Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medicare Plus Blue home health care claims

Frequently asked questions for providers

For Medicare Plus Blue℠

April 2022

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with CareCentrix® to manage the authorization of home health care for Medicare Advantage members. CareCentrix authorizes and supports the coordination of home health care services, such as skilled nursing and physical, occupational and speech therapies.

This document answers specific questions pertaining to claims for members with Medicare Plus Blue plans. For more information on the CareCentrix program, such as submitting prior authorization requests, registering for access to the CareCentrix HomeBridge portal, and additional information about submitting claims, review our Home Health Care Frequently asked questions for providers document.

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For start of care that begins on or after Jan. 1, 2022, should I submit a RAP or an NOA?

HHAs must not submit RAPs for any home health period of care with a start-of-care date on or after Jan. 1, 2022. Instead, for each admission to home health, the HHA must submit an NOA prior to submission of a final claim. Only one NOA is required for any series of HH periods of care, beginning with admission to home care and ending with discharge. After a discharge has been reported to Medicare, a new NOA is required before the HHA submits any additional claims.

For all beneficiaries receiving HH services in 2021 whose services will continue in 2022, see question below.

As of Jan. 1, 2022, what SOC date should we put for continued authorizations whose services began in 2021and require an authorization every 30 days? The original SOC date or the new January 2022 date?

For all beneficiaries receiving home health services in 2021 whose services will continue in 2022, the home health agency shall submit an NOA with a one-time, artificial 'admission' date corresponding to the SOC date of the first period of continuing care in 2022. For example, if a period of care begins in 2021 and ends on Jan. 10, 2022, the HHA submits an NOA with an admission date of Jan. 11, 2022, and then submits a claim when the 30-day period of care is over.

Are we supposed to put Health Insurance Prospective Payment System code 1AA11 on Medicare Plus Blue's Notice of Admission or the HIPPS codes in iQIES that have been on our recertifications and start-of-care dates from the authorizations?

Medicare Plus Blue will accept HIPPS code 1AA11 on the NOA. However, when prior authorization requirements exist the HIPPS code on the final claim must match the HIPPS code on the authorization for the level of care provided.

What HIPPS code should be on the authorizations?

We'll accept HIPPS code 1AA11 on the NOA, but the HIPPS code on the final claim must match the level of care provided. When prior authorization requirements exist the HIPPS code on the final claim must also match the HIPPS code on the CareCentrix authorization.

Should the NOA, authorization and claim all have the same HIPPS codes on them, or just the authorization and claim? We want to make sure everything is in line with the authorization and the claim for payment.

Medicare Plus Blue will accept HIPPS code 1AA11 on the NOA if the HIPPS code for the actual level of care is not available at the time you submit your NOA. However, the HIPPS code on the final claim and the authorization must match and be the actual HIPPS code for the level of care provided.

Is an episode ID required on the home health claim?

An authorization number or episode ID on the claim is recommended but not required for a claim to pay. If you choose to add the authorization number or episode ID, please follow these instructions:

- For Medicare Plus Blue members who receive services in Michigan include the episode ID on the claim. This is recommended only because a provider can receive multiple authorization numbers that are linked to a single episode ID due to the 30-day authorization period.
- For all BCN Advantage members and for Medicare Plus Blue members who receive services outside of Michigan, include the authorization number.

NOAs submitted on Type of Bill 32A are receiving a 01G denial with a message stating, “Incorrect bill type.” Per Medicare guidelines, Type of Bill for Notice of Admission is 32A. Why are NOAs being denied?

NOAs processed by Medicare Plus Blue between Jan. 1, 2022, and Feb. 10,2022, received a 01G denial. This denial does not mean your NOA was rejected. It means that it was received, but no payment will be made. Once the final claim is received, our system will check to see if your NOA is on file before the final claim is processed for payment.

Effective Feb. 11, 2022, NOA submissions began denying with event code NOA – HHA Not Eligible for Reimbursement. This event code is to acknowledge receipt of the NOA since no payment is made until submission of a final claim. Currently, all final claims will pend for manual review so Blue Cross can verify that the provider’s NOA is in the system. If so, and there is no other reason identified to deny, Blue Cross will process the final claim for payment. This process will continue until our system has been updated.