Bridgeview COMPANY

BlueCross BlueShield Minnesota



# Bridgeview Company

# Elderly Waiver Claims Processing Manual

Updated 04/18/2025

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## Bridgeview Introduction

The Bridgeview Company has been processing Elderly Waiver claims since implementation of the MSHO program in 2005. As of October 1, 2024, Bridgeview also processes Community First Services and Supports services (CFSS). Our claims system facilitates prompt, accurate processing of non-traditional claims meeting all regulatory requirements. We provide payers with strong and detailed reporting that enables them to identify cost trends, areas of opportunity for savings as well as fraud and abuse monitoring.

Bridgeview contracts with Availity Essentials, a HIPAA compliant clearinghouse for providers to submit EW claims to Bridgeview. Availity Essentials can accommodate all provider claims submission types such as direct data entry, batch claims and will work with other clearinghouses to transmit claims and remittances.

Based on the 2009 MN Statute 62J536 Uniform Electronic Transactions & Implementation Guide Standards-* all claims must be submitted electronically to Bridgeview Company. Simplification standards prohibit all paper claims and invoice submissions. All claim forms received at Bridgeview Company by paper or invoice will be returned to provider requesting the claim or invoice be submitted electronically through Availity Essentials at https://Availity Essentials.com .

## Billing Requirements

Bridgeview Company follows the Department of Human Services/Minnesota HealthCare Provider (DHS) billing guidelines and payer specific requirements and only register providers who are in the MHCP (Minnesota Health Care Provider) network. Below are additional guidelines as noted:

- Providers who render or supervise services are responsible for submitting claims
- Submit claims only after you provide Elderly Waiver covered services
- Bill only for dates of service when services were provided
- Bill the rate that is listed on the service agreement or authorization letter
- Bill only one calendar month of service per claim
- Submit claims electronically

### Bridgeview Payment

- Providers must accept Bridgeview payment as payment for covered services provided to a client on Elderly Waiver. A provider may not request or accept payment from a recipient, recipient's relative, the local human service agency or any other source, in addition to the amount allowed under the service agreement or authorization for services, unless the request is for one of the following:
    - Waiver obligation
    - LTC (long term care insurance), Medigap, Medicare or any other insurance supplement.

### Timely Billing

- Effective 01/01/2024 timely filing limits are 6 months from the date of service.
- Submit claims correctly. Refer to the service agreement for the correct billing information such as service agreement number, provider billing NPI or UMPI (Unique Minnesota Provider Identifier), authorized date span, service codes and units of service authorized based on the service description located on the service agreement.

## Claim Appeals

- Appeals may be submitted to the Bridgeview company by completing the following:
- AUC (The Minnesota Administrative Uniformity Committee) Appeal Request form. You can find this form on the Minnesota Department of Health website: www.health.state.mn.us/auc/forms.htm
- Fill out form completely
- Include the payer claim numbers that are appealed and the reason
- Email to EWProviders@bluecrossmn.com OR fax to 651.662.4056
- Bridgeview has sixty (60) days to respond to the appeal
- A response to the appeal letter will be in writing and mailed to the person requesting the appeal

## Service Agreement Authorization Letter to Providers

Care coordinators have the capability to enter all service agreements for their members through a web-based portal. Once the authorization is entered, a letter to the provider is generated by Bridgeview Company the next business day and available to providers through a secure link in Availity Essentials. Care coordinators also have the option of sending a service agreement letter to members via mail.

**The Service Agreement (or Prior Authorization) letter will notify providers of specific authorized services for the member they are providing the service for. Information that can be found on the Service Agreement or Prior Authorization letter includes:**

• Date the authorization was issued—**not required on the claim form.** If you receive more than one copy of the authorization, you should refer to the most recent issue date and validate units authorized. When changes or updates are made to the authorization, a new letter will be generated. The current authorization that exists in the Bridgeview Company system is what will be used for claims adjudication.

• Case Manager Contact Information- **Not required on claim form.** The provider must contact the person listed in this area regarding questions or clarification for the services being authorized.

• Provider Name- **The letter will show the provider's name as it appears at Bridgeview Company. This should match what you registered to bill with through Availity Essentials.**

• Provider NPI/UMPI number that was authorized by care coordinator **– Required on claim form. This must be the same NPI/UMPI number being billed on the claim to Bridgeview Company.**

• Service Agreement number- **SA number is an 8-digit number starting with 88 and is required on all claims to Bridgeview. Please remember to include the authorization number on the Availity Essentials Express Entry Claim form.**

• Member Id Number and Name- **Consists of the PMI with an "8" in front. This will be a 9-digit number only. Do not include the alpha prefixes or trailing 00s at the end.**

• Authorized From and To Dates-**Date range of authorization- providers must only bill inclusive of one month's date span per claim form.**

• Diagnosis codes- **Required on the claim form.**

• HCPCS- service code and modifier if indicated-**Required on the claim form.**

• Authorized Units-**The maximum number of units the provider will be allowed to render to the member for the duration of the authorization.**

• Rate per unit- **The rate that provider and care coordinator have agreed upon.**

• Total authorized amounts- **The maximum amount the provider will be reimbursed for services to the member for the duration of the authorization.**

• Frequency of service-**The expected frequency the provider will be rendering the services to the member.**

• Code Narratives notes or messages for the provider -**Only required on the claim if it is for a NOC (Not Otherwise Classified Code) such as T2029, T2038, T2039, T2039 UC, T1028 or S5165. If authorization is for one of these codes, the provider must submit specific information in the claim note of the claim form.**

Providers should only submit Elderly Waiver and CFSS claims to Bridgeview Company after they receive a Service Agreement/Prior Authorization letter. The letter will include information that the provider needs to bill for services rendered to the member. If you have not received a letter, contact the members' care coordinator. Claims submitted to Bridgeview Company for services that do not match authorization on file will be rejected.

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# Service Agreement Example

Bridgeview COMPANY

Care Manager Name and Contact information for Questions regarding the service agreement:

**Case Manager Contact**
**Susan Smith**
**651-123-4567**
**A012345678**

Your business name

SunnyDay Assisted Living
12345 Country Lane N
Smithville, MN 55551

Your billing NPI/UMPI needs to be the same as the service agreement and registered with Availity

**Provider NPI**

**Provider UMPI A087654321**

THIS ELDERLY WAIVER SERVICE AGREEMENT HAS BEEN REVIEW. MEMBERS MUST CONTINUE TO MEET PROGRAM ELIGIBLITY CRITERIA AND, IN THE CASE OF THE WAIVER PROGRAMS, BE ELIGIBLE FOR MEDICAL ASSISTANCE. IT IS THE PROVIDER'S RESPONSIBILITY TO REVIEW THE MEMBER'S CONTINUED PROGRAM ELIGIBILITY ON THE MN-ITS ELIGIBILITY VERIFICATION SYSTEM PRIOR TO SUBMITTING CLAIMS FOR THESE SERVICES. PROVIDERS MUST CONTINUE TO BE ACTIVELY ENROLLED TO PROVIDE THESE SERVICE (S).

IF YOU HAVE QUESTIONS REGARDING THE SERVICES LISTED ON THIS SERVICE AGREEMENT, PLEASE CONTACT THE CASE MANAGER.

| PRIOR AUTH # | MEMBER ID | MEMBER NAME | FROM DATE | TO DATE |
|---|---|---|---|---|
| 88123456 | 801234567 | JOHN DOE | 07/01/2016 | 12/31/2016 |

The information listed above and below are required on the Availity claim form. Keep in mind you will only be billing one claim per month within the authorization date span.

| DIA CODE | SERVICE HCPCS MODIFIER | | |
|---|---|---|---|
| I10. E13.311 | T2031 TG | FREQUENCY: | Daily |
| | 24 hour Customized Living Services- | Daily | |

**AUTHORIZED UNITS:** 365 **RATE/UNIT:** $59.65 **TOTAL AUTHORIZED AMOUNT:** $21772.25

THIS MEMBER MAY HAVE A WAIVER OBLIGATION THAT MUST BE MET

THIS IS A NEW SERVICE AUTHORIZATION.

## Bridgeview Provider Registration and Requirements and Guidelines

- Billing providers must be enrolled in the MHCP (Minnesota HealthCare Provider) program to provide elderly waiver services. Go to https://www.dhs.state.mn.us Enrollment information can be found under HCBS (Home and Community Based Services) tab. Please complete the enrollment information and send it to DHS for registration.
- All billing providers must register with the Bridgeview Company to receive a service agreement, OR **AUTHORIZATION FOR PROVIDING SERVICES FROM THE CARE COORDINATOR ASSIGNED TO YOUR CLIENT**, and bill for Elderly Waiver services.

## Provider Enrollment with Bridgeview:

Please go to Bridgeview Company website at BV Portal (Public) –

https://www.Bridgeview@Bluecrossmn.com

- Select under Bridgeview Links, Elderly Waiver Program documents
- Complete the Bridgeview Registration Request form for enrollment.
- Email requests to the EWProviders@Bluecrossmn.com or fax to 651.662.4056.
- If there is no direct deposit or W9 on file for your organization, you will be emailed a direct deposit request and W9 form for completion. Please include banking verification in the form of a voided blank check.
- Expect 5-8 business days for the request to be processed.

- Once the request has been processed a "Welcome to Bridgeview" letter is sent to the newly enrolled provider by email. The "Welcome to Bridgeview" letter will review:
  - Registering with Bridgeview- registration and set up for payment processing.

- Registering with Availity Essentials- registration for claims submission and service agreement view and printing.
- Availity Essentials- Payer Spaces- information regarding Bridgeview registration, provider manual, tutorial on how to look up service agreement through Availity Essentials portal.
- When providers register with the Bridgeview Company for access to service agreements, providers may list all facilities or business types that they provide and bill services for. Below is an example of a provider who may have multiple facilities.
- Step by step instructions on how to submit a claim through Availity Essential select the following: Payers Spaces/Bridgeview and select the Resources tab.

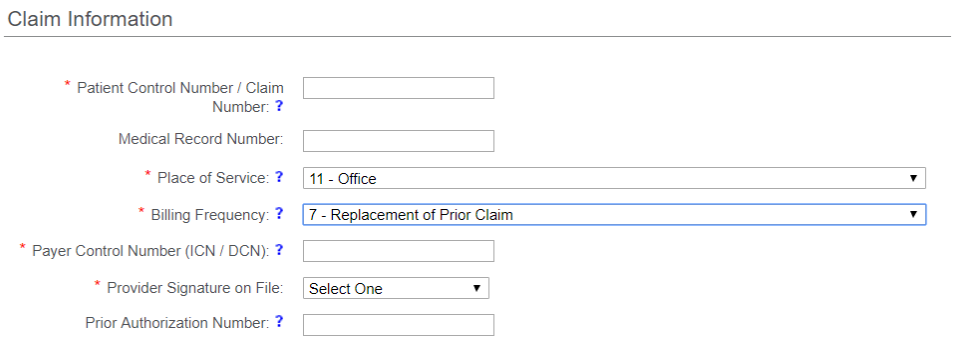
## Replacement/Void Claim

Providers will only send replacement claims to Bridgeview Company when the provider has already had their claim processed resulting in a paid claim. Replacement claims may result in a payment correction due to a revised billed amount, number or units, or it may simply change a piece of information in the claim such as a date. The Bridgeview Company payer claim number must be entered. The claim payer number can be found on the ERA electronic remittance advice under Claim Information and Payer Claim number. If the Bridgeview Company claim number is not included on the replacement claim, it will result in a denial with ANSI 16 Remark N152 **Claim/service lacks information which is needed for adjudication: Missing/incomplete/invalid replacement claim information.**

Providers who submit replacement claims as their initial claim or in response to a claim denial will have those claims rejected with ANSI 125 Remark N142 **Submission/billing error(s): The original claim was denied. Resubmit a new claim, not a replacement claim.**

**Below is where you would select Replacement Claim in Availity Essentials' Express entry under Claim information. Add the Bridgeview claim number - I think referring to claims entry on Availity Essentials would be good and a note that claim # and serv agreement are required.**

**The service agreement number is also required**




**Voided Claims**

Providers that submit claims to Bridgeview Company in error must use this process for Bridgeview Company to recoup monies paid out to provider. When a voided claim is submitted, it must be an exact match to the claim information that was originally submitted. If the information does not match, the void request will be denied. If the claim is not submitted as a void, it will be rejected as a duplicate claim.

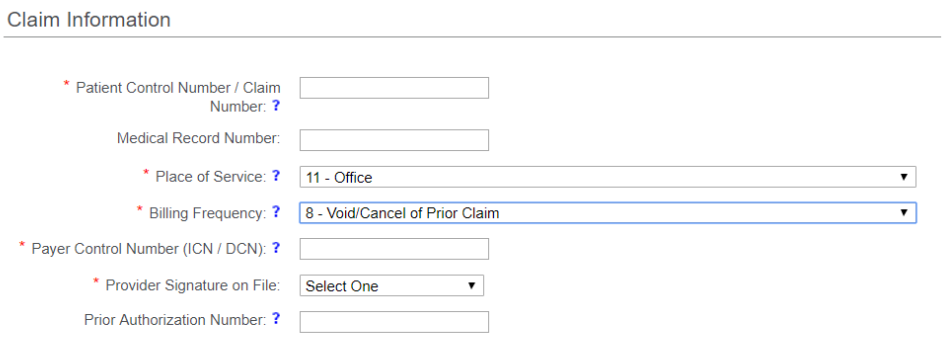
The Bridgeview Company claim number must be entered in the **Payer Control Number (ICN/DCN**.)

The claim number can be found on providers' electronic remittance advice under Claim Information and Payer Claim number. Once the voided claim is received by Bridgeview Company, the claims examiner will void the claim as requested. The payment recovery amount will be subtracted from the provider remittance and will display on the ERA page with a claim status 22 Reversal of Previous Payment. There will also be negative amounts in the submitted charge section when the claim recovery is processed. The claim submitted as the void will then be denied with ANSI 129 Remark MA67 **Submission/billing error(s): Correction to a prior claim.**

***Below is an example of a Void claim and where to enter the payer claims number.**

Make sure you add the claim number of the claim you are requesting to void.

The service agreement number is also required




## Examples of why a replacement or voided claim could be sent to Bridgeview Company:

**Replacement vs. Void Claim Examples**

| **Replacement**<br>*Please note the replacement list is not all-inclusive* | **Void** |
|---|---|
| Date of Service needs to be added<br>Date of Service needs to be modified<br>Diagnosis code change or addition<br>Change to billed amount<br>Change to units billed | Member information change<br>Billing Provider information change<br>HCPCS or Modifier is now incorrect due to revised Service Agreement<br>Billed to Bridgeview Company in error |

## Bridgeview EW Billing Guidelines for Successful Claim form Completion and Submission

• Member ID number: Don't forget the number "8" in the member identification number on the claim form.

This number should be the PMI with an "8" in the front of it. ***Example: 801234567***

• Make sure you are billing the right services to the appropriate health plan. Please refer to the section **Elderly Waiver Service Codes to Submit to Bridgeview Company** below for more information.

• Make sure the service code does not require a modifier. You can verify by checking your service agreement authorization letter.

• Based on the Minnesota Uniform Companion Guides, Minnesota Statutes section 62J.536, all services that are billed to Bridgeview Company must indicate the specific date that services were provided to member and appropriate units based on code definitions.

**• A diagnosis code is required on all claims. The diagnosis code is in the lower left had corner of the service agreement letter to the provider. Failure to add the diagnosis code on the claim form will result in a rejection.**

• Elderly waivers claim service date spans should only be within the same calendar month.

• Supplies should be billed with the purchase date rather than the span of days.

• The following service codes require a narrative that specifically identifies the items being provided

- Extended Supplies and Equipment (T2029)
- Modifications and Adaptations (S5165)
- Environmental Accessibility Adaptation/Home Assessment (T1028)
- Environmental Accessibility Adaptations/Vehicle/Assessment (T2039 UD)
- Environmental Accessibility Adaptations/Vehicle Install (T2039)
- Transitional Services (T2038)
- **Specialized Supplies and Equipment (T2029) may require Medicare and or a Medicaid denial or payment when submitting a claim to Bridgeview.** Elderly Waiver is the payer of last resort, all billing

providers specifically with extended equipment and supplies are required to know primary payers for all items billed.

- A service agreement authorization number is required. The Service Agreement number is an eight-digit number that is located in the on the left-hand side of the form. It is called Prior Authorization number: *Example: 88003366*

• All denied claims need to be resubmitted as a **new** claim.

• A void/replacement claim can only be submitted when the claim has been previously paid (not denied) and the provider is looking for adjustment in payment or to correct information that was submitted on the adjudicated claim.

• All remittances are located on the Availity Essentials portal under the remittance viewer tab

• Once the claim has been submitted, go to the EDI File Management/Send and Receive EDI Files, Receive File Folder (also called mailbox). The Receive File Mailbox is the first level of response on the claim submitted to Bridgeview (or payer). Check your Receive File Mailbox to make sure that the claim (s) has been "Accepted or Rejected" from Bridgeview. If "Accepted," wait approximately 30 days then to the Remittance Viewer to access the remittance where you will see in detail how the claim was paid. If your claim was "Rejected" we should refer to Availity Essentials on how to get to these files.

• Bridgeview Company will process and pay all Elderly Waiver and CFSS claims within 30 days receipt of a clean claim.

## Electronic Remittance Advice (ERA)

All providers who submit claims to Bridgeview Company must be set up by Bridgeview to access their remittance advice under Claims & Payment and Claim Status & Payment/Remittance Viewer on the Availity Essentials portal. The

electronic remittance advice (ERA) are where providers will be informed of the adjudication status and payment amount on the claims submitted. If you have not received a rejection or payment under the 30-day time period, please follow up directly with Bridgeview by telephone or email. Claims determinations must be made within 30 days after claim acceptance or prompt payment interest penalties will be paid by Bridgeview Company.

Daily files are sent to Availity Essentials of claims that are denied for payment. Claims payment cycles will take place each Friday with the exception of holidays. The Remittance Viewer will list the provider payment made by Bridgeview Company.

For instructions on how to access your electronic remittance advice (ERA) on the Availity Essentials portal go to www.availity.com/ Payer Spaces/Bridgeview/Resources for a tutorial of how to access payments in Availity Essentials.

## Waiver Obligations

• A waiver obligation is the amount a member is required to contribute toward the cost of EW services when the person has income at or greater than the Special Income Standards (SIS) as determined by member's county financial case manager.

• Bridgeview Company receives a monthly file for members with retroactive changes and updates from DHS (Department of Human Services) which is automatically updated into the claims processing system.

• Waivers 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 waiver obligation changes and updates and reprocess claims as necessary.

## ACH/Direct Deposit & W9 Form

Bridgeview Company requires all providers to enroll in ACH/Direct Deposit. A completed direct deposit form is required that it must include the following:

- Business Name on the Account
- Address, City, State and Zip Code
- Telephone Number
- Federal Tax ID or Social Security number associated with bank account
- NPI (s), UMPI (s) registered for claim submission
- Bank name
- Bank location
- Bank routing number
- Account number
- Specific for checking or savings account
- Banking verification in the form of a “Voided” bank check.

W9 Forms

Bridgeview is required to have all registered providers complete a W9 form for our records.

Bridgeview Company claims are processed every Friday. Direct Deposit and W9 forms are located on the Bridgeview Company website under “Bridgeview Links”, Elderly Waiver Program documents.

https://www.Bridgeview@bluecrossmn.com

## Change in the Status of a Member

The case manager should inform providers and the county financial worker of any status changes of the member, such as the living arrangement, address and/or phone number, or an incorrect birth date. The county financial worker should notify the case manager of any changes in the person's eligibility for MA or enrollment in managed care.

The authorized service providers and case manager should notify one another when it is known that a member is hospitalized because the provider will not be able to bill for the dates of the member's hospitalization.

The authorized service providers and case manager should also notify one another when a member is admitted to a long-term care facility so the financial worker can update the living arrangement and make appropriate changes to the member's waiver span.

## Change in Member Need

Providers need to contact the lead agency when the need to a member change. The case manager is responsible for reassessing the members and amending the Community Support Plan. This may include change of provider, increasing or decreasing services, addition of a new service, and other appropriate assessed needs.

## Inpatient and Nursing Home Stays Affect Member Eligibility for EW Services

Waiver services are not covered during a hospital, nursing facility, or ICF/MR 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. This applies to all types of elderly waiver services, including chore services, extended medical supplies and equipment, homemaking and PERS services.

Bridgeview Company performs retrospective claims review utilizing inpatient and nursing home claim data received from the member's MCO. The detailed admission and discharge dates are compared to the elderly waiver claim date spans and any claims that conflict with the inpatient or nursing home spans will be recovered. You will need to contact the care coordinator for a revised service agreement and any new claims submitted must be outside the date span of the inpatient or nursing home stay.

## Elderly Waiver Service Codes and Definitions

# Elderly Waiver Services Paid by the Bridgeview Company

| Service Name | Service Unit | Service Code | Modifier 1 | Modifier 2 | Modifier 3 |
|---|---|---|---|---|---|
| Adult Companion | 15 minutes | S5135 | | | |
| Adult Companion Services, Remote | 15 minutes | S5135 | U5 | | |
| Adult Day Service | 15 minutes | S5100 | | | |
| Adult Day Services FADS | 15 minutes | S5100 | U7 | | |
| Adult Day Service Bath | 15 minutes | S5100 | TF | | |
| Adult Day Services, Remote | 15 minutes | S5100 | U4 | | |
| Caregiver Counseling | 15 minutes | S5115 | TF | | |
| Caregiver Counseling, Remote | 15 minutes | S5115 | TF | U4 | |
| Caregiver Training | 15 minutes | S5115 | | | |
| CDCS Background Check | Per Print | T1040 | | | |
| Chore Services | 15 minutes | S5120 | | | |
| Chore Services | Daily | S5121 | | | |
| Consumer Directed Support Services (CDCS) | Per month | T2028 | | | |
| Customized Living | Daily | T2031 | | | |
| Customized Living, 24 hour | Daily | T2031 | TG | | |
| Environmental Accessibility Adaptations, Home Assessment | Per Assessment | T1028 | | | |
| Environmental Accessibility Adaptions, Home Install | Per Waiver Year | S5165 | | | |
| Environmental Accessibility Adaptations, Vehicle Assessment | Per Assessment | T2039 | UD | | |
| Environmental Accessibility Adaptions, Vehicle Install | Per Waiver Year | T2039 | | | |
| Foster Care, Adult, Corporate | Daily | S5140 | U9 | | |
| Foster Care, Adult, Family | Daily | S5140 | | | |
| Home Care Nursing, LPN Complex, Extended | 15 minutes | T1003 | TG | UC | |
| Home Care Nursing, LPN, Regular, Extended | 15 minutes | T1003 | TG | | |
| Home Care Nursing, LPN Shared, 1:2 Extended | 15 minutes | T1003 | TT | UC | |
| Home Care Nursing, RN Complex, Extended | 15 minutes | T1002 | TG | UC | |
| Home Care Nursing, RN Regular, Extended | 15 minutes | T1002 | UC | | |
| Home Care Nursing, RN Shared, 1:2, Extended | 15 minutes | T1002 | TT | UC | |
| Home Delivered Meals | One Meal Per Day | S5170 | | | |
| Home Health Aide, Extended | 15 minutes | S1004 | | | |

| | | | | | |
|---|---|---|---|---|---|
| Homemaker, Assistance with Personal Cares | 15 minutes | S5130 | TG | | |
| Homemaker, Cleaning | 15 minutes | S5130 | | | |
| Homemaker, Home Management | 15 minutes | S5130 | TF | | |
| Homemaker, Home Management, Remote | 15 minutes | S5130 | TF | U4 | |
| Individual Community Living Support (ICLS), In Person/Remote | 15 minutes | H2015 | U3 | | |
| Individual Community Living Support (ICLS), Remote | 15 minutes | T2015 | U3 | U4 | |
| PERS Installation and Testing | Each Time | S5160 | | | |
| PERS Monthly Service Fee | Per month | S5161 | | | |
| PERS Purchase | Each Time | S5162 | | | |
| Personal Care Assistance (PCA), 1:1, Extended | 15 minutes | T1019 | UC | | |
| Personal Care Assistance (PCA), 1:2, Extended | 15 minutes | T1019 | TT | UC | |
| Personal Care Assistance (PCA), 1:3, Extended | 15 minutes | T1019 | HQ | UC | |
| Personal Care Assistance (PCA), Complex, 1:1, Extended | 15 minutes | T1019 | TG | UC | |
| Personal Care Assistance (PCA), Complex, 1:2, Extended | 15 minutes | T1019 | TG | TT | UC |
| Personal Care Assistance (PCA), Complex 1:3, Extended | 15 minutes | T1019 | HQ | TG | UC |
| Personal Care Assistance (PCA), Supervision | 15 minutes | T1019 | UA | | |
| Respite Care Services, In Home | 15 minutes | S5150 | | | |
| Respite Care Services, In Home | Daily | S5151 | | | |
| Respite Care Services, Remote | 15 minutes | S5150 | U4 | | |
| Respite Care Services, Out of Home | 15 minutes | S5150 | UB | | |
| Respite Care Services, Out of Home | Daily | H0045 | | | |
| Respite Certified Facility | Daily | H0045 | | | |
| Respite Hospital, 24 Hours | Daily | H0045 | | | |
| Specialized Supplies and Equipment | Per Item | T2029 | | | |
| Transitional Services | Per Occurrence | T2038 | | | |
| Transitional Services, Remote | Per Occurrence | T2038 | U4 | | |
| Transportation | One Way Trip | T2003 | UC | | |
| Transportation, Mileage, Commercial Vehicle | Per Mile | S0215 | UC | | |
| Transportation, Mileage, Non-Commercial Vehicle | Per Mile | S0215 | UC | | |

**The EW service code descriptions and definitions are from the DHS MHCP Provider Manual.**

**For further detailed information please go to:**

http://www.dhs.state.mn.us/main

**Listed below are commonplaces of service codes for the claim form:**

12 Home

13 Assisted Living Facility

33 Custodial Care Facility

34 Hospice

99 Other Place of Service

### Adult Companion Services

**Center Based S5135- 15 minutes =1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Services cover services that help a person work toward a therapeutic or community integration goal in their support plan. The adult companion may attend a movie with the person, go to a community event, play a board game, provide verbal instruction to the person, assist or supervise the person with tasks such as laundry, light housekeeping, meal prep and shopping. Does not cover activity fees, assistance with ADLS or hands-on nursing care.

### Adult Companion Care Remote

**Center Based S5135 U5- 15 minutes =1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Adult companion services can be delivered through remote support. Services delivered through remote support must meet all the requirements listed on CBSM – Remote support.

### Adult Day Services

**Center Based S5100 – 15 minutes = 1 unit**

**Family Adult Services S5100 U7 – 15 minutes= 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Services provided on a regularly scheduled basis, for one or more days per week, two or more hours per day in an outpatient setting. Meals that are provided as part of these services shall not constitute a "full nutritional regimen" (3 meals/day).

Services are designed to meet the health and social needs of the person. The individual support plan identifies the needs of the person and is directed toward the achievement of specific outcomes. The cost of transportation is not included in the rate.

**Bridgeview Company Billing Requirements S5100 and S5100 U7:**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Adult day service is billable by 15-minute units so provider must list each specific date the service was rendered along with the total number of units provided on that date in the appropriate boxes of the claim form.

**Each day must be listed separately on the claim form with the total units and charges for that day.**

### Adult Day Service Bath- **S5100 TF- 15 Minutes = 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

A member receiving adult day services may also receive a bath provided by an adult day service provider. To receive an adult day bath, a member must be receiving adult day services. The adult day service bath does require a separate service agreement entered by the care coordinator. Adult day service bath is billable by 15-minute units so the provider must list each specific date the service was rendered along with the total number of units provided on that date in the appropriate boxes of the claim form. DHS requirements are limited to two 15-minute units of service per day.

### Family Adult Day Services, FADS

**S5100 U7- 15 Minutes = 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Family adult day services (FADS) are provided in a family foster care license holder's primary residence.

Adult Day Services, Remote **S5100 U4= 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

An individualized and coordinated set of services provided via live, two-way communication by an adult day services center.

Live, two-way communication: Real-time audio or audio and video transmission of information between a person receiving services and an actively involved staff member.

Caregiver Counseling **S5115 TF- 15 minutes = 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

An individualized, person-centered service designed to support caregivers by helping them with their decision-making and problem-solving. Caregiver counseling covers an enrolled caregiver consultant's time spent with a caregiver providing counseling (i.e., a professional consultation) to help them make decisions and solve problems related to the caregiving role.

Caregiver Counseling, Remote **S5115 TF U4- 15 minutes = 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

An individualized, person-centered service designed to support caregivers by helping them with their decision-making and problem-solving. Caregiver counseling can be delivered through remote support. Services delivered through remote support must meet all the requirements listed in the CBSMN

Caregiver Counseling **S5115 TF- 15 minutes = 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

A service that provides caregivers with instruction to improve their knowledge and performance of specific skills related to their caregiving roles and responsibilities. This service builds caregivers' capacity to provide, manage and cope with the caregiving role. Caregiver training pays for the costs of training sessions and

registration fees for such topics as: Health, nutrition and financial management, caregiver roles, support with personal care, disease management. See the CBSMN Provider manual for additional information.

Caregiver Training, Remote: S5115 **TF U4- 15 minutes = 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Caregiver training can be delivered through remote support. Services delivered through remote support must meet all the requirements listed on CBSM Remote support link.

Case Management **T1016 UC- 15 minutes= 1 unit**

Case Management Aide or Paraprofessional- **T1016 TF UC- 15 minutes= 1 unit**

Case Management administrative activities are not billing under any HCBS program. Case management administrative activities including the following:

- Diagnosis
- Intake
- Responding to requests for conciliation conferences and appeals
- Review eligibility for services
- Screen activity
- Service authorization
- Transportation
- Determines financial eligibility

Paraprofessional and case management aides help the case manager carry out administrative activities of the case management function.

CDCS Background Check**- T2040-per print**

Background checks fall into three categories: personal/employment, driving, and criminal. Criminal background studies are not required under CDCS. A person can choose to request a criminal background study on any or all of their staff. If a criminal background study is completed, the person must abide by the results of the study. CDCS Background Checks must be billed showing the specific date the check was done. Make sure to follow the service agreement authorization (NPI/UMPI, HCPCS, modifier, date spans) and include the authorization number.

CDCS Mandatory Case Management-**T2041- 15 minutes= 1 unit**

Under CDCS, case management supports are separated into: Required case management for all who receive CDCS services and support planning services. Delegate agencies are required to bill up to 8 units each month and the member is on CDCS services.

### Chore Service- S5120**- 15 minutes= 1 unit**

### Chore Services- **S5121 Daily**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

Chore services maintain the home of a member as a clean, sanitary, and safe environment. Chore services will be covered only if **both** of the following conditions are met:

• Neither the member nor anyone else in the household is capable of performing or financially providing for the chore services.

• There is no relative, caretaker, landlord, local county or tribal agency, community volunteer/agency or third-party payer capable of or responsible for the provision of the chore services. The chore service is billable by 15-minute units so provider must list each specific date the service was rendered along with the total number of units provided on that date in the appropriate field on the claim form. Make sure to follow the service agreement authorization (NPI/UMPI, HCPCS, date spans) as well as include the authorization number.

**Chore services must be billed with the specific date of service being rendered as well as the units that relate to that date of service. If multiple individiuals are rendering services to a particular member, combine all units together and bill for the grand total of units provided to the member on that particular date. Do not submit ranges which include more than one day. The code has a 15 minute increment definition so so you are not allowed to bill a range such as 12/10/16-12/23/16 with 55 units and $206.80. Each line should contain a unique date and the units in th total that were rendered on that day by all individuals for the billing provider.**

### Emergency Response System Installation & Testing- **S5160**

Care coordinators must indicate a rate and unit on service authorization letter to the provider. This service is limited to one unit and the line item can cover a span of time or just a single date.

### Emergency Response Monthly Service Fee**- S5161 (excludes installation and testing) - monthly**

Care coordinators will indicate the unit (s) and rate authorized per month on service authorization letter to provider.

### Emergency Response System Purchase**-S5162**

This includes the equipment purchase, registration fee and costs for list, broken or additional equipment for a maximum of four units/per month. This service cannot cover a span of time.

**Bridgeview Company Billing Requirements:** Providers billing for installation and testing or for equipment purchases, must bill those claims separately from the monthly service fee. Providers who bill for personal emergency response services such as Lifeline, Medical Alert or Life Alert using service code T2029 after 12/31/2010 will have their claim rejected. Provider must use the appropriate HCPCS PERS codes and units as outlined in DHS Bulletin#10-25-09 issued on October 7, 2010.

### Companion Services- **S5135 - 15 minutes= 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs follow up with that member's care coordinator for review.**

Non-medical care, assistance or supervision and socialization provided to an adult in accordance with a therapeutic goal in the community support plan and are not purely diversional in nature.

The goal of adult companion services are directed at companionship, assistance or supervision of the member in the home or community. Adult companion services may include the assistance or supervision of member with such tasks as:

- Meal preparation
- Laundry
- Shopping
- Light housekeeping tasks are incidental to care and supervision.

**Bridgeview Company Billing Requirements:**

The companion service is billable by 15-minute units so provider must list each specific date the service was rendered along with the total number of units provided on that date in the appropriate field of the claim form. Make sure to follow the service agreement authorization (NPI/UMPI, HCPCS, date spans) and include the authorization number on the claim form.

**Billing Example above: Member received companion services for the month of September. Since the code has a "15 minute" definition, the specific date and number of units rendered must be provided. You cannot bill a range of dates and the grand total of all units; each date of service number be documented and the appropriate total of 15-minute increments assigned.**
**In the example above the member received companion services on the following dates: 09/08/2016 - 4.25 hours, 09/12/2016 – 2.5 hours and 09/15/2016-5 hours.**

## Home Health Services

Members who receive EW services must first access the Medicaid State Plan home care services to the highest extent before the care coordinator authorizes EW services to the community support plan.

The member's Medicaid benefits cover the following home care services:

- Home Health Aide (HHA) visits
- Occupational Therapy (OT)
- Personal Care Assistant (PCA)
- Physical Therapy (PT)
- Private Duty Nursing (PDN)
- Respiratory Therapy (RT)
- Skilled Nursing Visits (SNV)
- Speech Therapy (ST)

Providers must bill the members home care services directly to manage care health plan under the medical benefits. When members have exceeded the home care limitations of those programs impose, providers may then be authorized to bill for the following extended home care services based on the care coordinator service agreement authorization letter.

**All home care services as listed above must be billed to the medical health plan for reimbursement. Bridgeview Company only processes the extended home health claims based on the service agreement authorization letter approving the extended services.**

## Extended Home Health Services

When members have exceeded the home care limits those programs impose, providers can bill for the following extended home care services based on the care coordinator service agreement authorization letter. Below is a listed of the extended home health services with service codes and service unit definitions.

| | |
|---|---|
| **Extended Home Health Aide Service** | **T1004 - 15 minutes = 1 unit** |
| **Extended LPN, Regular** | **T1003 UC - 15 minutes = 1 unit** |
| **Extended LPN, Shared** | **T1003 TT UC- 15 minutes = 1 unit** |
| **Extended LPN, Complex** | **T1003 TG UC- 15 minutes= 1 unit** |
| **Extended PCA 1:1** | **T1019 UC- 15 minutes = 1 unit** |
| **Extended PCA 1:2** | **T1019 TT UC- 15 minutes = 1 unit** |
| **Extended PCA 1:3** | **T1019 UC HQ- 15 minutes = 1 unit** |
| **Extended RN, Regular** | **T1002 UC- 15 minutes = 1 unit** |
| **Extended RN, Regular Shared** | **T1002 TT UC 15 minutes = 1 unit** |
| **Extended RN, Complex** | **T1002 TG UC 15 minutes = 1 unit** |

## Extended PCA Services-

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

T1019 UC – **15 minutes= 1 unit**

T1019 TT UC- **15 minutes = 1 unit**

T1019 HQ UC- **15 minutes =1 unit**

Personal care assistance (PCA) services aid and support for people with disabilities, living independently in the community. This includes the elderly and others with special health care needed. PCA services are provided in the members' home or in the community when normal life activities take him/her outside the home.

Be sure that you are billing the appropriate payer for the PCA services Bridgeview **Company should only should be billed for the Extended PCA services** that are authorized above and beyond the member's regular

Medicaid covered PCA authorization. You will need to submit the Medicaid benefit claims to the MCO that is responsible for the member, not to Bridgeview Company.

Examples of Extended PCA service claims that would be billed to Bridgeview Company:
This example below shows extended PCA services rendered on 06/02/2016, 06/13/2016 and 06/30/2016. A reminder to follow:

- Refer to your service agreement for billing date spans
- Service Agreement number
- Service is billed by unit rates to refer to your service agreement for the correct unit rate. A rate that is billed of the authorized amount will be subject to a fee schedule adjustment (FSA).
- Make sure you include the specific individual PCA UMPI number who rendered the service for each day on the claim line.

### Home Delivered Meals **S5170- One meal per day= 1 unit**

An appropriate nutritionally balanced meal, delivered to the residence of the EW member. All home delivered meals must contain at least one-third of the current Recommended Dietary Allowance (RDA) established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.
Modified diets, when appropriate, will be provided to meet the individual requirement of the person. Home delivered meals are provided to a person who is unable to prepare his or her meals and has no other person (s) available to do so or when the home delivered meal is the most cost-effective method to provide a person with a nutritionally adequate meal.

**Bridgeview Company Billing Requirements**

Home delivered meals are billable per day so the provider must list each specific date and show 1 unit for each date in the appropriate field of the claim form. A date span can only be billed if it is a continuous range of days, and the member receives services on each of those days.
Make sure to follow the service agreement authorization (NPI/UMPI, HCPCS, date spans) and include the service agreement number on the claim form.
Meals must be billed so the specific date of service can be determined. If the member is authorized to receive meals Monday through Sunday or Saturday, the follow date spans listed above would be used for April 2016.

If the member receives meals for each day during the month, the entire month span can be included as 05/01/2016-05/30/2016 with 31 units and bill charges of total units (31) for the per meal rate amount that is indicated on the service agreement. However, if there is a break in the service days, then multiple lines must be used to indicate the specific days.

Homemaker Services /Assistances with Personal Cares- **S5130 TG- 15 minute = 1 unit**

Homemaker Services/Cleaning**- S5130- 15 minutes= 1 unit**

Homemaker Services/Home Management**- S5130 TG -15 minute -= 1 unit**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

General household activities provided by a trained homemaker, when a person is unable to manage the home or when the person regularly responsible for these activities is temporarily absent or unable to manage the home.

Homemaker cleaning services include light housekeeping tasks. Homemaker cleaning services must meet the needs defined in the client's community support plan and not duplicate other homemakers or cleaning services. Homemakers or cleaning providers exclusively deliver home cleaning services.

Homemaker or home Management activities may include help with the following:

- Laundry
- Meal prep
- Shopping for food
- Clothing and supplies
- Simple household repairs
- Arranging for transportation

Homemaker or assistance with activities of daily living (ADL) includes help with the following:

- Bathing
- Toileting
- Grooming
- Eating
- Ambulating

**Example claim for a member receiving Homemaker services S5130 with the 15-minute service definitions which are being billed at $4.61* per unit. * Refer to your current authorization for the appropriate rate per unit.**

**Members received homemaker services for the month of August. Since the code has a "15 minute" definition, the specific date and number of units rendered must be provided. You cannot bill a range of dates and the grand total of all the units; each date of service must be documented and the appropriate total of 15-minute increments assigned.**

**In the example above, on 08/01/2016 the members received 1 hour of homemaking services; on 08/10/2016 member received 4 hours and on 08/30/2016 the member received 1.75 hours of homemaking services.**

## Service Codes that Require a Narrative Description**- T2038, S5165, T2029, T1028, T2039 UC, and T2039**

There are certain codes used in the EW program that are considered Unlisted/Not Otherwise Classified codes that can represent a large variety of services or items. When care coordinators use these codes to authorize EW services for their members, they are required to put a narrative description into the service agreement that specifically indicates the item or service they are authorizing.

## Transitional Services **– T2038 per Occurrence**

Community transitional support services include expenses related to establishing community-based housing for person transitioning to independent or semi-independent community residence from a certified nursing facility or other setting.

Covered Services Examples:

- Lease and rental deposits
- Essential furniture
- Utility set up fees and deposits
- Personal support to assist in locating and transitioning to the community base housing
- Basic household items
- Personal items
- One-time pest and allergen treatment of the setting

Expenses must be reasonable and do not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

**Bridgeview Company Billing Requirements**

When submitting claims for the T2038 code, the provider must list in the claim notes section a description of the specific item or services that is being billed for. The information submitted will be reviewed against the service agreement and if an appropriate level of detail is not provided regarding the service, the claim will reject for invalid narrative provided for a Not Otherwise Classified code.

The T2038 service definition is per occurrence, so the claim must be submitted to correspond to the service agreement that was issued by the care coordinator. If there were several service agreements issued for various components of the transitional services, the provider will need to bill according to those service agreement letters.

**Environmental Accessibility Adaptations**

Environmental Accessibility Adaptations **- S5165- Home Install**

Assessment of Environmental Accessibility Adaptations for Home **T1028-**

Environmental Accessibility Adaptation- Vehicle Install **T2039-**

Assessment of Environmental Accessibility Adaptations for Vehicle **T2039 UD-**

These services cover physical adaptations to the home and/or vehicle required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual with mobility problems, sensory deficit or behavior problems, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

- Environmental modifications and adaptations include modifications to adaptive equipment such as: adaptive furniture and utensils required by the individual. The service will reimburse the purchase, installation, maintenance and repairs of environmental modifications and equipment provided that the repairs are cost efficient compared to replacement of the items.
- Costs may be average over the span of a service agreement (up to 12 months) provided the person is expected to remain on the EW program 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 exists the program, the program cannot pay for any service or time billed after the individual's exit date (the date the person is no longer EW eligible).

- All Modifications and Adaptations (S5165) require a narrative that matches the service agreement authorization letter.
- Authorization of assessments to determine the most appropriate adaptation or equipment (T1028).
- Authorization of vehicle installations that may include but are not limited to: adapted seat devices, door handle replacement, lifting devices, roof extensions and wheelchair securing devices (T2039)
- Authorization of assessments to determine the most appropriate vehicle modifications (T2039 UD)

### Specialized Supplies and Equipment- **T2029-**

Devices, controls or appliances, specified in the care plan, that enable the person to increase their ability to:

- Perform activities of daily living
- To perceive, control or interact with their environment or communicate with others.

A physician's order **may be required for the** Specialized Medical Supplies and Equipment (T2029) purchases under the EW program.

For Specialized Medical Supplies and Equipment (T2029) care coordinators must specifically identify each medical supply and equipment item (s) with the service agreement. Providers are required to submit a narrative description on their claim when they bill for this item on the claim form.

- **Providers must not dispense the item or equipment until service agreement letter is received by the provider.**
- **Providers who submit a claim with an EOB (Explanation of Benefits denial or payment) on a previously paid claim, must submit the claim as an adjustment or claim will reject as duplicate.**

The Care Coordinator is responsible for authorizing covered services according to the appropriate payer and 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) are exhausted prior to utilizing EW 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.

Monthly equipment rental should be billed with the start date of the rental period only rather than the span of days and must use the modifier RR with the T2029 service code.

Equipment rented on other than a monthly basis requires both "From" and "To" dates. Units of service should be reported as one (1) per rental period. These service spans should only be within the same calendar month.

Supplies should be billed with the purchase date rather than the span of days.

Claims must be billed consistently with the authorization for units. For example, if the care coordinator authorizes nutritional supplements each day must be consistent with the authorization units and price per unit methodology.

The EW program does not pay for separate shipping and handling and must be included in the cost of the product or item.

HCPCS Code A9270- "Non covered item or services" is not acceptable HCPCS code on an EOB because it does not list the specific item that was submitted to the primary insurer.

All specialized supplies and equipment must include one of the following modifiers on each line of the claim form. Use the most appropriate modifier for the extended supply or equipment you are billing for.

- NU- New
- RR- Rental
- RB- Repair
- UE- Used

**Respite Care**

**Please refer to the service agreement description of what specific unit/hours the care coordinator is authorizing. If more units are required based on the member's needs, follow up with that member's care coordinator for review.**

In Home Respite Care **S5150 and S5150 UB - 15 Minute = 1 Unit**

In Home Respite Care **S5151 - Per Day= 1 Unit**

Out of Home Respite Care **H0045 – Per Day= 1 Unit**

(Includes hospital and other certified facilities providing 24-hour overnight service)

Services provided to persons unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid family caregivers.

• Respite care can be provided in settings that have appropriate licensure and qualifications.

• Respite care is limited to 30 consecutive days per respite stay in an out-of-home placement in accordance with the care plan.

**Bridgeview Company Billing Requirements:**

Respite care services S5150 is billable by 15-minute units so the provider must list each specific date the service was rendered along with the total number of units provided on that date in the appropriate field of the professional claim form.

Respite care services S5151 and H0045 are billable per day so provider must list each specific date and show 1 unit for each date in the appropriate of the claim form. A date span can only be billed if it is a continuous range of days, and the member was receiving services on each of those days.

Make sure to follow the service agreement authorization (NPI/UMPI, HCPCS, modifier, date spans) and include the service agreement number on the claim.

## Transportation Services

**T2003 with modifier UC – Per one-way trip = 1 unit**

**S0215 with modifier UC – Per mile**

Transportation services may be approved by the care coordinator to enable consumers to gain access to EW services, along with other community services, activities, and resources. The case manager must specify the goals and needs for the service in the care plan. Whenever possible, family, neighbors, friends, or community agencies that provide this service without charge must be utilized.

• Transportation services may be authorized and billed using the mileage rate when simultaneously provided by an individual/organization providing companion services.

• Adult day services and transportation are always separately covered, but are sequentially, not simultaneously provided.

• The mileage rate cannot be used when payment for transportation is received for more than one rider for any portion of the trip regardless of payer.

• The trip rate may be used when transporting and receiving payment for more than one person on any portion of a trip.

• The mileage rate cannot be authorized or billed for miles when the member is not in the vehicle.

**Bridgeview Company Billing Requirements**

T2003 UC transportation is billable per one- way trip and provider must list each specific date on a separate line and either show 1 unit (if only a one-way trip) or 2 units (if round trip service was provided) for each date in the appropriate field of the claim form.

S0215 UC transportation is billable per mile and the provider must list each specific date on a separate line and the total number of miles for each date in the appropriate field of the claim form.

Make sure to follow the service agreement authorization (NPI/UMPI, HCPCS, modifier, date spans) and include the authorization number on the claim.

### Consumer Directed Community Supports (CDCS) **T2028- Per service**

An individual who wishes to receive CDCS must meet all eligibility criteria for one of the programs and be determined eligible or already be receiving EW services. CDCS may include traditional goods and services provided by EW including alternatives that support individuals which are part of the community support plan. The member normally receives an annual budget for the CDCS and can flex the amounts used during that time frame. If the authorization is for less than a year, the amounts will be prorated based on the number of months authorized. The limits for CDCS are set by the Legislature and will be a lower amount than what is allowed under the traditional Elderly Waiver program case mix caps.

A Fiscal Support Entity (FSE) is the only provider who is allowed to submit claims for members who have elected CDCS services.

In CDCS four service categories are covered. Listed below are the service codes with modifiers that identify services:

T2028 U1 Personal Assistance

T2028 U2 Medical Treatment and Training

T2028 U3 Environmental Modifications and Provisions

T2028 U4 Self-Direction Support Activities

**Bridgeview Company Billing Requirements**

Providers billing CDCS services must bill T2028 service code with the appropriate modifier and must not exceed the grand total of the amount authorized on service agreement letter by the care coordinator. The service agreement does not include the specific modifiers, but the FSE must include them when submitting claims to Bridgeview Company. The one unit should be billed for each line item and the provider must not bill overlapping date spans during any given month.

When submitting claims, it would be best to submit all services for an entire month or use a bi-monthly cut-off. The total dollar amount for each modifier for the date spans being billed should be totaled together. It

would be best to submit all services for an entire month or use a bi-monthly cut off but not limited to. Make sure to include the service agreement number on the claim form.

## Customized Living Services/Adult Foster Care Changes-

Providers must check under the Provider Service Agreement section of the Bridgeview Company website for a new service agreement with the daily service codes for:

Customized Living 24 hour - T2031 TG- Daily

Customized Living – T2031- Daily

Foster Care, Adult- S5140- Daily

Foster Care. Corporate S5140 U9- Daily

**Customized Living Services- T2031 Daily= 1 unit**

Customized living services are up to 24 hours of supervision, individualized home care aide tasks, home health aide tasks, and home management tasks provided to residents of a congregate living setting licensed as a home care provider and registered as Housing with Services Establishment. EW providers must not bill for full days in which the member is absent.

**Additional Information**

• Service delivery is directed by the recipient, or provider, with oversight from the care coordinator.

• The care coordinator is the primary party that is responsible for negotiations with the provider to assure that the needs of the recipient are fully met through the package that is created specifically for that recipient.

• All homemaker and chore services needed by a recipient are included in the Customized Living services package that is initially negotiated with the provider. These services are not separately authorized or billed.

• Customized Living services may be provided in any number of apartments in a residential center for recipients who rent or own distinct units.

• Customized Living services are covered under the EW program costs. Room and board, or raw food (groceries), and rent, while a recipient receives customized living services, are paid by the recipient's income, which may include Supplemental Security Income, RSDI and other retirement. If the recipient has inadequate income for room and board or rent charges, he/she may be eligible for a Group Residential Housing (GRH) payment to the provider.

• Lead agencies should negotiate rates based on the level of service needed and provided.

Customized daily service rates should be negotiated up to the individual limit described in Bulletins and updated annually or as the Legislature permits

**Non-Covered Services**

• Room and board

• EW funded homemakers, chore, and respite are not billable services during the period that the person is receiving Customized Living services

• EW providers cannot bill for days on which the client is absent

• Payment for Customized Living services when the recipient is not in the setting

**Bridgeview Company Billing Requirements**

Providers must bill T2031 with 1 unit as the code is defined as one day. The provider must bill within the parameters outlined on the service agreement authorization letter from care coordinator. When billing for customized living around residential absence days, please refer to the section regarding billing guidelines for **Facility Stays or Residential Absence Days** as explained previously in this provider manual.

When billing for a one-month date span, providers can enter on the "From Date" the beginning of the month and the "To" date the last day of the month if there were no residential absence days during that date span. Units must correspond with the number of days/units within the "From" and "To" date span.

If the client had residential absence days, list on the first line of the claim form the "From" and "To" date span up to the admission date and enter the number units/days that correspond to the date span. On the second claim line enter the "From" date the first day the client returned to the customized living facility and the "To" date the last day of the month OR the next date the client had another residential absence day. Providers should not need to bill services on two separate claims.

Providers who submit a claim with a TG modifier will receive a claims rejection because the service code billed did not match the service agreement authorization letter that the care coordinator authorized. The authorization number that is listed on the service agreement letter is also required on the claim form.

**Example claim for a member receiving customized living services (T2031) with the daily rate service definitions for 30 days without residential absence days for the month of June. Provider must calculate the daily rate * the number of days each month. Refer to your current authorization for the appropriate rate per unit.**

**Example claim for a member receiving customized living services (T2031) with residential absence days for the month of July. Members had residential absence days from 07/14/2016-07/19/2016 in the month of July. The provider must create two claim lines each listing the consecutive days in the customized living facility, calculate the days for each line listed below at the daily rate that is listed on the service agreement. Please make sure that your units and "To" and "From" date span match. Total the line items and list the total amount of your claim under "Total Charge."**

**24 Hour Customized Living Services- T2031 TG- Daily = 1 unit**

24 Hour Customized Living services must meet the service definitions in accordance with an individualized community support plan for "Customized Living." In addition, 24-hour Customized Living service providers provide 24 hour on site supervision and on bill the 24-Hour Customized Living service rate to members whose community support plans include a 24-hour plan of care which includes individual supervision plan.

**Additional Information**

• Service delivery is directed by the recipient, or the provider, with oversight from the care coordinator/service coordinator.

• The care coordinator is the primary party responsible for negotiations with the provider to assure that the needs of the recipient are fully met through the package that is created specifically for that recipient.

• Lead agencies can negotiate individualized monthly rates up to the recipient's budget cap based on the level of service needed and provided.

• All homemaker tasks and chore services are a part of the 24 Hour Customized Living Services package initially negotiated with the provider and meets all of the home management task service needs for the recipient.

**Non-covered Services**

• Room and board

• Personal emergency systems (i.e. lifeline, med alert)

• EW funded homemaker, chore, and respite are not billable services during the period that the person is receiving 24 Hour Customized Living Services

• EW providers cannot bill for days on which the client is absent Bridgeview Company Elderly Waiver Claims Processing Manual - Confidential and Proprietary Page 39

**Bridgeview Company Billing Requirements**

Providers must bill monthly the T2031 TG with 1 unit as the code is defined as one day. The provider must bill within the parameters outlined on the service agreement authorization letter from care coordinator.

When billing for more than one date span in a month, providers should not bill services on two separate claims. Instead use the detail line items on the claim form to show the service "From" date and the service "To" date for each span of care. The second line will start with the date after the residential absence and will end with either the end of the month or the last date before the member has another residential absence date (whichever is sooner). Use units corresponding with the "To" and "From" date span for each line item.

Providers who do not include the TG modifier on their claims, based on the service agreement authorization letter will receive a rejected claim. The authorization number that is listed on the service agreement letter is also required on the professional claim form.

**Foster Care, Adult S5140- Daily = 1 unit**

**Foster Care Adult Corporate S5140 U9- Daily= 1 unit**

Foster care services are individual EW services provided to a member living in a home licensed as foster care. Foster care services are individual and are based on the individual needs of the members, and service rates must be determined accordingly.

**Bridgeview Company Billing Requirements:**

Providers must bill monthly the S5140 U9 or S5140 with 1 unit as the code is defined as one day. The provider must bill within the parameters outlined on the service agreement authorization letter from the care coordinator.

Providers who render monthly defined EW services and do not provide services continuously during the month must indicate the exact dates of service being rendered in the line-item detail. Providers can do this by breaking out the date ranges on a separate line when the claim is submitted.

## Community First Support Services (CFSS)

## Community First Support Services (CFSS) Paid by the Bridgeview Company

| Service Name | Service Unit | Service Code | Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4 |
|---|---|---|---|---|---|---|
| CFSS, Agency 1:1 | 15 minutes | T1019 | U9 | | | |
| CFSS, Agency 1:2 | 15 minutes | T1019 | U9 | UN | | |
| CFSS, Agency, 1:3 | 15 minutes | T1019 | U9 | UP | | |
| CFSS, Agency 45 day temp start | 15 minutes | T1019 | U8 | | | |
| CFSS, Agency, Complex 1:1 | 15 minutes | T1019 | U9 | TG | | |
| CFSS, Agency, Complex 1:2 | 15 minutes | T1019 | U9 | TG | UN | |
| CFSS, Agency, Complex 1:3 | 15 minutes | T1019 | U9 | TG | UP | |
| CFSS, Agency, Complex 45 day temp start | 15 minutes | T1019 | U8 | TG | | |
| CFSS, Agency, Complex, Continuation of Benefits 1:1 | 15 minutes | T1019 | U9 | U4 | TG | |
| CFSS, Agency, Complex Continuation of Benefits 1:2 | 15 minutes | T1019 | U9 | U4 | UN | TG |
| CFSS, Agency, Complex, Continuation of Benefits 1:3 | 15 minutes | T1019 | U9 | U4 | UP | TG |
| CFSS, Agency Complex, Extended, 1:1 | 15 minutes | T1019 | U9 | UC | TG | |
| CFSS, Agency Complex, Extended 1:2 | 15 minutes | T1019 | U9 | UC | UN | TG |
| CFSS, Agency Complex, Extended 1:3 | 15 minutes | T1019 | U9 | UC | UP | TG |
| CFSS, Agency Complex, Reduction, 1:1 | 15 minutes | T1019 | U9 | U5 | TG | |
| CFSS, Agency Complex, Reduction, 1:2 | 15 minutes | T1019 | U9 | U5 | TG | |
| CFSS, Agency Complex, Reduction, 1:3 | 15 minutes | T1019 | U9 | U5 | TG | |
| CFSS, Agency, Complex, Temporary Increase 1:1 | 15 minutes | T1019 | U9 | U6 | TG | |
| CFSS, Agency, Complex, Temporary Increase 1:2 | 15 minutes | T1019 | U9 | U6 | TG | UN |
| CFSS, Agency, Complex, Temporary Increase 1:3 | 15 minutes | T1019 | U9 | U6 | TG | UP |
| CFSS, Agency, Continuation of Benefits 1:1 | 15 minutes | T1019 | U9 | U4 | | |
| CFSS, Agency, Continuation of Benefits 1:2 | 15 minutes | T1019 | U9 | U4 | UN | |
| CFSS, Agency, Continuation of Benefits 1:3 | 15 minutes | T1019 | U9 | U4 | UP | |
| CFSS, Agency, Extended, 1:1 | 15 minutes | T1019 | U9 | UC | | |
| CFSS, Agency, Extended, 1:2 | 15 minutes | T1019 | U9 | UC | UN | |
| CFSS, Agency, Extended, 1:3 | 15 minutes | T1019 | U9 | UC | UP | |

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|---|---|---|---|---|---|---|
| CFSS, Agency, Goods | Per Authorization Year | T5999 | U9 | | | |
| CFSS, Agency, PERS Installation and Testing | Each Time | S5160 | U9 | | | |
| CFSS, Agency, PERS Monthly Service Fee | Monthly | S5161 | U9 | | | |
| CFSS, Agency, PERS Purchase | Each Time | S5162 | U9 | | | |
| CFSS, Agency, Reduction 1:1 | 15 minutes | T1019 | U9 | U5 | | |
| CFSS, Agency Reduction, 1:2 | 15 minutes | T1019 | U9 | UN | | |
| CFSS, Agency Reduction, 1:3 | 15 minutes | T1019 | U9 | U5 | UP | |
| CFSS, Agency, Worker Training & Development | Per Authorization Year | S5116 | U9 | | | |
| CFSS, Agency, Worker Training & Development, Classroom | Per Authorization Year | S5116 | U9 | UD | | |
| CFSS, Budget, 1:1 | 15 minutes | T1019 | UB | | | |
| CFSS, Budget, 1:2 | 15 minutes | T1019 | UB | UN | | |
| CFSS, Budget, 1:3 | 15 minutes | T1019 | UB | UP | | |
| CFSS, Budget, Complex, 1:1 | 15 minutes | T1019 | UB | TG | | |
| CFSS, Budget, Complex, 1:2 | 15 minutes | T1019 | UB | TG | UN | |
| CFSS, Budget, Complex, 1:3 | 15 minutes | T1019 | UB | TG | UP | |
| CFSS, Budget, Complex, Continuation of Benefits, 1:1 | 15 minutes | T1019 | UB | U4 | TG | |
| CFSS, Budget, Complex, Continuation of Benefits, 1:2 | 15 minutes | T1019 | UB | U4 | TG | UN |
| CFSS, Budget, Complex, Continuation of Benefits, 1:3 | 15 minutes | T1019 | UB | U4+ | TG | UP |
| CFSS, Budget, Complex, Extended 1:1 | 15 minutes | T1019 | UB | UC | TG | |
| CFSS, Budget, Complex, Extended 1:2 | 15 minutes | T1019 | UB | UC | TG | UN |
| CFSS, Budget, Complex, Extended 1:3 | 15 minutes | T1019 | UB | UC | TG | UP |
| CFSS, Budget, Complex Reduction, 1:1 | 15 minutes | T1019 | UB | U5 | TG | |
| CFSS, Budget, Complex Reduction, 1:2 | 15 minutes | T1019 | UB | U5 | TG | UN |
| CFSS, Budget, Complex Reduction, 1:3 | 15 minutes | T1019 | UB | U5 | TG | UP |
| CFSS, Budget, Complex, Temporary Increase, 1:1 | 15 minutes | T1019 | UB | U6 | TG | |
| CFSS, Budget, Complex, Temporary Increase, 1:2 | 15 minutes | T1019 | UB | U6 | TG | UN |
| CFSS, Budget, Complex, Temporary Increase, 1:3 | 15 minutes | T1019 | UB | U6 | TG | UP |
| CFSS, Budget, Continuation of Benefits 1:1 | 15 minutes | T1019 | UB | U4 | | |
| CFSS, Budget, Continuation of Benefits 1:2 | 15 minutes | T1019 | UB | U4 | UN | |
| CFSS, Budget, Continuation of Benefits 1:3 | 15 minutes | T1019 | UB | U4 | UP | |

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|---|---|---|---|---|---|---|
| CFSS, Budget, Extended, 1:1 | 15 minutes | T1019 | UB | UC | | |
| CFSS, Budget, Extended, 1:2 | 15 minutes | T1019 | UB | UC | UN | |
| CFSS, Budget, Extended, 1:3 | 15 minutes | T1019 | UB | UC | UP | |
| CFSS, Budget, Failed background study fee | Per Print | T2040 | UB | UA | U6 | |
| CFSS, Budget, FMS Fee | Monthly | T2040 | UB | UA | | |
| CFSS, Budget, Goods | Per Authorization Year | T5999 | UB | | | |
| CFSS, Budget, PERS Installation and Testing | Each Time | S5160 | UB | | | |
| CFSS, Budget, PERS Monthly Service Fee | Monthly | S5160 | UB | | | |
| CFSS, Budget, PERS Purchase | Each Time | S5162 | UB | | | |
| CFSS, Budget, Reduction, 1:1 | 15 minutes | T1019 | UB | U5 | | |
| CFSS, Budget, Reduction, 1:2 | 15 minutes | T1019 | UB | UN | | |
| CFSS, Budget, Reduction, 1:3 | 15 minutes | T1019 | UB | U5 | UP | |
| CFSS, Budget, Temporary Increase, 1:1 | 15 minutes | T1019 | UB | U6 | | |
| CFSS, Budget, Temporary Increase, 1:2 | 15 minutes | T1019 | UB | U6 | UN | |
| CFSS, Budget, Temporary Increase, 1:3 | 15 minutes | T1019 | UB | U6 | UP | |
| CFSS, Budget, Worker Training & Development Classroom | Per Authorization Year | T1019 | UB | UD | | |
| CFSS, Consultation, Ongoing Support | Per Session | T1023 | TS | | | |
| CFSS, Consultation, Orientation/Annual Renewal | Per Session | T1023 | | | | |
| CFSS, Consultation, QA/Remediation | Per Session | T1023 | U2 | | | |
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Effective 10/01/2024 CFSS is a health care program in Minnesota that offers flexible options to help people with disabilities living independently in their homes and Communities.

All providers who desire to provide CFSS services must enroll with DHS CFSS program.

PCA reassessments starting 10/01/2024 members will transition to the CFSS program. Any new member in need of any PCA services will directly enroll in the CFSS services after 10/01/2024.

Provider service agreements for CFSS services are in the Availity Essentials website under Bridgeview Service agreements the next business day after the care coordinator enters the Service Agreement. Bridgeview process all CFSS service claims.

**The CFSS service code descriptions and definitions are from the DHS MHCP Provider Manual.**

**For further detailed information please go to: www.dhs.com**

http://www.dhs.state.mn.us/main

Consultation Services: Provider responsible to educate and help people make informed decisions about how to meet their needs using CFSS: T**1023-, T1023 TS, T1023 U2- 1 visit**

Claim requirement is 1 claim for each visit

Worker and Training Development: A separate budget available to employers or CFSS workers to pay for training, observation, monitoring and coaching of CFSS workers: A one-time fee per year when member starts CFSS services:

Agency: S5116 U9, S5116 U9 UD

Budget: S5116 UB UD

**CFSS/PCA Agency: T1019 U9-T1019 U9 U6 UD**: CFSS/PCA support workers who help people with daily tasks in either PCA or CFSS. Service agreement authorizes units (1 unit represents 15 minutes of service) for the CFSS participant to the CFSS provider agency. Providers must bill authorized units per day on a single day basis. Rendering PCA is also required, and the rate should be the rate of the based on the documented minimum wage rate based on the hours DHS has calculated when enrolled with DHS. Failure to include the rendering PCA will result in claims rejections. Providers must bill the tiered rate their PCA accrued.

**CFSS/PCA Budget: T1019 UB- T1019 UB U6 UD**: Service agreement authorizes is for the total amount of budgeted amount of money for the CFSS participant. The participant is the employer of their support workers and will recruit, hire, train and supervise their support workers. The participant will select an FMS provider to help with employer-related tasks. FMS provider can bill up to the total authorized amount for the service agreement date span.

**CFSS, Agency Goods: T5999 U9:** People who use CFSS may purchase covered goods and services that are related to the assessed needs and for the direct benefit of the person. Examples are grab bars, wheelchair ramps, vehicle modifications, specialized devices for dressing or grooming. Providers must list the item they are billing for in claim notes that are listed in the service agreement.

**CFSS, Budget Goods T5999 UB:** People who use CFSS may purchase covered goods and services that are related to the assessed needs and for the direct benefit of the person. Examples are grab bars, wheelchair

ramps, vehicle modifications, specialized devices for dressing or grooming. Providers must list the item they are billing for in claim notes that are listed in the service agreement.

**CFSS, Agency, PERS Install and testing, PERS monthly service fee, PERS purchase- S5160 U9, S5161 U9, S5162 U9:** Personal Emergency Stems (PERS)- an electronic device typically worn as a pendant or bracelet that includes an alert or panic button the person can press in the event of a fall or other emergency: PERS provider must bill the service code and rate that is listed on the member's service agreement.

**CFSS, Budget, PERS Install and testing, PERS monthly service fee, PERS purchase-S5160 UB, S5161 UB, S5162 UB**

Personal Emergency Stems (PERS)- an electronic device typically worn as a pendant or bracelet that includes an alert or panic button the person can press in the event of a fall or other emergency: PERS provider must bill the service code and rate that is listed on the member's service agreement.

**Providers Billing Other Health Coverage**

The provider is responsible for billing only the appropriate payer for the member and the item (s). For EW all other private and public payers (private insurance, Medicare, Medical Assistance) are exhausted prior to utilizing EW funds for coverage. The provider must submit copies of the denials from those payment sources to the lead agency. If inappropriate billing is revealed in an audit, the provider is responsible and risks payment recovery.

**Inquiries**

Providers must check their ERA tab for claims problems and payments regularly. If a provider does not see their claim results on the ERA tab thirty days after submission, they may contact Bridgeview Company at:

**1-800-584-9488**

**Or**

**218- 740-2336**

**Email to:** **EWProviders@bluecrossmn.com**