CASE MANAGEMENT

WHEN TO CALL YOUR CASE MANAGER

- Facility event affecting all or some members (fire, infectious outbreak, bed bugs, etc.)
- Suspected fraud/abuse of member
- Changes in member condition
- Hospital admission or discharge
- Bed Hold request (medical or therapeutic leaves)
- Member expired
- Member fall or injury (increase LOC, decrease LOC, skilled coverage change, move on/off specialty unity, member wandering or no longer wandering)
- Cognitive changes
- Skin breakdown or wounds
- Discharge from facility
- Admission to facility
- Enrollment onto or off of Hospice services
- Changes in primary insurance
- Caregiver escort needed for an outside appointment (member should have exhausted all informal support options)
- Issuing of 30 Day Notice (copy of the notice must be sent to the case manager)
- Notification of scheduled care plan or discharge meetings (case manager to attend on an as needed basis)

HOW TO REQUEST A BRIDGEWAY AUTHORIZATION FOR CUSTODIAL STAYS

Contact the member’s assigned Bridgeway Case Manager:

- Provide the case manager with:
  - the member’s name,
  - dates of service and
  - additional documentation as requested
SPECIALTY PLACEMENT CRITERIA AND SUPPORTIVE DOCUMENTATION

Dementia/Wandering Care

Service Goal: To ensure the provision of residential care for demented members in need of a protective environment for wandering behavior.

A. Placement Criteria - the member must meet the following admission criteria:
   1. The member has a diagnosis of dementia (includes Alzheimer’s disease), organic brain syndrome, or other diagnoses affecting their cognitive ability such as traumatic brain injury; and
   2. Member has failed to adequately improve with appropriate psychiatric evaluation and treatment attempts; and
   3. In a residential setting, there is documentation that the member exhibits problematic wandering behavior which endangers the member or other residents and is characterized by one or more of the following:
      1) Repeatedly exits through outside doors
      2) Frequently wanders into off-limit areas such as the kitchen, laundry, storage, maintenance, resident rooms and other off-limit areas without responding to redirection.
      3) Wanders into other member rooms and is unable to find their way back to their own room
   4. In home and community based services (HCBS) setting, there is documentation that the member exhibits problematic wandering behavior characterized by one or more of the following:
      a. Repeatedly wanders away from home, requiring local police, or others to return them because of confusion about which house in the neighborhood is theirs
      b. Requires the family or other caregiver to lock the member in the house when leaving the member unattended to prevent them from getting out and lost
      c. Unsafe driving despite actions taken by family or authorities

B. Intensity of Service – the member must be provided with:
   1. Secure living area indoors and outdoors by means of locks and/or electronically controlled access.
   2. Activities appropriate for persons with dementia
   3. All services, medications, supplies and equipment necessary to manage the needs of the member.

C. Discharge Criteria
1. Member no longer meets placement criteria, and 2 or 3
2. Member is able to be safely managed in a lower level of care
3. Member requires higher level of care than what is able to be provided

Dementia with Behaviors Care

*Service Goal:* To ensure the provision of residential care for members with cognitive impairments in need of a protective environment for significant behaviors.

A. Placement Criteria - the member must meet all of the following admission criteria:
   1. The member has a diagnosis of dementia (includes Alzheimer’s disease), organic brain syndrome, or other diagnoses affecting their cognitive ability such as traumatic brain injury; and
   2. The member has failed to adequately improve with appropriate psychiatric evaluation and treatment attempts; and
   3. Documentation that the member exhibits problematic behavior on a daily basis which endangers the member, or other residents, that cannot be managed in a traditional nursing facility or in an HCBS setting as characterized by one or more of the following:
      a. Repeated attempts to exit through an outside door, repeatedly banging on locked door (unable to redirect)
      b. Physical aggression toward other residents
      c. Suicide attempts or other self-injurious behaviors
      d. Throwing things uncontrolled and unable to redirect
      e. Yelling continuously for several hours during the day or night despite treatments for pain and non-pharmacological interventions
      f. Repeatedly throwing self out of a wheelchair, out of bed, throwing self to floor requiring increased staffing for safety concerns
      g. Displaying sexualized behaviors, including attempts to inappropriately touch other residents
      h. Misuse/abuse of medications, alcohol and drugs
      i. Mental disorders such as psychosis or depression, not manageable at a lower level of care
      j. Two documented attempts to step member down from dementia/wandering unit have been attempted and failed causing an exacerbation of symptoms and increased behaviors.

B. Intensity of Service – The member must be provided with:
   1. Secure living area indoors and outdoors by means of locks and/or electronically controlled access that is separate from the areas of other facility residents, and
   2. Staff ability to directly observe and supervise the member at all times, and
   3. Psychiatric nursing care services with observation and assessment of
members’ changing condition, and
4. Activities appropriate for persons with dementia, and
5. All services, medications, supplies and equipment necessary to manage the needs of the member.

C. Discharge Criteria
1. Member no longer meets placement criteria, and 2 or 3
2. Member is able to be safely managed in a lower level of care, or
3. Member requires higher level of care than what is able to be provided

Dialysis Care
Service Goal: To provide skilled nursing, residential care, and supervision for members with high acuity and specialized dialysis needs.
A. Placement Criteria – The member must meet the following admission criteria:
   1. Member requires dialysis and is unable to attend in an outpatient setting due to a medical condition such as pericarditis, pneumonia or other infection, gastrointestinal bleeding, confusion or dementia, or hemodynamic instability; and
   2. Member is unable to sit up for 4 hours at a time and one of the following:
      a. The member has a wound that prohibits outpatient dialysis, OR
      b. The member has to use a Hoyer lift for transfers.

B. Intensity of Service – The member must be provided with:
   1. Dialysis treatment as prescribed by a nephrologist, and
   2. Evaluation and monitoring of member’s condition on an on-going basis, and
   3. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   4. All services, medications, supplies and equipment necessary to manage the needs of the member.

C. Discharge Criteria
1. Member no longer meets placement criteria, and 2 or 3
2. Member is able to be safely managed in a lower level of care, or
3. Member requires higher level of care than what is able to be provided

Respiratory Care
Service Goal: To provide skilled nursing, residential care, and supervision for members requiring respiratory care who need nursing services on a 24-hour basis, but who do not require hospital care under the daily direction of a physician.
A. Placement Criteria – The member must meet the following admission criteria:
   1. The member requires 3 or more of the following in a 24-hour period performed by the facility licensed staff
      a. Trach care twice a day and as needed
      b. Tracheal suctioning every 4 hours and as needed
      c. Aerosol therapy, cool mist FIO2 28% or greater
      d. Chest physical therapies - percussion and postural drainage.
      e. CPAP/BIPAP continuous or during sleep
      f. CPAP or PSV setting on a ventilator.
      g. Mechanical ventilation <6 hours in a calendar day, without weaning in progress.

B. Intensity of Service – The member must be provided with:
   1. Respiratory therapy needs as prescribed by member’s physician, and
   2. Evaluation and monitoring of member’s condition on an on-going basis, and
   3. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   4. All services, medications, supplies and equipment necessary to manage the needs of the member.

C. Discharge Criteria
   1. Member no longer meets placement criteria, and 2 or 3
   2. Member is able to be safely managed in a lower level of care, or
   3. Member requires higher level of care than what is able to be provided

Ventilator Care

Service Goal: To provide skilled nursing care, residential care, and supervision for members who are dependent on mechanical ventilation to sustain life and who need nursing services on a 24-hour basis, but do not require hospital care under the daily direction of a physician.

A. Placement Criteria – The member must meet the following admission criteria:
   1. Requires mechanical ventilation for ≥ 6 hours per day to sustain life. Acceptable setting modes for ventilator care include
      a. Assist control (AC), or
      b. Spontaneous intermittent mandatory ventilation (SIMV); OR
      c. The member requires < 6 hours of mechanical ventilation and weaning from the ventilator is in progress.

B. Intensity of Service – The member must be provided with:
   1. Mechanical ventilation needs as prescribed by member’s physician, and
   2. Evaluation and monitoring of member’s condition on an on-going basis, and
3. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
4. All services, medications, supplies and equipment necessary to manage the needs of the member.

C. Discharge Criteria
   1. Member no longer meets placement criteria, and 2 or 3
   2. Member is able to be safely managed in a lower level of care, or
   3. Member requires higher level of care than what is able to be provided

**Bariatric Care**

*Service Goal:* To provide skilled nursing care, residential care, and supervision for members with high acuity and specialized care due to extreme obesity.

A. Placement Criteria – The member must meet both of the following:
   1. BMI ≥ 50 kg/m², and
   2. Member is unable to change position, ambulate, or transfer without hands on assistance from three or more caregivers.

B. Intensity of Service – The member must be provided with:
   1. Nutritional counseling to assist with appropriate caloric needs, and
   2. Physical, occupational or restorative therapies tailored to the member, and
   3. An ongoing, multidisciplinary approach to weight loss, and
   4. All services, medications, supplies and bariatric equipment necessary to manage the needs of the member.

C. Discharge Criteria
   1. Member no longer meets placement criteria, and 2 or 3
   2. Member is able to be safely managed in a lower level of care, or Member requires higher level of care than what is able to be provided

**Sub-Acute Care**

- Request through the Prior Auth (PA) Department.
  - Direct PA Phone: 1-866-295-9729, PA Fax: 1-866-638-6126

**Insurance Coverage Criteria for Bridgeway to authorize Sub-Acute placement:**
A. Long Term Care covered (ALTCS) only member in a Nursing Home.
   Note: Member should not currently be under Hospice services.
B. Medicare covered member who has Medicare B only or has exhausted all of their
Medicare days under their primary insurance and continues to meet criteria for sub-acute care

1. Placement Criteria
   Member requires one or more of the following:
   a. Nastro tracheal or tracheal suctioning by licensed personnel more than two times per eight-hour shift.
   b. Multiple complex treatments ordered by the member’s medical provider to be performed by registered nursing staff more than two times per eight-hour shift. (A complex treatment is one that requires at least 20 minutes)
   c. Intravenous infusions and/or medications that may or may not require an infusion pump and are administered more frequently than one time per twenty-four hour period.
   d. Unstable or severe medical problems that require changes in the therapeutic regimen as ordered by the medical provider.
   e. Total Parenteral Nutrition (TPN)
   f. Complex wound care:
      Multiple wounds
      Flaps for multiple wounds
      Stage III and or IV decubitus
      Non- healing surgical wounds

CHALLENGING BEHAVIORS
What do I do when the resident is acting out? It is important to note that all behavior is communication; some behaviors can be eliminated by addressing the problem that the communication is indicating.

1. Rule out any and all potential medical causes of the behavior. Assessing current lab work, checking for UTI and addressing pain issues are common ways to curtail behaviors.
2. Discuss with the prescriber if the behaviors are being elicited by any existing medication that the resident is on.
3. Discuss with the PCP any potential medication changes that need to occur.
4. Do a thorough assessment of any environmental factors that can be contributing to the behaviors. Are there any simple changes that can be made that will be a deterrent to
the behaviors? Consider a referral to a Clinical Social Worker, Psychologist or Behaviorist for assessment and development of an individual behavior plan.

5. Consider a referral for a psych eval and medication management from a Psychiatrist or Psychiatric Nurse Practitioner.

6. If the behaviors still persist, gather supporting documentation and send to the Bridgeway Case Manager for a review of placement options.

**Accessing Behavioral Health Services**

1. Although the Bridgeway Case Manager is there to assist, any behavioral health referral can be made independent of them.

2. Review the resident’s primary insurance. Visit the website or call the primary insurance plan to find providers in your area (for Bridgeway Advantage and Bridgeway LTC visit [www.bridgewayhs.com](http://www.bridgewayhs.com)). Keep in mind that ALTCS plans cannot pay for BH services without first going through any existing primary insurance.

3. When a provider is located, you may call the provider directly to see if they are accepting new clients and can service your resident. (Over time, it is best to develop relationships with behavioral health providers that accept the insurances common to residents in your facility and are able to visit them on site)

4. Our Bridgeway Case Managers are available to help in this process if at any time you need assistance.

**GENERAL MEDICAL SERVICES AUTHORIZATION**

Bridgeway requires prior authorization for certain acute outpatient services and planned hospital admissions. Please go to [www.bridgewayhs.com](http://www.bridgewayhs.com) and view the prior authorization list or you can use the “Pre-Auth Needed?” tool ([http://www.bridgewayhs.com/for-providers/pre-auth-needed/](http://www.bridgewayhs.com/for-providers/pre-auth-needed/)). Simply put the CPT code in the tool and it will identify if you need a prior authorization or not.

Bridgeway concurrent review nurses authorize all skilled stays for Bridgeway LTC and Bridgeway Advantage members.

Bridgeway LTC case managers authorize custodial stays for all Bridgeway Long Term Care members.

When requesting authorization for a skilled SNF admission, please provide the following information along with the request:

- Facility face sheet
- Admit date
• Admit diagnosis
• Services that will be provided under the skilled stay

DURABLE MEDICAL EQUIPMENT
Bridgeway Advantage Non-custodial Nursing Facility stay: All DME is included in the RUG or per diem rate.

Bridgeway Custodial Nursing Facility stay: All durable medical equipment is included in the SNF per diem rate with the exception of customized equipment and specialty beds.

A. Specialty Beds: A specialty bed or mattress (high air loss mattress or clinitron bed) must be medically necessary and does require a prior authorization.

B. Customized Equipment: Customized equipment requires prior authorization

THERAPY AUTHORIZATIONS
The Nursing facility must use contracted therapy providers and the services must be prior authorized.

Bridgeway Advantage: When a SNF is paid under RUGS, therapies are included in the RUGS reimbursement.

Bridgeway Long Term Care: The SNF must obtain authorization for therapy services from the prior authorization department. Covered therapy services are not included in the per diem rate. To obtain authorization for therapy, you must complete a prior authorization request form. You should include any and all evaluations along with supporting documentation for review.

NURSING FACILITY: Discharges and Appeals

Bridgeway Advantage Skilled Stay
Discharges:

• The Notice of Medicare Non Covered (NOMNC) Services is required by the centers for Medicare and Medicaid Services for all Advantage and FFS members. This notice is time sensitive and must be given by the facility to the member at least two full days before the anticipated discharge date. The notice must be completed as directed by CMS or it will not be a valid notice.

• If the enrollee disagrees with the discharge, they can request an expedited appeal by the QIO. The QIO will request medical records supporting the discharge decision. Bridgeway will submit those records to the QIO by the end of that day of the request.
• If the QIO agrees with the discharge date, the enrollee is responsible for payment if they decide to stay past the discharge date stated. If the QIO overturns the appeal, disagrees with the discharge date, the QIO will notify Bridgeway Advantage and the discharge date will be rescinded and payment by Bridgeway Advantage will continue at that level of care.
• Discharge notice also applies when a Bridgeway Advantage enrollee needs to be moved to a lower level of care within the same facility.

Appeals:
• The concurrent review nurse is to come to an agreement between the Nursing Facility and the health plan at the time the member is in placed in the SNF.
• If the SNF disagrees with the level of care or length of stay after the member has been discharged, the SNF must follow appropriate appeal/reconsideration steps based on who the primary payer’s process.

Bridgeway Long Term Care Custodial Stay
• All discharges from a nursing facility must be coordinated with the Bridgeway LTC case manager.
• Regardless of reason, the member, their representative, and the Bridgeway LTC case manager must be involved in the discharge planning.

Appeals:
• If the nursing facility disagrees with a level of care determined by the Bridgeway LTC case manager, the first conversation will be with the Bridgeway LTC case manager.
• If the issue is not resolved, the nursing facility should call the Bridgeway LTC case manager’s supervisor to discuss the level of care.

**PHARMACY**

Current version of the Bridgeway Advantage and Bridgeway Health Solutions preferred drug list (PDL) is found on Bridgeway’s website:

http://www.bridgewayhs.com/for-members/altcs/pharmacy/

• Bridgeway Advantage skilled nursing stays: Prescription drugs are included in the RUG payment
• Bridgeway LTC is primary payer: Nursing facilities must use a contracted pharmacy vendor.
• Hospice medications are covered by the hospice vendor.

CLAIMS PAYMENT AND SUBMISSION

ELECTRONIC CLAIMS SUBMISSION
Network providers are encouraged to participate in Bridgeway’s Electronic Claims/Encounter Filing Program through Centene. Centene has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Bridgeway has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

Bridgeway Health Solutions
C/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at:
EDIBA@centene.com

Submitting a claim through EDI submission has benefits:

• EDI claims are systematically received and processed
• EDI claims are adjudicated much quicker, if all necessary typed information is submitted properly, due to the time required for imaging and manual processing

To submit claims via our web site go to www.bridgewayhs.com. Providers will need to sign up for using the web claims submission, but your Provider Relations Specialist can assist you in obtaining a user ID and set up a time to train staff in using the web for claims submission.

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.
**ELECTRONIC FUND TRANSFER (EFT)**

Bridgeway offers providers the option of receiving payment by electronic fund transfer instead of a mailed paper check.

To participate, providers must complete a Centene EFT agreement. The agreement form includes registration to receive ERA.

A copy of the Centene EFT agreement is in the Appendix Pack. You can also obtain a copy by accessing the Provider Web site or by calling the Provider Inquiry Line.

**BRIDGEWAY’S EXPLANATION OF PAYMENT**

Bridgeway understands that payment to our providers is extremely important and will generate payments on a weekly basis. With your payment you will receive an Explanation of Payment (EOP) which will give you information including but not limited to how we paid your claim, other insurance (if applicable), and member’s Share of Cost or Room and Board (if applicable). If for any reason, your claim is denied, the denial reason will also be on the EOP. Bridgeway will give you all applicable denials so that when you resubmit with a corrected claim, you will know everything that would need to be corrected.

**SHARE OF COST (SOC)**

**Definition**

The amount an ALTCS recipient is required to pay towards the cost of long term care services is called the share of cost. Share of Cost (SOC) is determined on a month-by-month basis by AHCCCS.

Under the Arizona Long Term Care System (ALTCS), members may be responsible for a share of the cost for their care. This is determined during the eligibility process.

- If the member receives income such as a retirement, Medicare or SSI check, ALTCS decides how much of this income members will be required to pay to offset part of the cost of the services that they receive.
- ALTCS will inform the member what their “Share of Cost” is.
- If the member is living in a nursing home, the nursing home will collect the “Share of Cost”
- If the member lives at home, they probably will not have a “Share of Cost” since they need to pay for living expenses. If they do have a “Share of Cost”, Bridgeway will collect the “Share of Cost” from them.
• Case Managers will help members understand their “Share of Cost” responsibilities.

**SOC Refund**
If a member who is enrolled with Bridgeway is residing in a nursing facility at the beginning of the month and then moves home (or into an HCBS setting) sometime during the month, the share of cost must be returned to the member. The community PNA applies because the member did not reside in a nursing facility for the entire calendar month.

<table>
<thead>
<tr>
<th>IF the member...</th>
<th>THEN Bridgeway...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is eligible, but not enrolled during a specific month</td>
<td>Is not responsible for collecting the member's share of cost for that month.</td>
</tr>
<tr>
<td>Is eligible and is enrolled with Bridgeway for one or more days within a month</td>
<td>Is responsible for collecting the share of cost</td>
</tr>
<tr>
<td>Changes Health Plans during the month</td>
<td>Each Health Plan is entitled to a portion of the monthly share of cost, based on the number of days the member is enrolled with each Health Plan</td>
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<td>The Health Plan with whom the member is first enrolled during the month is responsible for:</td>
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<tr>
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<td>• Collecting the share of cost;</td>
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<td></td>
<td>• Calculating each Health Plan’s prorated share of cost; and</td>
</tr>
<tr>
<td></td>
<td>• Transferring the correct prorated SOC amount to the receiving Health Plan.</td>
</tr>
</tbody>
</table>

**EXAMPLE:**
September is a 30-day month. The member’s share of cost is $500.00. The member is enrolled with Health Plan A for 7 days and with Health Plan B for 23 days. Each Health Plan’s portion of the monthly SOC is calculated as follows:
- Health Plan A: $500 \times 7 \div 30 = 116.50$
- Health Plan B: $500 \times 23 \div 30 = 383.50$

**PRIOR PERIOD COVERAGE**
ALTCS also allows for Prior Period of Coverage for some members. Prior Period is the time period prior to Bridgeway being notified of a member’s enrollment in the plan. During this Prior Period of Coverage, Bridgeway is retro-actively responsible for payment of medically
necessary and covered services. If you have seen a Bridgeway member during their Prior Period of Coverage enrollment, please submit a claim for the services rendered. The services must be a covered benefit and medically necessary in order to be eligible for payment. If a member has paid for any covered service during Prior Period of Coverage, you must refund their money to them.

If you have any questions about Prior Period Coverage for a member, you may contact Member Services or your Network Representative.

**COMPLETING A UB-04 CLAIM FORM**

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by Bridgeway. In addition, a UB-04 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, hospice services, and dialysis services.

<table>
<thead>
<tr>
<th>FIELD #</th>
<th>REQUIRED</th>
<th>FIELD NAME</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>R</td>
<td>Remit Payment To</td>
<td>Enter billing provider’s name, address including Zip code +4, and phone number</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Unassigned</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td></td>
<td>Member Control Number</td>
<td>Number assigned by provider</td>
</tr>
<tr>
<td>3b</td>
<td></td>
<td>Medical/Health Record</td>
<td>This number is assigned to the patient’s medical/health record by the provider</td>
</tr>
<tr>
<td>4</td>
<td>R</td>
<td>Type of Bill</td>
<td>Describes type of facility (1st digit), classification (2nd digit), and frequency (3rd digit)</td>
</tr>
<tr>
<td>5</td>
<td>R</td>
<td>Federal Tax Number</td>
<td>Maintained in Bridgeway provider records</td>
</tr>
<tr>
<td>6</td>
<td>R</td>
<td>Statement Covers Period, From/Through</td>
<td>Enter the beginning and ending service dates included on this bill. For all service rendered on a single day, use both the FROM and THROUGH dates. Required for Inpatient and LTC</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>8 a - e</td>
<td>R</td>
<td>Patient Name/Identifier</td>
<td>Last name, first name and middle initial of the patient</td>
</tr>
<tr>
<td>9</td>
<td>R</td>
<td>Patient Address</td>
<td>Mailing address of patient</td>
</tr>
<tr>
<td>FIELD #</td>
<td>REQUIRED</td>
<td>FIELD NAME</td>
<td>DESCRIPTION</td>
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<tr>
<td>10</td>
<td>R</td>
<td>Patient Date of Birth</td>
<td></td>
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<tr>
<td>11</td>
<td>R</td>
<td>Patient Sex</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>R</td>
<td>Admission/Start of Care Date</td>
<td>The start date for this episode of care or date of admission</td>
</tr>
<tr>
<td>13</td>
<td>R</td>
<td>Admission Hour</td>
<td>Enter the hour during which the member was admitted for inpatient care. Required for Inpatient</td>
</tr>
<tr>
<td>14</td>
<td>R</td>
<td>Type of Admission</td>
<td>Applicable for all inpatient claims. For emergency outpatient claims provider must enter &quot;1&quot; Emergency. Admission codes: 1 - Emergency: Member requires medical intervention for severe, life threatening or potentially disabling conditions. 2 - Urgent: The member requires immediate attention. 3 - Elective: PA number must be entered in FL 63. 4 - Newborn. Required for Inpatient and LTC</td>
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<tr>
<td>15</td>
<td>R</td>
<td>Source of Admission</td>
<td>Enter the member's source of admission</td>
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<tr>
<td>16</td>
<td>C</td>
<td>Discharge Hour</td>
<td>Code indicating discharge hour of the patient from inpatient care</td>
</tr>
<tr>
<td>17</td>
<td>R</td>
<td>Patient Discharge Status</td>
<td>Enter the code indicating status as of the ending service date of the period covered on this bill. Member Status Codes: 01 - Discharged to Home or Self Care 02 - Transferred to Another Short Term General Hospital for inpatient care 03 - Discharged or transferred to a SNF 04 - Discharged or transferred to an ICF 06 - Discharged to Home under care of an Organized Home Health Service Organization 07 - Left Against Medical Advice 08 - Discharged/Transferred to Home Under Care of Home IV provider 20 - Expired or Did Not Recover 30 - Still a Member Required for Inpatient and LTC</td>
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<tr>
<td>FIELD #</td>
<td>REQUIRED</td>
<td>FIELD NAME</td>
<td>DESCRIPTION</td>
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<tr>
<td>18 - 28</td>
<td>C</td>
<td>Condition Codes</td>
<td>Enter the applicable code(s) to identify conditions relating to this bill that may affect processing</td>
</tr>
<tr>
<td>9</td>
<td>RI</td>
<td>Accident State</td>
<td>A two-digit state abbreviation where the accident occurred. This information is required when services are related to an auto accident</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>31 - 34</td>
<td>C</td>
<td>Occurrence Codes and Dates</td>
<td>Enter the applicable code(s) to identify significant events relating to this bill that may affect processing. Dates are entered in a MMDDYY format. Occurrence code 22 should be utilized on last Part A covered claim</td>
</tr>
<tr>
<td>35 - 36</td>
<td>C</td>
<td>Occurrence Spans Codes and Dates</td>
<td>A code for related dates that identify an event that relates to the payment of the claim</td>
</tr>
<tr>
<td>37</td>
<td></td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>C</td>
<td>Responsible Party Name and Address</td>
<td>Enter name and address of responsible party if applicable.</td>
</tr>
<tr>
<td>39 - 41</td>
<td>C</td>
<td>Value codes and Amounts</td>
<td>Enter the value code, as appropriate to identify data elements necessary to process this claim. Enter the two-digit code and the associated amount. The valid value codes are 50 (Physical therapy visits) 51 (Occupational therapy visits) 52 (speech therapy visits)</td>
</tr>
<tr>
<td>42</td>
<td>R</td>
<td>Revenue Codes</td>
<td>Enter the applicable revenue code that, ancillary service, or billing calculation. The appropriate three-digit, numeric revenue code must be entered to explain each charge entered in for locator 47</td>
</tr>
<tr>
<td>43</td>
<td>R</td>
<td>Revenue Description</td>
<td>Enter a narrative description of the related revenue categories on this bill</td>
</tr>
<tr>
<td>44</td>
<td>C</td>
<td>HCPCS/Accommodation Rates</td>
<td>Enter the HCPCS code applicable to the service provided. Only one service code per line is permitted. Required for Home</td>
</tr>
<tr>
<td>FIELD #</td>
<td>REQUIRED</td>
<td>FIELD NAME</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>45</td>
<td>R</td>
<td>Service Date</td>
<td>The date the indicated service was provided</td>
</tr>
<tr>
<td>46</td>
<td>R</td>
<td>Service Units</td>
<td>Enter the number of units corresponding to the revenue code (or HCPCS code) billed</td>
</tr>
<tr>
<td>47</td>
<td>R</td>
<td>Total Charges</td>
<td>Enter the total charges pertaining to the related revenue code for the statement covers period. Enter revenue code 001 to indicate totals, with the sum of all charges billed reflected in the form locator</td>
</tr>
<tr>
<td>48</td>
<td>C</td>
<td>Non-covered Charges</td>
<td>If applicable</td>
</tr>
<tr>
<td>50</td>
<td>R</td>
<td>Payer Identification</td>
<td>A - Enter the Medicare carrier's name or other primary insurer. B - Enter the Medicare supplement carrier's name and additional payer names. C - Enter the applicable Medicaid Assistance Program</td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>Health Plan Identification Number</td>
<td>This is a number used by the health Plan to identify itself</td>
</tr>
<tr>
<td>52</td>
<td>R</td>
<td>Release of Information Certification Indicator</td>
<td>Code indicates whether the provider has on file a signed statement (from the patient or the legal representative Permitting the provider to release data to another organization</td>
</tr>
<tr>
<td>53</td>
<td>R</td>
<td>Assignment of Benefits Certification Indicator</td>
<td>Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider</td>
</tr>
<tr>
<td>54a - c</td>
<td>C</td>
<td>Prior Payments - Payer</td>
<td>The amount the provider has received (to date) by the health plan toward payment of this bill. A. Primary</td>
</tr>
</tbody>
</table>
### FIELD # REQUIRED FIELD NAME DESCRIPTION

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Estimated Amount Due - Payer</th>
<th>The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td></td>
<td>Nation Provider Identifier (NPI) - Billing Provider</td>
<td>The unique identification number assigned to the provider submitting the bill</td>
</tr>
<tr>
<td>56</td>
<td>R</td>
<td>Other (Billing) Provider Identifier</td>
<td>Provider may list their AHCCCS ID number here</td>
</tr>
<tr>
<td>57a</td>
<td>C</td>
<td>Insured's Name</td>
<td>The name of the member</td>
</tr>
<tr>
<td>58</td>
<td></td>
<td>Insured's Unique Identifier</td>
<td>The member’s Medicaid ID number, begins with an A</td>
</tr>
</tbody>
</table>

### FIELD # REQUIRED FIELD NAME DESCRIPTION

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Patient's Relationship to Insured</th>
<th>Code indicating the relationship of the patient to the identified insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>59</td>
<td></td>
<td>Insured's Unique Identifier</td>
<td>The member’s Medicaid ID number, begins with an A</td>
</tr>
<tr>
<td>60</td>
<td>R</td>
<td>Insured's Group Name</td>
<td>Not applicable</td>
</tr>
<tr>
<td>61</td>
<td></td>
<td>Insured's Group Number</td>
<td>Not applicable</td>
</tr>
<tr>
<td>62</td>
<td></td>
<td>Treatment Authorization Code</td>
<td>Enter the Authorization number for services rendered</td>
</tr>
<tr>
<td>63</td>
<td>C</td>
<td>Document Control Number</td>
<td>Not applicable</td>
</tr>
<tr>
<td>64</td>
<td></td>
<td>Employer Name</td>
<td>Not applicable</td>
</tr>
<tr>
<td>65</td>
<td></td>
<td>Diagnosis and Procedure code Qualifier</td>
<td>The qualifier that denotes the version of ICD reported</td>
</tr>
<tr>
<td>66</td>
<td></td>
<td>Principal and Other Diagnosis Codes and POA Indicator</td>
<td>Enter the principal and other ICD-9 diagnosis codes. Present on Admission (POA) Indicator applies to the diagnosis codes for claims involving inpatient admissions</td>
</tr>
<tr>
<td>67a-q</td>
<td>R</td>
<td>Admitting Diagnosis</td>
<td>Required for inpatient claims. Enter the ICD-9 diagnosis code that represents the significant reason for admission</td>
</tr>
<tr>
<td>68</td>
<td></td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>R</td>
<td>Admitting Diagnosis</td>
<td>Required for inpatient claims. Enter the ICD-9 diagnosis code that represents the significant reason for admission</td>
</tr>
<tr>
<td>FIELD #</td>
<td>REQUIRED</td>
<td>FIELD NAME</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>70 a - c</td>
<td></td>
<td>Patient's Reason for visit (outpatient only)</td>
<td>If applicable</td>
</tr>
<tr>
<td>71</td>
<td></td>
<td>Prospective payment System (PPS) code</td>
<td>If applicable</td>
</tr>
<tr>
<td>72 a - c</td>
<td>C</td>
<td>External Cause of Injury code</td>
<td>The ICD-9 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect</td>
</tr>
<tr>
<td>73</td>
<td></td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>74 a - e</td>
<td>C</td>
<td>Principal and Other Procedure Codes and Dates</td>
<td>Enter the ICD-9 code that identifies the procedure performed at the claim level during the period covered by the bill and the corresponding date. Enter data as MMDDYY</td>
</tr>
<tr>
<td>75</td>
<td></td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>R</td>
<td>Attending Provider name and NPI number</td>
<td>Enter NPI of individual in charge of patient care. If UPIN number is entered, qualifier must be 1G. Enter the last and first name below</td>
</tr>
<tr>
<td>77</td>
<td>C</td>
<td>Operating Physician Name and NPI number</td>
<td>Required when surgical procedure is performed. Enter the NPI. If UPIN number is entered, qualifier must be 1G. Enter the last and first name</td>
</tr>
<tr>
<td>78 - 79</td>
<td></td>
<td>Other Provider (Individual) Names and NPI</td>
<td>Enter the NPI. If UPIN number is entered, qualifier must be 1G. Enter the last and first name</td>
</tr>
<tr>
<td>80</td>
<td>C</td>
<td>Remarks Field</td>
<td>Area to capture additional information necessary to adjudicate claim</td>
</tr>
<tr>
<td>81CCa</td>
<td>R</td>
<td></td>
<td>Enter B3 in the qualifier if locations 76-79 contain an NPI. <strong>Enter the corresponding provider taxonomy of provider NPI’s entered in locations</strong> 76a – 81CCa 77b – 81CCb 78c – 81CCc 79d – 81CCd</td>
</tr>
</tbody>
</table>
Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

**BILLING FOR SERVICES**

Facilities must obtain initial authorization prior to admission unless the member becomes retroactively eligible. Ongoing authorization for services must be obtained from the Bridgeway Case Manager.

Long term care facilities must bill for room and board services on the UB-04 claim form.

Bridgeway pays for the date of admission up to, but not including, the date of discharge, unless the patient expires.

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-04 claim forms using the appropriate bill types and patient status codes.

Long term care facilities cannot submit claims that overlap months. The member’s SOC is calculated on a monthly basis, and claims that overlap two or more calendar months cannot be processed accurately.

**Paper Claims**

Providers must file claims using standard claims forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners).

Claims missing the necessary requirements are not considered “clean claims” and will be returned to providers with a written notice describing the reason for return.

Initial Paper Claims may be submitted to:

**For Long Term Care:**
Bridgeway Health Solutions  
P.O. Box 3040  
Farmington, MO 63640-3814

**For Bridgeway Health Solutions Advantage:**  
P.O. Box 3060  
Farmington, MO 63640-3822

*See the “ELECTRONIC CLAIMS SUBMISSION” section of this guide for instructions on billing electronically.*
BILLING CORRECTED CLAIMS AND RECONSIDERATIONS

Corrected Claims
Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.
- Submit a corrected claim electronically via a Clearinghouse
  - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
  - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
- Submit a corrected paper claim to:
  - For Long Term Care: Bridgeway Health Solutions
    P.O. Box 3040
    Farmington, MO 63640-3814
  - For Bridgeway Health Solutions Advantage: Bridgeway Health Solutions Advantage
    Corrections, Reconsiderations or Appeals
    P.O. Box 4000
    Farmington, MO 63640-4000
  - Include the original Explanation of Payment (EOP). Failure to submit the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing or denial for exceeding the timely filing limit.

Reconsiderations

- A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records
- The documentation must also include a description of the reason for the request.
  - Indicate “Reconsideration of (original claim number)”
  - Include a copy of the original Explanation of Payment
  - Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim
- The “Request for Reconsideration” should be sent to:
  - For Long Term Care:
BILLING SECONDARY CLAIMS ELECTRONICALLY

Submitters must use this CAS segment to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged. Only one Group Code is allowed per CAS.

<table>
<thead>
<tr>
<th>5010</th>
<th>837I - Institutional EDI Segment and Loop</th>
<th>837P - Professional EDI Segment and Loop</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COB Field Name</strong></td>
<td><strong>The below should come from the primary payer's Explanation of Payment</strong></td>
<td></td>
</tr>
<tr>
<td>COB Payer Paid Amount</td>
<td>If 2320/AMT01=D, MAP AMT02 or 2430/SVD02</td>
<td>If 2320/AMT01=D, MAP AMT02 or 2430/SVD02</td>
</tr>
<tr>
<td>COB Payer Name</td>
<td>Map 2010BB as the 2ndy becomes the destination payer</td>
<td>Map 2010BB as the 2ndy becomes the destination payer</td>
</tr>
<tr>
<td>COB Total Non-Covered Amount</td>
<td>If 2320/AMT01=A8, map AMT02 and CAS01, CAS02 &amp; CAS03 required</td>
<td>If 2320/AMT01=A8, map AMT02 and CAS01, CAS02 &amp; CAS03 required</td>
</tr>
<tr>
<td>COB Remaining Patient Liability</td>
<td>If CAS01 = PR, map CAS01, CAS02 &amp; CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01=EAF, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR</td>
<td>If CAS01 = PR, map CAS01, CAS02 &amp; CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01=EAF, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR</td>
</tr>
<tr>
<td>COB Patient Paid Amount</td>
<td>Segment Deleted</td>
<td>Segment Deleted</td>
</tr>
</tbody>
</table>
COB Patient Estimated Amount Due  |  If 2300/AMT01=F3, map AMT02, map CAS01, CAS02 & CCAS03  | Segment Deleted
---|---|---
COB Facility Tax Amount - Total Claim Before Taxes Amount  |  If 2400/AMT01 = N8, map AMT02 and SV203 should be included in this total  | Segment Deleted
COB Claim Adjudication Date  |  IF 2330B/DTP01 = 573, map DTP02 & DTP03  | IF 2330B/DTP01 = 573, map DTP02 & DTP03
COB Claim Adjustment Indicator  |  IF 2330B/REF01 = T4, map REF02 with a Y  | IF 2330B/REF01 = T4, map REF02 with a Y

**REIMBURSEMENT METHODOLOGY**

Skilled Nursing Inpatient Service reimbursement is based on Resource Utilization Groups (RUG). This reimbursement is similar to MS-DRGs in the fact that they are a Per Diem based amount.

RUG reimbursement methodology is based on Medicare RUG base fee schedule multiplied by the Core Statistical Base Area (CBSA) or wage index. Each state is made up of CBSA or regions that will have varied wage index. The RUG base rates updates are released annually by CMS.

When Medicare is the primary payer, Bridgeway will pay the full Medicare coinsurance amount minus any other third party payment and share of cost (SOC). Payment will equal the full Medicare coinsurance amount for the covered days. The Medicare allowed amount includes all ancillary services covered under the Medicare per diem. Providers should not bill separately for those ancillary services.

**TRANSPORTATION**

**Non-Emergency**

1. Bridgeway can assist with medically necessary non-emergent transportation to and from covered healthcare visits if needed when no other transportation is available. Non-routine, non-medically necessary transportations is not covered
2. Member transportation can be scheduled by calling the transportation vendor directly at (877) 986-7420 or calling (866) 475-3129 and selecting “Transportation.”

**Emergency**

Bridgeway covers ambulance service for Emergency Care
SPECIAL MEDICAL VEHICLE (SMV)

Bridgeway covers transportation by special vehicle for those in wheelchairs. We may also cover this service for other reasons if requested by the PCP.

CLAIMS DISPUTE

In accordance with Arizona Administrative Code (AAC) R9-22-702 registered providers are prohibited from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative except as outlined in AAC R9-22-702 D.

Submit claim disputes in writing to:
Bridgeway Health Solutions
Provider Claims Disputes
1850 E. Rio Salado Parkway
Suite 201
Tempe, AZ 85281

ADVANTAGE APPEALS

In accordance with the Medicare Managed Care Manual Chapter 13, contracted providers do not have Medicare appeal rights; however, Bridgeway has an adjustment and reconsideration process for review of any contracted provider claim issues.

Requests for reconsiderations from contracted providers must be received by Bridgeway within 60 days of the date of the Explanation of Payment (EOP). A copy of the EOP and supporting justification or documentation (such as medical record) must accompany any request for reconsideration. Requests sent to the wrong address will be returned to the submitter.

Please mail claim adjustment/reconsideration requests (e.g., error in processing) to:
Bridgeway Health Solutions Advantage
Claims Reconsideration
P. O. Box 4000
Farmington, MO 63640-4000
Appeals related to a medical necessity decision made during the authorization, prior authorization or concurrent review process can be made orally or in writing to:

Bridgeway Health Solutions
Appeals/Grievance Department
1850 W. Rio Salado Parkway
Suite 201
Tempe, AZ 85281
1-866-475-3129