Bridgeview COMPANY

BlueCross BlueShield Minnesota

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Bridgeview Care Coordination User Guide

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

Updated April 1, 2021

*Recent changes in Red

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Getting Started

Contacting Bridgeview

https://www.bridgview.bluecrossmn.com home page

Email: EWProviders@bluecrossmn.com
Phone: 1- 800-584-9488 or 218-740-2336 Monday – Friday 8am-4:30pm

Roles/Definitions

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

Access

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

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. Registration will take 10 business days, if you have any questions contact Bridgeview at EWProviders@bluecrossmn.com.

Completing the Care Coordinator Web Tool User ID Request Form

- This form should be completed by the Care Coordination Delegate Representative/Supervisor.
- When requesting access, select the level of access needed. (see Roles/Definitions above).
- Bridgeview requires all Care Coordinators to have a DHS assigned UMPI number.
- 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.
- 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.
- While waiting for the permanent DHS UMPI number, Bridgeview will assign a

temporary, unique Bridgeview ID number.

- The Care Coordinator Web Tool User ID Request Form can be submitted through Bridgeview while a request for a DHS UMPI number is being processed.
- 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.
- For Delegate Representative/Support Staff are not required to have an UMPI number (leave this field blank on the form).
- Once an UMPI number is received from DHS, Care Coordinator must update Bridgeview with the UMPI number via email to EWProviders@bluecrossmn.com.

Name Changes

To request a name change in Bridgeview, please email EWProviders@bluecrossmn.com (and cc partner.relations@bluecrossmn.com) with the following information:

Delegate agency information
Previous name
New name (first and last name) Email
Address
Contact telephone number

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 the date access should be ended. Email the completed form to Bridgeview at EWProviders@bluecrossmn.com (and cc partner.relations@bluecrossmn.com).

Log In

Go to https://bridgeview.bluecrossmn.com website. Mouse over the Bridgeview Links and select Care Coordinator Web Tool.

You will then be taken to the Okta Login screen where you will enter your email address and password.

To keep member's PHI secure, the log in process requires a two-step authentication. A "verification code" will be sent to your e-mail address. Enter the verification code once received. You may need to authenticate multiple times a day.

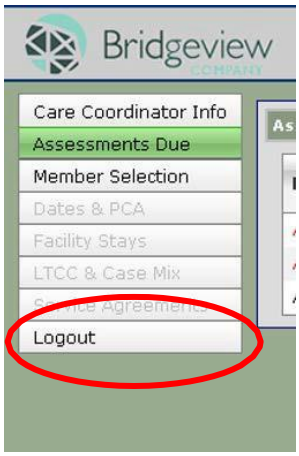
Once you get to the Okta login page you can save the link to your favorites.

Log in issues

If you encounter an error when trying to enter your login email address or password, you can select at the bottom of the page links for password resets and support located on the Bridgeview website.

Logging Out

When you have completed your work in the Bridgeview system, select Logout from the tabs on the left.

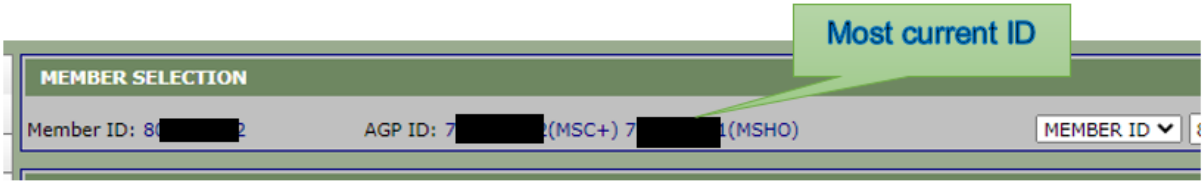


After logging out, you will be returned to the Bridgeview homepage.

Member IDs in Bridgeview

Members are identified in Bridgeview using an 8 plus PMI (exp 801234567). This is a "dummy" ID number to be able to pull up a member. This will be referred to as the "Bridgeview ID number" in this manual. Members still have their Amerigroup/Blue Cross ID number for all other purposes (i.e., 726212345).

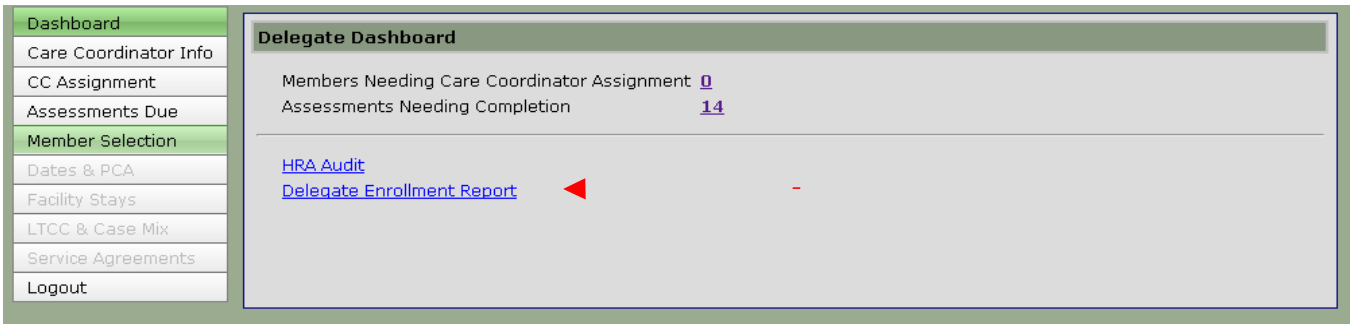
Tip: Member IDs in Bridgeview. If there are two ID numbers listed at the top of the Member Selection screen in the AGP ID field, the ID and Product closest to the MEMBER ID dropdown selection is the most current information.



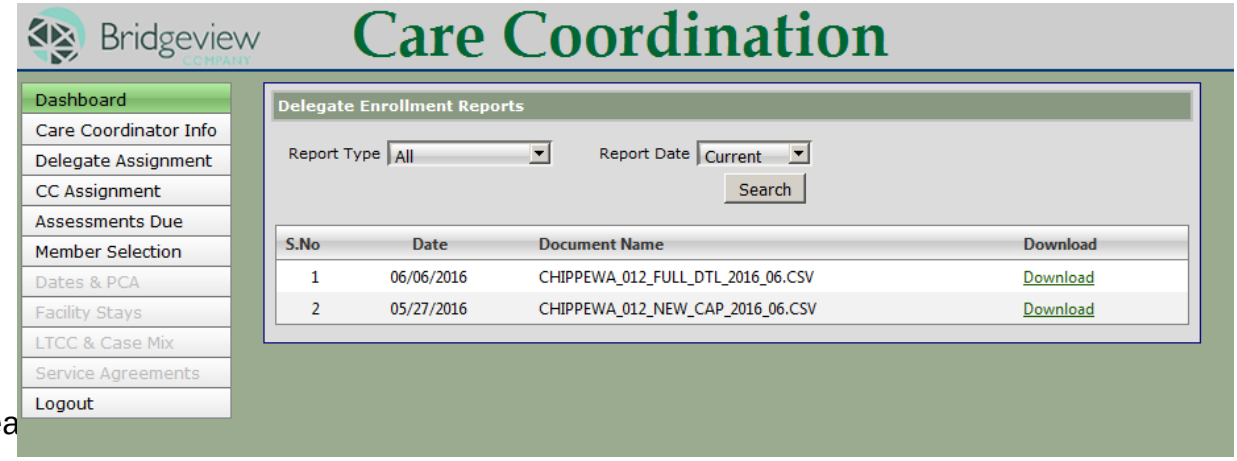
Enrollment Reports

All Delegate Blue Plus enrollment reports are available on the Bridgeview Company Web Tool. The Delegate Representative/Support Staff Role has access to these reports.

When the Delegate Representative/Support Staff logs into the Web Tool, the first screen displays a link to the Enrollment Reports. Click on the blue “Delegate Enrollment Report” link.

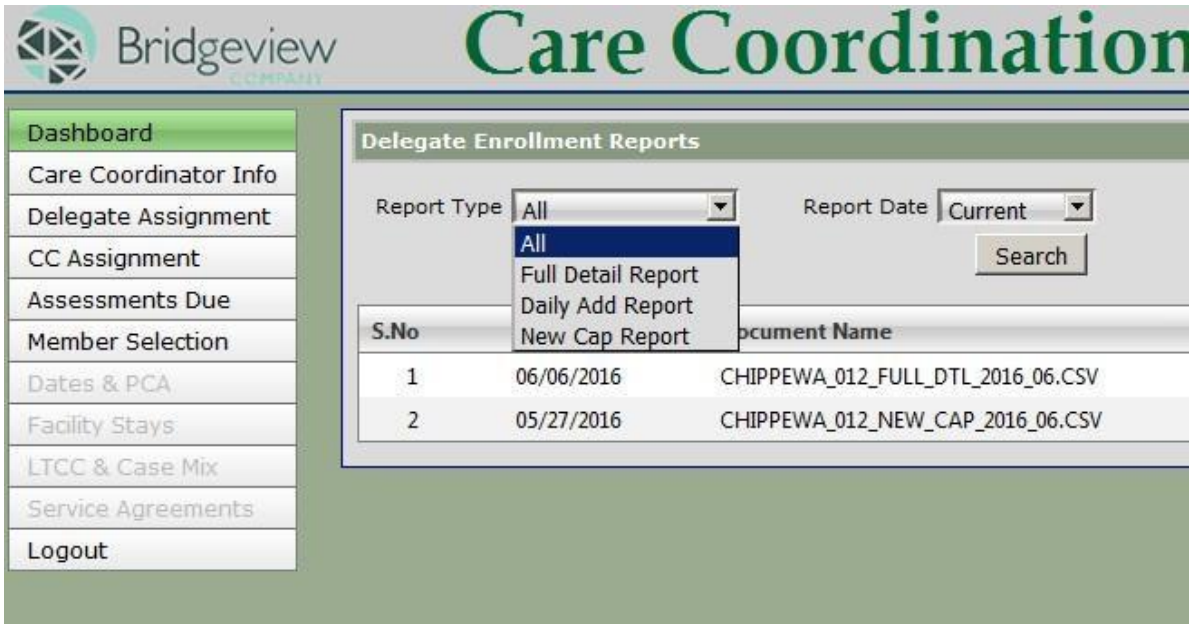


This will take you to the Delegate Enrollment Reports screen where you can see the most current reports already displayed, or you may search for a specific report.

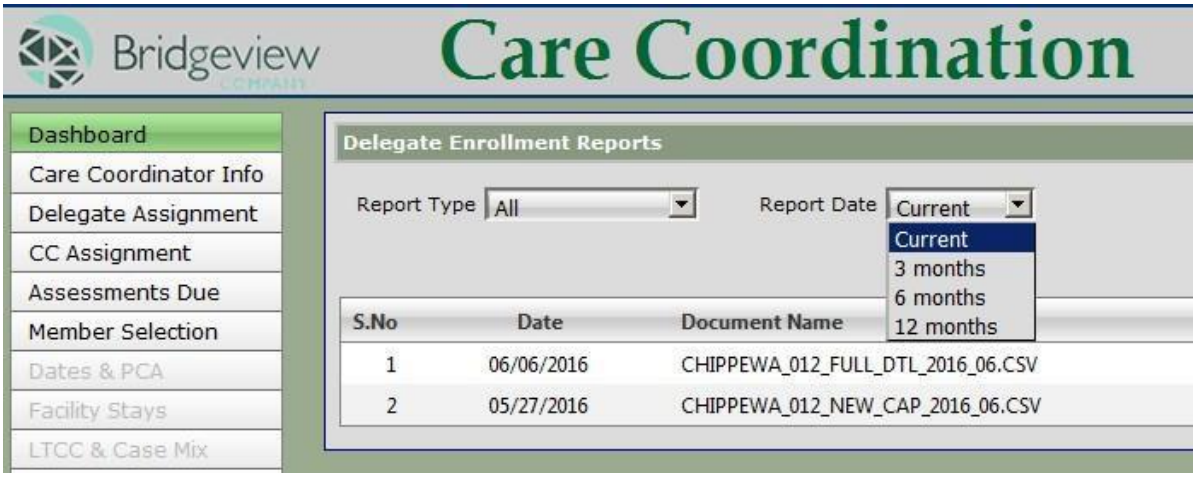


To sea

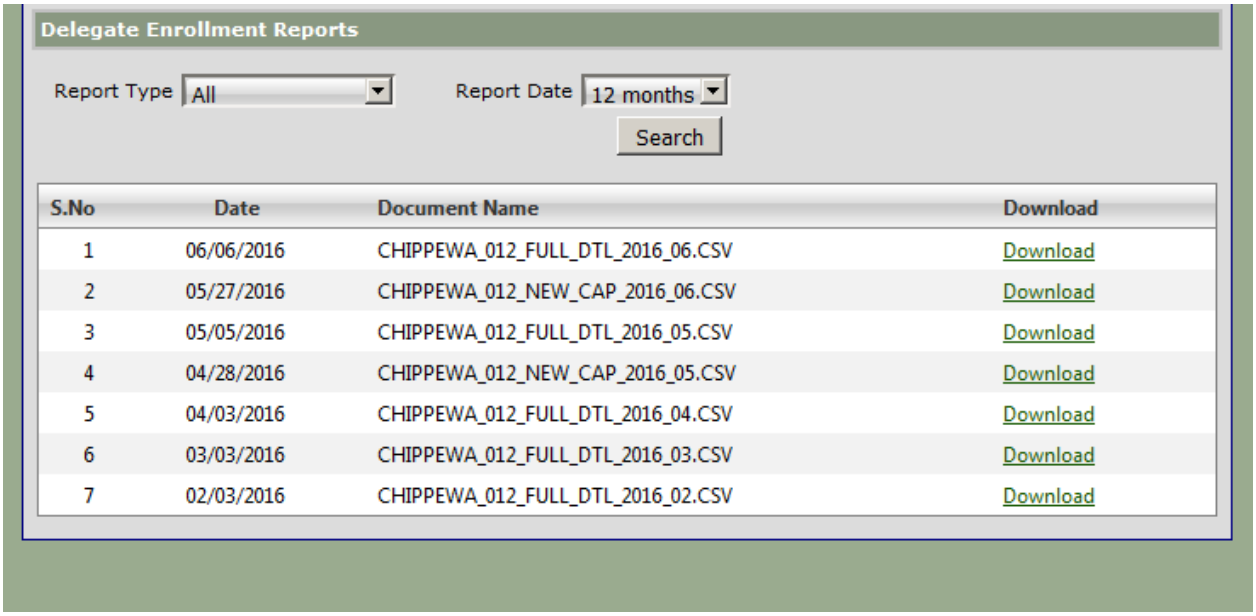
**Reminder: enrollment reports are only available for 12 calendar months.*



Then choose the desired Report Date, then click Search



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.



Definitions:

- New CAP Report: Lists NEW members for the month.

- Full Detail Report: Provides a full member list to each Delegate and may also include some NEW members who enrolled at the very end of the previous month which includes the following flags:

  - NEW: Enrollees who enrolled after the DHS capitation
  - REINSTATED: Members who were going to term but were reinstated with no lapse in coverage
  - TERMED: Coverage termed
  - PRODUCT CHANGE: Changed from MSC+ to MSHO or vice versa (these members are treated as brand new enrollees and will need a new HRA)
  - TRANSFER: Existing enrollee who transferred to you. Official notification is via form 6.08 Transfer in Care Coordination Delegation.
  - TERMED FUTURE: Lists Month/Year. Member will be termed at the end of the month listed. CC should follow up to determine if the reason for disenrollment requires mediation (i.e., MA paperwork not submitted yet).
  - GRACE PERIOD ENDING: Lists Month/Date/Year which will be 30/60/90 days out from the enrollment month. These are MSHO members whose MA has termed but continue to have MSHO coverage for 90 days. See 90 Day Grace Period (MSHO only) section of the guidelines for care coordinator tasks.

- Daily Add Report: This report is generated as needed for those members who are retroactively enrolled by DHS after capitation. This report will list NEW and/or REINSTATED members.

Assigning Care Coordinators 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. Do not enter HRA information before the Care Coordinator is assigned with Bridgeview. All Blue Plus MSHO and MSC+ members in all rate cells must be entered into the Bridgeview system.

There are 2 levels of access dedicated in Bridgeview.

1. Delegate Representative/Support Staff
2. Care Coordinator

Delegate Representative/Support Staff and/or Care Coordinators may:

- access dashboard information about upcoming and past due assessments (**all roles**),
- assign care coordinators to the members (**delegate representative/support staff roles**),
- enter assessment information **(all roles),** and
- receive enrollment and other reports (**delegate representative/support staff role**).

Reminder: Delegate Representative/Support Staff and Care Coordinators are NOT able to edit HRAs once they have been saved into Bridgeview without submitting an Edit or Deletion request. Do not enter another HRA to correct the error. You will NOT be able to directly edit an HRA after you save it, you will have to request a fix through the Edit process. If you make an error with your HRA data entry, please follow the instructions in section titled Requesting an Edit or Deletion of HRA to send a change request for review.

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

Delegate Representative/Support Staff roles have the capability to assign or edit Care Coordinators. A Care Coordinator must be assigned within 10 days of notification of member enrollment. Do not enter HRA information before the Care Coordinator is assigned with Bridgeview. When a member is assigned to your agency, you will use the **Assign Care Coordinator** function (see instruction below).

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

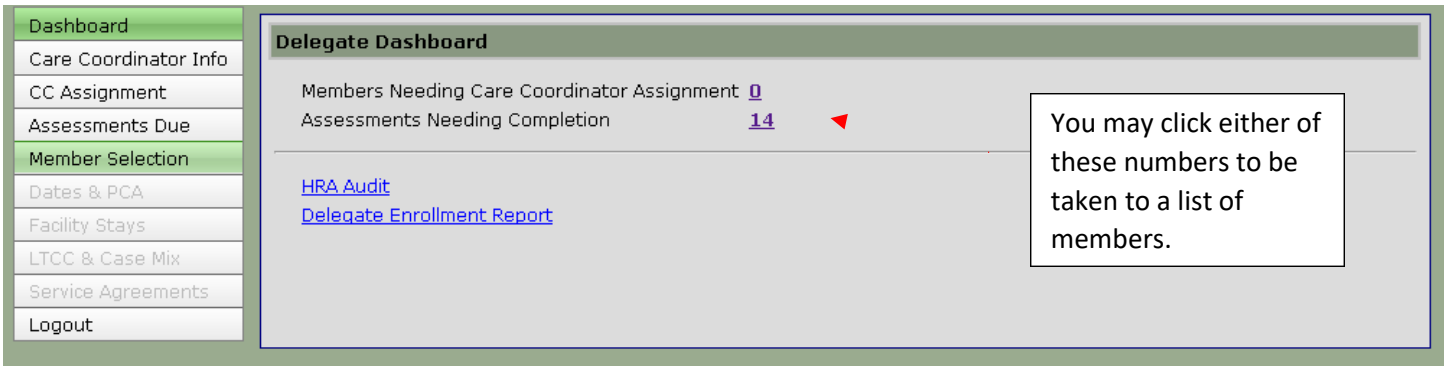
Assign CC: if you want to change the CC. Choosing Assign CC will keep a history of the previous CC.

Edit CC: use the Edit CC if you assigned the member to a CC and now want to

change it (i.e. you assigned the wrong CC, etc.). This overwrites the previously assigned CC.

Delegate Representative/Support Staff Role:

As a **Delegate Representative/Support Staff**, your first screen will look like this



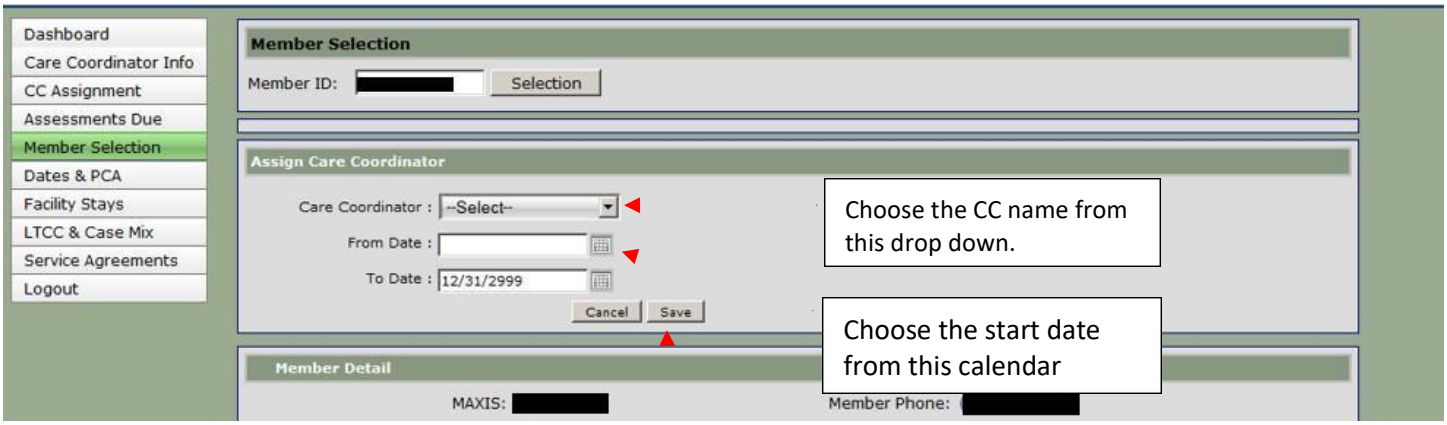
This Delegate Dashboard shows how many members need to be assigned a Care Coordinator and how many Assessments need completion. It also links to your Enrollment Reports and HRA Audit Dashboard.

You may navigate using both the tabs in the list on the left, or by following links embedded on the screen.

Select CC Assignment or click on the number of members needing CC assignment. You can now click directly on a member's name.

On the Member Selection screen, you will click the Assign Care Co. button.

You will be taken to this screen, where you may enter the Care Coordinator name and start date of assignment.



Click save when finished.

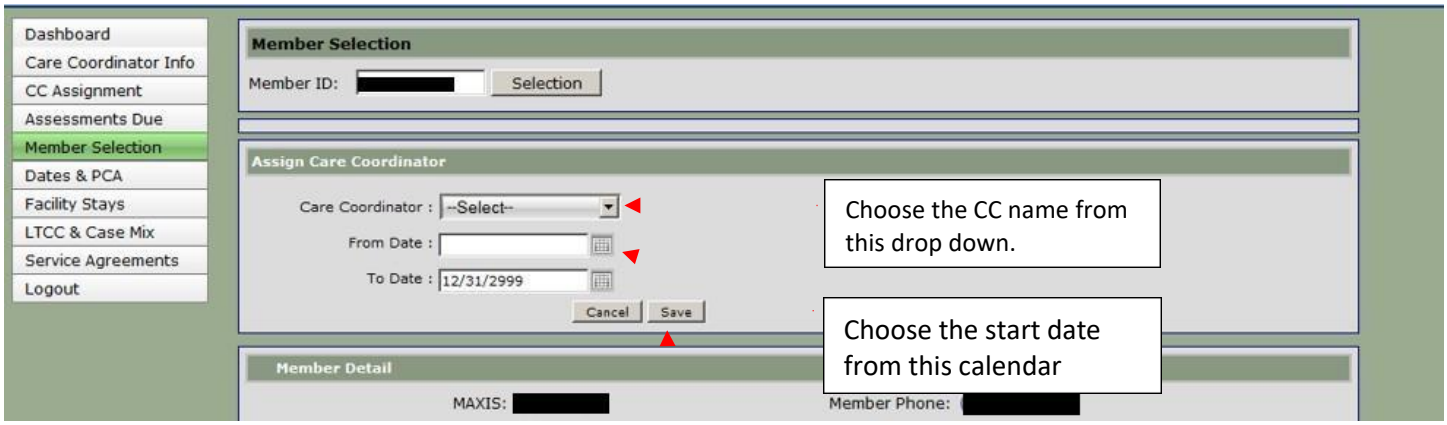
You can also assign a Care Coordinator by doing a member search. To search for a member, click on the Member Selection tab on the left in the list:

You will be taken to this screen:

There are two ways to search for a member:

- Type in the member's Bridgeview ID number (8+PMI), drop down will default to MEMBER ID, press "Selection" member data will be displayed
  OR
- Type in the member's Amerigroup (AGP) ID number and change the drop down to AGP ID, press "Selection", member data will be displayed.

You will be taken to this screen, where you may assign or edit the Care Coordinator name and start date of assignment.

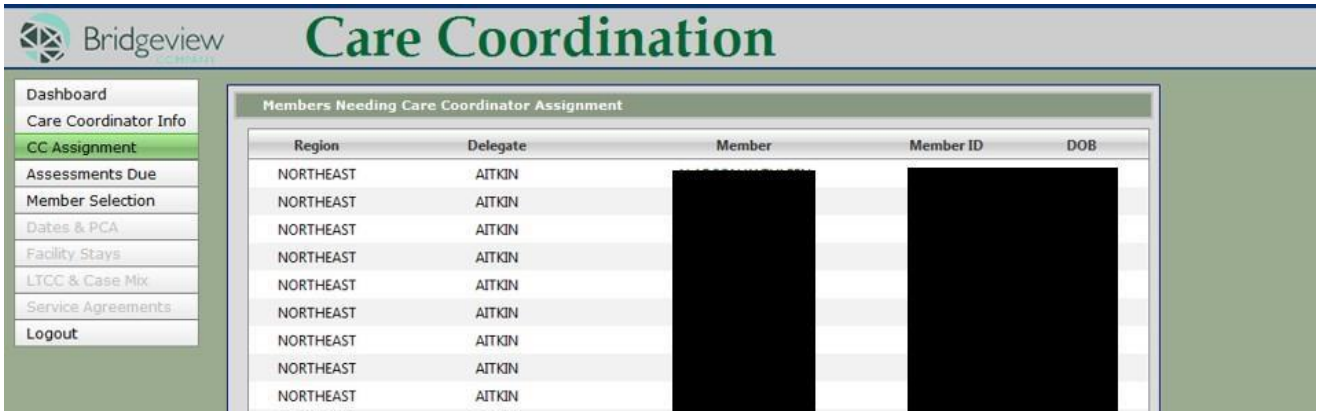


Click save when finished.

If you need to reassign or edit the Care Coordinator, you may select Assign Care Co. or Edit Care Co. from the Member Selection Screen. By choosing Assign Care Co., you will maintain a history of the previously assigned Care Coordinators. If you chose Edit Care Co., your changes will overwrite the current Care Coordinator.

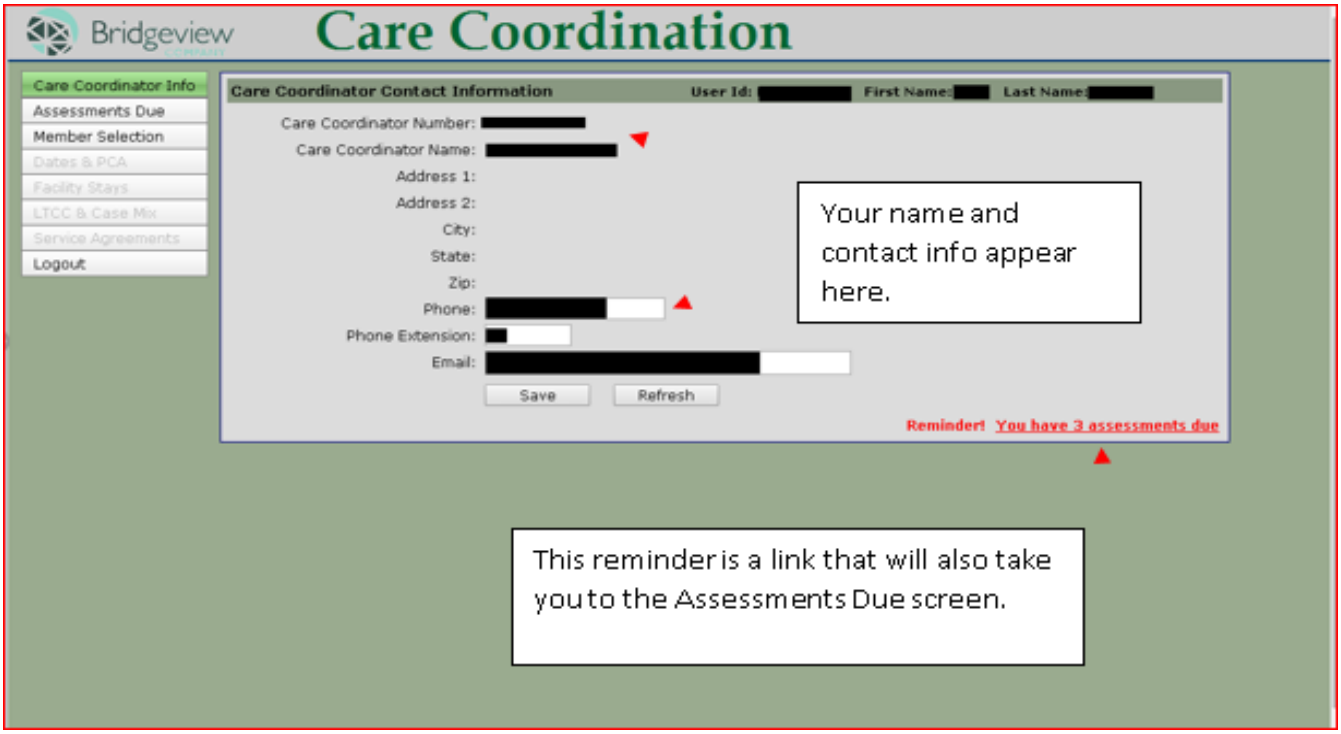
You also have the option to use the CC Assignment tab on the left

Select CC Assignment. You can now click directly on a member's name.



Logging on as a Care Coordinator Role:

Your first screen will look like this:



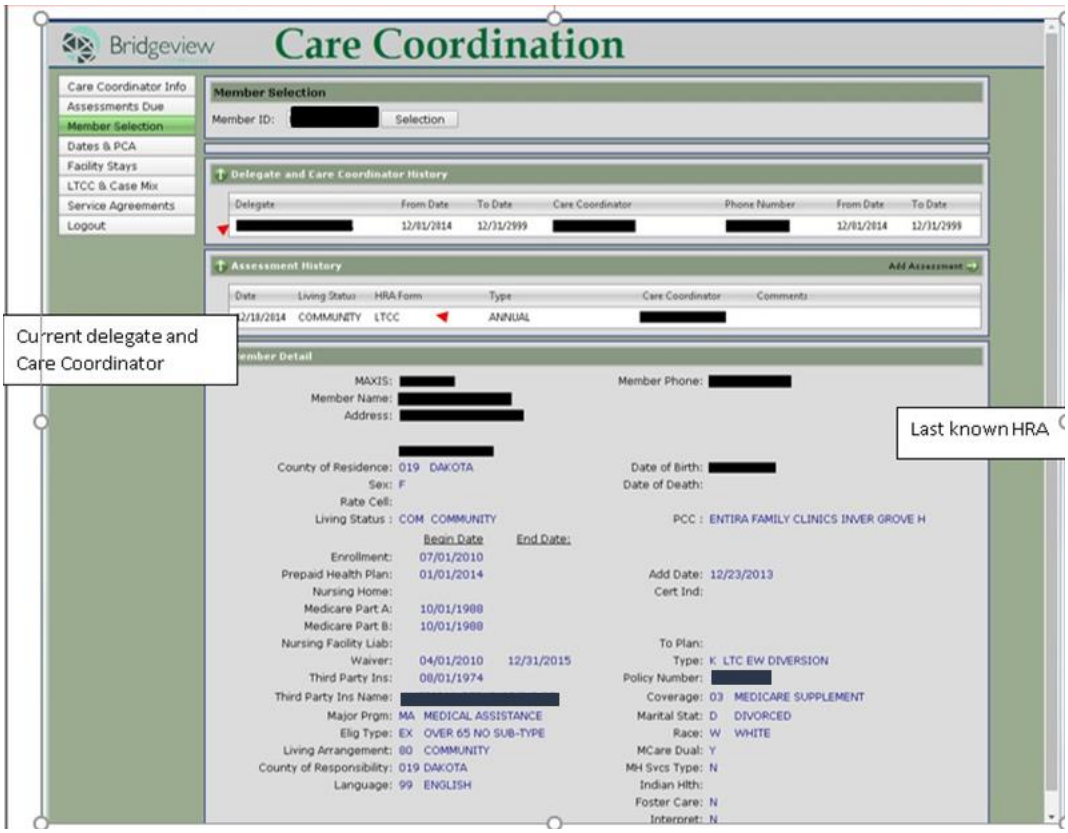
You may navigate using both the tabs in the list on the left, or by following links embedded on the screen.

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

You will be taken to this screen.

There are two ways to search for a member:

- Type in the member's Bridgeview ID number (8+PMI), drop down will default to MEMBER ID, press "Selection" member data will be displayed
  OR
- Type in the member's Amerigroup (AGP) ID number and change the drop down to AGP ID, press "Selection", member data will be displayed.



Health Risk Assessment Entry (Delegate Representative/Support Staff, Care Coordinator roles).

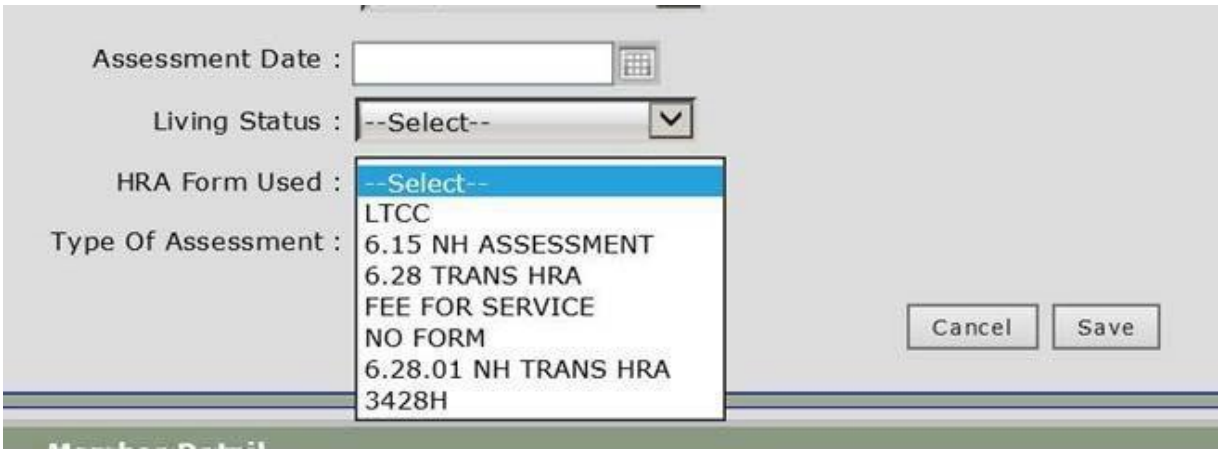
*****Do not enter HRA information until after a Care Coordinator is assigned**.

HRA Definitions (see Care Coordination Guidelines for additional detail)

Living Status 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.

HRA Form Used Drop-Down:



- *LTCC:* Long-Term Care Consultation Form DHS 3428 (or DHS3428A).
- *6.15 Nursing Home Assessment:* Use for members residing in the nursing facility or Intermediate Care Facility (ICF) and the 6.15 NH-ICF Member Annual Assessment-Care Plan Review has been completed.
- *6.28 Transitional HRA:* For newly enrolled members who have had a MnCHOICES assessment, LTCC or 3428H within the past 365 days. CC must have a copy of MnCHOICES, LTCC or 3428H.
- *Fee for Service:* For Transitional HRAs when the MnCHOICES or LTCC assessment that was completed prior to enrollment with Blue Plus. Document the date of the previous assessment by selecting this option following the process outlined below in section: LTCC/MnCHOICES completed prior to enrollment.
- *No Form:* Select No Form for Refusals and Unable to Reach.
- *6.28.01 Nursing Home Transitional HRA for Product Change*: Use for members residing in the nursing home or Intermediate Care Facility (ICF) who have a product change who have a 6.15 NH-ICF Member Annual Assessment-Care Plan Review completed within the past 365 days
- *3428H:* (For telephonic assessments; face-to-face assessment for CW members who choose not to complete an LTCC; and assessments for members on another waiver*)*

Type of Assessment Drop-Down:

- *Annual:* Annual assessment or reassessment
- *Initial:* Initial assessment after enrollment with Blue Plus. Can also be used when entering initial FFS assessment.
- *Significant Health Change:* Use when the member requires a reassessment due to a significant change.
- *Refusal:* Member refuses HRA.
- *Product Change (MSC+ to MSHO):* Member switches from MSC+ to MSHO.
- *Health Plan Change (Non-BP to BP):* Member is transferring from another

health plan. Choose health plan change to enter the initial Blue Plus HRA.

- *Unable to Reach:* Care Coordinator is unable to reach the member.
- *Product Change (MSHO to MSC+):* Member switches from MSHO to MSC+.

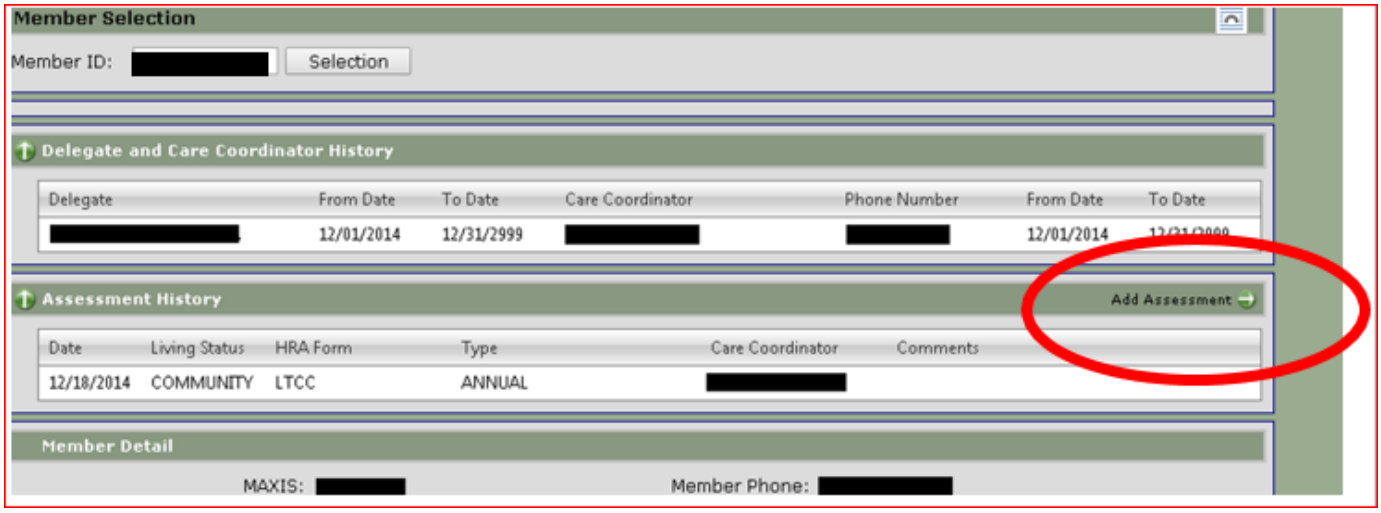
Entering Assessments

You may select Assessments Due from the left tab or follow the reminder link in Red from your main login page. This will bring you to this screen.

Here you can see 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.

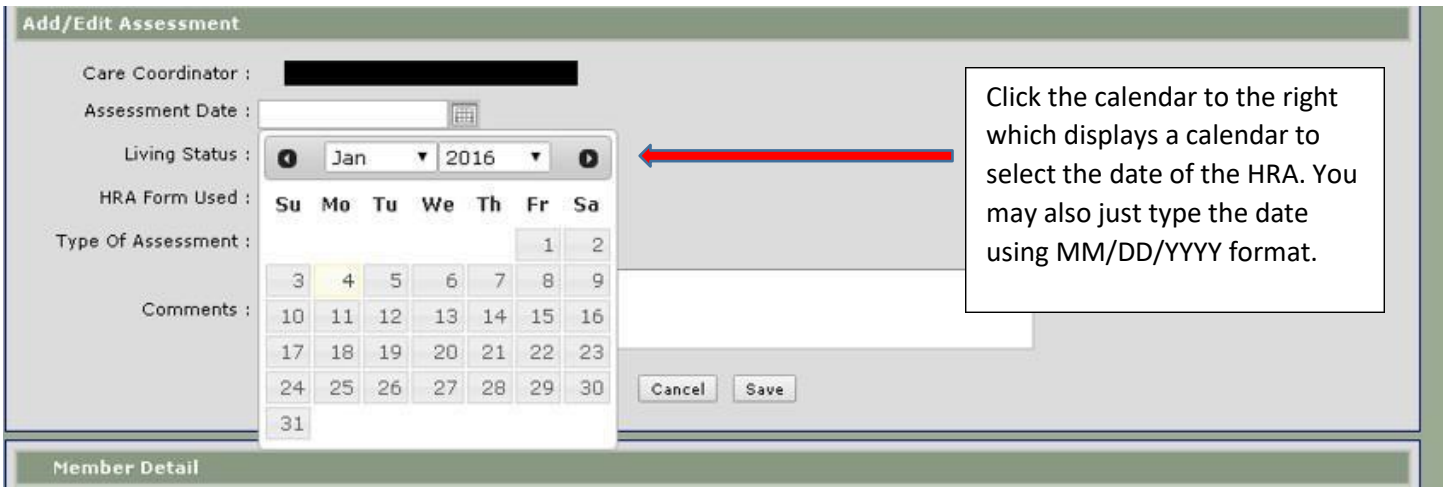
Past Due assessments will be displayed in red. You may click on the member name to be taken to their information, or click "Member Selection" on the left, enter the Bridgeview ID number and be taken to the same information.

To add previous or current HRA information, click the **Add Assessment** button

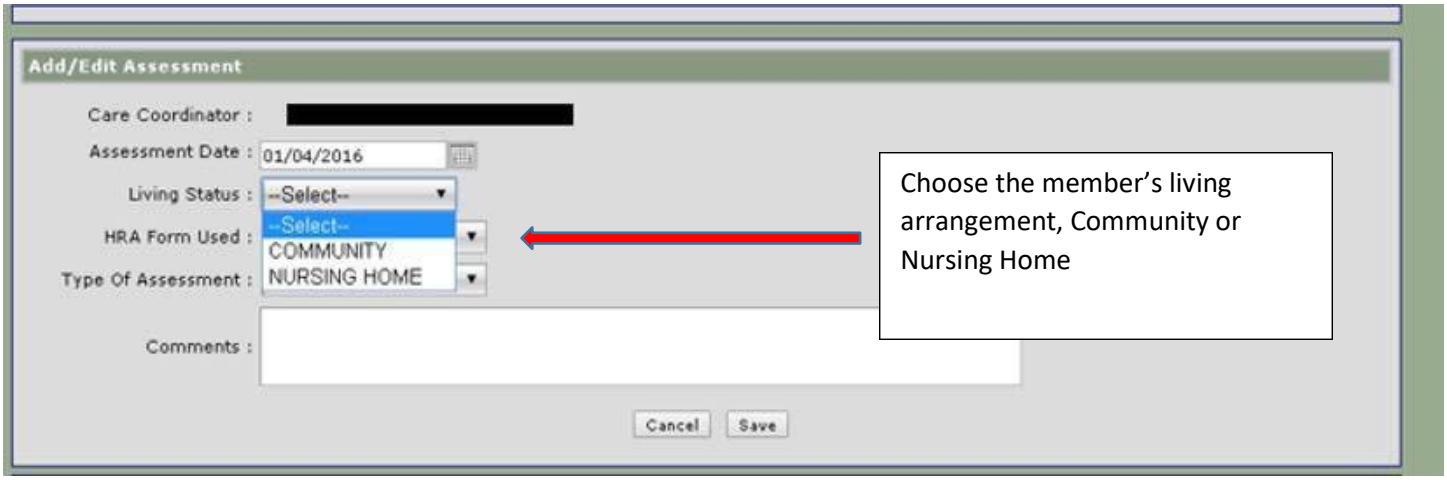


You will be taken to this screen:

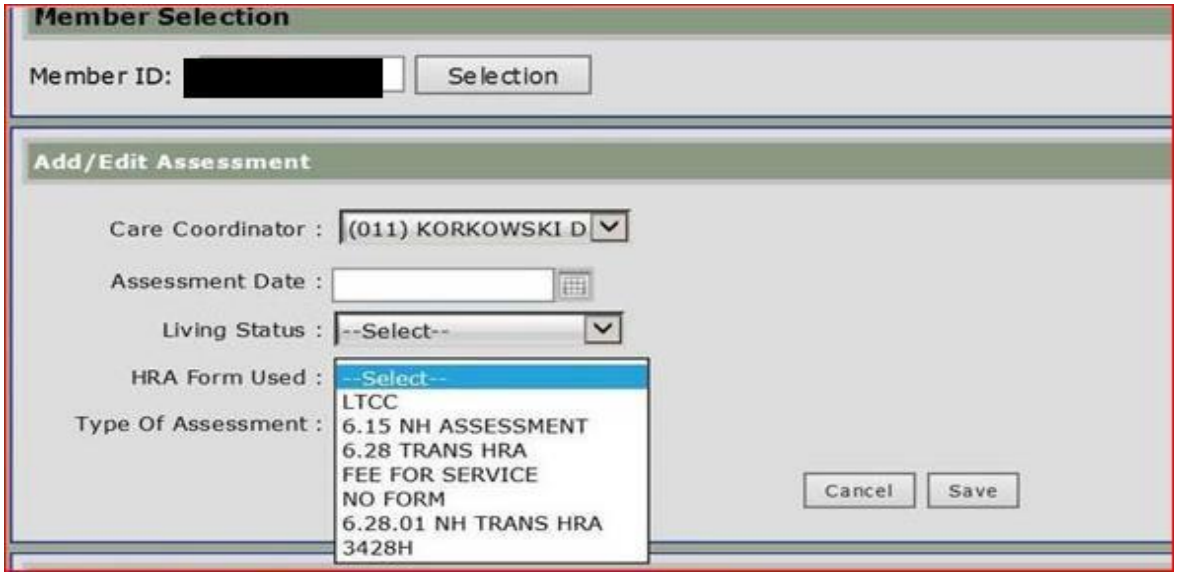
Choose the relevant information for ALL fields:

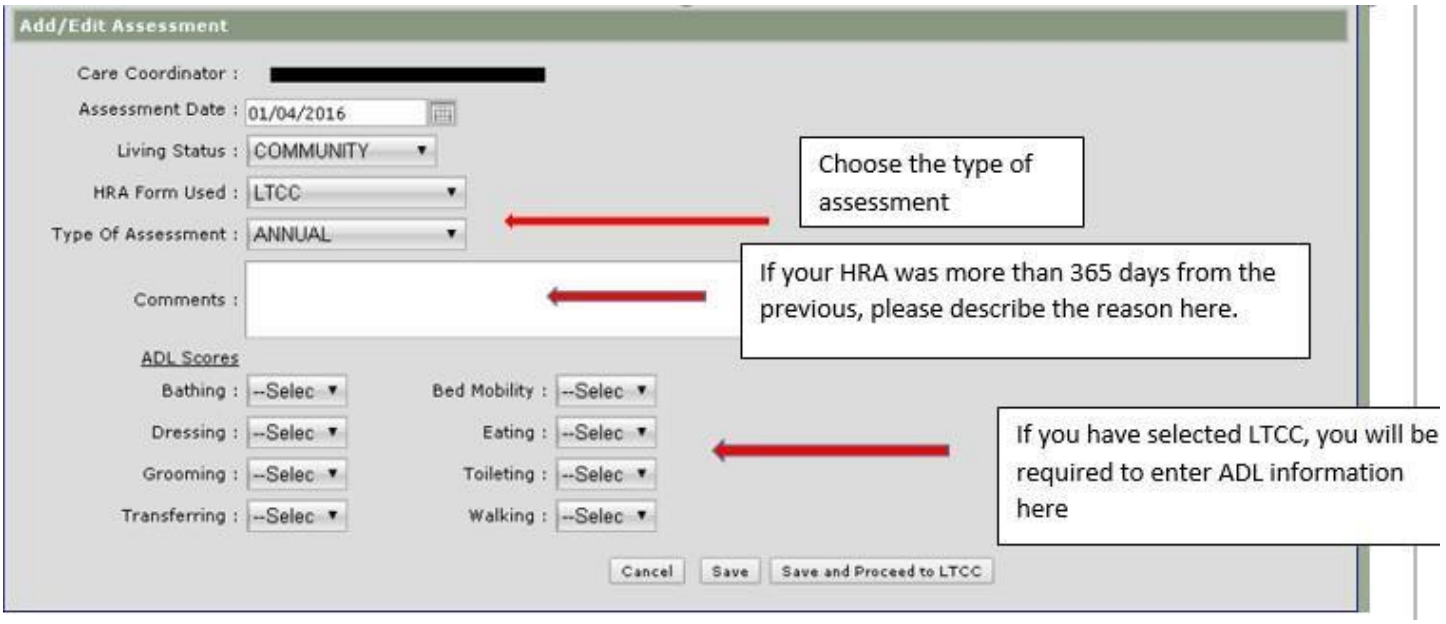


Click the calendar to the right which displays a calendar to select the date of the HRA. You may also just type the date using MM/DD/YYYY format.



Depending on the type of HRA or Living Status, there are different field requirements.



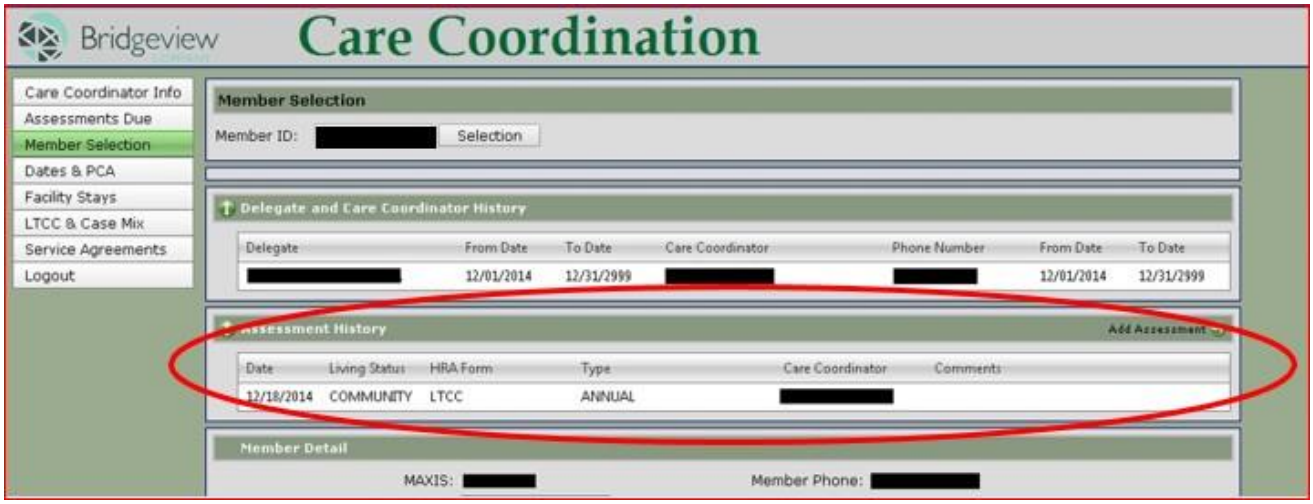


When you have entered all the relevant and required information, click "**Save**"

> **Important:** 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. If you make an error with your HRA data entry, please follow the instructions in the section below, Requesting an Edit or Deletion of an HRA entry.

Or, if this member is on EW and you would like to begin their Service Agreements, you may click "Save and Proceed to LTCC." **LTCC data must be entered in both the Member Selection tab and the LTCC & Case Mix tab for EW members.**

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



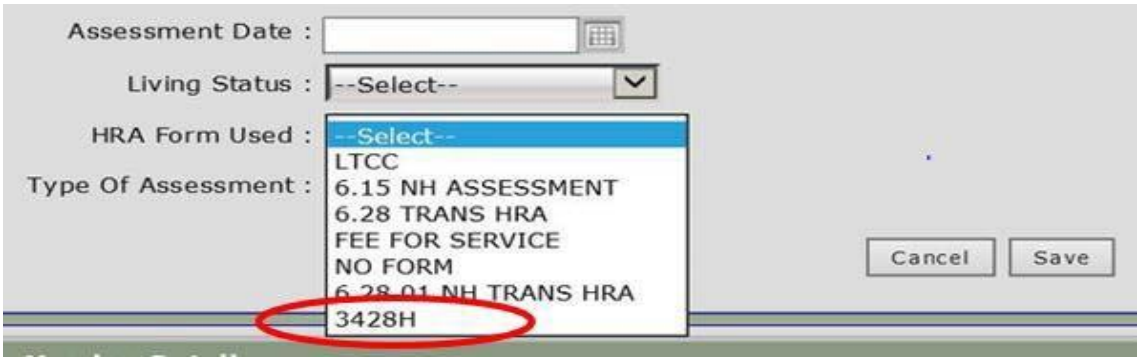
3428H Minnesota Health Risk Assessment Form entry

The 3428H should be used for CW members under the following circumstances:

- For CW members who refused a face-to-face assessment and consent to a telephonic assessment
- assessment for members on non-EW waivers (DD, CAC, CADI, or BI)
- face-to-face assessment for CW members who choose not to complete an LTCC

Reminder: Do not use 3428H if member is determined to be eligible for EW or receiving PCA services.

1. On the Member Selection screen, click on **Add Assessment**.
2. Enter the date that the Care Coordinator completed the 3428H.
3. Enter Living Status: *Community*: Member lives in the community or is planning to return to the community.
4. Enter 3428H as the HRA Form Used.
5. Enter Type of Assessment:
    - *Annual:* Annual assessment or reassessment *or*
    - *Initial:* Initial assessment after enrollment with Blue Plus.



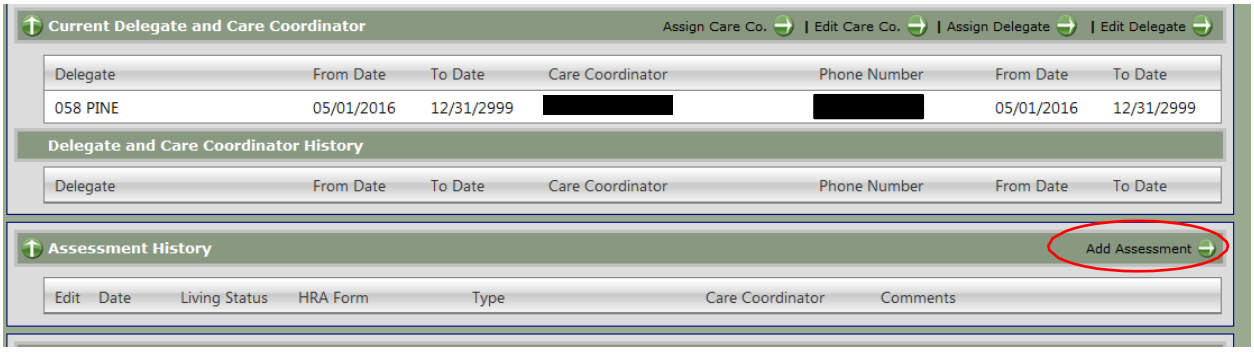
6. Click **Save**

Transitional HRA entries

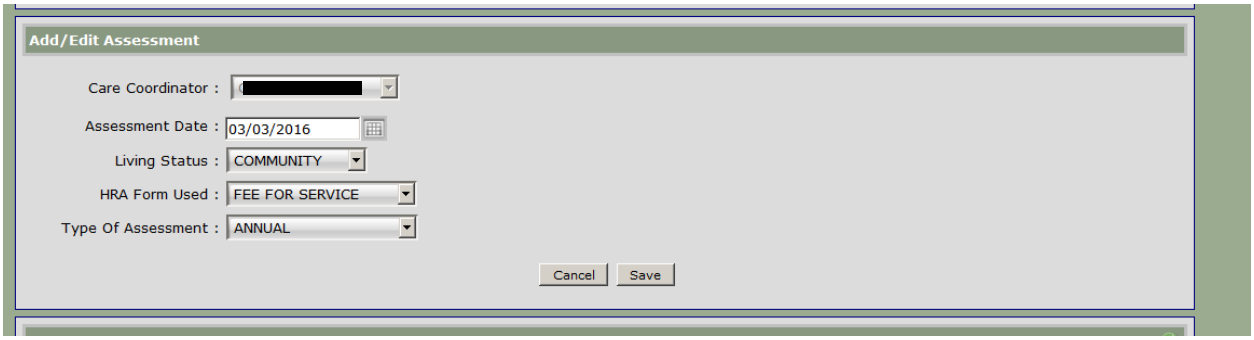
LTCC/MnCHOICES completed prior to enrollment

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. When you conduct a Transitional HRA, you must 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.

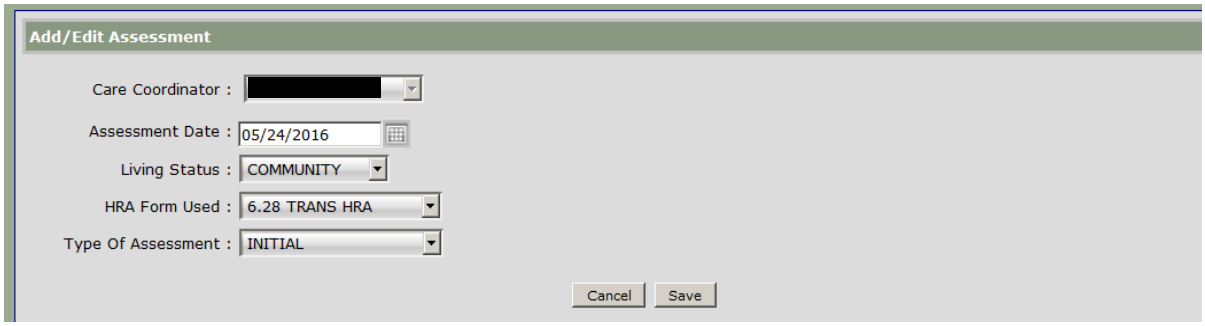
1. On the Member Selection screen, click on **Add Assessment**



2. 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 box. Select FEE FOR SERVICE even if the assessment was completed by another health plan.
5. When all fields are completed, click **Save**.

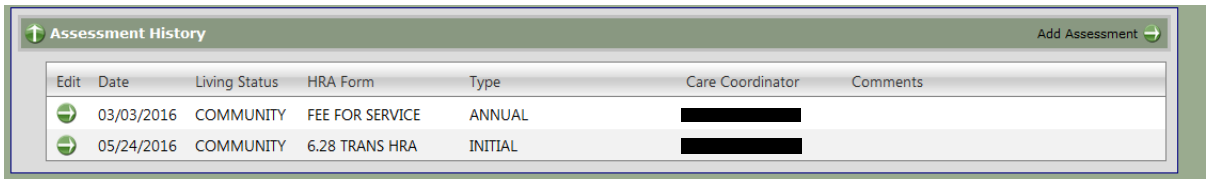


1. Choose **Add Assessment** again from the Member selection screen. This time, you will enter the Transitional HRA you completed after the member's enrollment into Blue Plus.
2. Enter the date you completed the Transitional HRA.
3. Enter Living Status as Community
4. Choose 6.28 TRANS HRA from the drop box.
5. Select INITIAL.
6. Then click **Save**.



The Assessment History shows both assessments for this member, and the next face-to- face assessment will correctly trigger 365 days from the previous face-to-

face assessment (LTCC or MnCHOICES assessment).



Transitional HRA for Product Changes

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 an LTCC or 3428H completed within the last 365 days.

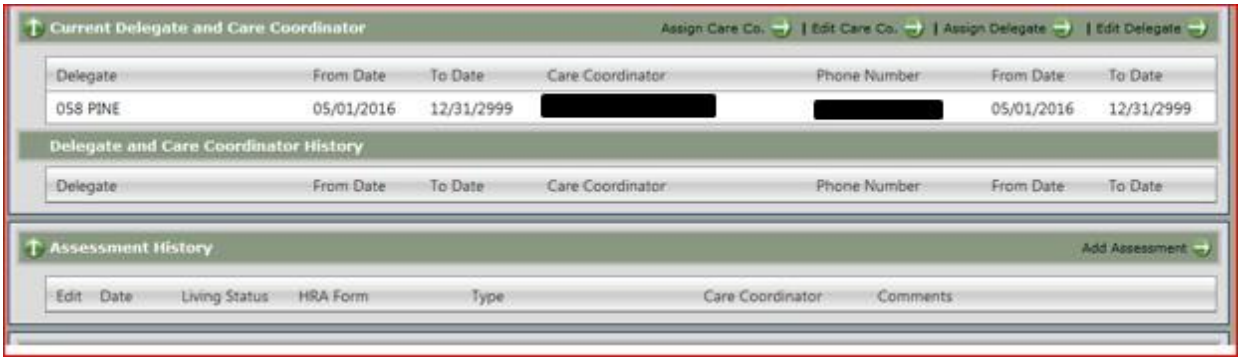
1. Choose **Add Assessment** from the Member selection screen.
2. Assessment Date: Enter the date you completed the Transitional HRA.
3. Living Status: Enter Community
4. HRA Form Used: Choose 6.28 TRANS HRA from the drop box.
5. Type of Assessment: select Product Change (MSC+ to MSHO or MSHO to MSC+)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

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

Transitional HRA for Nursing Home/ICF Members

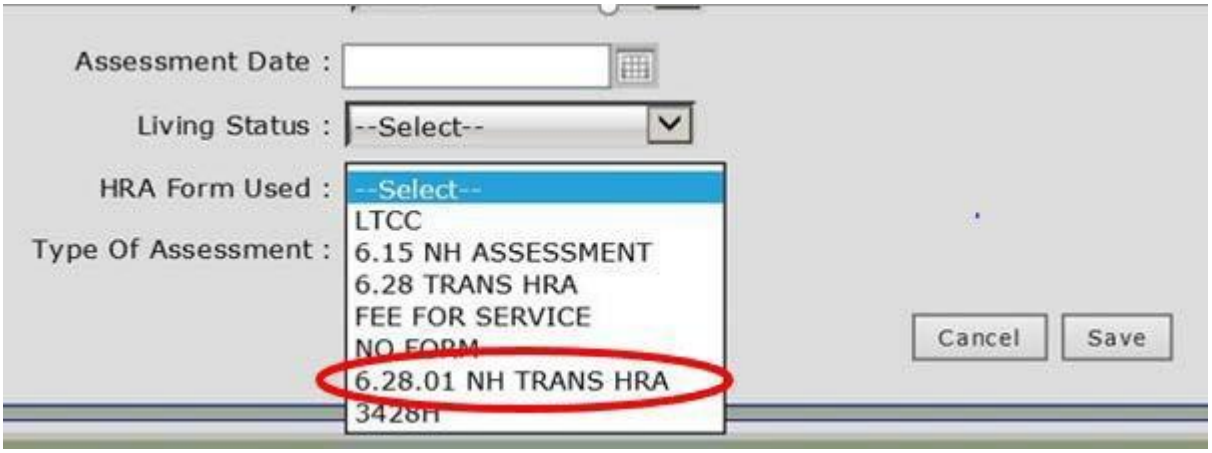
The 6.28.01 Nursing Home Transitional HRA for Product Change may be used for members residing in the nursing home/ICF who have a product change who have a 6.15 NH-ICF Member Annual Assessment-Care Plan Review completed within the past 365 days.

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



2. Assessment Date: Enter the date the Transitional HRA 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 MSHO to MSC+)



6. Click **Save**

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

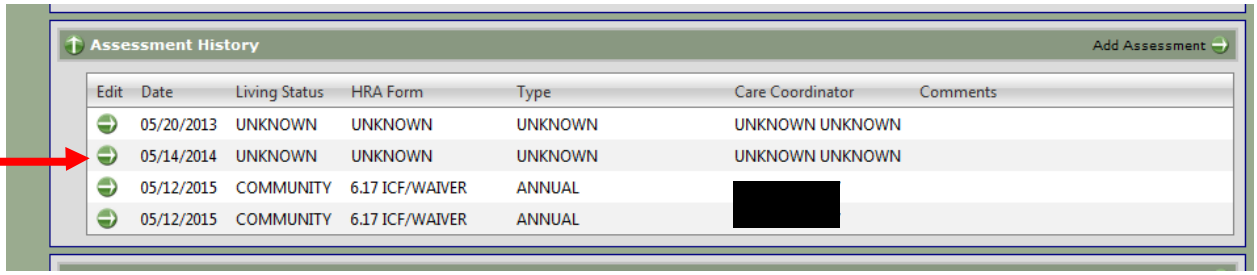
Entering Assessments for Members that have been Transferred

The previous delegate can enter HRAs for members who have been transferred for up to 90 days. Enter the member's Bridgeview ID number in the Member Selection box and click on Add Assessment.

Requesting an Edit or Deletion of an HRA entry in the event of errors

As a reminder, 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.

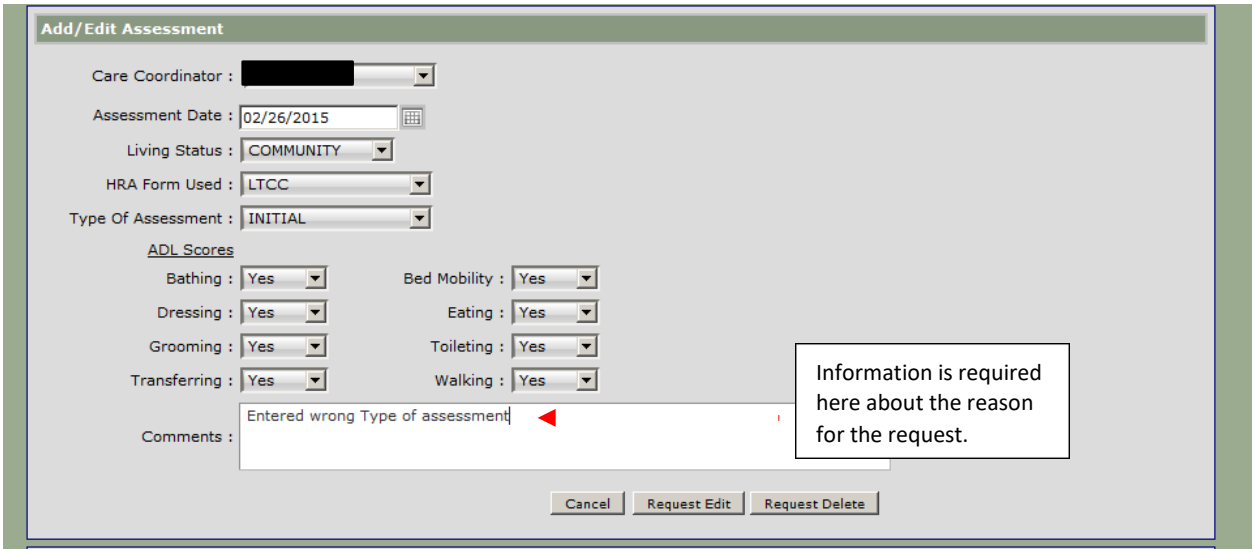
1. All roles have access to request an Edit, or request Deletion of an HRA entered in error.
2. From the Member Screen in the Assessment History section, find the green Edit button to the left of the HRA you wish to Edit or Delete and click on it.



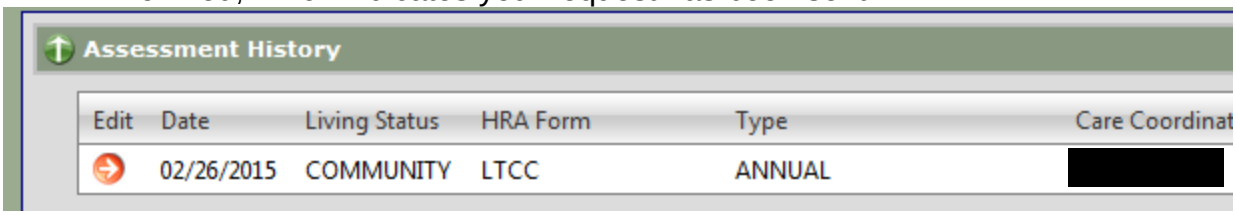
3. This will take you to a screen where you may edit any of the fields previously saved. Make the corrections using the drop boxes in the field(s) you wish to change.

4. You must enter information into the Comments box about why you are requesting an edit.

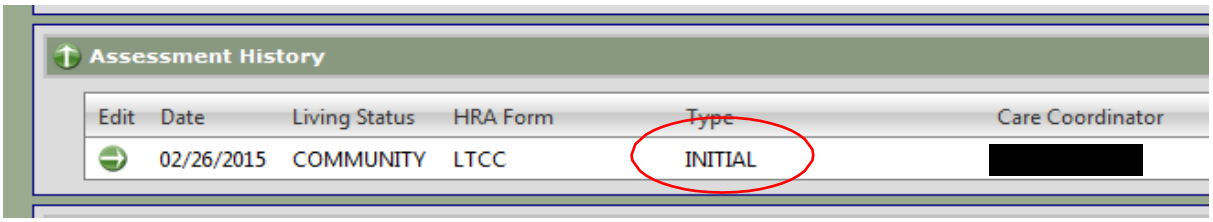
5. When you have finished making your corrections, click **Request Edit** or **Request Delete** depending on your intended action.g



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



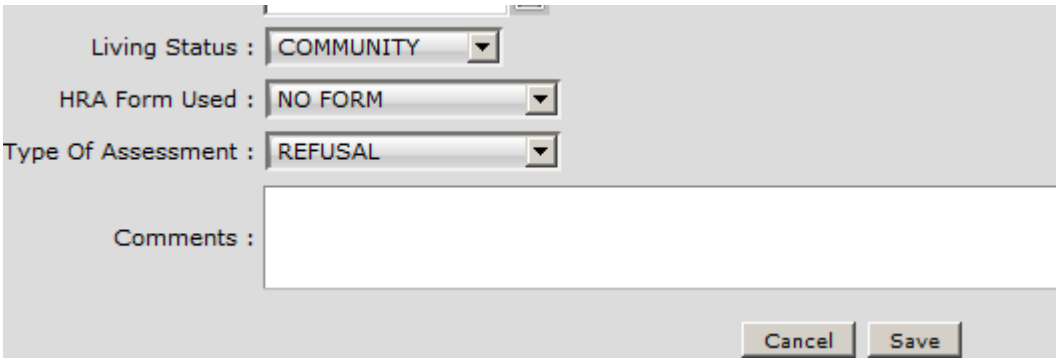
7. Upon approval and processing by Blue Plus, the Edit button will return to green, and any approved changes will be made, or the assessment will be deleted as appropriate.



Community Well Refusals and Unable to Reach

1. CW **Refusals**

If a Community Well member *refuses* a face-to-face and telephonic assessment (3428H), choose **No Form and Refusal**, then click Save.



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

2. CW Unable to Reach

If you have been *unable to reach* the member, Choose HRA Form Used: **No Form** and **Unable to Reach**. Proceed with entering the required attempted outreach contacts. You must match the "Assessment Date" to the date you sent the Unable to Reach letter, as this was your final attempt at this assessment.

Important tips for Unable to Reach:

- Follow-up contacts need to be started with plenty of time to accommodate 3 attempts and a letter as the final contact attempt (total of 4 attempts) before the initial or 365- day deadline.
- If applicable, CCs should be reaching out to other contacts to obtain a working phone number. You may document those dates in Bridgeview as contactattempts.
- You may enter the same date in BV if your attempts occurred on the samedate.
- Attempts may be via phone, letter oremail.
- The date of the Unable to Contact Letter should be the same date entered in BV and should be the same date as the activity date and effective date for the Refusal SD in MMIS.

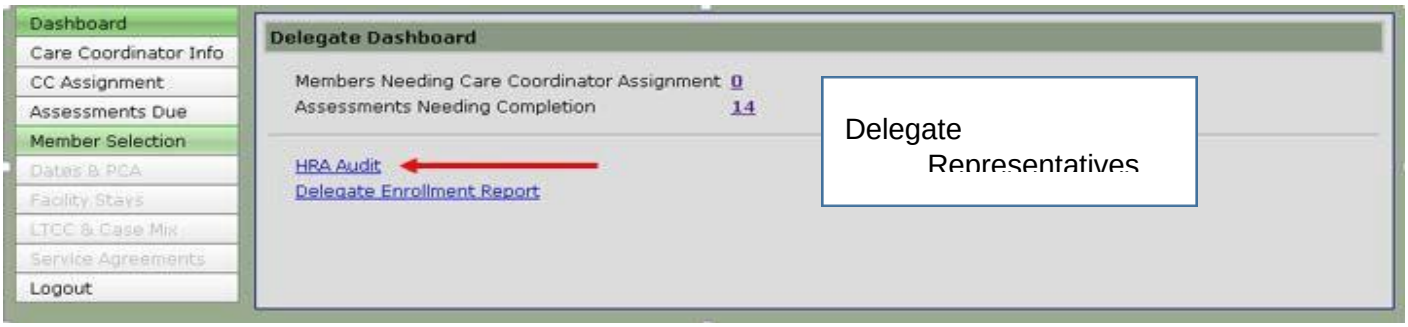
CC must indicate the 3 unsuccessful contact attempts in addition to the date the letter was sent (total of 4 attempts). Assessment date must match the date of the Unable to Reach Letter.

Health Risk Assessment (HRA) Audit Process

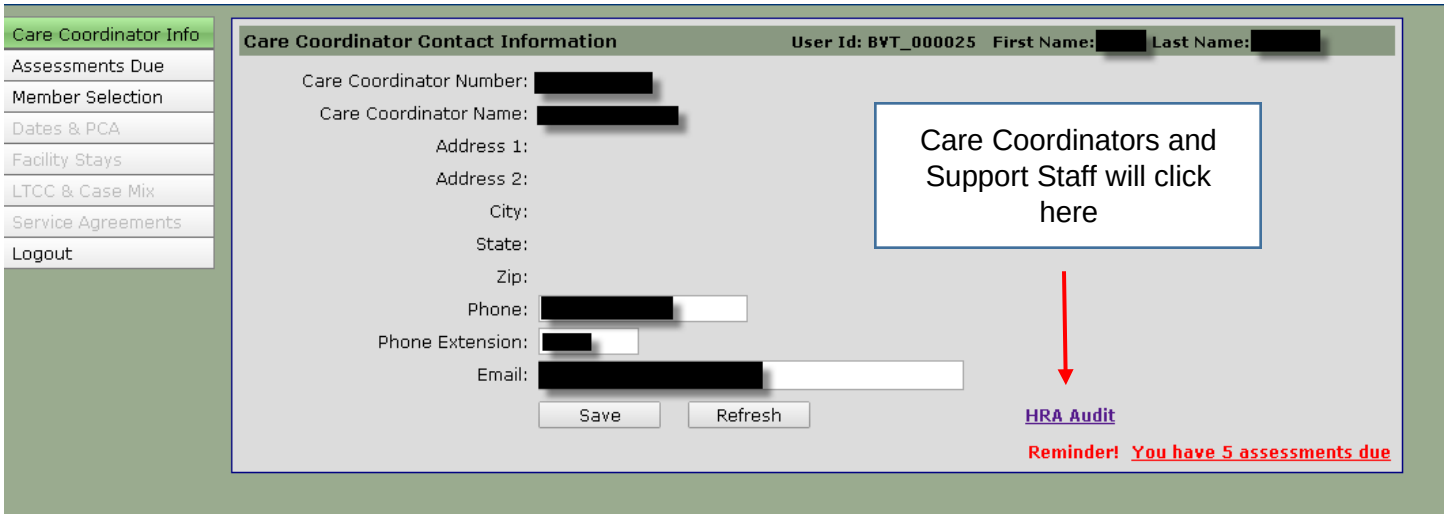
HRAs are audited on a regular basis to ensure accuracy of entry into the Bridgeview system. The date entered into Bridgeview **must be** the date the member assessment was completed or the date the Unable to Contact Letter was sent. HRA information in Bridgeview are compared to the assessment documentation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

Delegates will receive an email from Partner Relations with log in instructions on how to look for which members' assessments have been selected for audit. Follow the email instructions to log into Bridgeview and view the members selected for audit.

Delegate Representative/Support Staff will click on the HRA Audit link to take you to the HRA Audit Dashboard.

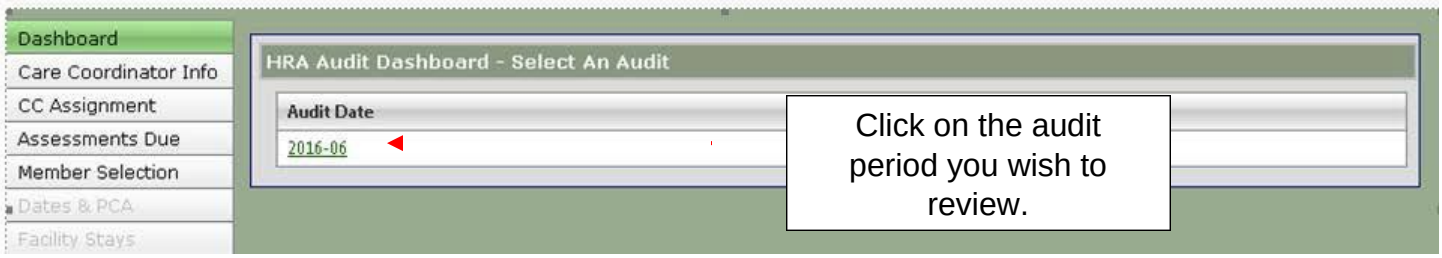


Support Staff must first select the Care Coordinator and then click on the HRA Audit Link. Care Coordinators will see the HRA Audit link display on the Care

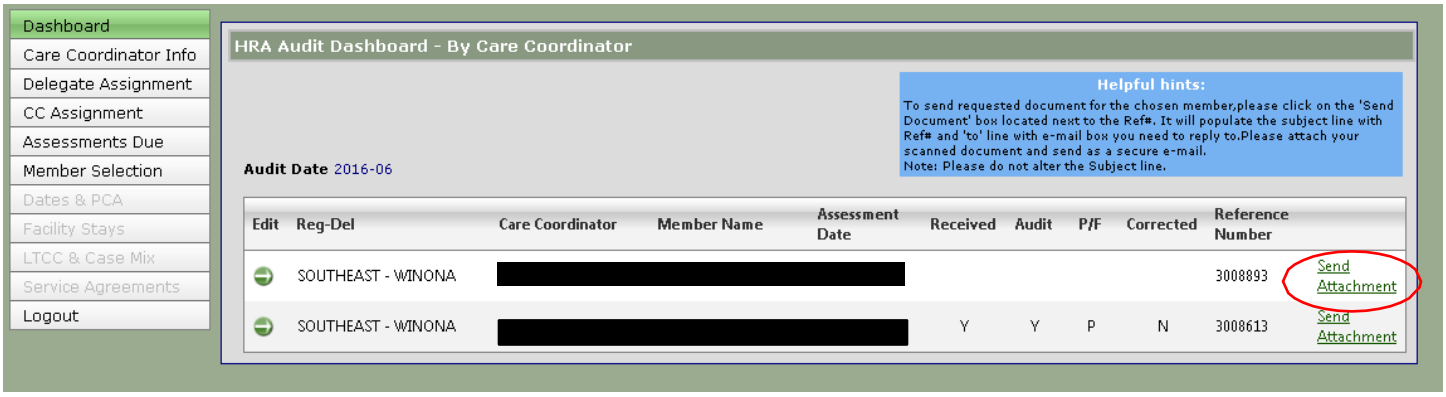


Coordinator Info screen.

The HRA Audit Dashboard will then be displayed.



You will then be taken to this screen. Select the Send Attachment link for each identified member.



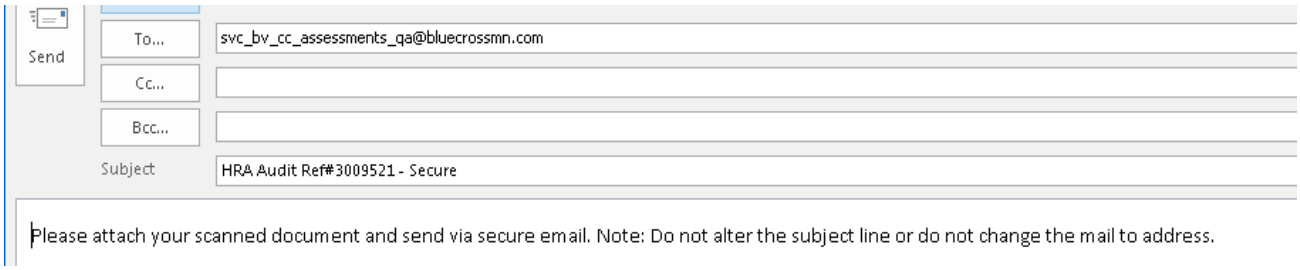
When you click on **Send Attachment** in Bridgeview, your email system will open a new email for you to attach the documentation. Required documentation for each member(s) is one of the applicable documents outlined below:

- First page of the completed LTCC
- First page of the completed 6.15 NH Assessment
- First page of the completed 6.28 Transitional HRA

- Unable to Contact Letter and case notes documenting 3 additional contact attempts
- Copy of case notes documenting the refusal
- Copy of the completed 3428H

IMPORTANT: Our automated system can only accept one attachment via email. Attachments must be submitted in PDF format. If you are providing more than one document per member, you must combine them into one PDF document before attaching them to the email. For example, if you are supplying contact notes and an Unable to Contact Letter, combine them as one PDF and attach to the email.

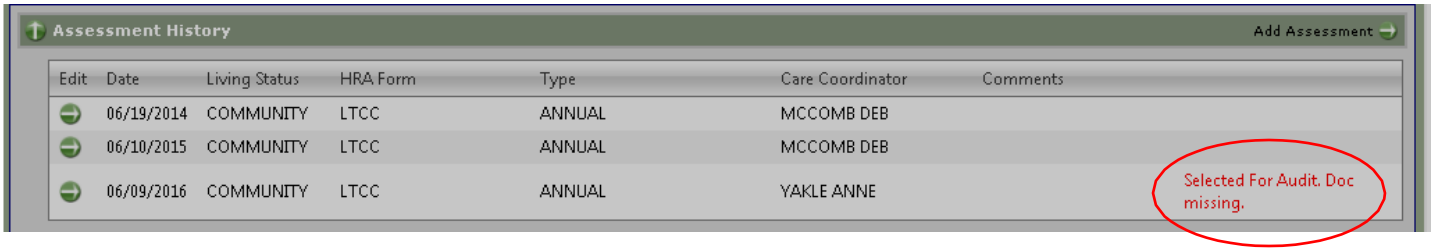
Attach the requested documentation to the email and hit send. Please do NOT change the subject line or the "TO" address field on the email as these have been prepopulated with the correct information. Do not alter the body of the email, this includes affixing a signature.



You have up to 7 days to submit the requested documentation. When submitting required documentation; do not change or add information in the email "To" or "Subject" field. Do not affix a signature to the email.

When the delegate has submitted all the required documentation for all members selected and the audit has been performed, you will receive an email from Partner Relations with the results of the audit.

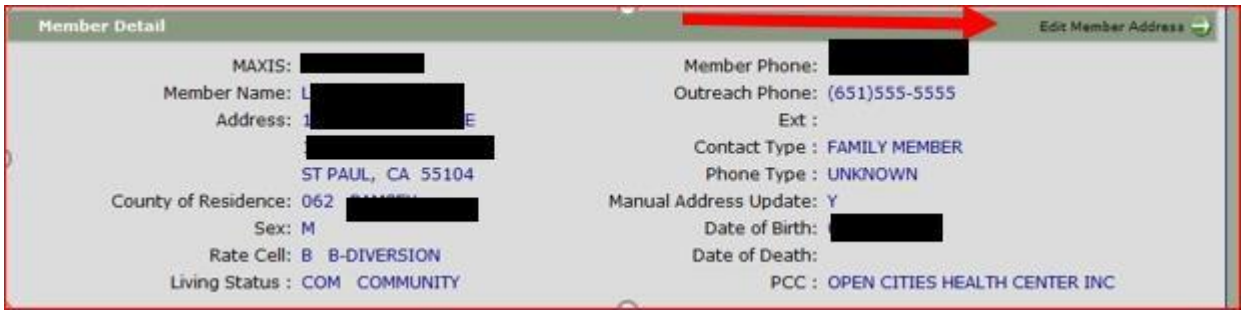
The HRA audit information will also display on the Member Selection screen in the Assessment History section for each member selected for audit.



Once the audit documentation has been received, the message will be updated to reflect this.

Updating the Member Information (Delegate Representative/ Support Staff, Care Coordinator roles)

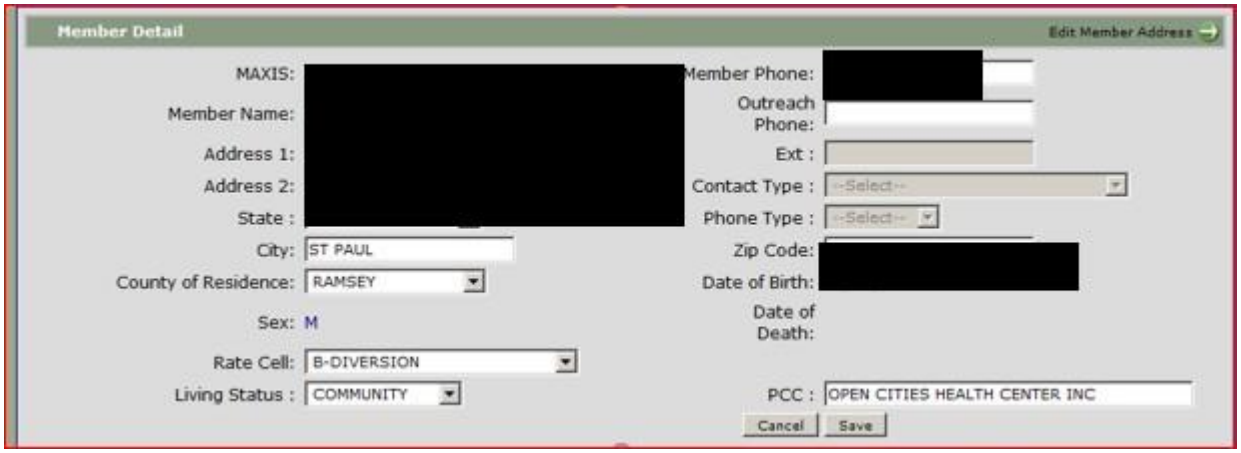
All roles have access to update member information from the Member Selection tab. Select Edit Member Address.



Type new information in the applicable field and click on **Save**.

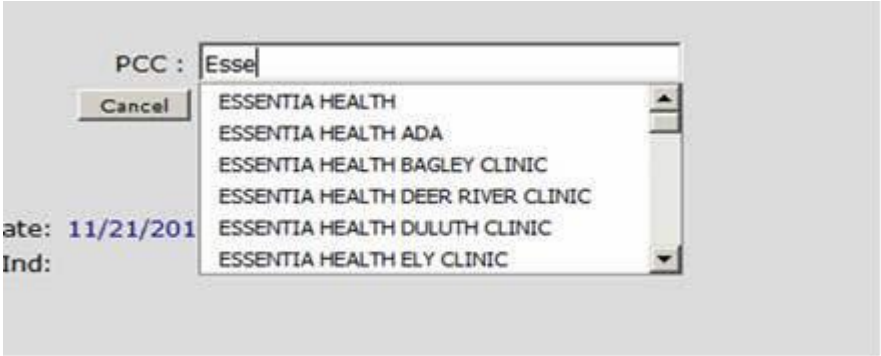
Fields that can be updated include:

- ✓ Member Address, City, State and Zip Code
- ✓ Member Phone
- ✓ Outreach Phone, Ext, Contact Type, Phone Type
- ✓ County of Residence
- ✓ Rate Cell
- ✓ Living Status
- ✓ PCC

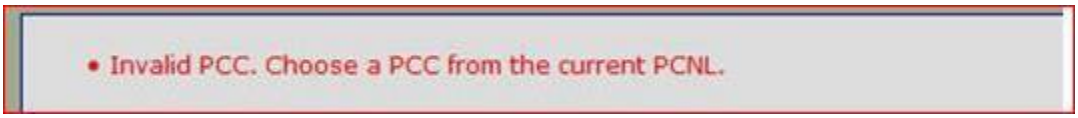


PCC Changes:

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



If you do not choose a clinic from one of the listed drop-down options, you will get the error below. You must choose a clinic from the list. If the member's PCC is not listed in Bridgeview, it may not be in our Primary Care Network. Consult with your Partner Relations Consultant if you have any questions.

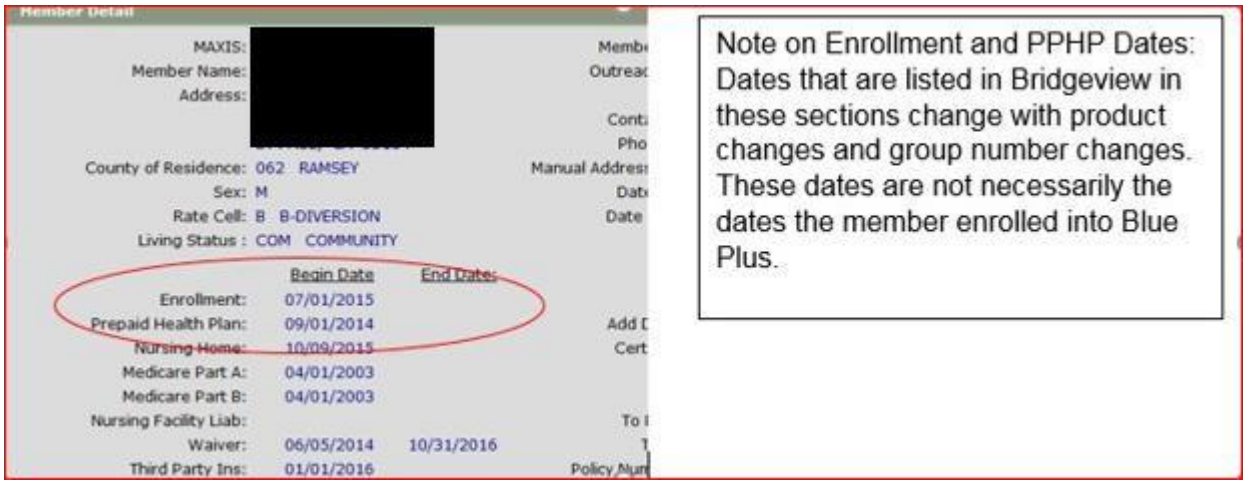


***Important Reminder*:** If the PCC change results in a change in Care Coordination delegation, you are required to follow the notification and transfer processes outlined in the Guidelines; for Blue Plus to Blue Plus transfers send form 6.08 Transfer in Care Coordination Delegation directly to the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

Reminders:

- 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.
- Manual changes made to the member information in Bridgeview are effective for only 90 days. In the meantime, you must update the financial worker to permanently change the member's information.
- Delegates are still required to follow the Transfers of Care Coordination processes outlined in the Blue Plus Care Coordination Guidelines when the member will be transferring to a new delegate.
- 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.

- Select PCC changes may trigger delegate reassignment. Refer to Transfers of Care Coordination to Another Blue Plus Delegate in the Community and Nursing Home Care Coordination Guidelines for a list of affected PCC's. If PCC is changed prior to transfer effective date, member will appear on the receiving delegates enrollment report early. Contact your Partner Relations Consultant if this occurs.
- Click Save when making any changes.
- Do not use the back arrow on your internet browser.
- Select **Save** or **Cancel**.



Navigating to the Elderly Waiver Service Agreement Tool for members on EW (Delegate Representative/Support Staff, Care Coordinator roles)

You can navigate to the Elderly Waiver Service Agreement Web Tool for members on EW without having to log out. See Navigating the Service Agreement Web Tool section for more details.

Performance Reports

Performance reports will be generated and sent to delegates on a quarterly and annual basis. These reports include both MSHO and MSC+ members and are meant to help delegates monitor assessment completion timeliness and Bridgeview data entry. Delegates will receive an email from Partner Relations, including their current report and instructions on how to read the report.

- The top portion of the report shows the overall performance of timely completion of HRAs.

- The lower portion of the report provides detail at a member level of HRAs that have been entered in Bridgeview or not.

Review the report and identify areas where you need to act. Some common action items are:

- If the Care Coordinator fields are blank, log into Bridgeview and assign members to individual Care Coordinators.
- If assessment dates are missing, log into Bridgeview and enter the HRA completion dates and required fields.
- If you see a field with FLG, this means there was no HRA date entered in Bridgeview and the member has been enrolled with Blue Plus for more than a year. Please enter the appropriate HRA data on these members in Bridgeview.
- If you see a field with NO, please review the HRA date input in Bridgeview against the assessment form to ensure the correct date was entered in Bridgeview.
- Please note, any reported refusals will be flagged as a NO in the compliance portion of this report. You will also see a YES flag in the refusal or unable to reach column. These will always be flagged as NO. CMS does not allow us to count a refusal as a completed assessment. No action is required in these cases.

There is no requirement to report back to Partner Relations on the action you take on these reports unless you have questions or are reporting a discrepancy or another issue.

Navigating the Elderly Waiver Service Agreement Web Tool (EW and select MSHO Supplemental Benefits only)

Once you have logged into the Bridgeview Company Web Tool, care coordinators may navigate through the following tabs in the Bridgeview Web Tool related to Elderly Waiver Service Agreements.

- Member Selection
- Dates and PCA
- Facility Stays
- LTCC & Case Mix
- Service Agreements

Member Selection

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

If you encounter an error message, please check MN-ITS to verify coverage under Blue Plus. If the member should have Blue Plus coverage, please contact your Partner

Relations Consultant. You may also verify coverage with Blue Plus by contacting SecureBlue.Enrollment@bluecrossmn.com

If the member is valid, you will see Member Detail information that has been sent to Blue Plus by DHS. The care coordinator can change some Member Detail fields in the Bridgeview Web Tool. Please refer to **Updating the Member Information (Delegate Representative/Support Staff, Care Coordinator roles)** for more information. If 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.

The Member Detail information is sent by DHS to Blue Plus once per month, so there may be a delay that does not allow the most current information to be displayed. This informational screen should not

have an impact on your ability to enter a service agreement unless it shows the member is not enrolled in Blue Plus or has lost eligibility under the waiver program.

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. The web tool service agreement entry system is not designed to be an eligibility verification system. The web tool entry system was designed to accommodate the ability to enter service agreements for disenrolled members because of eligibility reinstatements.

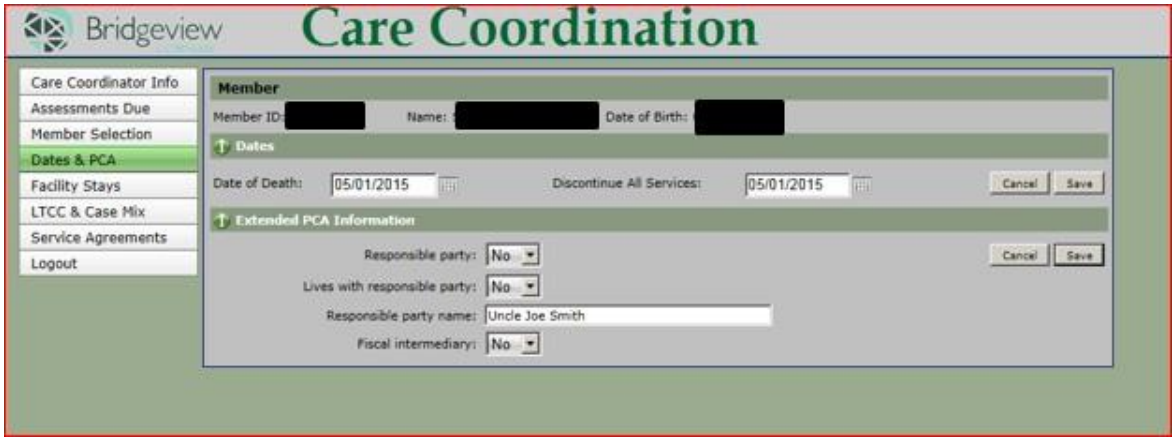
Members with Other Insurance Coverage

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.

Dates and Extended PCA Entry



Enter the following information under the Dates and PCA tab.

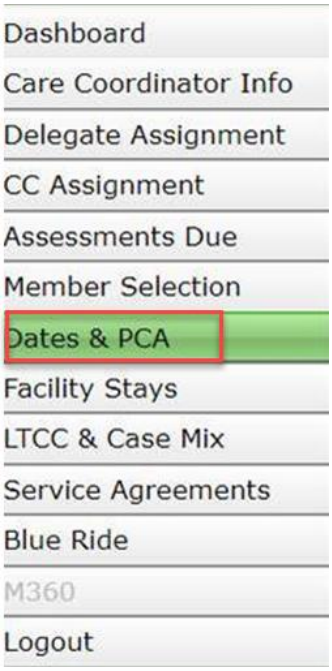
- ✓ Date of Death
- ✓ Discontinue All Services (optional)
- ✓ Extended PCA Information

✓ **Date of Death**

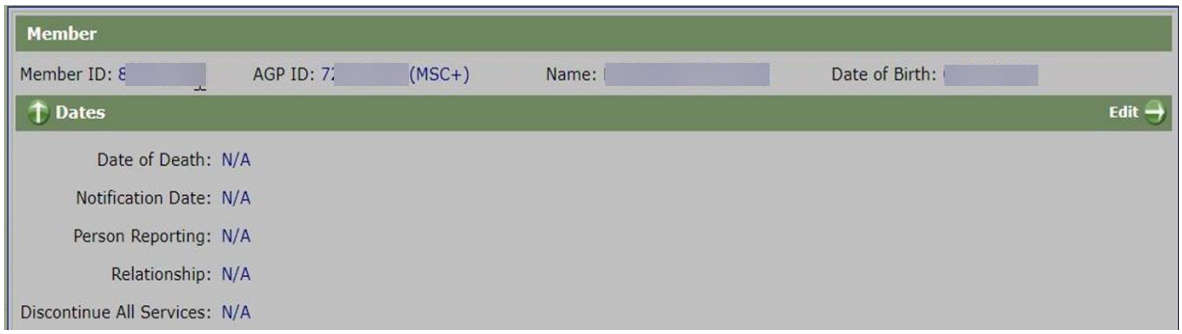
Enter the member's date of death if the member is deceased and the date of death is not populated in the member detail screen. When you enter a date in this field, all

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.

When in Bridgeview Click on "Dates & PCA"



This screen will appear:



Enter :

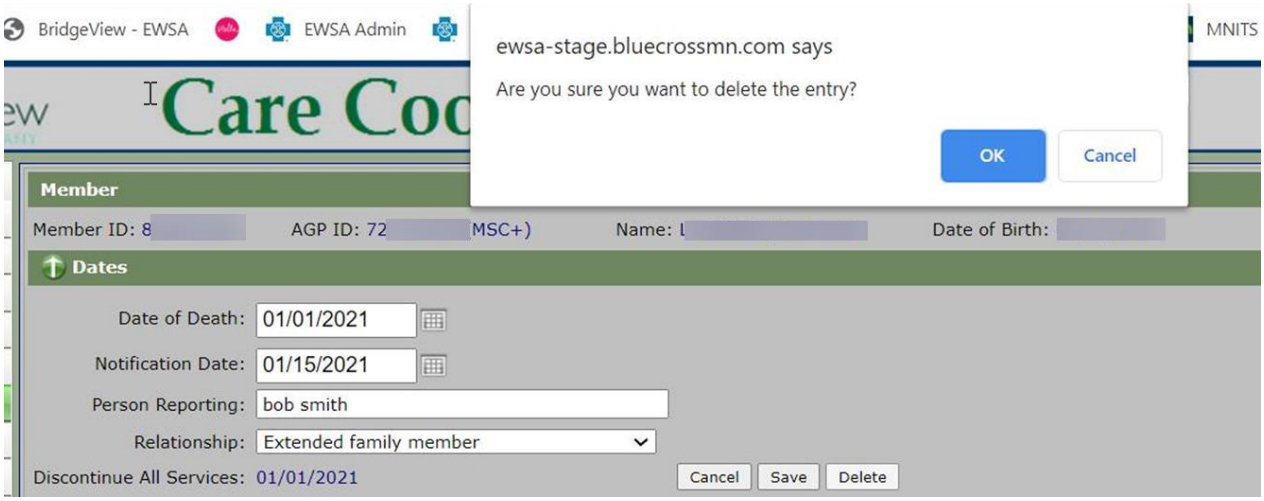
- Date of Death
- Notification date
- Person reporting
- Relationship

- Discontinue all services date

Click **Save**

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 update. You must manually update the "To Date" first for the LTCC/Case Mix with the corrected end date. Then edit the Service Agreements with the corrected end date.



✓ **Discontinue all services (optional)**
You can enter a date in this field to indicate the member is no longer eligible for EW services. You must also go into all line items on the service agreement to terminate services as of this date.

This field should only be used to end authorizations permanently for all providers, but the member is still enrolled on the Blue Plus health plan. An example would be if member lost Waiver Eligibility but remains on Blue Plus medical coverage. *Once this termination field date is entered, you will need to create all new service agreements to re-authorize services.*

You must go into the line items and prorate the amounts allowed in the partial

month of coverage to accommodate the shortened service date span.

✓ **Extended PCA Information**

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

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

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

Facility Stays

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

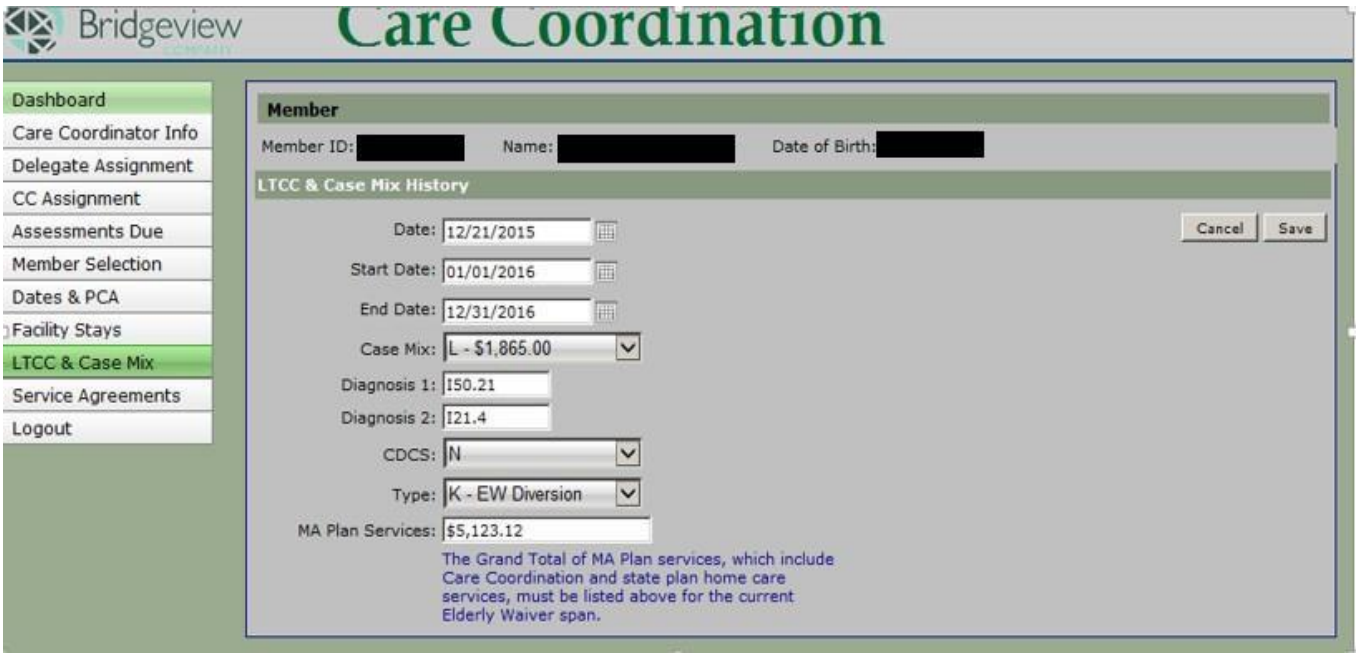
You can select dates from the system calendar to indicate the inpatient hospital or nursing home stay spans for the member. You can enter just the Admit Date if the Discharge Date is unknown, and then later go back in and populate the Discharge Date.

LTCC and Case Mix 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, and Medicaid covered plan services. If you are using the Add or Edit option, you will be required to complete all the fields described in the headings below.

Any information that has been previously received from DHS or a care coordinator for the member will be displayed on the page. However, due to timing issues created by the DHS system calendar cut off dates, not all information may be up to date. You will see a blank screen if there has not been information populated from another source. You will then need to select the Add button to enter the information.

Click on the Add button to add a new LTCC and Case Mix entry or click on the Edit arrow button to edit an existing entry. Note: you must first enter the HRA data prior to entering a new corresponding LTCC and Case Mix. The LTCC and Case Mix entry should be completed within 60 days of the assessment date.



The following fields need to be completed in the LTCC & Case Mix section:

- ✓ Date
- ✓ Start Date
- ✓ End Date
- ✓ Type
- ✓ Case Mix
- ✓ CDCS
- ✓ Diagnosis
- ✓ MA Plan Services

Date

Enter the current date in this field.

LTCC Start and End Date Entry

The LTCC Start and End Dates fields must be entered. The start date should be the same as the MMIS effective date for the LTCC assessment.

For members new to Blue Plus who are on Elderly Waiver at the time of enrollment to Blue Plus, the LTCC Start Date must be the Blue Plus enrollment date (not the fee for service EW start date).

The LTCC End Date should match the end of the member's EW waiver span.

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 may want to review the Service Agreement entries before making a change to the LTCC & Case Mix date spans. If the date spans don't align, you may need to close a service agreement line item(s) by editing the line to have zero units and then create a new line item after you have made the appropriate changes to the member's LTCC & Case Mix date spans.

Type

Enter the correct Agreement Type:

EW Conversion	J
EW Diversion	K

See the Care Coordination Guidelines for more details on Request to Exceed the Case Mix Cap and Conversion rates. These budgets must be verified through a special process before

the service agreement will be allowed in the system as a Case Mix Z. Blue Plus will review the Request to Exceed/Conversion rates. If approved, Blue Plus will notify the care coordinator and Bridgeview the terms of the approval. At that time, you may proceed with entering the LTCC & Case Mix and Service Agreement(s).

Case Mix

The care coordinator must select the Case Mix from the drop-down box. The displayed Monthly Cap is based on the DHS issued Monthly Budget Case Mix Caps currently in effect for the EW program. The selected Case Mix in Bridgeview must match the assessed case mix on the LTCC as well as entry into MMIS.

See the Care Coordination Guidelines for more details on Request to Exceed the Case Mix Cap and Conversion rates. These budgets must be verified through a special process before the service agreement will be allowed in the system as a Case Mix Z. Blue Plus will review the Request to Exceed/Conversion rates. If approved, Blue Plus will notify the care coordinator and Bridgeview the terms of the approval. At that time, you may proceed with entering the LTCC & Case Mix and Service Agreement(s).

Mid-Month Case Mix Changes

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

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

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

Members with Breaks in Elderly Waiver Eligibility

The LTCC & Case Mix example below illustrates that this member has a break in EW coverage. The member is not eligible to receive services under EW from 06/26/2019 through 08/09/2019. The member regains eligibility on 08/10/2019 and is assigned to case mix D at that time.

Agmt	Case	Case	CDCS	MA PLAN	MA PLAN

From Dt	To Dt	Type	Mix	Limit	CDCS	Amt	Diag1	Diag2	SERVICES	MONTHY AMT
01/01/19	06/25/19	K	A	$3,256	N	$ 762	290.10	327.11	$ 6,097.62	$1,016.27
08/10/19	07/31/19	K	D	$4,519	N	$1,472	290.10	327.11	$20,535.50	$1,711.29

In the example above, you would not be able to authorize EW services from 06/26/19 through 08/09/19 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 under EW which can give the member more flexibility and responsibility for directing his/her services and supports. CDCS services have their own case mix caps based on the member's assessed needs.

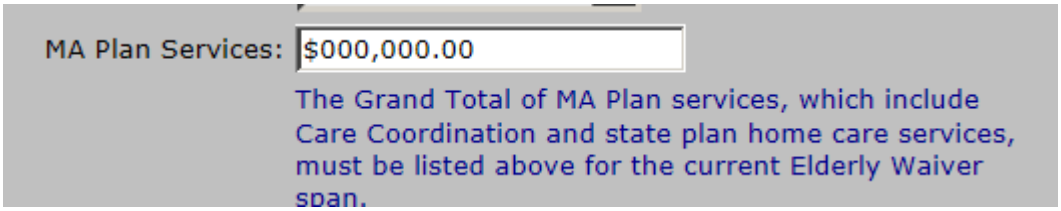
The CDCS field will populate from information found in the member's history if available. The CDCS Monthly Amount field will automatically populate based on the member's case mix. This does not mean the member has elected the CDCS option; it is simply displaying the maximum CDCS budget the member would be allowed if they were to elect CDCS. This field will default to No if there is no history record to support the member has elected CDCS. Update this field to Yes if the member has elected the CDCS option. The displayed Monthly Cap is based on the DHS published CDCS Service Budget Amounts currently in effect for the Elderly Waiver Program **(excludes the case management and background check amounts).** See CDCS Service Agreement section below for additional information about creating CDCS Service Agreements.

As applicable, for mandatory 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 EWProviders@bluecrossmn.com.

Diagnosis

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

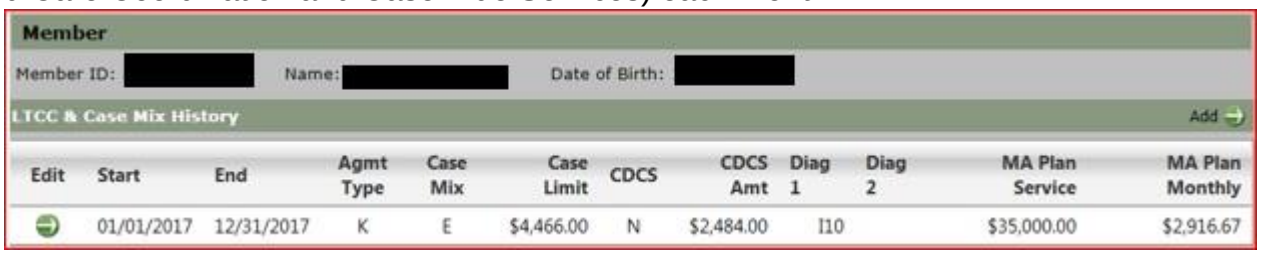
MA Plan Services (this field must also include Care Coordination and Case Aide amounts)



All MA state plan service authorizations, including PCA, are faxed to Amerigroup for service authorization entry. For EW members, it is required to account for the dollars spent on MA plan services in Bridgeview. This is done in the MA Plan Services field.

Enter the Grand Total of MA Plan service which include Care Coordination, Case Aide and state plan home care services including PCA, Home Health Aide and Skilled Nurse Visits (HCPCS codes T1016 UC, T1016 TF UC, PCA, HHA, SNV, Home Care Nursing (formerly known as Private Duty Nursing) for the current Elderly Waiver date span. Make sure to enter the full amount for the waiver span; not the monthly amount. The yearly amount will automatically be converted to a monthly amount. This amount will be counted toward the monthly case mix cap.

The system will automatically determine the number of months based on the LTCC Start Date and the LTCC End Date and will calculate an average monthly amount. See the example below. This member will need $2916.67 each month for Medicaid (PCA, HHA, SNV, Home Care Nursing (formerly known as Private Duty Nursing) and Care Coordination and Case Aide Services) each month.



Edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag 1	Diag 2	MA Plan Service	MA Plan Monthly
	01/01/2017	12/31/2017	K	E	$4,466.00	N	$2,484.00	I10		$35,000.00	$2,916.67

Make sure to allocate the correct MA Plan Service amount s to each LTCC and Case Mix date range. If you edit the date ranges in the future, you must also make sure that the expense(s) you are reporting under the MA Plan Services is still accurate for the date ranges being used.

If there are changes to the MA plan services or care coordination amounts (adding or decreasing services), you must update the amount allocated for those services to reflect the correct amount.

Prior to implementing new or increasing existing services for members enrolled in elderly waiver, it is the responsibility of the Care Coordinator to review the service plan. Bridgeview Company will notify you if the member exceeds the case mix cap budget and

does not have an approval to exceed the case mix cap. The Care Coordinator must review the services plan and make necessary changes.

Service Agreements

Adding a New Service Agreement

Add a new service agreement for a member before start of service. If the member is eligible for EW services during the time frame the services will be authorized. You would authorize new services by clicking on the Service Agreement button, then click on the Add button. Service agreement line items must fall within the LTCC and case mix date span.

View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88507057	MCKENNA CROS	A330047200	11/01/2015	02/29/2016	N	T2030 TG	4	$1,956.66	$7,826.64	Y	3	$5,869.98
	88288964	MERWIN HOME	1750338851	10/01/2015	02/29/2016		T2029	10	$8.99	$89.90	Y	0	$0.00
	88287432	PRESBYTERIAN	1881618544	10/01/2015	10/31/2015		T2030 TG	1	$1,956.66	$1,956.66	Y	1	$1,956.66
	88226321	PRESBYTERIAN	1881618544	07/01/2015	09/30/2015		T2030 TG	3	$1,956.66	$5,869.98	Y	3	$5,869.98
	88272598	MERWIN HOME	1750338851	03/01/2015	09/30/2015	N	T2029	14	$8.99	$125.86	Y	2	$8.99
	88272597	PRESBYTERIAN	1881618544	03/01/2015	06/30/2015	N	T2030 TG	4	$1,937.29	$7,749.16	Y	4	$7,749.16
	88215228	PRESBYTERIAN	1881618544	07/01/2014	02/28/2015		T2030 TG	8	$2,068.38	$16,547.04	Y	8	$16,547.04
	88213363	MERWIN HOME	1750338851	07/01/2014	02/28/2015		T2029	16	$8.99	$143.84	Y	5	$44.95
	88219574	PRESBYTERIAN	1881618544	04/01/2014	06/30/2014	N	T2030 TG	3	$1,969.89	$5,909.67	Y	3	$5,909.67
	88245059	JACKSON MEDI	1003870957	04/01/2014	05/31/2014	N	T2029	1	$396.00	$396.00	Y	0	$0.00

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.

Required Service Agreement Fields Needing Completion:

- ✓ Provider NPI/UMPI Number
- ✓ Pass Thru Billing (as applicable)
- ✓ From Date
- ✓ Service Description
- ✓ Total Units Authorized
- ✓ Rate Per Unit

✓ To Date
✓ Authorized Services
✓ Prorated
✓ Frequency

Provider NPI/UMPI Number
The Provider NPI/UMPI must be entered by the Care Coordinator and 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 left blank or is invalid, an N/A will display. The care coordinator should:

- 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 waiver provider
- Contact Bridgeview Company to verify if the provider needs to be registered with Bridgeview

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

Pass Thru 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 County 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**.

Enter the county NPI/UMPI number.

Select “Yes” if billing on behalf of a non-enrolled Approval Option service. Select “No” if the County provides the services.

If “Yes” the Care Coordinator must complete the Approval Option service provider name in the Enter Provider Name field.

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

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

Authorized Services
Select the appropriate service from the list of Authorized Services.

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

Code Narrative

This is a mandatory field that will only display when you authorize the S5165, T2028, T2029, T2038, T2039 and T2039 UD services. A narrative description is required to outline the specific item or service that is being authorized for the member. You must enter up to 2 lines of comments for these codes which 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
You may enter up to 4 lines of comments which will print on the service agreement notifications. Any person with access to the service agreement file may view your comments in this section.

The service description should be used to:

- record or clarify information (i.e. adult day services bath: 0.5 hour per week/2 units x 52 weeks = 104 units/year; homemaking 2 hours per week/8 units x 52 weeks= 416 unit/year),
- write text to explain a change on the service agreement,
- elaborate on why another service agreement letter/notification is being produced
- indicate if the member has residential absence days that must not be billed for
- specific rate included on the member's Residential Services Workbook
- Enter description of an item authorized using the T2029 code (see section Service Description Requirements for T2029 below).
- Document that the case was reviewed and approved by their Supervisor and/or Partner Relations Consultant for specified T2029 authorizations (see section Service Description Requirements for T2029 below).
- For lift chair mechanism: If the DME provider says the member does not meet Medicare/Medicaid criteria for the lift mechanism, the service description must also include the specific reason member did not meet Medicare/Medicaid criteria.

Total Units Authorized

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.

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.

If you want to restrict the provider to only use a specific number of the authorized units per month, week or day instead of just allowing the grand total, you must enter multiple lines

for the date ranges and units. This will generate a unique Prior Authorization number for each service that the provider will bill with and will restrict the number of units, rate per unit, and date range as you have indicated on the service agreement.

Rate Per Unit
Enter the rate per unit amount based on the definition of the service being authorized. If the service being authorized is a daily rate for T2031 or T2031 TG, the daily service limit maximum will be validated by the system. For all other codes, the appropriate maximum rates will be validated against the DHS published maximum. If the provider does not bill based on the service agreement, the claim may be rejected.

Daily Rate Calculation
The system will automatically determine the daily rate for any codes you authorize that have a monthly service unit definition. You can also determine the Daily Rate using the formula Total Monthly Authorization Amount x 12 months divided by 365 days.

Apply Waiver Obligation
When the member has a waiver obligation, all elderly waiver service agreements apply towards the waiver obligation, with some exceptions. Refer to Waiver Obligations section below for details. The first claim(s) that arrive in the Bridgeview claim system will be applied to the member's monthly waiver obligation. Assigning a designated provider is not an option. This will continue until the member's waiver obligation is met for the current month OR no other claims are sent for the month. New Waiver Obligations apply each month based on the first claim submitted to Bridgeview.

Prorated
This is important when the member only has partial month services for any reason, such as an inpatient or nursing home stay, they are deceased, or change to a new provider during the middle of a month.
This field should be changed to "Yes" when you have a member who will get services prorated due to:

- A change in eligibility during a month,
- A change in case mix mid-month,
- A change in services mid-month or
- If the member has an inpatient or nursing home stay and you have calculated the exact amounts that should be billed for the services.

Make a manual rate per unit calculation to the prorated line items for the exact amount that the provider will be authorized to bill for. Select "Yes" from the drop-down box indicating you are only authorizing a prorated amount. This will help administer claim payment to the provider accurately.

Frequency
Select from the drop-down box one of the values, which will print on the service agreement letter/notification, indicating how many times the service may be provided.

This will not restrict the payment of claims however, it will offer guidance to the provider related to the frequency the service is authorized. If you want to place specific limitations or restrictions on the provider for rendering services, please refer to the "Total Units Authorized" instructions.

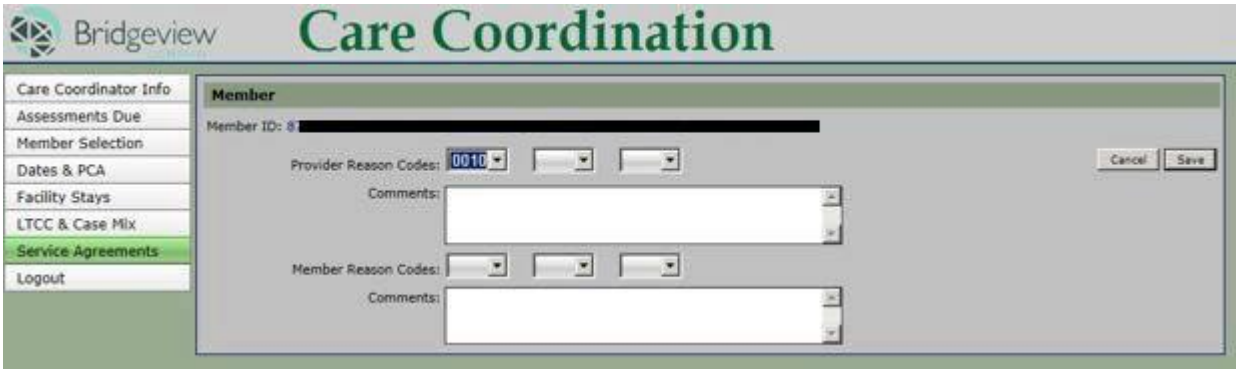
Values are:

1 – DAILY
2 – WEEKLY
3 – MONTHLY
4 – ONE TIME USE
5 – FLEXIBLE USE

Select "Save" once all fields have been completed.

Provider and Member Reason Codes

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. It is mandatory to select at least one reason code in the Provider Reason Codes section. Member Reason Codes are optional and are printed out and mailed daily by Bridgeview Company. See reason codes on the Bridgeview Company Website under Bridgeview Links, Elderly Waiver Program Documents.



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.

Service Agreements for T2029—Specialized Supplies and Equipment:

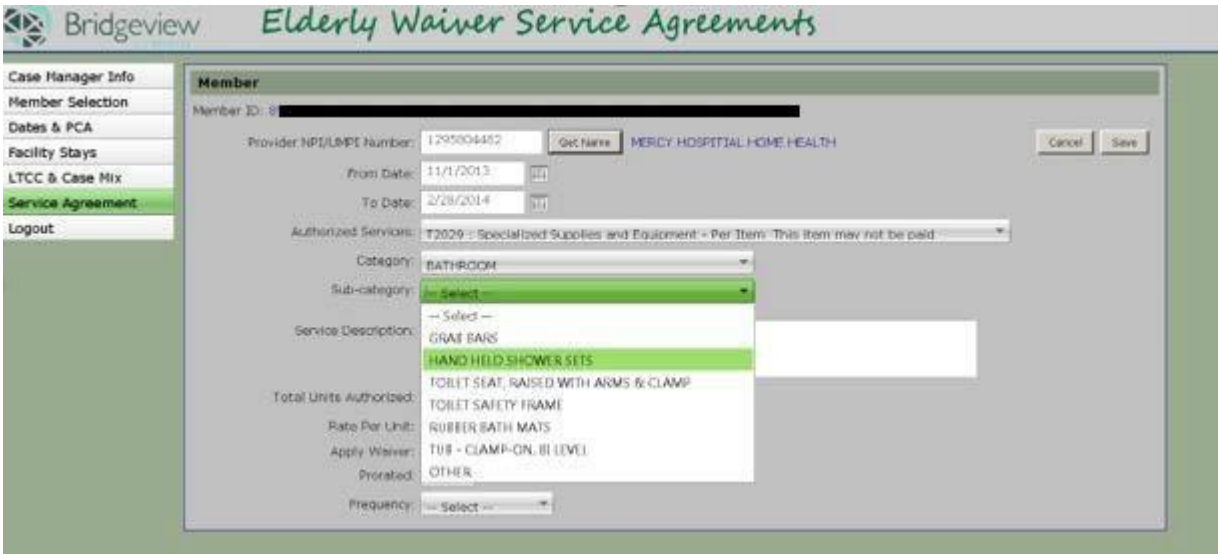
There are specific guidelines for all specialized supplies and equipment items authorized by Care Coordinators. Because EW is the payer of last resort **it is essential that Care Coordinator determine the correct payer for items authorized under the T2029 service code prior to entering a service agreement for EW coverage**. Do not enter a SA until you have confirmed that the item does not meet Medicare and/or Medicaid coverage criteria. If the item can potentially be covered under MA or Medicare, the provider must submit the item for coverage under insurance prior to being authorized under EW. If the item is denied under MA/Medicare, the Care Coordinator can assess for coverage under EW.

Please Note:

- The Care Coordinator must follow the process outlined in the MSHO-MSC+ Community Guidelines section titled: EW Specialized Supplies and Equipment (T2029)
- A physician's order is required for all Extended Medical Supplies and Equipment purchased under EW.
- You must identify each separate Medical Supply and Equipment item. Providers are required to submit a narrative description on their claim(s).
- The Care Coordinator is responsible to authorize covered services according to the appropriate payer. The provider is responsible to bill only the appropriate payer for the member and the item(s). For EW, all other private and public payers (private insurance, Medicare, Medical Assistance) must be exhausted prior to utilizing EW funds for coverage. The provider submits copies of the denials from those payment sources to the lead agency. If inappropriate billing shows up in an audit, the provider is responsible and risks payment recovery.
- 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.
- The cost of Extended Supplies and Equipment must be included in the member's monthly cap amount. 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.



As you can see in the selection above 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 on the Bridgeview Company website for coverage.

4. All items authorized under T2029 must include a description of the item in the **Service Description** field. If no description is entered, the SA will pend for review by the Bridgeview team, possibly delaying approval.

   a. 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. This specific reason must be indicated in the service description)

- An attestation that the case was reviewed and approved by their Supervisor and/or Partner Relations Consultant for the following:
  - Chair portion of the lift chair is over $950 (note: waiver does not pay for upgrades)
  - Single item over $500
  - Items marked as "No" in the "Elderly Waiver Eligible" column of the T2029 Guide

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:

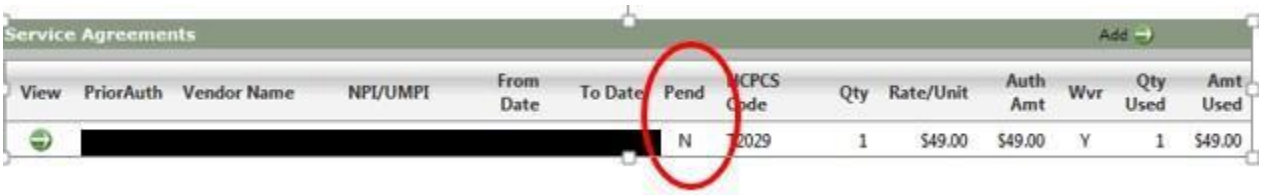
- If the chair portion of the lift chair costs over $950, the Care Coordinator must consult with their supervisor and/or the Partner Relations Consultant prior to authorizing in Bridgeview and must include a narrative in the **Service Description** field, that the case was reviewed and approved by the Supervisor and/or Partner Relations Consultant.

- If lift mechanism is being paid for by Medicare/MA benefits, enter one service agreement for the total cost of only the chair portion in Bridgeview.
  Note: If the cost of the lift mechanism is greater than $400 the DME provider must request a prior authorization.

- If the DME provider determines the member does NOT meet Medicare/Medicaid criteria for coverage of the lift mechanism portion of the chair, the DME provider must provide the Care Coordinator detailed reason for not meeting criteria.

- The Care Coordinator must enter two Service agreement for the total cost of both the lift mechanism and chair portion in two separate service agreements. 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).

Service Agreement Pend codes for T2029 Extended Supplies and Equipment



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

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

Service Agreement for Nutritional Supplements

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

When authorizing any nutritional supplement please do the following:

- Select the service code T2029
- Category Nutritional Supplement
- Subcategory
    - Ensure
    - Boost
    - Nepro
    - Glucerna
    - Other
    - Enter the number of cans per day.
    - Enter rate of amount for each can. The cap amount for this field is $3.99 per can.
- Select Daily as frequency

If you choose to enter any nutritional supplements that are listed in the subcategory field "Other" you must enter the specific information in the code narrative description. Enter the service agreement based on cans not cases.

Service Agreement for Environmental Accessibility Adaptations

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

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

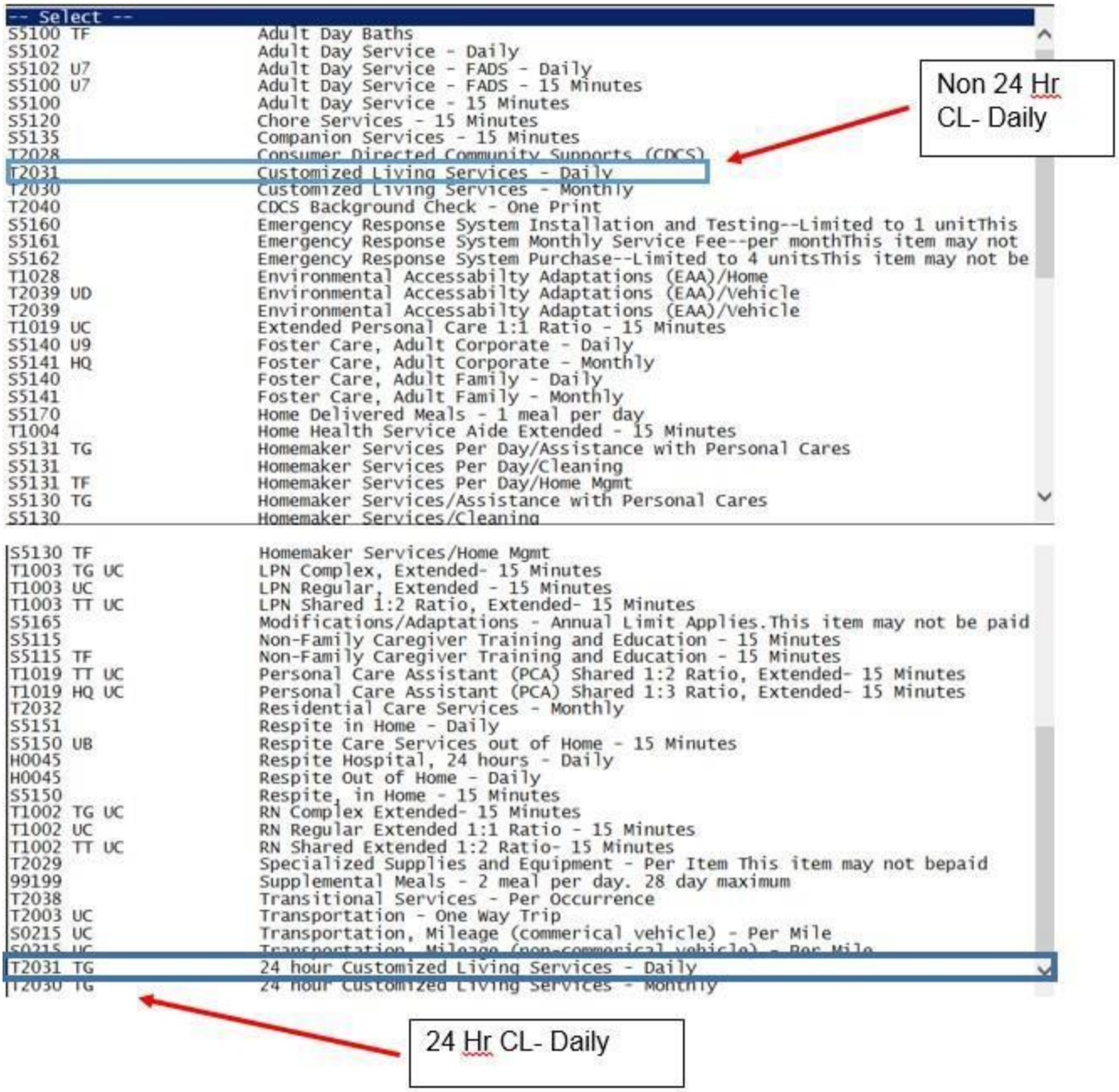
Service Agreements must be within the limits set by the legislature, even if authorizing multiple service codes. Effective adaptations and modifications are limited to a combined total of $20,000.00 per member per waiver year.

- 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

Include a brief description of the work being done in the Service Description field (i.e., bathroom remodel; ramps; widening of doorways for accessibility, etc.).

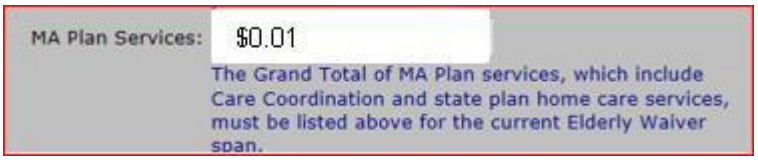
Service Agreement for Customized Living (CL) or 24 Hr. Customized Living

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



Consumer-directed community supports (CDCS) Service Agreements

When selecting CDCS, remember to include the MA Plan Services amount when you calculate CDCS services towards the member's CDCS case mix cap. **Do NOT include Care Coordination amounts in this field for members on CDCS as you will enter a separate service agreement for Required Case Management.**



If there are no MA Plan Services, you must enter .01 in this field. The MA Plan Service Field cannot be left blank.

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

1. Ensure "To" and "From" dates are within LTCC & Case Mix Date Span
2. Ensure Rate is under the CDCS Budget Cap.
3. Enter a service agreement for the authorized amounts determined in the CDCS service plan T2028. Note: this amount should also include the FMS management fees.
4. Enter a ***separate*** Service Agreement for:
    - T2040 background checks (if applicable) and
    - T2041 Required Case Management (this will be the Care Coordination amount for this member) for 8 units/month.

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

Notes on entering CDCS service agreement:

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

Service Description Requirement (CDCS)

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

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

CDCS Legislative Rate Changes

If there is a legislative rate change to the CDCS Budget Limits by Case Mix (DHS-3945) during an existing LTCC and Case Mix date span and the member's assessed needs support the need for additional services, complete DHS 6633A CDCS CSP Addendum with YYYY Budget Increase. The amount billed each month under CDCS can be used flexibly from month to month, however, the Financial Management Service (FMS) provider must stay within the total annual dollar amount authorized during the annual span. The Bridgeview Web Tool will not allow you to enter a service agreement at the increased rate prior to the effective date of the legislative rate increase.

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

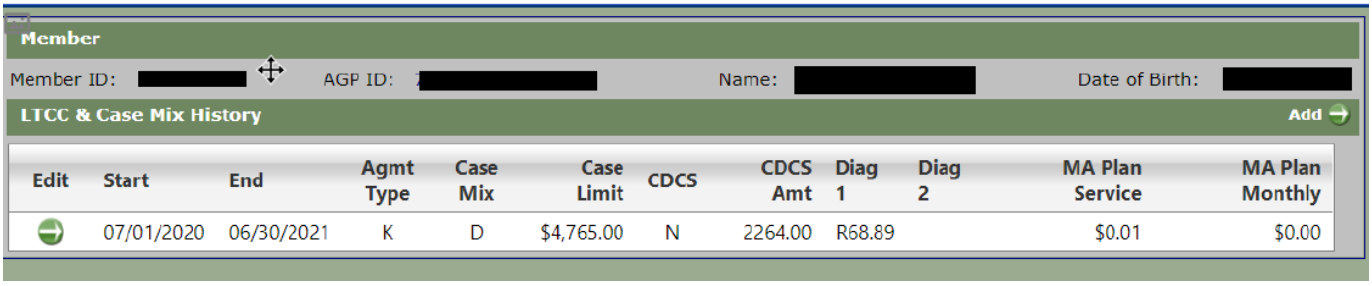
1. End the current CDCS current Service Agreement.
   a. To Date: End the current CDCS service agreement (T2028) the last day of the month prior to the rate change.
   b. Service Description—enter attestation that the "care plan was reviewed with the member and an addendum was completed with increased amounts for CDCS services."
   c. Total Authorized Units: Reduce total authorized units to the new To and From date span.
2. Create a new service agreement
   a. Make a copy of recently edited service agreement.
   b. From Date: Enter the first date of the new month of the rate increase.
   c. To Date: enter the end of the current LTCC and Case Mix Span.
   d. Total Authorized Units: Enter the remaining units.
   e. Rate Per Unit: Enter the new monthly amount that includes the CDCS rate increase.
3. Request Bridgeview staff to combine both service agreements into one service agreement. Contact EWProviders@bluecrossmn.com.

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

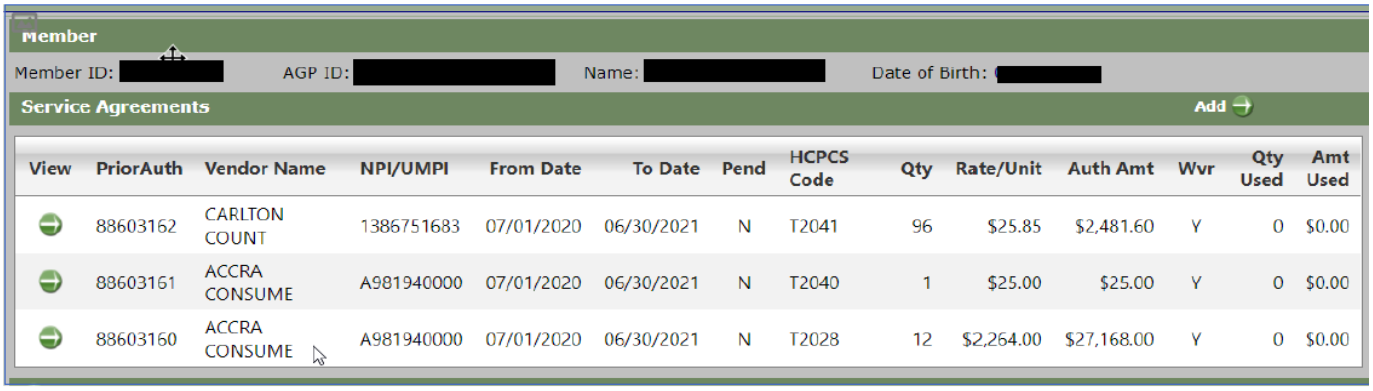
- Modify the original service agreement to include the updated end date for that waiver span.
- Update the units to coincide with start and end date.
- Add new monthly rate to equal the new waiver span amount that includes the increase.

5. FMS provider now has one service agreement that covers the full waiver span and includes the CDCS increase amount.

Before:

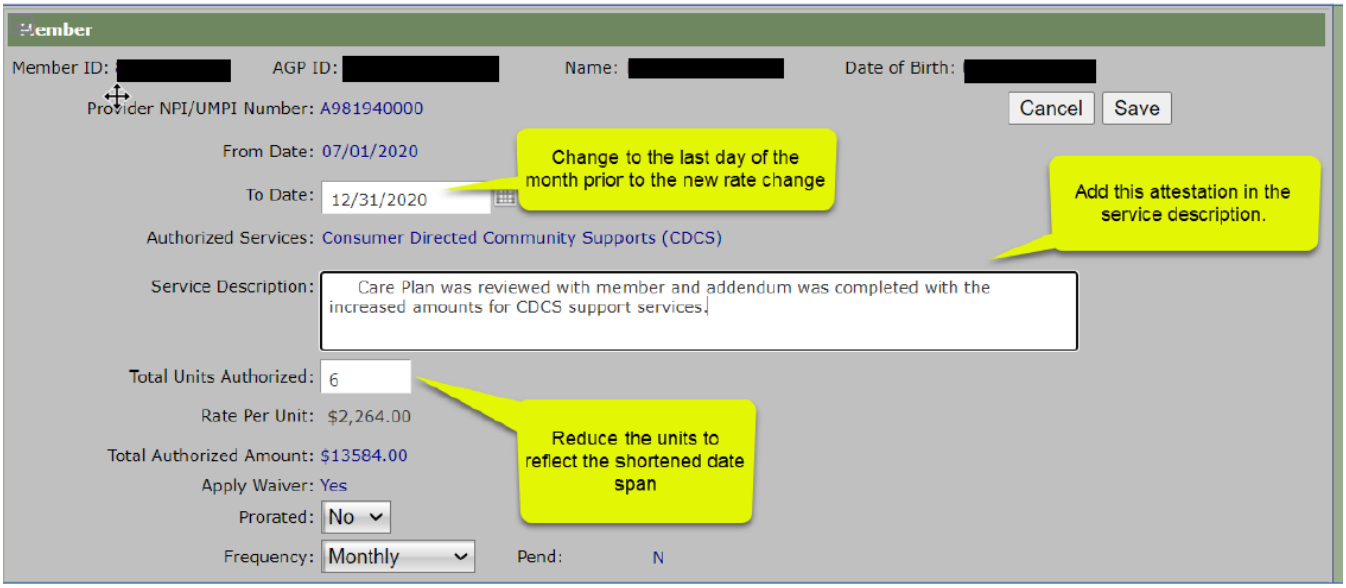


Edit	Start	End	Agmt Type	Case Mix	Case Limit	CDCS	CDCS Amt	Diag 1	Diag 2	MA Plan Service	MA Plan Monthly
	07/01/2020	06/30/2021	K	D	$4,765.00	N	2264.00	R68.89		$0.01	$0.00

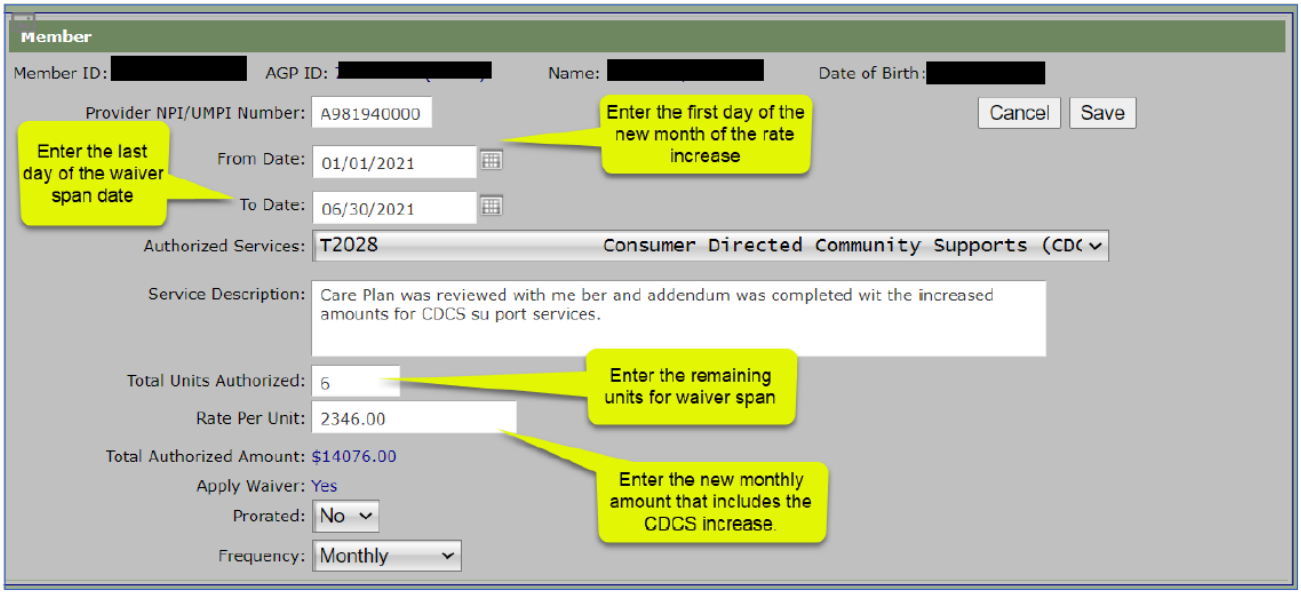


View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88603162	CARLTON COUNT	1386751683	07/01/2020	06/30/2021	N	T2041	96	$25.85	$2,481.60	Y	0	$0.00
	88603161	ACCRA CONSUME	A981940000	07/01/2020	06/30/2021	N	T2040	1	$25.00	$25.00	Y	0	$0.00
	88603160	ACCRA CONSUME	A981940000	07/01/2020	06/30/2021	N	T2028	12	$2,264.00	$27,168.00	Y	0	$0.00

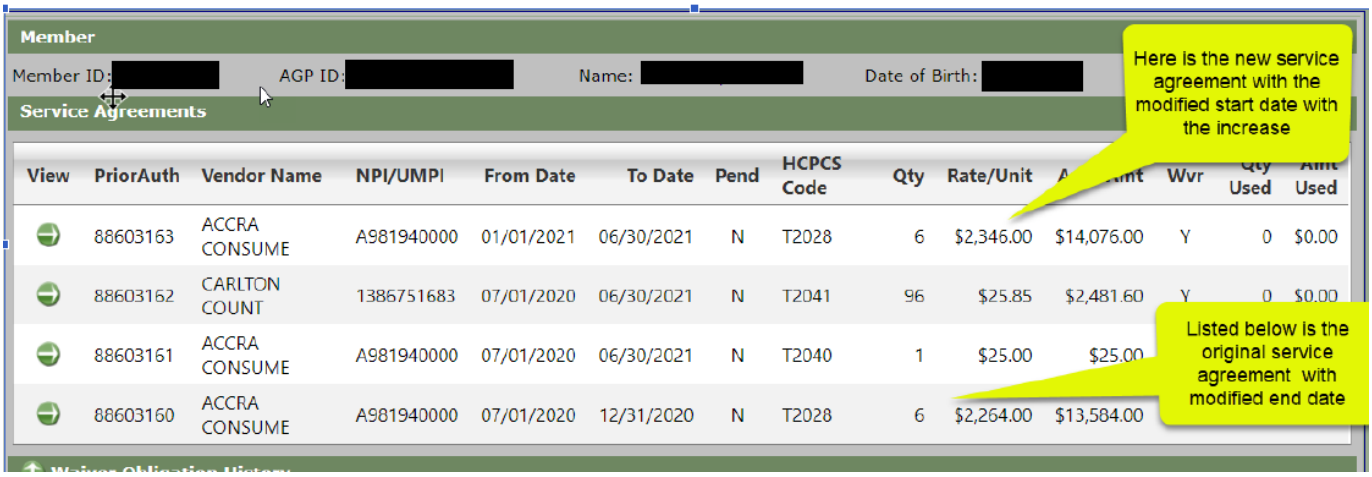
Modifying current CDCS service agreement:



Adding new CDCS Service Agreement:



After all changes have been made:



View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Amt	Wvr	Qty Used	Amt Used
	88603163	ACCRA CONSUME	A981940000	01/01/2021	06/30/2021	N	T2028	6	$2,346.00	$14,076.00	Y	0	$0.00
	88603162	CARLTON COUNT	1386751683	07/01/2020	06/30/2021	N	T2041	96	$25.85	$2,481.60	Y	0	$0.00
	88603161	ACCRA CONSUME	A981940000	07/01/2020	06/30/2021	N	T2040	1	$25.00	$25.00			
	88603160	ACCRA CONSUME	A981940000	07/01/2020	12/31/2020	N	T2028	6	$2,264.00	$13,584.00			

New Enrollees on CDCS with unused funds

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

1. CCs must notify PR Team of the remaining unused $ dollar amount from previous health plan or MA fee for service.
2. PR will communicate to BV staff this amount to add on to existing waiver span.

3. The LTCC/Case mix will be listed as a case mix “Z” for the remaining CDCS Waiver span.

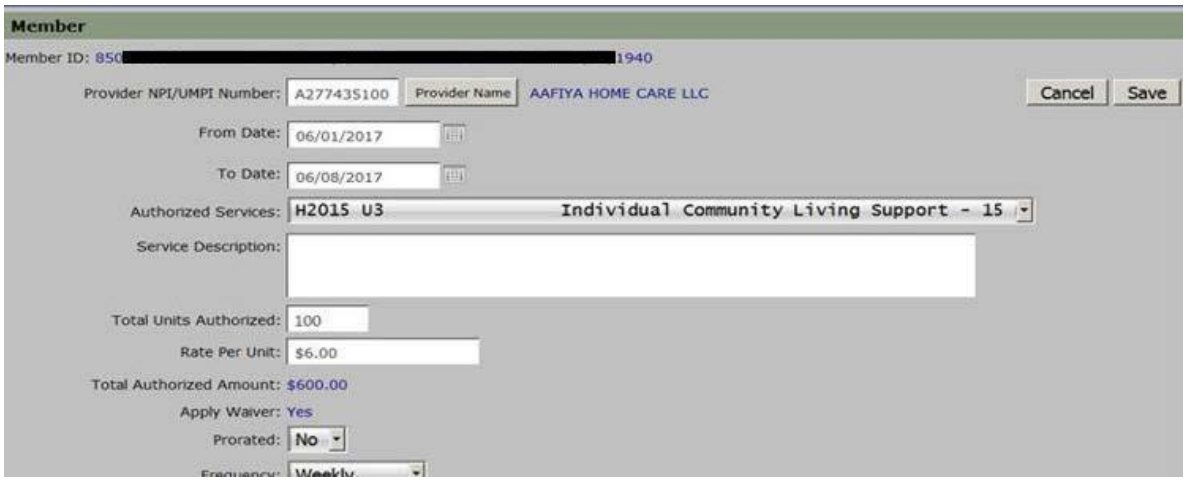
Service Agreement for Individual Community Living Supports (ICLS)

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

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

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

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



Extended Home Care Services:

Extended home care services can only to 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 claims are processed by Bridgeview

Service Agreement Entry: Helpful Information

- 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.
- If more than one provider is rendering the same service code, additional lines for each provider must be entered.
- If you are authorizing T2029, S5165, 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.
- All services which have a monthly service unit definition should be put on a single service agreement line item—do not split monthly code defined services that will be billed by a single provider into more than one authorization line. Only one prior authorization number can be issued, and the provider must submit only one claim combining all charges for all services rendered the entire month.
- Monthly service codes that are billed with a gap in services being rendered must be entered as a single authorization and billed by the provider on one claim.
- Non-Covered or Exclusions from Modifications/Adaptations (S5165) are adaptations or improvements to the home which are of a general utility and not of direct medical or remedial benefit to the individual such as carpeting, roof repair, or central air conditioning, or adaptations that add to the square footage of the home.
- Transitional Services (T2038) should be described in the narrative. Indicate what specific services/supports will be provided through the EW program.
- Follow MHCP Guidelines, CBSM Manual, and Blue Plus Care Coordination Guidelines for more information.

Service Agreements Listed on the Bridgeview Company Website

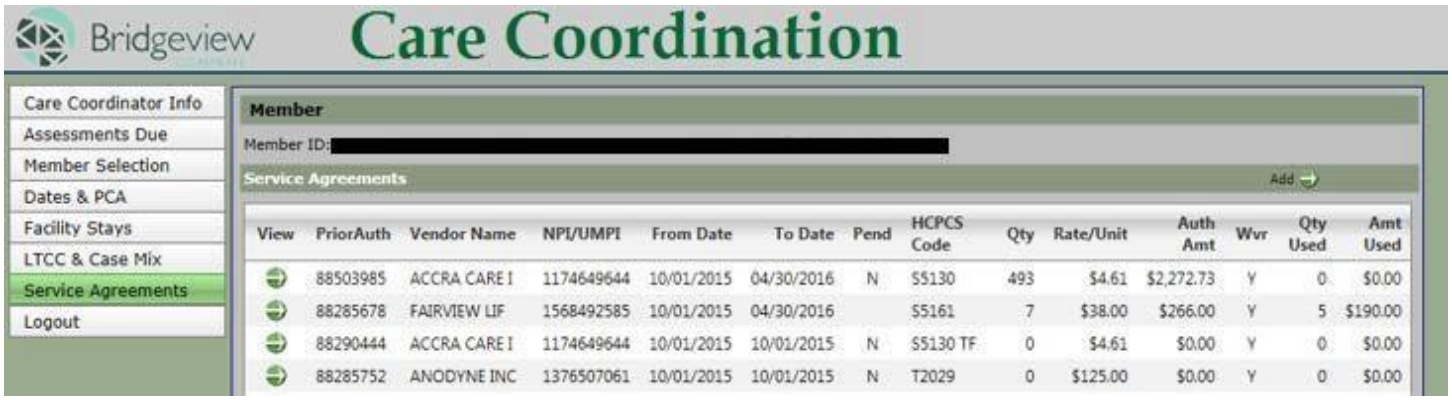
Once the service agreement has been completed it will be converted to a PDF document and posted on the Bridgeview Company website the next business day for the provider.

For the provider to gain access to the service agreements on the Bridgeview Company website, the provider will need to log into the Bridgeview website using their Blue Cross assigned USER ID number and password. The Blue Cross user ID number can be obtained by having the provider complete a Bridgeview User ID request form with the required information. This form is located on the Bridgeview Company website under “Bridgeview Links” and “Elderly Waiver Program Documents.”

Editing an Existing Service Agreement

You can click on the forward arrow under View to edit an existing service

agreement or view the detail.



View	PriorAuth	Vendor Name	NPI/UMPI	From Date	To Date	Pend	HCPCS Code	Qty	Rate/Unit	Auth Amt	Wvr	Qty Used	Amt Used
	88503985	ACCRA CARE I	1174649644	10/01/2015	04/30/2016	N	S5130	493	$4.61	$2,272.73	Y	0	$0.00
	88285678	FAIRVIEW LIF	1568492585	10/01/2015	04/30/2016		S5161	7	$38.00	$266.00	Y	5	$190.00
	88290444	ACCRA CARE I	1174649644	10/01/2015	10/01/2015	N	S5130 TF	0	$4.61	$0.00	Y	0	$0.00
	88285752	ANODYNE INC	1376507061	10/01/2015	10/01/2015	N	T2029	0	$125.00	$0.00	Y	0	$0.00

Changes that can be made:

- ✓ Edit the total authorized units
- ✓ Edit the To Date
- ✓ Generate letters/notifications
- ✓ Close a service agreement

Changes that cannot be made once entered into the system:

- Provider NPI/UMPI
- From Date
- Authorized Service Codes
- County of Residence
- Rate per Unit.
- Line items cannot be deleted once entered

You will need to zero out the current service agreement and create a new service agreement with the correct information

Editing the total authorized units

- Total Units Authorized can be increased or decreased
- Do not decrease the number of units to a number that is lower than what that has already been used unless you are changing the authorized units to zero indicating the provider will be submitting adjustment claims that will reprocess against a replacement service agreement
- You will not be able to increase the units to more than what can fit within the period

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.

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 have the situation resolved.

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. YOU ARE NOW ALLOWED TO PROVIDE UP TO THE NUMBER OF UNITS AND TOTAL AUTHORIZED AMOUNT SHOWN ON THIS AUTHORIZATION.
4. Once the provider has received the new service agreement notification, 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 receive the service agreement notification. The claim will process against the revised or newly added service agreement.

Editing the “From” and “To” Date

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

For example: you previously authorized a service for 09/01/2019 to 09/30/2019 but it should have been entered as 08/01/2019 to 09/30/2019. The provider billed for 08/03/2019 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 08/03/2019.

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

Scenario #1

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

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. Keep in mind this option will also automatically generate recovery of any claims that had been paid against the service authorization.
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 in the From Date and then the appropriate end date up to 08/31/2019 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 #2

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
- 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 has been institutionalized 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 elected EW CDCS from non-CDCS services or vice versa

When a person is terminated from a waiver program it is the responsibility of the care coordinator to go into the Service Agreement and change the “To Date” on all line items to the last day the member was eligible for services. Adjust the units on the line items as needed.

Closing the service agreement in the Bridgeview web tool does not close the MMIS screening document and vice versa. Enter an LTC screening document in MMIS to close the waiver and contact the member’s financial worker to inform him/her of the waiver closing. Remember to also update the LTCC & Case Mix History section to close the current waiver span. For EW, claims submitted against the service agreement will not be payable beyond the date of death.

If you do not want claims to pay against a service agreement line item that was entered

in error or should no longer be in effect, you must change the service authorization. Situations where this is applicable is a service is no longer needed, was never provided, the rate per unit was incorrect, or the provider number is incorrect.

Replacement or Void Claims

Bridgeview Company will accept replacement or void claims only after the initial claim has been processed. If an original claim was rejected, the provider should submit a “New” claim when they attempt to rebill for the services, not a “Replacement” or “Void” claim. These two options should only be used to indicate the payment received was not correct and either needs to be revised or completely taken back.

When a “Replacement” claim is submitted, the initial claim will be reversed, and the replacement claim will be processed for payment. The “Replacement” claim is normally correcting one of the key components of the initial claim, such as the number of units, line item date listing, or billed charges.
The remittance advice will reflect the original claim being taken back and the corrected reimbursement amount for the “Replacement” claim.

When the provider submits a “Void” claim, the initial claim will be taken back. Providers typically submit these when they intend to retract any previously submitted claims, such as when they should have billed Medicare or Medicaid as primary

Waiver Obligations

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

Reminder: waiver obligation only applies to Elderly Waiver services, not MA state plan services. Services not applied to the waiver obligation:

- 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:

Waiver obligation will be applied to all claims submitted for the members in the order claims are received. All members with EW service authorizations and a waiver obligation will have the first claim that is adjudicated with a payment for that month apply the waiver amount as appropriate. Providers are notified of waiver obligation amounts deducted from services billed on the ERA tab. The ANSI code 178 “PATIENT HAS NOT MET THE REQUIRED SPENDDOWN AMOUNT” will appear along
with the dollar amount that must be billed to the patient in the “Patient Responsibility” field on the remittance. Members are responsible to pay the amount of the obligation towards the services that were utilized that month to provider. This may be a portion of the billed amount or the entire service amount. Bridgeview Company claim examiners review monthly reporting of wavier obligation changes and updates and reprocess

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

Appendix

I. Opening and Closing Elderly Waiver in Bridgeview

Open Elderly Waiver—Complete the following tasks in the Bridgeview Web Tool:

- Add Member HRA in Assessments Due tab
- Complete PCA information in Dates and PCA tab (if applicable)
- Add LTCC and Case Mix under LTCC & Case Mix tab
- Complete the MA Plan Services amount
- Add Service Agreement line items in Service Agreements tab

Close Elderly Waiver—Complete the following tasks in the Bridgeview Web Tool:

- Update the Dates and PCA tab (if applicable)
- Complete Facility Stays tab (if applicable/optional)
- Enter an End Date on LTCC & Case Mix tab
- Modify the To Date on Service Agreements

- Prorate the authorized units as applicable
- Prorate the authorized MA plan services amount as applicable

You do not need to update the Assessments Due tab to "close" the current assessment.

Reminder: Communicate any status changes to the Financial Worker and make required changes in MMIS.

For more information on completing any of the required tasks, refer to **Navigating the Elderly Waiver Service Agreement Web Tool (EW only)** for specific instruction related to each field.

II. Closing Service Agreements: Scenarios

1. Closing a Waiver 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 within24 hours of the determination in addition to completing the *Care Coordinator Request for DTR* form when denying, terminating or reducing a service.

TYPE OF FACILITY STAY	SITUATION OR LIVING ARRANGEMENT CODES	EW WAIVER IMPACT SA (Service Agreement Web Tool) SD (Screening Document in MMIS)
Hospital	Person goes into a hospital for acute care (less than 30 days)	SA- close all line items during the stay SD- no change
Hospital	Person goes into a hospital for 30 or more consecutive days	SA- close all line items and close the SA as of the hospital admission date SD- close the waiver as of the hospital admission date
Nursing Facility	Person goes into a nursing facility for acute care (less than 30 days)	SA- close all line items during the stay SD- no change
Nursing Facility	Person goes into a nursing facility for 30 or more consecutive days	SA- close all line items and close the SA as of the nursing facility admission date SD- close the waiver as of the nursing facility admission date
Other Facility	Person goes into other facility for acute care or long-term stay. Other facilities include: • ICF/MR • METO • Psychiatric Hospital • Rule 31 Program Setting Rule 36 Program Setting Residential Treatment Center	SA- close all line items and close the SA as of the admission date SD- close the waiver as of the admission date

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.

2. Closing Service Agreement Line Items When Claims Have Not Been Paid When a line item was added in error or is no longer needed, and the provider has not yet submitted claims that processed against the authorization, you should close the line item and send a service agreement notification showing it was terminated.

To edit a service agreement to show the authorization should no longer be in effect:

A. Select the specific line item that you need to close by using the forward arrow under View
B. Change the "To Date" of the line item to be the same date as the "From Date"
C. Change the Total Units Authorized to zero
D. Generate a notification using the service agreement reason code that best explains why you are retracting the previously entered information.

3. Closing Service Agreement Line Items When Claims Have Been Paid

There will be three scenarios involved when closing a service agreement where claims have paid against it.

A. A change is needed to a service agreement, but the claims submitted so far have been adjudicated correctly.
B. A provider will be resubmitting claims after corrections have been made to an authorized service.
C. There was some sort of error and claims should have never been paid at all against the service agreement.

When you do not want additional claims to be paid from an approved line item, you must edit the line item so the provider can no longer use the authorization. The Bridgeview Company claims system will automatically take back any

claims that have been paid against a service agreement if you change the “To Date” to be the same date as the “From Date” and the authorized units are changed to zero.

4. Closing Service Agreement Line Items Due to a Change in Rate per Unit or New Rendering Provider but Claim Payments Do Not Need to be Recovered

The contracted rate for a provider may have been increased or decreased during the service authorization date span, or a different provider may need to be authorized to render the remaining units on the service agreement line item for some reason. The rate per unit and provider fields are protected thus a new service agreement will need to be entered after you have closed the existing one.

When you close a service agreement that has units used against it and the correct payments have been made for the time period so far, you must make the appropriate changes so additional claims do not process against the line item in the future. This is also important so paid claims will not automatically be recovered by the system.

To close a service agreement when there is no need to recover claims or for a provider to resubmit adjustment claims for processing:

A. Edit the existing service agreement line item by changing the “To Date” to the last service date that the provider will be billing for. Do not make the “To Date” the same as the “Start Date” or claims will automatically be recovered from the provider.
B. Adjust the “Total Authorized Units” to account for the reduced date range and the number of units that should be allowed in total for the service agreement parameters. You should never reduce the authorized units to a number that is less than the used units.
C. Generate a service agreement notification to the provider and/or member with the most appropriate reason codes that are being used to close the service agreement.
D. You can then enter the new service agreement that will authorize a different rate per unit or provider to render the services.

Claims will not be taken back from the provider, however if the provider later realizes they should not have submitted a claim against the closed service agreement, they are still able to initiate a “Replacement” or “Void” claim to correct their billing error (see Replacement Claims or Void Claims section below for further information.)

5. Closing Service Agreement Line Items Due to Incorrect Rate per Unit

Occasionally, the authorized rate per unit on a service agreement is entered incorrectly. If a provider receives an underpayment on a service agreement line item due to such an error as this, follow the procedures outlined below to correct the service agreement so the provider can submit corrected or adjustment claims.

6. Correcting Underpayments of Waivered Services

Provider received a service agreement notification with authorized rates and billed services under that service agreement. When they received payment, they realize your authorization was less than their county contracted payment for the services. The provider will need to contact you to have the situation resolved.

The provider should not resubmit a claim yet because the existing service agreement amount is incorrect, and the resubmitted claim will process the same as the original. The claim does not need to be paid back before the line item is changed to reflect the correct rate, so the provider must wait until you close the incorrect service agreement line item and generate a new corrected one. **To correct an authorization that has resulted in an under payment to a provider, you must:**

A. Edit the initial service agreement line item with the incorrect rate and change the "Total Units Authorized" to zero so additional claims will not process against it. You do not need to change the date span.
B. Generate a service agreement notification using reason code 0510 "THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THE RATE PER UNIT WAS INCORRECT".
C. Create a new service agreement line for the provider making sure the From and To Date, Total Authorized Units, and the Rate Per Unit is now correct based on the information in the county's contract with the provider.
D. Generate a service agreement notification using reason code 0080 "THIS SERVICE AGREEMENT REPLACES A PREVIOUSLY ISSUED AUTHORIZATION THAT HAS BEEN CLOSED BECAUSE IT HAD AN INCORRECT RATE PER UNIT."

After you enter the new service agreement, the provider should submit a replacement claim. The original underpaid claim will then be taken back and the replacement claim will process against the corrected service agreement line item.

Provider must be sure to submit the claim as a "replacement" claim or the system will automatically reject the resubmission as a duplicate claim.

7. Closing Service Agreement Line Items for Errors or Over Payments

You may discover when reviewing the service agreement history that an error was made in authorizing services. For instance, the authorized rate per unit was

too high or the wrong provider could have been entered.

If a provider has been overpaid or paid in error, you must take corrective action to revoke the authorization and initiate a claims recovery from the provider.

8. Overpayment of Claims or Claims Paid in Error

To Revoke a Service Agreement and Initiate Claims Payment Recovery from a Provider:

A. Edit the service agreement line item and change the "To Date" to the same date as the "From Date" so additional claims will not process against it.
B. Change the "Total Units Authorized" to Zero. The combination of changing the "To Date" and "Total Units Authorized" to Zero will trigger the claims recovery process for the provider for any claims that paid under the authorization.
C. Generate a service agreement notification using the most appropriate reason code (below). Enter a new service agreement if applicable.

0400	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.
0510	THIS SERVICE AGREEMENT WAS CLOSED BECAUSE THE RATE PER UNIT WAS INCORRECT.

9. Closing Service Agreement Line Items When a Member is Deceased, Discontinues All Services or Has Facility Stays

A member may be deceased, change waiver programs, or be admitted for facility stays which may impact the service agreements that have been entered into the system. You will need to change the service agreement authorizations and determine the appropriate date ranges and services that should be authorized due to these situations. You should indicate Prorated "Yes" in the drop-down selection whenever you make an adjustment on service agreement line items for these situations.

You must go into the service agreement line item detail and prorate the days, units and/or amounts allowed in the partial month of coverage to accommodate the shortened service date span. You should indicate you have prorated these services by selecting "Yes" in the drop- down box whenever you make an adjustment on service agreement line items for these situations.

You should put comments in the service description or in the provider reason code comment field specifying the date ranges they would be allowed to bill on the individual line items in Field 24 on the HCFA claim. When a provider who renders monthly definition service codes does not render continuous services

during a month span, they must indicate the exact dates of service in the line item detail.
They do this by breaking out the date ranges on separate lines when they submit the claim.

The EW provider may bill for the date of admission if any services were provided to the member on those days, but the provider cannot bill for full days the member was absent from the facility.

III. Entering Health Risk Assessments and Assigning Care Coordinators FAQs

Log In/Access Questions

I have a Care Coordinator (CC) going on a leave of absence. If an assessment is done by another CC during that time, do I change the CC Assignment, or will the covering CC be able to add data being logged in as their self?

Delegates do not have to reassign the member to a new CC in this instance. A CC can enter an assessment on ANY member even if they are not the assigned CC. So, in this case, the covering CC will be able to enter the assessment without having to reassign the CC.

Why is a CC not able to assign themselves as the CC when they obtain a new Blue Plus member?

Not all Delegate Agencies are set up the same and may not want all the CCs to have the ability to assign CCs to the members. Delegate Representative/Support Staff roles currently have access to assign CCs.

I completed the Bridgeview Web Tool User Login ID Request but never heard back with a login info. On the form, I only completed the Care Coordinator Information and left the Manager Contact Information and Support Staff Contact Information blank. Is there something I did not do correctly?

All applicable areas of the form must be completed to obtain Bridgeview access. Once completed please email the form to the EWProviders@bluecrossmn.com *for processing. Please expect 10 business days. You may also want to check your "junk" mail or "spam" for emails from Bridgeview security access.*

How do I request access to Bridgeview?

Please use 6.19 Bridgeview Web Tool User Login ID Request *form located on the BridgeviewCompany Website at* www.bluecrossmn.com/healthy/public/bridgeview/home or the *Blue Plus Care Coordination website* https://www.bluecrossmn.com/carecoordination

I am now the assigned CC, however the initial assessment was completed by a previous CC. Is there a way to input the assessment information but label it with the correct CC that completed them?

You are correct, if you enter the assessments it will populate your name as the assessor and not the applicable CC.

There are a few options on how to enter the assessments in question under the previous CC's name:

1. *The CC who completed the assessment can log into Bridgeview and add the assessments even though someone else is the assigned CC now.*
2. *Whomever at your agency has Care Coordinator Support access, can log into Bridgeview and act on behalf of the CC who completed the assessment to enter the information.*
3. *Whomever at your agency has Delegate Rep access, can log into Bridgeview and act on behalf of the CC who completed the assessment to enter the information.*

What do I do if the Delegate Agency is not correct for my member?

Please follow the process for reporting enrollment discrepancies and email SecureBlue.Enrollment@bluecrossmn.com with the discrepancy information.

Enrollment Reports

We didn't receive the member on an enrollment report until XX day this month. What date do we use for our documentation?

The date you receive the email notification that your enrollment is ready is your official notification of enrollment. Document this in the member's case notes.

What does "TERMED FUTURE X-2019" mean on the Full Detail?

The member's MA is closing at the end of this month. Most of the time this is due to MA renewal. CC can follow up with the member/FW to make sure MA renewal has been sent in.

Data Entry Questions

What is the difference between Assign Care Co and Edit Care Co?

Assign CC: if you want to change the CC, choosing Assign CC will keep a history of the previous CC.

Edit CC: use the Edit CC if you assigned the member to a CC and now want to change it (i.e. you assigned the wrong CC, etc.). This overwrites the previously

assigned CC.

What does the CC do if the assessment type in Bridgeview reflects the wrong type of assessment?

See Requesting an Edit or Deletion section for instructions on how to request deletion or edit of an HRA.

Is there a specific date that assessments need to be entered by?

Bridgeview is considered "real time" so you can enter the assessment information as they are completed. We do ask that the previous month's assessment information is entered no later than the 10th of the next month. Example: enter January assessments by February 10th.

Regarding the editing of a member address – Is this field to be updated with the member's physical address, mailing address, A-Rep address, other?

The address in Bridgeview should correlate with the member's physical address. This will determine our enrollment assignment for the member. The address in Bridgeview does not impact letters or other information that Blue Plus mails out.

I entered assessment information into Bridgeview incorrectly for one of my members and was hoping to have the assessment information removed so I can enter in the accurate information.

See Requesting an Edit or Deletion section for instructions on how to request deletion or edit of an HRA.

What is the difference between Refusal and Unable to Reach?

Refusal should be used for members who are decline the in person and the telephonic assessment. The CC must document that they offered the assessments to the member and the member refused.

Unable to Reach should only be used when the CC has not been able to contact the member to offer the assessment (i.e. due to an incorrect phone number, the member hasn't returned the CC's calls/letters, member not found, etc.). The CC must indicate 3 attempted contacts and the date a letter was mailed to the member (total of 4 contact attempts). The date the letter was mailed is the HRA date and the effective date in MMIS.

What do I enter in the ADL Scores section?

Select Yes or No for each ADL Score. Select Yes if the member has a dependency in the ADL on the assessment (LTCC or MnCHOICES). Select No if there is no dependency in that area.

When entering an HRA, what do I enter for Living Status if it is a community member that is temporarily residing in the nursing home?

If the member resides in the community, enter the Community for Living Status. Only use Nursing Facility for those who have permanently moved to a nursing facility.

What do I need to enter for a new enrollee who is already on EW?

1. *Enter the FFS (LTCC or MnCHOICES) assessment*
2. *Enter your Blue Plus HRA*
3. *Enter your LTCC and Case Mix date span*
4. *Enter your SA information*

What is the Outreach Phone number?

This is meant to be an alternate phone number for the member or an authorized representative. It can also be a facility contact.

EW and Service Agreement Web Tool Questions

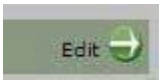
If I enter information into the HRA section of the Bridgeview Web Tool for an Elderly Waiver member, does it transfer to the LTCC & Case Mix section?

No, at this time information entered into the HRA fields do not populate into the LTCC & Case Mix section. You must enter the information in both areas.

IV. Navigation in the Elderly Waiver Service Agreement Web Tool

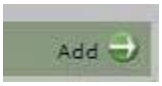
In the upper left-hand corner, you will see tabs that you can left click on which will allow you to enter additional information in each section.

 Collapse and Expand buttons. Click on these arrows to see more information or hide information.



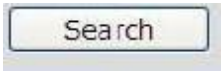
Edit Button

When you click on the forward arrow Edit button, it will open the section for you to edit.



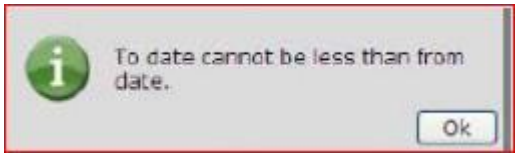
Add Button

When you click on the forward arrow Add button, it will allow you to enter a new item in the section you are in.



Command Buttons

There are different Command buttons that appear depending on the section you are working in. Click on these buttons to execute that command. The delete feature will only be available in a limited number of sections.



Error Warnings

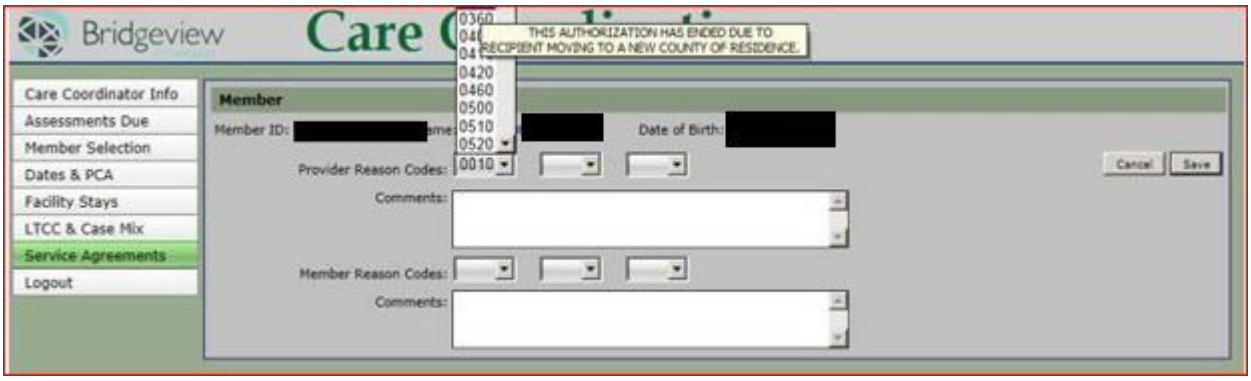
If you enter information that violates one of the web tool logic checks, a pop-up box will display that tells you what error has occurred. You will have to click Ok and make corrective action to the field that has been flagged with the error.

Blank Entry Field

A blank entry field will indicate that you must type input in that field. These fields will generally be validated by a system check and are required fields. There is no spell check feature in these fields.

Calendar Button

You will see a calendar button in all entry fields that require a date. You can simply type the date or use the calendar button to see an actual calendar from which you can select the desired dates.



Drop Down Button

Drop down selection boxes will allow you to choose the various field entries that will be allowed.

When you click on the drop-down button, it will show you the possible field entries to choose from. Specific rules will apply to certain fields. Refer to the user manual on that section for additional information.

V. MSHO Supplemental Benefits:

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

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

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

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

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

$750 Safety Benefit

MSHO members residing in the community may benefit from additional durable medical equipment for assessed safety needs. Prior to accessing this benefit the member must exhaust their medical benefit. This benefit is limited to safety items up to $750 per calendar year. The CC can make a referral to any Blue Plus in network

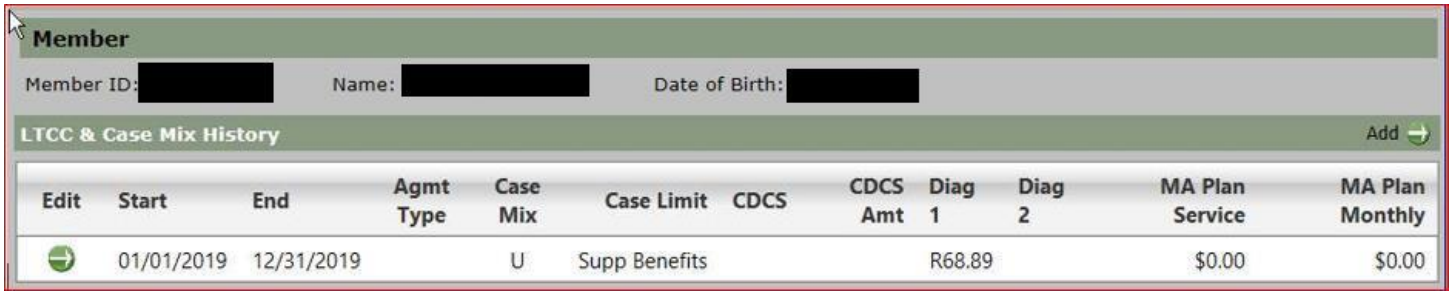
Durable Medical Equipment (DME) provider. Care Coordinators may enter multiple service agreements within the calendar year up to the maximum supplemental benefit amount of $750.00.

Once the request to the DME provider is complete, log into the Bridgeview system to create a service authorization for the safety benefit.

MSHO Community Well, complete Steps 1-2: If the member is NOT on Elderly Waiver, you will need to create a LTCC span using Case Mix U -Supp Benefits. After creating the LTCC span, you will create a new service authorization.

Step 1: Enter LTCC/Case Mix.

- In the left menu, select "LTCC/Case Mix"
- Click "Add"
- Fill in "Date"
- Complete "Start Date" and "End Date"
- Under "Case Mix" select: **U-Supp Benefits**
- Fill in Diagnosis 1 (must be entered)
- Click "Save" (on right)



Step 2: Enter Service Agreement for Safety Supplemental Benefit Authorized

- In the left menu, select Service Agreements
- Click "Add"
  - Fill in "Provider NPI/UMPI number"
  - Fill in "From Date" and "To Date"
  - Under "Authorized Services": select E1399 U4 Supp Benefit- Safety Benefit
  - Fill in "Total Units Authorized" (one time)
  - Fill in "Rate Per Unit": (cost of equipment)
  - Under "Prorated" select: NO
  - For "Frequency" select: One-time
  - Use reason code 10 new authorization

Elderly Waiver MSHO, complete Steps 2 above only.

If authorizing more than one safety supplemental benefit at a time, CC must enter separate service agreements.

Entry of Non- Medical EW Bus Passes

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

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):

- Provider NPI/UMPI Number: A797648100
- Provider Name: Metro Transit Go-To Card
- Enter Service agreement "From Date" and "To Date"
- Select Authorized Services: Transportation one-way trip - T2003UC

Service Description:

- Indicate which card you are authorizing *and* the monthly dollar amount:
  - "**Metro" Mobility Go- To Card** or **Metro Transit Go-To Card**

- New OR existing card
- Description of Pass
- Monthly amount for pass
- Example: Metro Transit Go-To Card @ $60.00 monthly
- The service description must also include the mailing address for the bus pass. This ensures the pass is sent timely and avoids delay if a replacement pass is

requested.

- Total Units Authorized: enter the monthly units multiplied by number of months.
- Rate Per Unit: $0.01
- Total Authorized Amount: total units authorized multiplied by $0.01.
- Apply Waiver: Yes
- Prorated: “NO” (this should always be NO)
- Frequency: “Flexible” (for all Go-To Cards)
- Provider Reason Code: select appropriate reason code based on your authorization.

Create your service agreement based on one month Go-To Card. For example, if you want to authorize $60 per month (divide 60 by 0.01 [unit rate] = 6000), multiply your monthly units of 6000 by 12 months (number of months in your span) = 72,000 total units authorized.

Reminder: All accounts with Metro Transit are limited to a maximum of $400.00 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 $400.00, *resulting in no ability to apply additional funds to the account.*

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.

Multi-day passes

31-Day Pass

Good for unlimited rides for the corresponding cash fare until midnight on the 31st day after first use.

Cash Fare	Pass Price	Best value when you ride:
$1.75	$59.00	34+ times/month, not including transfers
$2.25	$85.00	38+ times/month, not including transfers
$3.00	$113.50	38+ times/month, not including transfers
$.75	$31.50*	42+ times/month, not including transfers

*$31.50 Pass is available only to persons with limited mobility who must show proper ID for purchase and use. NOTE: This pass is not valid on Metro Mobility Buses. For information on certification, call Customer Relations at 612-373-3333.

Types of Value Available on Go-To Cards

Type	Denominations	Benefits
Stored Value	$10, $20, $30, $40, $50, $70, $100, $120, $140 and $180	Every purchase includes a 10% bonus. *Example: Pay $20, get $22 in fare value.* Go-To Card readers automatically deduct the cash fare in effect at the time and embed a transfer. Easy!

pl

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:

- For new service agreements, service description must include the member's current mailing address for bus pass/card delivery.
- 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 with the bus pass serial number (https://www.metrotransit.org/go-to-card; under Go-To-Cards and Passes)

Northeast Area Entry of Non-Medical EW Bus Passes

a. Complete a service agreement in Bridgeview using the following:
   i. Request Date
   ii. Provider NPI: 1801114301 (Arrowhead Transit)
   iii. Service Code "T2003 UC"
   iv. "To" and "From" date
   v. List in the Service Description field
      1. New pass OR
      2. Existing pass
      3. Description of Pass
      4. Monthly amount for pass
   vi. Total units authorized: monthly units multiplied by number of months auth.
   vii. Rate Per Unit: $0.01
   viii. Total Authorized Amount: total units authorized multiplied by $0.01.
   ix. Prorated: "NO" (this should always be NO)
   x. Frequency: "Flexible"
   xi. Select Provider Reason Code: select appropriate reason code based on your authorization

b. 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; bus passes will be mailed to each member.

Northwest Area Entry of Non-Medical EW Bus Passes

a. Complete a service agreement in Bridgeview using the following:
    i. Request Date
    ii. Provider NPI: UMPI 542871 (Friendly Rider)
        1285923490 (Productive Alternatives)
    iii. Service Code “T2003 UC”
    iv. “To” and “From” date
    v. List in the Service Description field
        1. New pass OR
        2. Existing pass
        3. Description of Pass
        4. Monthly amount for pass (see below for a description of passes)
    vi. Total units authorized: monthly units multiplied by number of months auth (5900 units x 4 months = 23600)
    vii. Rate Per Unit: $0.01
    viii. Total Authorized Amount: total units authorized multiplied by $0.01 (this example is $236.00)
    ix. Apply Waiver: Yes
    x. Prorated: “NO” (this should always be NO)
    xi. Frequency: “Flexible”
    xii. Select Provider Reason Code: select appropriate reason code based on your authorization

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

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 for individuals who are unable to ride Fixed Route buses and require door-through-door driver-assisted service.

DAR offers 3 different options to purchase bus passes:

- Per ride: $4.75/ride
- 31-day pass $75
- 10-Ride pass $25

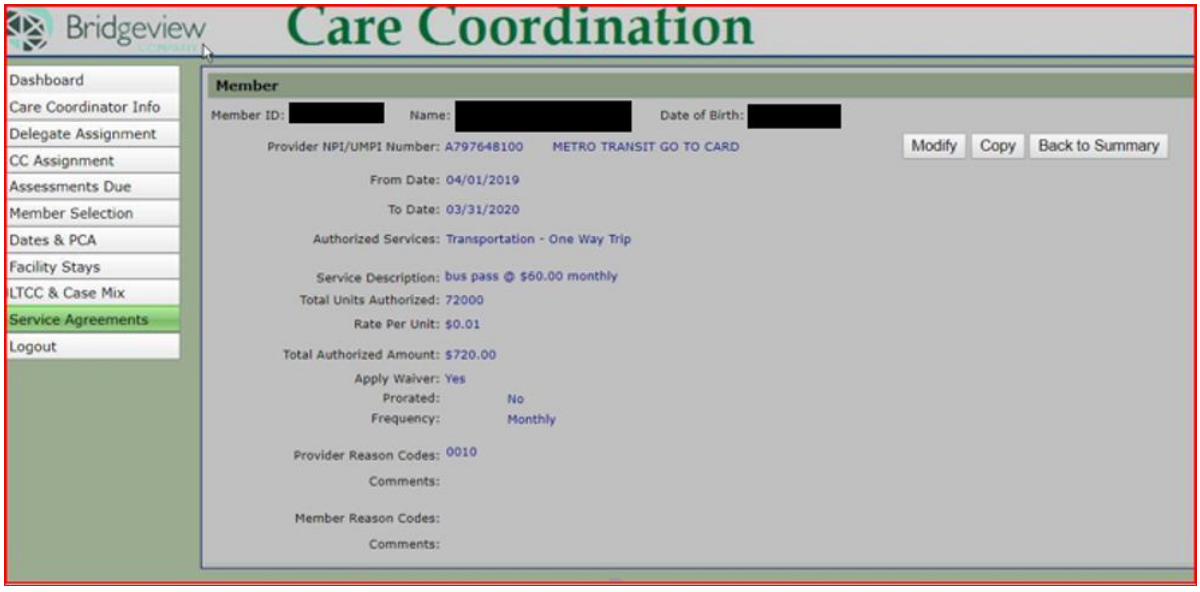
To access Dial-a-Ride, complete the following:

1. Apply for eligibility by completing the Dial-A-Ride Service Application

2. Receive certification approval from Dial-A-Ride
3. Call 320-252-1010 to schedule a ride
4. Dial-a-Ride password is TRANSPORTATION
5. Complete a service agreement in Bridgeview using the following:
    a. Request Date
    b. Provider NPI: UMPI 1652975 (Dial-A-Ride)
    c. Service Code “T2003 UC”
    d. “To” and “From” date
    e. List in the Service Description field
        i. New pass OR
        ii. Existing pass
        iii. Description of Pass
        iv. Monthly amount for pass
    f. Total units authorized: monthly units multiplied by number of months auth.
    g. Rate Per Unit: $0.01
    h. Total Authorized Amount: total units authorized multiplied by $0.01 (exp. 31-day pass for
    $75.00 would be 7500 units per month, 10 Ride Pass for $25.00 would be 2500 units per month)
    i. Apply Waiver: Yes
    j. Prorated: “NO” (this should always be NO)
    k. Frequency: “Flexible”
    l. Select Provider Reason Code: select appropriate reason code based on your authorization

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

Example of Service Agreement for Metro Go-To Cards:



Example of a Service Agreement for a bus pass:

*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.)

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
Bags of tokens: 10 to a bag for $15 The rides are $1.50 each way for 0-5 miles.

BENTON, SHERBURNE & STEARNS COUNTY: St Cloud Metro Transit via Dial-a-Ride (DAR)
Serves Benton, Sherburne and Stearns County
UMPI1652975
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
City Bus: $26 unlimited pass for 30 days
$40 unlimited pass for 30 days
Packet =20 individual tickets for $30 or 10 ride card for $15

CROW WING COUNTY: CITY OF BRAINERD
Serves Crow Wing County
UMPI652959
Enter SA in Bridgeview
Call 218-825-7433 to arrange a ride

METRO: Metro Transit Go-To Card
Serves Metro County
UMPI A797648100
Enter SA in Bridgeview
No additional referral necessary

OTTERTAIL COUNTY: PRODUCTIVE ALTERNATIVES/THE OTTER EXPRESS
Serves Parkers Prairie, Perham, Fergus Falls
UMPI: 1285923490
Enter SA in Bridgeview
Call 218-998-3002 to schedule a ride
Punch pass=10 for $15 Unlimited=$60

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
Adult 31-day pass at $40/each (count for 31 days starts when card is swiped and activated)
STRIDE coupon book at $15/each

WILKIN COUNTY: PRODUCTIVE ALTERNATIVES/THE OTTER EXPRESS
Serves Breckenridge
UMPI: 1285923490

Call 218-998-3002 to arrange a ride
10 rides = $15 punch pass

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

Amerigroup Member360

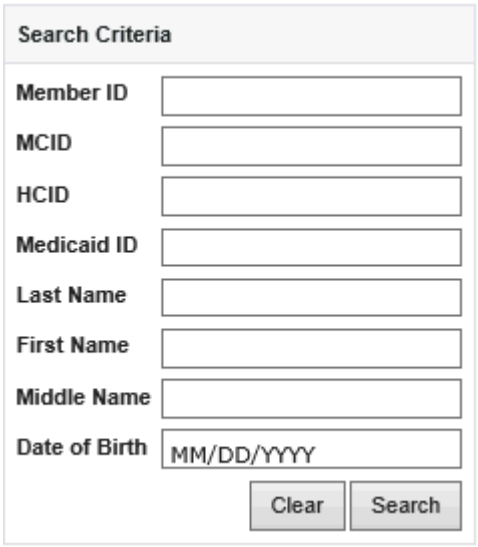
Member360 is an easy-to-use, ready only system giving Care Coordinators access to many types of healthcare related information including:

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

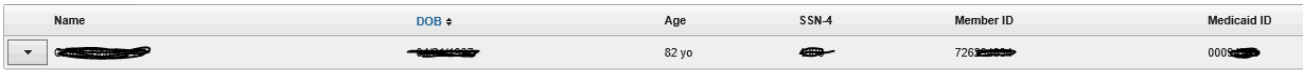
All CCs who currently have BV access has access to member 360. Contact help desk if the link is not working.

How to access information in Member360

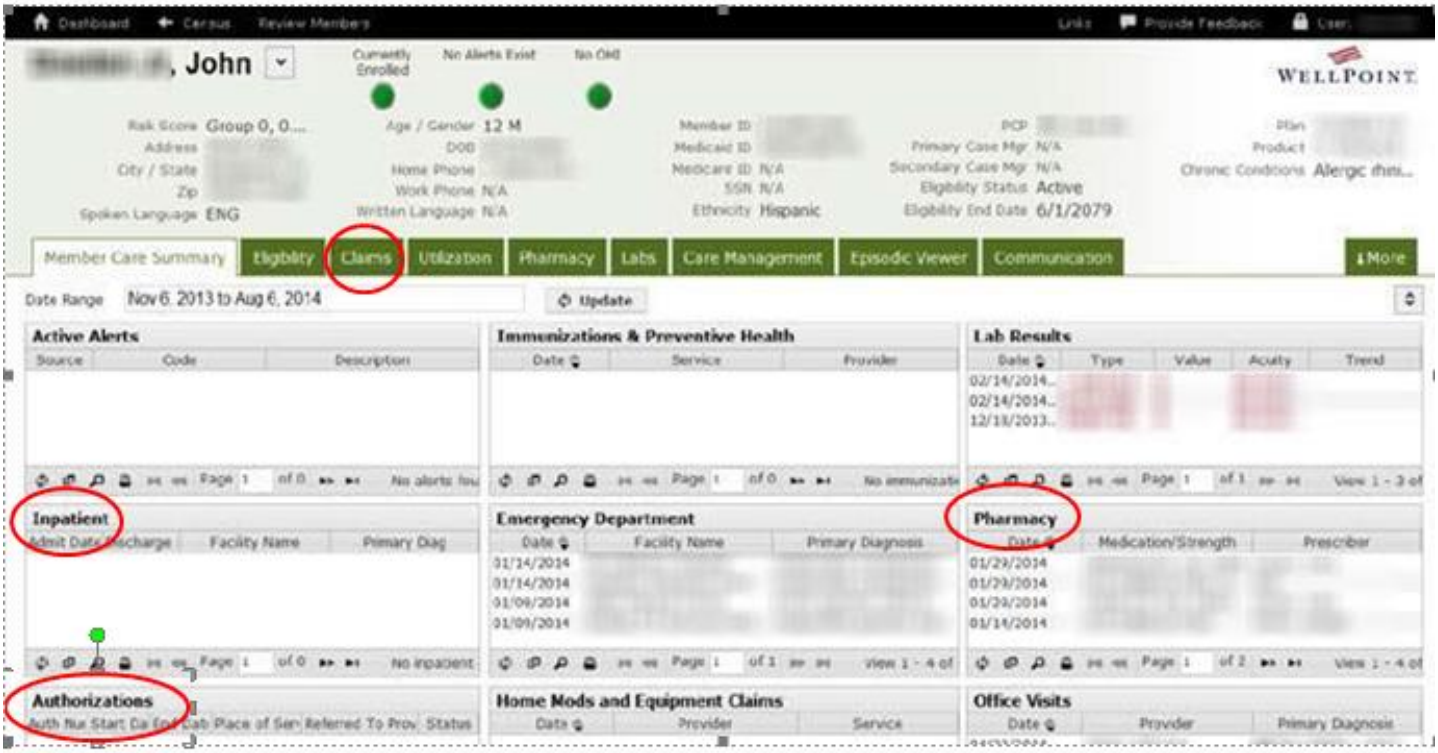
1. Once logged into Member360, CC can search member here using AGP Member ID, Medicaid ID, or any of the following search criteria options.



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



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



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

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

Navigation Features

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

Icons

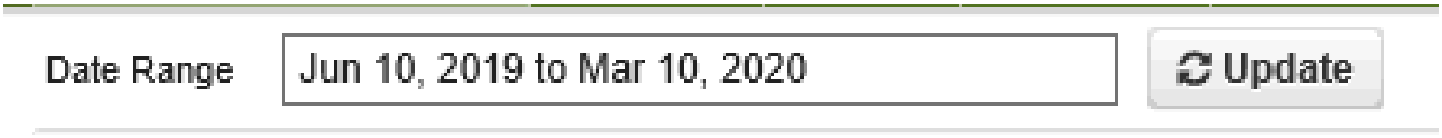
The Reload/Refresh icon is used to reload the original search information

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

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

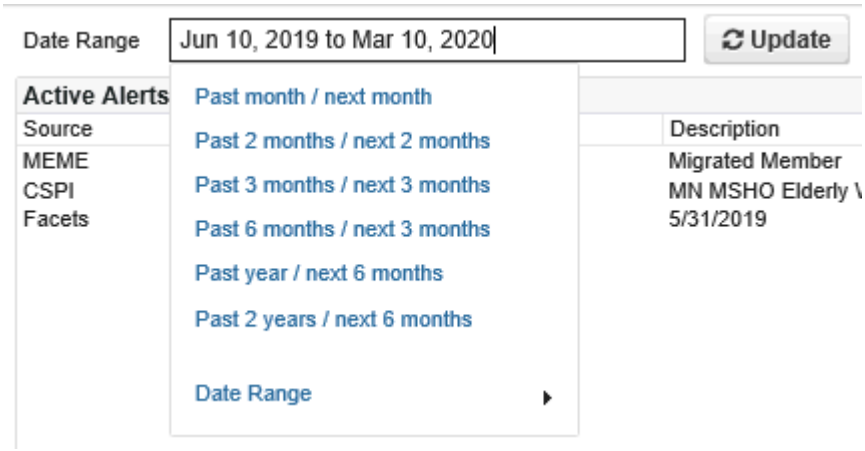
The Print icon is used to request a print of the data

Tips



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

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



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