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.

October 3, 2024

*Recent changes in Red

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GETTING STARTED

Contacts

Resources—for Care Coordinator use only	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	• Any Bridgeview webtool issues (all service agreements, LTCC & Case Mix, etc.) ***This for Care Coordinators use only**—not to be shared with members or families
Care Coordination Website - Bridgeview tab	See this page for the following Bridgeview resources: - Bridgeview Web Tool MnSP & Revised MnCHOICES User Access Request Form - Bridgeview Care Coordination User Guide - Link to Bridgeview Company home page which has the link for User access - Bridgeview Web tool, MnSP, and Revised MnCHOICES User Access Request Form. - Bridgeview Tuesdays meeting link; Recordings and slides. - EW Transportation information - Bridgeview Bite-Sized Learnings
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 card needed" in the subject line.
*EWProviders@bluecrossmn.com *1 (800) 584-9488	Refer Elderly Waiver Providers to these resources to contact Bridgeview related to: - EW Provider registration - Elderly waiver claims/billing questions or

Resources—for Care Coordinator use only	Questions
Monday – Friday 8:00 a.m. - 4:30 p.m.	concerns ***This for EW Provider use only**—not to be shared with members or families
*Partner.Relations@bluecrossmn.com	Send completed Bridgeview Care Coordinator Web Tool Access Request form to Partner Relations e-mailbox and Secureblue.Enrollment@bluecrossmn.com (add, remove or changes) ***This for Care Coordinators use only**—not to be shared with members or families or Providers.

Secureblue.Enrollment@bluecrossmn.com	• Send completed Bridgeview Web Tool MnSP and Revised MnCHOICES User Access Request Form for:
	  - Add
	  - Remove
	  - Updates to User Information (name, phone, e-mail address changes)
	• Inquiries about status of access requests.
	• Role access issues
	• Bridgeview HRA audit questions
	• Enrollment questions
	  - Report discrepancies
	  - Incorrect delegate assignment(s)
	  - Cannot see enrollment report

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 Bridgeview Web Tool MnSP and Revised MnCHOICES User Access Request Form to have a user account created/removed. This form can be found at the Care Coordination

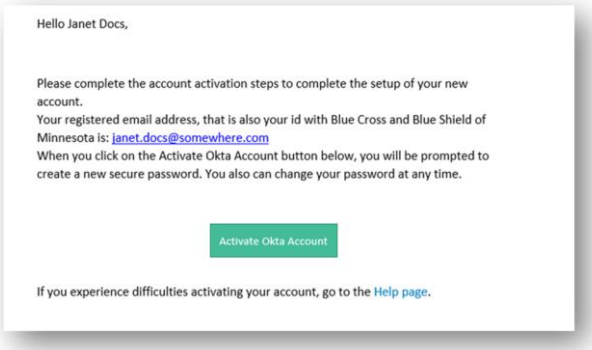
website, Bridgeview page.

CC Website-Bridgeview page

Completing the Bridgeview Web Tool MnSP and Revised MnCHOICES User Request Form

1. This form should be completed by the Care Coordination Delegate Representative/Supervisor to request; remove access or update User information.
2. Select the level of access needed (refer to Roles/Definitions above).
3. Complete the effective date that the Care Coordinator needs access/removal/change.
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 user access Request Form can be submitted 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 Secureblue.enrollment@bluecrossmn.com.

12. 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 Secureblue.enrollment@bluecrossmn.com.



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 Secureblue.enrollment@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

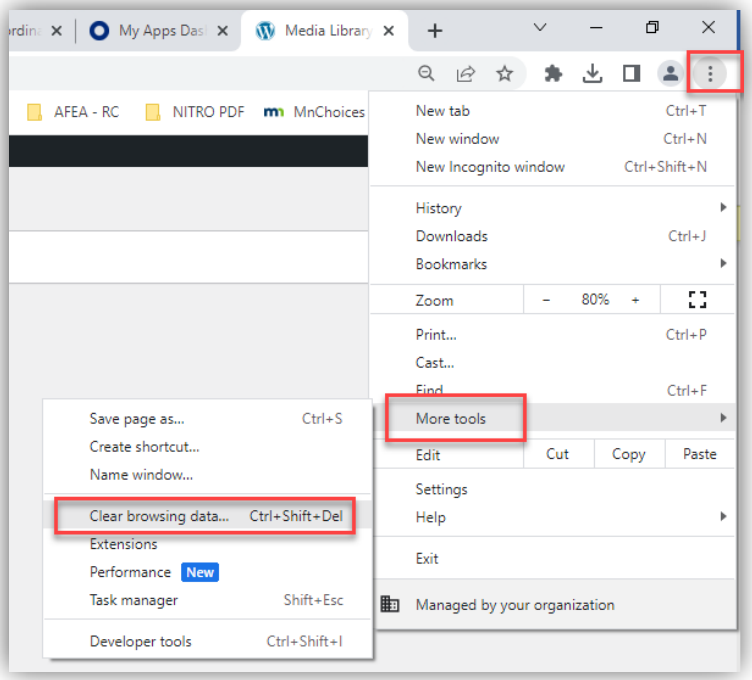
We recommend you log in quarterly if you do not access Bridgeview regularly. BCBS Security team will automatically terminate a User after 365 days of inactivity. Please complete a new Web Tool User ID Request Form if deactivated and access is needed.

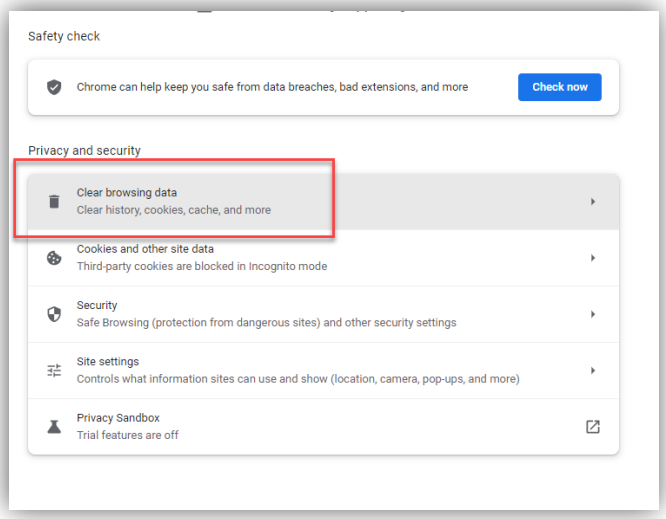
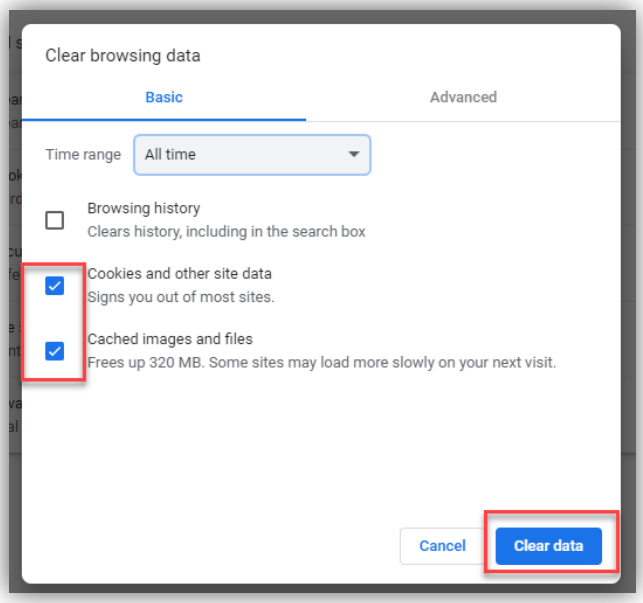
User Contact Information Changes

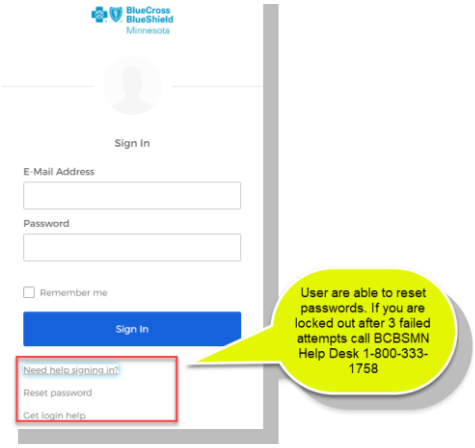
To request changes to any User’s contact information in Bridgeview:

1. Complete the Bridgeview-Web-Tool-MnSP-and-Revised-MnCHOICES-User-Access-Request Form.
    a. Include new information on the top and check “Edit Existing User” and include the previous information (such as previous last name, previous e-mail address, etc.) and “Effective date.”
2. E-mail to Secureblue.enrollment@bluecrossmn.com and partner.relations@bluecrossmn.com

Trouble Shooting Tips for Access Issues

Issue	What to do
Unable to modify or save entry in webtool	▪ 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* See below. ▪ Resave your favorite or bookmark ▪ Contact the BCBSMN Help Desk for support 1-800-333-1758
Clearing your Cache	**Caution:** If you have "checked out" assessments/support plans from the Revised MnCHOICES application, do **not** clear your cache until they are checked in. 1. Select the three ellipses at the top right corner of your browser screen 2. Select "More Tools" 3. Select "Clear browsing data"  4. Click on "Clear browsing data"

Issue	What to do
	 5. Unselect “Browsing history” 6. Select “Cookies and other site data” 7. Select “Cached images and files” 8. Click on “Clear data” 
Receiving a “404” error when logging in	- 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

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
What to do if locked out	• Call Blue Cross Help Desk if need access sooner than an hour. • Or you can wait an hour and then log in and click on change your password. 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. 

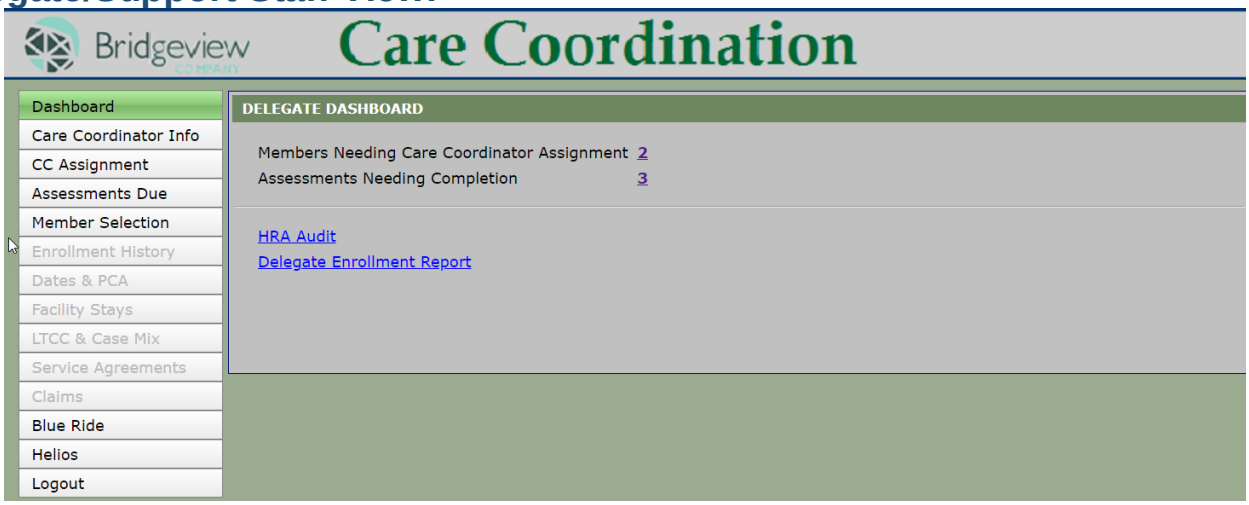
Log In

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.

AFTER LOG-IN

Delegate/Support Staff View:

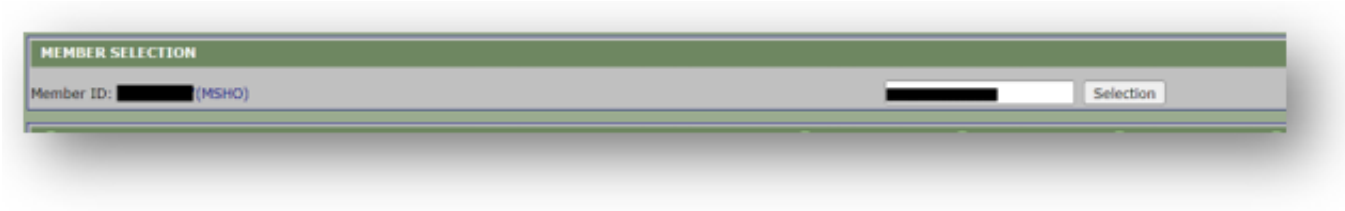


Care Coordinator View:

Subscriber IDs in Bridgeview

Members are identified in Bridgeview using their Subscriber ID number. This will be 8 plus PMI (i.e., 801234567). If, in the unlikely event, a member has two PMI numbers, send an e-mail to Bridgeview.service.agreements@bluecrossmn.com for assistance. Include member name and previous and current PMI.

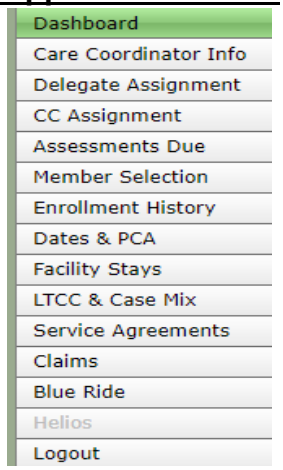
If needed for provider billing purposes, the prefixes are:
MSC+: MQG (example – MQG80123456)
MSHO: MQS (example – MQS80123456)



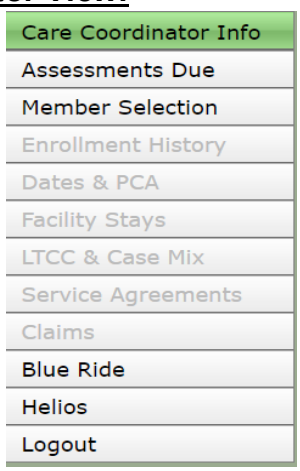
MEMBER DETAIL SCREEN OVERVIEW

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

Delegate/Support Staff View:



Care Coordinator View:



Member Selection

1. Click on Member Selection.
2. Enter the member's 9-digit subscriber ID number (8 plus the member's PMI).
3. 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 the Member Detail screen. The care coordinator can change some Member Detail fields in the Bridgeview Web Tool. Complete instructions for updating these fields can be found here: *Updating Member Information*.

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.

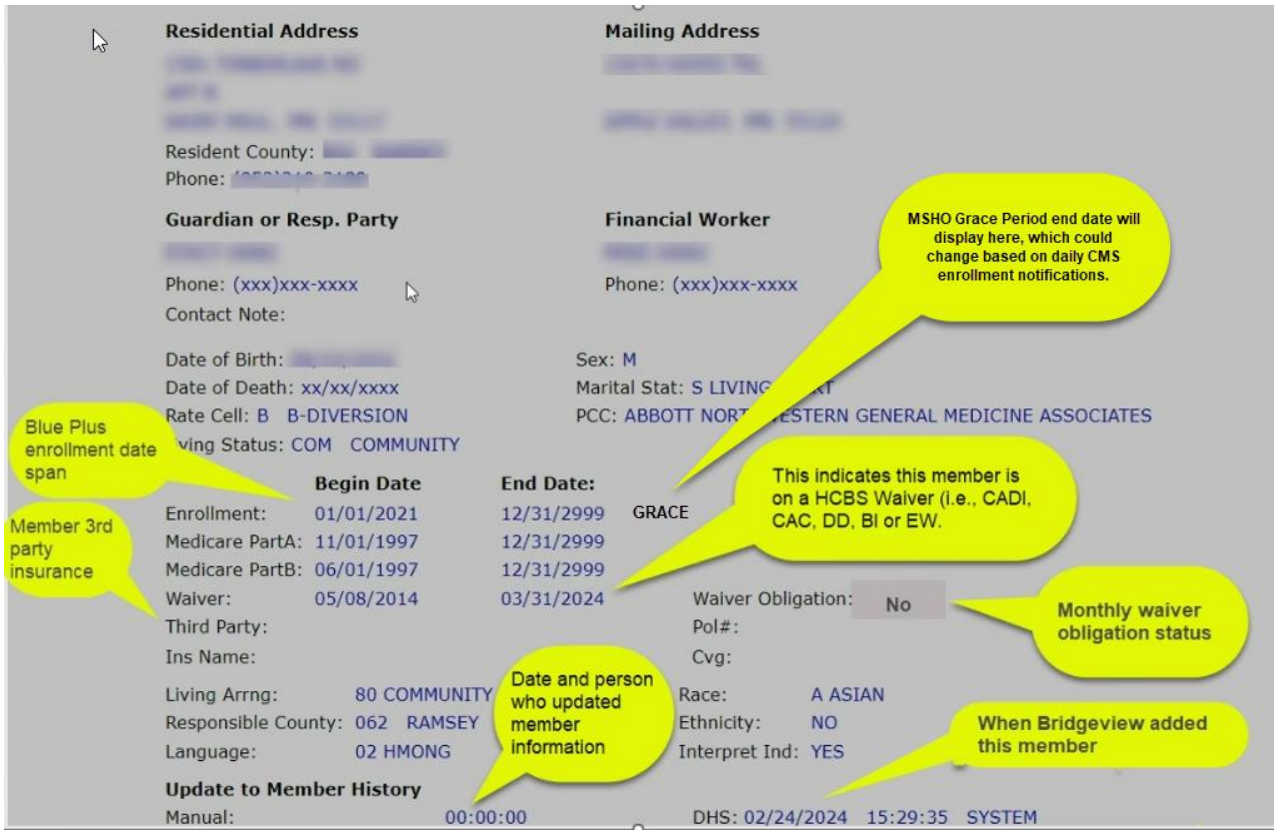
If you see that a member has an end date under the Prepaid Health Plan record, you should verify the member's EW eligibility before continuing to enter a service agreement authorization.

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.

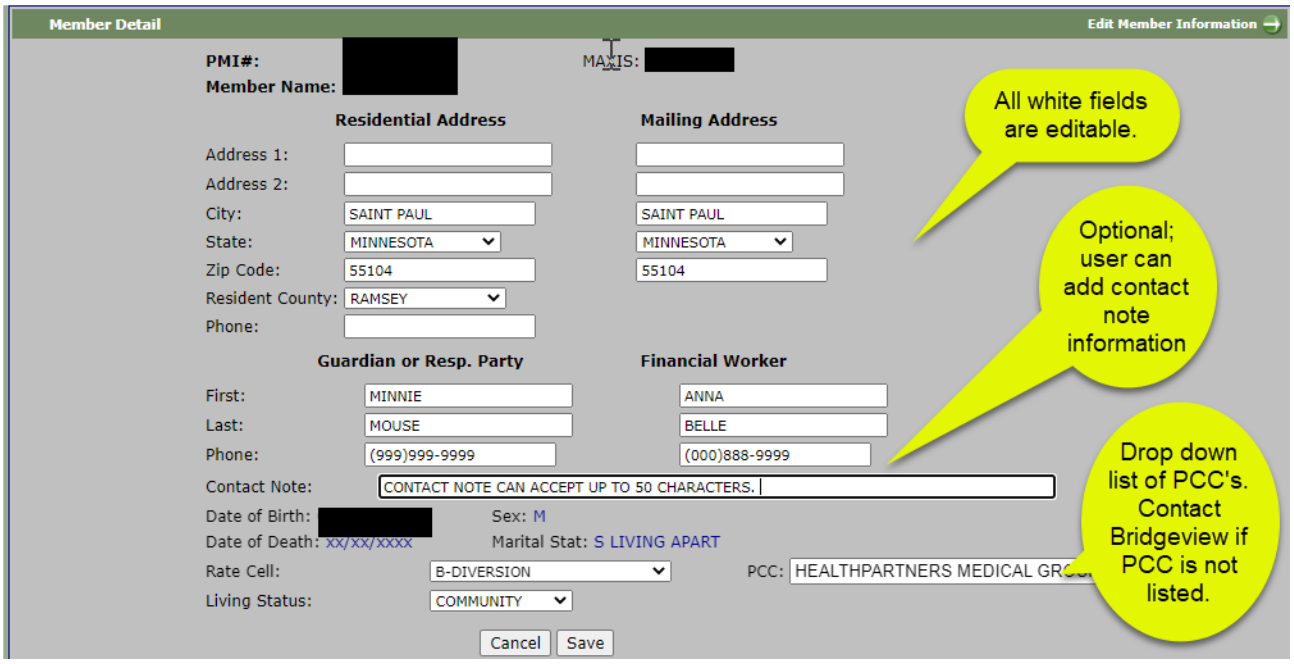
When changing member information in the Bridgeview Web Tool, you must also contact the county financial worker to make sure that the member's information has been updated in the DHS recipient database. If recipient files don't get updated, any changes made will revert back to the previous information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

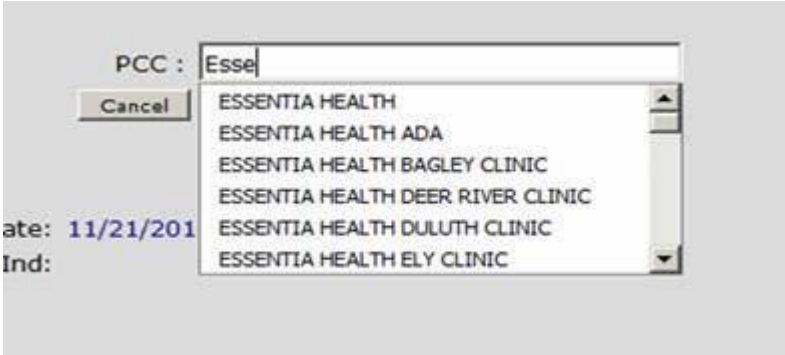
1. Select **Edit Member Information**.
2. Type new information in the applicable field(s)

3. Optional—document reason for making the change in the **Contact Note** field.
4. Click on **Save**.



PCC Changes:

The PCC field lists **most** 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, Subscriber ID, and name of new clinic.

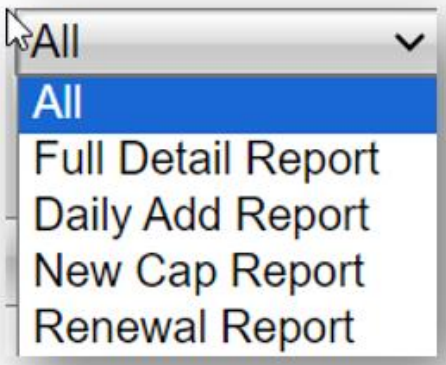
PCC changes may trigger delegate reassignment. Refer to section, *Transfers of Care Coordination to Another Blue Plus Delegate* in the Community and Nursing Home Care Coordination Guidelines for a list of affected PCC's. If PCC is changed prior to transfer effective date, member will appear on the receiving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

Contact Bridgeview.service.agreements@bluecrossmn.com.

***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.

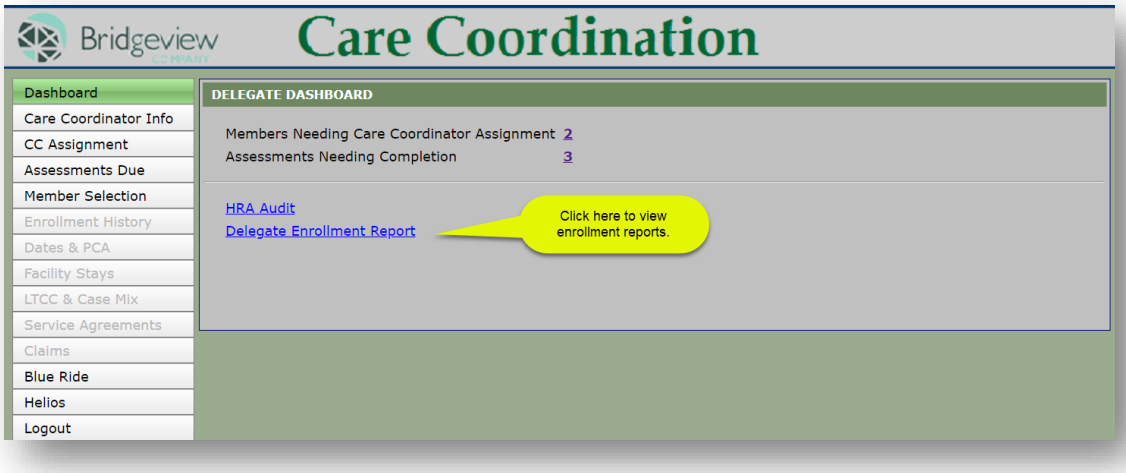
REPORTS

All Delegate Blue Plus 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.



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

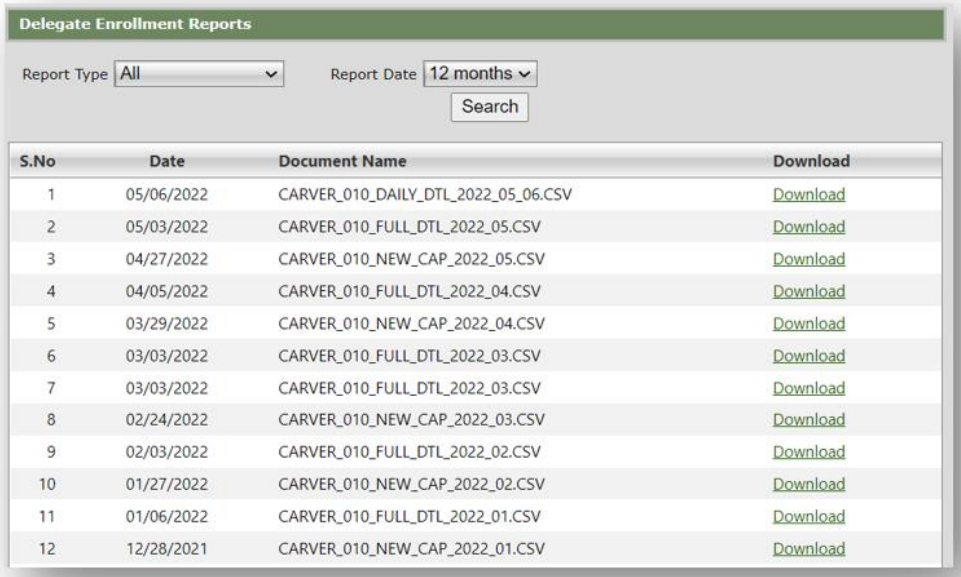
1. Click on the blue "Delegate Enrollment Report" link.



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.



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.

Important difference between "Assign" and "Edit":

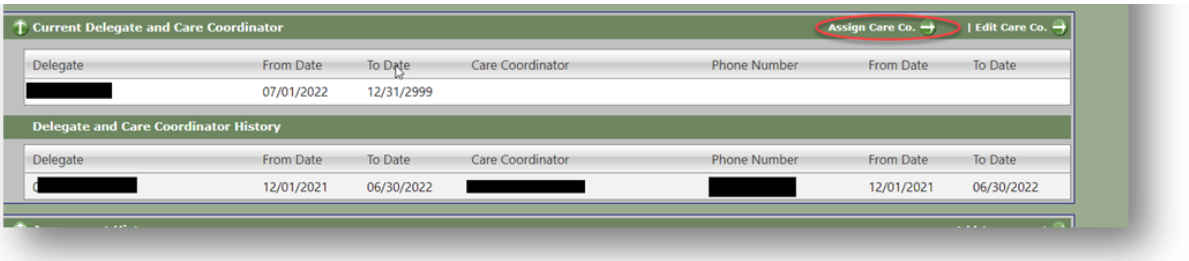
Assign CC: Use this to assign or update the CC. Choosing Assign CC will keep a history of the previous CC.

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.

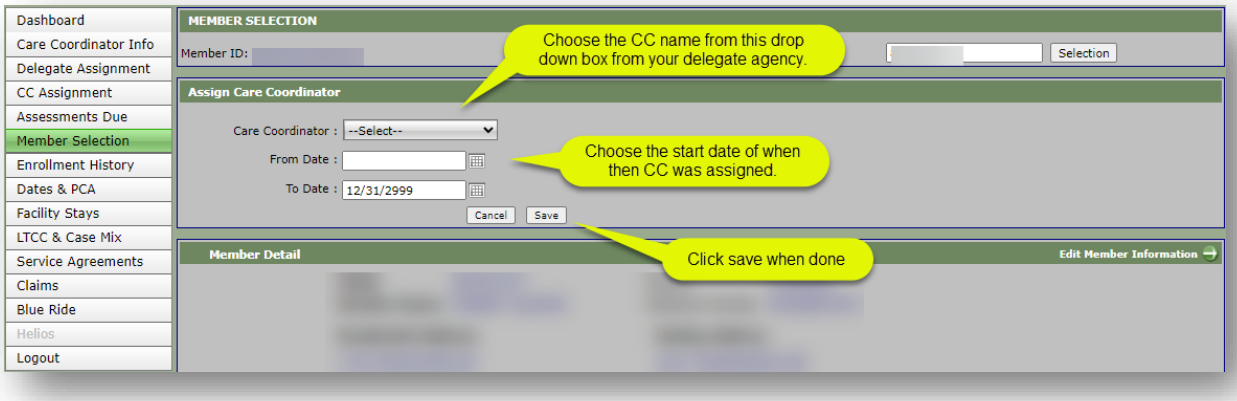
When a member is assigned to your agency, you will use the **Assign Care Coordinator** function (see illustrations below).

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).

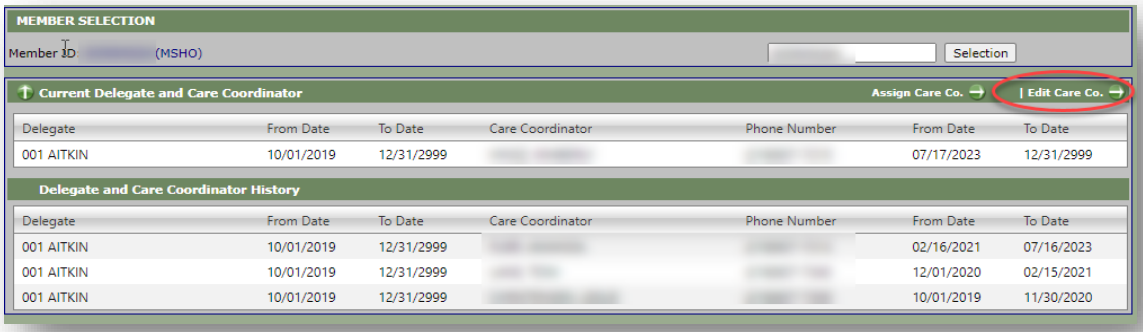
Once a Care Coordinator is assigned, you may reassign or edit the Care Coordinator by choosing **Assign Care Co.** or **Edit Care Co.** on the Member Selection screen.

Important difference between "Assign" and "Edit":

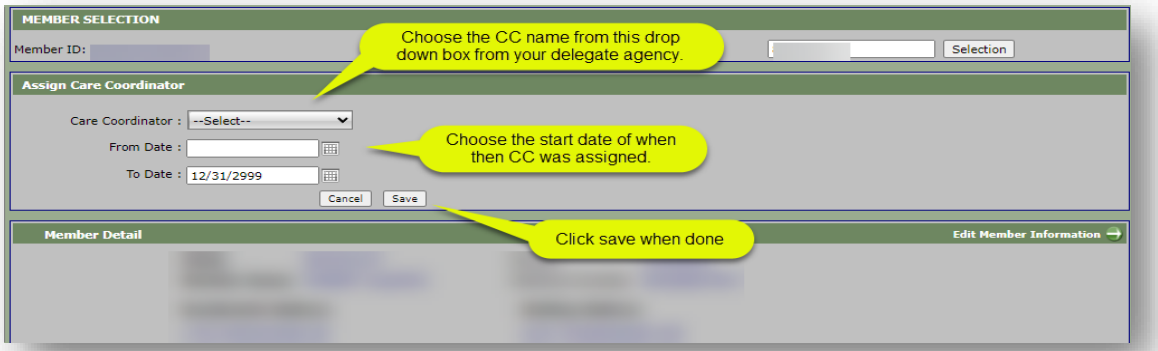
Assign CC: Use this to assign or update the CC. Choosing Assign CC will keep a history of the previous CC.

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



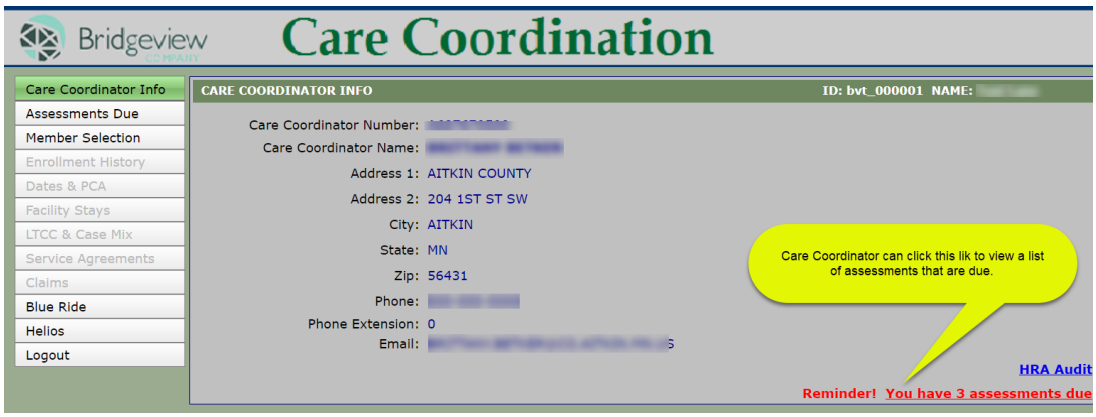
2. Choose the Care Coordinator name from the drop-down
3. Enter start date of assignment.
4. Click **Save**.



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:

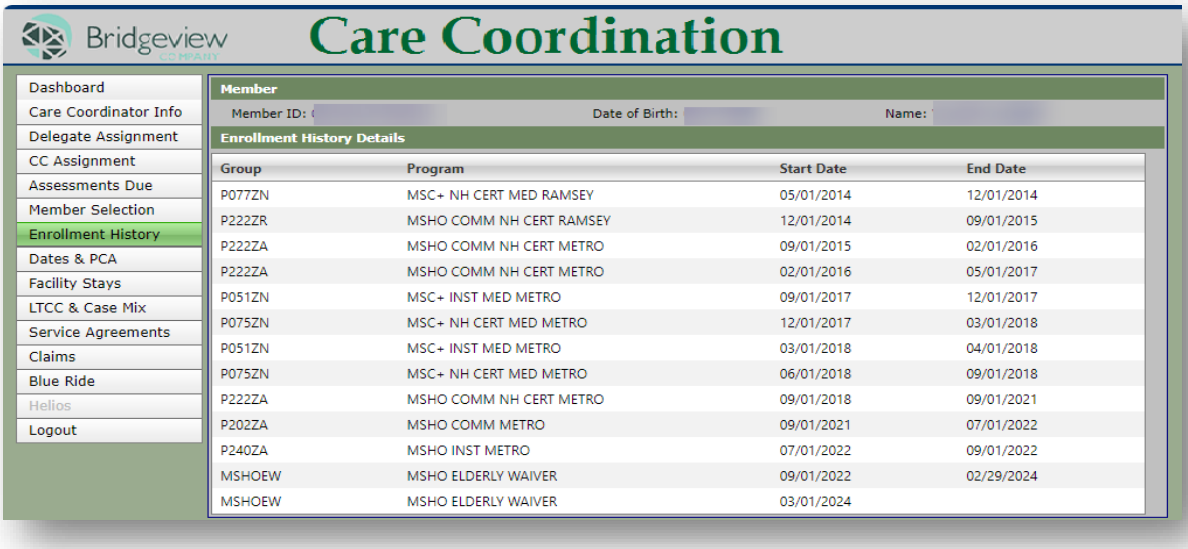


1. To view a member, click on the **Member Selection** tab from the list on the left.
2. If applicable, select HRA Audit to enter requested audit documentation. Refer to Heath Risk Assessment (HRA) Audit Process for details of the HRA audit process.
3. Click on **Reminder!** for a list of assessments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

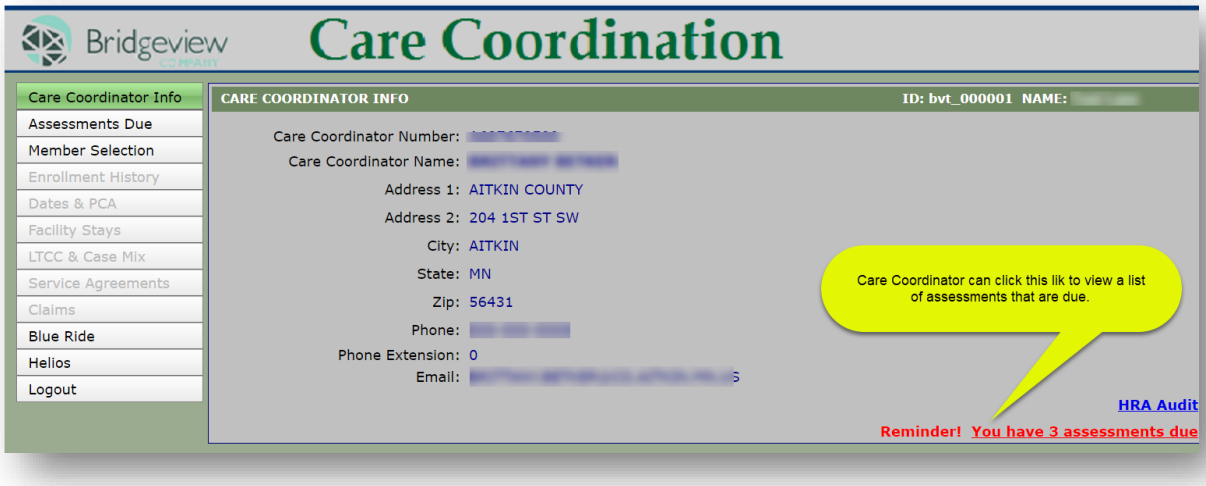
*****Do not enter HRA information until after a Care Coordinator is assigned**.

Entering Health Risk Assessments General Process

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 view

Care Coordinator view



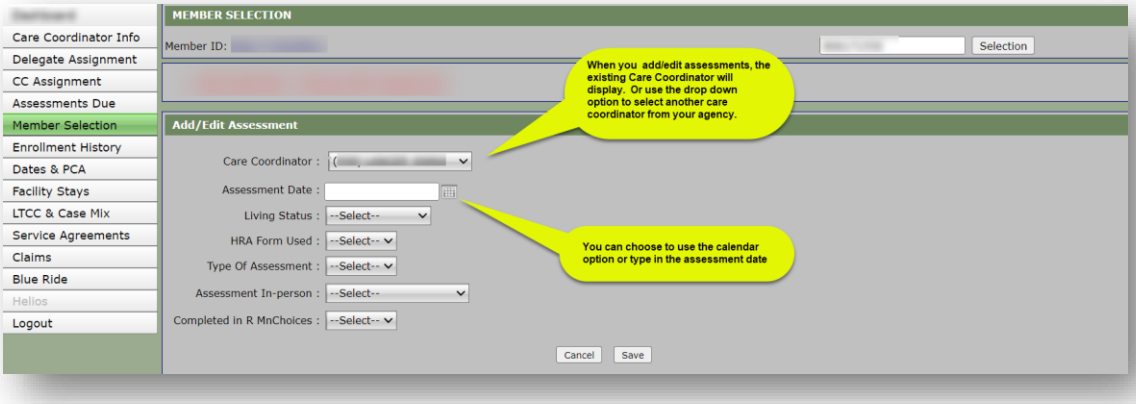
2. Review this screen for a list of past due and upcoming assessments based on the previous HRA date in the system. The type of assessment is either “I” for Initial assessments due for new enrollees, or “R” for reassessments for existing enrollees. Past Due assessments will be displayed in red.
3. Click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

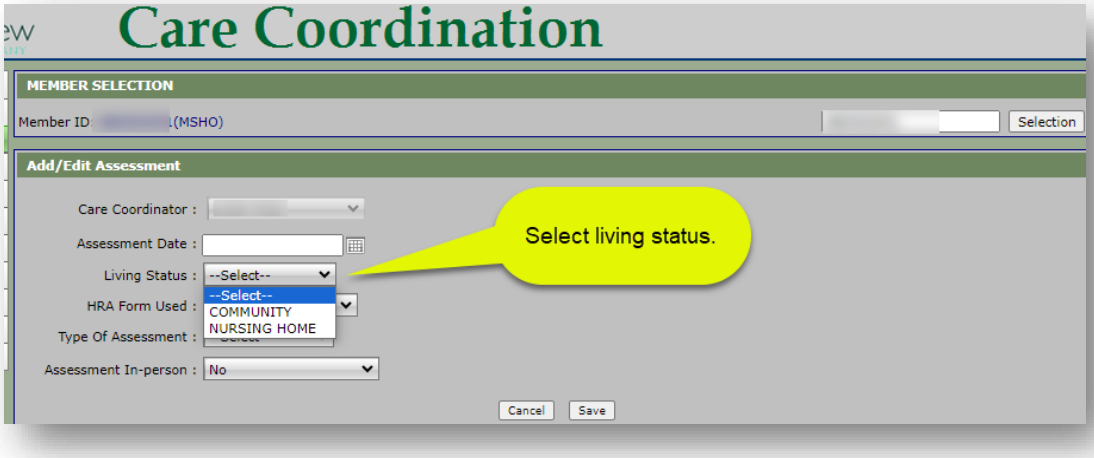
4. Add Assessment information by clicking on **Member Selection** and entering the Subscriber ID. This screen shows the entire assessment history.

5. Click on **Add Assessment** arrow



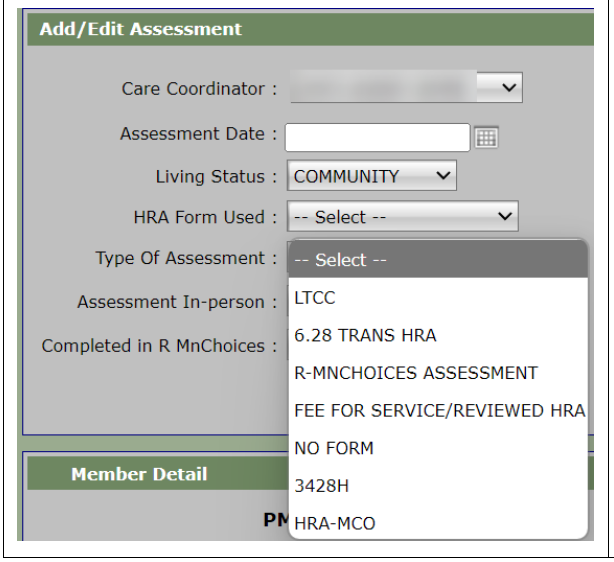
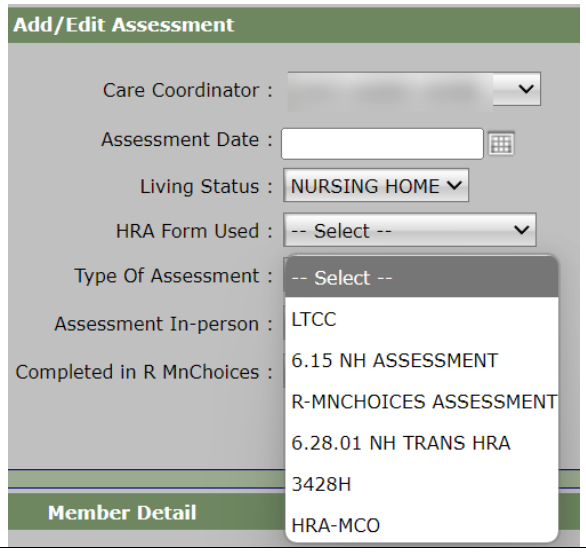
6. **Care Coordinator** name is displayed. Use the drop-down to select another care coordinator if needed. Trouble-shooting tip: If there is no CC listed, refer to section *Assigning Care Coordinators to Members (Delegate Representative/Support staff role)* to assign the CC.
7. **Assessment Date**: Enter either the date of the assessment; date of refusal; or for Unable to Reach enter the date on the UTR Member Support Plan Letter.
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). This should not be used after 7.1.24. If used after 7.1.24 Users will get an edit and will need a Partner Relations Consultant approval to enter.
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	Select this when 6.28 Transitional HRA is completed. Reminder this is in combination with review of newly enrolled members MnCHOICES assessment, LTCC, 3428H or HRA-MCO within the past 365 days and includes Product changes.
R-MNCHOICES ASSESSMENT	Select when a Blue Plus Care Coordinator completes a full MnCHOICES assessment in the Revised MnCHOICES application to determine program eligibility for PCA and/or Elderly Waiver.
FEE FOR SERVICE/REVIEWED HRA	Select this to document the date of the previous MnCHOICES, LTCC, 3428H or HRA-MCO assessment that was completed prior to Blue Plus enrollment and reviewed with member when completing the Transitional HRA. Follow the process outlined below in section, *LTCC/MnCHOICES completed prior to enrollment*.
NO FORM	For Refusals and Unable to Reach, regardless of the assessment tool used.
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. For use with CW members not on EW nor receiving PCA Services, and for those members on another waiver. Cannot be used to determine eligibility for EW or PCA. This should not be used after 7.1.24. If used after 7.1.24 Users will get an edit and will need a Partner Relations Consultant approval to enter.
HRA-MCO	Select when a Blue Plus Care Coordinator completes a HRA-MCO in the Revised MnCHOICES application. For use with CW members not on EW nor receiving PCA Services, and for those members on another waiver. **Notes:** Cannot be used to determine eligibility for EW or PCA. Do not select this form for UTR, Refusals or THRA's completed in the Revised MnCHOICES application.

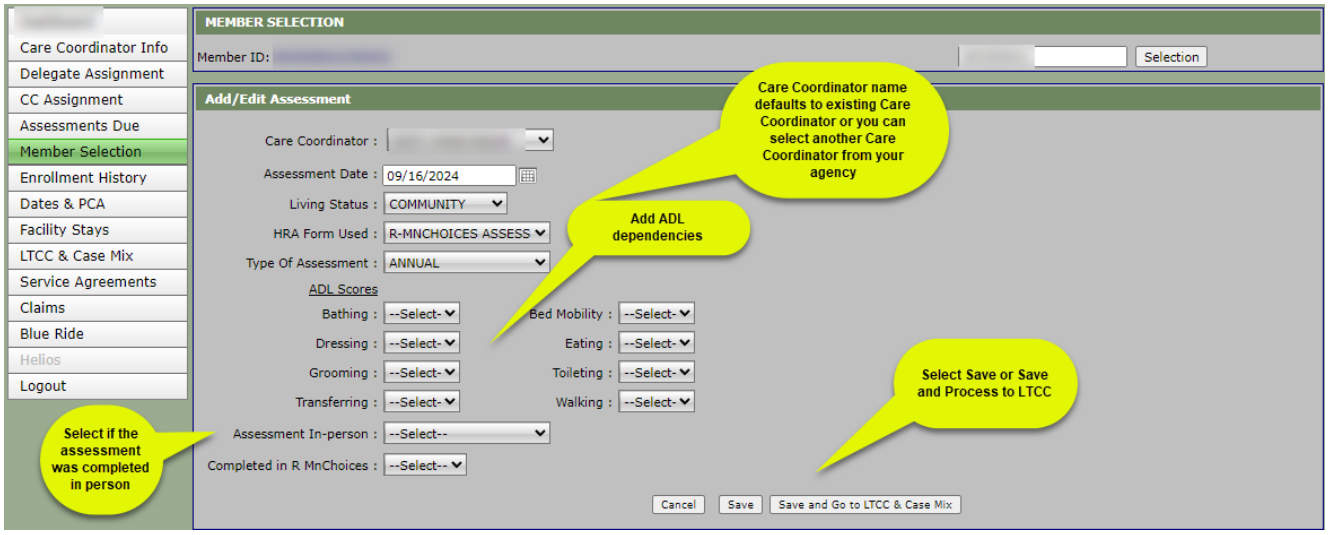
Community	Nursing Home
	

10. Select the **Type of Assessment** from the drop-down: Options vary depending on the Living Arrangement and type of HRA form selected.

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 or full MnCHOICES assessment completed in the Revised MnCHOICES application 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 **Assessment In Person**

- Select "**yes**" if assessment was completed in person
- Select "**no**" for the following reasons:
    - Assessment was completed remotely
    - Refusal
    - Unable to Reach
- Select "**Done by FFS/Other/MCO/Unknown**" only when entering the FFS assessment for Transitional HRA and CC is unaware if the previous assessment was done in person.

13. **Completed in R MnChoices**.

- Select "**yes**" if the assessment was completed in the Revised MnChoices application.
- Select "**no**" for the following:
    - Assessment was not completed in Revised MnChoices
    - Nursing home assessment entries. When entering either "6.15 NH Assessment or 6.28.01 NH TRANS HRA in the HRA Form Used field Users must select "no". An error message will appear if User selects "yes" and Users will not be able to save.

14. 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.

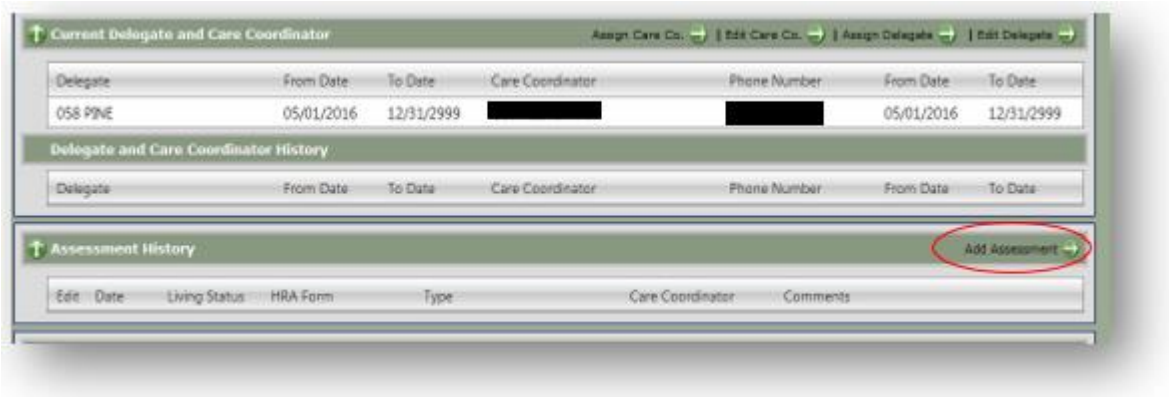
Important: In the event of errors, you will NOT be able to directly edit an HRA after you save it. Do NOT enter another HRA to replace the HRA that was entered in error. For errors in HRA data entry, see section, *Requesting an Edit or Deletion of an HRA entry*.

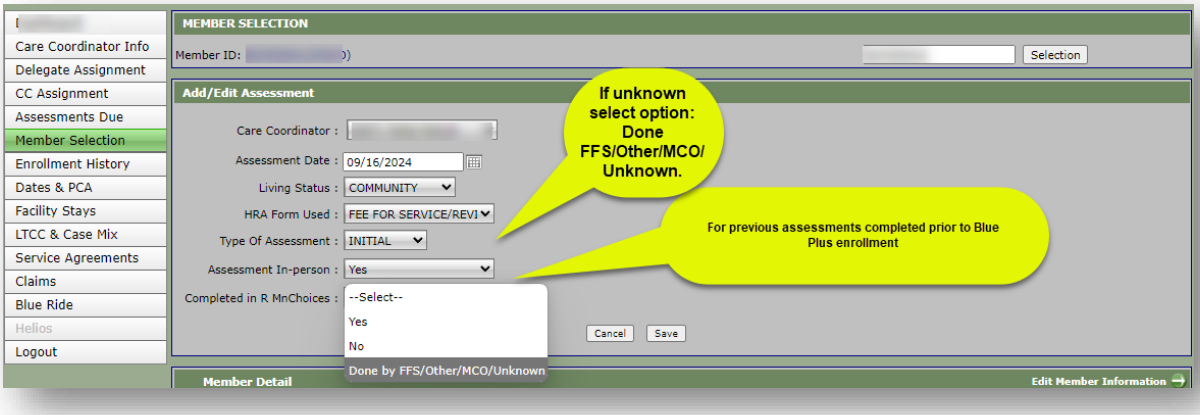
Transitional HRA entries

LTCC/MnCHOICES completed prior to enrollment

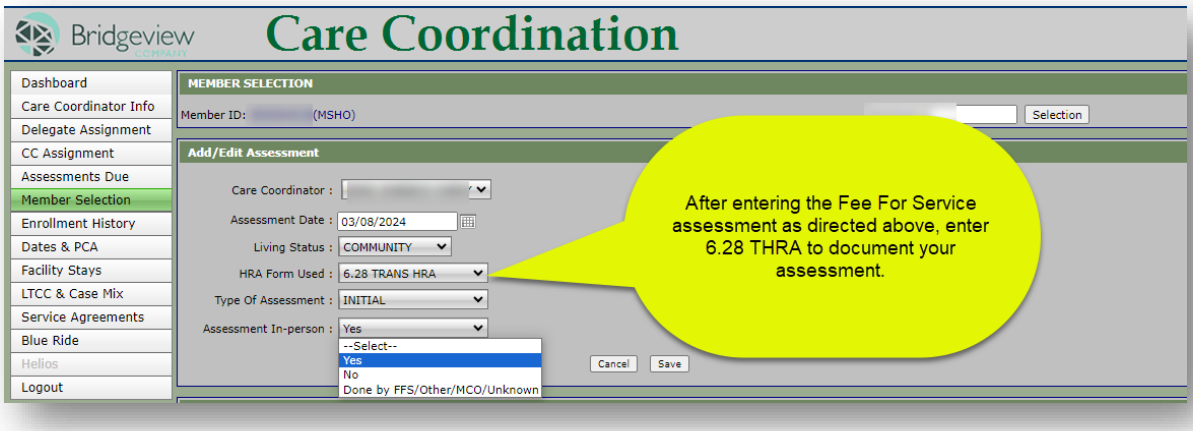
Follow this process for new Blue Plus members who have had an LTCC or MnCHOICES assessment completed prior to enrollment by a county assessor, or another health plan and the Care Coordinator is conducting a Transitional HRA. It is required to enter **both** the date of the previous assessment (LTCC or 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 in-person assessment to correctly trigger 365 days from the date of the previous LTCC or MnCHOICES assessment.



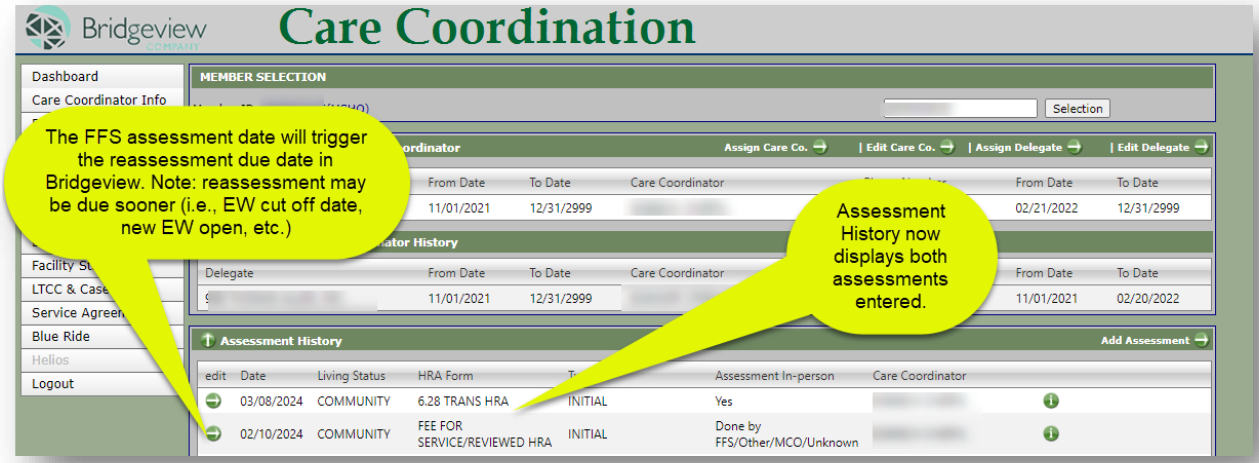


1. On the Member Selection screen, click on **Add Assessment**
2. For the **Assessment Date**, enter the date of the previous LTCC/MnCHOICES assessment.
3. Enter **Living Status** as Community.
4. Choose FEE FOR SERVICE from the **HRA Form Used** drop-down. Select this option for all assessments completed by the county under Fee-for-Service or another health plan prior to Blue Plus enrollment.
5. **Type of Assessment** Enter INITIAL
6. **Assessment In-Person** Select "**yes**" if assessment was completed in person. Select "no" if assessment was completed remotely.*The only time *Done by FFS/Other/MCO/Unknown* should be selected is when the assessment was completed by another lead agency and Care Coordinator cannot verify if the assessment was completed in-person or remotely.
7. When all fields are completed, click **Save**.
8. 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.



9. Enter the **Assessment Date** which is the date the Transitional HRA was completed.
10. Enter **Living Status** as Community
11. Choose **HRA Form Used as** 6.28 TRANS HRA from the drop-down.
12. **Type of Assessment:** Select INITIAL.
13. **Assessment In-Person** Select Yes or No. *Do not select Done by FFS/Other/MCO/Unknown for THRA
14. Click **Save**.

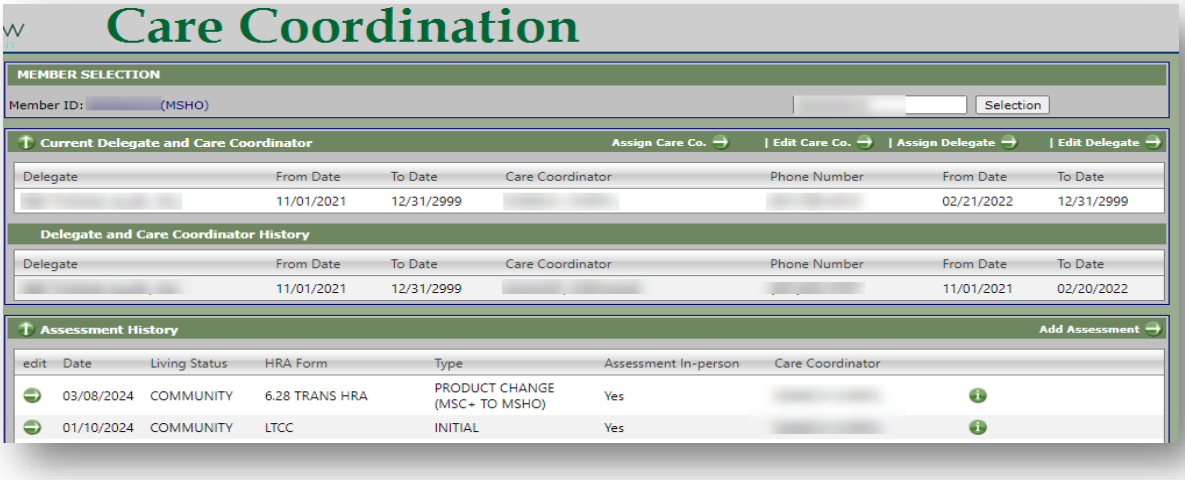
The Assessment History now shows both assessments for this member. The next in-person assessment will now trigger 365 days from the previous in-person assessment (LTCC or MnCHOICES assessment).
Note: Reassessment may be due sooner than 365 days from their last in-person assessment due to Blue Plus cutoff date or new EW open, etc.



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/R-MnCHOICES/ 3428H/MCO-HRA 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. **Assessment In-Person** Select Yes or No. *Do not select Done by FFS/Other/MCO/Unknown for THRA
7. Then click **Save**.

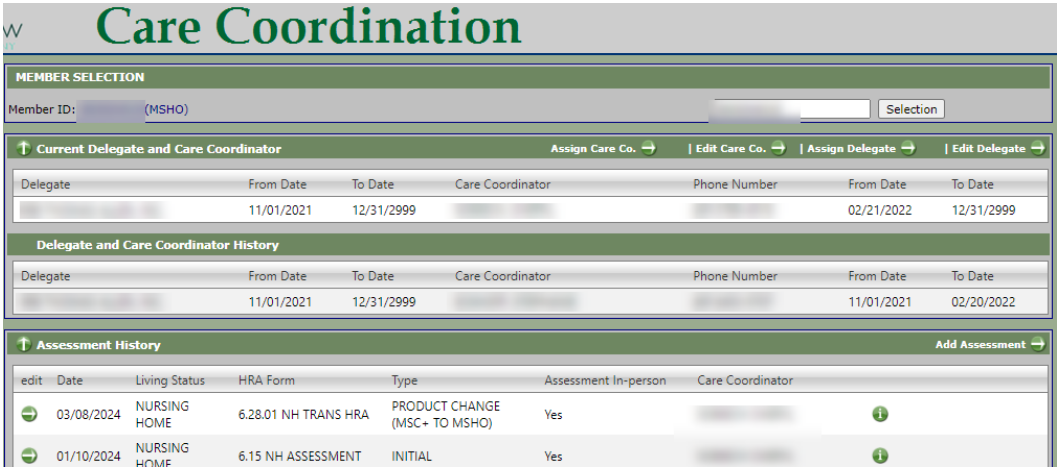


Note: If entered according to instructions above, the next in-person assessment will correctly trigger 365 days from the date of the previous in-person assessment not the date of the Transitional HRA.

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. **Assessment In-Person** Select Yes or No. *Do not select Done by FFS/Other/MCO/Unknown for THRA
7. Click **Save**



Note: If entered according to instructions above, the next in-person assessment will correctly trigger 365 days from the date of the previous in-person 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 Subscriber ID number in the Member Selection box and click on Add Assessment. Click here for directions on entering HRA information.

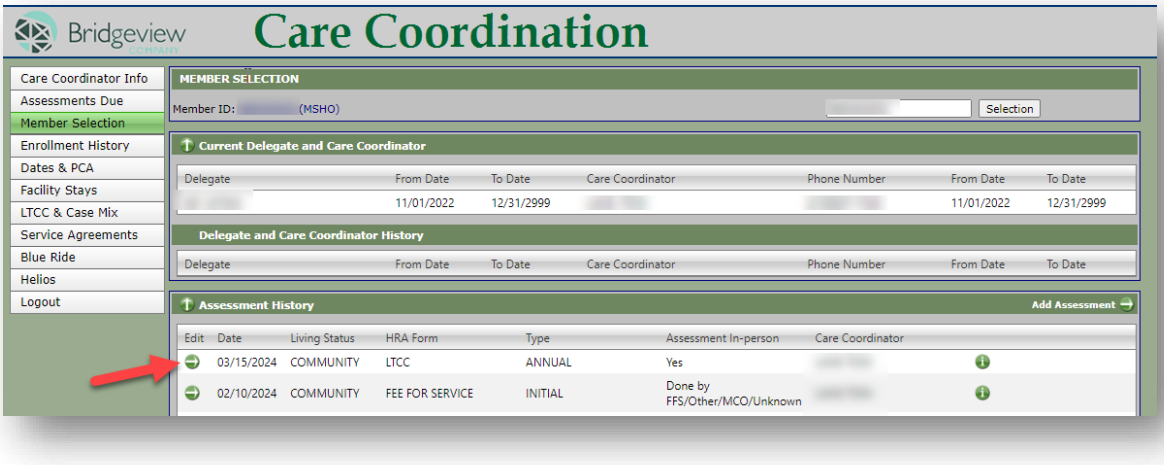
Requesting an Edit or Deletion of an HRA entry

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).

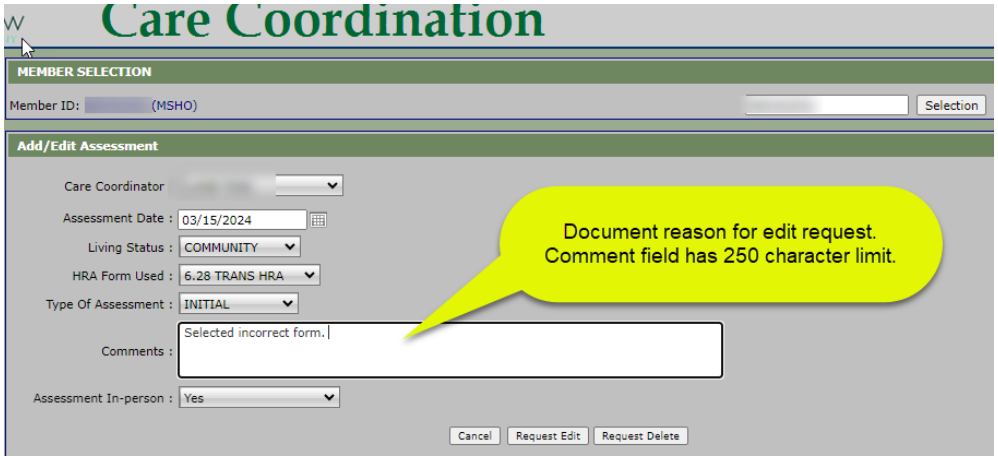
1. From the Member Screen in the **Assessment History** section, select the Edit button to the left of the HRA you wish to Edit or Delete and click on it.



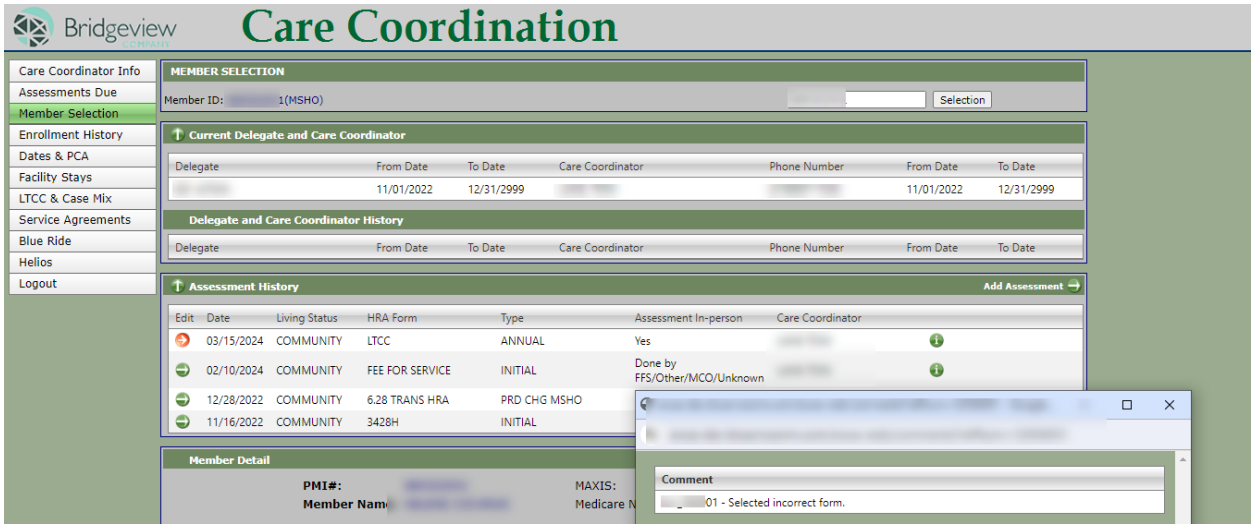
2. In the next screen edit any of the fields previously saved (such as changing name of Care Coordinator). Make the corrections using the drop boxes in the field(s) you wish to change.

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

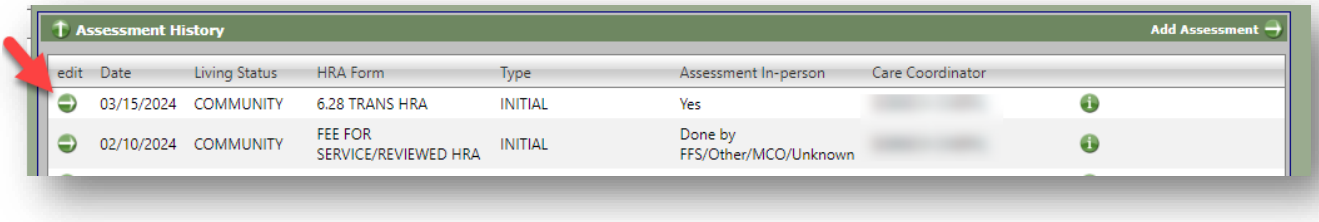
4. When you have finished making your corrections, click **Request Edit** or **Request Delete** depending on your intended action.



5. Upon returning 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. The “I” icon will display the comment(s) associated with the change requested.



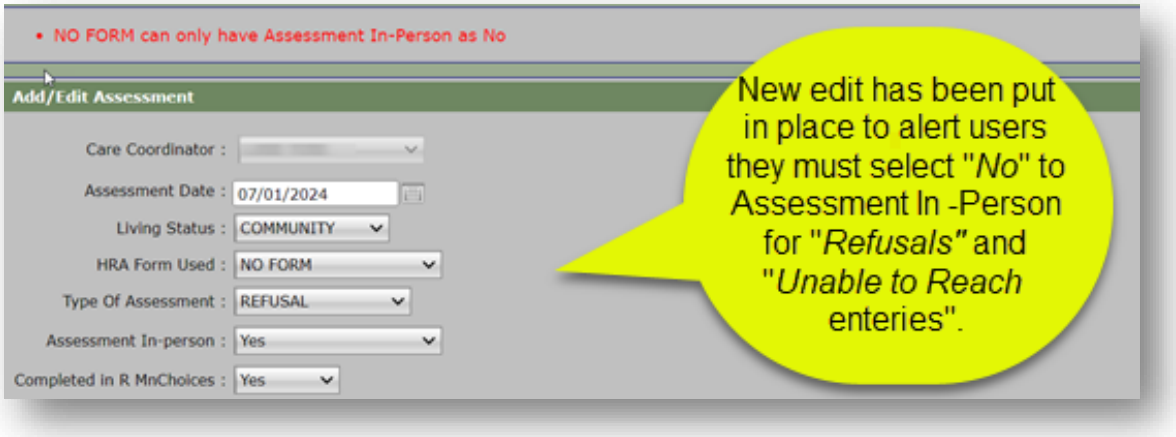
CW Refusals

Enter the date of the refusal when a Community Well member *refuses* both in-person and telephonic assessment (MCO-HRA). **Reminder:** CW members living in the community using MA plan services cannot have a refusal, except for members on another Home Community Base Service waiver who has had an assessment completed by their waiver Case Manager.

1. Enter **Assessment date**: This date must be the date of the refusal.
2. **Living Status**: Select “Community”
3. Select “NO FORM” in the **HRA Form Used** field.
4. Select “REFUSAL” for **Type Of Assessment**
5. **Assessment In-person:** Select “No”. If you select yes, you will get an edit.
6. **Completed in R MnCHOICES:** Select “Yes”. If you select no, you will

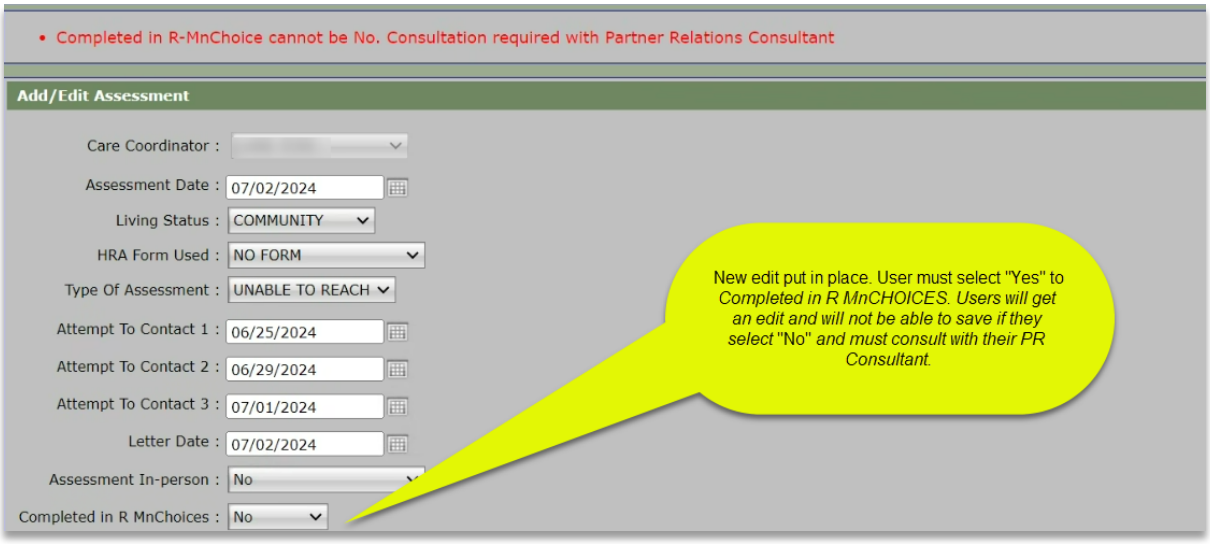
get an edit.

7. Click **Save**.



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. Must be in sequential order or you will get an edit.
6. **Letter Date:** Enter the date on the UTR Member Support Plan letter. This date must match the assessment date entered. This is the 4th and final attempt.
7. **Assessment In-person:** Select “No”. If you select yes, you will get an edit.
8. **Completed in R MnCHOICES:** Select “Yes”. If you select no, you will get an edit.



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.
- Make a total of four attempts to contact the member via phone, e-mail, or letter to offer an assessment.
- 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 refusal date; or the date the Unable to Reach Member Support Plan 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 secureblue.enrollment@bluecrossmn.com with instructions on how to identify the members' assessments selected for audit. You have **up to 7 days** to submit the requested documentation.

Audit Frequency

- ❖ Perfect audit for four consecutive months: delegate graduates to a **quarterly audit**

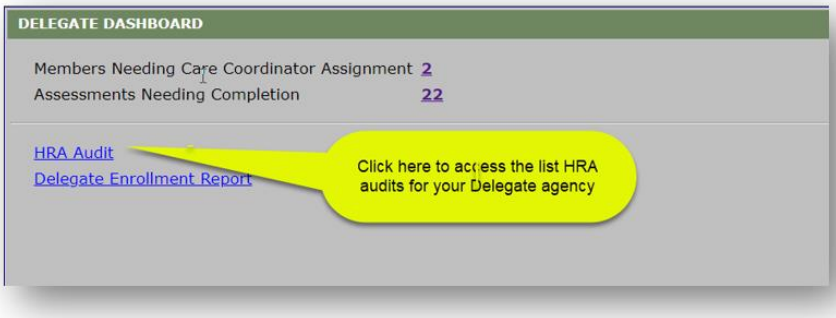
- ❖ Two perfect quarterly audits: delegate graduates to a **semiannual audit**
- ❖ Delegate remains on semiannual audit cycle unless an error is identified in the semiannual. In this event the delegate would revert to a quarterly audit schedule.

Monthly Audits

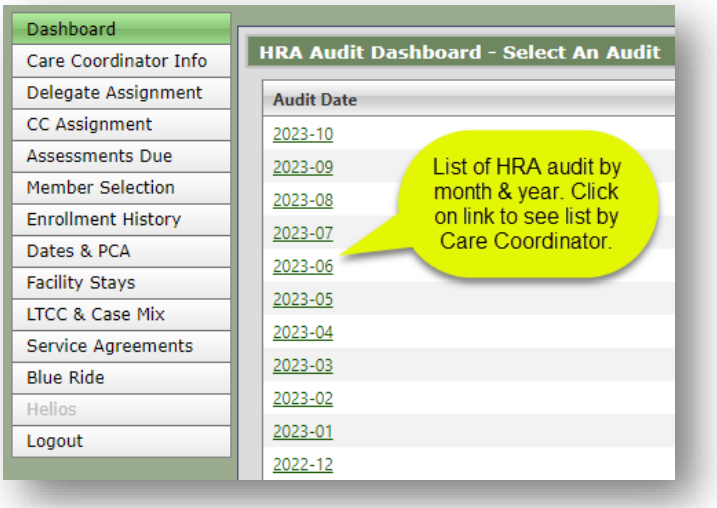
Even if a Delegate has graduated to a quarterly or semiannual audit as indicated above, monthly audits continue for:

- Assessment date = enrollment date
- Type of Assessment = Unable to Reach
- Type of Assessment = Nursing Home Transitional HRA
- Assessment completed on a recognized national holiday.
- Assessment completed on date county offices are closed.
- Assessment completed on weekends.
- Assessment date entered is prior to enrollment date.

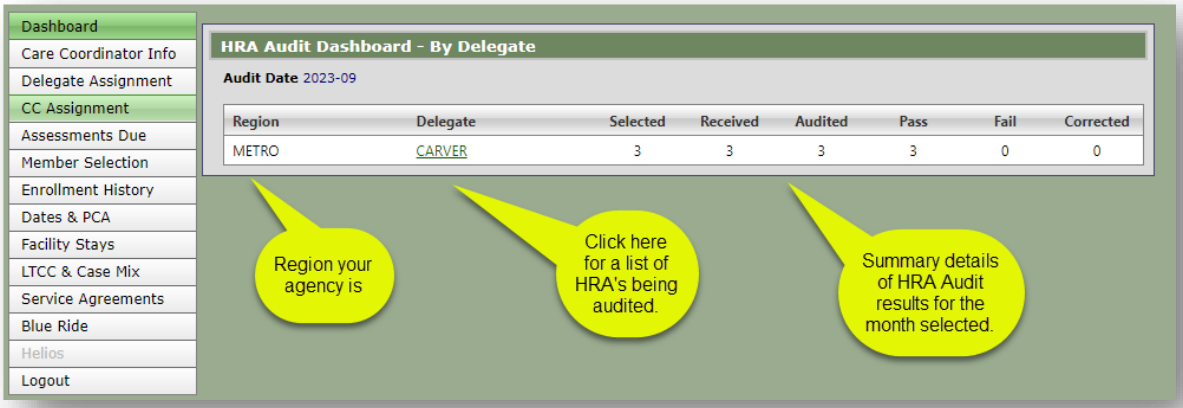
1. Delegate Representative/Support Staff will click on the **HRA Audit** link on the Delegate Dashboard to access the HRA Audit Dashboard.



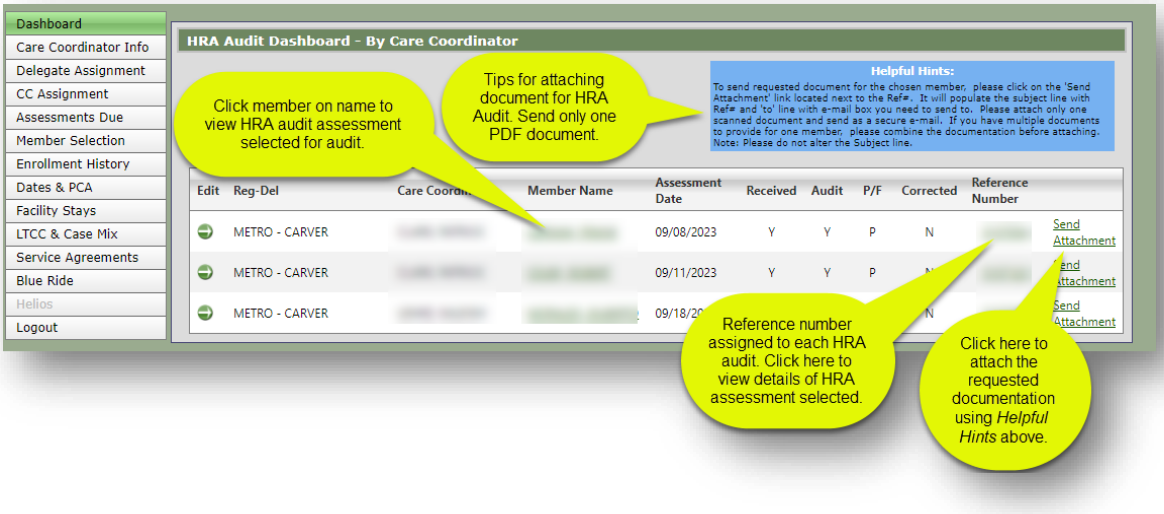
2. Click on the applicable month/year link in the HRA Audit Dashboard screen to view HRA audits that will be listed by Care Coordinator.



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. To send attachments, 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.

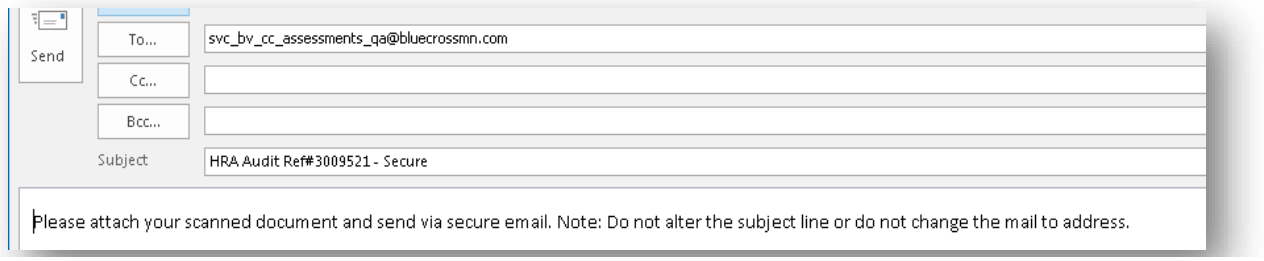
7. Save the requested document(s) in PDF form. Our automated system can only accept one attachment via email. If you are providing more than one document per member, you must combine them into one PDF document. (For example, if you are supplying contact notes and an Unable to Contact Letter, combine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

   Documents needed are listed below:

- ❑ **LTCC:** submit first page of the assessment
- ❑ **6.15 NH Assessment:** submit first page of the assessment
- ❑ **6.28 Trans HRA:** submit first page of the completed 6.28, regardless of documenting in Revised MnCHOICES.
- ❑ **R-MnCHOICES Assessment:** no documentation needed (auditor will review in the Revised MnCHOICES application)
- ❑ **Fee for Service/Reviewed HRA:** submit 1st page of the MnCHOICES assessment
- ❑ **No Form** (used for Unable to Reach and Refusals regardless of the tool used):
  - ✓ **Unable to Reach:** submit notes showing 3 missed contact attempts along with a copy of the Unable to Reach Support Plan Letter if not already attached in MnChoices. (If the assessment date is not the same as the activity date in MMIS for community members this will fail audit).
  - ✓ **Refusal:** submit the case notes from the day of refusal
- ❑ **6.28.01 Transitional NH HRA:** submit full 6.15 NH assessment
- ❑ **3428H:** submit the first page of the assessment
- ❑ **HRA-MCO:** no documentation needed (auditor will review in the Revised MnCHOICES application). (HRA-MCO should not be used for Transitional HRA, UTR, or Refusals)

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. No need to reach out as HRA audit staff will contact the CC if the documents were not received.

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.

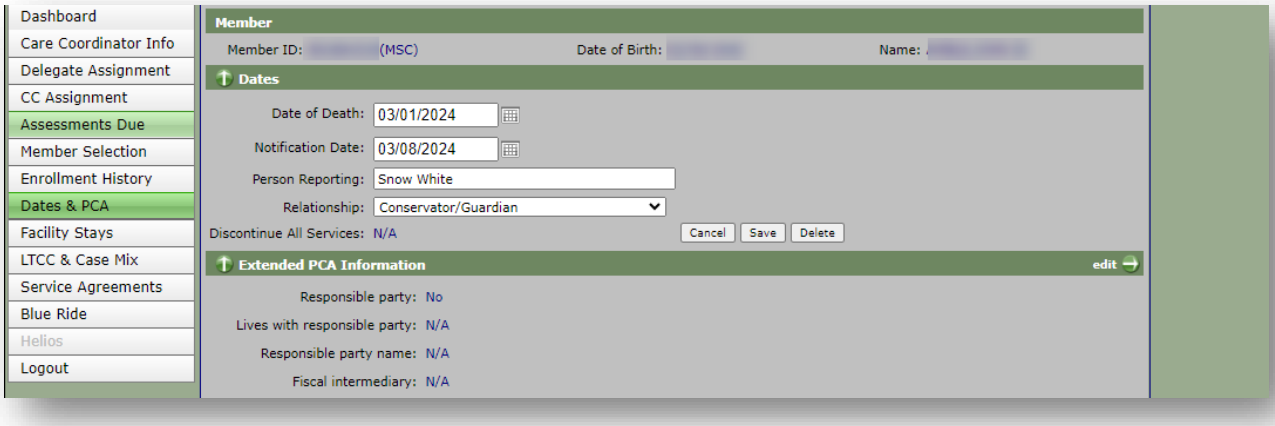
DATES AND EXTENDED PCA ENTRY

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. Members may continue to show as due/past due for their reassessment, confirm the DOD is entered in this field and the DHS 5181 has been completed and sent to the Financial Worker. If this been completed and you want the assessment due/past due flag removed, send a secure email to bridgeview.service.agreements@bluecrossmn.com.

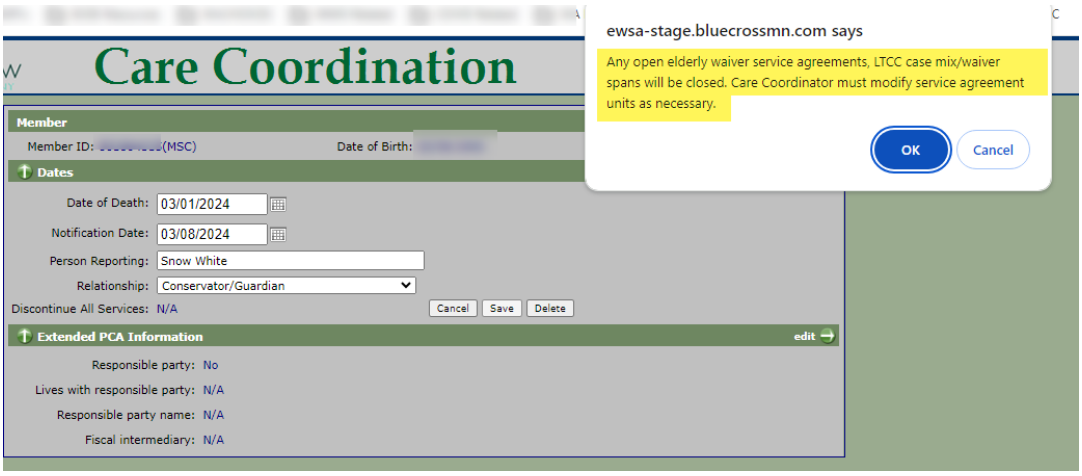
All claims submitted against any service agreement will not be payable beyond the date of death.



All fields are required.

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

Reminder: When you click Save you will get a message alerting you to modify the service agreement units accordingly.



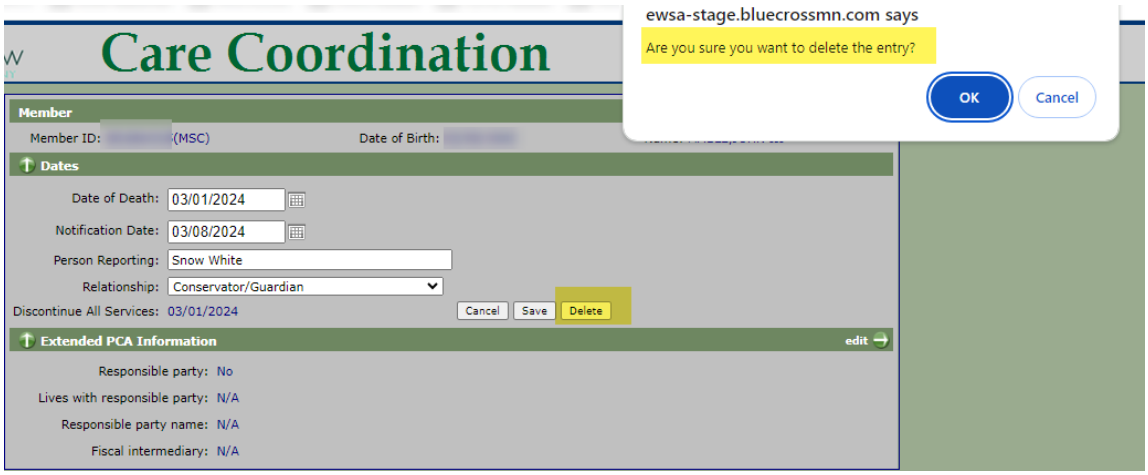
Upon successfully entering and saving the DOD, the date entered as the DOD will prepopulate in the *Discontinue All Services* field and automatically closes the Service Agreements. This does not modify the total units authorized. User must review and update the units if applicable.

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.



The DOD will populate in the Member Detail section.

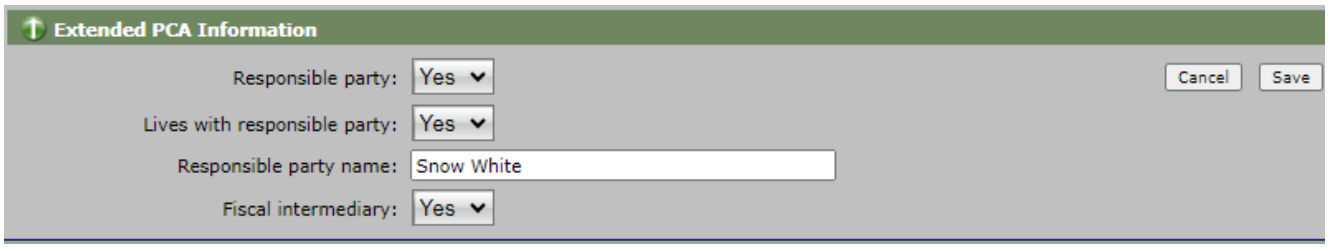
Extended PCA Information

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.

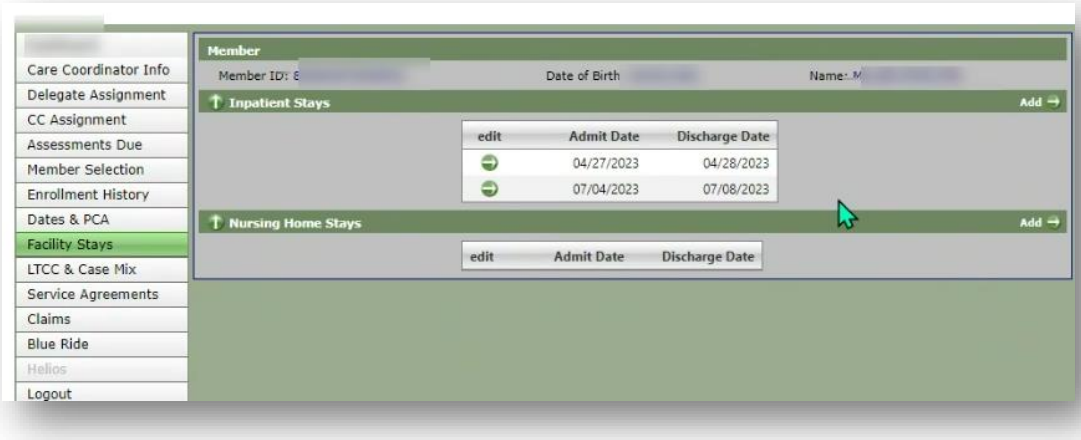
Lives with Responsible Party: This field will default to blank. You must select Yes or No from the drop-down box if you are going to authorize services for Extended PCA. If you have chosen Yes in the Responsible Party field, this is a mandatory field.

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 include PCA Choice.



Facility Stays



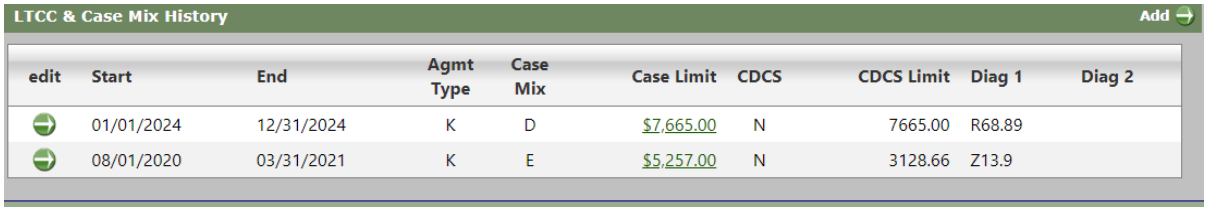
The Facility Stays section is optional. It can be a mechanism for Care Coordinators to track the member's facility stays and to help ensure providers are correctly submitting claims.

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

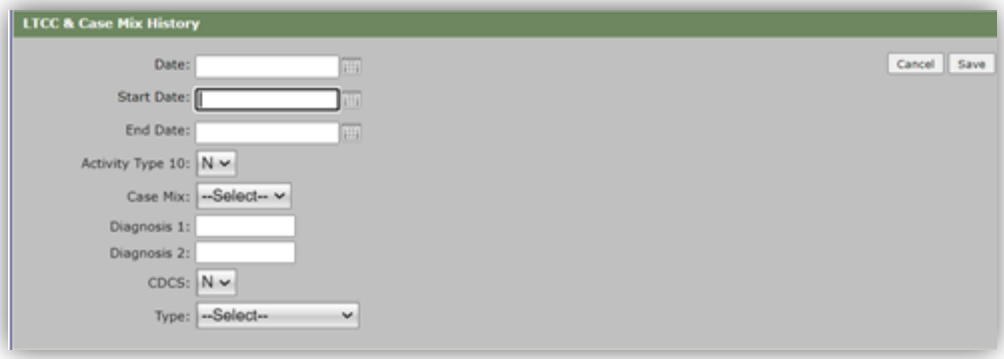
In the LTCC and Case Mix section, you will be able to view, add, or edit the member's LTCC and case mix span.



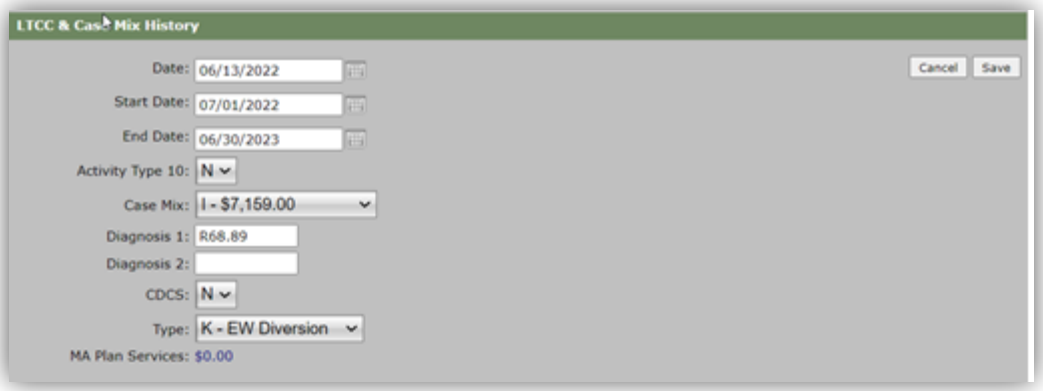
If you are using the Add option, you will be required to complete all the fields described in the headings below. If you select Edit option, you will be able to update the following fields.

- ✓ 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, this date cannot be earlier than the Blue Plus enrollment date, 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 timespan.

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 reduced or 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 (general process)

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 (select Case Mix W)
- Member on another home community-based service waiver with MA State Plan Home Care Services (select Case Mix W)

***(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/HRA – MCO/Revised MnCHOICES 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).
- 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 Limit 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 limit 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.

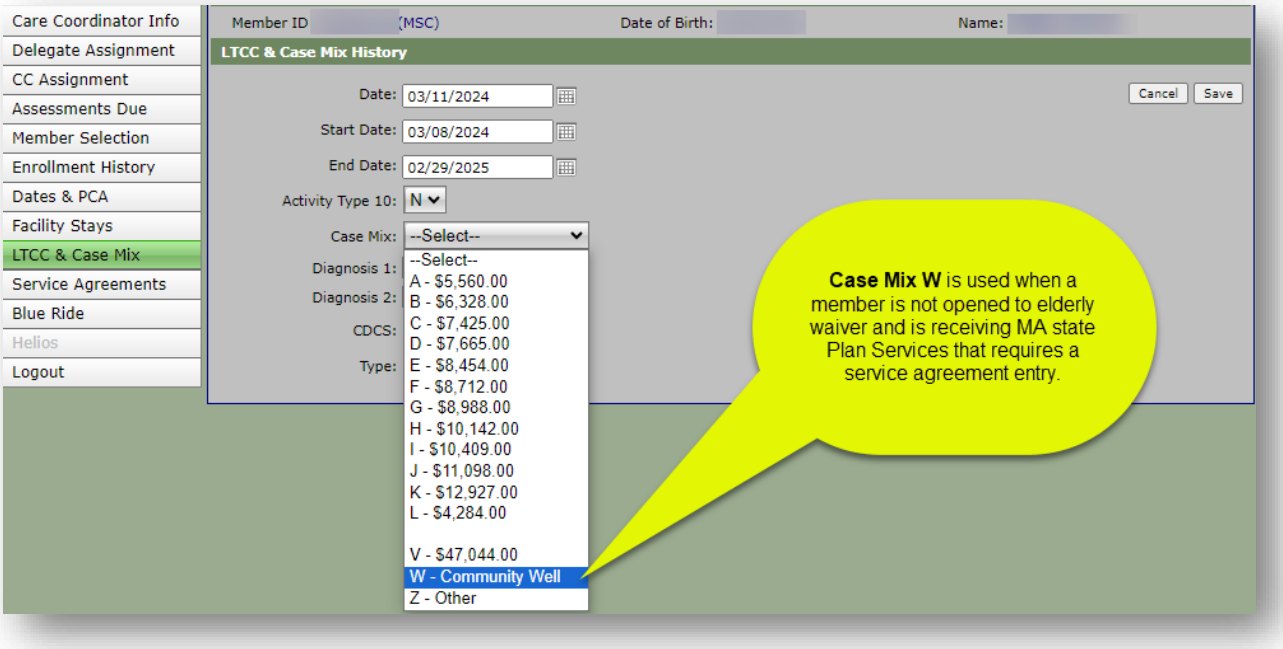
Type: Select EW conversion or diversion. (For CW this section is not applicable and is grayed out)

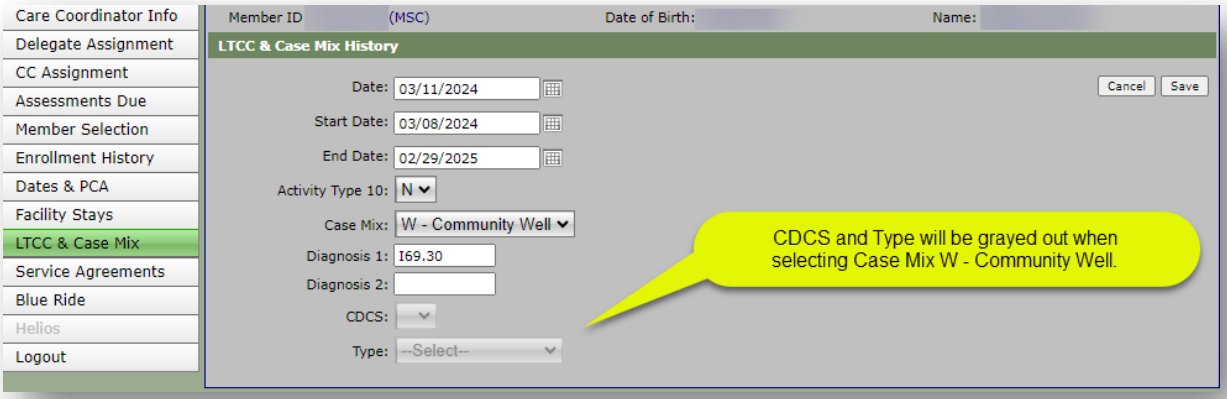
3. Click **"Save"**.

   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.

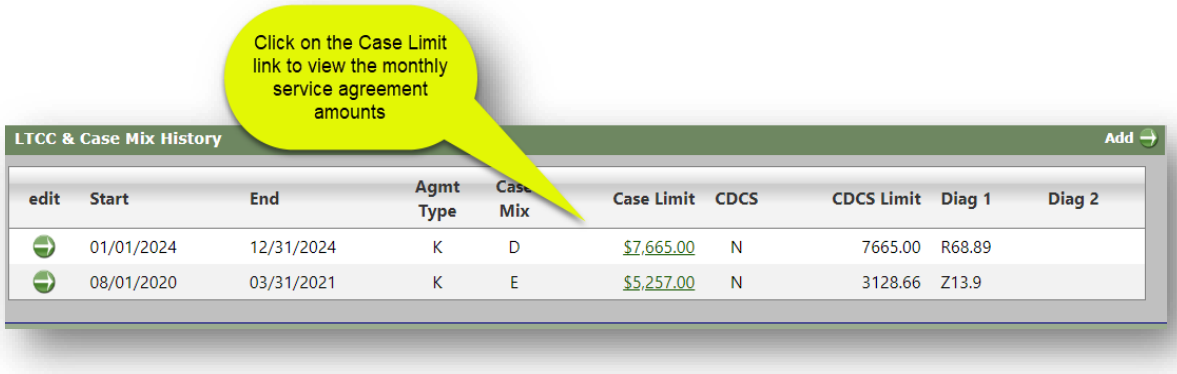
The start and end dates must coincide with the case mix assigned to the member, and there could be periods when the member has lost EW eligibility. In this case, you will see multiple date ranges with a break in the LTCC Start Date on the new line and the LTCC End Date on the previous line. This happens 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 or modify existing service agreement(s). This can be completed by changing the "To Date" with corresponding units authorized based on the "Qty Used".

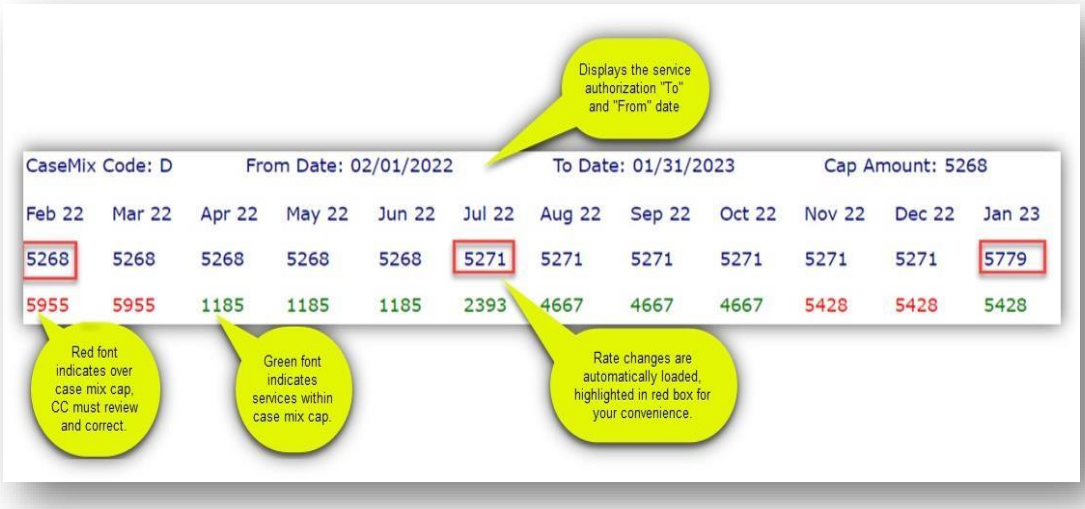




Summary page displays Case Mix cap and a link to view the Service Agreement accumulations based on the Elderly Waiver span. If member is case mix W this link is not available.



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 subscriber 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 directions in this *section*.

Mid-Month Case Mix Changes

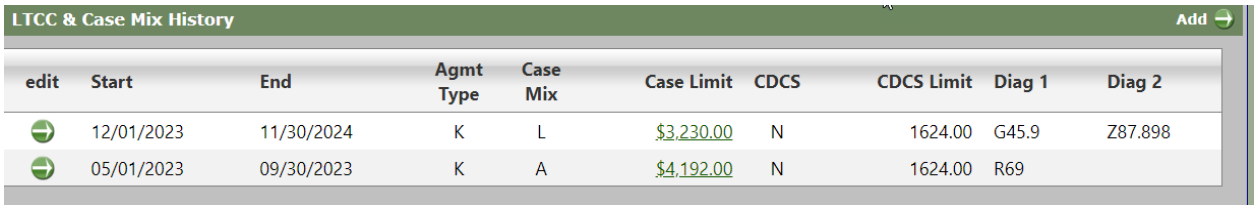
For situations when a member is changing to a different case mix in the middle of a month:

- 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 10/1/2023 through 11/30/2023. The member regains eligibility on 12/1/2023 and is assigned to case mix L at that time.



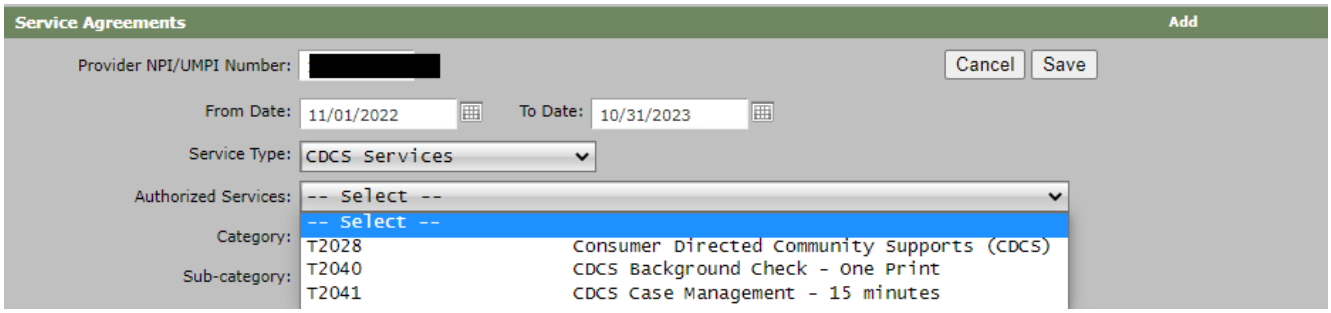
edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Limit	Diag 1	Diag 2
	12/01/2023	11/30/2024	K	L	$3,230.00	N	1624.00	G45.9	Z87.898
	05/01/2023	09/30/2023	K	A	$4,192.00	N	1624.00	R69	

In the example above, you would not be able to authorize EW services from 10/1/2023 through 11/30/2023 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 Limit 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 EW CDCS. Update this field to Yes if the member has elected the EW CDCS option. The Monthly Limit displayed on the LTCC & Case Mix History is based on the DHS published monthly CDCS Service Budget Amounts currently in effect for the Elderly Waiver Program. The displayed monthly CDCS amount does not include the background check or the required CDCS Case Management or Care Coordination. It is important to note, when Yes is selected, a "Y" will appear in the CDCS 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 document/R-MnCHOICES assessment 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/R-MnCHOICES 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)

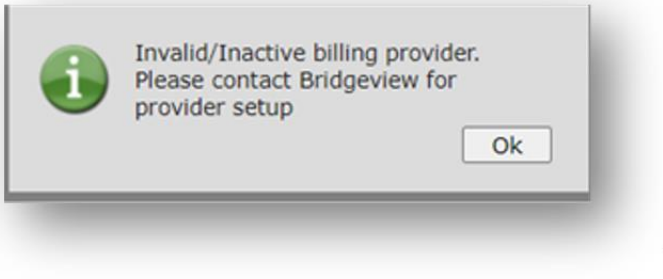
Entering Service Agreements for new EW; EW w/ MA State Plan Home Care Services; or Community Well with MA State Pan Home Care Services.

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.*

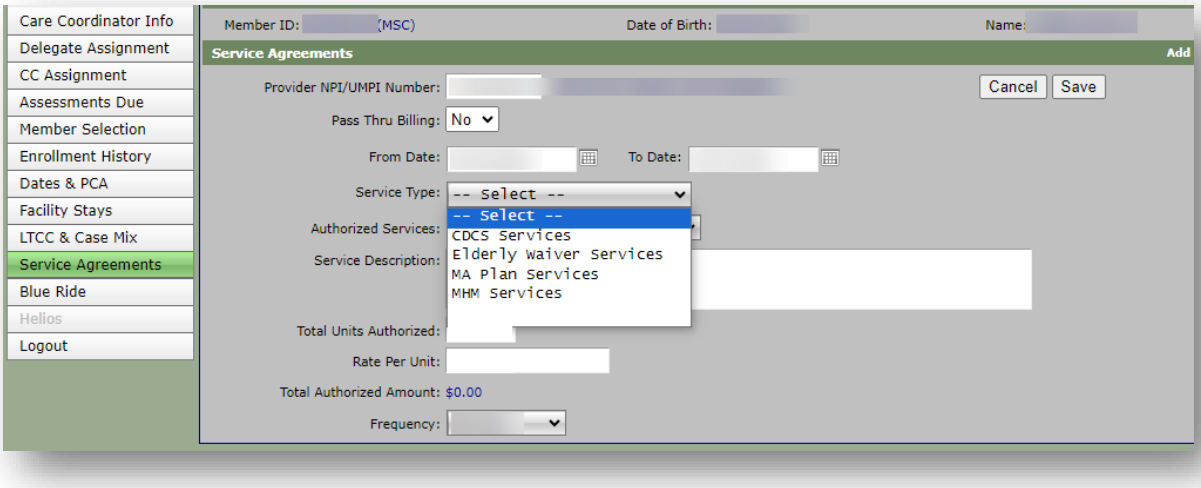
The Provider NPI/UMPI number is a protected field which cannot be changed once the line item has been entered.

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.

Optional for state plan home care services only: Add Provider's fax number, if known, to expedite delivery of authorization to Provider.

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*. Or the standalone document, Service Agreement Provider & Member 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.

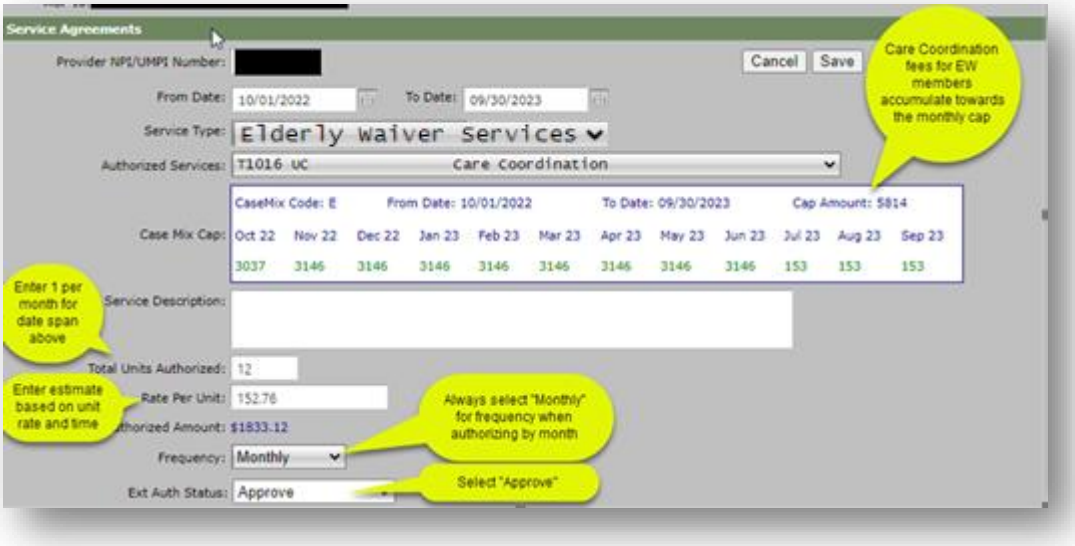
6. Click **Save**. Service agreement is now displayed on the service agreement summary page.

Care Coordination Service Agreements

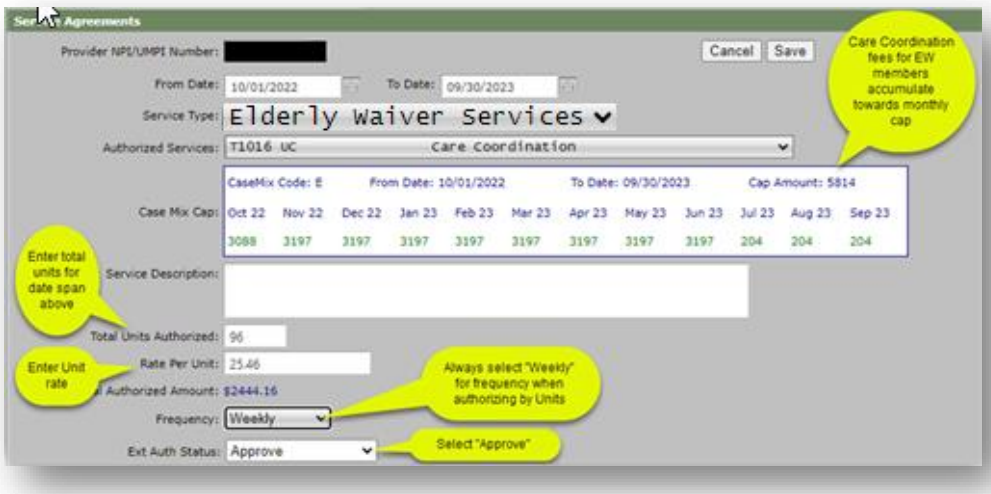
Entry of Care Coordination fees will depend on your Delegate Agency's Care Coordination Contract, which may be authorized by monthly, units or PMPM.

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

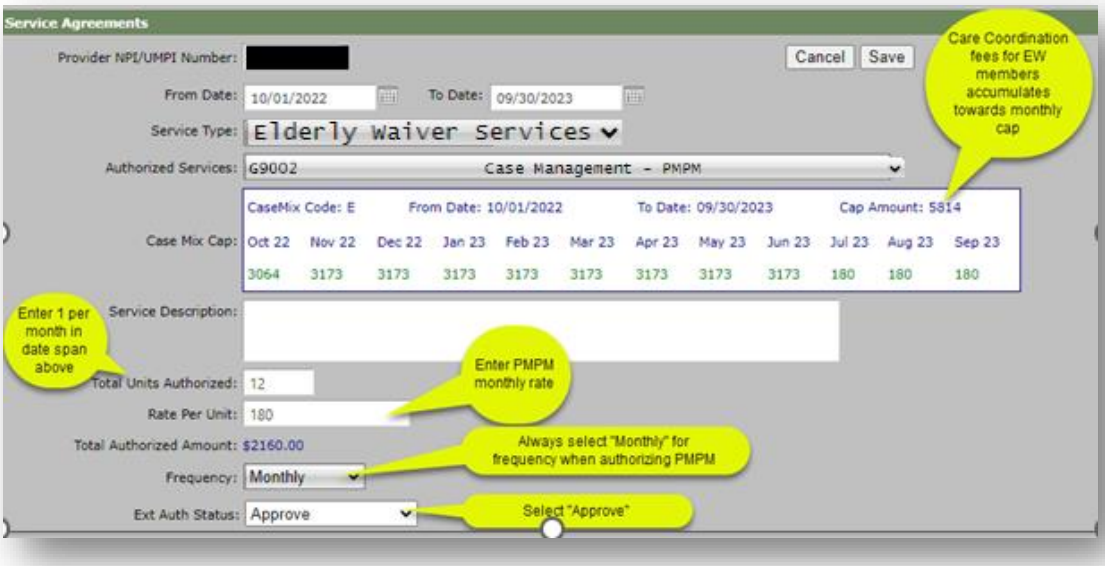
Monthly Care Coordination Example*



By Unit - Care Coordination Example*



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



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

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. Select Service Type CDCS services.
3. Ensure the Rate is under the CDCS Limit.

4. Enter a service agreement T2028 for the approved CDCS amount determined by the approved CDCS Community Support Plan.
5. 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. Delegate agencies who bill monthly PMPM are still required to enter this Service Agreement for T2041 Required Case Management but do not bill against it (the PMPM rate includes all services).
      Note: Do not go over 2 hours a month (8 units) or 24 hours a year for CM activities for CDCS members.
      Case Aide—Do not enter an SA for members on CDCS.

If you are adding money to a CDCS plan and need to adjust the CDCS Service Agreement (for example legislative increases or an increase/decrease to the approved CDCS services via an addendum)**.**

Notes on entering the CDCS service agreement:

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

- 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 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 limit (T2028).
- All EW services should be included in the T2028 service agreement.
- MA Homecare Services (PCA/CFSS, PCA RN Supervision, HHA, Skilled Nursing) need to be reflected in the CDCS CSP. When doing the authorization, reduce T2028 line by the amount of homecare services and enter separate service agreements for these services.

Service Description Requirement (CDCS)

In the event the individual's assessed needs support an increase/decrease in services (i.e., addendum or legislative changes); the CC must include an attestation in the service agreement description documenting the CDCS care plan or CDCS addendum was reviewed

and completed supporting additional services.

CDCS Legislative Rate Changes and/or approving unallocated funds through Plan Addendum

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 to 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 approved limit authorized during the annual span which cannot be more than the CDCS Limit. 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 AND approving a Plan Addendum, 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/decreased 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.

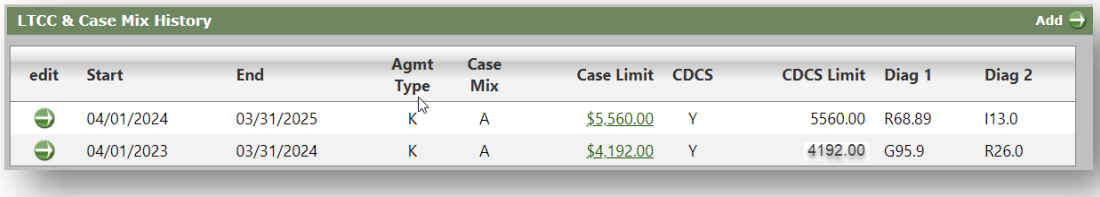
    Include the following:
    - Member Name.
    - Subscriber ID number.
    - Include both CDCS Service Agreement numbers.

- 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.

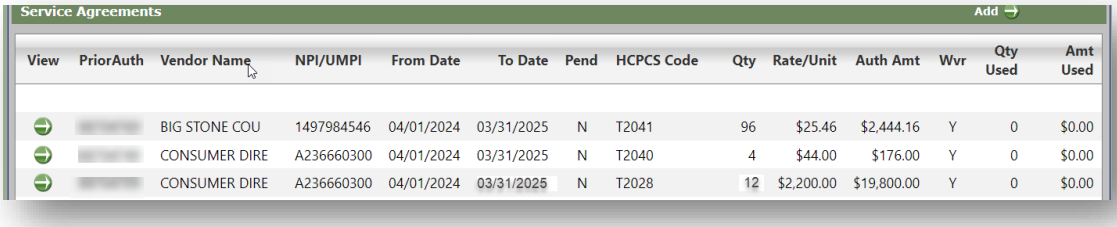
4. Bridgeview staff will do the following:
   - Modify the original service agreement to include the updated end date for that waiver span.
   - Update the units to coincide with start and end date.
   - Add new monthly rate to equal the new waiver span amount that includes the increase.
5. FMS provider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

Modifying current CDCS service agreement:

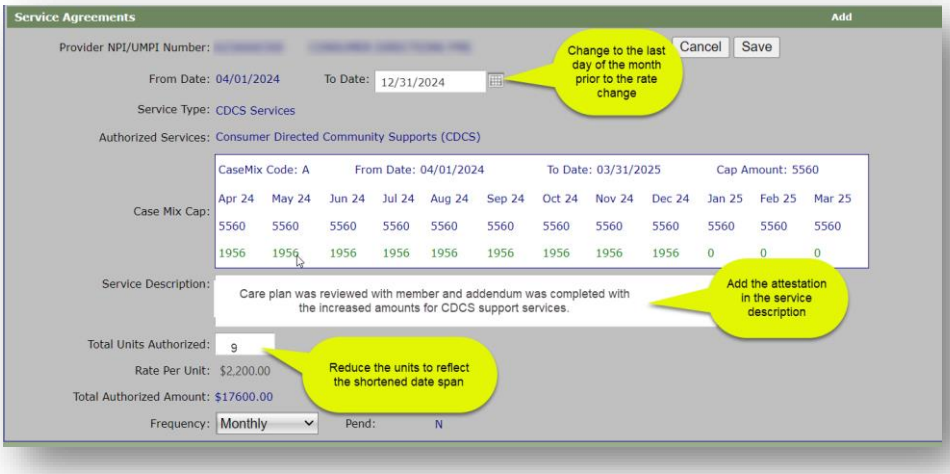
Before:



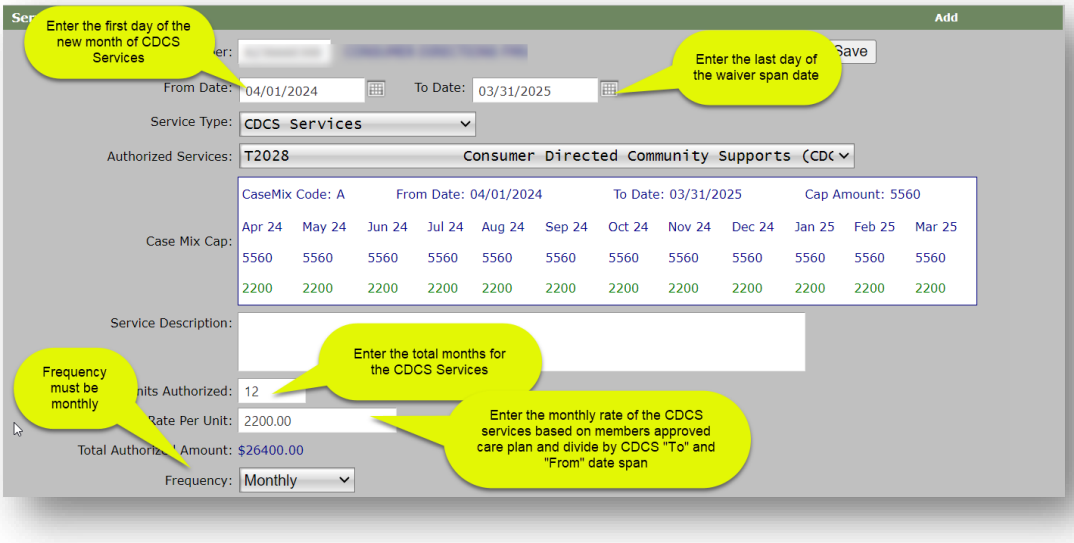
edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Limit	Diag 1	Diag 2
	04/01/2024	03/31/2025	K	A	$5,560.00	Y	5560.00	R68.89	I13.0
	04/01/2023	03/31/2024	K	A	$4,192.00	Y	4192.00	G95.9	R26.0



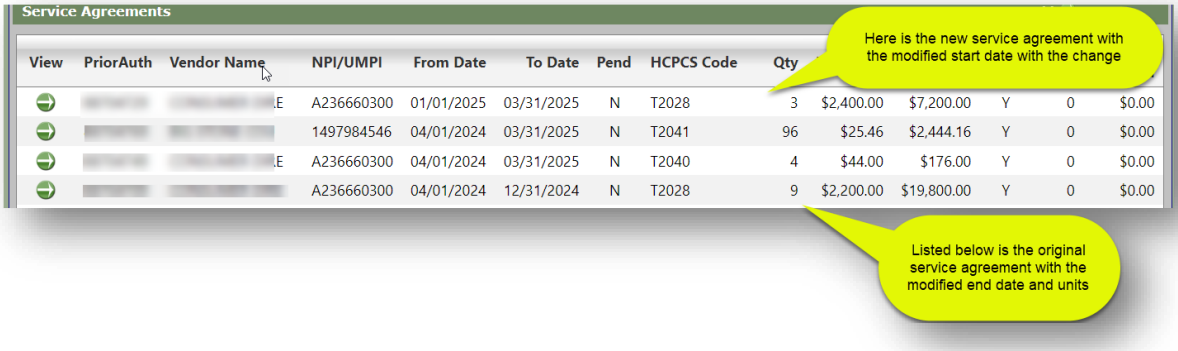
View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
		BIG STONE COU	1497984546	04/01/2024	03/31/2025	N	T2041	96	$25.46	$2,444.16	Y	0	$0.00
		CONSUMER DIRE	A236660300	04/01/2024	03/31/2025	N	T2040	4	$44.00	$176.00	Y	0	$0.00
		CONSUMER DIRE	A236660300	04/01/2024	03/31/2025	N	T2028	12	$2,200.00	$19,800.00	Y	0	$0.00



Adding new CDCS Service Agreement:



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



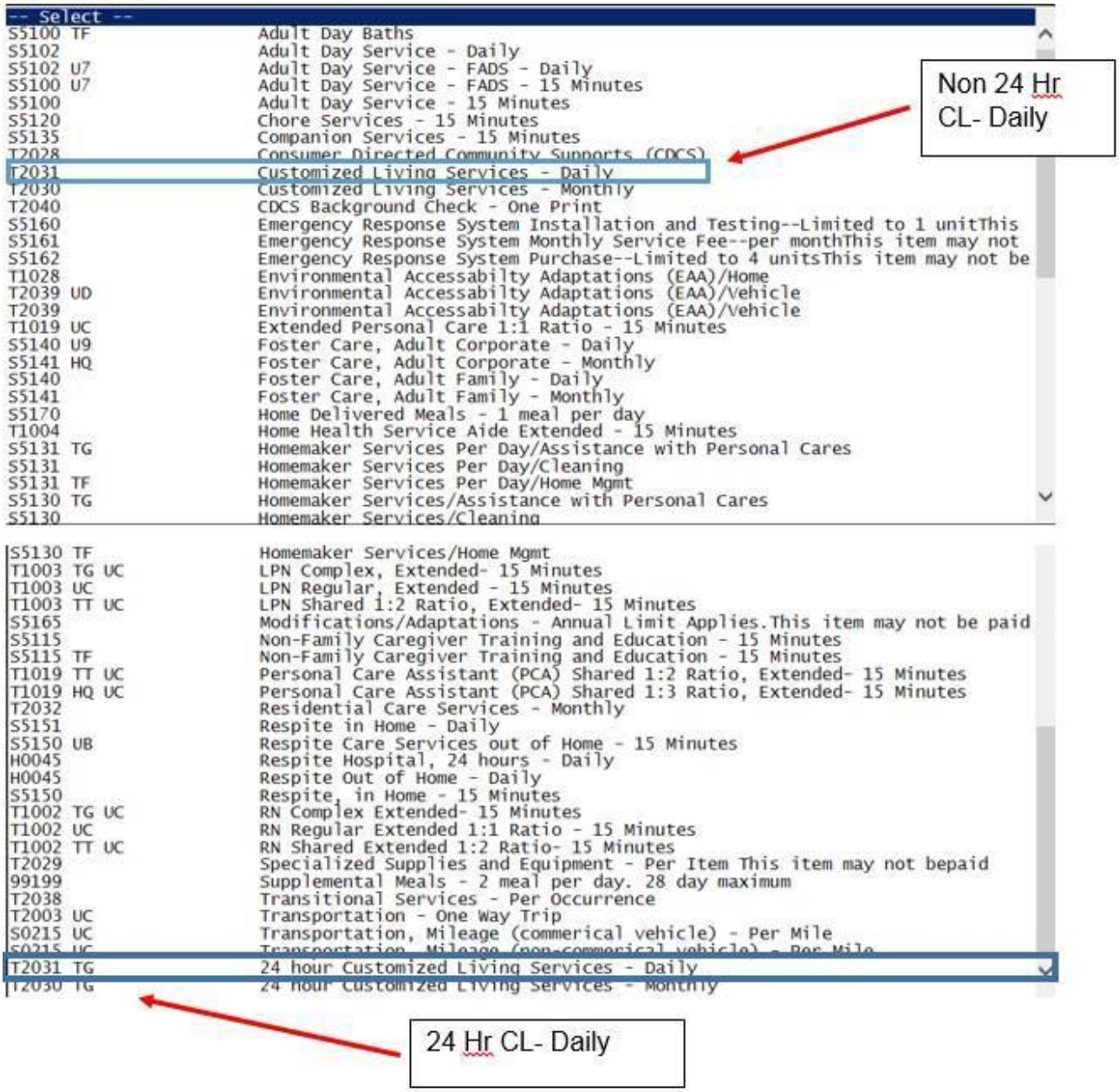
New Enrollees on CDCS with unused funds

Follow the processes below when there are confirmed unused CDCS funds from the current waiver span before 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 the PR Team of the remaining unused $ dollar amount from the previous health plan or MA fee for service.
2. PR will communicate to BV staff this amount to add on to the existing waiver span.
3. The LTCC/R-MnCHOICES Case mix will be listed as a case mix “Z” for the remaining CDCS Waiver span.

Customized Living (CL) or 24 Hr Customized Living Service Agreements*

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.



Environmental Accessibility Adaptations (EAA) Service Agreements*

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-R-MnCHOICES assessments 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 $20,600.00 effective 1/1/2024 per member per waiver year.

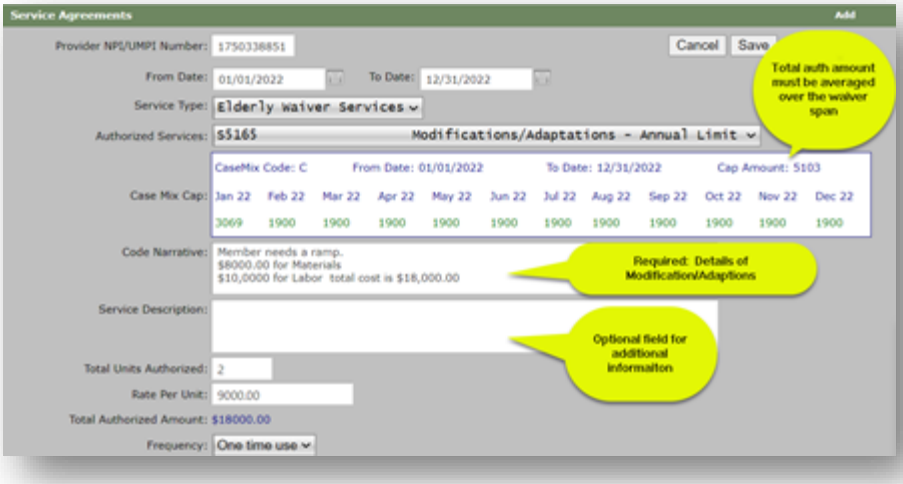
Service Agreements created should include two units of service.
Materials and supplies.
When project is completed.

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.

Extended Home Care Services Service Agreements

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

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

Individual Community Living Supports (ICLS) Service Agreements*

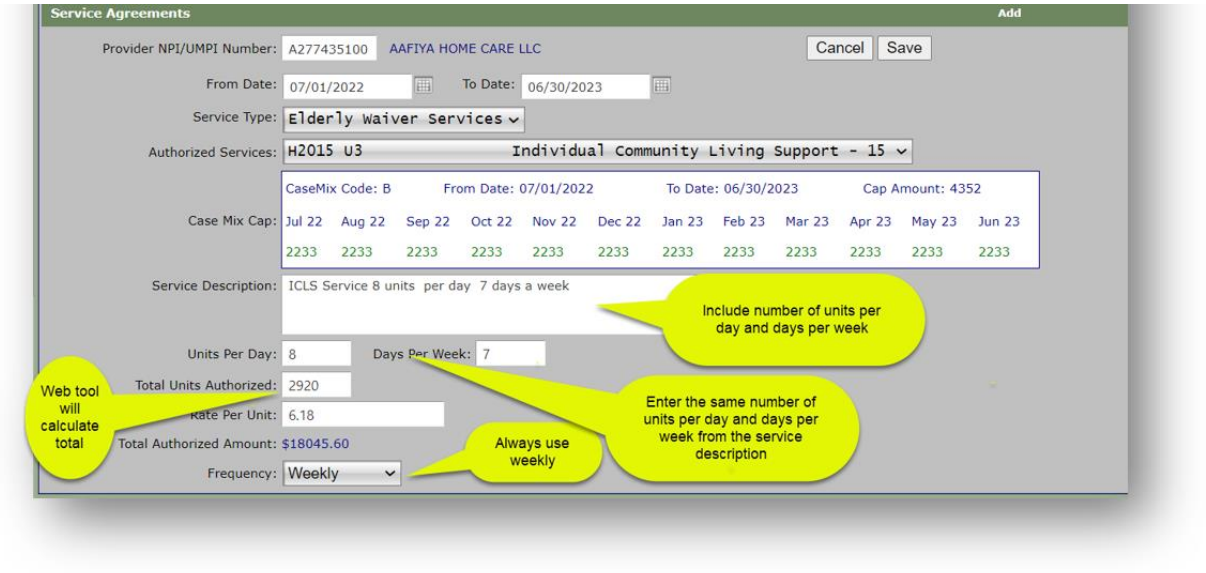
ICLS is a bundled service that includes 6 service categories. There are 2 HCPC codes to choose from when authorizing ICLS:

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.

- 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 and is based on the member assessed needs.

- 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.

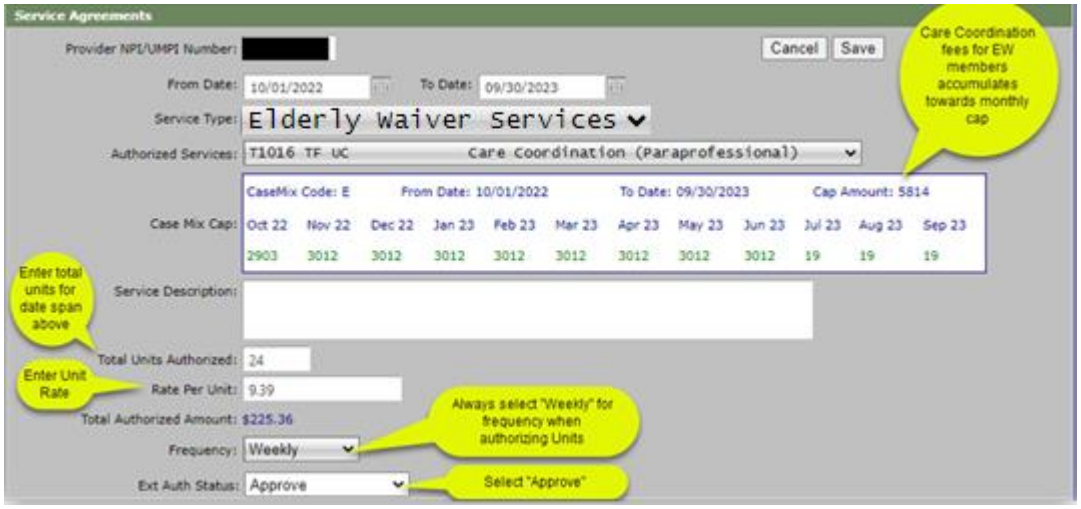
Para Professional Service Agreements

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 (Case mix W).
- Do not enter Paraprofessional fees for a member utilizing CDCS services.

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.

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

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

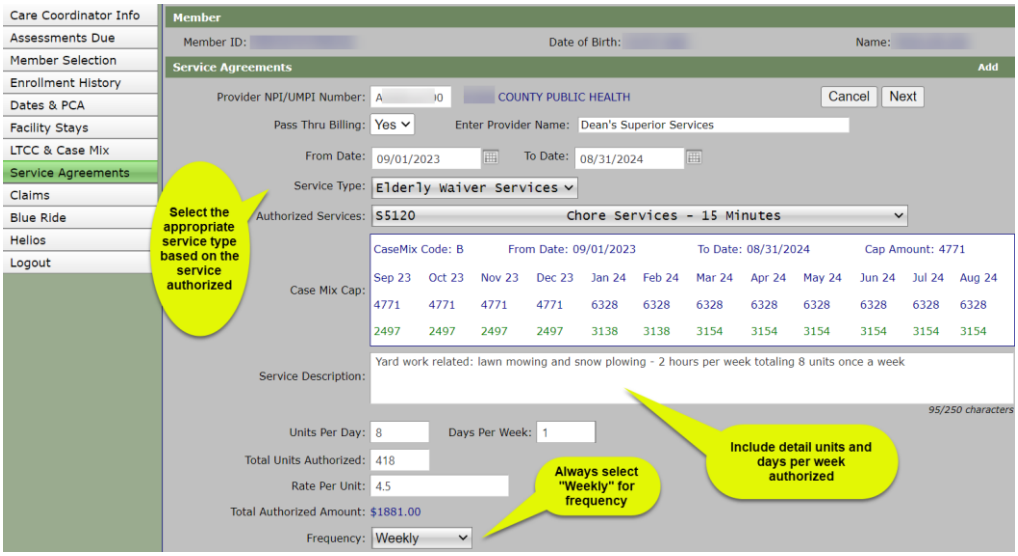
Blue Plus identifies all counties that are contracted to be "pass-through" billing providers for Approval Option service providers. After entering the County billing NPI or UMPI number, the Care Coordinator decides if the services authorized will be paid through the "pass-through" process. The service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

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

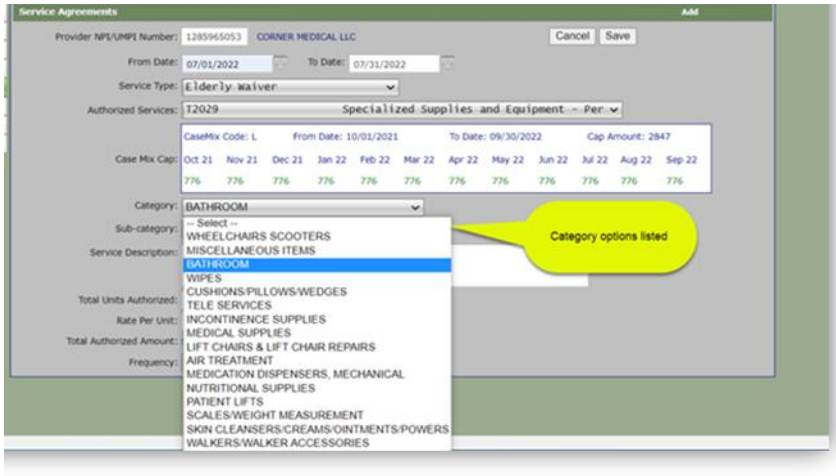
T2029—Specialized Supplies and Equipment Service Agreements*

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.

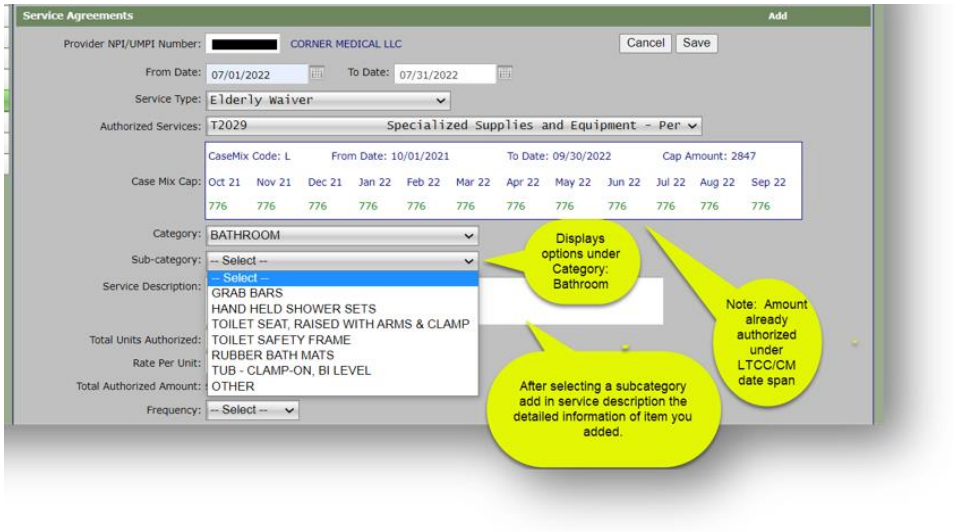
Reminder: DME and supplies & equipment that would require a prescription under medical coverage determination will also require a prescription under EW specialized supplies & equipment.

- 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.

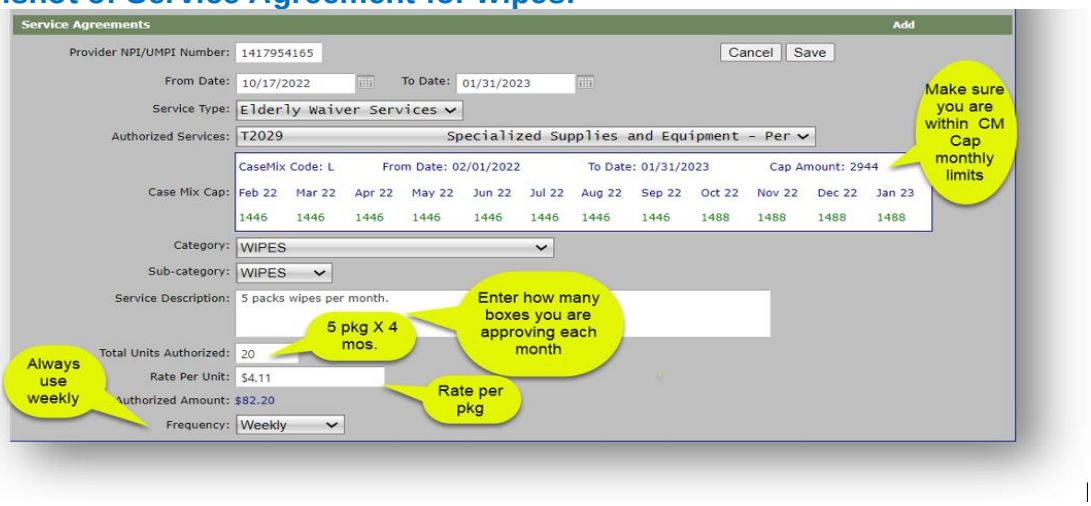
(i.e. EW member has an order for orthotic shoes but does not have one of the qualifying diagnoses per DME provider).

- 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 $1400 (note: waiver does not pay for upgrades)
  - Single item over $800
  - 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 Service Agreement for wipes:



Service Agreements for Lift Chairs*

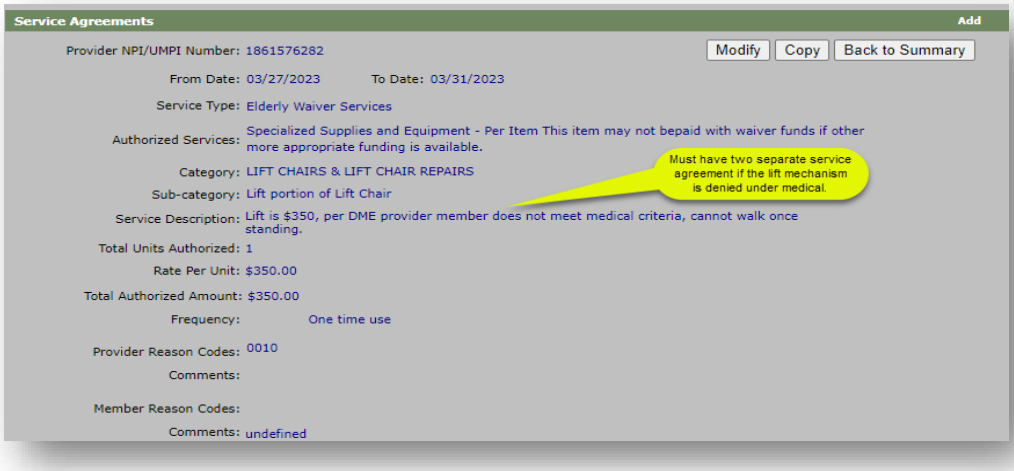
Before entering a Service Agreement for Lift Chairs, the Care Coordinator must follow the process outlined in the MSHO-MSC+ Community Guidelines section titled: Authorization Process for Lift Chairs.

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

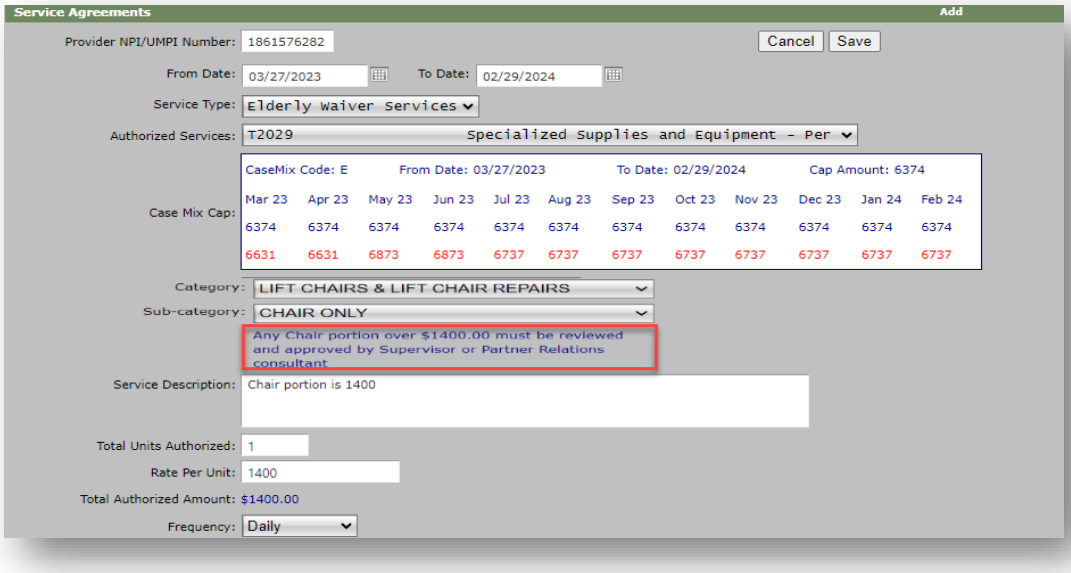
- When the lift mechanism is being paid for by Medicare/MA benefits, enter one service agreement for the total cost of the chair portion only.

- 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 $1400 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*

Nutritional Supplements Service Agreements*

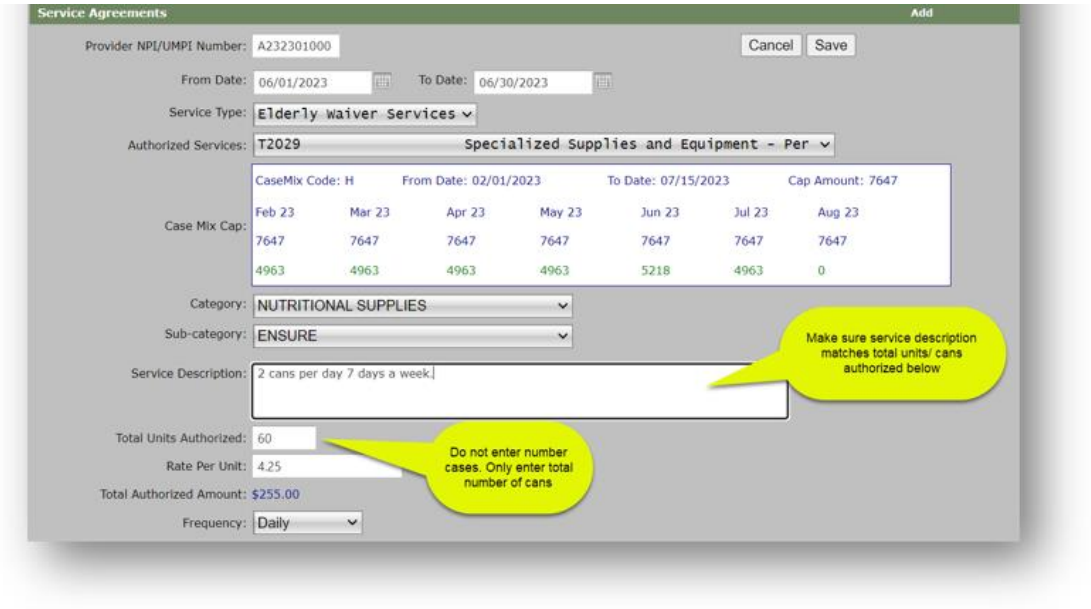
Service Agreements for nutritional supplements such as Boost and Ensure must list quantities and unit rates by the can; not cases. Quantities of 4

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.

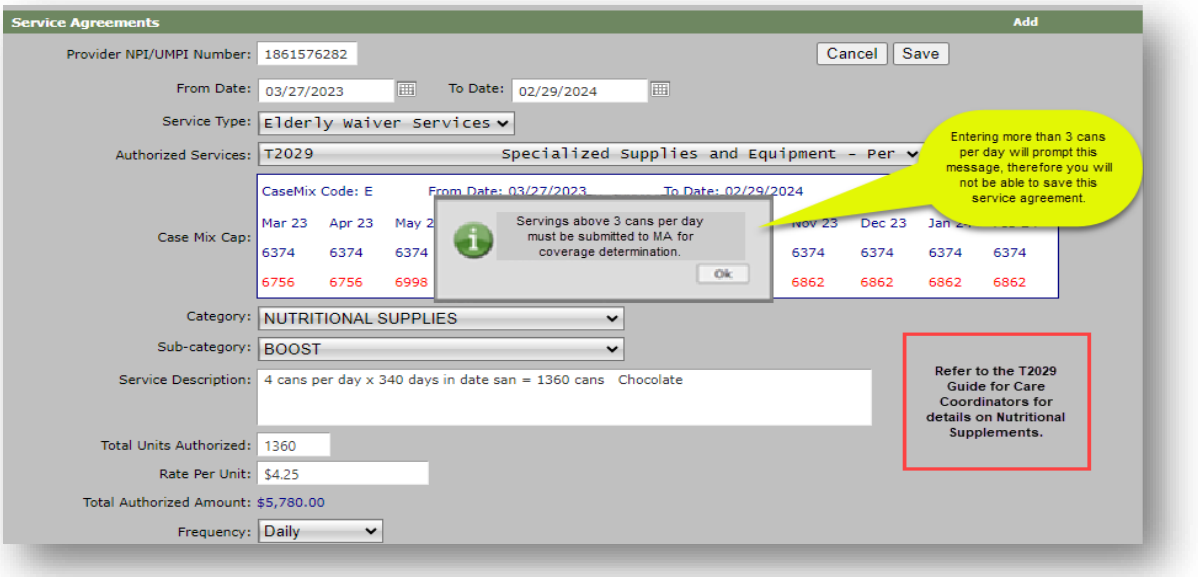
When authorizing any nutritional supplement please do the following:

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 $4.25 per can.
8. Select **Daily** as **Frequency**

Example



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



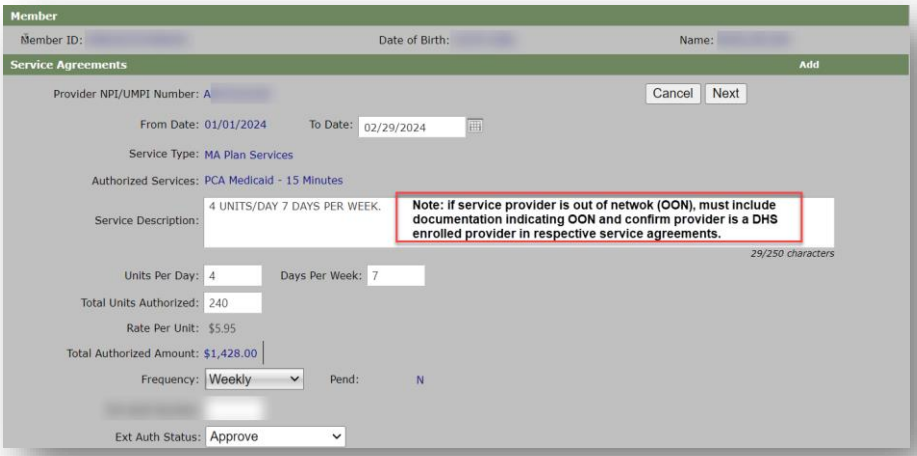
*See "*Adding a New Service Agreement*" for complete instructions.

State Plan Home Care Service Agreements

All state plan home care services authorized by the Care Coordinator that are entered in Bridgeview will not be visible in Availity. Utilization Management (UM) will mail all state plan home care service authorizations directly to the member and service provider. Optional: Add Provider's fax number, if known, in the Service Description to expedite delivery of authorization to Provider. Care Coordinators will not receive a notification from UM. Care Coordinators can view the authorizations in Helios up to 10 days after entry into Bridgeview.

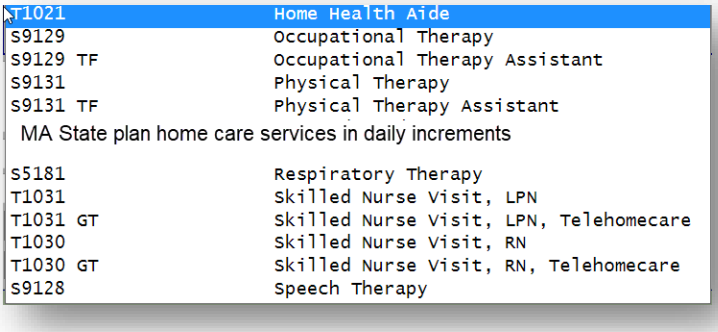
Out of Network Providers—Required documentation

The Service Description for all state plan home care service agreements must include documentation if the Provider is Out of Network (OON). It must also include documentation that CC confirmed that the provider is enrolled with DHS. Refer to CC guidelines for entire processes related to OON providers.



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.

Home Health Aide Visit *

Frequency: Must always select "Weekly"

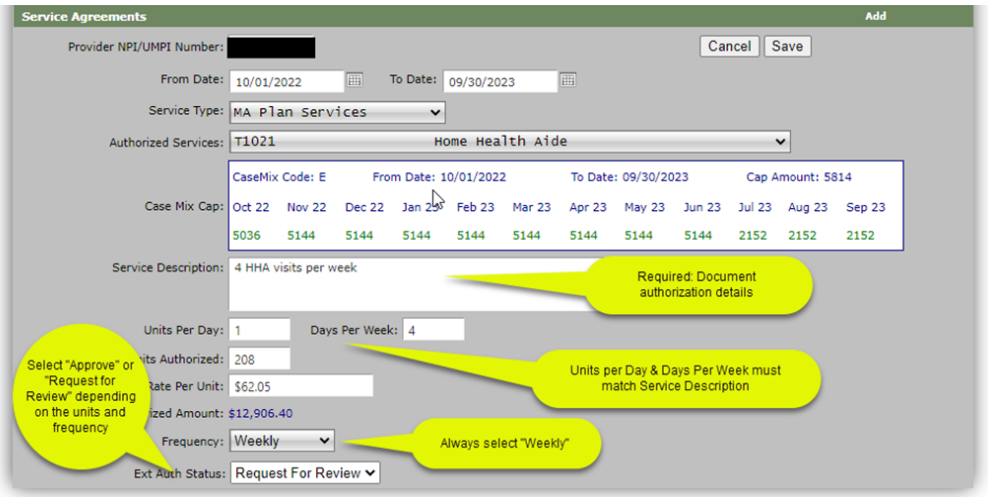
Service Description: Must document specific authorization details (I.e., "2 hours a day. 1X per week" or "1 visit every other week"). Be sure your entry in the Units Per Day and Days Per Week field match as documented here. Optional: Add Provider's fax number, if known, to expedite delivery of authorization to Provider.

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

Or

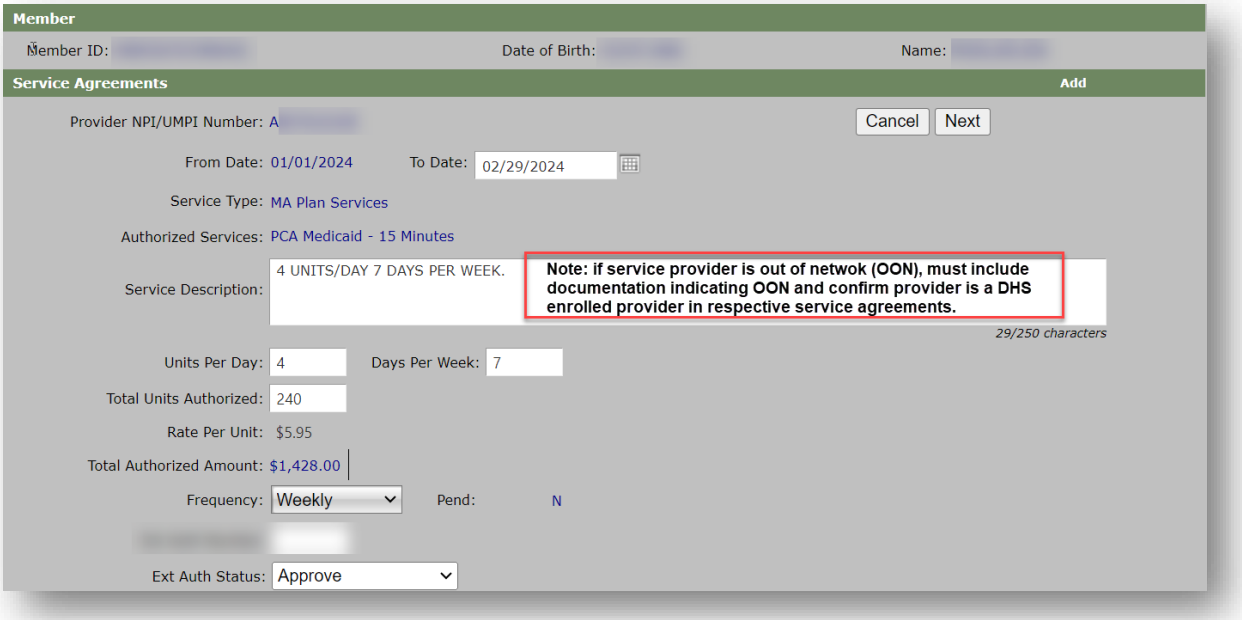
Select **Request for Review** if authorization is greater than 156 Home Health Aide

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 a PCA provider.

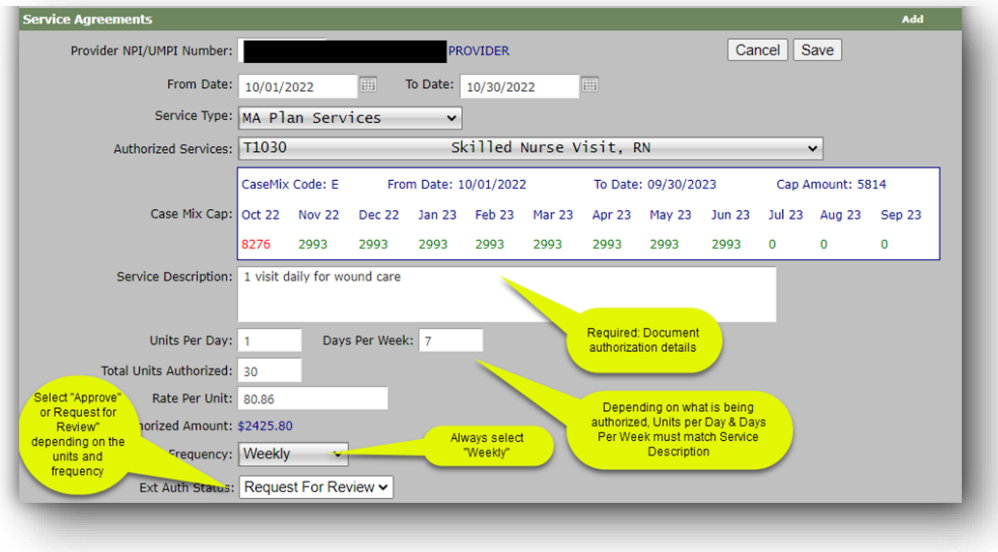


Skilled Nurse Visit *

Service Description: Must document the number of visits authorized and how often. (I.e., 1 visit every other week.) Optional: Add Provider's fax number, if known, to expedite delivery of authorization to Provider.

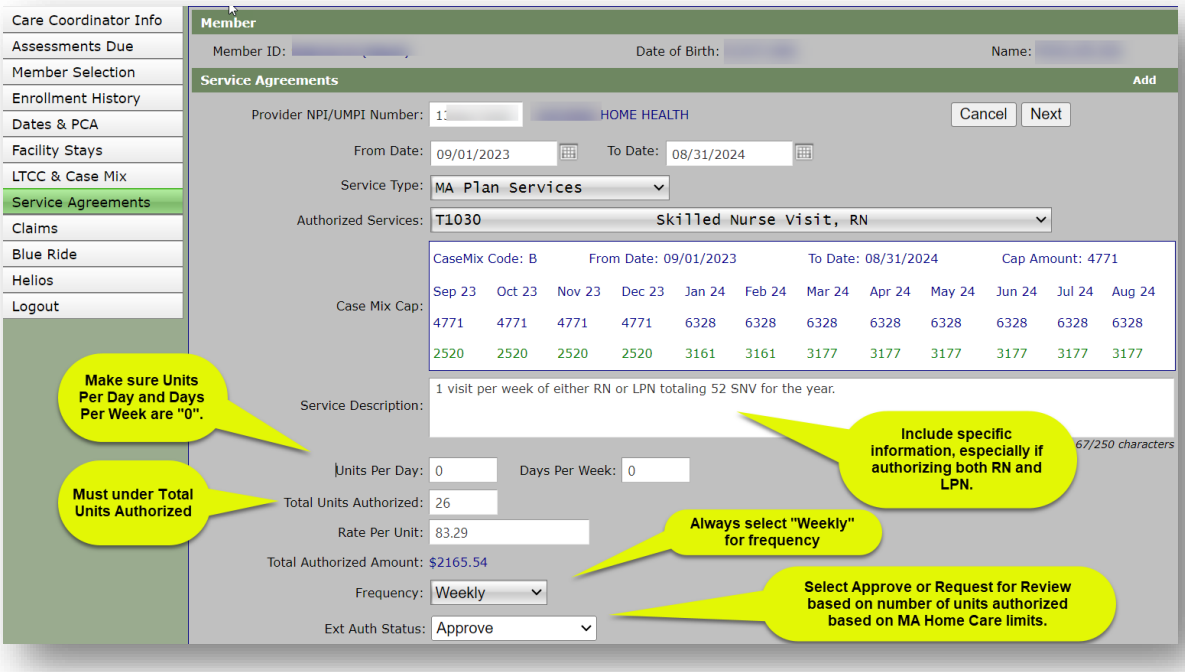
Frequency: Must always select “Weekly” for frequency.

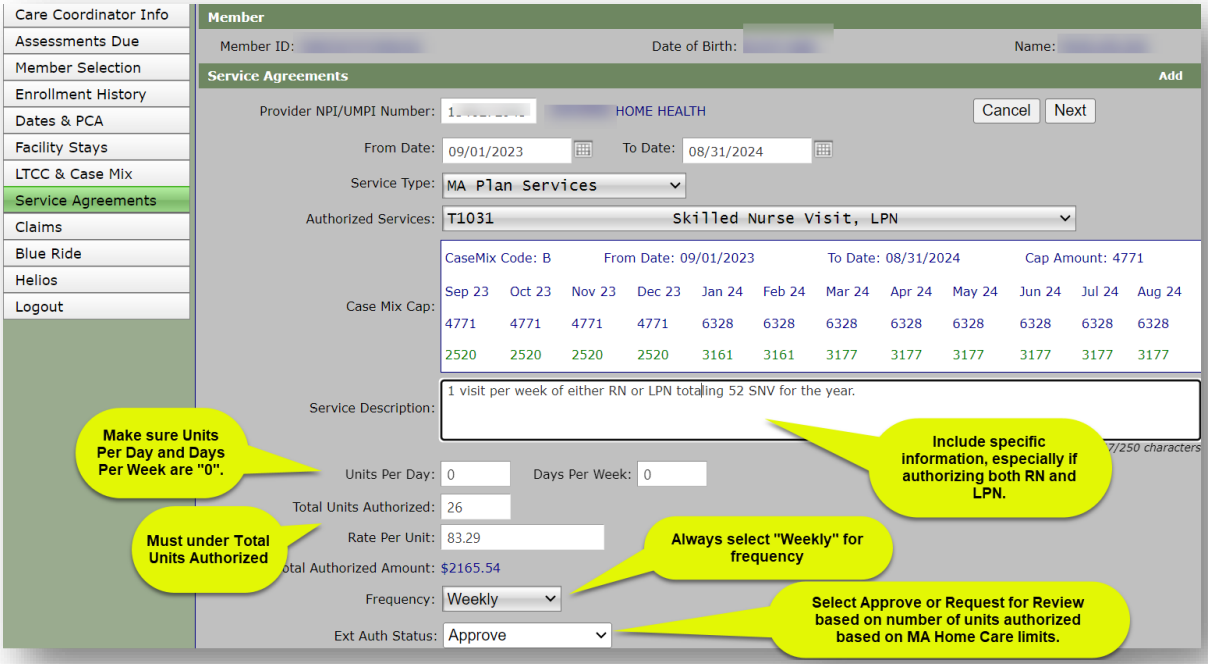
Ext Auth Status: Select **Approve** if authorization is 52 Skilled Nurse Visits per year or less (not to exceed 2 visits per week) OR,
Select **Request for Review** if authorization is greater than 52 Skilled Nurse Visits per year or greater than 2 visits per week. Follow directions in Care Coordination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



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. If updates are needed the User must make updates to both service agreements indicating how many units are needed for each discipline. Following the process outlined in section *Modifying Service Agreements*.

In this example below the Care Coordinator wanted to authorize 52 SNV which does not require UM review: Select Approve versus Request for Review.



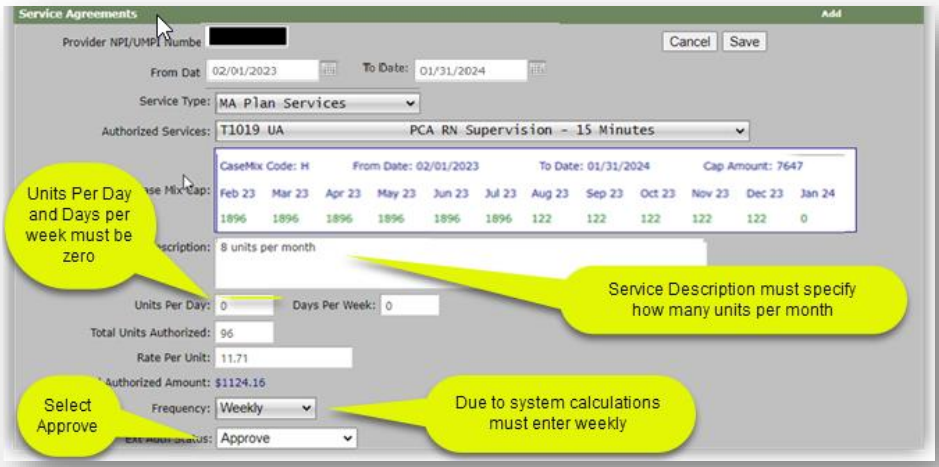


*See "*Adding a New Service Agreement*" for complete instructions.

PCA Service Agreements

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

Do not split the PCA supervision, supervision is authorized for the full PCA service span.

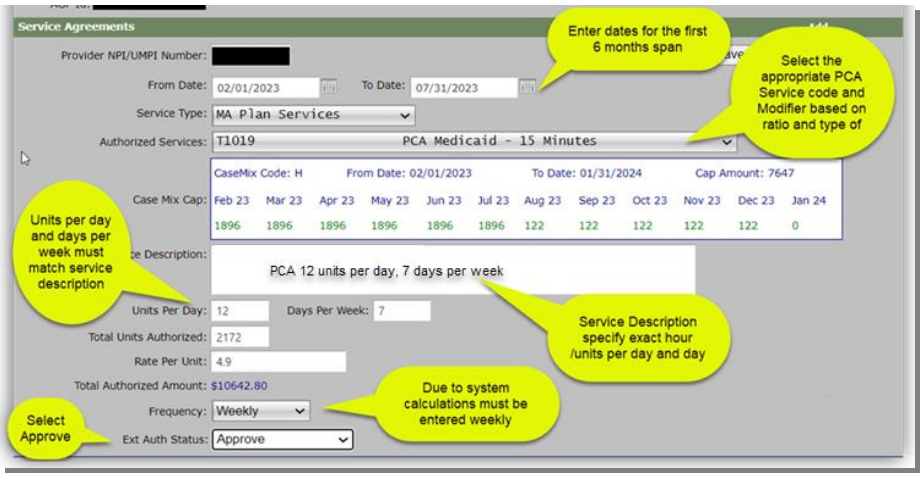


*See "*Adding a New Service Agreement*" for complete instructions.

PCA Daily (authorized in 15-minute units) *

PCA service agreement must be entered in 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.

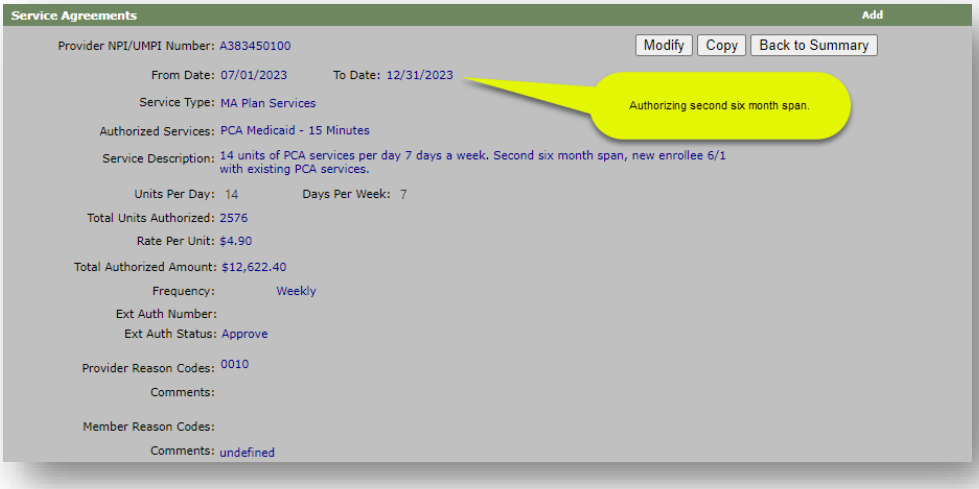
All services authorized in 15-minute unit increments must include the units and frequency in the service description, i.e., 12 units per day, seven days per week.



With non Blue Plus transitions mid service span, the service agreement span “From Date” cannot be authorized prior to the Blue Plus enrollment date. The second six month service agreement span “To Date” cannot exceed the date of the next PCA reassessment due date. Anytime a PCA service agreement is not authorized for the full six-month span, document the reason in Service Description.

Example:
Member was assessed by the county or another health plan prior to Blue Plus enrollment. Their original six month spans were 1/1/2023 – 6/30/2023 and 7/1/2023 -12/31/2023. They enroll in Blue Plus effective 6/1/2023.

The Blue Plus Care Coordinator would authorize the first six month span as 6/1/2023-6/30/2023 and include a note in the service description, “span less than six months due to BP enrollment 6/1/2023 with existing services”. Then authorize the second six month span starting 7/1/2023 -12/31/2023, not to exceed the PCA reassessment due date. In this transition example, the PCA supervision would be authorized from 6/1/2023-12/31/2023.



Unassigned PCA Providers

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

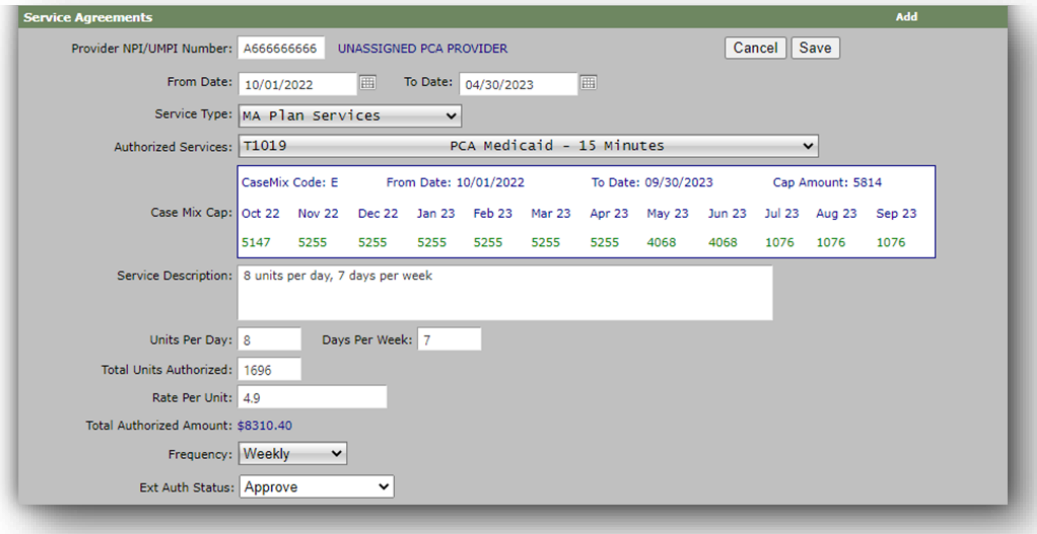
UNASSIGNED PCA PROVIDER UMPI: A666666666

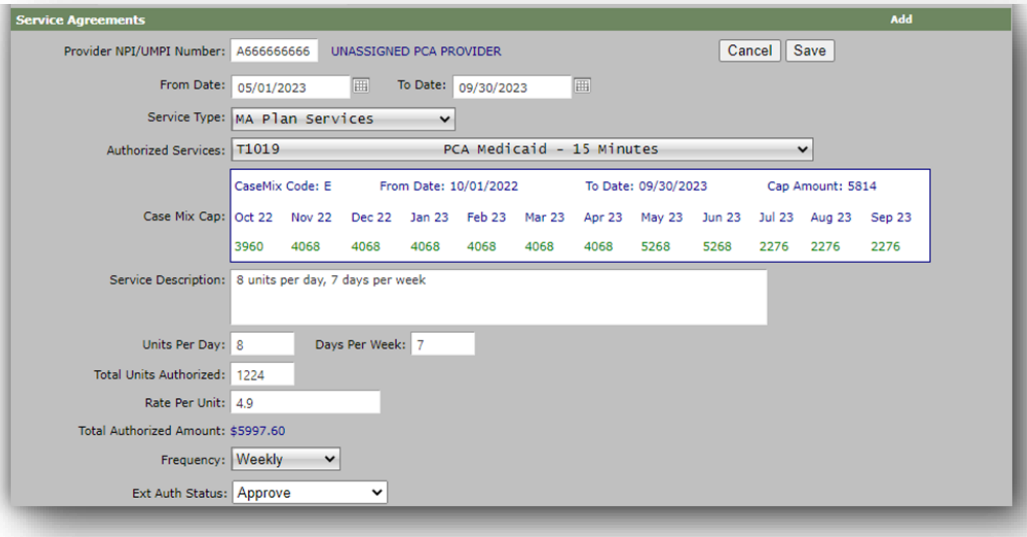
Continue entering the service agreement based on the instructions included in this document.
Once this authorization is created, a daily file is sent to the UM authorization team to enter the authorization and assign an authorization number.

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

- Member name
- Subscriber 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.

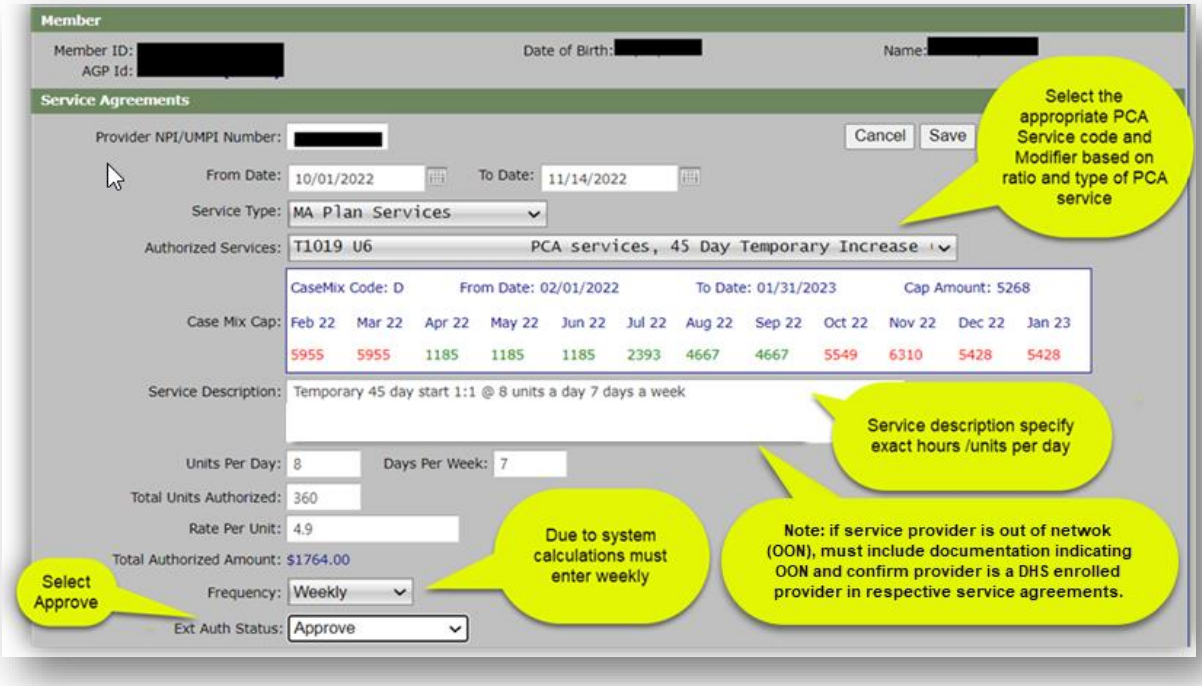
*Must enter all parts (two six months spans and PCA supervision) of the PCA authorizations on the same day.





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.



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

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 listed within Availity Essentials

Once the elderly waiver 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.

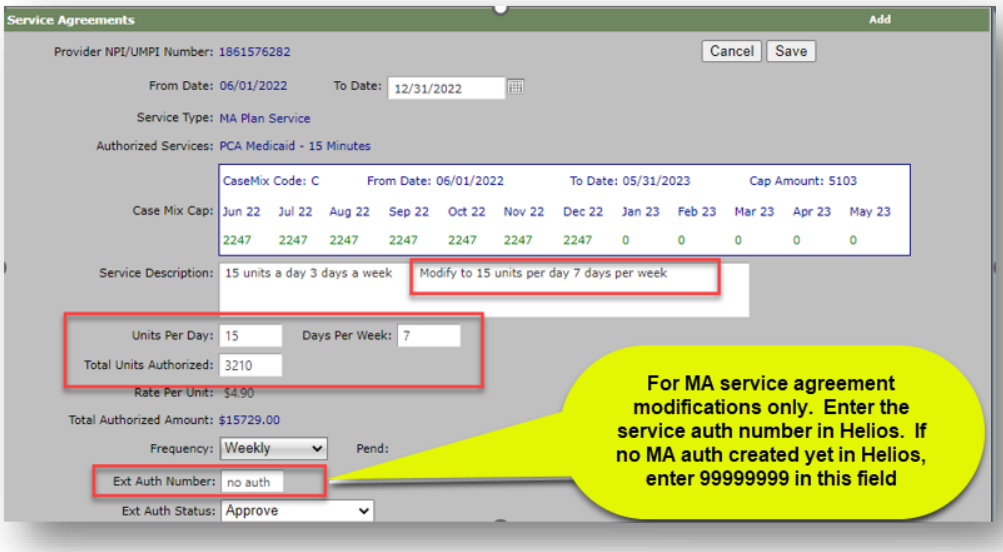
*Important: Medicaid (MA) service agreements are not visible in Availity Essentials, UM will mail out authorizations letters to MA providers within 10 business days of processing the daily report. If Care Coordinator includes the Providers fax number in the Service Description, UM will also fax the authorization to the service Provider.

Modifying Service Agreements

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 state plan home care service DTR, CCs must wait for the DTR effective date from UM (unless DTR is due to a greater than 30 day Hospital and/or NF stay).
4. **Service Description:** Enter the updated service agreement information. Include the reason for modifying the service agreement. For state plan home care service DTRs, not related to hospital/nf stays 30 days or greater, must document "DTR completed". For MA Plan Services agreements recently entered in Bridgeview that are not visible in Helios yet, include comment "New authorization number not available at time of change, auth not in Helios" 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 after verifiying with the service provider. 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 Helios 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 Helios 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)*. See *Reason Codes*.
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. See *Reason Codes*.
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.
- 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.

REASON CODES

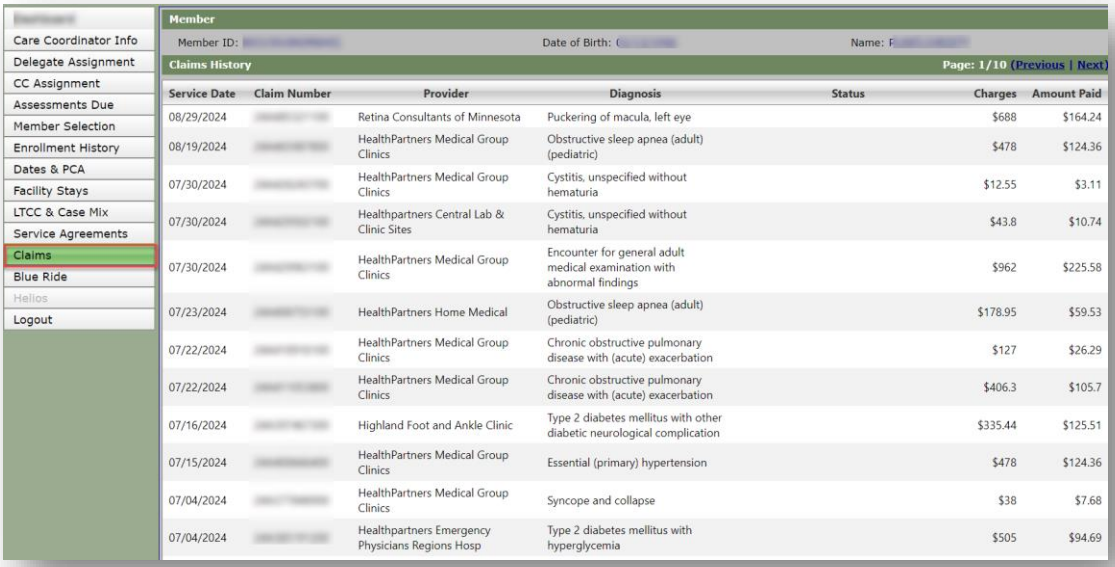
REASON CODE	DESCRIPTION
10	THIS IS A NEW SERVICE AUTHORIZATION
40	THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED SERVICE AGREEMENT THAT WAS CLOSED BECAUSE IT HAD THE WRONG HCPCS CODE
50	THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED SERVICE AGREEMENT THAT WAS CLOSED BECAUSE IT HAD THE WRONG HCPCS CODE
60	THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT HAS BEEN CLOSED BECAUSE THE PROVIDER NPI/UMPI WAS INCORRECT
70	THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT HAS BEEN CLOSED BECAUSE IT HAD THE INCORRECT NUMBER OF TOTAL UNITS
80	THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT HAS BEEN CLOSED BECAUSE IT HAD AN INCORRECT RATE PER UNIT
90	THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT HAS BEEN CLOSED BECAUSE IT HAD AN INCORRECT TOTAL UNITS AND RATE PER UNIT AUTHORIZED
100	THIS IS A REVISED SERVICE AGREEMENT THAT HAS REDUCED THE TOTAL UNITS AUTHORIZED. YOU MAY ONLY PROVIDE THE REDUCED NUMBER OF UNITS AND TOTAL AUTHORIZED AMOUNT AS INDICATED ON THIS AUTHORIZATION
120	THIS IS A REVISED SERVICE AGREEMENT THAT HAS REDUCED THE DATE SPAN ON

REASON CODE	DESCRIPTION
	THE ORIGINAL AUTHORIZATION. YOU CAN ONLY PROVIDE SERVICES FOR THIS REVISED TIME PERIOD
130	THIS IS A REVISED SERVICE AGREEMENT THAT HAS REDUCED THE TOTAL UNITS AND DATE SPAN OF THE ORIGINAL AUTHORIZATION. YOU AN ONLY PROVIDE THE SERVICES AS INDICATED ON THIS REVISED AUTHORIZATION
150	THIS IS A REVISED SERVICE AGREEMENT THAT HAS INCREASED THE TOTAL UNITS AUTHORIZED. YOU ARE NOW ALLOWED TO PROVIDE UP TO THE NUMBER OF UNITS AND TOTAL AUTHORIZED AMOUNT SHOWN ON THIS AUTHORIZATION
210	THIS IS A REVISED SERVICE AGREEMENT THAT HAS INCREASED THE DATE SPAN FOR THIS SERVICE. THE SERVICE MAY BE PROVIDED FOR A LONGER PERIOD
250	THIS IS A REVISED SERVICE AGREEMENT THAT HAS INCREASED THE UNITS AND DATE SPAN OF THE ORIGINAL AUTHORIZATION. YOU MAY NOW PROVIDE THE SERVICE FOR THE UNITS AND DATE SPAN SHOWN ON THIS AUTHORIZATION
260	THIS IS A REVISED SERVICE AGREEMENT THAT REFLECTS A DECREASE IN THE CL RATE DUE TO AN ABSENCE FROM THE FACILITY
300	THIS SERVICE IS NO LONGER NEEDED. YOU ARE NO LONGER AUTHORIZED TO PROVIDE ANY SERVICES THAT WERE AUTHORIZED UNDER THIS SERVICE AGREEMENT
310	THE REMAINING UNITS AND AMOUNTS ON THIS SERVICE AGREEMENTWERE DELETED BECAUSE IT HAS BEEN CLOSED. YOU CAN NO LONGER PROVIDE SERVICES THAT EXCEED THIS REVISED AUTHORIZATION
320	CDCS SERVICES ARE NO LONGER AUTHORIZED FOR THIS PERSON
340	THIS SERVICE AGREEMENT HAS BEEN ENDED DUE TO A FACILITY STAY THAT DOES NOT ALLOW FOR THE SERVICE AGREEMENT TO REMAIN OPEN
350	THIS SERVICE AGREEMENT IS BEING CLOSED DUE TO CLIENT ENTERING THE NURSING FACILITY
355	THIS AUTHORIZATION HAS ENDED DUE TO RECIPIENT MOVING TO A NEW COUNTY OF RESIDENCE
360	THIS LINE ITEM WAS CLOSED BECAUSE THE PROVIDER IS NO LONGER ACTIVE UNDER THIS PROVIDER NUMBER BEYOND THE END DATE
400	THIS SERVICE AGREEMENT IS NOT VALID BECAUSE IT WAS ENTERED BY MISTAKE OR HAS ERRORS THAT CANNOT BE CORRECTED. YOU ARE NOT AUTHORIZED TO BILL FOR ANY SERVICES UNDER THIS AUTHORIZATION NUMBER
410	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE IT HAD AN INCORRECT DATE

REASON CODE	DESCRIPTION
	SPAN. YOU ARE NOT AUTHORIZED TO BILL FOR ANY SERVICES THAT HAD BEEN LISTED ON THIS AUTHORIZATION
420	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE IT HAD THE WRONG HCPCS SERVICES AUTHORIZED
460	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THE PROVIDER NPI/UMPI WAS INCORRECT
500	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THE TOTAL NUMBER OF UNITS WAS INCORRECT
510	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THE RATE PER UNIT WAS INCORRECT
520	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THE NUMBER OF UNITS AND RATE PER UNIT WERE INCORRECT
530	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THIS ITEM(S) ARE NO LONGER COVERED UNDER THE ELDERLY WAIVER PROGRAM
800	NOTE TO PROVIDERS: REFER TO CLIENT'S "INDIVIDUAL CARE PLAN" (LTC) APPROVED BY THE COUNTY CASE MANAGER FOR DETAILS REGARDING THE TYPE, AMOUNT, FREQUENCY AND DURATION OF SERVICES TO BE PROVIDED
810	THIS ITEM MAY NOT BE PAID WITH WAIVER FUNDS IF OTHER MORE APPROPRIATE FUNDING IS AVAILABLE
900	THIS SERVICE AGREEMENT HAS BEEN CHANGED DUE TO A COLA RATE ADJUSTMENT. FOR BILLING PURPOSES, PLEASE MAKE SURE YOU SAVE THIS COPY
950	THIS SERVICE AGREEMENT IS BEING REVISED TO REFLECT THE MEMBER HAS A WAIVER OBLIGATION THAT MAY APPLY FOR THIS SERVICE

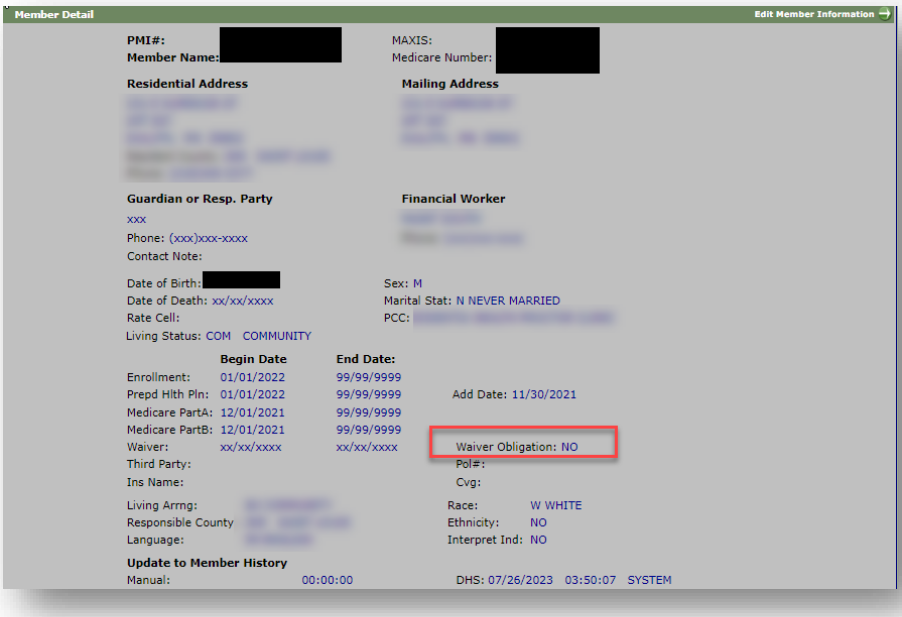
CLAIMS

Users will be able to view a high-level summary of a member's medical service (MA state plan services, procedures, etc.) claims. Elderly waiver claims will not display. If there are any questions about these claims refer providers to Provider Services.



WAIVER OBLIGATIONS

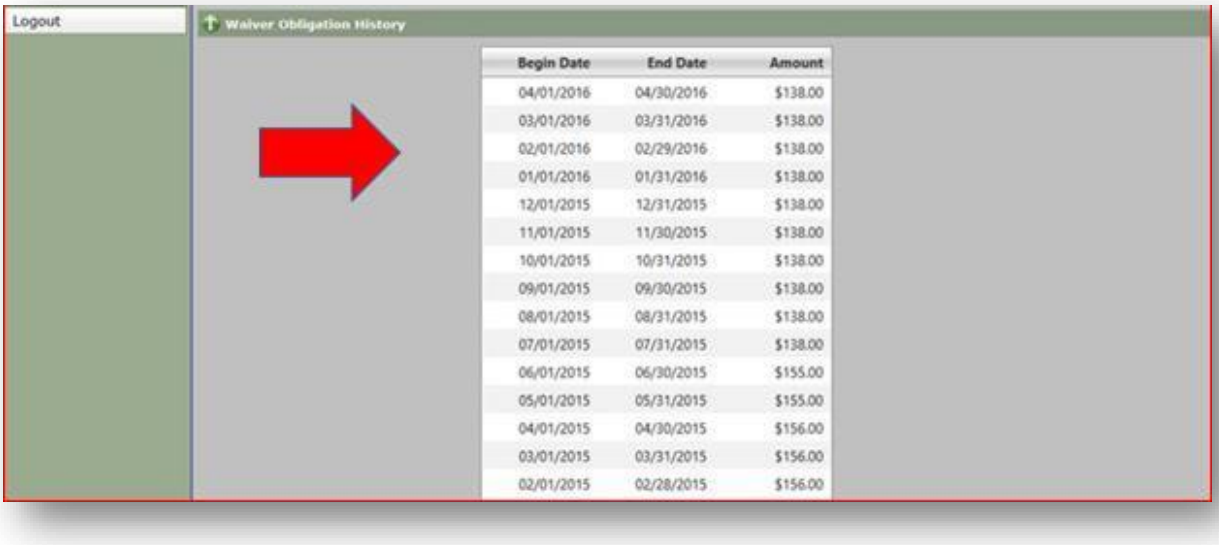
If a member has a waiver obligation that must be met each month, you will be able to view the information in the Service Agreement tab under the Waiver Obligation History. If there is no waiver obligation, it will state “NO” on the Member Detail on the Member Selection tab. Waiver obligations are reported monthly from the Department of Human Services on the 12th business day of each month. To ensure waiver obligations are applied correctly, claims submitted prior to the 12th business day of the month will pend until receipt of this report.



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

Members on managed care cannot assign a designated provider for waiver obligations. Waiver obligations will be applied to all elderly waiver claims submitted for the members in the order claims are received. If a member has more than one EW provider, the elderly waiver obligation may be applied to different providers from month to month. 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.

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 with the dollar amount that must be billed to the patient in the “Patient Responsibility” field on the remittance. Members are responsible for paying the amount of the obligation towards the services that were utilized that month to the 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. These 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

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

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.)

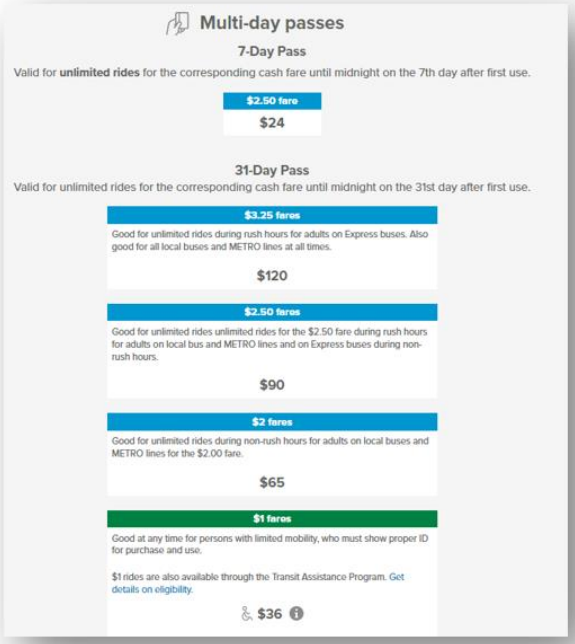
Please include the following information when entering a service agreement authorization for non-medical EW Transportation into Bridgeview (failure to add this detailed information will delay your Go-To Card request for both new or renewal).

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)

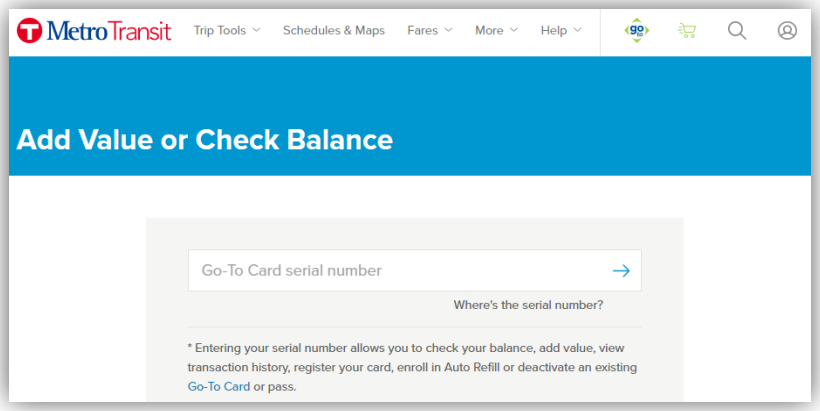
*Stored value cards are valid until the funds have been depleted



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.

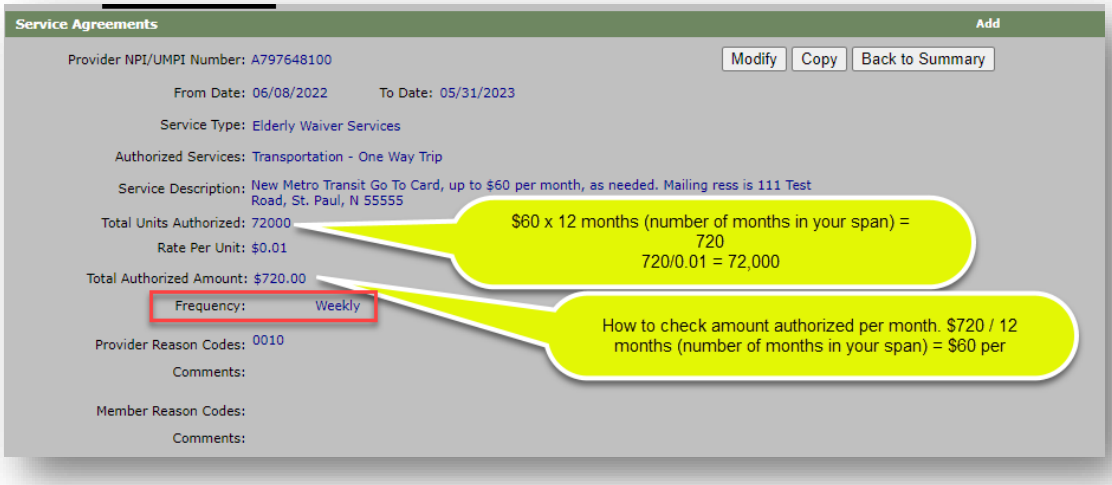
***Reminders:

- 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

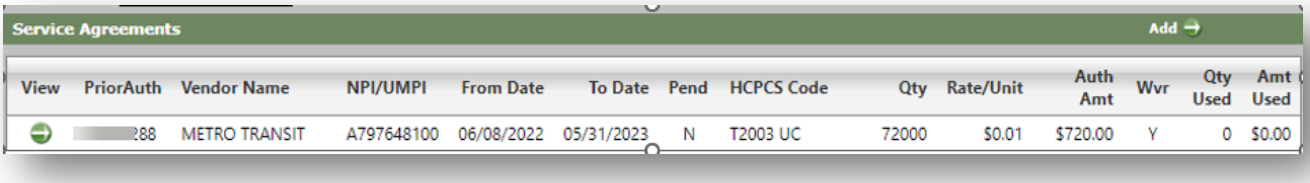


Create your service agreement based on one month Go-To Card:

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 T2003 UC 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. See *Reason Codes*.
12. **Member Reason Code:** select appropriate reason code based on your authorization. See *Reason Codes*



The service agreements dashboard will display the following:



Service Agreements — Add

View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	288	METRO TRANSIT	A797648100	06/08/2022	05/31/2023	N	T2003 UC	72000	$0.01	$720.00	Y	0	$0.00

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:

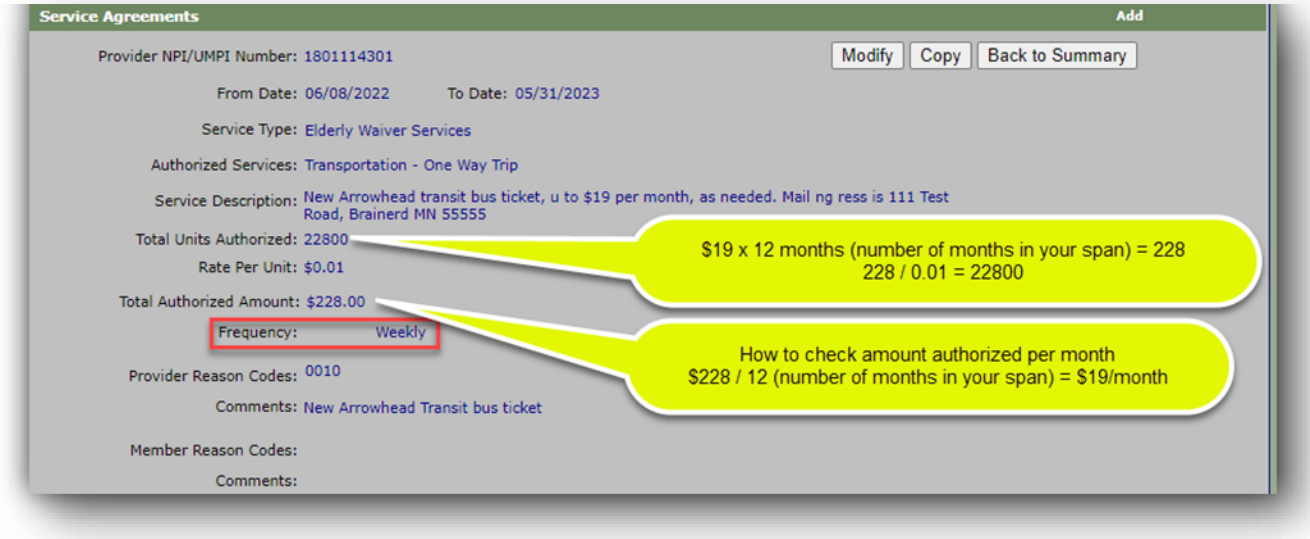
1. **Provider NPI/UMPI Number**: 1801114301
2. **Provider Name: Arrowhead Transit**
3. Enter Service agreement **From Date** and **To Date**
4. **Service Type:** Select Elderly Waiver Services
5. **Authorized Services**: Select T2003 UC Transportation one-way trip
6. **Service Description** must include: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

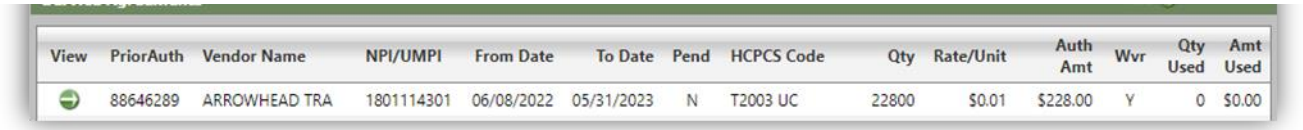
2) 228 divided by 0.01 = **22,800**

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



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.

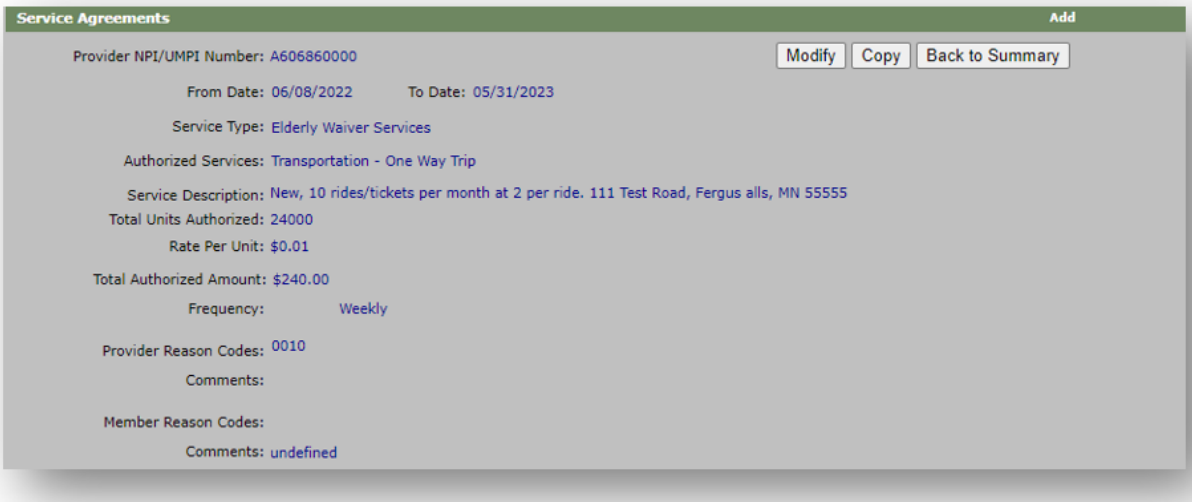
Complete a service agreement in Bridgeview using the following:

1. **Provider NPI/UMPI Number**:

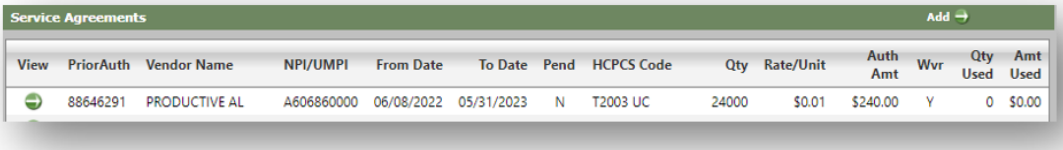
- A606860000 (Productive Alternatives)

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



The service agreements dashboard will display the following:



Service Agreements — Add

View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88646291	PRODUCTIVE AL	A606860000	06/08/2022	05/31/2023	N	T2003 UC	24000	$0.01	$240.00	Y	0	$0.00

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.)

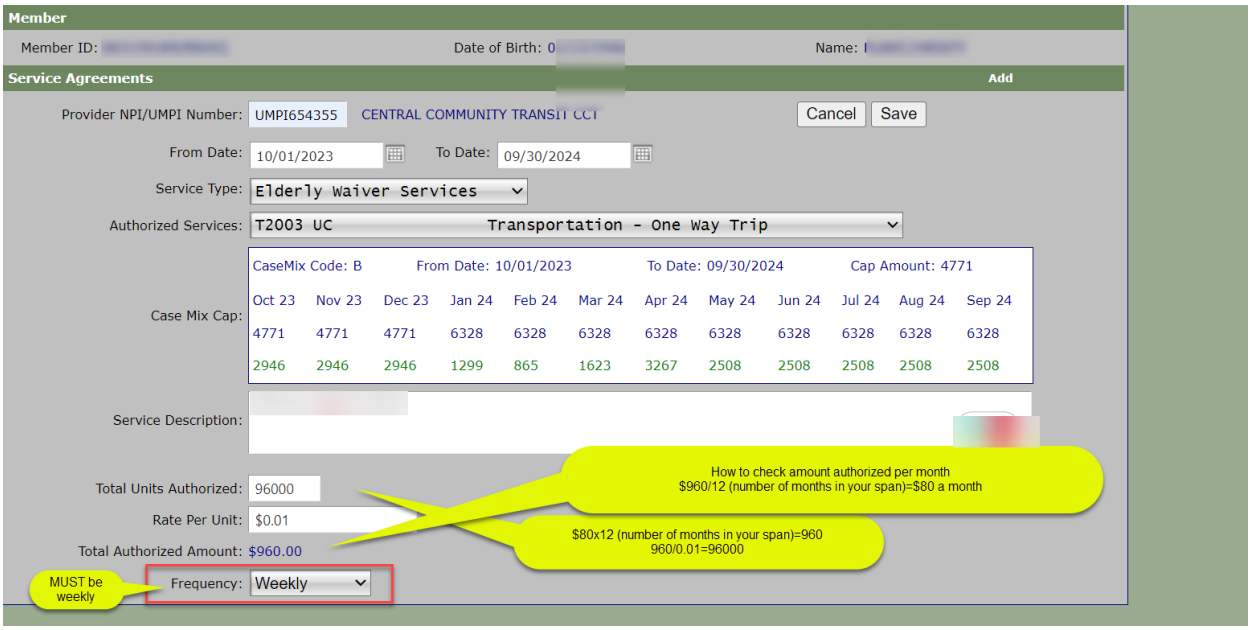
Contact Dial-a-Ride for current rates and route information.

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

1. Apply for eligibility by completing the Dial-A-Ride ServiceApplication
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. See *Reason Codes*.
16. **Member Reason Code:** select appropriate reason code based on your authorization. See *Reason Codes*



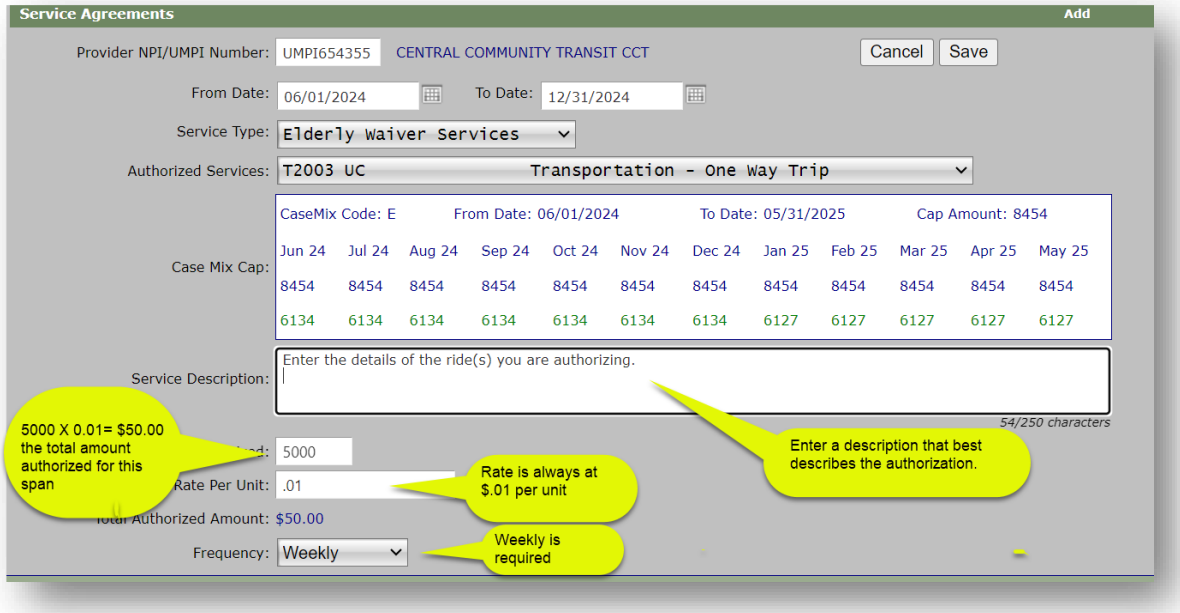
Entry of non-EW Bus Passes for Kandiyohi, Meeker, Renville County area.

For members who are on Elderly Wavier and have an identified need for non-medical transportation documented in their care plan there is now a transportation option in the counties listed above through Central Community Transit (CCT).

Instructions:

1. Assure total amount is within EW budget cap. Total amount must include the number of passes and shipping and handling fee.
   Note: Additional administration fees are incorporated into the total amount of the punch pass options listed on the form.
2. Choose the bus pass option as listed on the CCT form. Rate sheet and form is found on CC website Bridgeview page:
   https://carecoordination.bluecrossmn.com/bridgeview/
3. Order the tickets:
   Complete form and e-mail to: SMolenaar@CCTbus.org

4. CCT will mail the tickets to member's address
5. Enter Service Agreement in Bridgeview



Helpful Information:

CCs may visit the CCT website (information on website is found on the form) or contact the applicable office by e-mail or phone to discuss the value of each option to determine which Punch Pass or Token(s) would work for the request.

If possible, have the form emailed by the 20th of month in order to have the pass(es) ready for USPS mail by the first of next month.

To avoid confusion for both sides in the beginning, it would be helpful to CCT Dispatch team if the Care Coordinator could call Dispatch (There is a different number for each county as noted on top of the form) to help the client get established in their system. Dispatch will need the name, pickup address, a good phone number for the client, and a start date, if known. Once established, Dispatch should be able to arrange the date and drop-off address, etc.

Care Coordinators should explain to the client that arranging the ride at least one or more days before the service day is more helpful to the bus company, and costs less for the client. For "same day service", there is an additional $1 for each pickup, or an additional $2 for every round trip.

Passes never expire, so if the client does not need twenty rides in one month, the pass is good until all the values have been punched out.

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

KANDIYOHI, MEEKER, RENVILLE COUNTY: Central Community Transit (CCT)

Serves Kandiyohi, Meeker, Renville County UMPI654355
See detailed instructions above for the entire process.
Enter SA in Bridgeview

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

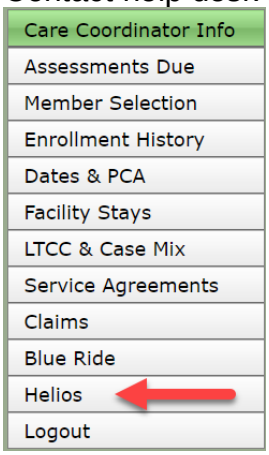
***For non-medical bus pass related questions or concerns send a secure email to: EWBusPasses@bluecrossmn.com**

Helios

Helios 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 Helios. Contact help desk if the link below is not working.



Refer to the Helios training available under Resources page on the Care Coordination website.

FINAL PAGE