeview.service.agreements@bluecrossmn.com.


Hello Janet Docs,

Please complete the account activation steps to complete the setup of your new account.
Your registered email address, that is also your id with Blue Cross and Blue Shield of Minnesota is: janet.docs@somewhere.com
When you click on the Activate Okta Account button below, you will be prompted to create a new secure password. You also can change your password at any time.

Activate Okta Account

If you experience difficulties activating your account, go to the Help page.

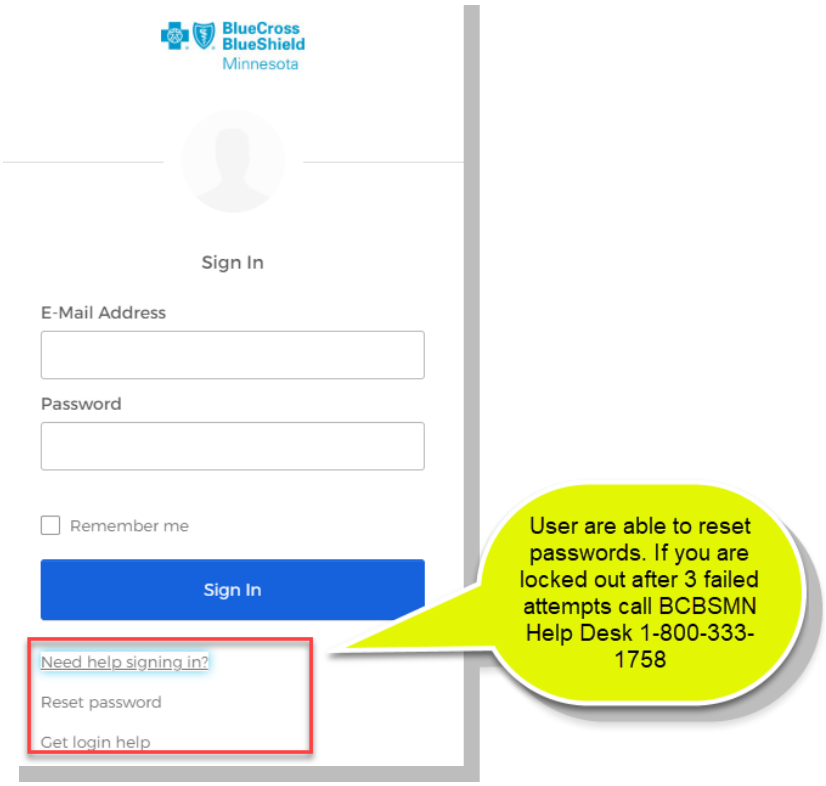
Trouble Shooting Tips

<table>
<tr><th>Issue</th><th>What to do</th></tr>
<tr><td>Unable to modify or save entry in webtool</td><td>

Confirm preferred browser: Google Chrome or Microsoft Edge
Clear your cache
Refer to resource located on Care Coordination Website under the Bridgeview tab: Bridgeview – Instructions for Clearing Cache
Resave your favorite or bookmark
Contact the BCBSMN Help Desk for support 1-800-333-1758

Reset and unlock your own account following the prompts on the bottom of the sign-in page.

If you are locked out of your account, contact the BCBSMN Help Desk 1-800-333-1758



</td></tr>
<tr><td>Receiving a “404” error when logging in</td><td>

Access the Bridgeview Company Website using the direct URL: https://bridgeview.bluecrossmn.com.
Click the link to log into the Bridgeview Webtool
Resave your favorite or bookmark

</td></tr>
</table>

Issue	What to do
Receiving multiple OKTA verification requests in a short period	• Access the Bridgeview Company Website using the direct URL: https://bridgeview.bluecrossmn.com. • Click the link to log into the Bridgeview Webtool • Resave your favorite or bookmark

Removing Access

If a person no longer requires access to the Bridgeview Web Tool, you must inform Bridgeview as soon as possible. Send in the Care Coordinator Web Tool User ID Request Form identifying the person for whom you would like to remove access. Check the Remove checkbox under Access Needed and enter an effective date that access should end. Email the completed form to Bridgeview at Bridgeview.service.agreements@bluecrossmn.com and partner.relations@bluecrossmn.com. All members under the termed Care Coordinator will need to be reassigned. See section "Assigning Care Coordinators to Members".

Inactivity—Access deactivation after 365 Days

We recommend you log in quarterly if you do not access Bridgeview regularly. BCBS Security team will automatically terminate a User after 365 days of inactivity. Please complete a new Web Tool User ID Request Form if access is needed.

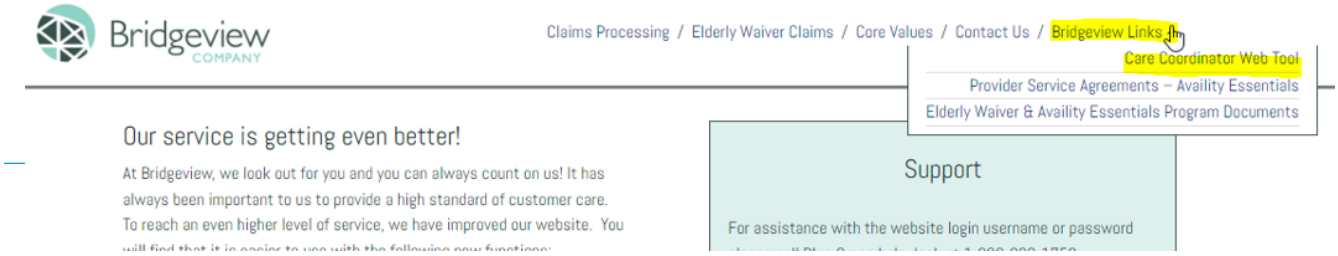
User Contact Information Changes

To request changes to any Users contact information in Bridgeview, email Bridgeview.service.agreements@bluecrossmn.com and partner.relations@bluecrossmn.com with:

1. Your Name
2. Delegate Name
3. Include information that needs changing:
   - New phone number.
   - If name changed—include both previous and current name
   - If e-mail changed—include both previous and current e-mail address

Log In

Go to Bridgeview Company website https://bridgeview.bluecrossmn.com. Mouse over the Bridgeview Links and select Care Coordinator Web Tool. Once you get to the Bridgeview web tool through the Bridgeview web tool link "Save" as a favorite in your web browser to reduce step in the future.

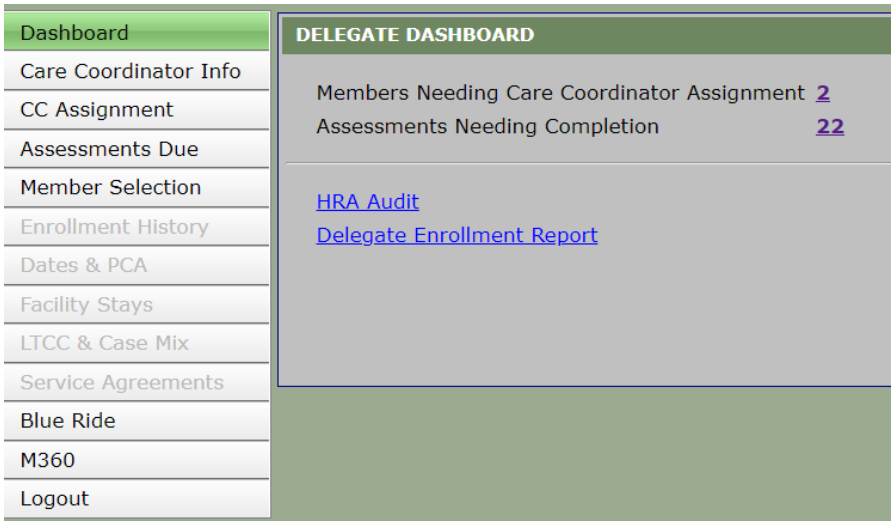


You will then be taken to the Okta Login screen where you will enter your email address and password.
To keep member's PHI secure, the log in process requires a two-step authentication. A "verification code" will be sent to your e-mail address. Enter the verification code once received. You may need to authenticate multiple times a day.

Once you get to the Okta login page you can save the link to your favorites.

AFTER LOG-IN

Delegate/Coordinator Support view

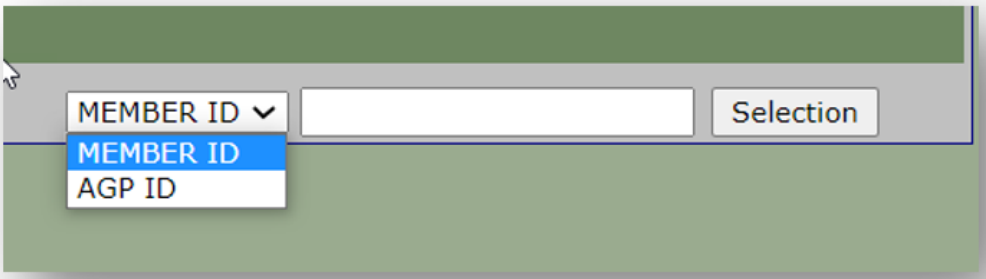


Care Coordinator View

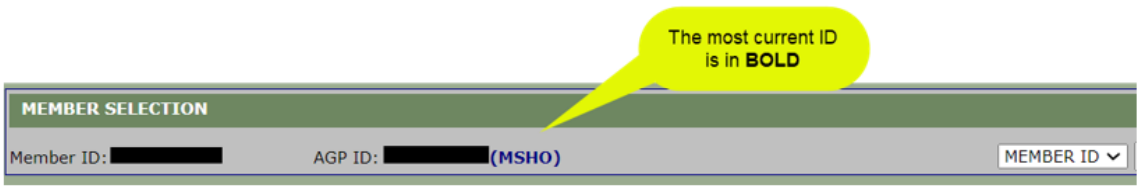
MEMBER IDs IN BRIDGEVIEW

Members are identified in Bridgeview using two ID numbers.

- 8 plus PMI (i.e., 801234567). This will be referred to as the “Bridgeview ID number”
  or
- Amerigroup (AGP)/Blue number (i.e., 726212345).

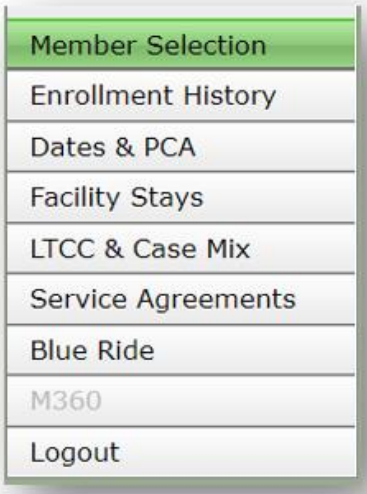


Tip: If there are two AGP ID numbers listed at the top of the Member Selection screen, the ID and Product that is **bolded** is the most current ID number.



MEMBER DETAIL SCREEN OVERVIEW

Once you have logged into the Bridgeview Company Web Tool, and selected a member, users can navigate through the following tabs.



Member Selection

1. Enter the member's 9-digit Bridgeview ID number (8 plus the member's PMI) or AGP ID (select appropriate drop down).

2. If you encounter an error message, please check MN-ITS to verify coverage under Blue Plus. If the member should have Blue Plus coverage, please contact your Partner Relations Consultant. You may also verify coverage with Blue Plus by contacting SecureBlue.Enrollment@bluecrossmn.com

If the member is valid, you will see Member Detail screen. The care coordinator can change some Member Detail fields in the Bridgeview Web Tool.

The Member Detail information is sent by DHS to Blue Plus/Bridgeview twice monthly. Once at the end of each month and one more updated early the following month. So, there may be a delay that does not allow the most current information to be displayed.

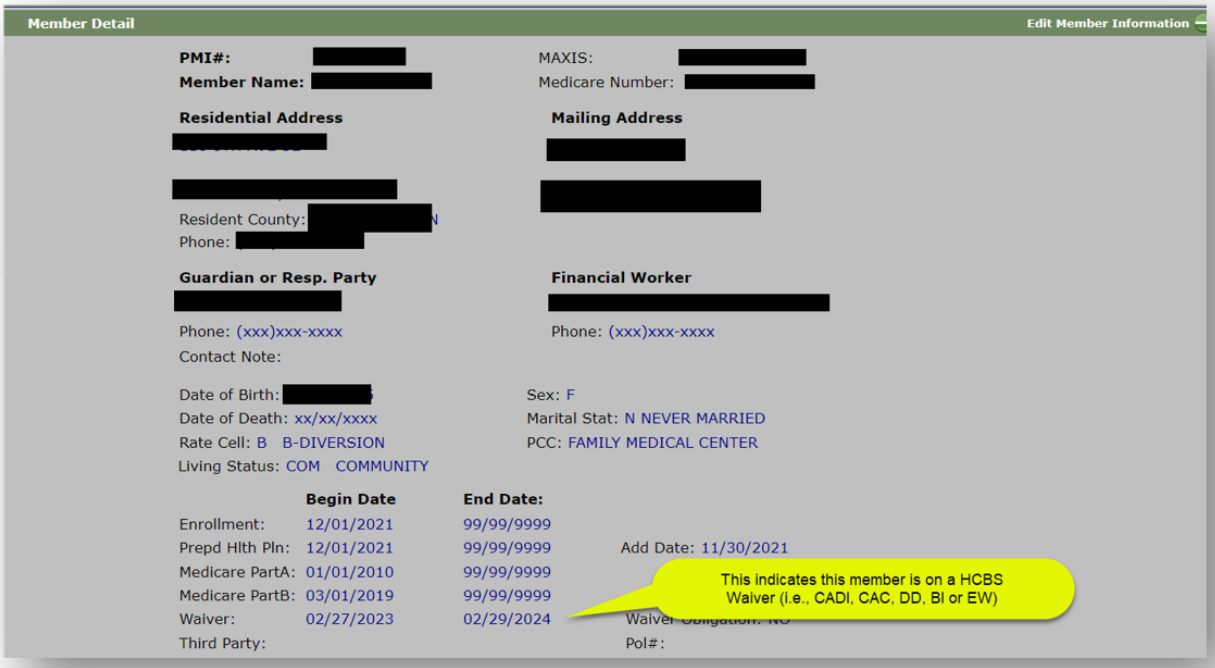
If you see that a member has an end date under the Prepaid Health Plan record, you should verify the member's EW eligibility before continuing to enter a service agreement authorization.

Members with Other Insurance Coverage

Care coordinators have a responsibility to know whether a member on Elderly Waiver is eligible for other coverage or programs, and to communicate with providers to determine whether services or durable or non-durable items are covered by another payer. This information is in the Member Detail. Care coordinators must not authorize services or items under Elderly Waiver that may be covered by other payers. Other insurance coverage would also be available in the MN- ITS or EVS system for providers to review.

Providers are responsible to verify whether other appropriate and available payers exist prior to billing services delivered to individuals participating in the Elderly Waiver program. Other payers include, but are not limited to, Medicare, state plan Medical Assistance, other third-party liability coverage, or long-term care insurance.

You will see the lines “Medicare Part A” and “Medicare Part B” populated with a coverage start date if the member is also eligible for Medicare Part A or B. The other insurance information will also appear on the screen. The Third-Party Insurance will have the coverage start and end date (if applicable) of the policy populated, along with the Policy Number, Name of the Insurer, and the Coverage Type.



UPDATING MEMBER INFORMATION (Delegate Representative/ Support Staff, Care Coordinator roles)

Both roles have access to update member information from the Member Selection tab. Changes to the Member Information fields result in enrollment reports being accurate with

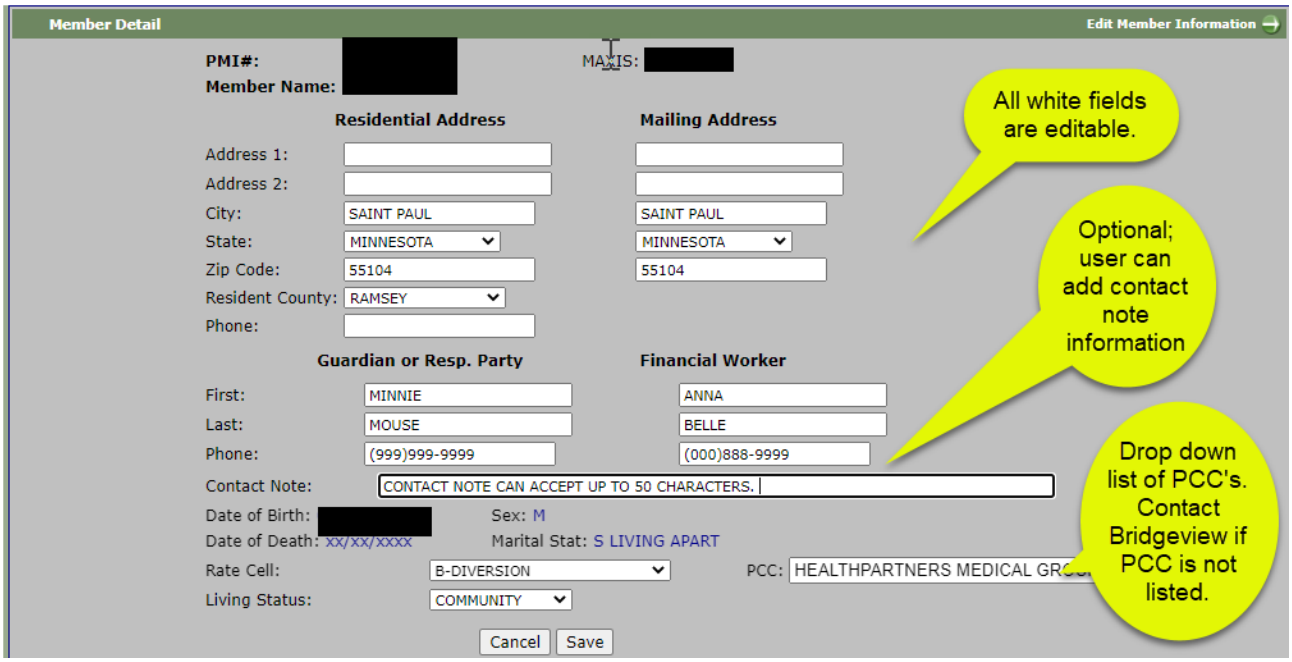
the most up-to-date information. Timely changes ensure the members are assigned to the correct delegate the following month.

When changing member information in the Bridgeview Web Tool, you must also contact the county financial worker to make sure that the member's information has been updated in the DHS recipient database. If recipient files don't get updated, any changes made will revert back to the previous information within 60 days.

If changes result in a change in Delegate, follow the Transfers of Care Coordination processes outlined in the Blue Plus Care Coordination Guidelines.

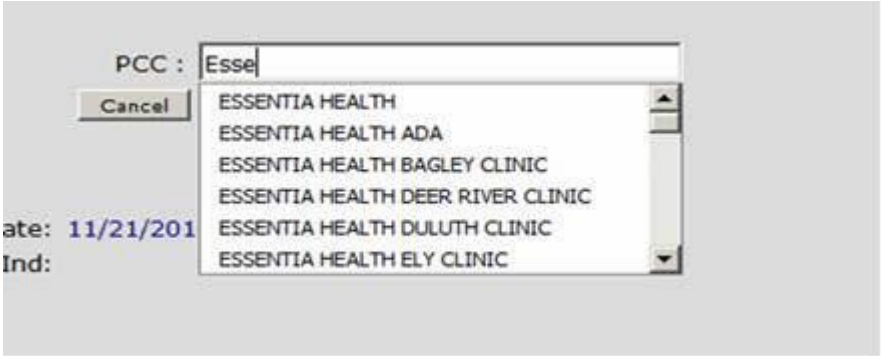
Delegate assignments will automatically be updated when address or county of residence changes are made. You don't need to close out the previous care coordinator or delegate. The new delegate will be responsible to assign the new care coordinator in Bridgeview. Members will be flagged as transfers on the new delegate's enrollment report.

1. Select **Edit Member Information**.
2. Type new information in the applicable field(s)
3. Optional—document reason for making the change in the **Contact Note** field.
4. Click on **Save**.



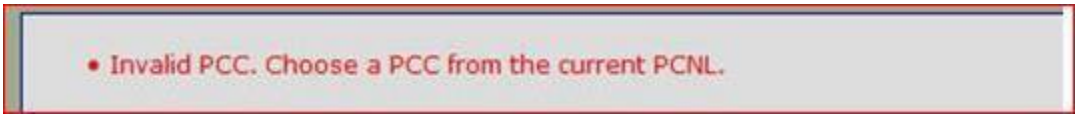
PCC Changes:

The PCC field lists all Primary Care Clinics from the Blue Plus Provider Directory in a drop-down format. As you start to enter the name of the Primary Care Clinic, the field will pre-fill with clinics that match your typing.



If you do not choose a clinic from one of the listed drop-down options, you will get the error below. If the member's PCC is not listed in Bridgeview send an e-mail to Bridgeview.service.agreements@bluecrossmn.com. Include member name, ID, and name of new clinic.

PCC changes may trigger delegate reassignment. Refer to section, *Transfers of Care Coordination to Another Blue Plus Delegate* in the Community and Nursing Home Care Coordination Guidelines for a list of affected PCC's. If PCC is changed prior to transfer effective date, member will appear on the receiving delegates enrollment report early. Contact your Partner Relations Consultant if this occurs.



***Important Reminder*:** If the PCC change results in a change in Care Coordination delegation, you are required to follow the notification and transfer processes outlined in the Guidelines; for Blue Plus to Blue Plus transfers send form 6.08 Transfer in Care Coordination Delegation directly to the new delegate. For mis-assignments send discrepancy to SecureBlue.enrollment@bluecrossmn.com.

ENROLLMENT REPORTS

All Delegate Blue Plus enrollment reports are available on the Bridgeview Company Web Tool. The Delegate Representative/Support Staff Role has access to these reports. E-mail will be sent to the Delegate agency's primary contact(s). Enrollment reports are only available for 12 calendar months.

Types of Enrollment Reports

1. **New CAP Report:** Lists NEW members for the month.

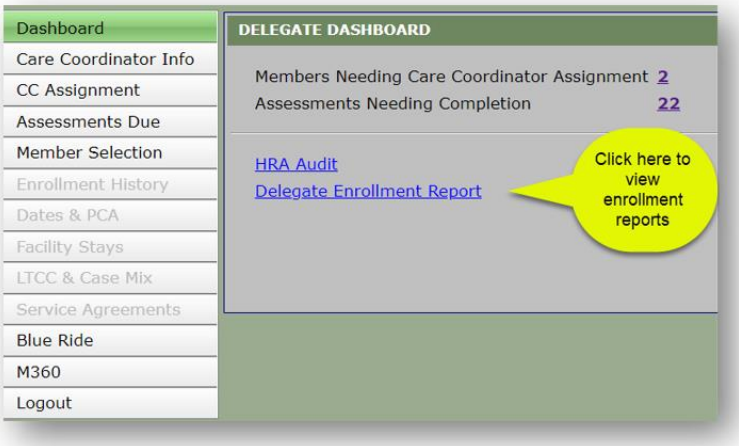
2. **Full Detail Report:** Provides a full member list of all members assigned to each Delegate agency is available by the 15th of each month and may also include some NEW members who enrolled at the very end of the previous month. This report includes the following flags:

FULL DETAIL REPORT FLAG DETAILS Refer to the Care Coordination Guidelines for required care coordination tasks	
FLAG	**WHAT DOES IT MEAN?**
NEW	Enrollees who enrolled after the DHS capitation
GRACE PERIOD ENDING	Lists Month/Date/Year which will be 30/60/90 days out from the enrollment month. These are MSHO members whose MA has termed but continue to have MSHO coverage for 90 days.
PRODUCT CHANGE	Changed from MSC+ to MSHO or vice versa.
RATE CELL CHANGE	Member rate cell changes to/from A (Community Well); B (Elderly Waiver); or D (Nursing home)
REINSTATED	Members who were going to term but were reinstated with no lapse in coverage
TERMED	Coverage termed. Refer to section "Close Service Agreements" as applicable.
TERMED DEATH	Coverage termed due to death. Follow requirements in section "Date of Death".
TERMED DISENROLLED ENTERED IN ANOTHER PLAN	Coverage termed due to enrollment in another health plan. Refer to section "Close Service Agreements" as applicable.
TERMED FUTURE	Lists Month/Year. Member will be termed at the end of the month listed.
TERMED OUT OF SERVICE AREA	DHS has them listed on our enrollment report as an "unknown" county or a residential address out of state.
TRANSFER	Existing enrollee who transferred to you.

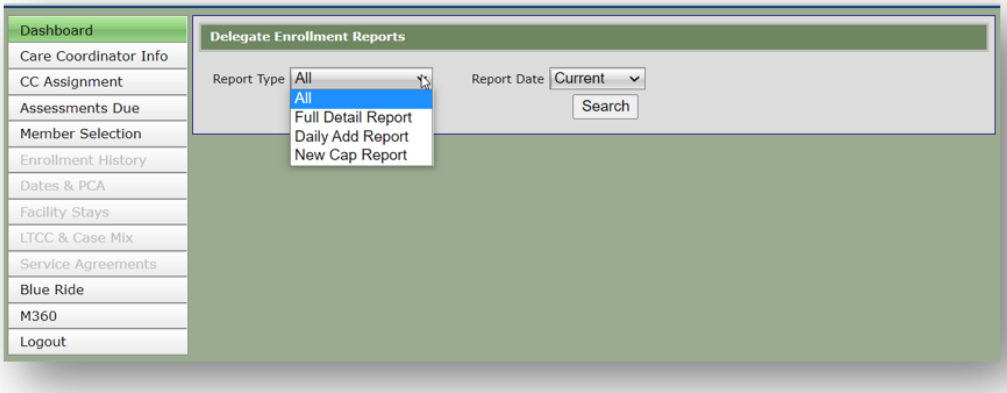
3. **Daily Add Report:** This report is generated throughout the month for those members who are retroactively enrolled by DHS after capitation. This report will list NEW (includes product changes) and/or REINSTATED members. An e-mail will be sent to the applicable Delegate.

When the **Delegate Representative/Support Staff** logs into the Web Tool, the first screen displays a link to the Enrollment Reports.

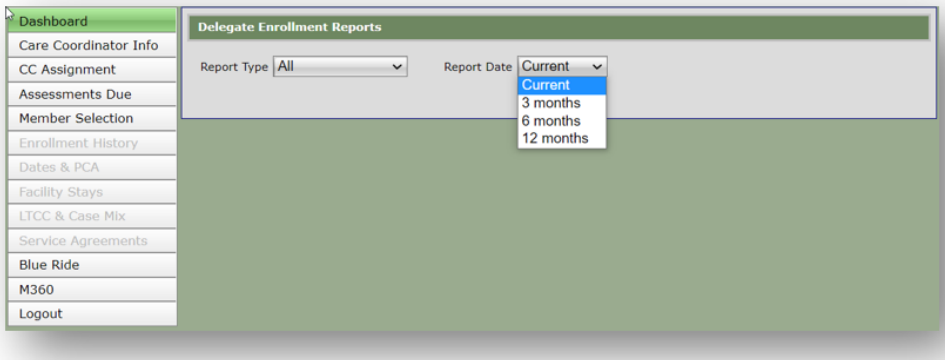
1. Click on the blue “Delegate Enrollment Report” link.



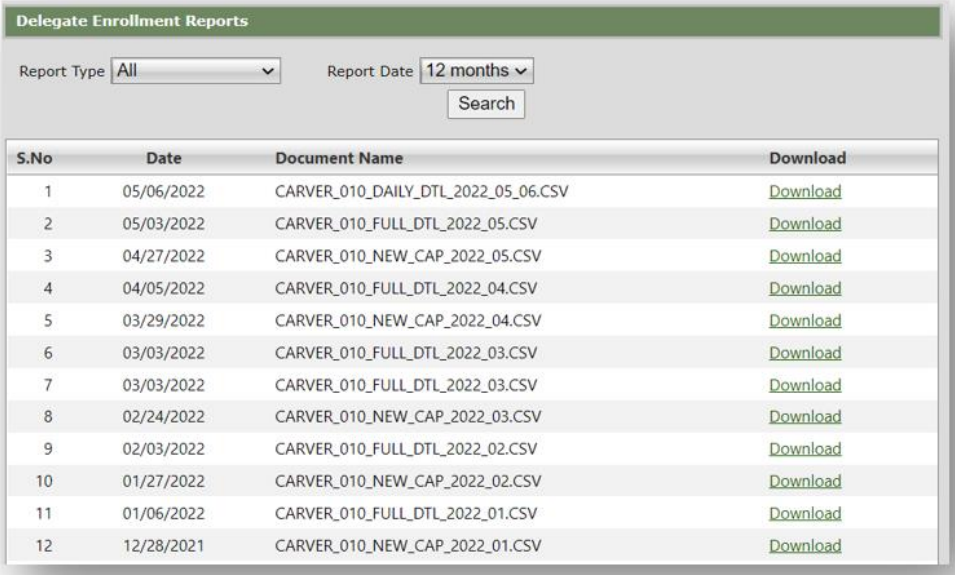
2. This will take you to the Delegate Enrollment Reports screen where the most current reports are displayed. Or you may search for a specific report. To search for a specific report, choose the appropriate Report Type.



3. Choose the desired Report Date, then click **Search**



4. All reports matching your criteria are displayed. Click **Download** to the right of the report(s) you wish to open. They will open in Excel and can be saved to an agency approved secured drive on your computer.



S.No	Date	Document Name	Download
1	05/06/2022	CARVER_010_DAILY_DTL_2022_05_06.CSV	Download
2	05/03/2022	CARVER_010_FULL_DTL_2022_05.CSV	Download
3	04/27/2022	CARVER_010_NEW_CAP_2022_05.CSV	Download
4	04/05/2022	CARVER_010_FULL_DTL_2022_04.CSV	Download
5	03/29/2022	CARVER_010_NEW_CAP_2022_04.CSV	Download
6	03/03/2022	CARVER_010_FULL_DTL_2022_03.CSV	Download
7	03/03/2022	CARVER_010_FULL_DTL_2022_03.CSV	Download
8	02/24/2022	CARVER_010_NEW_CAP_2022_03.CSV	Download
9	02/03/2022	CARVER_010_FULL_DTL_2022_02.CSV	Download
10	01/27/2022	CARVER_010_NEW_CAP_2022_02.CSV	Download
11	01/06/2022	CARVER_010_FULL_DTL_2022_01.CSV	Download
12	12/28/2021	CARVER_010_NEW_CAP_2022_01.CSV	Download

ASSIGNING CARE COORDINATOR TO MEMBERS

Background

- Care Coordination Delegates are responsible to record care coordinator assignments and Health Risk Assessment data into the Bridgeview web tool.
- A Care Coordinator must be assigned within 10 days of notification of member enrollment.
- If the Care Coordinator name does not show up on the list, it means the Care

Coordinator is not enrolled with Bridgeview yet. Refer to Bridgeview Care Coordinator Web Tool Access Request Form.

- Do not enter HRA information before the Care Coordinator is assigned with Bridgeview.
- When a Care Coordinators access is deactivated, all members assigned to that Care Coordinator will need care coordinator assignment within 10 days.

Assigning Care Coordinators to Members (Delegate Representative/Support staff role)

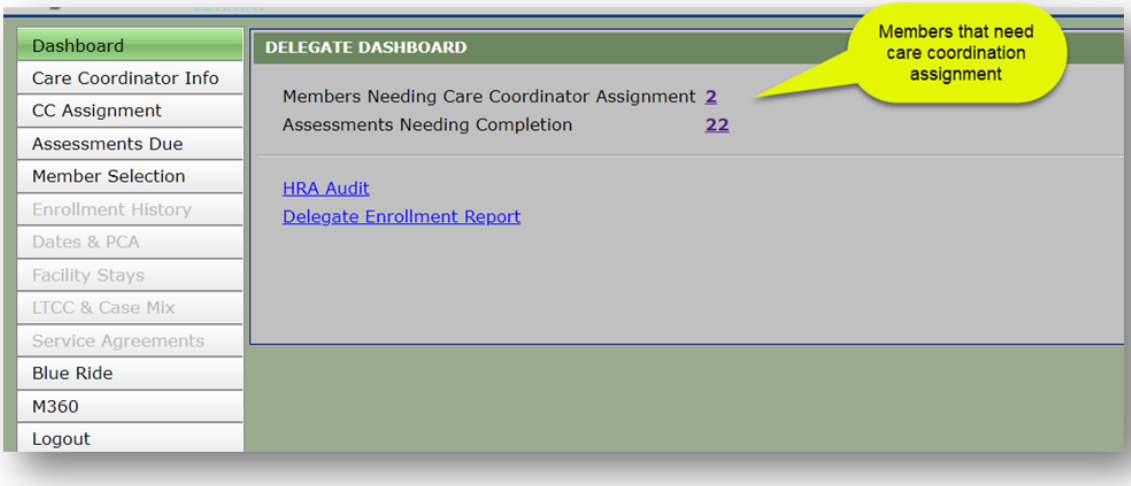
Only Delegate Representative/Support Staff role currently has access to assign CCs.

When a member is assigned to your agency, you will use the **Assign Care Coordinator** function (see illustrations below).

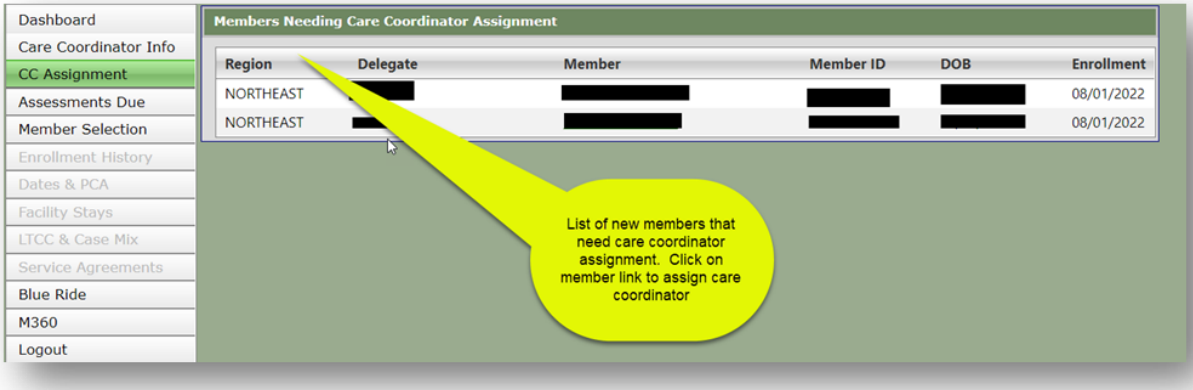
Important:

Assign CC: Use this to assign or update the CC. Choosing Assign CC will keep a history of the previous CC.

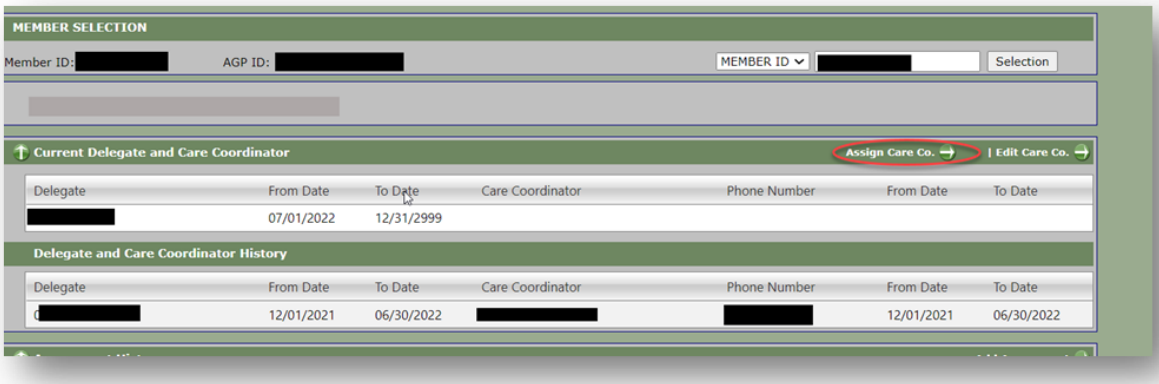
Edit CC: See Editing a Care Coordinator section below if you incorrectly assigned the member to a CC and now want to change it. This overwrites the previously assigned CC.



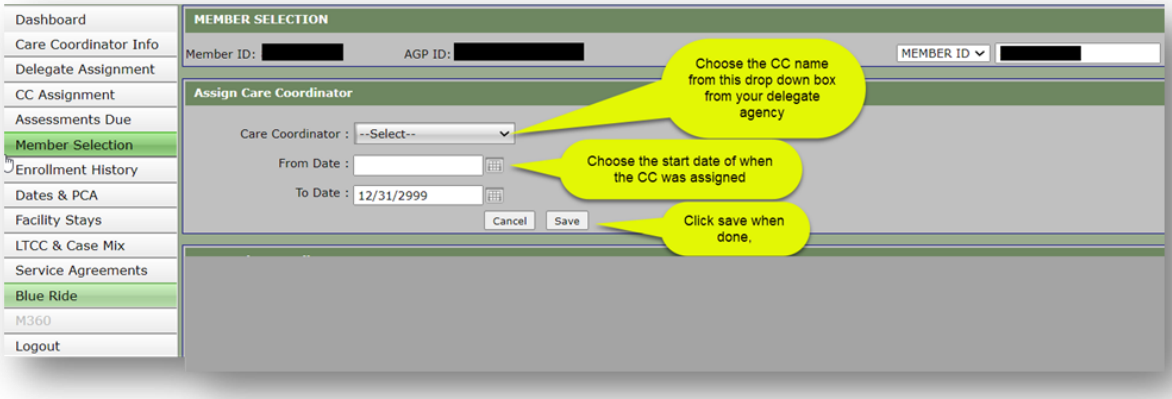
1. Click on the member's name to assign a Care Coordinator.



2. After clicking on the Member name, the Member Detail screen will be displayed. Click on **Assign Care Co**. arrow.



3. Choose the CC name from the drop-down box from your delegate agency list of Care Coordinators.
4. **From Date:** Enter the start of when the CC was assigned. Note: if new enrollee, the start date must be date of enrollment.
5. Click **Save**.



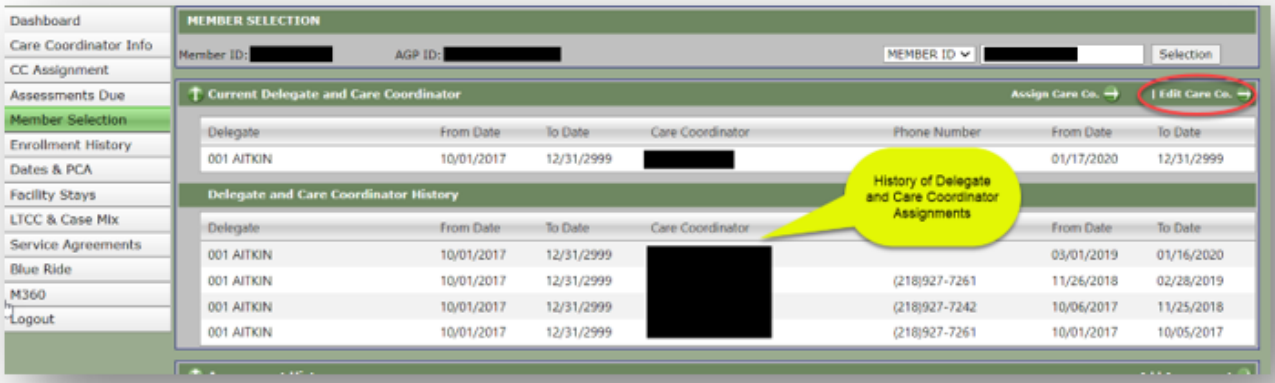
Editing a Care Coordinator (Delegate Representative/Support staff role).

Once a Care Coordinator is assigned, you may reassign or edit the Care Coordinator by choosing **Assign Care Co.** or **Edit Care Co.** on the Member Selection screen.

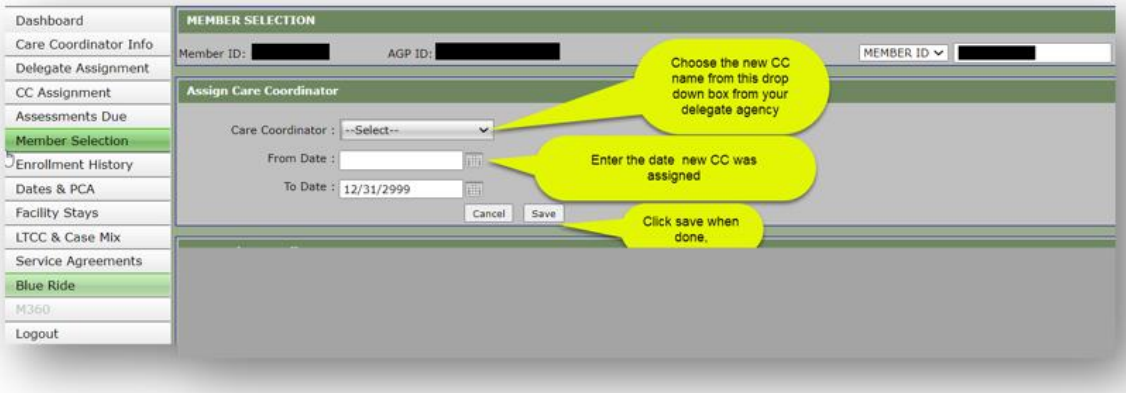
Assign CC: Use this to assign or update the CC. Choosing Assign CC will keep a history of the previous CC.

Edit CC: Use this if you incorrectly assigned the member to a CC and now want to change it. Using edit will overwrite the previously assigned CC.

1. On the Member Selection screen, click the **Edit Care Co**. arrow button.



2. Choose the Care Coordinator name from the drop-down
3. Enter start date of assignment.
4. Click **Save**.



Note: Optional you can also assign a Care Coordinator by doing a member search. To

search for a member, click on the Member Selection tab on the left in the list:

Logging on as a Care Coordinator Role:

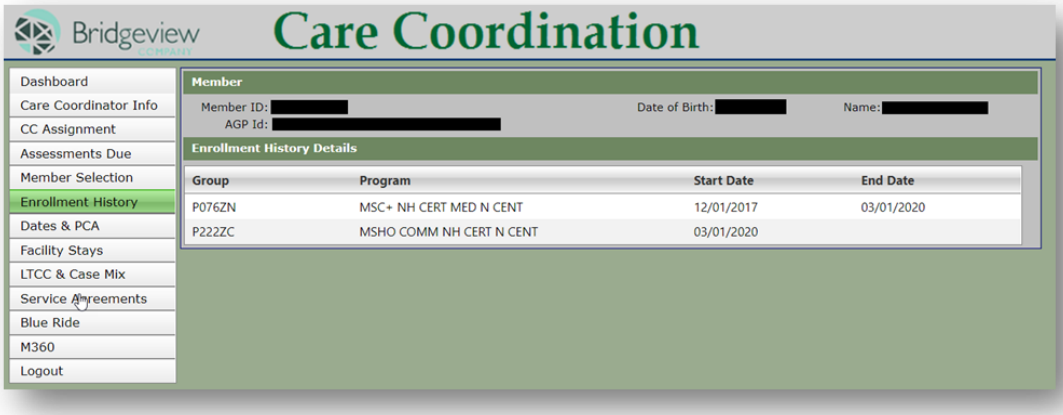
Your first screen will look like this:

1. To view a member, click on the **Member Selection** tab from the list on the left.
2. If applicable, select HRA Audit to enter requested audit documentation. Refer to Heath Risk Assessment (HRA) Audit Process for details of the HRA audit process.
3. Click on **Reminder!** for a list of assessments due.

NOTE: Any updates for the contact information, refer to section User Contact Information Changes.

ENROLLMENT HISTORY

Click on Enrollment History tab to view members enrollment history. This is helpful information to view product changes and lapse in coverage, if any.



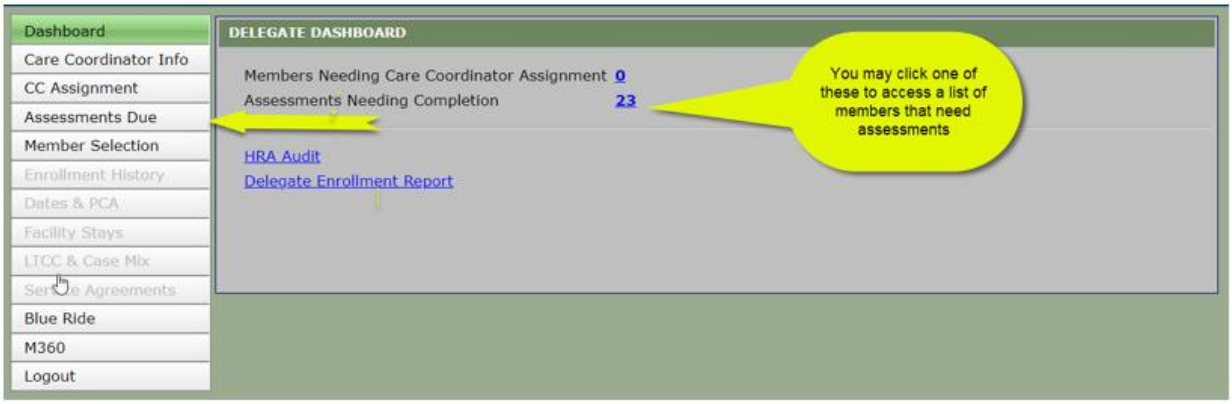
HEALTH RISK ASSESSMENT ENTRY (Delegate Representative/Support Staff, Care Coordinator roles)

*****Do not enter HRA information until after a Care Coordinator is assigned**.

Entering Health Risk Assessments

1. Search for assessments due by selecting the **Assessments Due** tab or follow the reminder link in red from your main login page.

Delegate Representative Support Staff

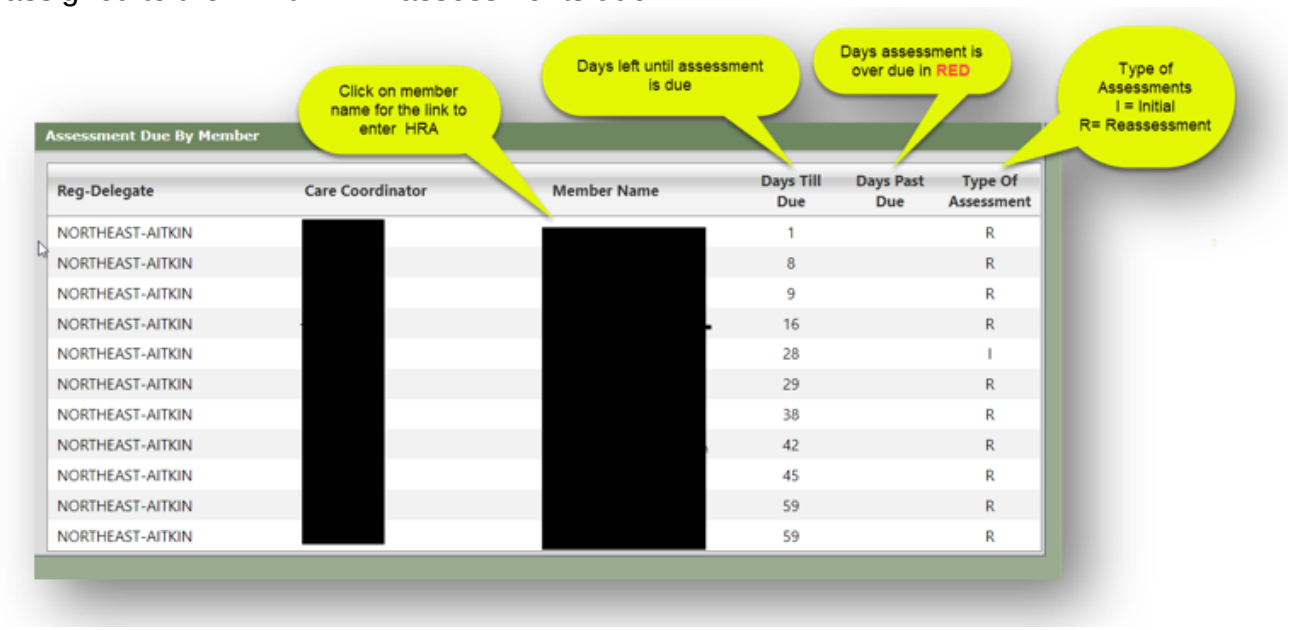


Care Coordinator view

2. Review this screen for a list of past due and upcoming assessments based on the previous HRA date in the system. The type of assessment is either “I” for Initial assessments due for new enrollees, or “R” for reassessments for existing enrollees. Past Due assessments will be displayed in red.
3. Click on the member’s name to be taken to their information.

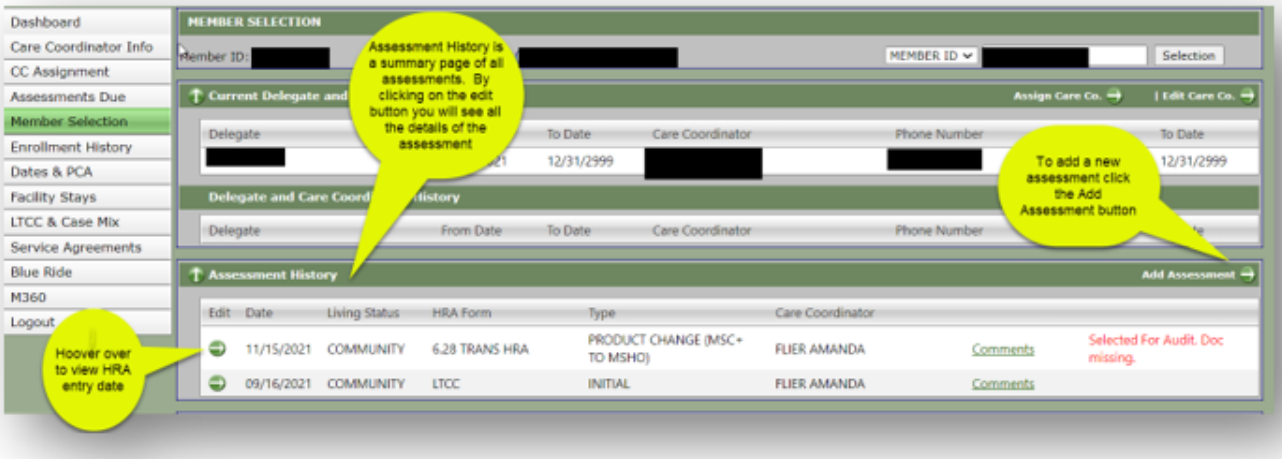
Delegate/Representative and Care coordinator Roles View

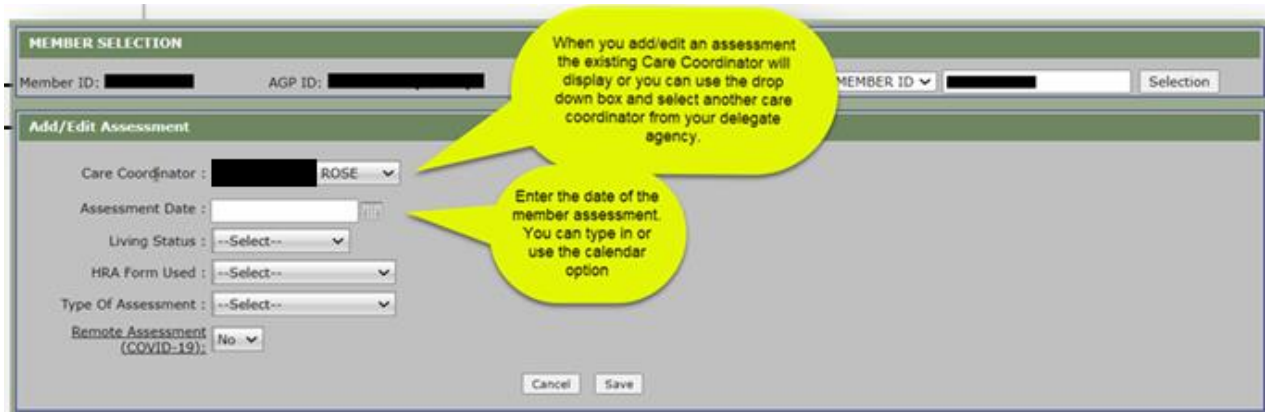
Delegate Representative View will list all Care Coordinators with HRAs due for the entire Delegate agency. Care Coordinators View will list all their own members assigned to them with HRA assessments due.



4. Add Assessment information by clicking on **Member Selection** and entering Member ID. This screen shows the entire assessment history.

5. Click on **Add Assessment** arrow





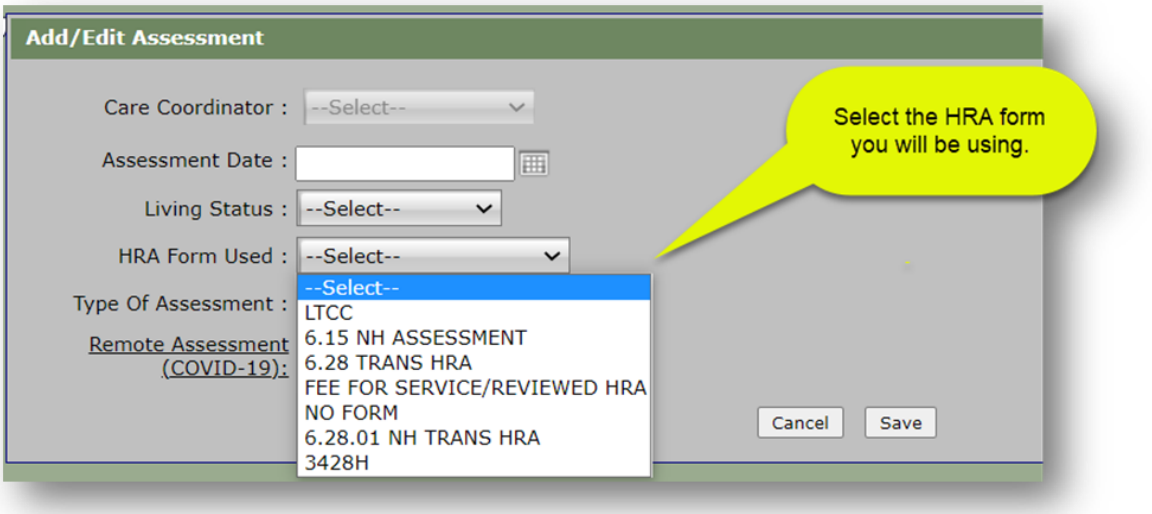
6. **Care Coordinator** name is displayed. Use the drop-down to select another care coordinator if needed.
7. Enter the date of the assessment.
8. Choose **Living Status** from the drop-down:

   - ***Community*:** Member lives in the community or is planning to return to the community. Choose Community when using a community assessment.
   - ***Nursing Home:*** Member lives in the Nursing Home or Intermediate Care Facility (ICF). Choose Nursing Home when using a Nursing Home assessment.

9. Select the **HRA Form Used** from the drop down:

HRA Form Drop Down Options	Select based on the type of HRA that was completed.
LTCC	Long-Term Care Consultation Form DHS 3428 (or DHS 3428A)
6.15 NH ASSESSMENT	6.15 NH-ICF Member Annual Assessment-Care Plan Review has been completed. (For members residing in the nursing facility or Intermediate Care Facility (ICF).
6.28 TRANS HRA	6.28 Transitional HRA is competed in combination with review of newly enrolled members MnCHOICES assessment; LTCC; or 3428H within the past 365 days.

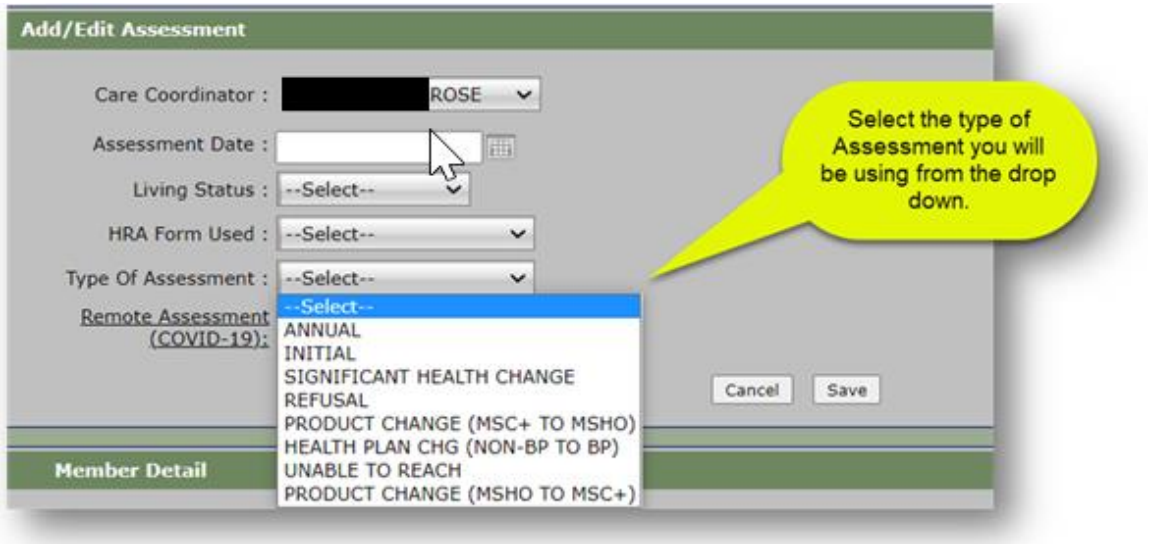
FEE FOR SERVICE/REVIEWED HRA	For Transitional HRAs select this to document the date of the previous MnCHOICES; LTCC; or 3428H assessment that was completed prior to enrollment. Follow the process outlined below in section, *LTCC/MnCHOICES completed prior to enrollment*.
NO FORM	For Refusals and Unable to Reach.
6.28.01 NH TRANS HRA	Transitional HRA nursing home/ICF members who have a product change. CC completes Section VI of the 6.15 NH-ICF Member Annual Assessment-Care Plan Review that was completed within the past 365 days.
3428H	Minnesota Health Risk Assessment Form DHS 3428H completed for CW members who choose not to complete an LTCC. Can be completed face-to-face or telephonic or as an assessment for members on another waiver. Do not use 3428H if member is determined to be eligible for EW or receiving PCA services.



10. Select the **Type of Assessment** from the drop-down**:**

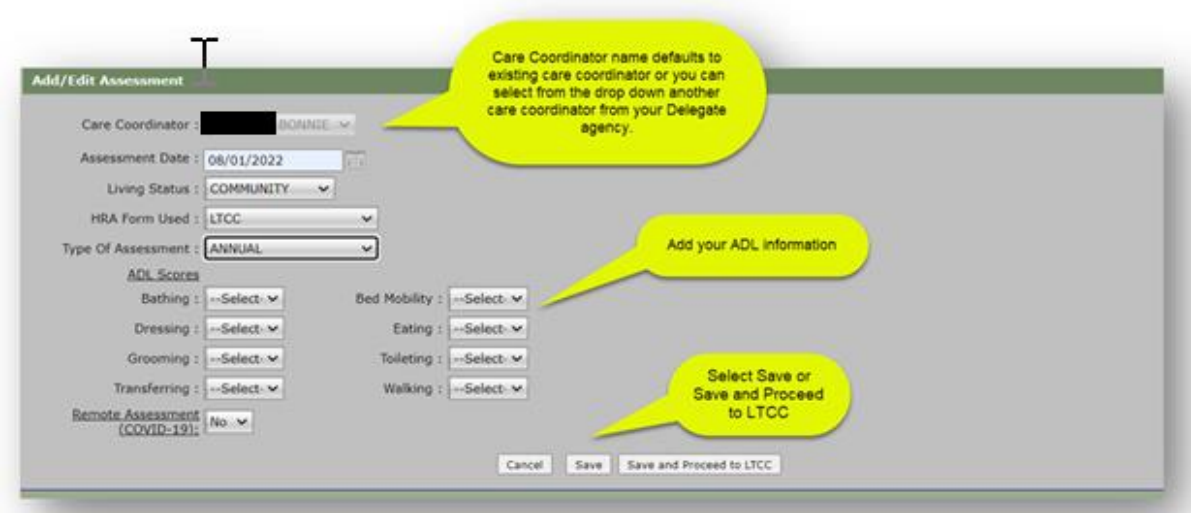
Type of Assessment	Select based on the reason for the HRA
ANNUAL	Annual assessment or reassessment
INITIAL	Initial assessment after enrollment. If applicable, use this to enter a FEE FOR SERVICE assessment date per Transitional HRA process. Refer to LTCC/MnCHOICES completed prior to enrollment.
SIGNIFICANT HEALTH CHANGE	Use when the member requires a reassessment due to a significant change.
REFUSAL	Member refuses HRAs.
PRODUCT CHANGE (MSC+ TO MSHO)	Current member switches from MSC+ to MSHO. Follow the transitional HRA process. Refer to Transitional HRA for Product Changes for Community or Nursing Home/ICF Members, as applicable.
HEALTH PLAN CHG (NON-BP TO BP)	Member is a new enrollee and is transferring from another health plan. This documents the initial Blue Plus HRA.

UNABLE TO REACH	Care Coordinator is unable to reach the member.
PRODUCT CHANGE (MSHO TO MSC+)	Current member switches from MSHO to MSC+. Follow the transitional HRA process. Refer to Transitional HRA for Product Changes for Community or Nursing Home/ICF Members, as applicable.



11. Enter **ADL Scores** for LTCC Assessment only. Required for Annual; Initial; Significant Health Change; Product Change (MSC+ to MSHO); Health Plan Change (non BP to BP); Product Change (MSHO to MSC+).

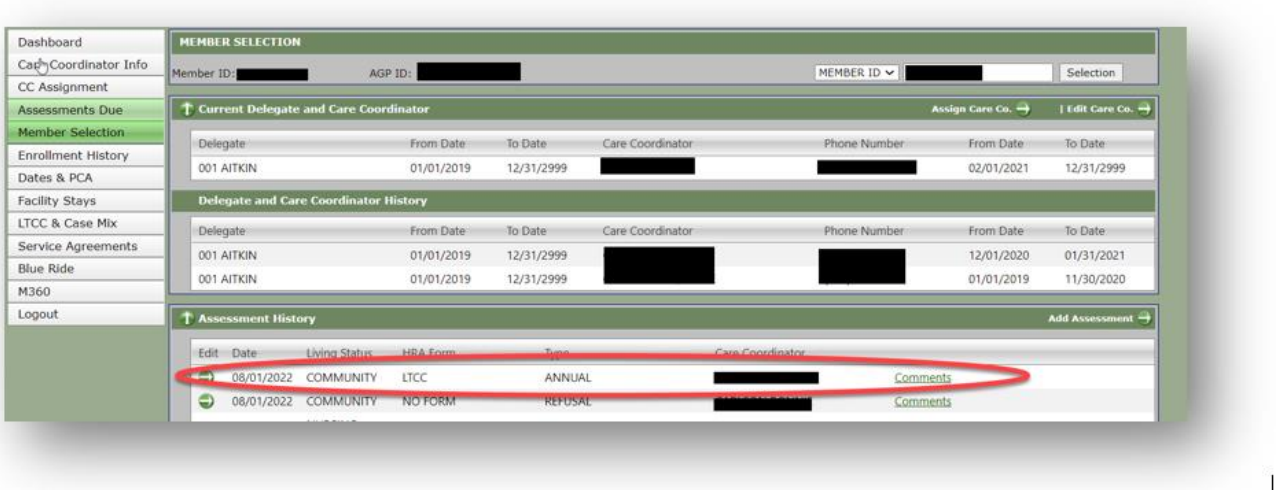
You will be taken to this screen:



12. For **Remote Assessment** select "**yes**" if assessment was completed remotely due to Covid-19. Select "no" if not a remote assessment.
13. Click on **Save** or for members on EW click **Save and Proceed to LTCC** to

proceed directly to LTCC & Case Mix tab and Service Agreement entry.

The assessment you have just entered will now appear in the Assessment History list on the Member Selection screen.



Important: In the event of errors, you will NOT be able to directly edit an HRA after you save it. Do NOT enter another HRA to replace the HRA that was entered in error. For errors in HRA data entry, see section, Requesting an Edit or Deletion of an HRA entry.

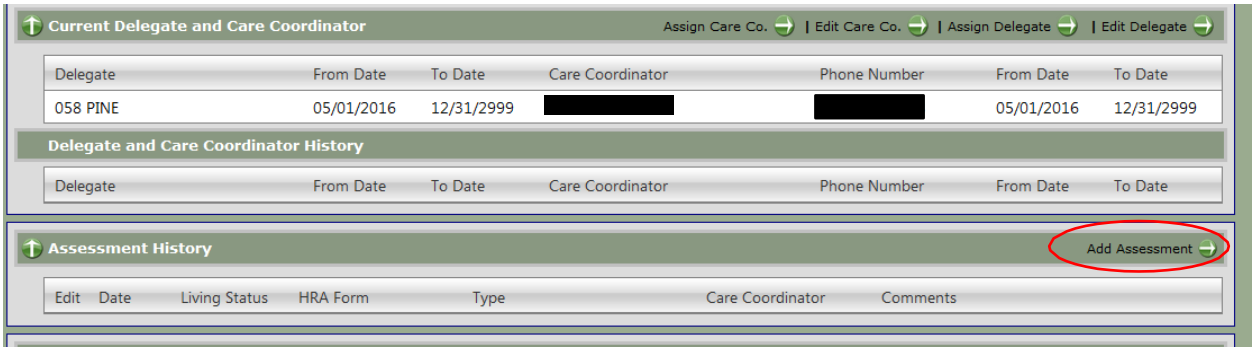
Transitional HRA entries

LTCC/MnCHOICES completed prior to enrollment

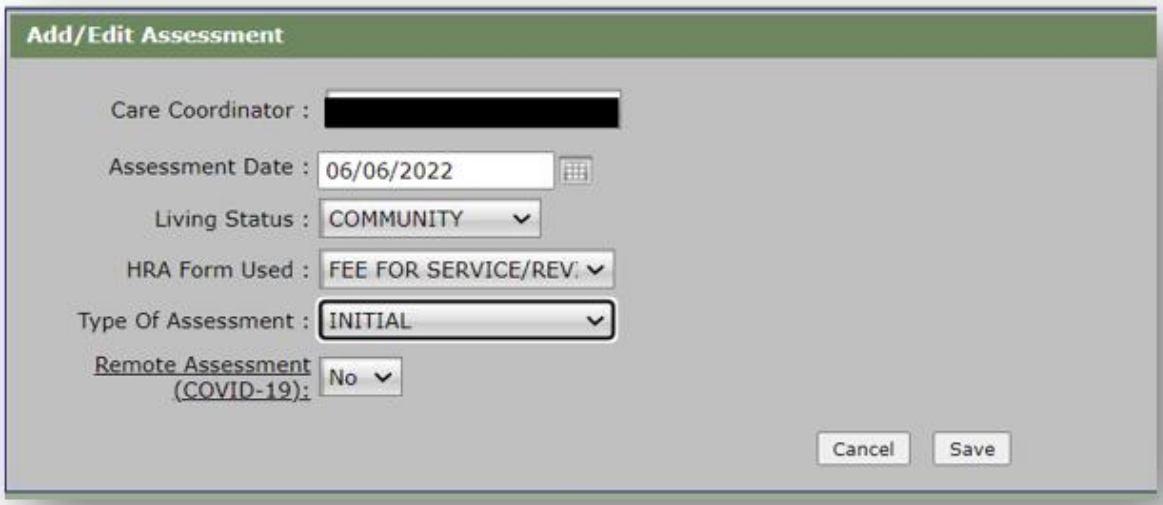
Follow this process for new Blue Plus members who have had an LTCC or MnCHOICES assessment completed prior to enrollment by a county assessor, or another health plan and the Care Coordinator is conducting a Transitional HRA. It is required to enter **both** the date of the previous assessment (LTCC or MnCHOICES assessment) that was done prior to enrollment and the date of the Transitional HRA.

Important: You must enter both in order for the next face-to-face assessment to correctly trigger 365 days from the date of the previous LTCC or MnCHOICES assessment.

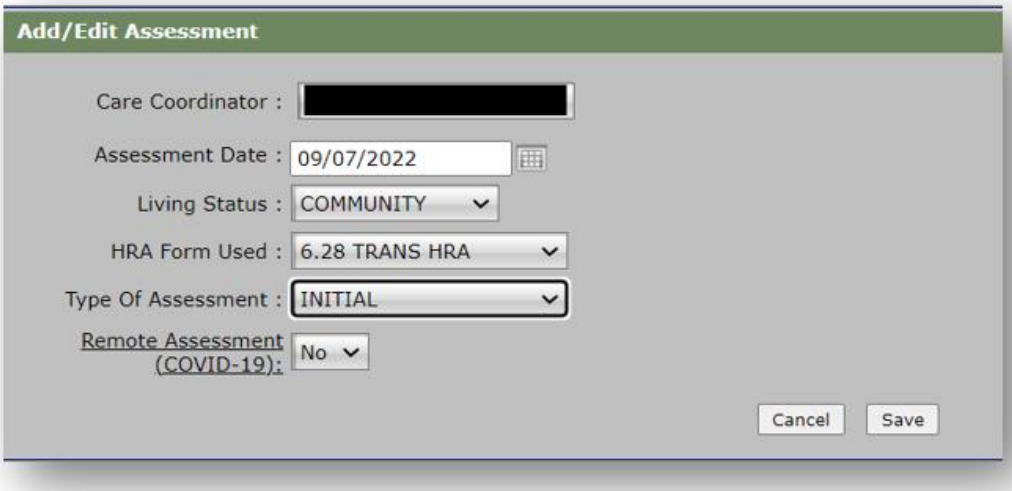
1. On the Member Selection screen, click on **Add Assessment**



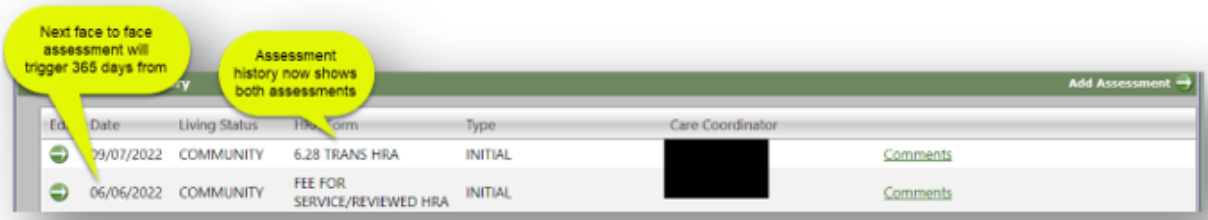
2. For the **Assessment Date**, enter the date of the previous LTCC/MnCHOICES assessment.
3. Enter **Living Status** as Community.
4. Choose FEE FOR SERVICE from the **HRA Form Used** drop-down. Do this even if the assessment was completed by another health plan.
5. **Type of Assessment**. Enter INITIAL
6. When all fields are completed, click **Save**.



7. Choose **Add Assessment** again from the Member selection screen. This time, you will enter the Transitional HRA you completed after the member's enrollment into Blue Plus.
8. Enter the **Assessment Date** which is the date the Transitional HRA was completed.
9. Enter **Living Status** as Community
10. Choose 6.28 TRANS HRA from the drop-down.
11. **Type of Assessment**: Select INITIAL.
12. Click **Save**.



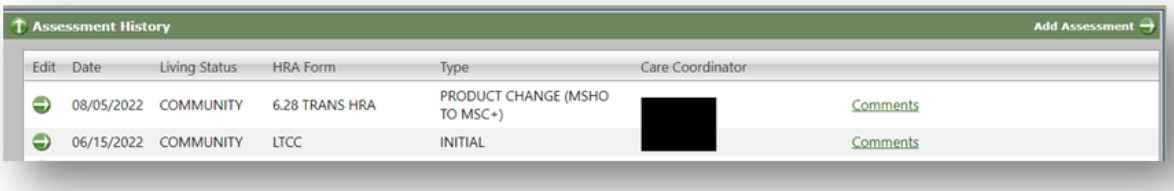
The Assessment History now shows both assessments for this member. The next face-to-face assessment will now correctly trigger 365 days from the previous face-to-face assessment (LTCC or MnCHOICES assessment).



Transitional HRA for Product Changes for Community

Follow this process when completing a 6.28 Transitional HRA for Blue Plus community members who have who have a Product change and who have a Blue Plus LTCC or 3428H completed within the last 365 days.

1. Choose **Add Assessment** from the Member selection screen.
2. **Assessment Date**: Enter the date you completed the Transitional HRA.
3. **Living Status**: Enter Community
4. **HRA Form Used**: Choose 6.28 TRANS HRA from the drop-down.
5. **Type of Assessment**: select either Product Change (MSC+ to MSHO) or Product Change (MSHO to MSC+)
6. Then click **Save**.

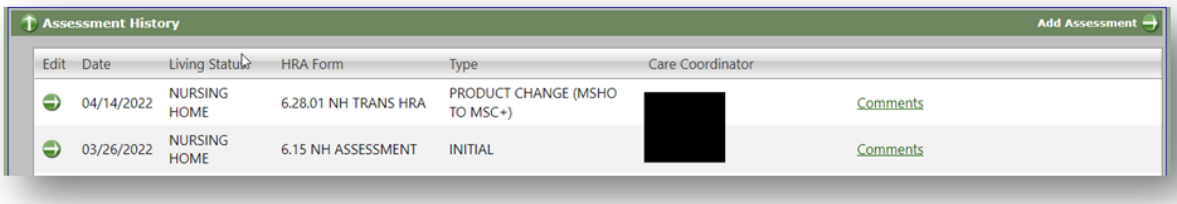


Note: If entered according to instructions above, the next face-to-face assessment will correctly trigger 365 days from the date of the previous face-to-face assessment not the date of the Transitional HRA.

Transitional HRA for Product Changes for Nursing Home/ICF Members

The 6.28.01 Nursing Home Transitional HRA for Product Change may be used for members residing in the nursing home/ICF who have a product change and have a 6.15 NH-ICF Member Annual Assessment-Care Plan Review completed within the past 365 days.

1. On the Member Selection screen, click on **Add Assessment**
2. **Assessment Date**: Enter the date the Section VI 6.28.01 Nursing Home/Intermediate Care Facility Transitional HRA for Product Change was completed.
3. **Living Status**: Enter *Nursing Home*
4. **HRA Form Used**: 6.28.01 NH TRANS HRA.
5. **Type of Assessment**: select Product Change (MSC+ to MSHO) or Product Change (MSHO to MSC+)
6. Click **Save**



Note: If entered according to instructions above, the next face-to-face assessment will correctly trigger 365 days from the date of the previous face-to-face assessment (6.15 NF-ICF Member Annual Assessment-Care Plan Review) not the date of the NH Transitional HRA.

Entering Assessments for Members that have been Transferred

For Blue Plus Delegate to Blue Plus Delegate transfers, the previous delegate can enter HRAs for members who have been transferred for up to 90 days. Enter the

member's Bridgeview ID number in the Member Selection box and click on Add Assessment.

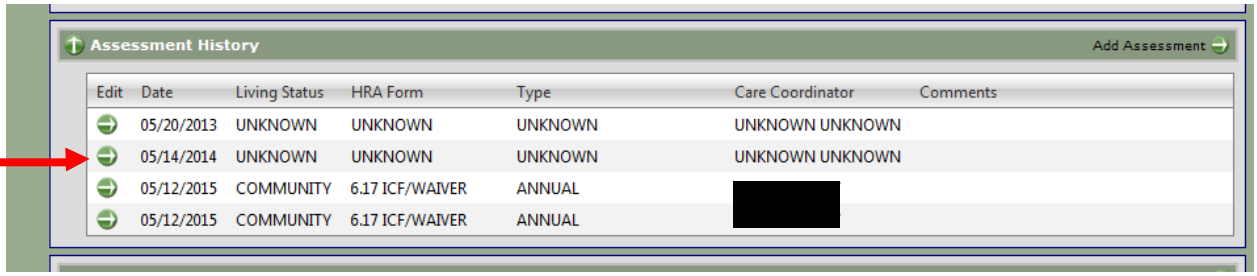
Requesting an Edit or Deletion of an HRA entry

You will NOT be able to directly edit an HRA after it has been saved. Do not enter another HRA data entry to replace the HRA that was entered in error. Follow this process to request a fix for any errors with your HRA data entry.

Both Care Coordinator and Delegate Rep/Support staff roles have access to request an Edit, or request Deletion of an HRA entered in error.

Potential reasons for making edits. I.e., Incorrect HRA form; incorrect Living Status; ADLs need changing; and other pertinent information based on assessment type; change in Care Coordinator completing the assessment (example: I am now the assigned CC, however the initial assessment was completed by a previous CC).

1. From the Member Screen in the **Assessment History** section, select the Edit button to the left of the HRA you wish to Edit or Delete and click on it.

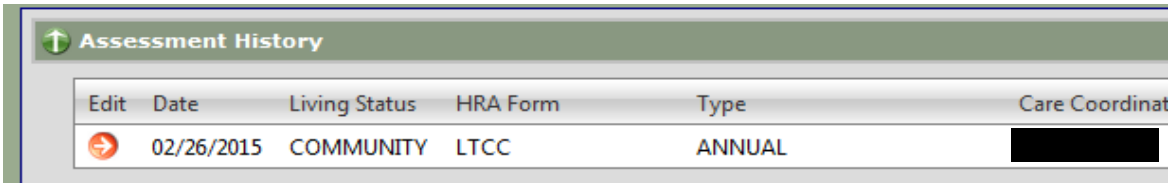


2. In the next screen edit any of the fields previously saved (such as changing name of Care Coordinator). Make the corrections using the drop boxes in the field(s) you wish to change.

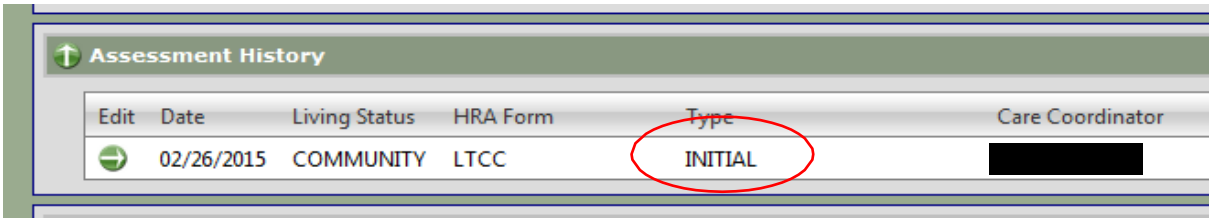
3. You must enter information into the Comments box about why you are requesting an edit. Character limit is 250.

4. When you have finished making your corrections, click **Request Edit** or **Request Delete** depending on your intended action.

5. When you are returned to the member screen, you will see the Edit button is now red, which indicates your request has been sent.



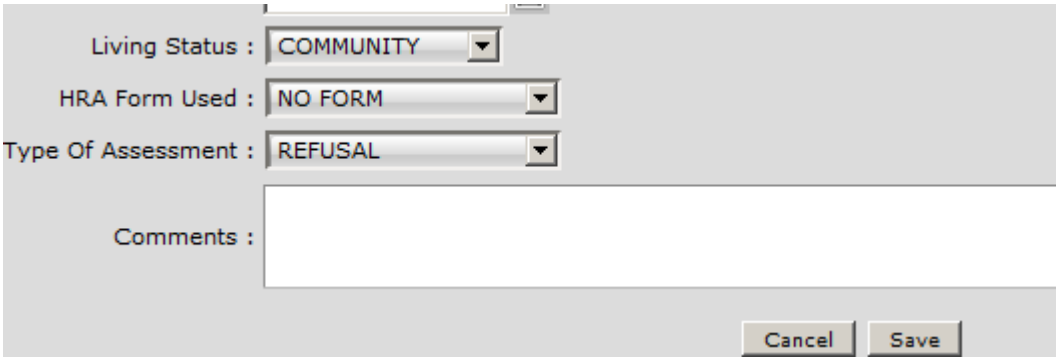
6. Upon approval and processing by Blue Plus, the Edit button will return to green, and any approved changes will be made, or the assessment will be deleted as appropriate.



CW Refusals

If a Community Well member *refuses* both face-to-face (LTCC and 3428H) and telephonic assessment (3428H),

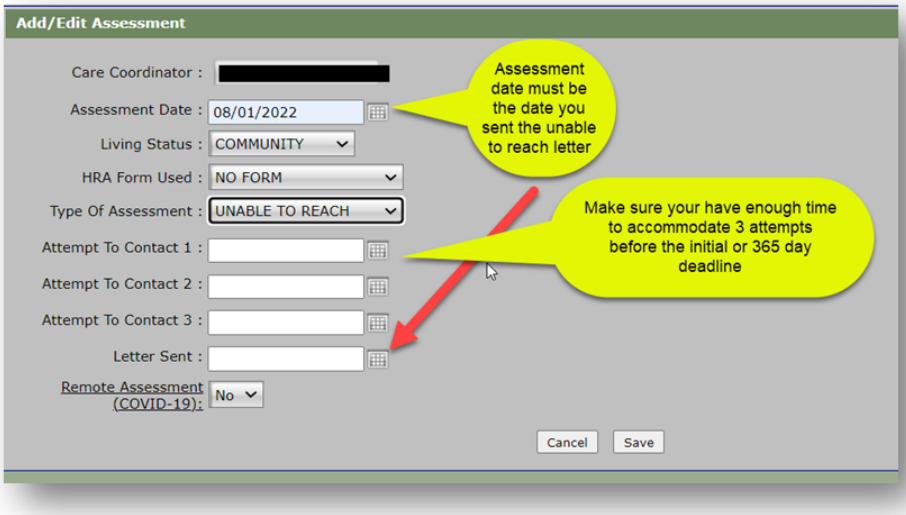
1. Select NO FORM in the **HRA Form Used** field.
2. Select REFUSAL for **Type Of Assessment**
3. Click **Save**.



Reminder: CW members living in the community using MA plan services cannot have a refusal.

CW Unable to Reach

1. Enter **Assessment date**. This date must match the date of the UTR letter.
2. **Living status**: Select “Community”
3. **HRA Form used**: Select NO FORM
4. **Type of Assessment**: Select UNABLE TO REACH
5. **Attempt to Contact** fields: Enter dates of your required 3 outreach attempts.
6. **Letter Sent:** Enter date the UTR letter was sent. This date must match the assessment date entered.



Important tips for Unable to Reach:

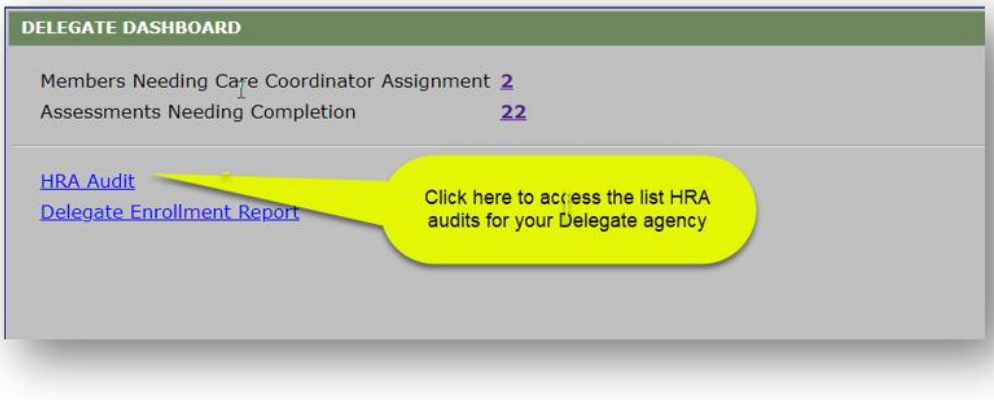
- If applicable, CCs should be reaching out to other contacts to obtain a working phone number. You may document those dates in Bridgeview as contact attempts.
- You may enter the same date in BV if your attempts occurred on the same date.
- Attempts may be via phone, letter or email.
- The date of the Unable to Contact Letter should be the same date as the Assessment Date field and the same date as the activity date and effective date for the Unable to Reach SD in MMIS.

HEALTH RISK ASSESSMENT (HRA) AUDIT PROCESS

HRAs are audited on a regular basis to ensure accuracy of entry into the Bridgeview system. The date entered into Bridgeview **must be** the date the member assessment was completed or the date the Unable to Contact Letter was sent. HRA information in Bridgeview are compared to the assessment documentation submitted. Delegates are audited on a monthly, quarterly, or semiannual basis.

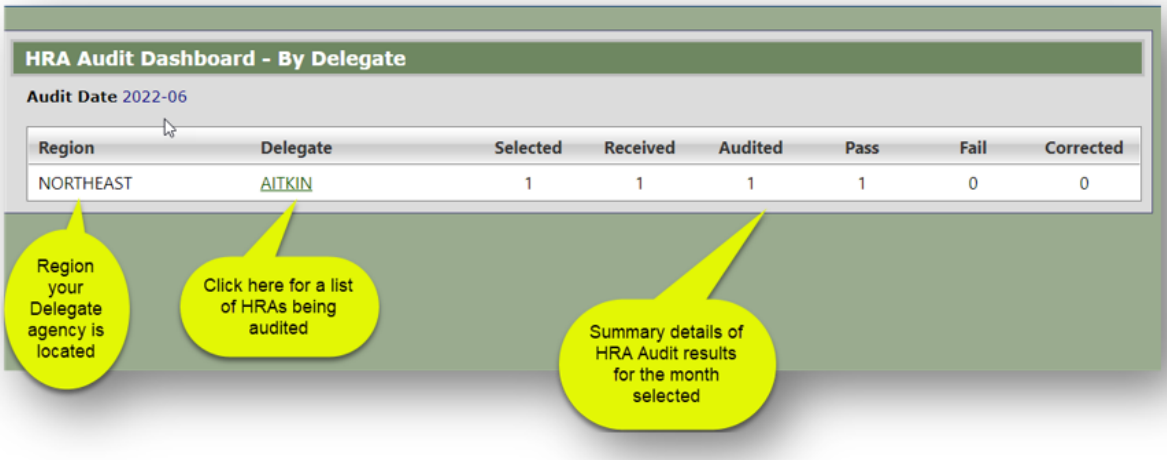
Delegates will receive an email from Partner Relations with instructions on how to identify the members' assessments selected for audit. You have **up to 7 days** to submit the requested documentation.

1. Delegate Representative/Support Staff will click on the **HRA Audit** link on the Delegate Dashboard to access the HRA Audit Dashboard.

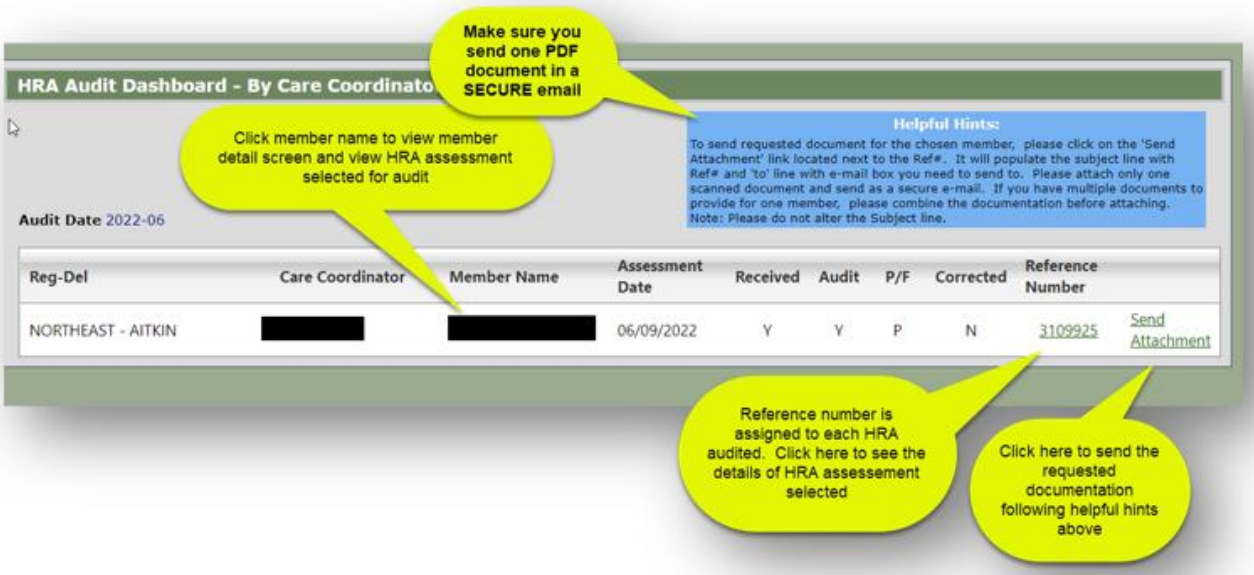


2. Click on the applicable month/year link in the HRA Audit Dashboard screen to view HRA audits that will be listed by Care Coordinator.

3. Click on the Delegate name to open up the list of HRAs being audited. The HRA Audit Dashboard also displays a summary of the HRA audit results for the month selected.



4. You will then be taken to this screen. The HRA selected for audit is listed by Care Coordinator and Member Name.



5. Select the **Send Attachment** link for each identified member. Be sure to follow the directions located in the Helpful Hints box.

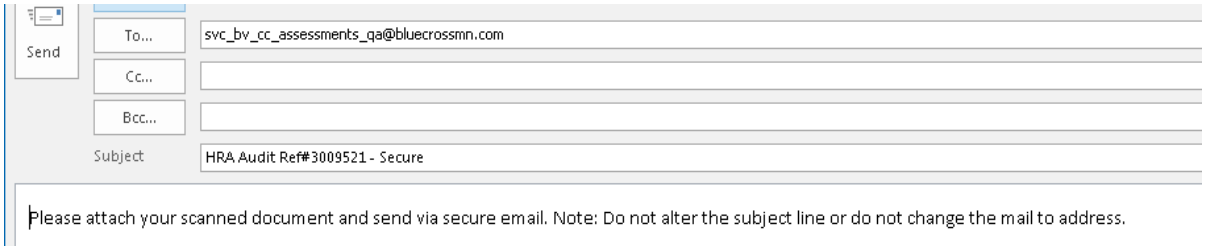
6. After clicking on **Send Attachment** in Bridgeview, your email system will open a new secure email for you to attach the documentation.

7. Save the requested document(s) in PDF form. Our automated system can only accept one attachment via email. If you are providing more than one document per member, you must combine them into one PDF document. (For example, if you are supplying contact notes and an Unable to Contact Letter, combine them as one PDF and attach to the email.)

   Documents needed are listed below, as applicable:
   - First page of the completed LTCC
   - First page of the completed 6.15 NH Assessment
   - First page of the completed 6.28 Transitional HRA
   - Unable to Contact Letter and case notes documenting 3 additional contact attempts
   - Copy of case notes documenting the refusal
   - Copy of the completed 3428H

8. Attach the PDF documentation, for each member(s) as applicable.

9. Do not Change the Subject line or the “TO” address field on the e-mail as these have been prepopulated with the correct information. Do not alter the body of the e-mail. Do not affix a signature. Hit send.



10. Blue Plus staff conduct the audit after all the required documentation for all members selected. Note: Uploading your document will not change the received field. The received field will only show as “received” after the HRA has been audited.

11. Audit results will be sent via e-mail from Partner Relations e-mail box.

12. A link to the HRA audit results information will also display on the Member Selection screen in the Assessment History section for each member selected.

DATES AND EXTENDED PCA ENTRY

Enter the following information under the Dates and PCA tab.

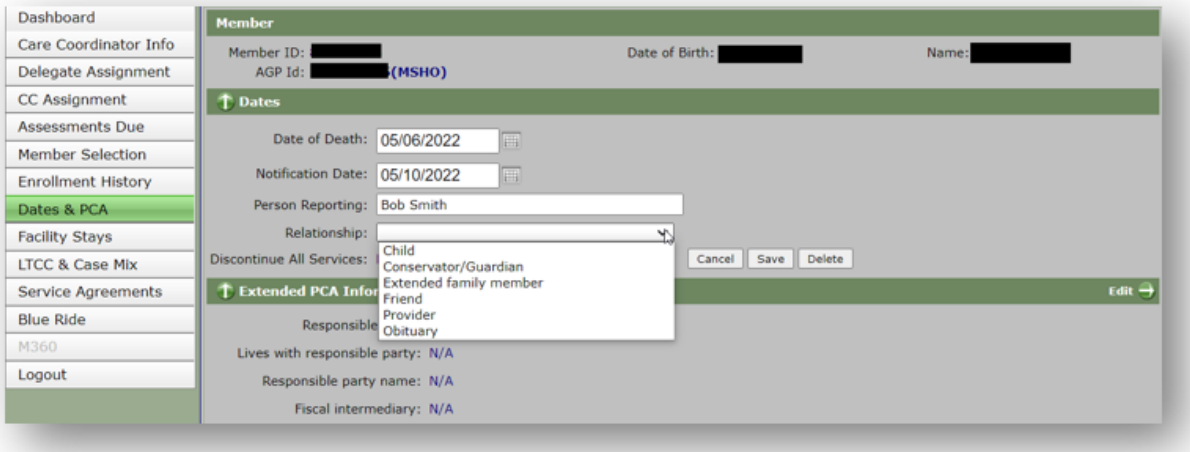
Date of Death (DOD)

Enter the member’s date of death if the member is deceased and the date of death is not populated in the member detail screen. When you enter a date in this field, all the line items in the service agreement will be closed as of the date of death. The LTCC/Case Mix waiver span will also be ended on the member’s date of death.

All claims submitted against any service agreement will not be payable beyond the date of death.

All fields are required.

1. Click on **Date and PCA** tab.
2. Enter:
    - Date of Death
    - Notification date
    - Person reporting
    - Relationship
3. Click **Save**.

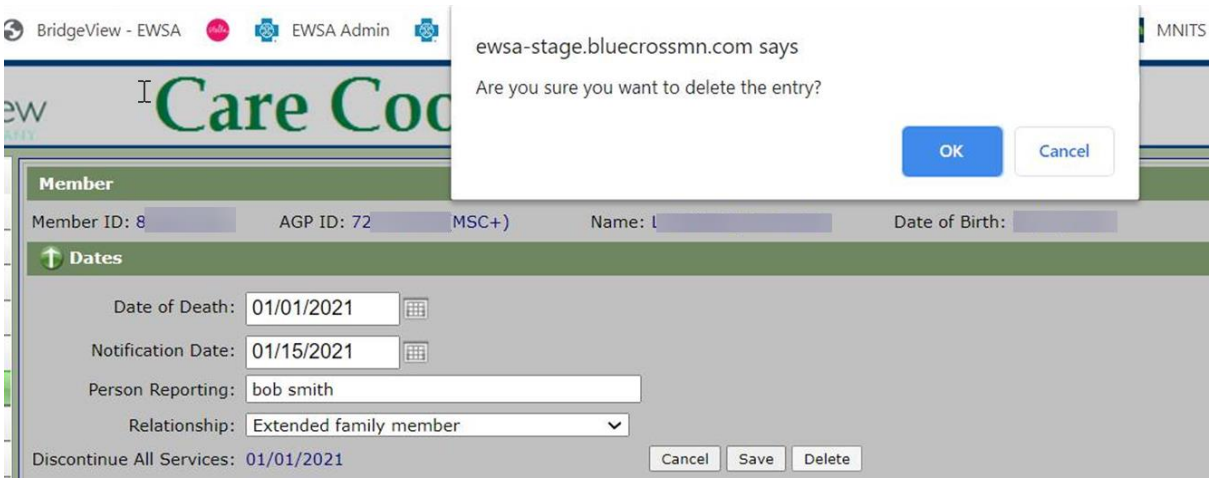


DOD entry e-mail reminders.

Blue Cross must report dates of death to the Department of Human Services monthly. An auto-generated e-mail will go out to Delegate contacts on the 18th of the month reminding CCs to enter any known dates of death that have not yet been entered.

Error in DOD Entry

Data entry errors: If an incorrect date of death has been entered you can delete the entire date of death entry. **However, the service agreements and LTCC/Case Mix end dates will not automatically repopulate. First, you must manually update the "To Date" for the LTCC/Case Mix with the corrected end date. Then edit the Service Agreements with the corrected end date.



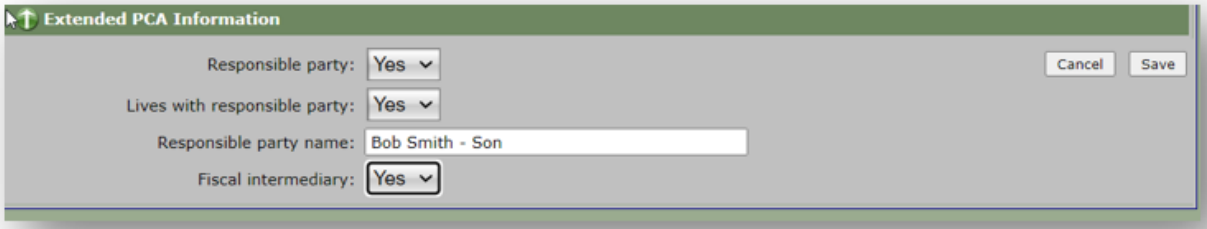
Extended PCA Information

Responsible Party: This field will default to blank. You must select **Yes** or **No** from the drop-down box if you are going to authorize services for Extended PCA.

Lives with Responsible Party: This field will default to blank. You must select Yes or No from the drop-down box if you are going to authorize services for Extended PCA. If you have chosen Yes in the Responsible Party field, this is a mandatory field.

Responsible Party Name: This field will default to blank. You must complete this field if you have chosen Yes in the Responsible Party field. You will be able to type up to 39 characters in this field.

Fiscal Intermediary: This field will default to blank. You must select Yes or No from the drop- down box if you are going to authorize services for Extended PCA. You must select Yes if the services will include PCA Choice.



Facility Stays

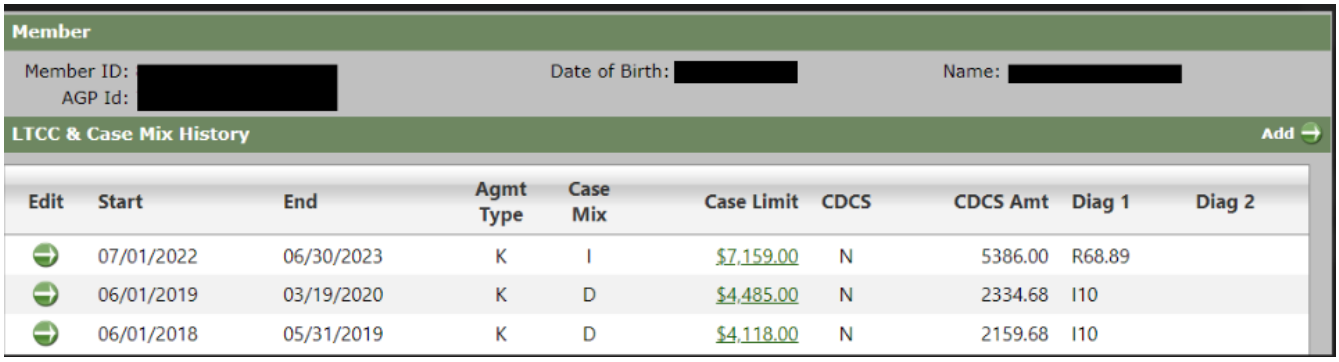
The Facility Stays section is optional. It can be a mechanism for Care Coordinators to track the member's facility stays and to help ensure providers are correctly submitting claims.

Select dates from the system calendar to enter the inpatient hospital or nursing home stay spans for the member. You can enter only the Admit Date if the Discharge Date is unknown, and then later go back in and populate the Discharge Date.

In addition, Inpatient and Nursing Home Stays are auto populated monthly from the inpatient reports.

LTCC AND CASE MIX SPAN ENTRY

In the LTCC and Case Mix section, you will be able to view, add, or edit the member's LTCC and case mix span.

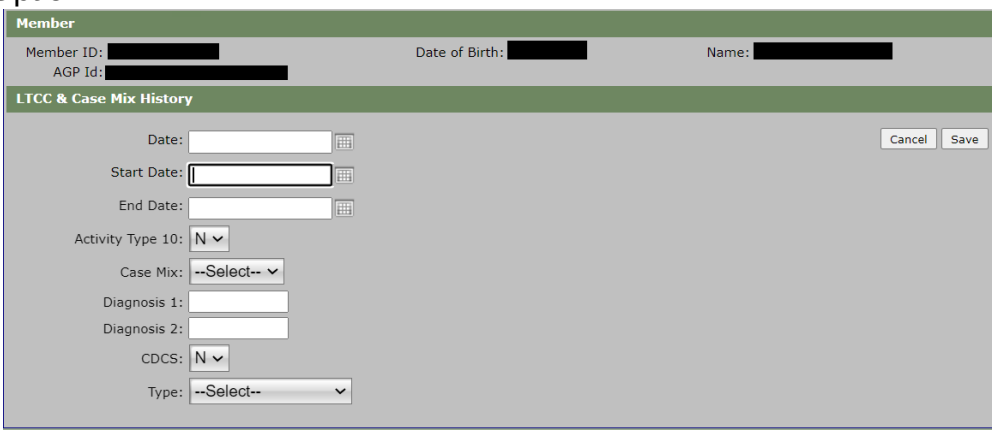


Edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag 1	Diag 2
	07/01/2022	06/30/2023	K	I	$7,159.00	N	5386.00	R68.89	
	06/01/2019	03/19/2020	K	D	$4,485.00	N	2334.68	I10	
	06/01/2018	05/31/2019	K	D	$4,118.00	N	2159.68	I10	

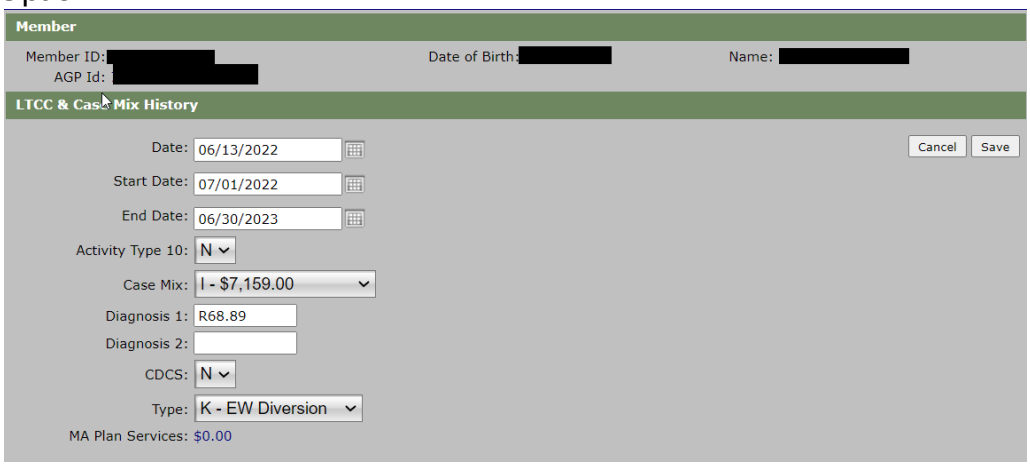
If you are using the Add option, you will be required to complete all the fields described in the headings below. If you select Edit option, you will be able to update the following fields.

- ✓ Date
- ✓ Start Date
- ✓ End Date
- ✓ Activity type 10
- ✓ Case Mix
- ✓ Diagnosis
- ✓ CDCS
- ✓ Type

Add Option:



Edit Option:



If you attempt to enter or add a LTCC & Case Mix date span that overlaps with another one, you will encounter an error message. It may require you to cancel out of the Add option and then go into the conflicting LTCC & Case Mix line item with the overlapping date. You would select the Edit button to change the End Date of the line item to the correct date, then save the entry. You can then proceed with entering the new LTCC & Case Mix date spans.

For members on EW, the start and end dates must coincide with the current EW date span assigned to the member, and there could be periods when the member has lost EW eligibility. In this case, you will see multiple date ranges with a break in the LTCC Start Date on the new line and the LTCC End Date on the previous line. This happens most often when a member has a facility stay or loses MA eligibility for a specific time span.

For changes to existing LTCC & Case Mix date spans, you may want to review the Service Agreement entries before making a change to the LTCC & Case Mix date spans. If the date spans don't align, you may need to close a service agreement line item(s) by editing the line to have zero units and then create a new line item after you have made the appropriate changes to the member's LTCC & Case Mix date spans. See Modifying an Existing LTCC & Case Mix Date Span for instructions on making changes to existing spans.
After you have completed your member assessment create a new date span entry in the LTCC & Case Mix section.

Creating a new LTCC & Case Mix date span

Enter a date span in the LTCC & Case Mix section for the following situations:

- New Elderly Waiver
- Community well with only MA State Plan Home Care Services.

- Member on another home community-based service waiver with MA State Plan Home Care Services (Case Mix W)
- Members accessing MSHO Supplemental benefits only (Case Mix "U"). Date span must be current calendar year.

***(Note:** A span is not necessary to be entered here for Community Well members who are not receiving any services.) See Modifying an Existing LTCC & Case Mix Date Span section when a member has an existing active span requiring updates.*

Note: you must first enter the HRA data prior to entering a new corresponding LTCC and Case Mix date span.

1. Click on "**Add**" button for new entry.

2. Complete fields per below:

   Date: Enter the current date.

   Start Date: Enter the date member starts new LTCC/Case Mix date span. *Date cannot be prior to Blue Plus enrollment date.

   - EW: Enter Member's Elderly Waiver span start date span start date. The start date should align with the MMIS effective date*.
   - CW with MA State Plan Services: Start date should be the date of the 3428H/LTCC or first date of service whichever is later.
   - Other HCBS waivers with MA State Plan Services: Start date should align with the other waiver span start date*.

   End Date:

   - EW: Member's elderly waiver span end date is the last day of the month prior to the new EW waiver span start date.
   - CW with MA State Plan Services: Align with end date of authorization span not to exceed 12 months from the date of the assessment.
   - Other HCBS waivers with MA State Plan Services: Align with end date of other HCBS waiver span.

   Activity type 10: Enter Y or N

   Case Mix:

   - For members on EW select the member's applicable EW case mix rate (A – K, L).
   - U - Supp Benefits. Select this for those who are electing MSHO supplemental benefits but do not have current span (I.e., Community Well members who are not receiving any services.
   - V - Vent dependent.

- W – Community Well. Select for Community Well members receiving MA - State Plan Home Care Services. This includes members on other HCBS waivers needing MA State Plan Services.
- Z – Other. Only Administration can select this option when there is a Blue Plus approved request to exceed case mix cap or conversion request (See Care Coordination guidelines for the approval process on these).

Diagnosis: Enter 1 and 2 diagnoses.

Enter the ICD-10 diagnosis codes that were used on the assessment. Providers are required to submit diagnosis codes on their claims, and in absence of a more accurate diagnosis code for the member, will submit the claim based on the diagnosis codes you provide from the assessment.

CDCS: Enter Y if member has elected CDCS option. Or N if member has not.

Note: The CDCS field will populate from information found in the member's history if available. The CDCS Monthly Amount field will automatically populate based on the member's case mix. This does not mean the member has elected the CDCS option; it is simply displaying the maximum CDCS budget the member would be allowed if they were to elect CDCS. This field will default to No.

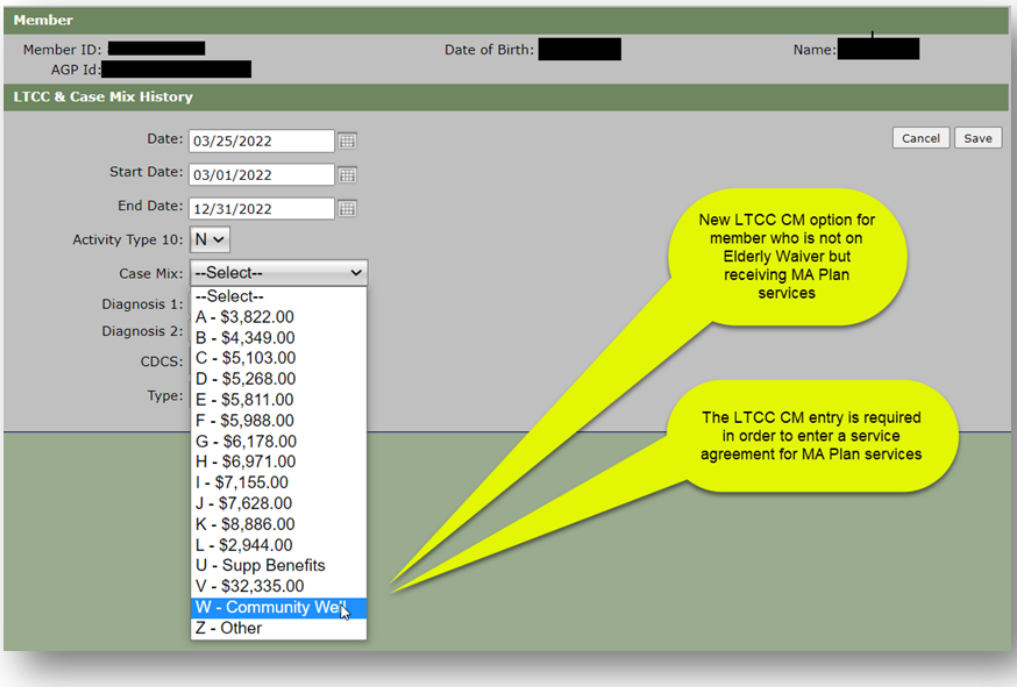
Members on other HCBS waiver CDCS (i.e., CADI CDCS) is not managed by the Blue Plus Care Coordinator.

Type: Select EW conversion or diversion. (For CW this section is not applicable and is grayed out)

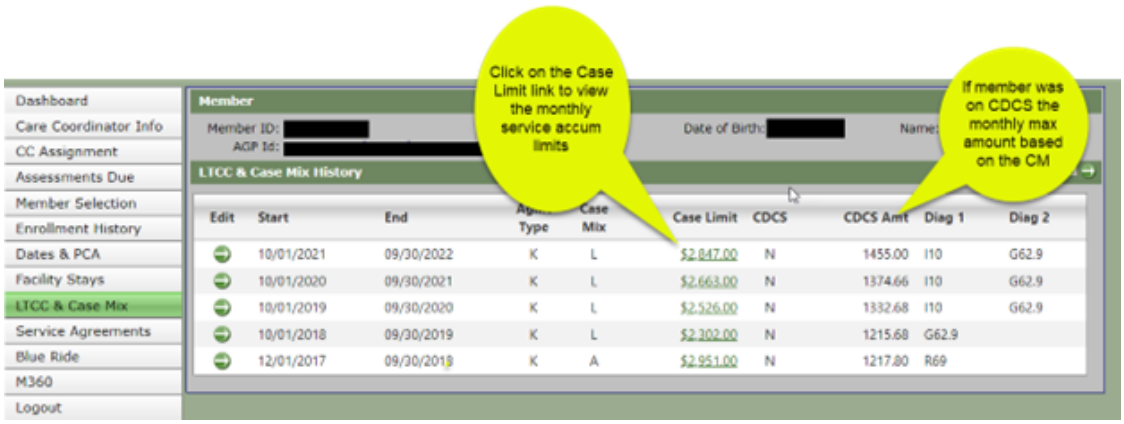
3. Click **"Save"**. **Note:** If you attempt to enter or add a LTCC & Case Mix date span that overlaps with another one, you will encounter an error message. It may require you to cancel out of the Add option and then go into the conflicting LTCC & Case Mix line item with the overlapping date. You would select the Edit button to change the End Date of the line item to the correct date, then save the entry. You can then proceed with entering the new LTCC & Case Mix date spans.

   The start and end dates must coincide with the case mix assigned to the member, and there could be periods when the member has lost EW eligibility. In this case, you will see multiple date ranges with a break in the LTCC Start Date on the new line and the LTCC End Date on the previous line. This happens most often when a member has a facility stay or loses MA eligibility for a specific time span.

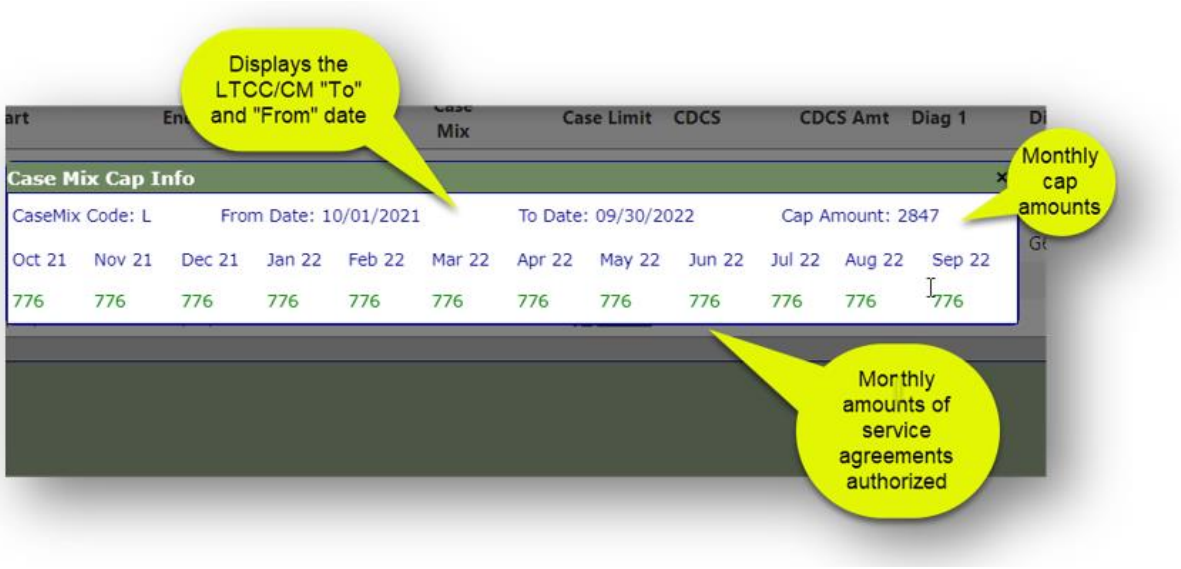
   You must review the Service Agreement entries before making a change to the LTCC & Case Mix date spans. If the LTCC start date spans do not align with your service agreements, you may need to close an existing service agreement(s) or modify the "To Date" with corresponding units authorized based on the "Qty Used".



Summary page displays Case Mix cap and a link to view the Service Agreement accumulations based on the Elderly Waiver span. If member is case mix U or W this link is not available.



After clicking on Case Limit link a display lists monthly accumulations for your Elderly Waiver Span.



Modifying an Existing LTCC & Case Mix Date Span

In order to modify an existing LTCC & Case Mix date span, all service agreements must be modified based on the changes by ending your **To Date** and adjusting **units authorized**.

Important: If you do not end all service agreements, you will **not** be able to enter a new LTCC & Case Mix date span. In addition, be sure to check on how many units have been billed by the provider so that units correspond with units already billed. Unless a member should not have received the services.

Instructions for editing LTCC & Case Mix Span:

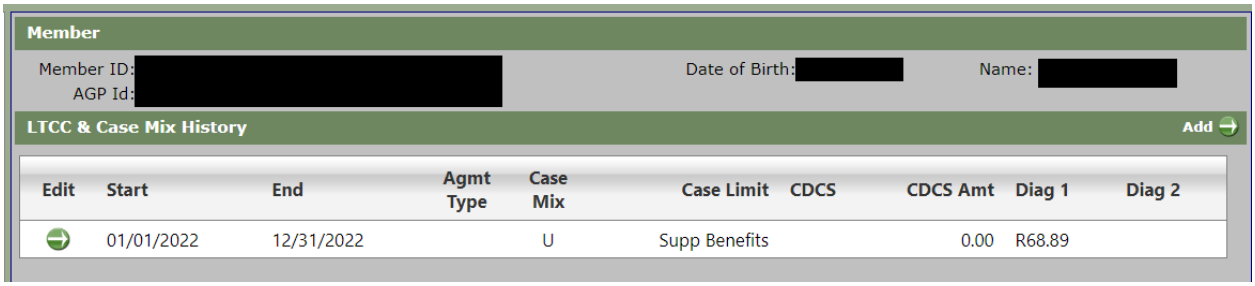
1. After entering member ID in Member Selection, click on Service Agreement tab.
2. Click “View” and modify the existing Service Agreement(s) by changing the **To**

Date to the day before your new LTCC & Case Mix span start date.

3. Click **Save**.
4. Go to LTCC & Case Mix tab and click “edit”
5. Modify the **End Date.** This date should be the day before the new LTCC & Case Mix start date.
6. Click **“Save”**
7. Create a new LTCC & Case Mix following directions in section above.
8. Enter new Service Agreements following in this section.

Scenario #1: When a member changes from CM “U” to Elderly Waiver

Member is currently on Supp Benefits (case mix “U”) from 1/1/2022 to 12/31/2022. Effective 07/01/2022 they start Elderly Waiver (assessed at case mix B).



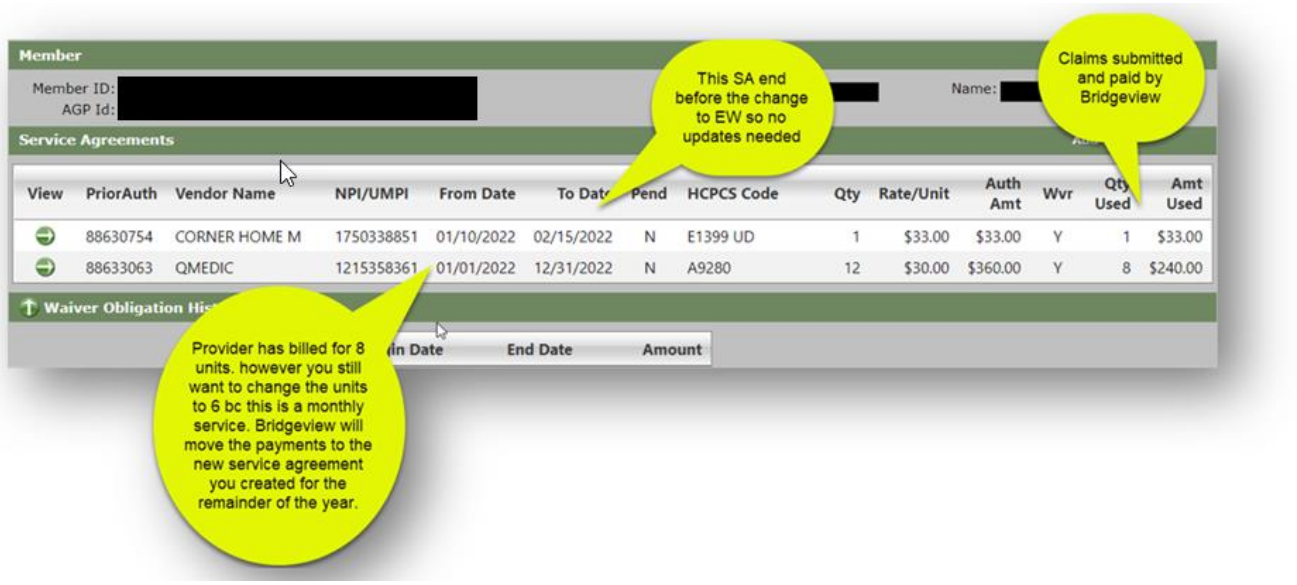
Member

Member ID: [redacted] Date of Birth: [redacted] Name: [redacted]
AGP Id:

LTCC & Case Mix History Add

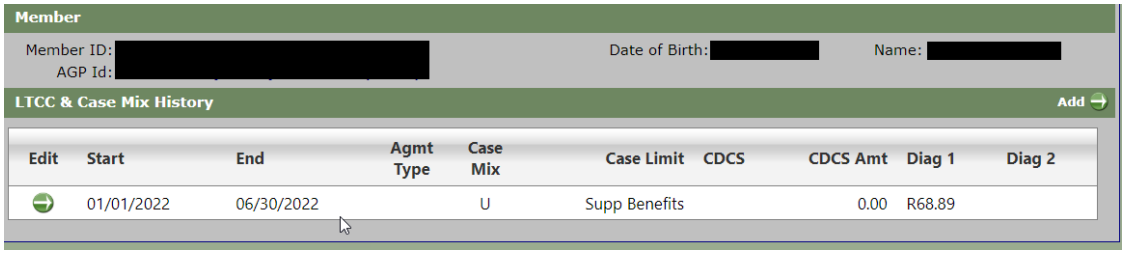
Edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag 1	Diag 2
	01/01/2022	12/31/2022		U	Supp Benefits		0.00	R68.89	

1. As always, complete LTCC assessment to open to elderly waiver and complete MMIS entry.
2. Listed below there are open service agreements under Supplemental benefits only. In fact, some providers have already submitted claims and have been paid.
3. End service agreement 88633063 for QMEDIC as of 06/30/2022 and change units from 12 to 6. Keep in mind the waiver span starts as of 07/01/2022 and will need to create a new service agreement for the supplement benefits until the end of the year. The MSHO Supplemental service agreement cannot exceed 12/31 of the current year. Any new MSHO Supplemental benefit service agreements after the new year cannot be entered until after the new year starts. Bridgeview team will automatically transfer the paid claims to the new service agreement.
4. In this scenario SA 88630754 Corner Home Medical for disposal face masks have already been delivered so nothing needs to be updated with this service agreement.

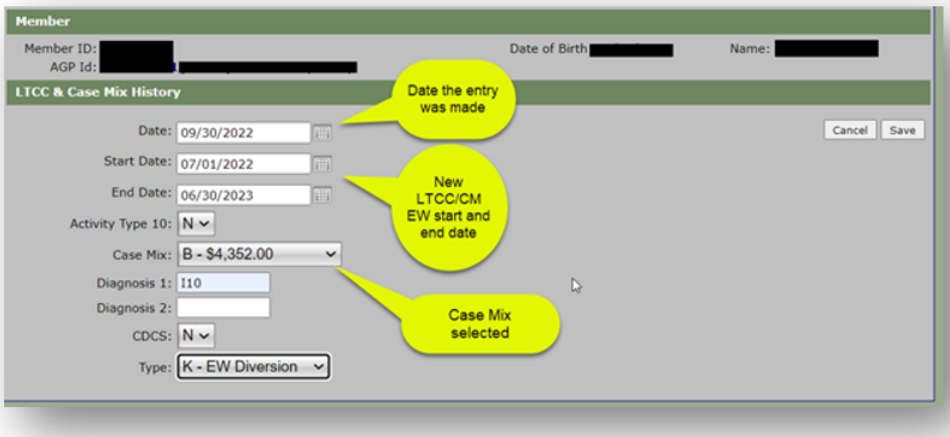


5. Next, end the current LTCC & Case Mix date span.
   a. To do this click on **Edit** on the LTCC & Case Mix
   b. Close the existing LTCC & Case Mix on the last day of the month before the member starts EW. In this case it would be 06/30/2022.
   c. Click **Save**

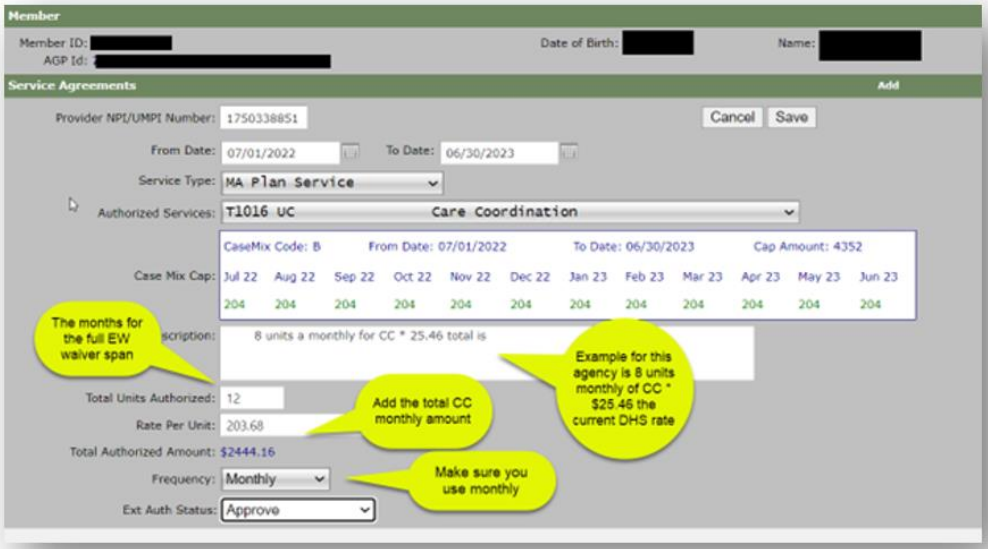
Below is the updated LTCC & Case Mix closing the current LTCC & Case Mix "U".



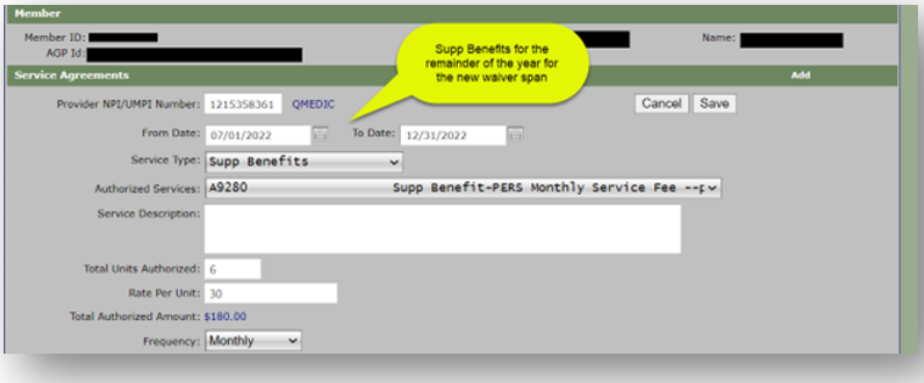
6. Add a new LTCC and Case Mix changing to a Case Mix B



7. Enter new service agreements for MA State Plan services, if applicable.
8. Required: Enter your Care Coordination and Paraprofessional service agreements if member on EW as they accumulate towards the members monthly case mix cap. There are specific codes (G9002 or T1016 UC, T1016 TF UC) based on your delegate's contract. Click here for additional CC and Paraprofessional Service Agreement screenshots.



9. Add the Service Agreement for the Supplemental Benefit(s) that must continue for the remainder of the 2022 calendar year (QMEDIC). In this scenario it will be 7-1-2022 through 12-31-2022.

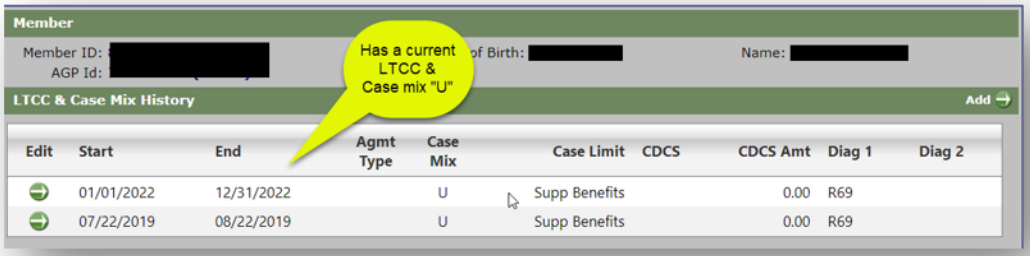


10. Enter any additional service agreements based on the assessment.

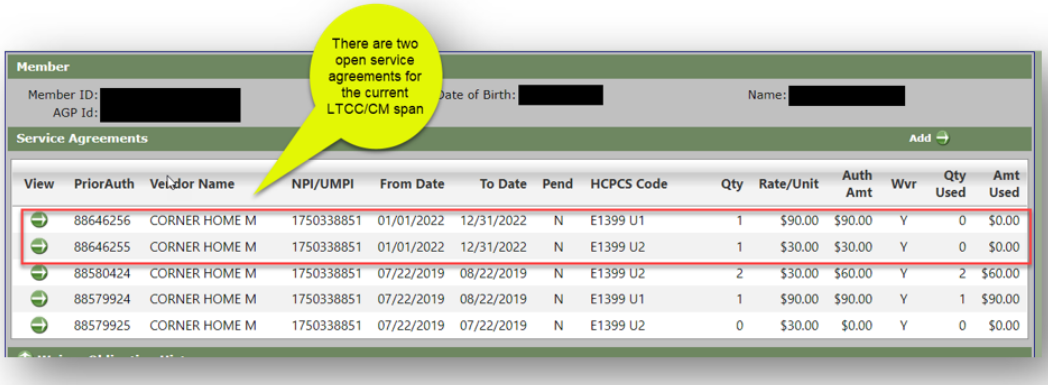
Scenario #2:

This member has a current date span from 1/1/22 to 12/31/22 accessing only MSHO Supplemental Benefits. Member is now receiving MA State Plan services (PCA, PCA Supervision, SNV) effective 7/1/2022.
Currently listed as Case Mix “U” (accessing Supplemental Benefits only) and now need to change to “W” Community Well.

Before:

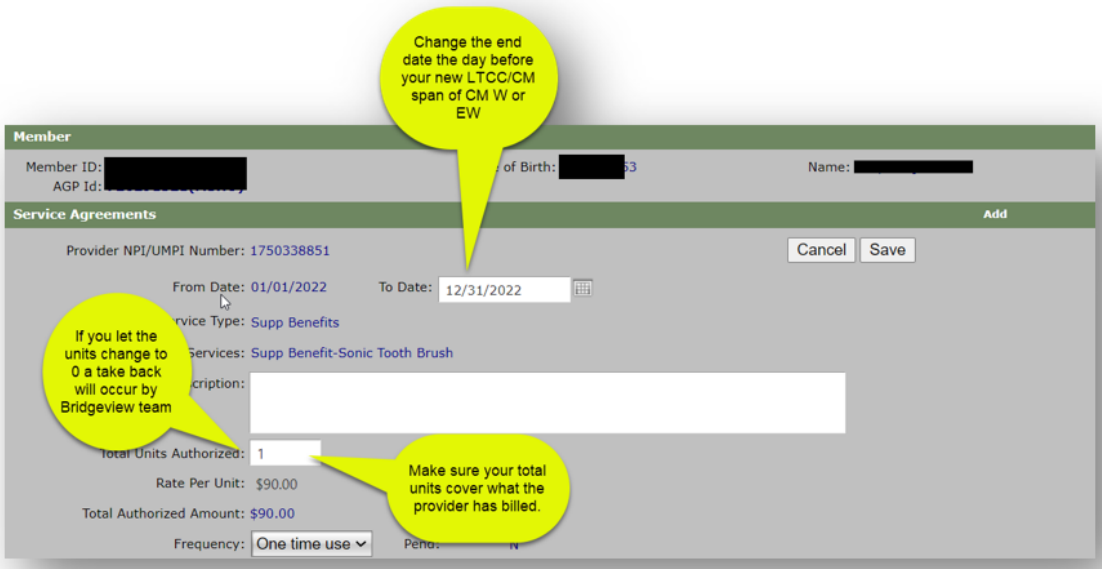


Edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag 1	Diag 2
	01/01/2022	12/31/2022		U	Supp Benefits		0.00	R69	
	07/22/2019	08/22/2019		U	Supp Benefits		0.00	R69	



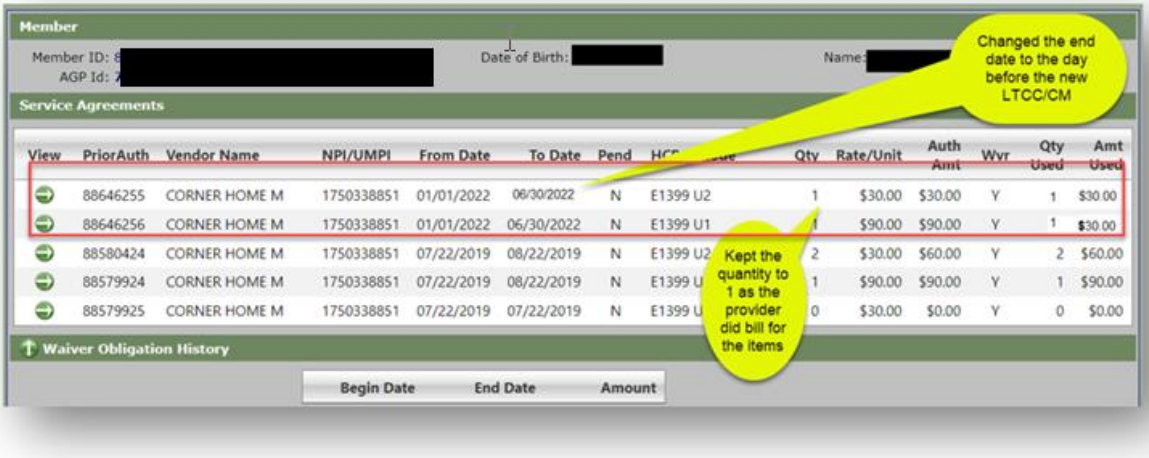
View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88646256	CORNER HOME M	1750338851	01/01/2022	12/31/2022	N	E1399 U1	1	$90.00	$90.00	Y	0	$0.00
	88646255	CORNER HOME M	1750338851	01/01/2022	12/31/2022	N	E1399 U2	1	$30.00	$30.00	Y	0	$0.00
	88580424	CORNER HOME M	1750338851	07/22/2019	08/22/2019	N	E1399 U2	2	$30.00	$60.00	Y	2	$60.00
	88579924	CORNER HOME M	1750338851	07/22/2019	08/22/2019	N	E1399 U1	1	$90.00	$90.00	Y	1	$90.00
	88579925	CORNER HOME M	1750338851	07/22/2019	07/22/2019	N	E1399 U2	0	$30.00	$0.00	Y	0	$0.00

Screenshot of changing service agreement **To Dates** for Scenario #2

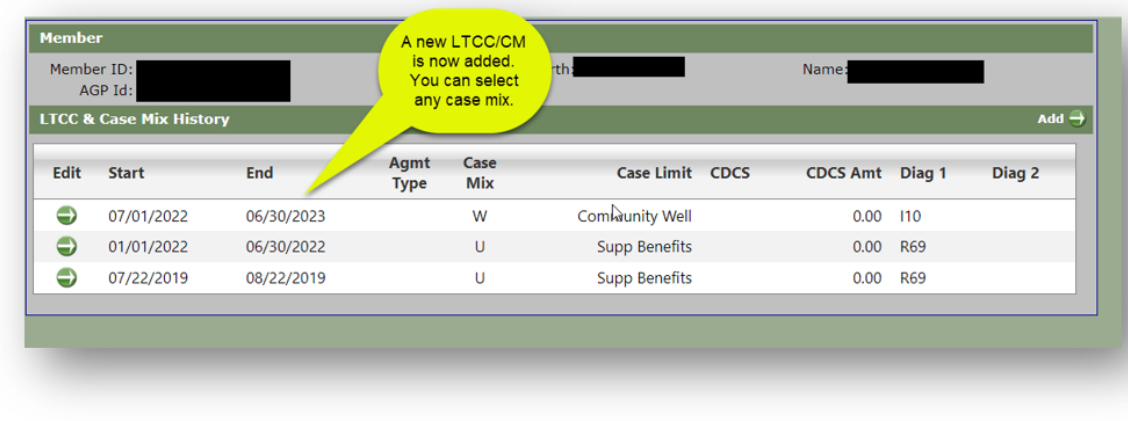


*Important: The *Total Units Authorized* field will default to "0" when modifying service agreements. Review and update the *Total Units Authorized* field to the new amount authorized, this must include units approved and already paid to the provider, for the new shortened time span.

After: Updated Service Agreements with new end date for Scenario #2.

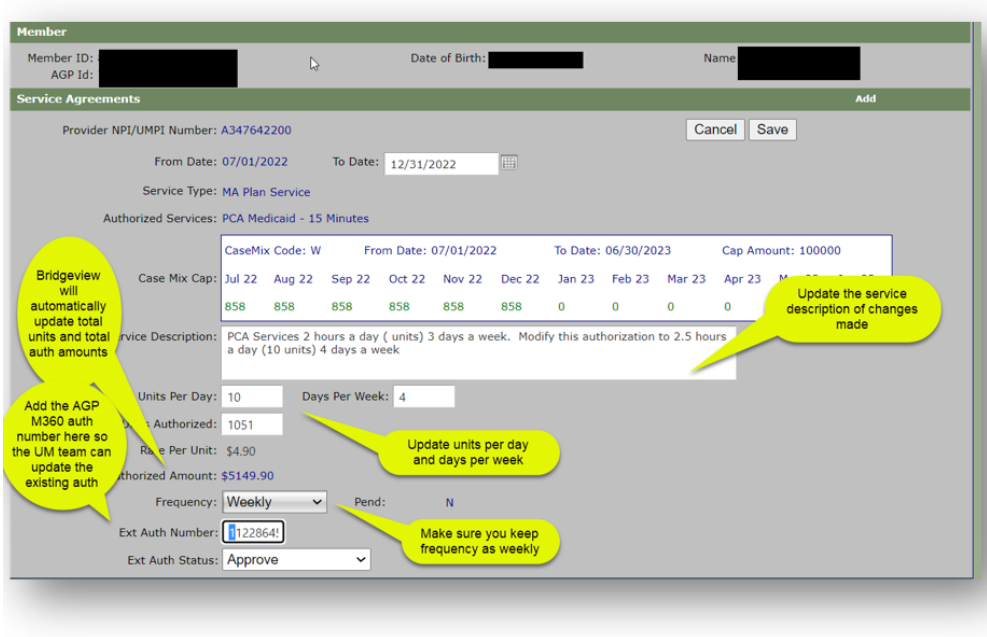


LTCC & Case Mix history screen displays new LTCC & Case Mix date span. Now you can enter Service Agreements for Scenario #2.

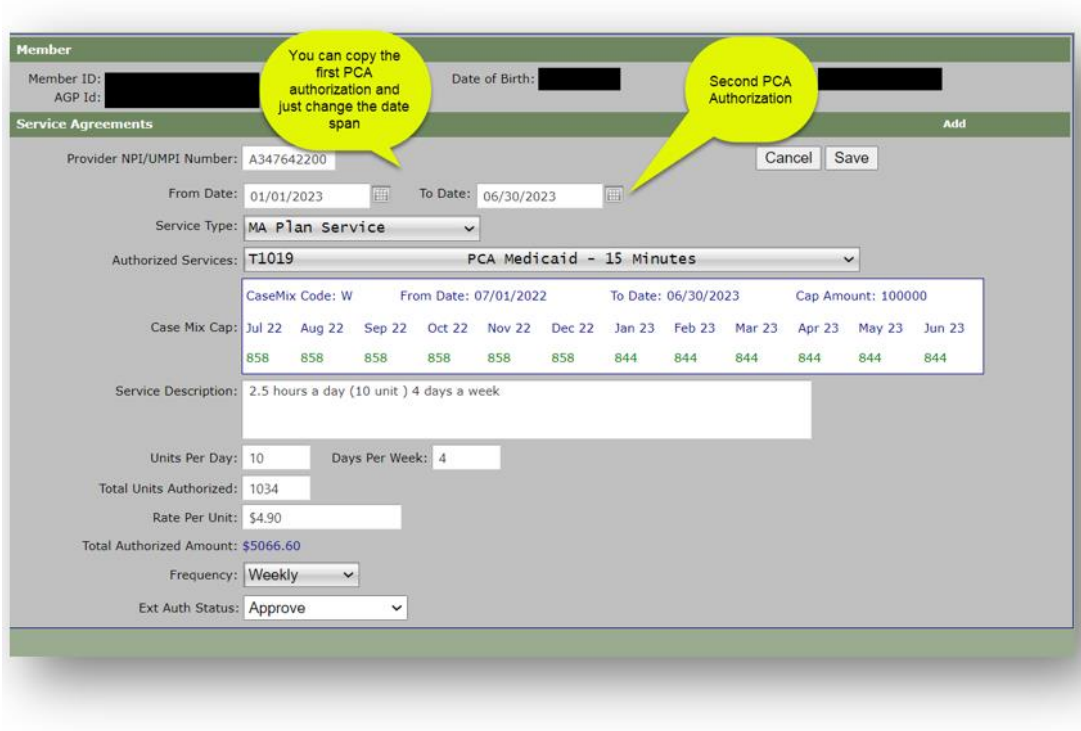


Entering MA State Plan Service Agreements for new span for scenario #2.

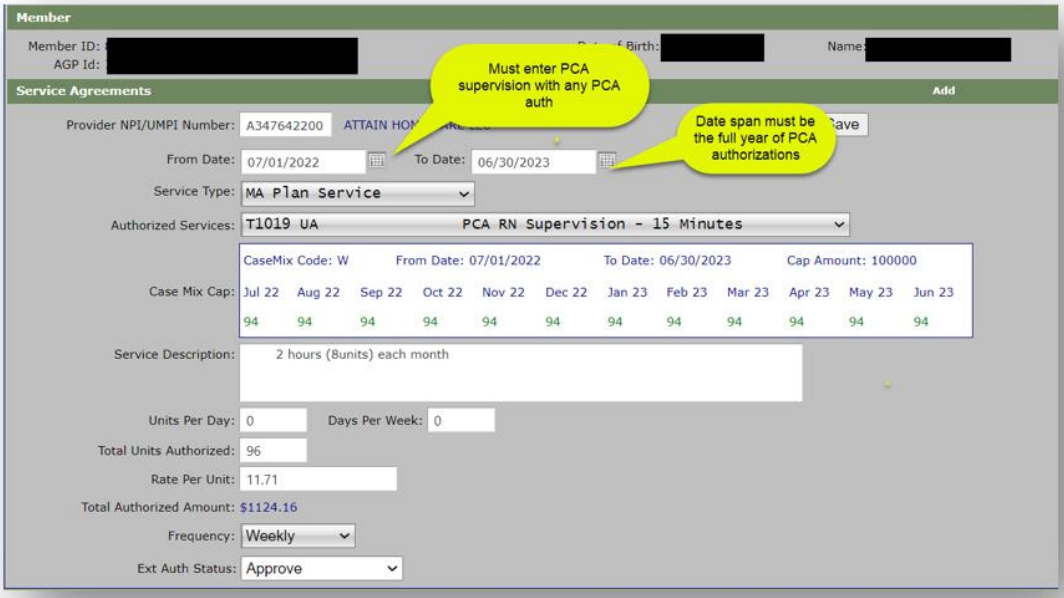
Example of PCA service agreement—first 6-month span for Scenario #2.



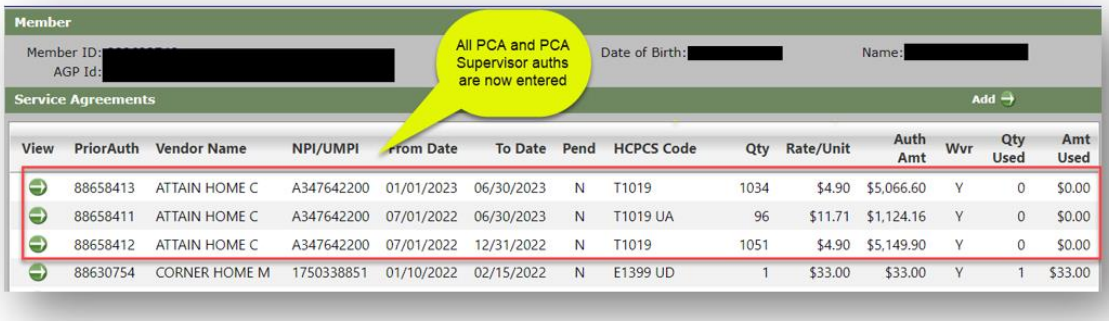
Example PCA Service Agreement—second 6-month span for Scenario #2.



Example PCA Supervision Service Agreement for Scenario #2



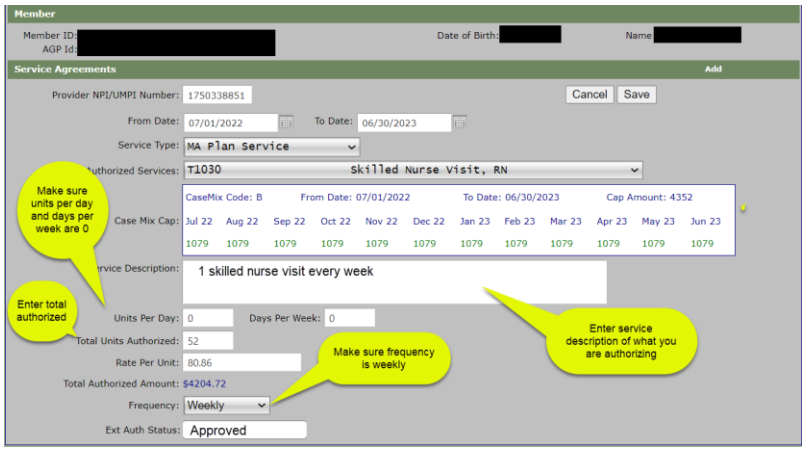
Service Agreement summary page displaying all PCA services now entered for Scenario #2.



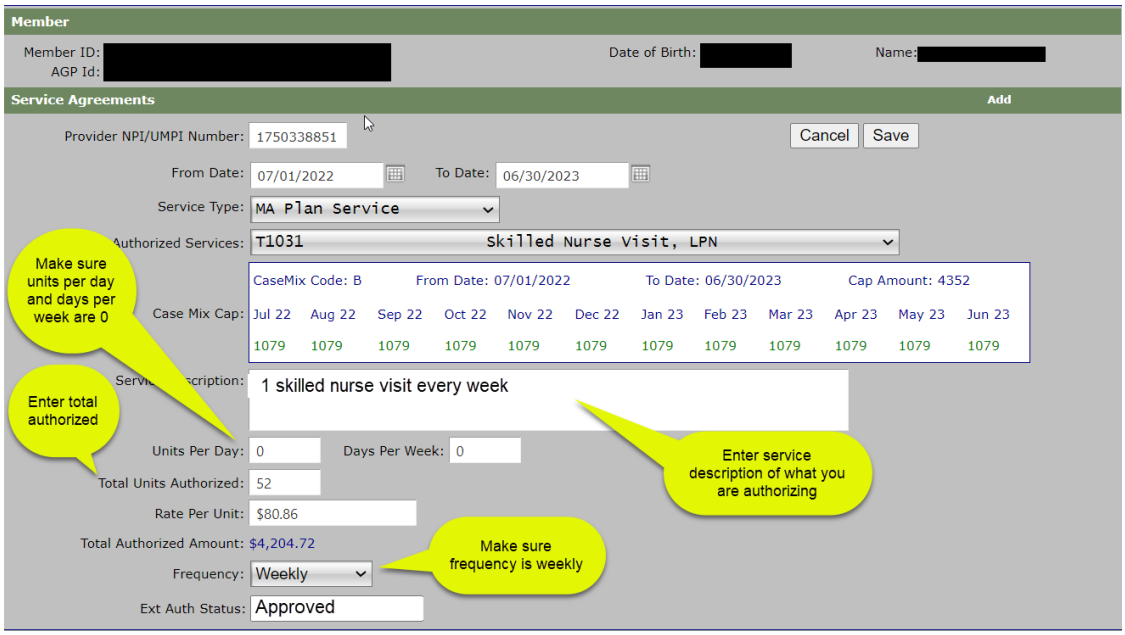
View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88658413	ATTAIN HOME C	A347642200	01/01/2023	06/30/2023	N	T1019	1034	$4.90	$5,066.60	Y	0	$0.00
	88658411	ATTAIN HOME C	A347642200	07/01/2022	06/30/2023	N	T1019 UA	96	$11.71	$1,124.16	Y	0	$0.00
	88658412	ATTAIN HOME C	A347642200	07/01/2022	12/31/2022	N	T1019	1051	$4.90	$5,149.90	Y	0	$0.00
	88630754	CORNER HOME M	1750338851	01/10/2022	02/15/2022	N	E1399 UD	1	$33.00	$33.00	Y	1	$33.00

Add Skilled Nursing Visit Service Agreements for Scenario #2

RN only:

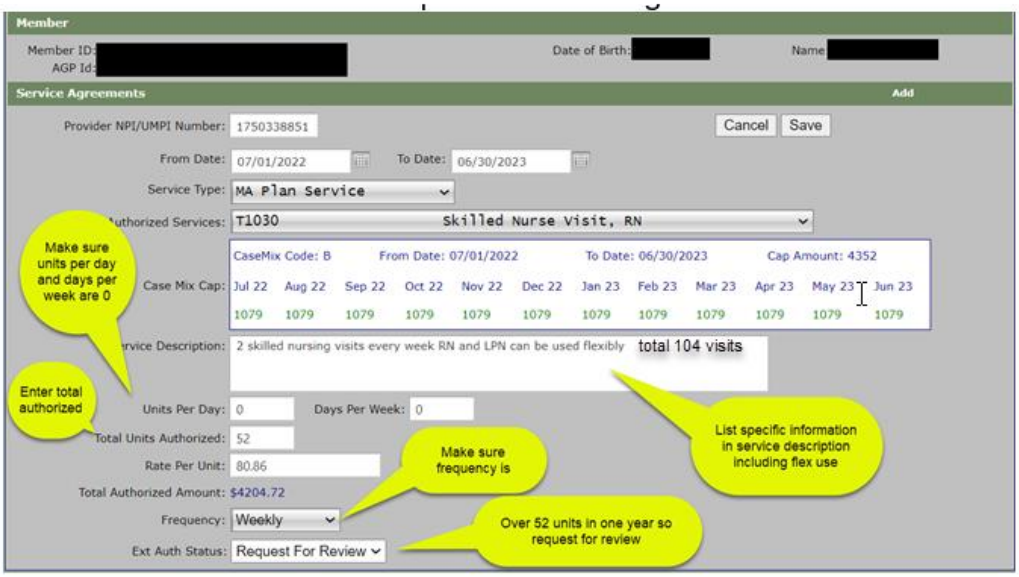

Member
Member ID:
AGP Id:
Date of Birth:
Name:
Service Agreements
Add
Provider NPI/UMPI Number: 1750338851
Cancel
Save
From Date: 07/01/2022
To Date: 06/30/2023
Service Type: MA Plan Service
Authorized Services: T1030 Skilled Nurse Visit, RN
Make sure units per day and days per week are 0
CaseMix Code: B
From Date: 07/01/2022
To Date: 06/30/2023
Cap Amount: 4352
Case Mix Cap:
Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23
1079 1079 1079 1079 1079 1079 1079 1079 1079 1079 1079 1079
Service Description: 1 skilled nurse visit every week
Enter total authorized
Units Per Day: 0
Days Per Week: 0
Total Units Authorized: 52
Rate Per Unit: 80.86
Total Authorized Amount: $4204.72
Make sure frequency is weekly
Enter service description of what you are authorizing
Frequency: Weekly
Ext Auth Status: Approved

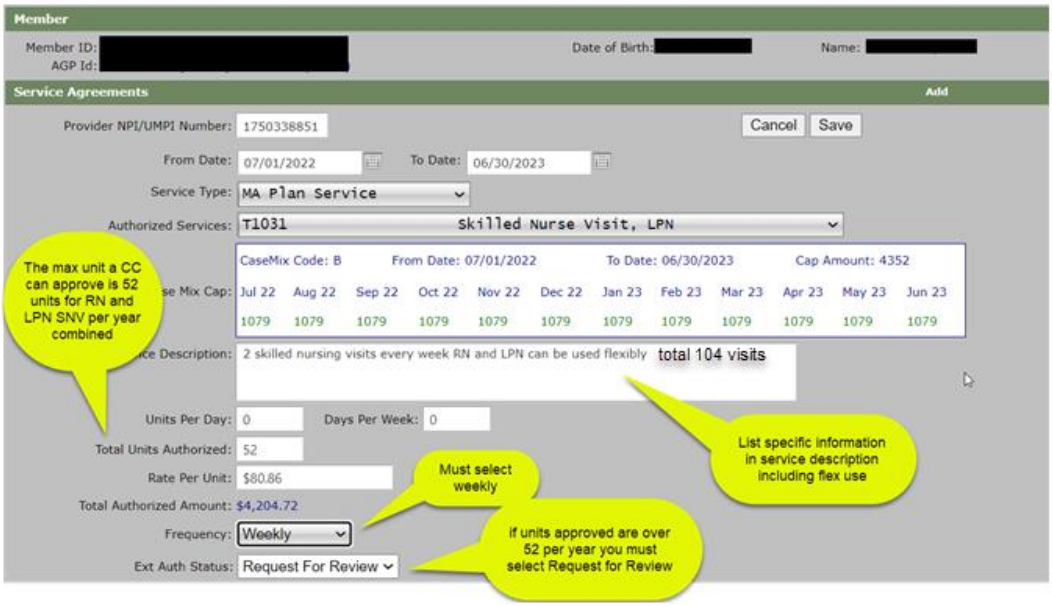
LPN only:


Member
Member ID:
AGP Id:
Date of Birth:
Name:
Service Agreements
Add
Provider NPI/UMPI Number: 1750338851
Cancel
Save
From Date: 07/01/2022
To Date: 06/30/2023
Service Type: MA Plan Service
Authorized Services: T1031 Skilled Nurse Visit, LPN
Make sure units per day and days per week are 0
CaseMix Code: B
From Date: 07/01/2022
To Date: 06/30/2023
Cap Amount: 4352
Case Mix Cap:
Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23
1079 1079 1079 1079 1079 1079 1079 1079 1079 1079 1079 1079
1 skilled nurse visit every week
Enter total authorized
Units Per Day: 0
Days Per Week: 0
Total Units Authorized: 52
Rate Per Unit: $80.86
Total Authorized Amount: $4,204.72
Make sure frequency is weekly
Enter service description of what you are authorizing
Frequency: Weekly
Ext Auth Status: Approved

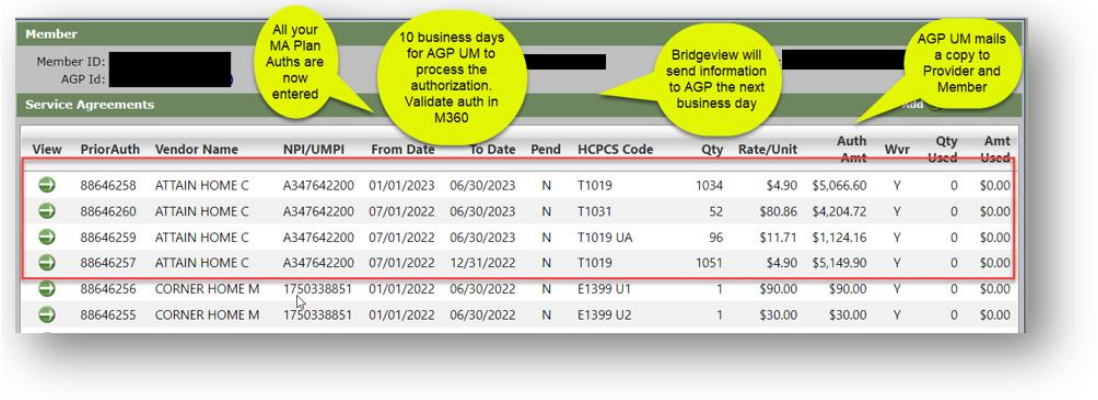
LPN and RN combined to be used flexibly:

Important: Will need to create two separate service agreements. In this example the authorization is for a total of 104 SNV's, divide the total accordingly for each service agreement.





Service Agreement summary page after SNV only was added for Scenario #2



View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88646258	ATTAIN HOME C	A347642200	01/01/2023	06/30/2023	N	T1019	1034	$4.90	$5,066.60	Y	0	$0.00
	88646260	ATTAIN HOME C	A347642200	07/01/2022	06/30/2023	N	T1031	52	$80.86	$4,204.72	Y	0	$0.00
	88646259	ATTAIN HOME C	A347642200	07/01/2022	06/30/2023	N	T1019 UA	96	$11.71	$1,124.16	Y	0	$0.00
	88646257	ATTAIN HOME C	A347642200	07/01/2022	12/31/2022	N	T1019	1051	$4.90	$5,149.90	Y	0	$0.00
	88646256	CORNER HOME M	1750338851	01/01/2022	06/30/2022	N	E1399 U1	1	$90.00	$90.00	Y	0	$0.00
	88646255	CORNER HOME M	1750338851	01/01/2022	06/30/2022	N	E1399 U2	1	$30.00	$30.00	Y	0	$0.00

- For members with existing SNV authorization(s) entered in Bridgeview that require changes or additions, see Modifying Service Agreement section.

Mid-Month Case Mix Changes

For situations when a member that is changing to a different case mix in the middle of a month:

- You may use the first day of that month that the member becomes eligible for services under the higher case mix as the LTCC start date instead of the actual date of the assessment, or
- You may start the higher LTCC and Case Mix entry effective the date of the assessment.
- If the case mix decreases, you would keep the higher LTCC & Case Mix entry in effect for a longer time, then start the lower LTCC & Case Mix the first day of the next month.

If you are authorizing a monthly service code for the member, you will not be able to authorize the services with a date range across more than one LTCC & Case Mix span. You would need to revise the previous LTCC End Date and newly effective LTCC Start Date for the time frame being impacted. You can then determine the prorated amount for the one month that has two rates and authorize that service separately from the remaining months (see the section “Closing Service Agreement Line Items When a Member is Deceased or has Facility Stays and Residential Absence Days” for additional information regarding entering prorated monthly services).

Members with Breaks in Elderly Waiver Eligibility

The LTCC & Case Mix example below illustrates that this member has a break in EW coverage. The member is not eligible to receive services under EW from 06/26/2022 through 08/09/2022. The member regains eligibility on 08/10/2022 and is assigned to case mix D at that time.

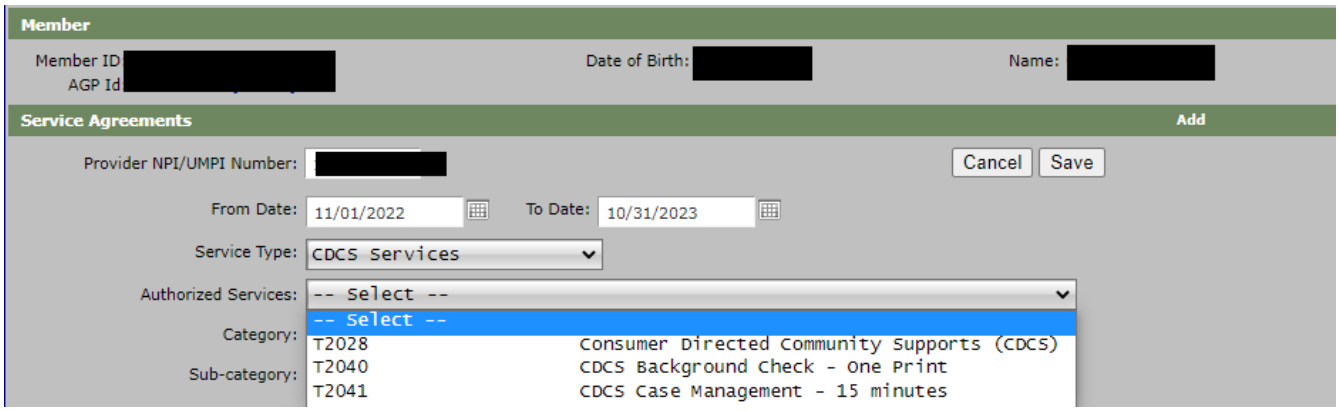
From Dt	To Dt	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag1	Diag2	MA PLAN SERVICES	MA PLAN MONTHY AMT
01/01/22	06/25/22	K	A	$3822	N	$ 762	290.10	327.11	$ 6,097.62	$1,016.27
08/10/22	12/31/22	K	D	$5271	N	$1,472	290.10	327.11	$20,535.50	$1,711.29

In the example above, you would not be able to authorize EW services from 06/26/22 through 08/09/22 because it is outside of the member's eligibility dates.

Most members will have one continuous date range that represents their yearly assessment. You will be allowed flexibility in entry, however, when you enter the line-item service authorizations, you must keep the authorized amounts within a single date span of the member's LTCC and Case Mix. These dates should be consistent with the information you are entering in MMIS under the member's LTCC screening documents.

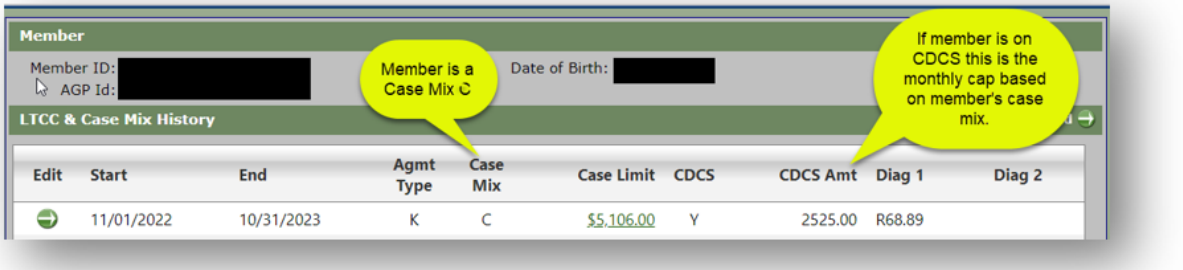
CDCS

CDCS (Consumer Directed Community Supports) is a service program under EW. When a member chooses EW CDCS, select the service type CDCS Services when entering your CDCS related service agreements.



The CDCS service program has different case mix caps which is based on the member's assessed needs. The CDCS Monthly Amount field will automatically prepopulate based on the member's case mix. This does not mean the member has elected the CDCS option.

The CDCS field will default to No if there is no history record to support the member has elected CDCS. Update this field to Yes if the member has elected the CDCS option. The displayed Monthly Cap is based on the DHS published CDCS Service Budget Amounts currently in effect for the Elderly Waiver Program **(excludes the case management and background check amounts).** It is important to note, when Yes is selected, a "Y" will appear in the CDCS column. For these members, the monthly case mix limit is listed under CDCS Amt column not the Case Limit column.



See CDCS Service Agreement section below for additional information about creating CDCS Service Agreements.

As applicable, for mandatory legislative rate increases see CDCS Legislative Rate Changes legislative rate increases, Bridgeview will work with the Care Coordinator to combine the member's CDCS service agreements. The Care Coordinator must contact Bridgeview at Bridgeview.service.agreements@bluecrossmn.com.

Diagnosis

The care coordinator should indicate the ICD-10 diagnosis codes that were used on the LTCC screening for the member. Providers are required to submit diagnosis codes on their claims, and in absence of a more accurate diagnosis code for the member, will submit the claim based on the diagnosis codes you provide from the LTCC assessment.

SERVICE AGREEMENTS

You must authorize services within a specific LTCC & Case Mix line-item entry. You cannot authorize services over dates that would span two or more LTCC & Case Mix entries.

Service Agreement Copy Function

If you need to create a new service agreement you can click on the copy button in the edit mode of any service agreement and the system will copy the existing service agreement with the capability of modifying any of the fields. This is especially helpful when you would like to create a new service agreement for an existing one that is in the system.

Adding a New Service Agreement (general process)

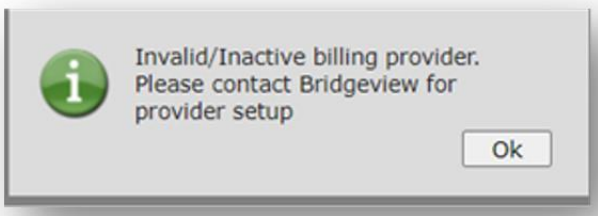
Entering Service Agreements for new EW; EW w/ MA State Plan Home Care Services; or Community Well with MA State Pan Home Care Services.

1. Click on **Service Agreement** tab.
2. Click on **Add** arrow
3. Enter the following:

Provider NPI/UMPI Number: Enter the provider NPI or UMPI number. The provider name will be displayed if the NPI/UMPI is validated. The NPI/UMPI is a 10-digit number that is assigned as a unique identifier for a provider. If the NPI/UMPI is is invalid or inactive, an edit will display. If this occurs, do the following:

- Verify with the provider that they have given you the correct NPI/UMPI number for that service.
- Check www.Minnesotahelp.info to verify that the provider is a DHS enrolled provider. If they are not enrolled the Care Coordinator must work with the member to find a provider that is enrolled with DHS.

- If you receive the following edit while trying to enter a provider this means:
  - the provider is not registered with Bridgeview. Or
  - it means they are not enrolled with DHS.



- Contact Bridgeview.service.agreements@bluecrossmn.com to verify if the provider needs to be registered with Bridgeview. Include provider name and contact information. Bridgeview staff will reach out to you to either confirm the provider is now registered with Bridgeview.

  Note: The Care Coordinator should always confirm Blue Plus network status with the provider or Member Services. As a starting point, for Home Care/PCA providers, Care Coordinators may also refer to the Home Care and/or the PCA Provider List located on the Care Coordination website under the Care Coordinator Resources page.

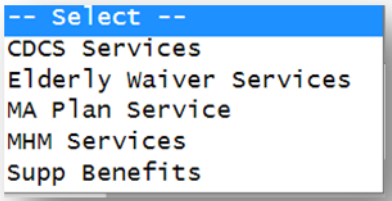
The Provider NPI/UMPI number is a protected field which cannot be changed once the line item has been entered.

From Date: Enter first date of service.

To Date: Enter last date of service

If the service code has a day or month definition, the system will do a validation check. If the code is a per day code, then the total number of units authorized cannot exceed the number of days between the "From Date" and "To Date" entered. If the code is a per month code definition, the total number of units authorized cannot exceed the number of months between the "From Date" and "To Date" entered.

Service Type: Select the service type



Authorized Services: Select the applicable service code(s) listed from the drop down based on the selected Service Type.

Case Mix Cap: For EW once you enter a service code from the drop down box a screen is displayed with the members Case Mix; date span previously entered in the LTCC & Case Mix section; Case Mix cap amount; and a monthly breakdown. For CW and Supplemental benefits this information will not display.

Service Description: Enter the service authorized, enter full description of what you are authorizing for the member, including total units per day and number of days per week as applicable. Note: Care Coordinator authorizing Out-of-Network (OON) Home Care/PCA provider must follow the Care Coordination Guidelines process for both new or existing enrollees. When it is necessary to use a provider that is registered with DHS but is not in the Blue Plus network, the Care Coordinator must add required note in the service description "Out of Network" and indicate the provider's DHS enrollment status.

Units per day: See examples below.

Enter the total number of units that are authorized for the provider. This must be a whole number from 0-99,999 and the total units should be based on the definition of the service being authorized.

Days per Week: See examples below.

Total Units Authorized: With the current system you may need to manually add total units based on the units per day/week/month, based on the "To" and "From" date. (**Always review this field to ensure it represents the total you intend for the service)

Rate Per Unit: DHS rate prepopulates. Some codes require manual entry of rates such as T2029, S5165, T2038, etc. If this is the case, enter the amount based on the service being authorized. i.e., Wipes are $5.00 per pack, enter this in the "Rate Per Unit" field $5.00.

Total Authorized Amount: Grand total of authorization is auto populated.

Frequency: Select from the drop-down box one of the values based on the Service code being entered and instructions on what frequency should be used. If you want to place specific limitations or restrictions on the provider for rendering services, please indicate that in the Service Description.
Values are based on the service provided:

- DAILY
- WEEKLY
- MONTHLY
- ONE TIME USE

Ext Auth Status: Select **Approve** if MA State Plan Home Care authorization does not require a Utilization Management (UM) review. Or **Request for Review** if MA State Plan Home Care Service authorization requires Utilization Management (UM) review. (See Care Coordination guidelines for guidance on when CC should be requesting UM review).

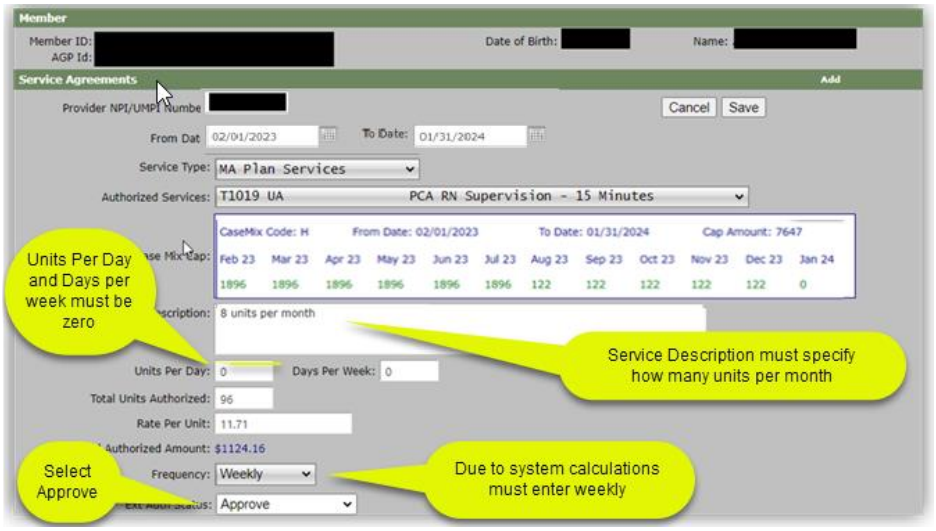
4. Click **Save.** Go to the next screen.

5. Enter **Provider and Member Reason Code**: Select a minimum of one reason code based on the new authorization. You may select up to three reason codes from the drop-down box. These codes will print on the notification generated for the service authorization. Member Reason Codes are optional and are printed out and mailed daily by Bridgeview Company. See reason codes on the Care Coordination website under the Bridgeview page. Provider Comments (optional). The Provider Comment screen is used to add text that will be shown on the provider service agreement notification. This text is not saved after the notification is generated for the provider. Member Comments (optional). The Member Comment Screen is used to add text that will be shown on the member letters. This text is not saved after the letter is generated for the member.

6. Click **Save**. Service agreement is now displayed on the service agreement summary page.

PCA Service Agreements

PCA Supervision Monthly (authorized in 15-minute units) *

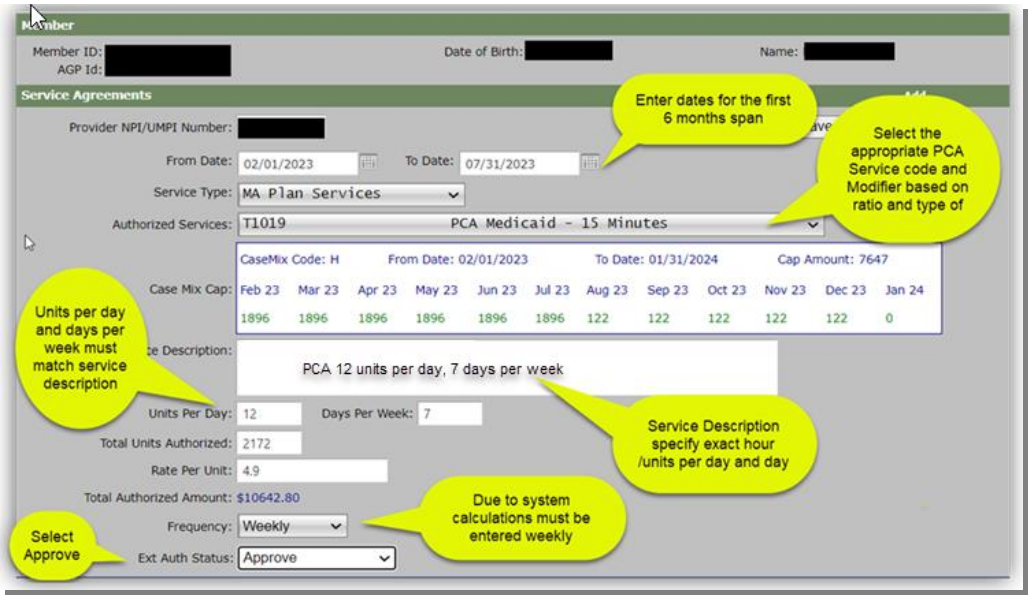


*See "Adding a New Service Agreement" for complete instructions.

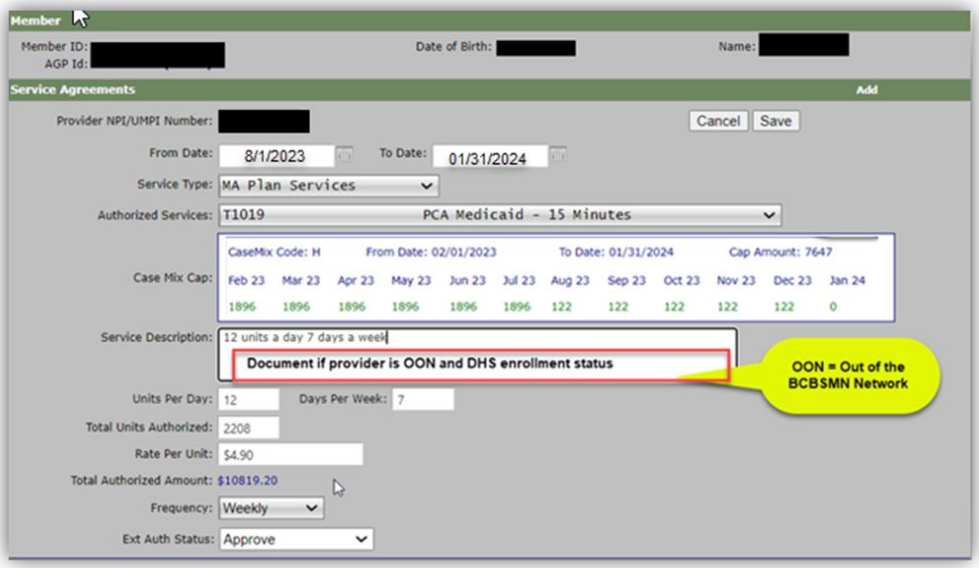
PCA Daily (authorized in 15-minute units) *

Must enter two Service Agreement lines, one for each 6 month span. Follow these directions for both six-month spans according to the PCA service span, as applicable.

Span end date cannot exceed the date of the next PCA reassessment due date. If this is the case, document in Service Description the reason the end date isn't a full six months.



Required documentation for Out of Network Providers



Unassigned PCA Providers

Use the UMPI below to add a service agreement for PCA when a PCA agency has not been determined.

UNASSIGNED PCA PROVIDER

UMPI: A666666666

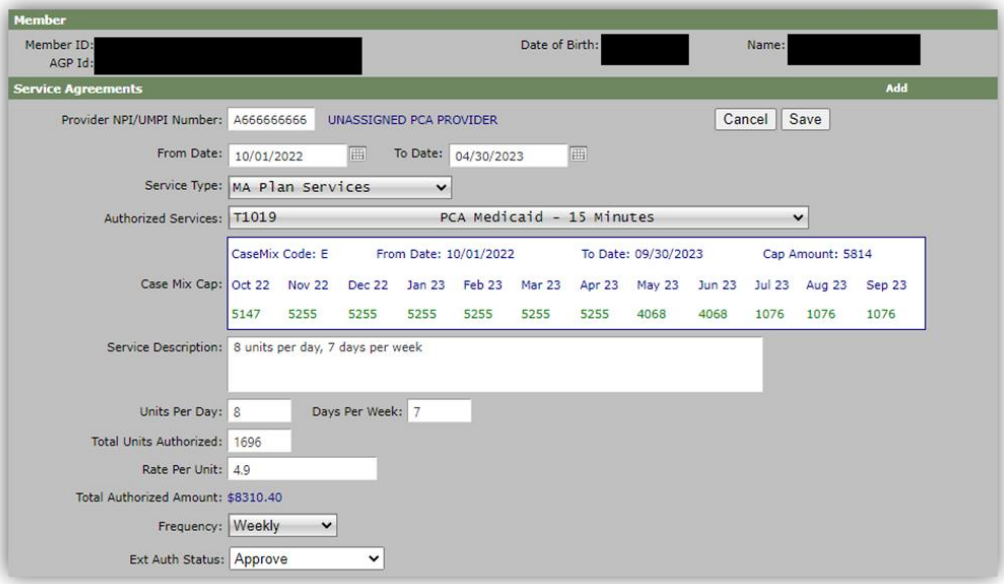
Continue entering the service agreement based on the instructions included in this document.
Once this authorization is created, a daily file is sent to the UM authorization team to enter the authorization and assign an authorization number.

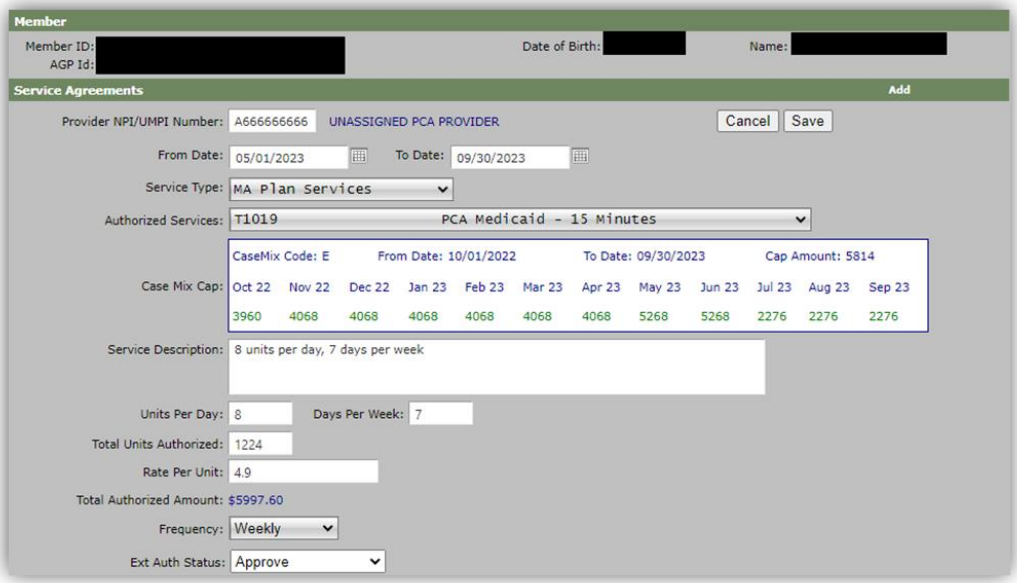
When the PCA agency has been determined, send an email to Bridgeview.service.agreements@bluecrossmn.com and include:

- Member name
- ID number
- Service Agreement number(s) you would like to assign a PCA agency
- UM authorization number of the original request
- Bridgeview team will update the information and send a new daily file the next business day to the UM team.

*Must enter all parts (two six months spans and PCA supervision) of the PCA

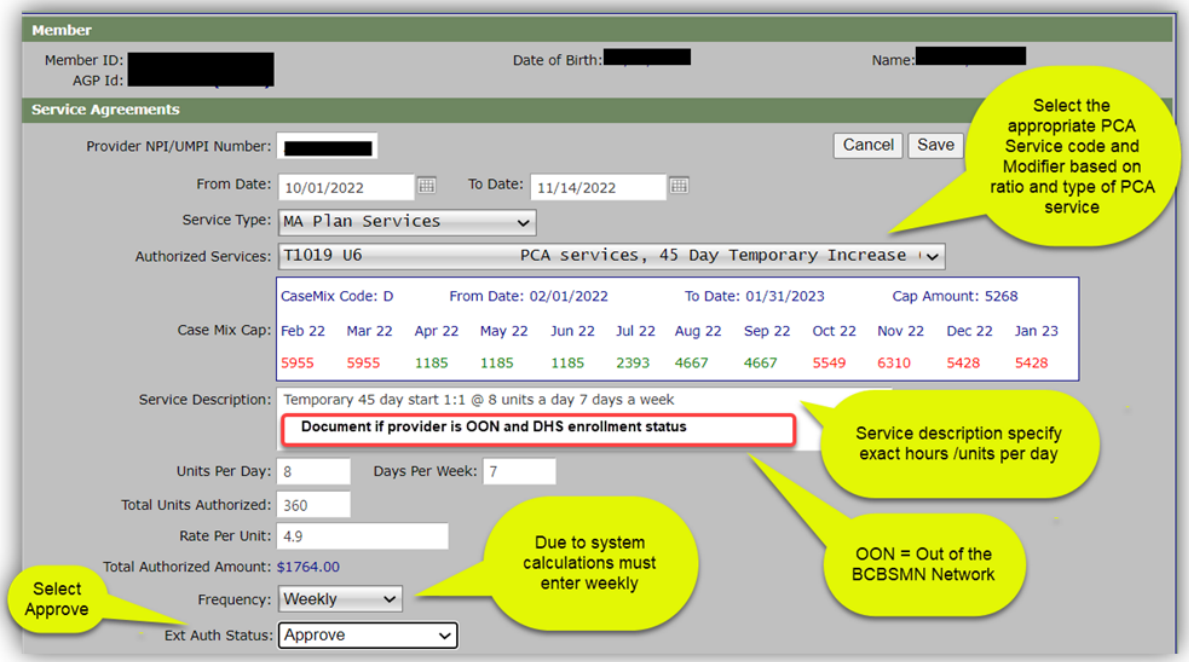
authorizations on the same day.





PCA 45-Day Temp Increase:

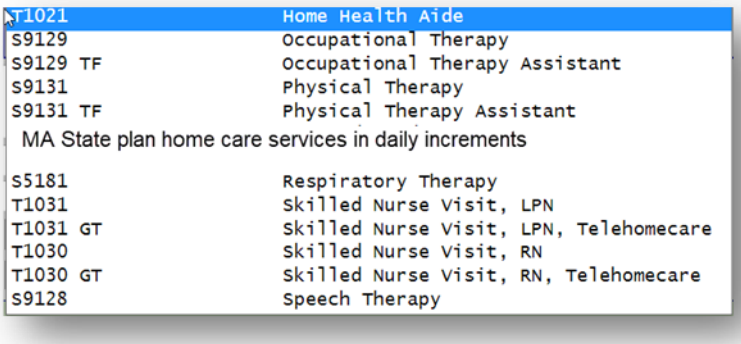
45-Day Temp authorizations should only be authorized for 45 days. If the provider is out of network (OON), follow the instructions for authorizing an out of network by ensuring the required documentation is included in the service description.



State Plan Home Care Service Agreements

MA State Plan Home Care Service Visit (authorized by the visit) *

Listed below are the State Plan Home Care service codes that are authorized per visit when selecting Service Type “MA Plan Services”. **Note:** OT, PT, ST, and RT do not accumulate towards the members case mix cap if on EW.



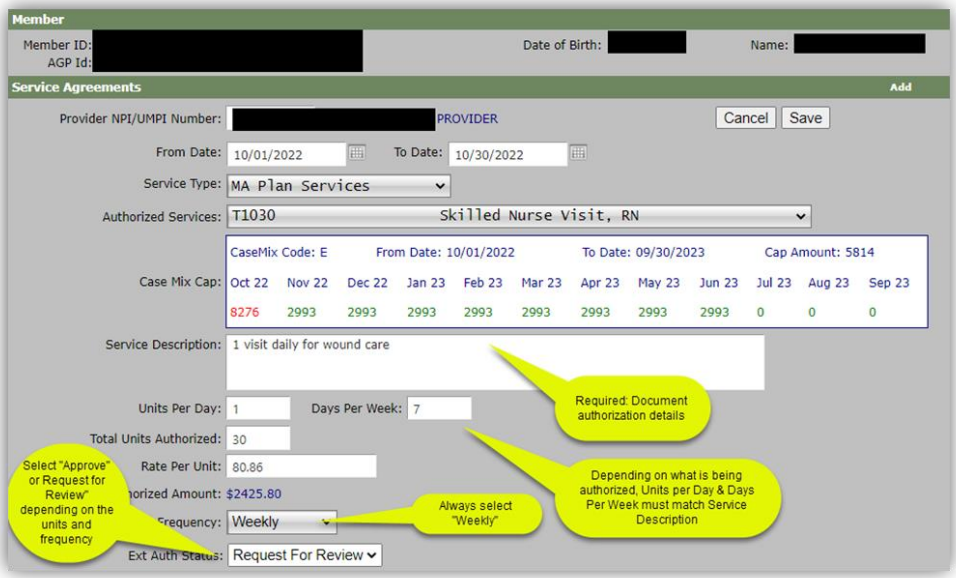
*See “Adding a New Service Agreement” for complete instructions.

Skilled Nurse Visit *

Service Description: Must document the number of visits authorized and how often. (I.e., 1 visit every other week.)

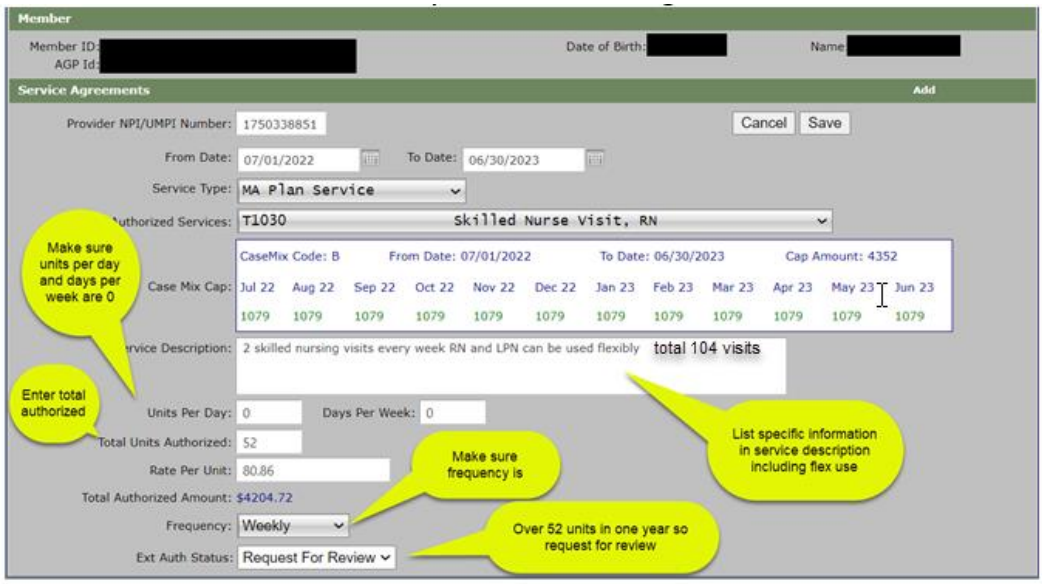
Frequency: Must always select “Weekly” for frequency.

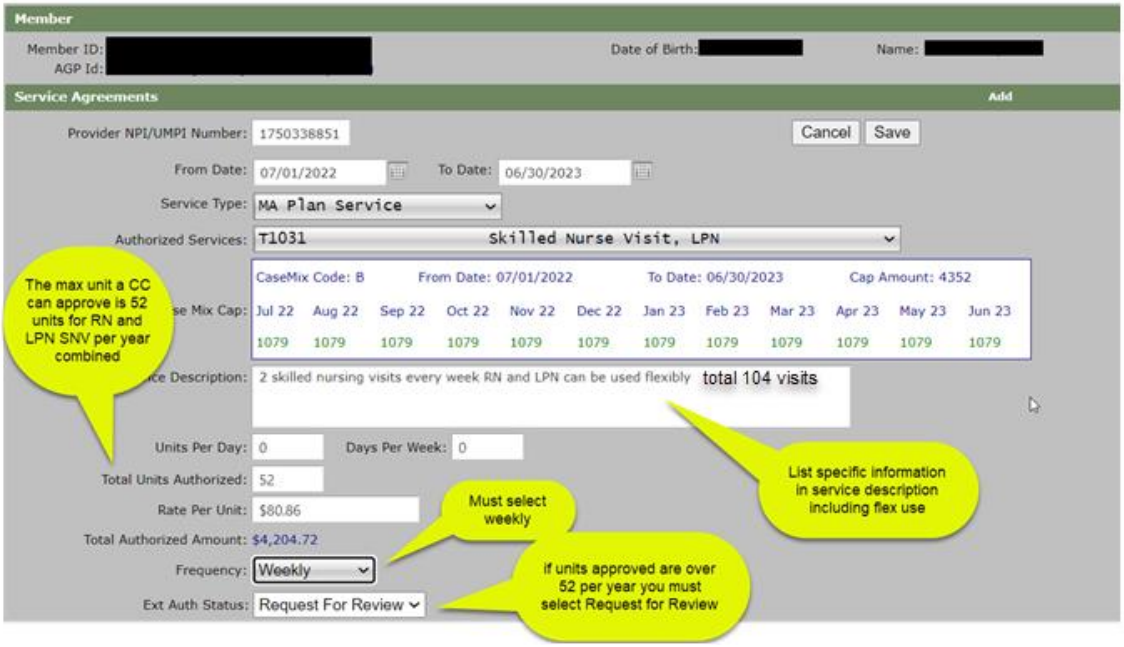
Ext Auth Status: Select **Approve** if authorization is 52 Skilled Nurse Visits per year or less (not to exceed 2 visits per week) OR,
Select **Request for Review** if authorization is greater than 52 Skilled Nurse Visits per year or greater than 2 visits per week. Follow directions in Care Coordination guidelines for submitting information for Utilization Management review.



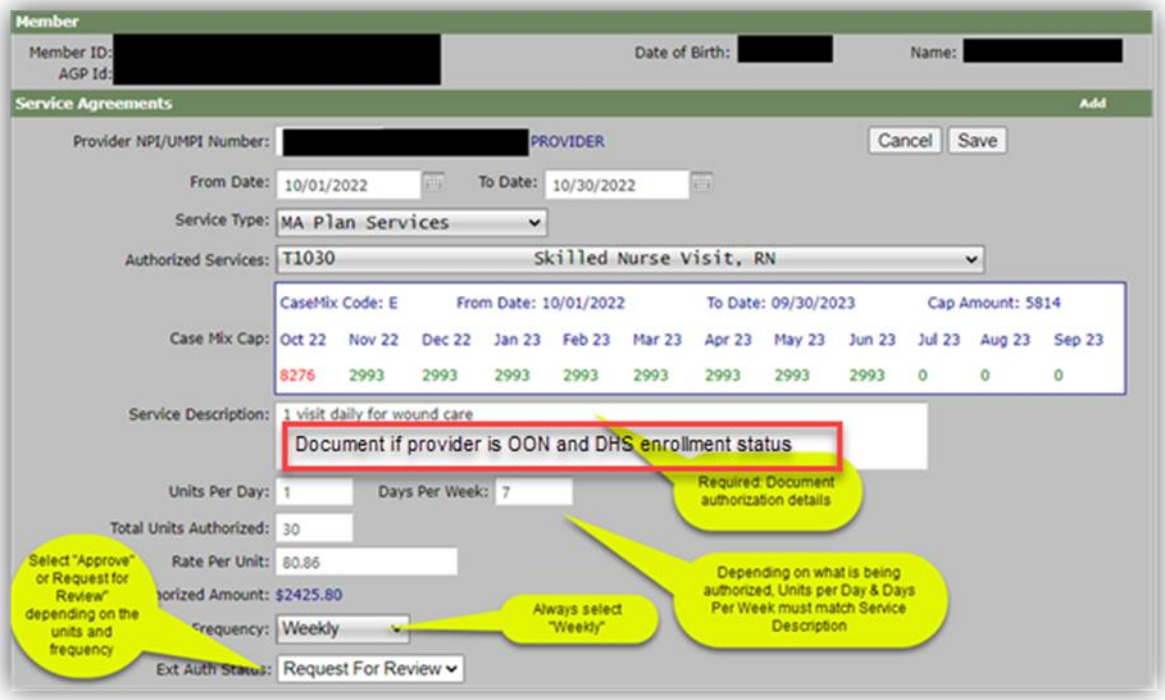
*See “Adding a New Service Agreement” for complete instructions.

When authorizing both LPN and RN Skilled Nurse Visits enter two separate service agreements. If the number of each type of skilled nurse visit is unknown, equally divide the total units authorized between LPN and RN with a note indicating the service is flexible use and the total visits in the service description:





Out of network example for skilled nursing services. Select the appropriate procedure code based on the member's plan:



Home Health Aide Visit *

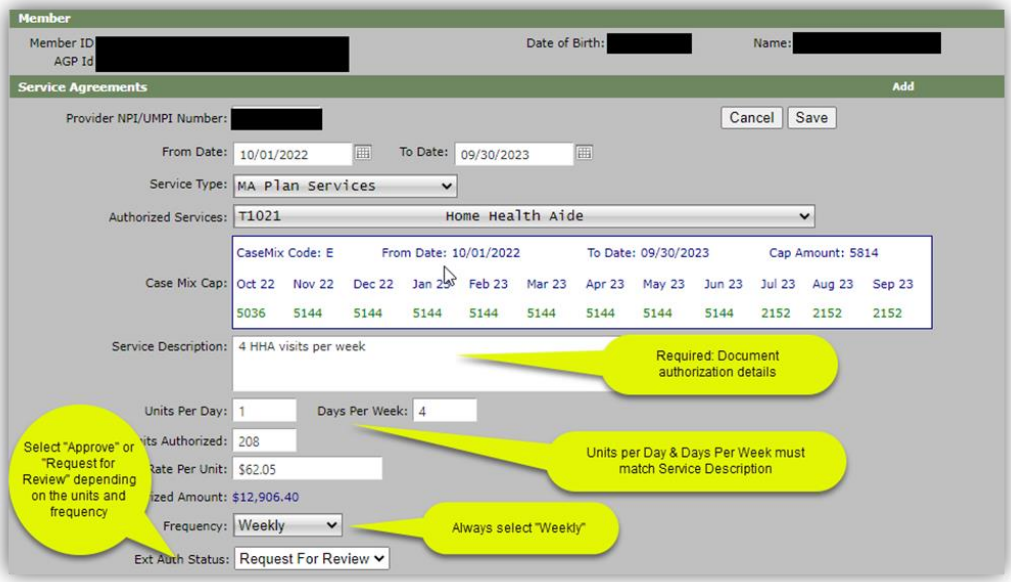
Frequency: Must always select "Weekly"

Service Description: Must document specific authorization details (I.e., “2 hours a day. 1X per week” or “1 visit every other week”). Be sure your entry in the Units Per Day and Days Per Week field match as documented here.

Select **Approve** if authorization is 156 Home Health Aide visits per year or less (not to exceed 3 visits per week)

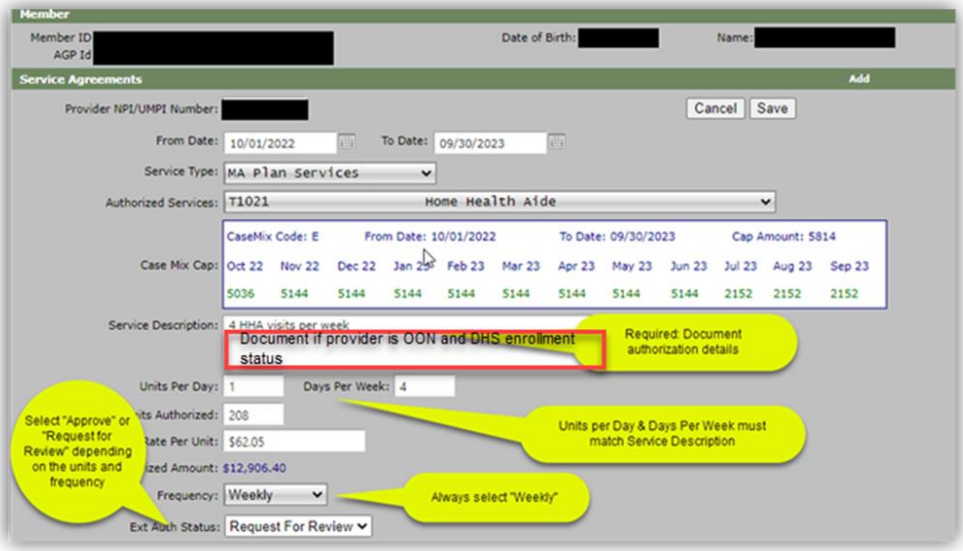
Or

Select **Request for Review** if authorization is greater than 156 Home Health Aide visits per year or exceeds 3 visits per week. Or the member lives in Adult Foster Care or Customized Living. Or the member is receiving PCA services. Follow directions in Care Coordination guidelines for submitting information for Utilization Management review.



* See “Adding a New Service Agreement” for complete instructions.

Out of network example for home health aide.

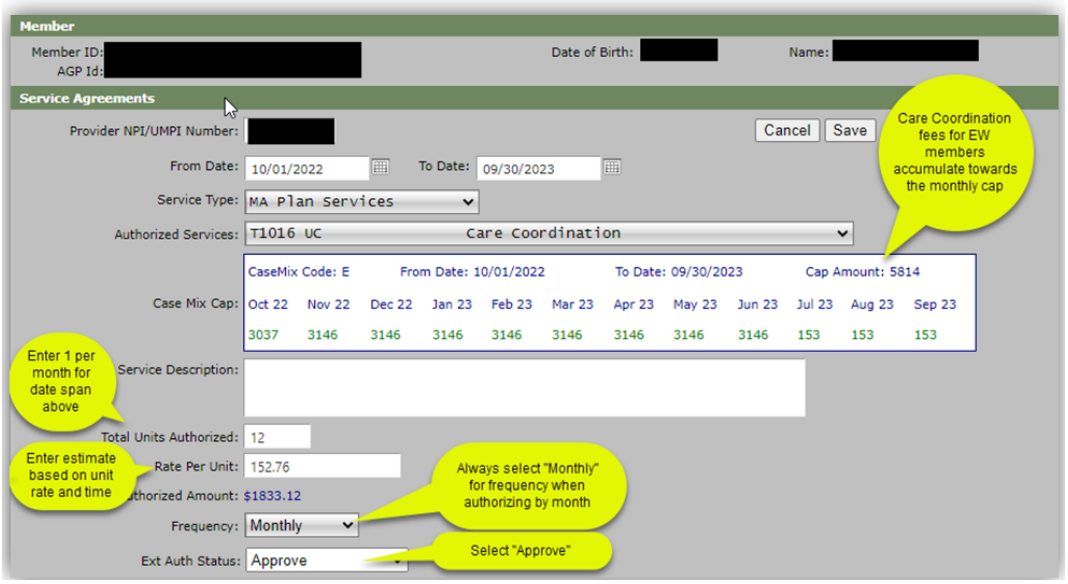


Care Coordination Service Agreements

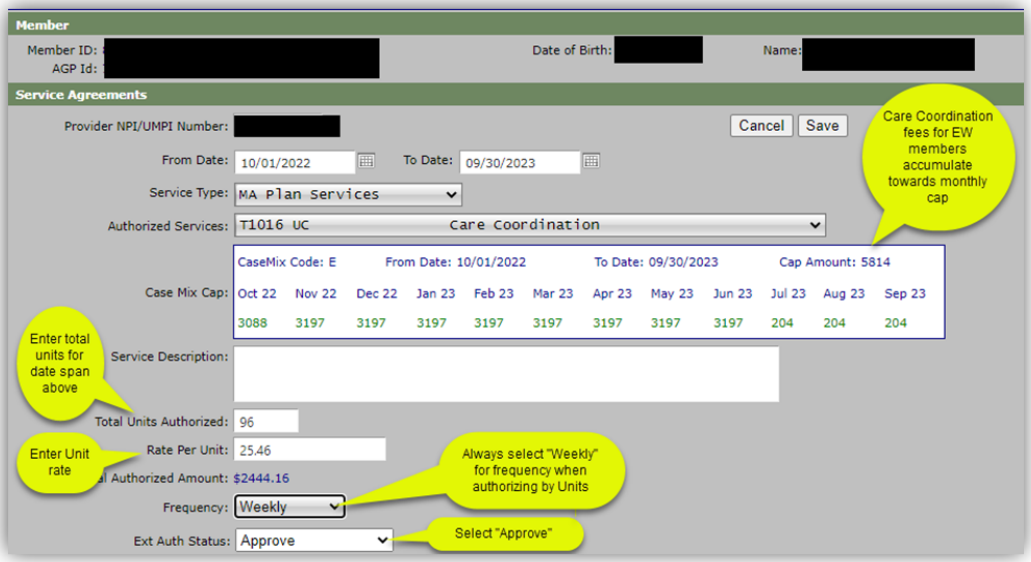
Entry of Care Coordination fees will depend on your Delegate Agency's Care Coordination Contract, which may be authorized by monthly, units or PMPM.

- For members open to Elderly Waiver it is required to enter Care Coordination fees.
- Not required to enter Care Coordination fees for CW or Supplemental Benefits (Case mix W).

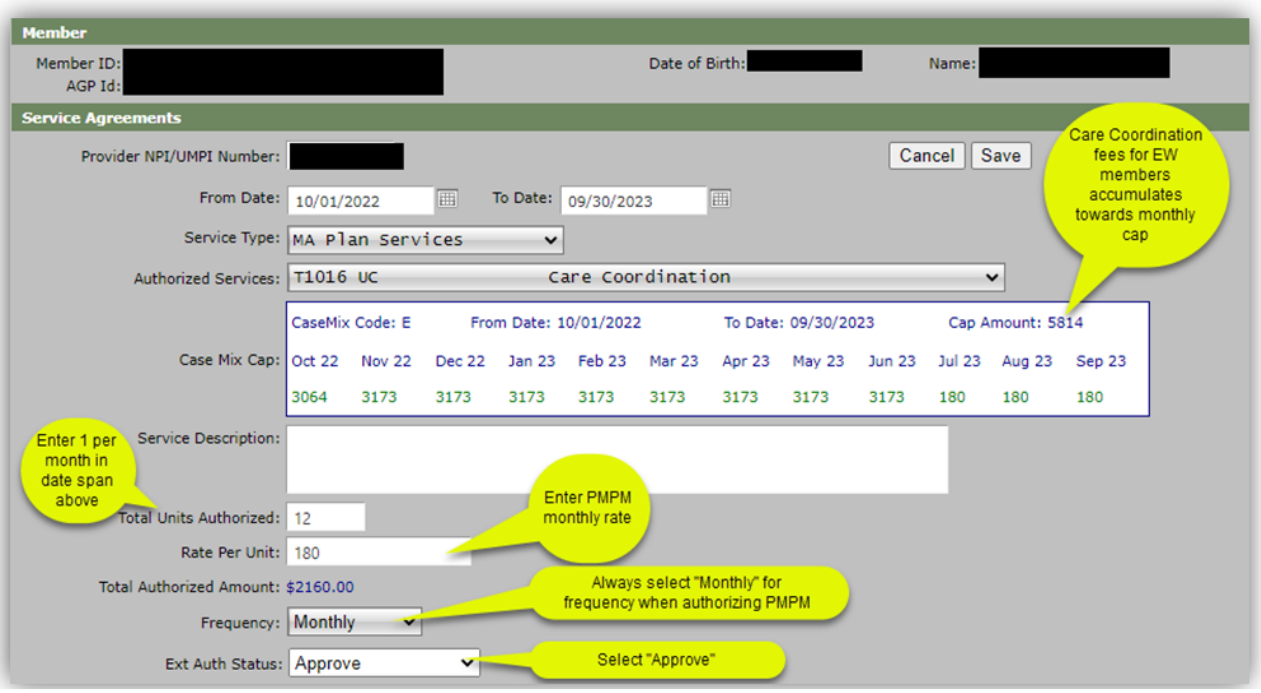
Monthly Care Coordination Example*



By Unit - Care Coordination Example*



Care Coordination Per Member/Per Month (PMPM) example*



*See "Adding a New Service Agreement" for complete instructions.

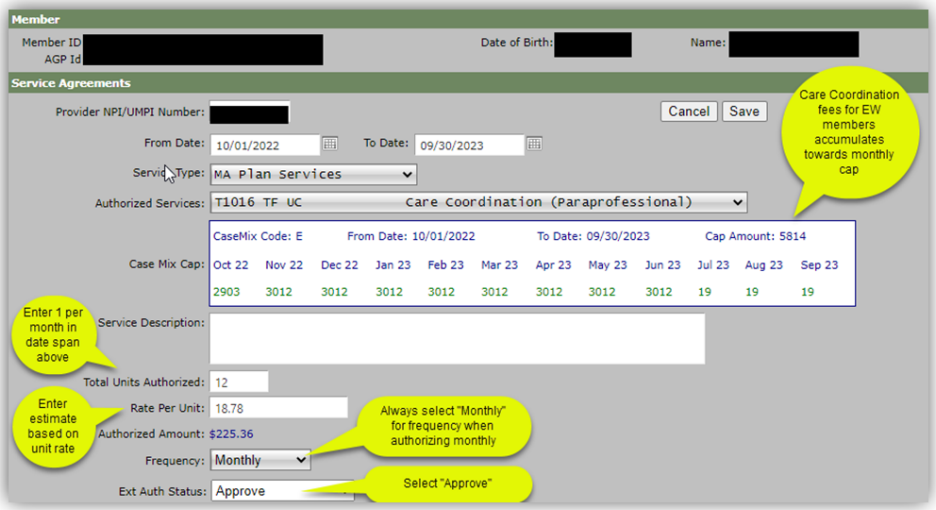
Para Professional Service Agreements

Entry of Paraprofessional fees will depend on your Delegate Agency's Care Coordination Contract, which may be authorized by monthly, units or PMPM.

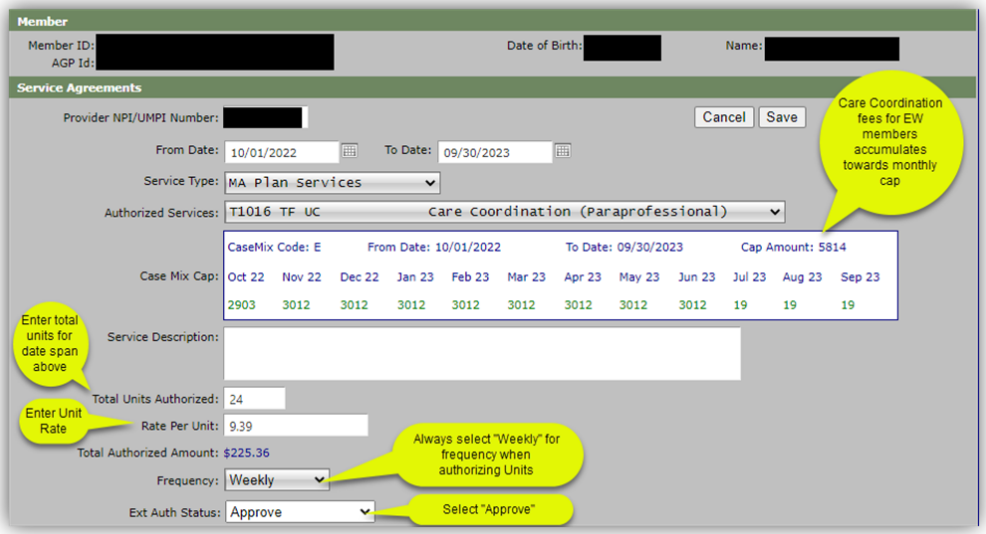
- For members open to Elderly Waiver it is required to enter Paraprofessional fees **except** for Delegates with PMPM arrangement. It is not required to enter a separate paraprofessional service agreement because it is included in your PMPM.

- Not required to enter Paraprofessional fees for CW or Supplemental Benefits (Case mix W).

Monthly Paraprofessional example*



By unit - Paraprofessional Example*



Paraprofessional Per Member/Per Month (PM/PM)—not required.

Do not enter a separate service agreement for Paraprofessional fees if your agency is contracted at a PMPM rate.

MSHO Supplemental Benefits Service Agreements

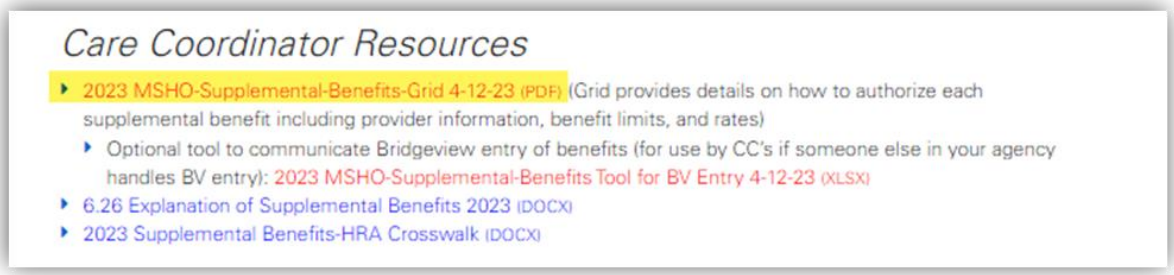
MSHO Supplemental Benefits do not apply towards the member's monthly elderly waiver case mix cap or towards their monthly waiver obligation.

MSHO Supplemental Benefits are approved by CMS for the calendar year and are subject to change yearly. Service agreements should not exceed 12/31 of each calendar year.

See the Care Coordination website for more information about eligibility for MSHO Supplemental benefits.

https://carecoordination.bluecrossmn.com/msho/secureblue-msho-supplemental-benefits/

Click on the MSHO Supplemental Benefits Grid for details on how to authorize each supplemental benefit including provider information, benefit limits, codes and rates.



$750 Safety Benefit Service Agreements

MSHO Supplemental Benefits do not apply towards the member's monthly elderly waiver case mix cap or towards their monthly waiver obligation.

MSHO Supplemental Benefits are approved by CMS for the calendar year and are subject to change yearly. Service agreements should not exceed 12/31 of each calendar year.

See the Care Coordination website for more information about eligibility for MSHO Supplemental benefits.

https://carecoordination.bluecrossmn.com/msho/secureblue-msho-supplemental-benefits/

Click on the MSHO Supplemental Benefits Grid for details on how to authorize each supplemental benefit including provider information, benefit limits, codes and rates.

Pass Thru Service Agreements/Billing (for Approval Option Service Providers—formerly non-enrolled Tier 2/3 service providers)

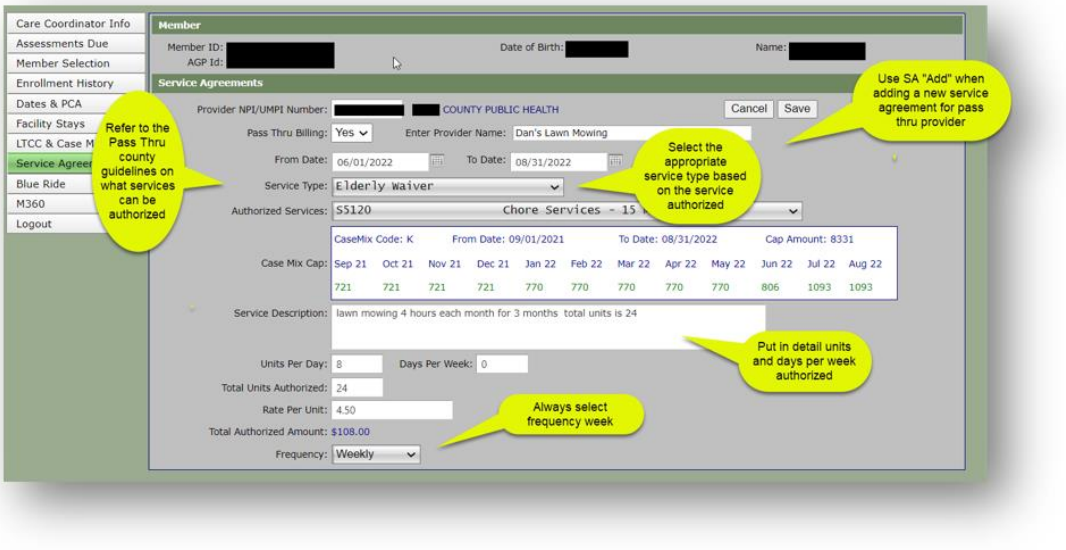
Blue Plus identifies all counties that are contracted to be "pass-through" billing providers for Approval Option service providers. After entering the County billing NPI or UMPI number, the Care Coordinator decides if the services authorized will be paid through the

“pass-through” process. The service may be a service provided through their Delegate agency (not acting as a “pass-through” provider. For Example, some counties provide Home Health Aide, nursing or other waiver services through their county).

When creating a service agreement for a pass-through claim, you must always create a “New” Service Agreement. **Do not use the Copy function to create a pass-through service agreement**.

1. **Provider NPI/UMPI Number**: Enter the Delegate NPI/UMPI number.

2. **Pass Thru Billing**:
   Select “**Yes**” if billing on behalf of a non-enrolled Approval Option service. If “Yes” the Care Coordinator must complete the Approval Option service provider name in the Enter Provider Name field.
   Select “**No**” if the County provides the services.



3. **From Date:** Enter the start date for the EW service (XX/XX/XXXX) or select the date using the calendar. This will be a protected field which cannot be changed once the line item has been entered.

4. **To Date:** Enter the end date for the EW service (XX/XX/XXXX) or select the date using the calendar.

5. **Service Type:** Enter the appropriate service type from the drop-down box.

6. **Authorized Services:** Select the appropriate service from the list of Authorized Services.

7. **Service Description:** Add description of what is being authorized such as “lawn mowing, shoveling, etc. and include description of frequency such as number of

hours/units per day/week. (Example: Lawn mowing for 2 hours 2/x week).

8. **Units per Day** and **Days per Week** must match information documented in the Service Description.

9. **Total Units Authorized**. Based on your entry of Units per day and Days per week, the grand total will be displayed.

10. **Rate:** The system automatically populates the current DHS fee schedule rates based on the date of service.

11. **Frequency:** Always select "Weekly"

County of Residence for Non-24 Hr Customized Living:

Non-24 Hour Customized Living (T2031) from the Authorized Services drop down; you must select the county the member resides in while receiving this service. The system will determine which region the county belongs to and will use that information to apply the correct maximum authorization amount when you enter the rate per unit. You cannot authorize an amount over the limit that has been set by the State. Members could reside in more than one county during a given LTCC span. If this is the case, you must make sure the date range of the specific authorization lines have the correct county of residence indicated for each provider services are authorized for.

Code Narrative

This is a mandatory field that will only display when you authorize the S5165; T1028; T2028; T2029; T2038; T2039; and T2039 UD services. A narrative description is required in this field to outline the specific item or service that is being authorized for the member. These codes and description added to the Narrative box will print on the service agreement notifications.

The provider must include this same narrative description on the claim that is billed to Bridgeview Company or the claim will reject for missing narrative.

Service Description is optional for adding additional information.

Service Agreements for T2029—Specialized Supplies and Equipment*

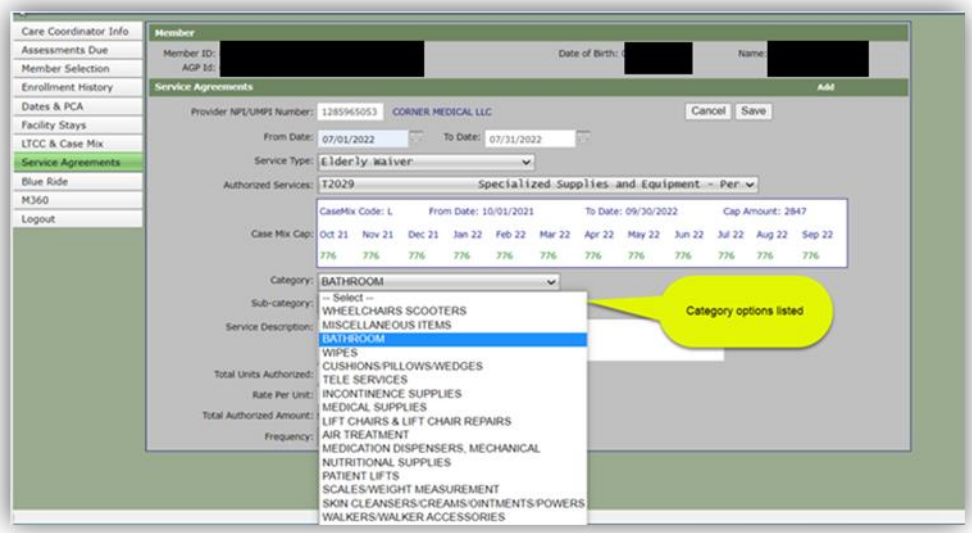
The Care Coordinator must follow the process outlined in the MSHO-MSC+ Community Guidelines section titled: EW Specialized Supplies and Equipment (T2029) to determine correct payer for items authorized under the T2029 service code prior to entering a service agreement.

- You must identify each separate Medical Supply and Equipment item based on category or sub-category selected and additional information in the Service

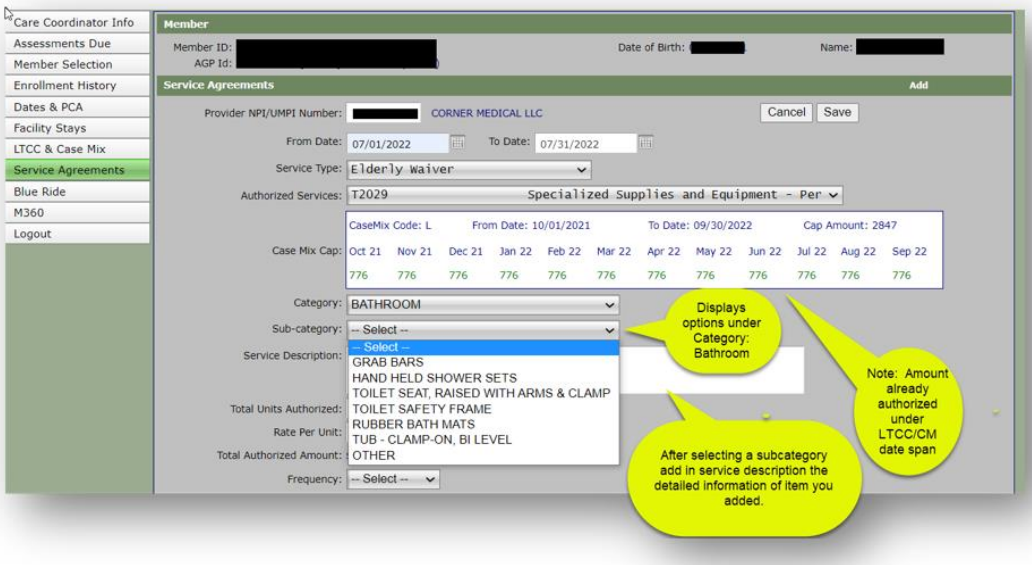
Description. Providers are required to submit a narrative description on their claim(s).

- The EW program does not pay for separate installation charges nor shipping and handling charges for Extended Medical Supplies and Equipment. These charges must be included in the cost of the product or item.
- Costs of supply and equipment items may be averaged over the span of a SA provided the person maintains program eligibility for the available span of the SA.
- If the same provider is authorized for more than one item, a new service agreement must be created.

1. Select the service code T2029 from the **Authorized Services** drop down box.
2. Select a **Category** for the item you are authorizing.



3. Once a Category is selected, for example “Bathroom” you will then move to the **Sub-Category** box and click on the drop-down box to select the next specific item you are authorizing



There are limited items on this listing. If the item(s) are not listed on the drop-down box, please view the most current T2029 Specialized Supplies and Equipment Guide located on the Care Coordination website under the Bridgeview page.

4. All items authorized under T2029 must include a description of the item in the **Service Description** field. If no description is entered, an edit will appear.

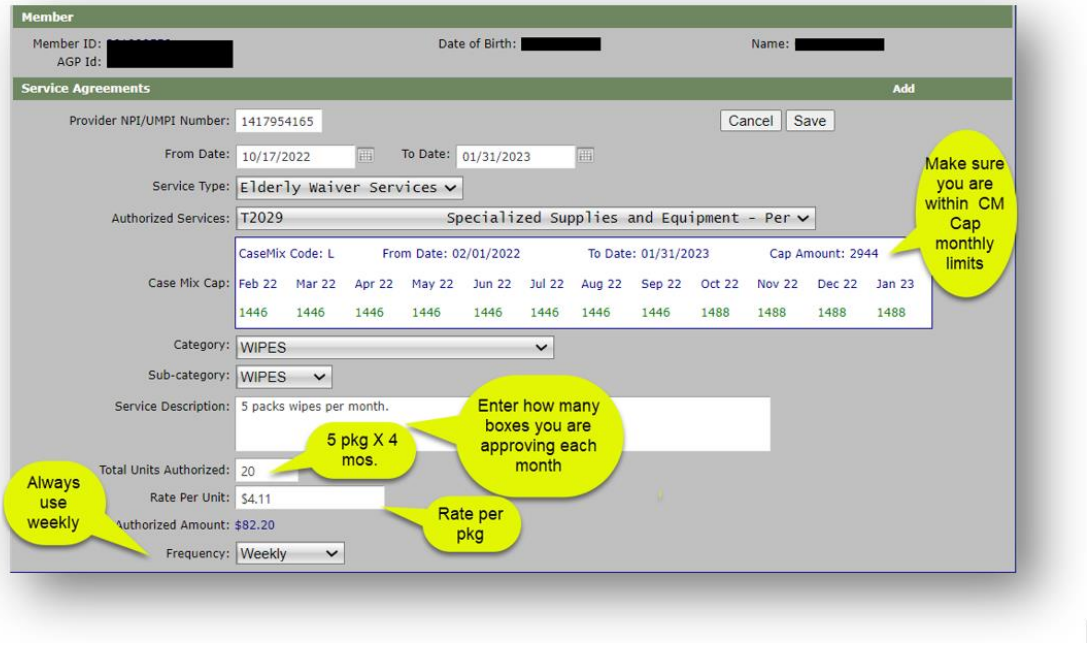
   For the following circumstances, the Care Coordinator must include in the **Service Description** field,

   - Description of the item (i.e., 4-wheeled walker with seat and hand brakes)
   - If the DME provider reports the member/item does not meet Medicare/Medicaid criteria, the service description must also include the specific reason member did not meet medical coverage criteria. (i.e. EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per DME provider).
   - An attestation that the case was reviewed and approved by their Supervisor and/or Partner Relations Consultant for the following:
     - Chair portion of the lift chair is over $950 (note: waiver does not pay for upgrades)
     - Single item over $500
     - Items marked as “No” in the “Elderly Waiver Eligible” column of the T2029 Guide

5. **Frequency**: Select Weekly if items/units is more than 1 per month. (example: 2 packs of wipes per month)

*See “Adding a New Service Agreement” for complete instructions.

Screenshot of SA for wipes:



Service Agreements for Lift Chairs*

Before entering a Service Agreement for Lift Chairs, the Care Coordinator must follow the process outlined in the MSHO-MSC+ Community Guidelines section titled: Authorization Process for Lift Chairs.

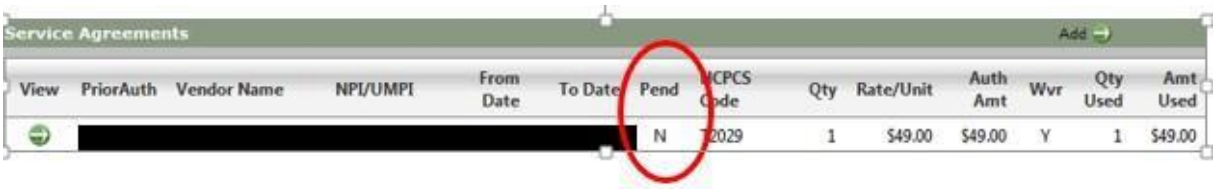
When entering the Service Agreement for lift chairs, keep the following in mind:

- When the lift mechanism is being paid for by Medicare/MA benefits, enter one service agreement for the total cost of the chair portion only.
- If the DME provider determines the member does NOT meet Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair or it is denied, the Care Coordinator must enter two Service agreements. One for the chair portion, and one for the lift mechanism. The service agreement for the lift portion of the chair must include the providers reason that the member does not meet criteria in the **Service Description** (Example: EW member does not qualify for coverage under Medicare/MA as member is unable to ambulate once standing).
- Chair portion exceeding $950 are required to be reviewed by the CCs supervisor and/or the Partner Relations Consultant prior to authorizing in Bridgeview. If approved, a narrative in the Service Description field must include that the case was reviewed and approved by the

Supervisor and/or Partner Relations Consultant.

*See "Adding a New Service Agreement" for complete instructions.

Service Agreement Pend codes for T2029 Extended Supplies and Equipment



Some Service Agreements for T2029 Extended Supplies and Equipment may be Pended by the Bridgeview Company. The service agreement will display a B, F, H or N for any T2029 authorization.

B: *Bypass*- the service agreement was reviewed and released to the provider.
F: *Flag- the service agreement is manually flagged and on hold until reviewed by Bridgeview staff. The SA will not be viewable to the provider to print until approved.*
H: *Hold- the service agreement is held when a T2029 Miscellaneous SA was entered. It will stay on hold until reviewed by Bridgeview staff. The SA will not be viewable to the provider and print until approved.*
N: *SA was processed*

Service Agreement for Nutritional Supplements *

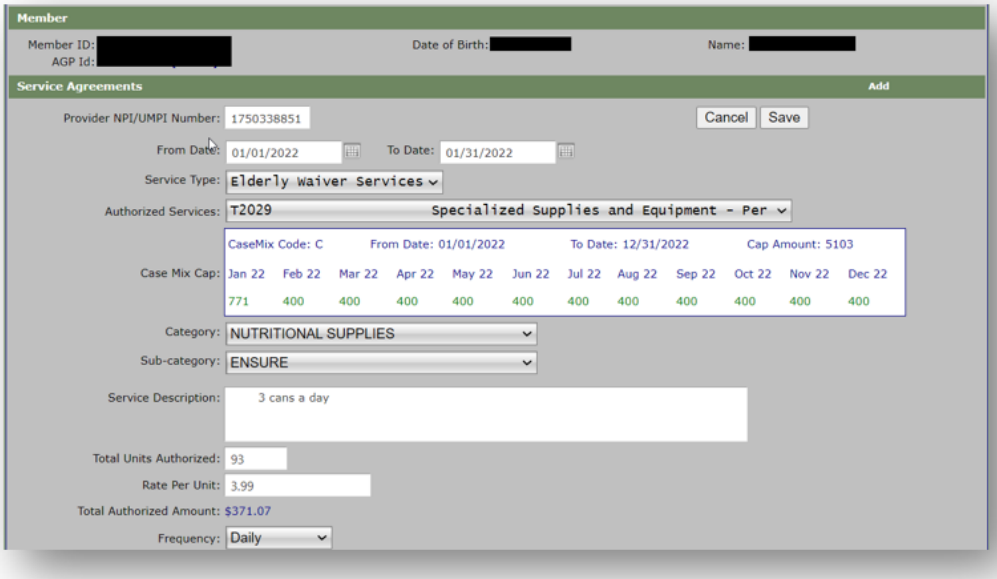
Service Agreements for nutritional supplements such as Boost and Ensure must list quantities and unit rates by the can; not cases. Quantities of 4 cans per day or more should be reviewed for coverage under the medical benefit. An 'edit' code is in place if the quantity entered is 4 cans or above.

When authorizing any nutritional supplement please do the following:

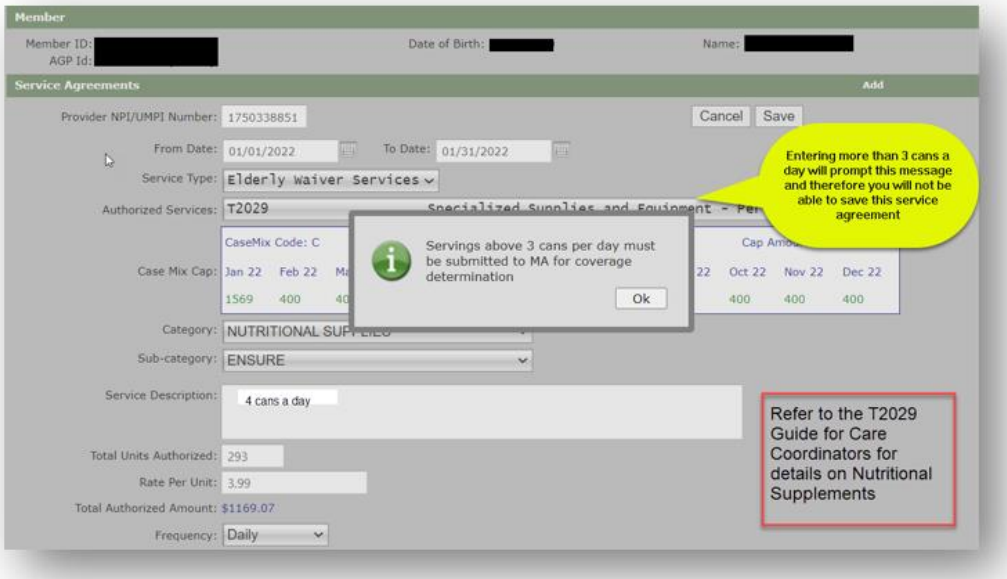
1. For **Service Type** select **Elderly Waiver Services**
2. For **Authorized Services** select the service code T2029
3. **Category** Select NUTRITIONAL SUPPLIES
4. **Subcategory** select applicable option:
    - Ensure
    - Boost
    - Nepro
    - Glucerna
    - Other
5. **Code Narrative** field is enabled when choosing sub-category "Other". A Description is required in this field
6. Enter the number of cans per day in the **Service Description** (required).

7. **Rate per Unit**: Enter rate of amount for each can. The cap amount for this field is $3.99 per can.
8. Select **Daily** as **Frequency**

Example



Example of edit if 4 or more cans are entered. Service Agreement will **not** save.



*See "Adding a New Service Agreement" for complete instructions.

Service Agreement for Environmental Accessibility Adaptations*

There are specific guidelines for all Environmental Accessibility Adaptations

authorized by Care Coordinators. Care Coordinators should review the DHS Community Based Services Manual for more information. Adaptations must be the most cost-effective solution. MHCP recommends that lead agencies consider bids from a minimum of two contractors or vendors. Services and items purchased before the LTCC screening and EW begin date or without case manager approval are not covered.

The cost may be averaged over the remaining waiver span for the service agreement (up to 12 months), provided the member is expected to remain on EW for the full span of the service agreement. However, should the cost of an item be spanned beyond the month the cost was authorized and incurred and the person exits the program, EW cannot pay for any service or time billed after the member's exit date.

If you are authorizing S5165, T1028, T2038, T2039 or T2039 UD services, each item must be listed on a separate line and not bundled together, even if the same provider will be rendering the services. You must provide a detailed narrative description of each item or service.

Service Agreements must be within the limits set by the legislature, even if authorizing multiple service codes. Effective adaptations and modifications are limited to a combined total of $20,000.00 per member per waiver year.

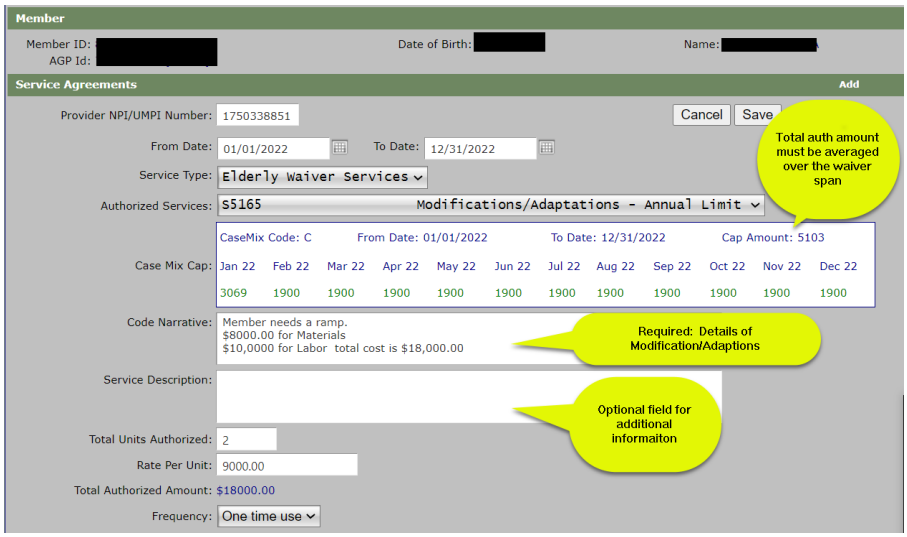
Service Agreements created should include two units of service.
Materials and supplies.
When project is completed.

Codes:

- S5165 Environmental Accessibility Adaptations – Home Install
- T1028 Assessment of Environmental Accessibility Adaptations for Home
- T2039 Environmental Accessibility Adaptation – Vehicle Install
- T2039 with modifier UD Assessment of Environmental Accessibility Adaptations for Vehicle

Code Narrative: Required a brief description of the work being done in the (i.e., bathroom remodel; ramps; widening of doorways for accessibility, etc.).

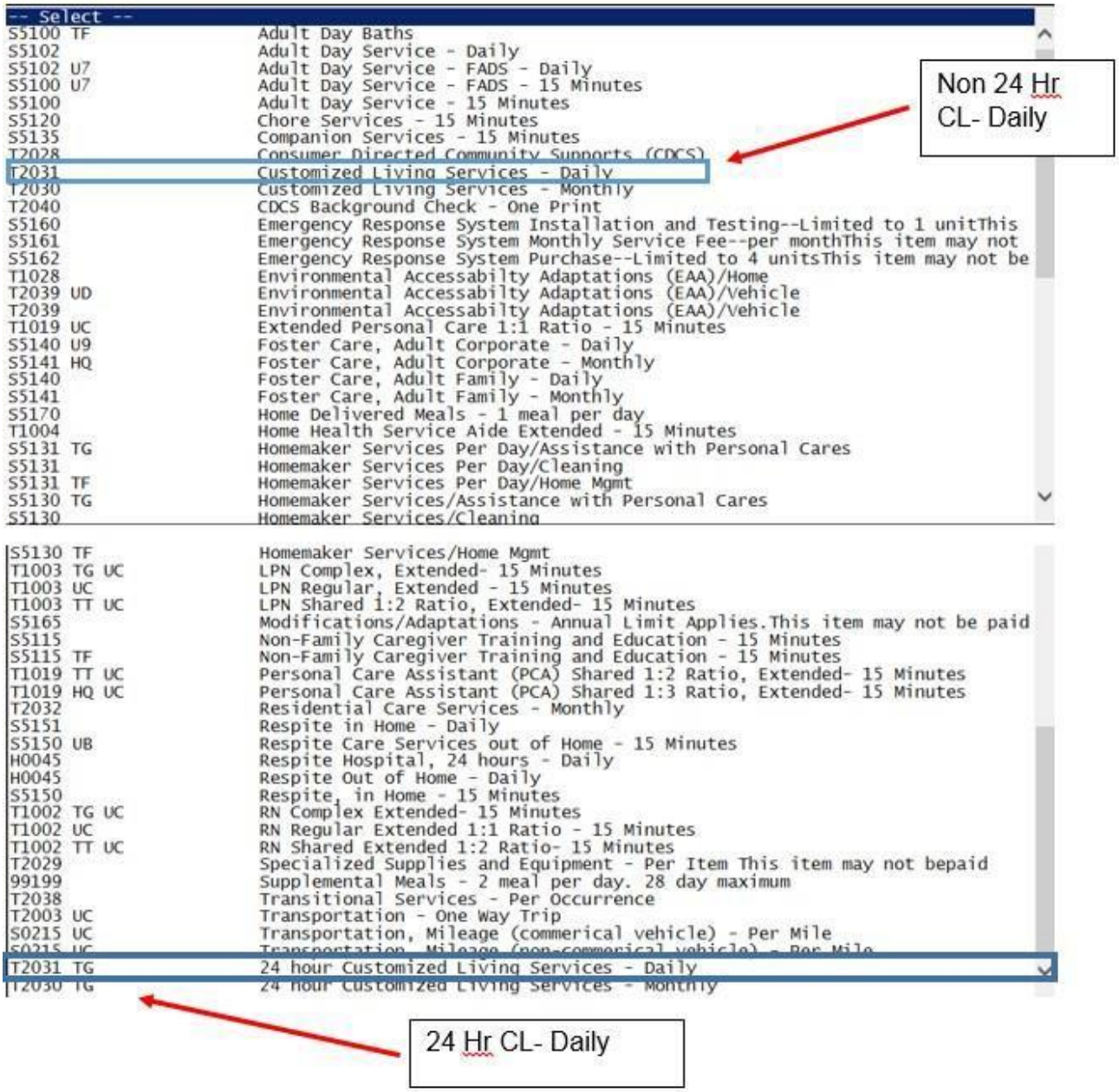
Service Description: Optional field.



*See "Adding a New Service Agreement" for complete instructions.

Service Agreement for Customized Living (CL) or 24 Hr. Customized Living*

When entering a service agreement for non-24 hr CL or 24 hr CL, make sure you select the correct code for the service. Note that the 24 hr CL code is near the bottom of the services list (see below). You should be selecting the daily option for any CL services. CL and 24 Hr CL services must be within the DHS rate limits for CL or 24 hr CL.



*See "Adding a New Service Agreement" for complete instructions.

Consumer-directed community supports (CDCS) Service Agreements

To enter a CDCS service agreement, follow the steps below:

1. Ensure "To" and "From" dates are within LTCC & Case Mix Date Span
2. Ensure Rate is under the CDCS Budget Cap.
3. Enter a service agreement for the authorized amounts determined in the CDCS service plan T2028. Note: this amount should also include the FMS management fees.

4. Enter a ***separate*** Service Agreement for:
    - T2040 background checks (if applicable) and
    - T2041 Required Case Management (this will be the Care Coordination amount for this member) for 8 units/month.

If you are adding money to a CDCS plan and need to adjust the CDCS Service Agreement (for legislative increases, see section titled **CDCS Legislative Rate Changes** below)

Notes on entering CDCS service agreement:

- For required legislative rate increases, see section titled **CDCS Legislative Rate Changes** below.
- There should only be 1 current CDCS (T2028) service agreement per LTCC and Case Mix Span.
- Complete a separate CDCS Required Case Management (T2041) service agreement (reminder: CDCS case management does not count towards the CDCS monthly budget limits and does not apply towards the waiver obligation, as applicable)
- Enter service agreement for CDCS background checks (T2040), as applicable (reminder: background checks do not count towards the CDCS monthly budget limits, and it does not apply towards the waiver obligation as applicable)
- No other services should be authorized over and above the CDCS service plan (T2028) such as PERS, extended supplies and equipment, etc.

Service Description Requirement (CDCS)

In the event the individual's assessed needs support an increase in services; the CC must include an attestation in the service agreement description documenting the care plan was reviewed and an addendum was completed supporting additional services.

For complete details, please refer to the CDCS section of the CBSM:

CDCS Legislative Rate Changes

If there is a legislative rate change to the CDCS Budget Limits by Case Mix (DHS-3945) during an existing LTCC and Case Mix date span and the member's assessed needs support the need for additional services, complete DHS 6633A CDCS CSP Addendum with YYYY Budget Increase. The amount billed each month under CDCS can be used flexibly from month to month, however, the Financial Management Service (FMS) provider must stay within the total annual

dollar amount authorized during the annual span. The Bridgeview Web Tool will not allow you to enter a service agreement at the increased rate prior to the effective date of the legislative rate increase.

After completion of the DHS 6633A, Care Coordinator must also do the following:

1. End the current CDCS current Service Agreement.

   a. **To Date:** End the current CDCS service agreement (T2028) the last day of the month prior to the rate change.

   b. **Service Description**—enter attestation that the "care plan was reviewed with the member and an addendum was completed with increased amounts for CDCS services."

   c. **Total Authorized Units:** Reduce total authorized units to the new To and From date span.

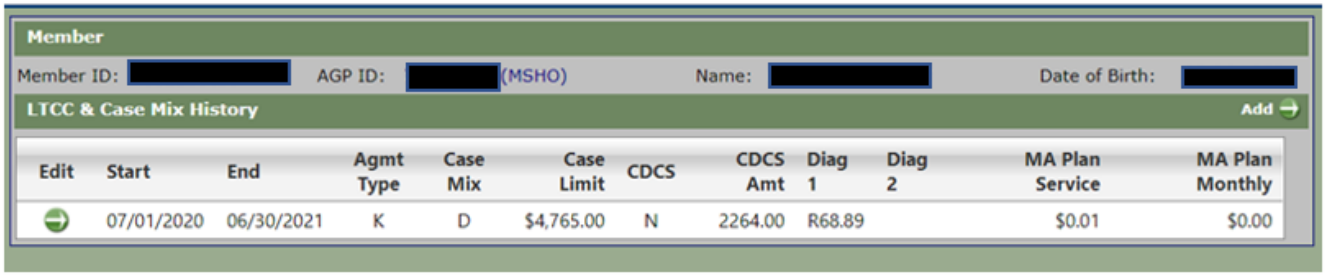
2. Create a new service agreement
   a. Make a copy of recently edited service agreement.
   b. **From Date:** Enter the first date of the new month of the rate increase.
   c. **To Date:** enter the end of the current LTCC and Case Mix Span.
   d. **Total Authorized Units:** Enter the remaining units.
   e. **Rate Per Unit:** Enter the new monthly amount that includes the CDCS rate increase.

3. Request Bridgeview staff to combine both service agreements into one service agreement. Contact Bridgeview.service.agreements@bluecrossmn.com.

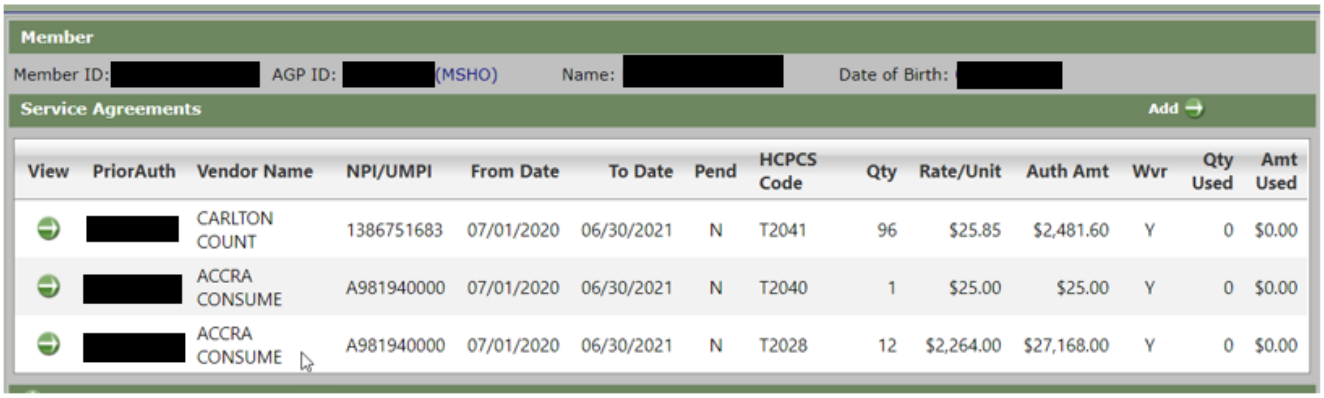
   Include the following:
   - Member Name.
   - Member ID number.
   - Include both CDCS Service Agreement numbers.
   - To and From fields. Should be the current LTCC/CM Waiver Span.
   - Total authorized amount for the total waiver span that includes the new total amount approved for the CDCS span.

4. Bridgeview staff will do the following:
   - Modify the original service agreement to include the updated end date for that waiver span.
   - Update the units to coincide with start and end date.
   - Add new monthly rate to equal the new waiver span amount that includes the increase.
5. FMS provider now has one service agreement that covers the full waiver span and includes the CDCS increase amount.

   Before:

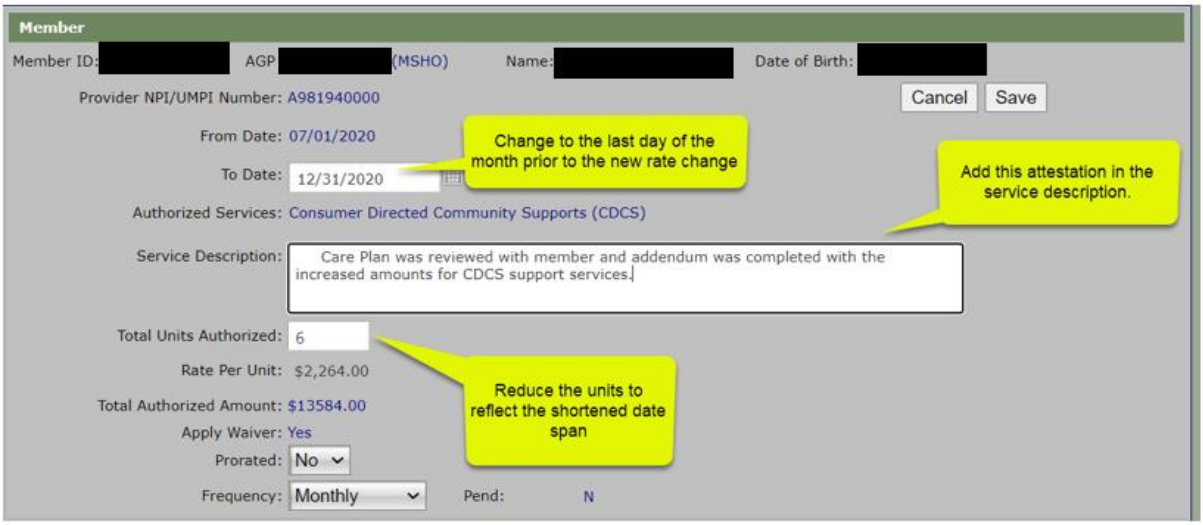


Edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag 1	Diag 2	MA Plan Service	MA Plan Monthly
	07/01/2020	06/30/2021	K	D	$4,765.00	N	2264.00	R68.89		$0.01	$0.00

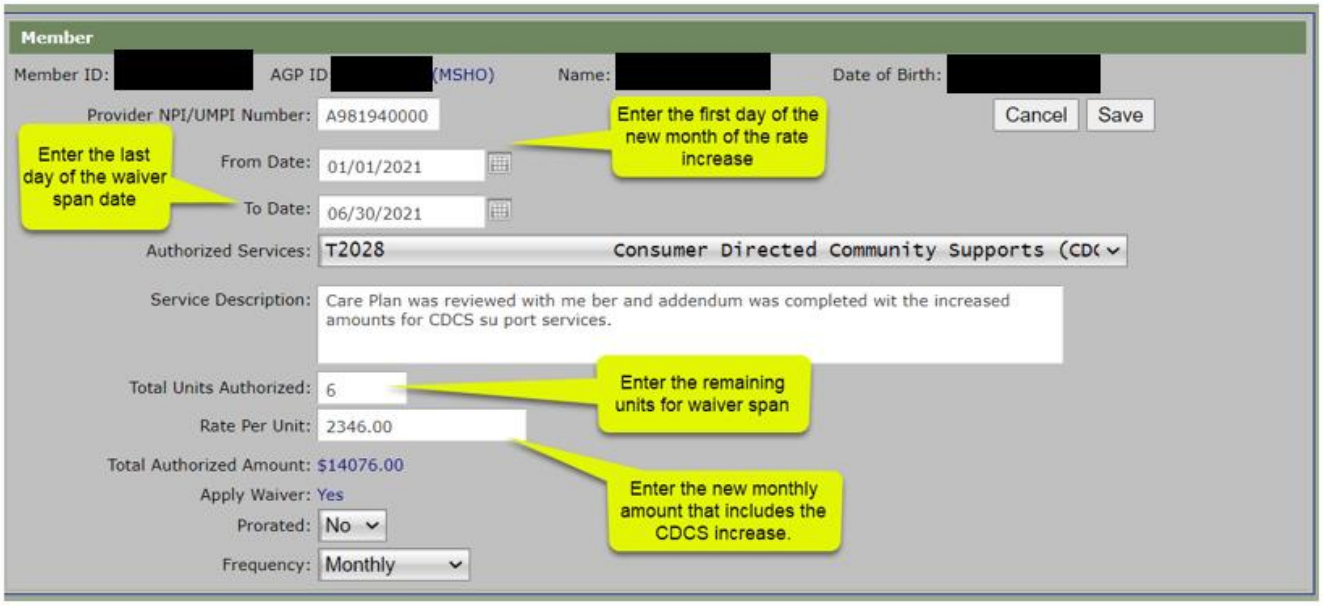


View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	[redacted]	CARLTON COUNT	1386751683	07/01/2020	06/30/2021	N	T2041	96	$25.85	$2,481.60	Y	0	$0.00
	[redacted]	ACCRA CONSUME	A981940000	07/01/2020	06/30/2021	N	T2040	1	$25.00	$25.00	Y	0	$0.00
	[redacted]	ACCRA CONSUME	A981940000	07/01/2020	06/30/2021	N	T2028	12	$2,264.00	$27,168.00	Y	0	$0.00

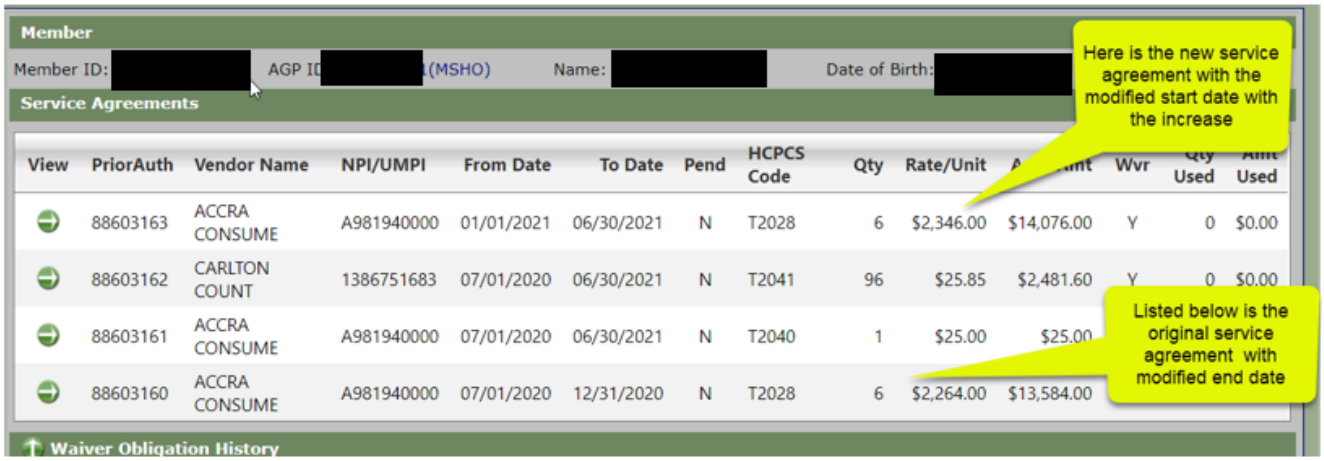
Modifying current CDCS service agreement:



Adding new CDCS Service Agreement:



<u>After all changes have been made:</u>



New Enrollees on CDCS with unused funds

Follow the processes below when there are confirmed unused CDCS funds from the current waiver span prior to Blue Plus enrollment.
Note: To confirm unused CDCS funds, the CC should follow the process outlined in the Community Care Coordination guidelines section titled, Consumer Directed Community Supports (CDCS).

1. CCs must notify PR Team of the remaining unused $ dollar amount from previous health plan or MA fee for service.

2. PR will communicate to BV staff this amount to add on to existing waiver span.
3. The LTCC/Case mix will be listed as a case mix “Z” for the remaining CDCS Waiver span.

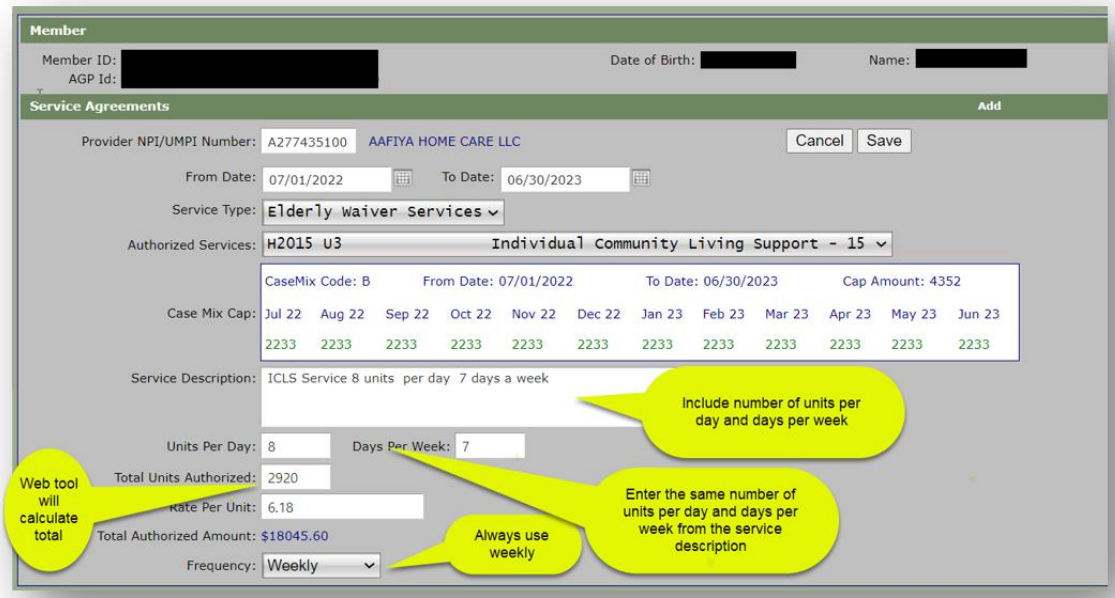
Service Agreement for Individual Community Living Supports (ICLS) *

ICLS is a bundled service that includes 6 service categories. There are 2 HCPC codes to choose from when authorizing ICLS:

H2015 (U3) In-person 15-minute unit (up to 48 units per day)
H2015 (U3 U4) Remote 15-minute unit (up to 1 unit per day)

- H2015 (U3) In-person 15-minute unit: If a provider delivered in-person services, the provider will bill using the 15-minute unit.
  - Face to face in person support must be provided at least once weekly.
  - The maximum time that can be billed for the 15-minute code H2015 (U3) is 48 units or 12 hours per day.

- H2015 (U3 U4) Remote 15-minute unit: If the only service provided in a day is remote services, the provider will bill using the remote rate. A full day constitutes 24 hours, beginning 12:00 a.m., ending at 11:50 p.m.
  - The maximum time that can be billed per day is 1 unit or 15 minutes.



*See “Adding a New Service Agreement” for complete instructions.

Extended Home Care Services

Extended home care services can only be authorized in addition to approved MA state plan services.

- Prior to authorizing extended home care services, members must access and exhaust MA state plan home care services.
- Extended home care service agreements must be entered into Bridgeview. CC must include how many units they are authorizing per day and days per week (i.e., 4 units/7 days a week).
- PCA Supervision must be entered under MA State Plan services. Refer to section PCA Supervision Monthly for instructions on entering PCA Supervision.
- Extended home care services claims are processed by Bridgeview

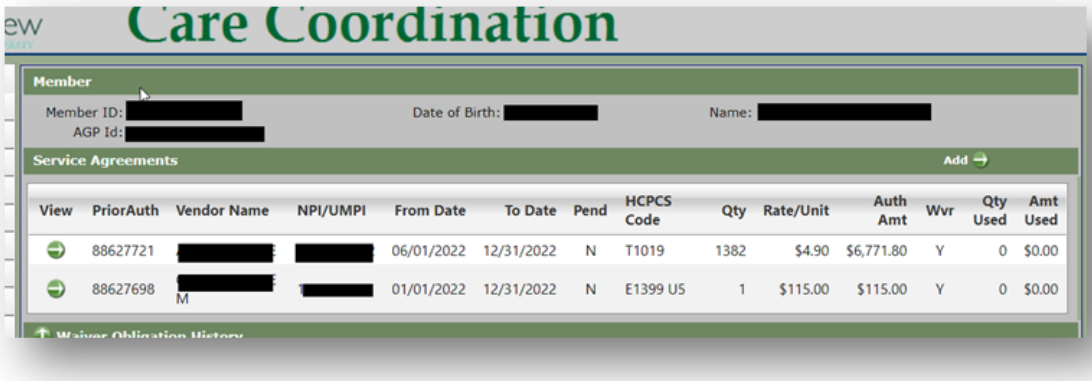
Service Agreements listed within Availity Essentials

Once the elderly waiver and/or MSHO supplemental service agreement has been completed it will be converted to a PDF and available to providers within 24 hours. A link to the service agreement in Bridgeview will be located within Availity Essentials.

*Important: Medicaid (MA) service agreements are not visible in Availity Essentials, UM will mail out authorizations letters to MA providers within 10 business days of processing the daily report.

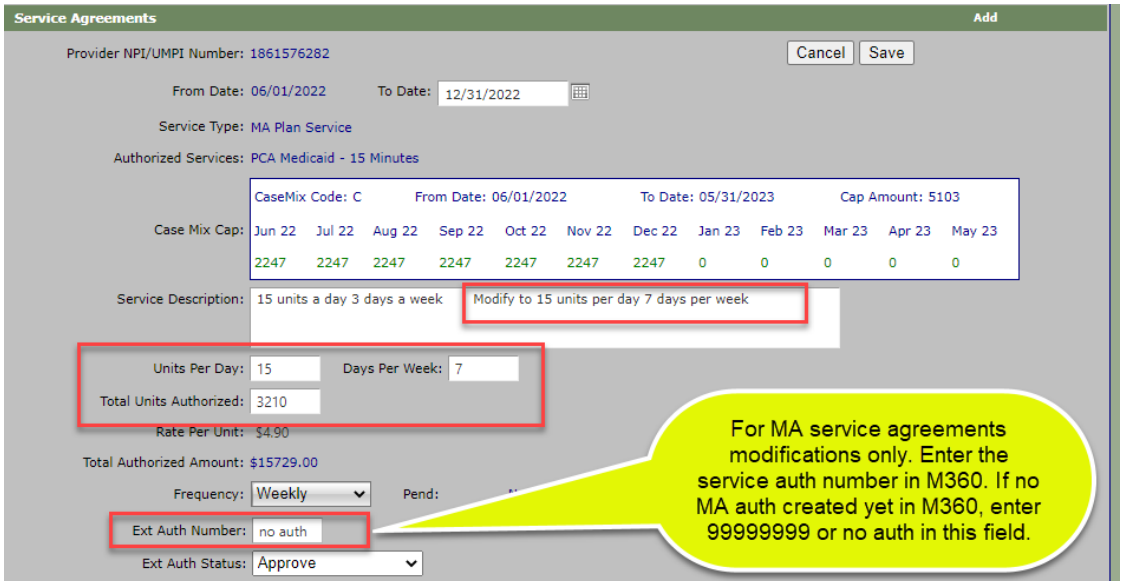
Modifying a Service Agreement

Reminder: You cannot modify an existing service agreement "From Date" or "Rate Per Unit". Instead, you must close out the existing service agreement and create a new one following the instructions below.



1. Click on the **View** arrow next to the Service Agreement that requires modification.

2. Select **Modify**. Changes can only be made to the fields displayed as white as illustrated below.
3. **To Date:** Enter the corrected end date, if applicable. If SA adjustment is related to a DTR, CCs must wait for the DTR effective date from UM.
4. **Service Description:** Enter the updated service agreement information. Include the reason for modifying the service agreement. For MA Plan Services agreements recently entered in Bridgeview that are not visible in M360 yet, include comment "New authorization number not available at time of change, auth not in M360." Examples: adding 5 SNV as needed visits; modifying and adding to a service agreement to allow flexible use of RN and LPN visits, etc.
5. **Units per Day:** Change the number of units per day.
6. **Days per Week**: Change the days per week.
7. **Total Units Authorized**: Enter the corrected (reduced/increased) units for the service agreement span. The case mix calcuator will calculate the total amount authorized for the new to and from dates of the service. If this information is not updated in the Total Units Authorized field the web tool removes all existing units and reverts to zero "0" and the claim recovery process begins. So be sure to update this field with the increased or decreased units based on claims that have already been paid.
8. **Frequency**: Always enter "Weekly" for 15 minute unit increment service codes.
9. **Ext Auth Number:** n/a for EW Service Codes. For MA Plan Service, enter the authorization number from M360 or from UM authorization confirmation document. If the MA service agreement was recently entered into Bridgeview and the service authorization has not been created in M360 yet, enter 99999999 or no auth.
10. **Ext Auth Status:** n/a for EW Service Codes. Select Approve or Request for Review, as outlined in the Care Coordination guidelines.
11. Click on **Save**
12. **Provider and member Reason Code**: Select the appropriate reason code based on the updated changes *(Member reason code is optional)*
13. Click on **Save**
14. The updated service agreement now displays on the service agreement summary page.



How to Decrease Total Authorized Units

1. Select the forward arrow under view button on the line item you need to change
2. Go to the Total Units Authorized field and change the previous units that are shown to the new number.
3. Click on Save to keep the changes
4. The Total Authorized Amount will recalculate based on the number of units and the price per unit that are now in the authorization
5. You may also need to change the To Date if you intend for the provider to render these services for a shorter period.
6. Generate a new notification using the most appropriate reason codes that apply to the changes you have made.
7. Refer to Care Coordination guidelines for DTR requirements.

How to Increase Total Authorized Units

Providers cannot bill for more units than authorized or the claim will deny. The provider must contact the care coordinator to discuss discrepancies.

There are two options if the care coordinator determines the Total Authorized Units needs to be increased:

Option#1:

1. Edit the existing service agreement line item and change the number of units to the higher number allowed.
2. Generate a notification to the provider using reason code 0150 “THIS IS A REVISED SERVICE AGREEMENT THAT HAS INCREASED THE TOTAL UNITS AUTHORIZED.
3. THE PROVIDER IS NOW ALLOWED TO PROVIDE UP TO THE NUMBER OF UNITS AND TOTAL AUTHORIZED AMOUNT SHOWN ON THIS AUTHORIZATION.
4. Once the provider has accessed the new service agreement through Availity Essentials, they can submit a new claim for the units that were authorized.

Option#2:

1. Go into the original service agreement line item and change the Total Units Authorized to be the same number as the quantity used.
2. Generate a notification to the provider using reason code 0310 “THE REMAINING UNITS AND AMOUNTS ON THIS SERVICE AGREEMENT WERE DELETED BECAUSE IT HAS BEEN CLOSED. YOU CAN NO LONGER PROVIDE SERVICES BEYOND THIS REVISED AUTHORIZATION.”
3. Add a new service agreement line item for the provider with the correct date range, revised Total Authorized Units, and the Rate per Unit. Use reason code 0010 “THIS IS A NEW SERVICE AUTHORIZATION”
4. You may want to choose this option if you want to monitor the quantity of services being billed or if the member has an increased need for services for a time span that is different than the original service agreement. Having the

separate line item allows for better tracking of the variation in the member's care plan.

5. The provider can submit a new claim for the additional units, once they have accessed the service agreement in Availity Essentials. The claim will process against the revised or newly added service agreement.

Editing the "From" and "To" Date - scenarios

The From Date cannot be changed on an approved service agreement. If you want to authorize services for an earlier start date on an existing service agreement line item, you must enter a new line item for a service to a provider

Scenario #1

You previously authorized a service for 09/01/2022 to 09/30/2022 but it should have been entered as 08/01/2022 to 09/30/2022. The provider billed for 08/03/2022 and the claim was rejected as unauthorized. For the provider to be paid for this service, you must enter a new line item using a new starting **From Date** of at least 08/03/2022.

There could be several scenarios that would dictate how to make this change:

Scenario #2

Provider will only be rendering the service for a specific date, or a date range that will not overlap with a previously entered service agreement line item. In this case, you will create a whole new service agreement and close the incorrect one:

1. Edit the previously entered service agreement and change the **To Date** to 09/01/2022 and the Total Authorized Units to "zero". This will indicate the service agreement should have never been used and will prevent the provider from billing services against this service agreement. Keep in mind this option will also automatically generate recovery of any claims that had been paid against the service agreement.
2. Generate a service agreement notification using reason code 0410 "THIS SERVICE AGREEMENT WAS CLOSED BECAUSE IT HAD AN INCORRECT DATE SPAN. YOU ARE NOT AUTHORIZED TO BILL FOR ANY SERVICES THAT HAD BEEN LISTED ON THIS AUTHORIZATION."
3. Enter a new line item with a start date of at least 08/03/2022 in the **From Date** and then the appropriate end date up to 08/31/2022 in the **To Date** field and only include the Total Authorized Units that would be allowed for this date span.
4. Generate a service agreement notification with a reason code 0050 "THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT WAS CLOSED BECAUSE IT HAD INCORRECT DATE SPANS. YOU ARE NOW ONLY ALLOWED TO PROVIDE THE SERVICES FOR THE DATES INDICATED ON THIS REVISED AUTHORIZATION."

Scenario #3

Provider will render services for the earlier start date and up through the original To Date on a previously entered authorization. Create a completely new authorization incorporating both the date ranges you intended to authorize:

1. Edit the previously entered authorization and change the To Date to 09/01/2019 and the Total Authorized Units to zero. This will indicate the authorization should have never been used and will prevent the provider from billing services against this authorization. It would also generate an automatic recovery of any claims that had been paid against this service agreement.
2. Generate a service agreement notification using reason code 0410 "THIS SERVICE AGREEMENT WAS CLOSED BECAUSE IT HAD AN INCORRECT DATE SPAN.YOU ARE NOT AUTHORIZED TO BILL FOR ANY SERVICES THAT HAD BEEN LISTED ON THIS AUTHORIZATION."
3. Enter a new line item with a start date of at least 08/03/2019 and then change the ending date of To Date field to 09/30/2019 and include the Total Authorized Units that would be used for the entire date span.
4. Generate a service agreement notification with a reason code 0050 "THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT WAS CLOSED BECAUSE IT HAD INCORRECT DATE SPANS. YOU ARE NOW ONLY ALLOWED TO PROVIDE THE SERVICES FOR THE DATES INDICATED ON THIS REVISED AUTHORIZATION."

Closing Service Agreements

A service agreement must be closed for the following reasons:

- The person is moving out of the EW program
- The person has enrolled in another managed care health plan
- The person dies (automatically updates once the date of death is entered in Bridgeview)
- The person no longer needs or wants Elderly Waiver services
- The person goes into the hospital, nursing home or other facility for more than 30 consecutive days
- The person loses MA financial eligibility
- A different lead agency will now manage the case
- Care Coordinator determines, based on a reassessment, that the person no longer meets Nursing Facility Level of Care
- Physician certifies that the person requires continued institutionalization for an indefinite period
- Home and community-based services no longer reasonably assure the health and safety of the person

- The person has been institutionalized for more than 30 consecutive days.
- The person elected EW CDCS from non-CDCS services or vice versa

When services are ending, it is the responsibility of the care coordinator to go into the applicable Service Agreement(s) and

1. Change the "**To Date**" on all applicable line items to the last day the member received services. If SA adjustment is related to a DTR, CC must wait for the effective date from UM .
2. Adjust the **units** on the line items keeping in mind claims that have already been paid for services rendered. Do not simply change units to zero as they may result in claims take-back. Note: If you do not adjust the total units authorized, the system will default to "0" resulting in possible claim payment take-backs.
3. Update the LTCC & Case Mix history to close the current span by changing the **To Date** to the last day the member was eligible for services.
4. Update MMIS accordingly and notify financial worker.

Closing a Service Agreement Due to Facility Stays

This table shows the screening document and service agreement actions for closings due to facility admissions.

Reminder: Care Coordinator must notify the member or authorized representative and service provider within 24 hours of the determination in addition to completing the *Care Coordinator Request for DTR* form when denying, terminating, or reducing a service. **Do not modify service agreements in Bridgeview until Care Coordinator receives confirmation from UM.**

Waiver services are not covered during a hospital, nursing facility, or ICF/DD stay. Providers may bill for waiver services provided on the date of the admission and/or the date of discharge if services were provided prior to the time of admission or after the time of discharge.

- Go into the individual line items on the service agreement and close them as of the date of admission after UM confirms DTR completion.
- Generate a notification when you close the service agreement line items with the appropriate reason code.

0340	THIS SERVICE AGREEMENT HAS BEEN ENDED DUE TO A FACILITY STAY THAT DOES NOT ALLOW FOR THE SERVICE AGREEMENT TO REMAIN OPEN.
0350	THIS SERVICE AGREEMENT IS BEING CLOSED DUE TO CLIENT ENTERING THE NURSING FACILITY.

Closing Service Agreement entered in error or no longer need; Claims Have Not Been Paid

Close the line item and send a service agreement notification showing this authorization is no longer in effect.

1. Select the specific line item that you need to close by selecting View button.
2. Click Modify
3. Change the "**To Date**" of the line item to be the same date as the "**From Date**"
4. Change the **Total Units Authorized** to zero
5. Click **Save**
6. Select an appropriate provider reason code that best explains why you are closing the previously entered service agreement.

WAIVER OBLIGATIONS

If a member has a waiver obligation that must be met each month, you will be able to view the information in the Service Agreement button under Waiver Obligation History. If there is no waiver obligation, it will state "None" in that section of the module. Waiver obligations are reported monthly from Department of Human Services to Blue Plus.

Reminder: waiver obligation does not apply to services below:

- Bus Passes (non-medical, EW only)
- CDCS Case Management
- CDCS Background check
- Care Coordination
- Case Management Aide (Paraprofessional)
- MSHO Supplemental Benefits
- State Plan Homecare Services

Sample screen showing member with a waiver obligation that varies each month:

Begin Date	End Date	Amount
04/01/2016	04/30/2016	$138.00
03/01/2016	03/31/2016	$138.00
02/01/2016	02/29/2016	$138.00
01/01/2016	01/31/2016	$138.00
12/01/2015	12/31/2015	$138.00
11/01/2015	11/30/2015	$138.00
10/01/2015	10/31/2015	$138.00
09/01/2015	09/30/2015	$138.00
08/01/2015	08/31/2015	$138.00
07/01/2015	07/31/2015	$138.00
06/01/2015	06/30/2015	$155.00
05/01/2015	05/31/2015	$155.00
04/01/2015	04/30/2015	$156.00
03/01/2015	03/31/2015	$156.00
02/01/2015	02/28/2015	$156.00

Waiver obligation will be applied to all claims submitted for the members in the order claims are received. All members with EW service authorizations and a waiver obligation will have the first claim that is adjudicated with a payment for that month apply the waiver amount as appropriate. There is no option to assign a designated provider for waiver obligations. Providers are notified of waiver obligation amounts deducted from services billed on the ERA tab. The ANSI code 178 "PATIENT HAS NOT MET THE REQUIRED SPENDDOWN AMOUNT" will appear along
with the dollar amount that must be billed to the patient in the "Patient Responsibility" field on the remittance. Members are responsible to pay the amount of the obligation towards the services that were utilized that month to provider. This may be a portion of the billed amount or the entire service amount. Bridgeview Company claim examiners review monthly reporting of waiver obligation changes and updates and reprocess

Previously paid claims impacted by retroactive waiver obligation changes are reprocessed by Bridgeview Company monthly according to our reconciliation process. It is the provider's responsibility to collect the waiver obligation amounts due from the member.

ENTRY OF NON-MEDICAL EW BUS PASSES

Metro Area Go-To Card (formerly known as EW bus passes for Metro Counties only)

Authorize bus pass for non-medical rides only. Select appropriate provider for your region and indicate type of ride and amount authorized in the service description (i.e. shopping 2 roundtrip rides per week or monthly pass with dollar amount approved, etc.)

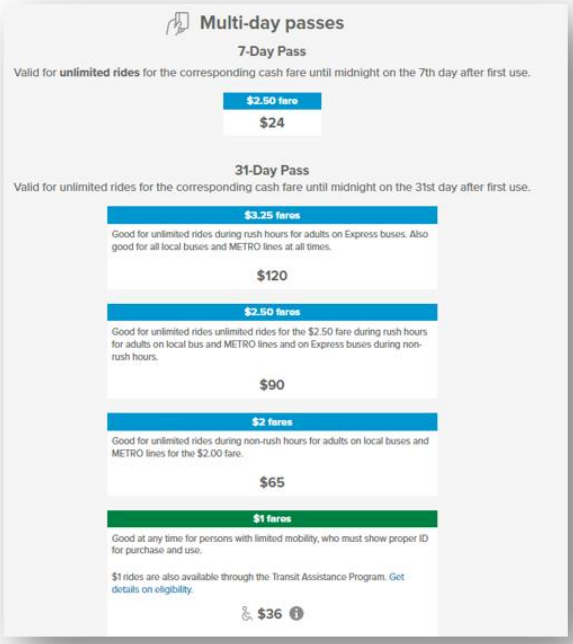
Please include the following information when entering a service agreement authorization for non-medical EW Transportation into Bridgeview (failure to add this detailed information will delay your Go-To Card request for both new or renewal).

Reminder: All accounts with Metro Transit are limited to a maximum of $350.00 per account. Every time the Go-To Card is used, the amount is deducted from the card/account. If the member does not use their card on a regular basis, the account could reach the maximum limit of $350.00, *this will result in no ability to apply additional funds to the account. Bridgeview staff may reach out to the Care Coordinator to evaluate service plan if this occurs, as applicable.*

Go-To Card Options:

- Metro Transit Go-To Card
- "Metro" Mobility Go-To Card (additional certification is needed for persons with limited mobility or ADA Certification)
- Stored value (ranges from $10.00-$180.00, only use $10 increments)

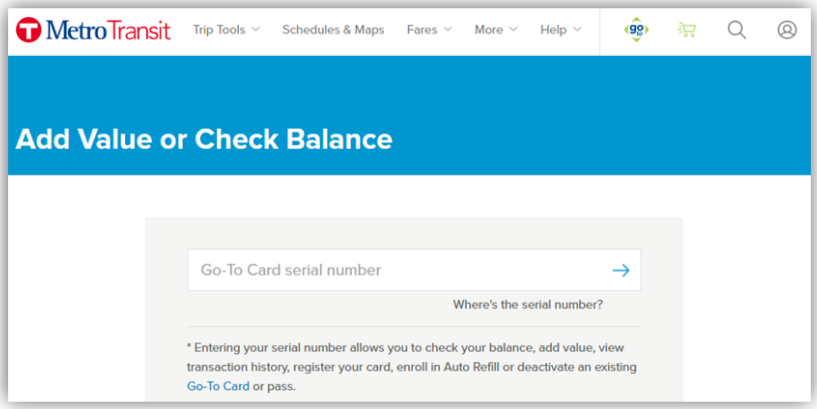
*Stored value cards are valid until the funds have been depleted



The direct link to Metro Transit Go-To Card is: https://www.metrotransit.org/go-to-card and can also be found on the Bridgeview Company website.

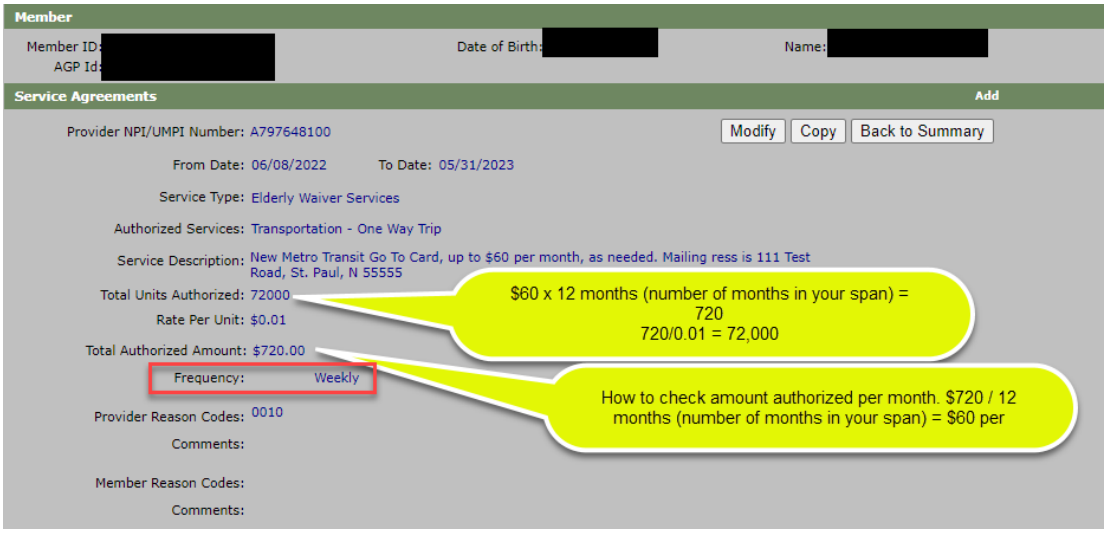
***Reminders:

- New Service agreement requests will be processed weekly.
- Go-To Cards are mailed to members within 7-10 business days.
- Monthly renewals are loaded monthly for the following month.
- Go-To Card should only have one active service agreement per applicable member at any given time
- Go-To Cards will show a zero balance until swiped; members will only be able to see their balance upon each use
- After card is swiped, user may look up balance and usage using the Metro Transit website. User must have the 16-digit bus pass serial number: https://store.metrotransit.org/farecard/CheckBalanceOrRefill

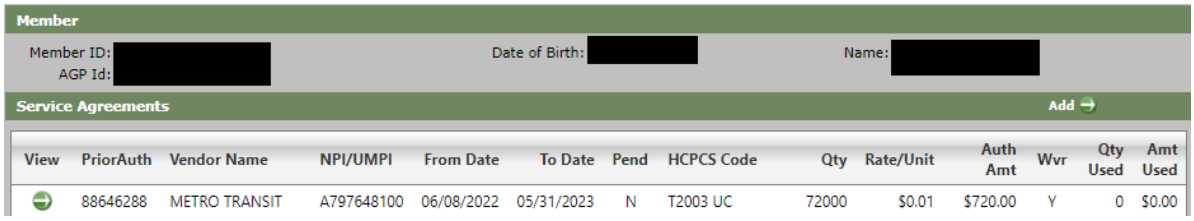


Create your service agreement based on one month Go-To Card:

1. **Provider NPI/UMPI Number**: A797648100
2. **Provider Name:** Metro Transit Go-To Card
3. Enter Service agreement **From Date** and **To Date**
4. **Service Type**: Select Elderly Waiver Services
5. **Authorized Services:** Select T2003UC Transportation one-way trip
6. **Service Description**: Include:
   - Indicate which card you are authorizing: Metro Mobility Go-To Card or Metro Transit Go-To Card
   - New or Existing card
   - Mailing address for the bus pass/Go-To Card (Ensures the pass is sent timely and avoids delays)
   - Monthly amount for the Go-To Card. Must use terminology "up to" to dollar amount.
     (Example: "**up to** $60.00 per month, as needed". Refer to sample below.)
7. **Total Units Authorized**: Enter the monthly units multiplied by number of months and divided by the rate per unit.
   Example: 1) $60 x 12 months (months in span) = 720
   2) 720 / 0.01 = 72,000)
8. **Total Authorized Amount:** this amount is auto calculated
9. **Rate Per Unit:** $0.01
10. **Frequency:** "Weekly
11. **Provider Reason Code:** select appropriate reason code based on your authorization.
12. **Member Reason Code:** select appropriate reason code based on your authorization.



The service agreements dashboard will display the following:



Northeast Area Entry of Non-Medical EW Bus Passes

Authorize bus pass for non-medical rides only. Select appropriate provider for your region and indicate type of ride and amount authorized in the service description (i.e. shopping 2 roundtrip rides per week or monthly pass with dollar amount approved, etc.)

Care Coordinator must complete the appropriate Arrowhead Transit referral form for the bus the member will be using and send DIRECTLY to Arrowhead Transit as indicated on the form. Arrowhead Transit will mail the bus passes directly to the member upon receipt. New Service agreements will be processed weekly and will be mailed to each member.

Forms can be found on the Care Coordination website under Bridgeview page.

Complete a service agreement in Bridgeview using the following:

1. **Provider NPI/UMPI Number**: 1801114301
2. **Provider Name: Arrowhead Transit**
3. Enter Service agreement **From Date** and **To Date**
4. **Service Type:** Select Elderly Waiver Services
5. **Authorized Services**: Select T2003 UC Transportation one-way trip

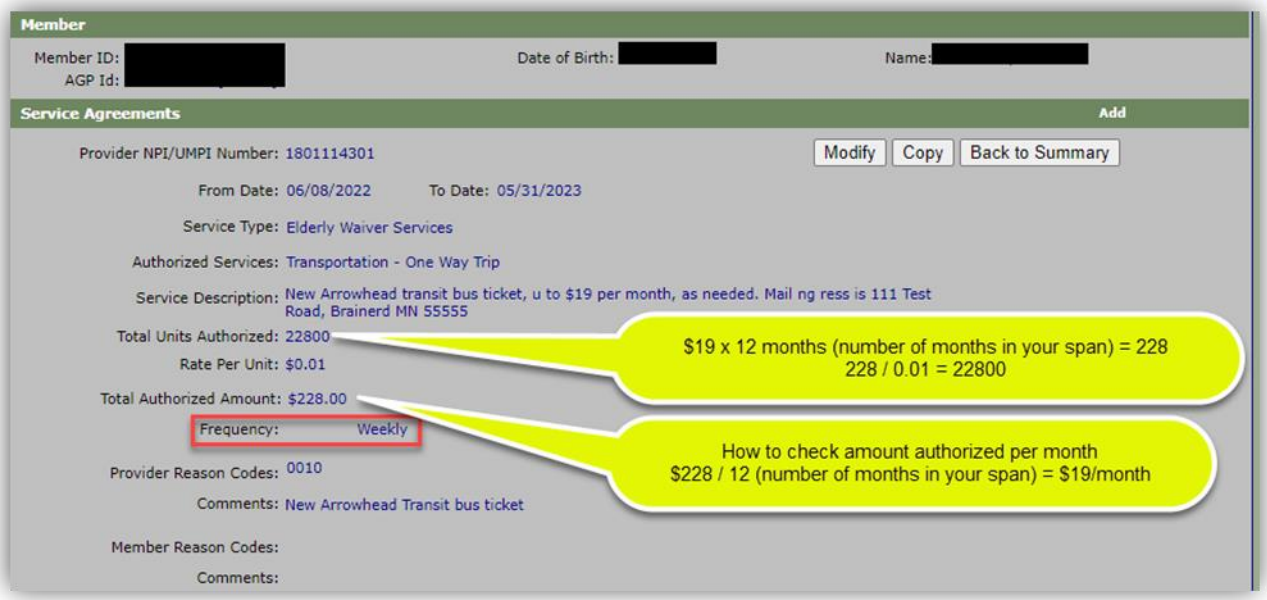
6. **Service Description** must include:
   - New OR Renewing ticket
   - Mailing address for the bus ticket. This ensures the ticket is sent timely and avoids delay.
   - Description of Pass (such as 1 book of 10 tickets; unlimited monthly pass, etc.)
   - Monthly amount for pass/ticket. Must use terminology “up to” to dollar amount.
     Example: Arrowhead transit bus ticket, **up to** $19.00 per month; or **up to** 2 books of 10 tickets at $25/book, etc.
7. **Total units authorized:** Enter the monthly units multiplied by number of months and divided by the rate per unit.

Example how to calculate total units authorized: 1) $19 per month x 12 months (months in span) = 228

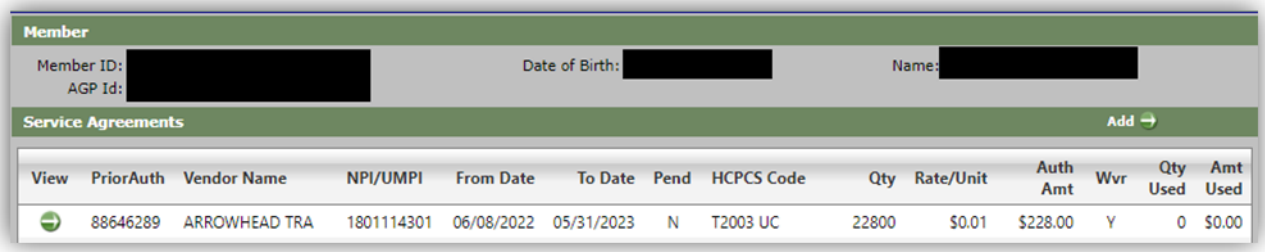
2) 228 divided by 0.01 = **22,800**

8. Rate Per Unit: $0.01
9. **Total Authorized Amount**: this amount is auto calculated

   Example how to check the math: take total authorized amount (**$228)** divided by the number of months in your span (12 months) = $19/month, in this example the amount you are authorizing is correct $19/month.
10. Select Provider Reason Code: select appropriate reason code based on your authorization
11. Member Reason Code: select appropriate reason code based on your authorization.



The service agreements dashboard will display the following:



View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88646289	ARROWHEAD TRA	1801114301	06/08/2022	05/31/2023	N	T2003 UC	22800	$0.01	$228.00	Y	0	$0.00

Northwest Area Entry of Non-Medical EW Bus Passes

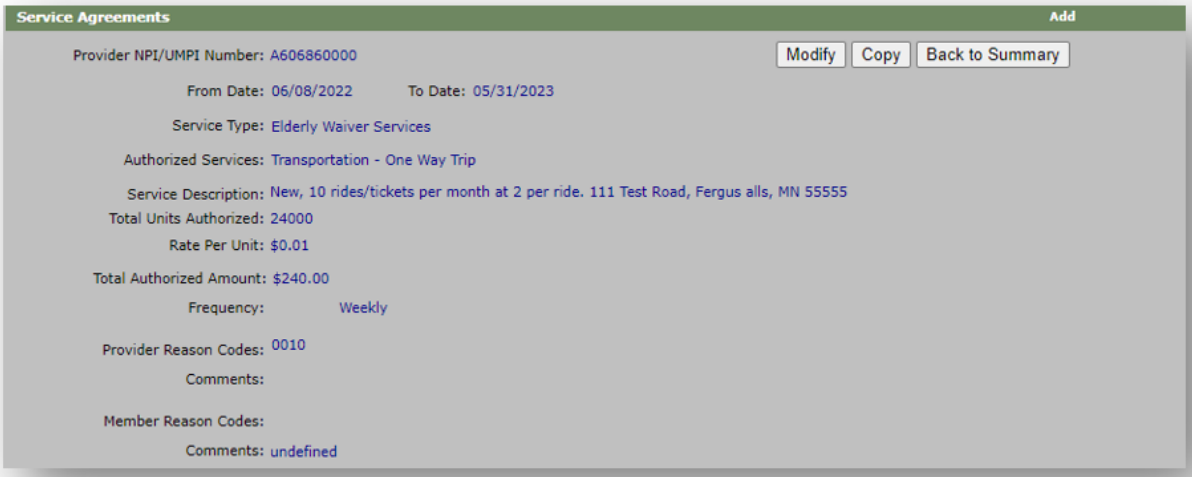
Authorize bus pass for non-medical rides only. Select appropriate provider for your region and indicate type of ride and amount authorized in the service description (i.e. shopping 2 roundtrip rides per week or monthly pass with dollar amount approved, etc.)

New Service agreements will be processed weekly and bus passes/tokens will be mailed to each member.

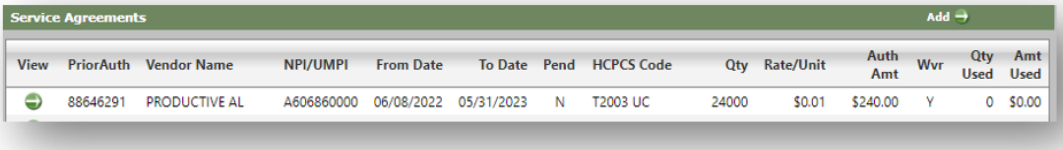
Complete a service agreement in Bridgeview using the following:

1. **Provider NPI/UMPI Number**:
   - A606860000 (Productive Alternatives)
2. **Provider Name: Productive Alternatives**
3. Enter Service agreement "**From Date**" and "**To Date**"
4. **Service Type:** Select Elderly Waiver Services
5. **Authorized Services:** Select T2003 UC Transportation one-way trip
6. **Service Description** must include:
   - New OR Renewing tickets
   - Mailing address for the bus tickets (Ensures the tickets are sent timely and avoids delays)
   - Total number of rides per month authorized.
   - Monthly amount for tickets
     Example: Up to 10 rides per month at $2.00 per ride; unlimited bus pass/ticket, up to $60.00 per month, etc.
7. **Total units authorized**: Enter the monthly units multiplied by number of months and divided by the rate per unit.
   Example how to calculate total units authorized: 1) 10 rides x $2/each = $20
   2) $20 x 12 months in your span = $240
   3) $240 divided by 0.01 = **24,000**
8. **Rate Per Unit:** $0.01
9. **Total Authorized Amount:** this amount is auto calculated
   Example how to check the math: take total authorized amount (**$240)** divided by the number of months in your span (12 months) = $20/month, in this example the amount you are authorizing is correct $20/month.
10. **Provider Reason Code:** select appropriate reason code based on your authorization.

11. **Member Reason Code:** select appropriate reason code based on your authorization.



The service agreements dashboard will display the following:



Entry of Non-Medical EW Bus Passes for Benton, Sherburne, and Stearns Counties

Care Coordinators can authorize non-medical EW Transportation by in communities that are served by St Cloud Metro Transit via Dial-a-Ride (DAR). DAR is a shared ride service for individuals who are unable to ride Fixed Route buses and require door-through-door driver-assisted service.

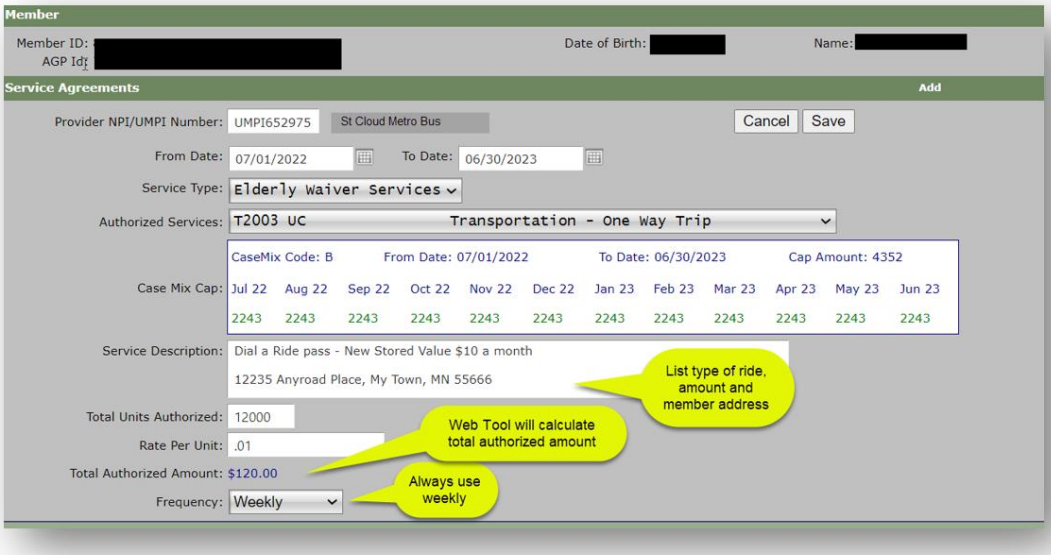
New Service agreements will be processed weekly and bus passes will be mailed to each member.

*Authorize bus pass for non-medical rides only. Select appropriate provider for your region and indicate type of ride and amount authorized in the service description (i.e. shopping 2 roundtrip rides per week or monthly pass with dollar amount approved, etc.)

Contact Dial-a-Ride for current rates and route information.

To access Dial-a-Ride, complete the following:

1. Apply for eligibility by completing the Dial-A-Ride Service Application
2. Receive certification approval from Dial-A-Ride
3. Call 320-252-1010 to schedule a ride
4. Dial-a-Ride password is TRANSPORTATION
5. Enter Service Agreement per below:
6. **Provider NPI/UMPI Number**: UMPI652975
7. **Provider Name: Dial a Ride**
   Enter Service agreement "**From Date**" and "**To Date**"
8. **Service Type:** Select Elderly Waiver Services
9. **Authorized Services:** Select T2003 UC Transportation one-way trip
10. **Service Description** must include:
    - New OR Existing request
    - Mailing address for the bus tickets (Ensures the pass is sent timely and avoids delays)
    - Description of pass (i.e., Total number of rides per month)
    - Monthly amount for pass
      (Example: 10 rides per month at $25; unlimited bus pass/ticket $10.00 per month, etc.)
11. **Total units authorized**: monthly units multiplied by number of months authorized.
    Example how to calculate total units authorized:
    a. $10/month x 12 months (months in your span) = 120
    b. 120 divided by 0.01 = **12,000**
12. **Rate Per Unit:** $0.01
13. **Frequency:** Always enter "Weekly"
14. **Total Authorized Amount:** this amount is auto calculated
    Example how to check the math: take total authorized amount (**$120)** divided by the number of months in your span (12 months) = $10/month, in this example the amount you are authorizing is correct $10/month.
15. **Provider Reason Code:** select appropriate reason code based on your authorization.
16. **Member Reason Code:** select appropriate reason code based on your authorization.



List of Non-Medical Transportation Providers

AITKIN, CARLTON, COOK, KOOCHICHING, LAKE, PINE & ST. LOUIS COUNTY: ARROWHEAD TRANSIT

UMPI: 1801114301
Enter SA in Bridgeview
Call 1-800-862-0175 to arrange a ride
Refer to Care Coordination Website for appropriate county request form

BECKER COUNTY: FRIENDLY RIDER (BECKER COUNTY TRANSIT)

Serves Becker County
UMPI542871
Enter SA in Bridgeview
Call 218-847-1674 to arrange a ride

BENTON, SHERBURNE & STEARNS COUNTY: St Cloud Metro Transit via Dial-a-Ride (DAR)

Serves Benton, Sherburne and Stearns County
UMPI652975
Enter SA in Bridgeview
Refer to Care Coordination Website for DAR Guide and Application

CLAY COUNTY: MATBUS

Serves Clay County, Fargo, Moorhead, Dilworth, West Fargo
UMPI652870
Enter SA in Bridgeview
Contact Moorhead for disabled members to request a service voucher to be filled out Application required for all services
Call 701-476-6782 to arrange a ride

CROW WING COUNTY: CITY OF BRAINERD

Serves Crow Wing County
UMPI652959
Enter SA in Bridgeview
Call 218-454-3429 to
arrange a ride

METRO: Metro Transit Go-To Card Serves Metro County

UMPI A797648100
Enter SA in Bridgeview
No additional referral necessary

OTTERTAIL COUNTY: PRODUCTIVE ALTERNATIVES/THE OTTER EXPRESS

Serves Parkers Prairie, Perham, Fergus Falls
UMPI: 1285923490
Enter SA in Bridgeview
Call 218-998-3002 to schedule a ride

ST. LOUIS COUNTY: THE HIBBING AREA TRANSIT

Serves City of Hibbing in St. Louis County
UMPI652892
Enter SA in Bridgeview
Call 218-263-7115 to arrange a ride

ST. LOUIS COUNTY: Duluth Transit Authority (DTA)

Serves Duluth MN area
UMPI652872
Enter SA in Bridgeview
No additional referral necessary

WILKIN COUNTY: PRODUCTIVE ALTERNATIVES/THE OTTER EXPRESS

Serves Breckenridge
UMPI: 1285923490
Call 218-998-3002 to arrange a ride

***For non-medical bus pass related questions or concerns send a secure email to:**
EWBusPasses@bluecrossmn.com

Amerigroup Member360

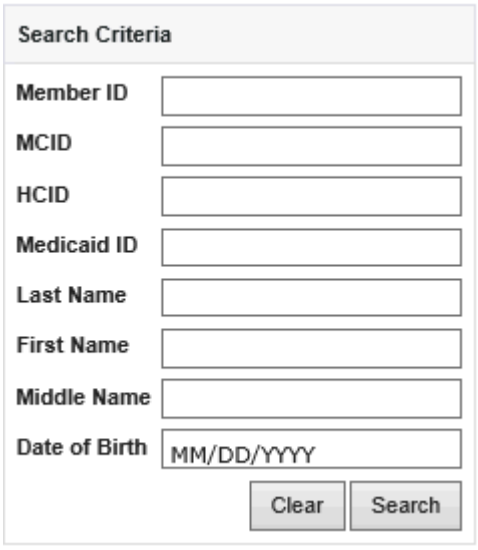
Member360 is an easy-to-use, ready only system giving Care Coordinators access to many types of healthcare related information including:

- Authorizations (including state plan home care/PCA)
- Inpatient stays/ER visits
- Medical claims
- Pharmacy claims

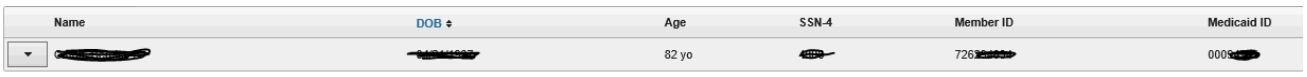
All CCs who currently have BV access has access to member 360. Contact help desk if the link is not working.

How to access information in Member360

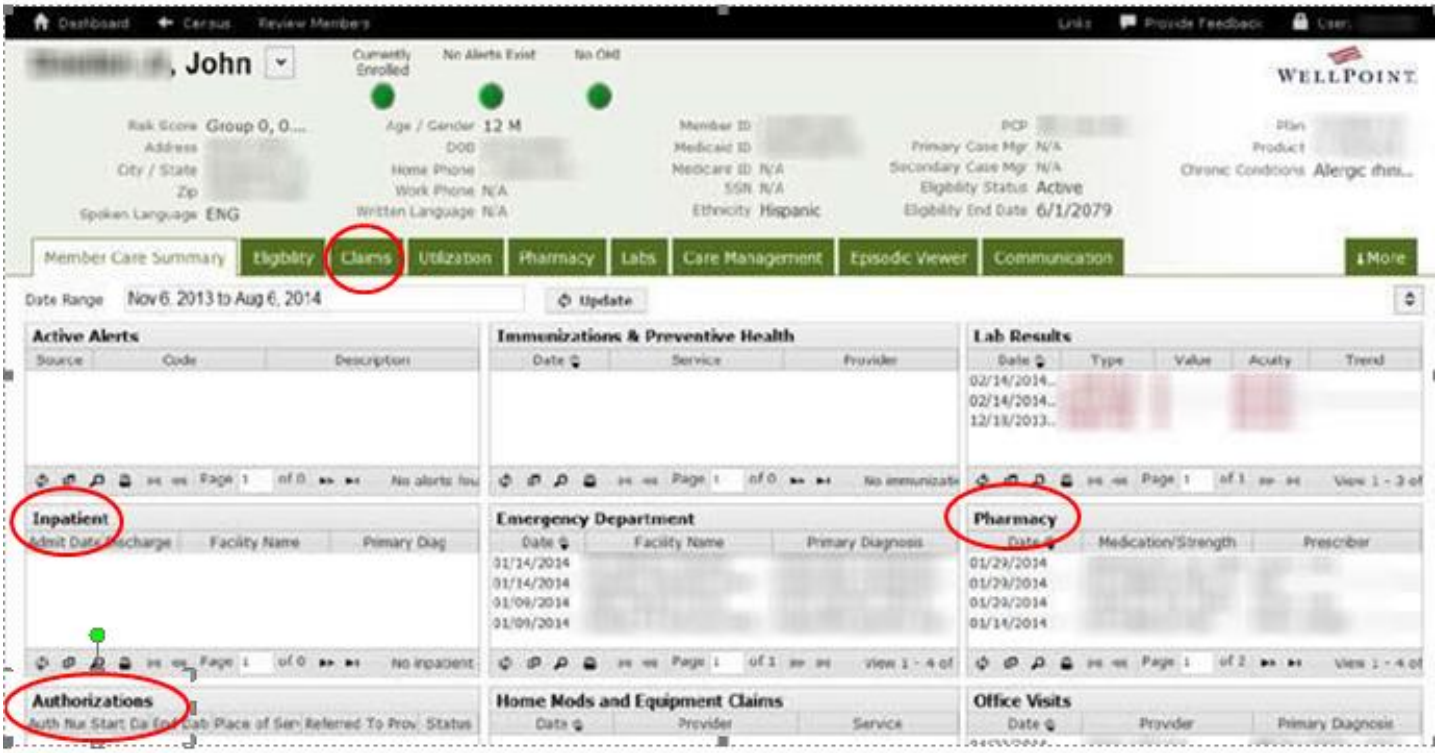
1. Once logged into Member360, CC can search member here using AGP Member ID, Medicaid ID, or any of the following search criteria options.



2. After clicking 'Search', a member list will display. Click on the member's name.



3. The member's Care Summary page will appear when you first access the member's case in Member360. The top of the screen displays the member's demographic information and below display different types of information as highlighted.



Below this banner are different tabs with specific types of information including:

Tab	Description
Member Care Summary	Displays the member's demographics.
Eligibility	Displays the member's benefits and eligibility information.
Claims	Provides a list of claims data.
Utilization	Provides a list of active and inactive service authorizations.
Pharmacy	Provides a list of prescription medications that has been dispensed.
Communication	Provides a list of written or faxed correspondence received or sent by the plan.
Documents	Choose 'MACESS: LETTERS' to access copies of authorization or appeal letters.

Navigation Features

There are navigation icons to help you move through Member360. See the sections below for more information.

Icons

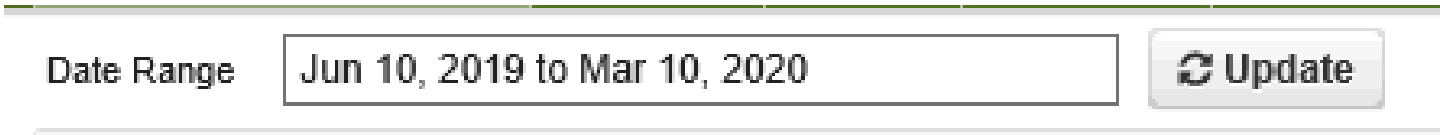
The Reload/Refresh icon is used to reload the original search information

The Expand icon is used to show more data within that box

The Search icon is used to customize your search in that box

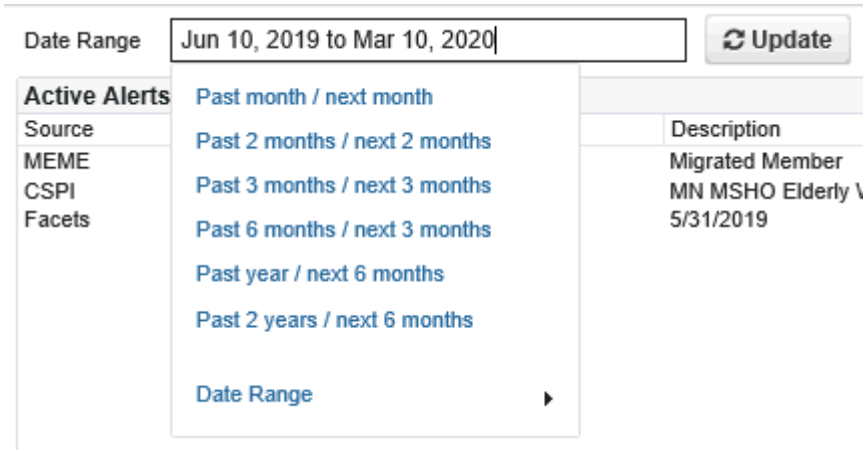
The Print icon is used to request a print of the data

Tips



If you are unable to locate information, specifically home care authorizations, make sure the date range is specific to the dates you are searching.

If not, click in the 'Date Range' box and choose a timeframe from the options and select 'Update'.



FINAL PAGE