Blue Cross Blue Shield Blue Care Network of Michigan

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

carecentrix

Home health care

Frequently asked questions for providers

For Medicare Plus Blue℠ and BCN Advantage℠

Revised July 2022

In this document

General information

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.

For episodes of care starting on or after June 1, 2021, providers need to request prior authorization from CareCentrix for Medicare Plus Blue℠ and BCN Advantage℠ members.

For episodes of care that start prior to June 1, 2021, and extend through or beyond June 1, 2021, see “Does a member need prior authorization for home health care services they started receiving prior to June 1, 2021?” on page 5.

CareCentrix manages authorizations for and supports the coordination of home health care services, such as skilled nursing and physical, occupational and speech therapies.

This home health care program is designed to:

- Use evidence-based guidelines and clinical documentation to make medical necessity determinations. CareCentrix uses the following criteria to make determinations:
  - InterQual®
  - The Centers for Medicare & Medicaid Services national and local coverage determinations within the appropriate jurisdiction
- Validate appropriate utilization and enhanced quality of care across home health services
- As needed, assist with coordinating member transitions from hospital to home

Providers must request prior authorization for home health services from CareCentrix. This applies to members transitioning from any setting to home health care.

CareCentrix will also perform service validation outreach to ensure the services that have been ordered are delivered in accordance with physician orders. If it is determined that services haven’t started, CareCentrix staff will work with the health plan and the home health agency to ensure that services begin as soon as possible.

Which members does this change affect?

This change affects Medicare Plus Blue and BCN Advantage members, for both in-state and out-of-state home health care.

Note: These changes don’t apply to Blue Cross commercial plans, BCN commercial plans or Blue Cross Complete (Medicaid) members. They also don’t apply to services that aren’t provided through a home health agency.

Why are Blue Cross and BCN adding the CareCentrix program?

Blue Cross and BCN are adding this program because we identified an opportunity to assist with member transition from hospital to home and to support a home-based center of care. The program will ensure that members receive the right type of services for the right amount of time, which will promote optimal recovery at home.

How does CareCentrix staff interact with providers?

The CareCentrix team interacts with providers through various modes of communication and training to support a positive provider experience.

Prior to the program launch, CareCentrix provided training, tools and support to the provider network so all were prepared to request prior authorization for home health services from CareCentrix.

On an ongoing basis, CareCentrix will:

- Guide providers through the utilization review process
- Be available to answer questions and provide additional support as needed
- Notify providers of decisions on authorization requests

How does CareCentrix staff interact with members?

CareCentrix interacts with members as follows:

- As approval and denial decisions are made
- During service validation outreach:
  - To ensure timely delivery of services
  - To request the completion of a member satisfaction survey at the conclusion of services

CareCentrix may contact members by phone, text or email for service validation. CareCentrix will work with servicing providers, the member, and Blue Cross or BCN to address any disruption of services or expression of dissatisfaction.

Did members' home health care benefits change when CareCentrix started managing these services?

No, there weren't any changes to members' benefits or any additional charges to members as a result of CareCentrix managing the services.

However, members' benefits can change annually as employer groups revise them. In addition, members' coverage can change as they enter or leave a group or change individual coverage.

How can I contact CareCentrix during business hours, after hours and on holidays?

For authorization requests and inquiries, providers can contact CareCentrix as follows:

Contact method	Details
Phone	1-833-409-1280
Fax	1-877-245-4891
CareCentrix HomeBridge® portal	• For authorization inquiries or requests: carecentrixportal.com/ProviderPortal* • For portal support: portalinfo@carecentrix.com

Days and hours of operation

- **Normal business hours:** 8 a.m. to 11 p.m. Eastern time every day, excluding the holidays specified below
- **After hours, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas:** CareCentrix on-call clinical staff is available for urgent prior authorization requests. Callers should follow the prompts to leave a message. On-call nurses are notified of the inquiry and will return the call within 30 minutes.

Authorizations

Who should submit prior authorization requests for home health care services?

Home health care agencies are required to submit authorization requests. However, any provider can request prior authorization, including primary care providers, acute care providers and post-acute care providers.

Does a member need prior authorization for home health care services they started receiving prior to June 1, 2021?

Episodes of care that started and ended before June 1, 2021, don't require authorization.

Episodes of care that started before June 1, 2021, and extended through or beyond June 1, 2021, require prior authorization at the earliest event listed below that occurs on

or after June 1, 2021:

- Next 60-day certification period (also known as “recertification”)
- Resumption of care, or ROC
- Significant change in condition, or SCIC

When do I submit prior authorization requests to CareCentrix?

Submit the authorization request after completing the initial evaluation and assessment. CareCentrix recommends you submit requests for authorizations within five days from the start-of-care date. This aligns with CMS requirements regarding the completion of initial assessments and allows time to complete the Outcome and Assessment Information Set, or OASIS, assessment and determine which services are needed. (A completed OASIS assessment isn’t required to submit a prior authorization request.)

CareCentrix will always approve the initial evaluation, unless another home health care provider is already providing services in the member's home. CareCentrix will review all other requested services for medical necessity, including services already rendered.

Note: If a member elects to change home health agencies, the agencies should follow the process outlined in Medicare Benefit Policy Manual, Chapter 7 – Home Health Services.

For continuation of services, CareCentrix recommends providers submit requests through the CareCentrix HomeBridge portal, by phone or by fax at least 72 hours prior to the end of the current authorization period. In addition:

- **For Medicare Plus Blue members who receive services in state:** CareCentrix reviews each case for medical necessity every 30 days.

  If a second 30-day authorization is required within a 60-day certification period, see the document titled Home health care: Clinical documentation requirements; this document outlines the information you must provide to support your request.

- **For all BCN Advantage members and Medicare Plus Blue members who receive services out of state:** Approved authorizations include start and end dates. These dates are based on the service dates the provider requested.

How do I submit authorization requests to CareCentrix?

Submit requests as follows:

Method of submission	Details
CareCentrix HomeBridge® portal	There are two ways to access the HomeBridge portal: 1. Through Blue Cross and BCN's provider portal (availity.com*) 2. Through direct access via the CareCentrix website For detailed information about these methods of access, see the document titled Home health care: Submitting authorization requests to CareCentrix. For information about working in the CareCentrix HomeBridge portal, see the CareCentrix HomeBridge Portal Auth Request Guide.*
By fax	Fax to 1-877-245-4891 Include a cover sheet, required member information and supporting clinical documentation.
By phone	Call 1-833-409-1280

What documentation should I submit with prior authorization requests?

For details about the member information and documentation you need to submit with each authorization request, see the document titled Home health care: Clinical documentation requirements.

For Medicare Plus Blue members who will receive services in state: See "Which assessments are required for members admitted to home health care?" on page 17 for information about OASIS assessments.

How do I submit referrals for home health care services?

All providers should continue to use their existing process for sending referrals for home health services directly to home health agencies.

How do I register for direct access to the CareCentrix HomeBridge portal?

If you have access to Blue Cross and BCN's provider portal (availity.com*), you can access the CareCentrix HomeBridge portal through Availity Essentials.

Note: If you haven't registered for Availity®, see the Register for web tools page on **bcbsm.com** for information about registering.

To learn how to register for access to the HomeBridge portal through the CareCentrix website, see the document titled Home health care: Submitting authorization requests to CareCentrix for the steps required to register for direct access to the HomeBridge portal through the CareCentrix website.

Does CareCentrix require authorizations to be updated when a visit for a specific discipline is performed by a clinician with a lower-level credential?

For both Medicare Plus Blue and BCN Advantage members, you don't need to update approved authorizations when services are provided by a clinician with a lower-level credential than the clinician who was authorized by CareCentrix. This substitution is allowed as long as the clinician with the lower-level credential is within the same discipline that CareCentrix authorized.

For example, you wouldn't need to submit a new authorization request in the following situations:

- A licensed practical nurse provided services to the member when CareCentrix authorized services to be provided by a registered nurse
- A physical therapy assistant provided services to the member when CareCentrix authorized services to be provided by a physical therapist

To determine which HCPCS codes are associated to revenue codes by discipline, see "Which revenue codes should I include on claims?" on page 21.

What criteria does CareCentrix use to make determinations on prior authorization requests?

CareCentrix applies the following criteria in making determinations on prior authorization requests:

- InterQual
- CMS national and local coverage determinations within the appropriate jurisdictions

In the event of a conflict between the sources listed, CareCentrix will apply the sources in the order of authority, using CMS national and local coverage determinations followed by InterQual criteria.

The factors we use to determine medical necessity are in alignment with CMS and InterQual criteria. For more information, see section 20 of the Medicare Benefit Policy Manual, Chapter 7 – Home Health Services.*

Does CareCentrix require a member to be homebound to qualify for home health care services?

Yes, homebound status is required for home health care services, subject to the special considerations required during the COVID-19 pandemic. For details on CMS emergency and disaster-related policies, see the CMS document titled Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only with a § 1135 Waiver.*

During the COVID-19 pandemic, CareCentrix supports CMS flexibility with respect to the definition of homebound. See the CMS document titled COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers* for more information.

CareCentrix follows CMS guidelines to determine homebound status.

To be considered confined to the home, CMS requires that members must meet the following two criteria:

1. The member must have an illness or injury and one of the following:
    - Need the aid of a supportive device (crutches, cane, walker or wheelchair)
    - Require the use of special transportation (such as an ambulance)
    - Require the assistance of another person to leave the home safely
    - Have a condition that makes leaving the home medically contraindicated

2. The member must have a normal inability to leave the home and leaving the home requires a considerable and taxing effort.

Per CMS guidelines, there are situations where a person can leave the home and still be considered homebound. These situations include but aren't limited to attending:

- Adult daycare
- Outpatient kidney dialysis
- Outpatient chemotherapy / radiation appointments
- Religious services

Other absences from the home don't automatically disqualify the member, but the absences need to happen on an infrequent basis and over relatively short durations of time. These examples don't indicate that the member has the capacity to obtain health care outside of the home (per CMS):

- Attending church or other religious appointments
- Going to a hairdresser or barber
- Walking around the block
- Going for a short drive
- Attending a family reunion
- Attending a funeral
- Attending a graduation

For more information, see the following sections of Chapter 7 of the Medicare Benefit Policy Manual:*

- Section 30 — "Conditions Patient Must Meet to Quality for Coverage of Home Health Services"
- Section 30.1 — "Confined to the Home"

Note: CareCentrix recognizes that each member is unique and reviews requests on an individual basis. CareCentrix will initiate the intent to deny process if homebound status is in question.

How long will the prior authorization approval be valid?

See below.

- **For Medicare Plus Blue members who receive services in state:**
  - Initial authorizations are valid for 30 days from start of care.
  - Each subsequent authorization is valid for 30 days
- **For all BCN Advantage members and for Medicare Plus Blue members who receive services out of state:** Approved authorizations include start and end dates. These dates are based on the dates the provider requested.

What authorization information will I receive from CareCentrix?

When CareCentrix approves an authorization request, they'll provide a Service Registration Form, or SRF, that outlines the following:

- Approved service (CPT code / revenue code)
- Dates of service
- Number of units per discipline
- **For all BCN Advantage members and for Medicare Plus Blue members who receive services outside of Michigan:** Authorization ID per approved discipline
- **For Medicare Plus Blue members who receive services in Michigan:**
  - Episode ID
  - A unique HIPPS code for each 30-day period — This is included on the SRF only when you provide a HIPPS code through the HomeBridge portal.
  - For more information about HIPPS codes, see "Which assessments are required for members admitted to home health care?" on page 17.

CareCentrix will send the SRF via fax when they approve an authorization request.

After faxing the SRF, CareCentrix will send a letter via postal mail that includes the approved services and authorization number.

What is the turnaround time for prior authorization requests?

Turnaround times for authorization requests are outlined in the table below:

Type of request	Expected turnaround time
Standard initial prior authorization requests and requests for continued services	By 4 p.m.[1] next business day, unless a peer-to-peer discussion is requested or insufficient information is provided with the request. When there is insufficient information and/or a peer-to-peer discussion is requested, CareCentrix will make a determination as quickly as possible (often within 1 business day) after receiving sufficient information and/or completing the peer-to-peer discussion. At maximum, CareCentrix will issue a determination within 14 days of the date on which they received the prior authorization request.
Expedited or urgent initial prior authorization requests and requests for continued services	• Requests received **before 4 p.m.**[1] will be processed the same day, unless a peer-to-peer discussion is requested • Requests received after **4 p.m.**[1] will be processed by 4 p.m.** the next calendar day, unless a peer-to-peer discussion is requested When peer-to-peer discussions are requested, CareCentrix will make a determination within 72 hours.
Post-service request	Within 14 calendar days

[1] Based on local time zone of requesting provider.

How can I check the status of a home health care prior authorization request?

You can check the status of **pending** requests in the CareCentrix HomeBridge Portal, if the request was submitted through the portal.

Once CareCentrix has made a determination on a prior authorization request, that request is available in the CareCentrix HomeBridge portal and through Blue Cross and BCN's e-referral system.

For authorization requests that were submitted by phone or by fax, you can check the status by calling CareCentrix at 1-833-409-1280. Once CareCentrix has issued the authorization determination, you'll be able to view the status through the CareCentrix HomeBridge portal.

Notes about Blue Cross and BCN's e-referral system:

- Authorization determinations display in the e-referral system 24 to 48 hours after CareCentrix makes an authorization determination.
- See the "Searching for a Referral or Authorization" section of the e-referral User Guide for more information.

Can I search for members by last name in the HomeBridge portal?

Yes. Here's how:

1. Complete all required fields other than the Last Name Search field.
2. In the Last Name Search field, do one of the following:
    - **If the member's last name DOESN'T include spaces or special characters:** Enter the member's full last name.
    - **If the member's last name includes spaces or special characters (such as hyphens, apostrophes or periods):** Enter only the first alphabetic character of the member's last name.

      If you enter a space or special character in the Last Name Search field, you'll receive an error message that reads "Patient last name cannot have characters other than alpha numeric."
3. Click *Continue*.

Can I see authorizations for all of my agency's locations?

In both the CareCentrix HomeBridge portal and Blue Cross and BCN's e-referral system, portal users with logins that are associated with multiple National Provider Identifiers, or NPIs, under the same Taxpayer Identification Number, or TIN, can view all authorizations that are associated with that TIN. For more information, see the following documents:

- Home health care: Linking your agency's NPI(s) and TIN(s)
- Home health care: Submitting authorization requests to CareCentrix

Referring providers and portal users who aren't employees of home health care agencies can view only the authorization requests they submitted.

How do I update the start date of service on a prior authorization request?

For authorization requests that were submitted through the CareCentrix HomeBridge portal, you can change the start date through the Edit an Authorization Tool in the CareCentrix HomeBridge portal.

For authorization requests that were submitted by phone or by fax, contact CareCentrix at 1-833-409-1280 to change the start date.

Do I need to notify CareCentrix if a member stops receiving services prior to the end date on their authorization?

CareCentrix can't approve a new prior authorization request for a member who has an active authorization for home health services. As a result, you need to notify CareCentrix if a member stops receiving services prior to the end date on their authorization due to one of the following circumstances:

- The member is discharged from a home health agency's care, is readmitted to an inpatient setting and then requires additional home health services following discharge
- A member changes home health agencies during a 30-day authorization duration
- A member's health care coverage is terminated during a 30-day authorization duration

To notify CareCentrix, call 1-833-409-1280. Once CareCentrix modifies the authorization end date, they will make determinations on new prior authorizations you submit for the member.

Can I submit retroactive authorization requests for home health care services?

You can submit retroactive authorization requests up to 90 days post-discharge for both Medicare Plus Blue and BCN Advantage members.

Note: We consider authorization requests to be retroactive when the authorization request is submitted to CareCentrix after the member has been discharged from home health care.

See the following table to determine whether to submit a retroactive authorization request based on the date on which services began:

Start date for the episode of care	Details
Episode of care began before June 1, 2021, and the member is now discharged	Authorization isn't required.
Episode of care began on or after June 1, 2021, and member is now discharged	Submit to CareCentrix either through the CareCentrix HomeBridge portal, by phone or by fax. Note: For up to 90 days from the discharge date, you can submit retroactive authorization requests through CareCentrix. After 90 days, CareCentrix won't review your authorization request unless there are extenuating circumstances.

What is the process if CareCentrix determines that a service doesn't meet medical necessity criteria?

If CareCentrix determines that services don't meet medical necessity criteria, these are the possible next steps:

1. Intent to deny: Prior to CareCentrix making a final determination:
    a. A CareCentrix medical director has reviewed the request and recommends a denial decision.
    b. Ordering physician / allowed practitioner is notified of the intent to deny via a courtesy fax and phone call. The practitioner can request a peer-to-peer discussion prior to CareCentrix issuing the denial.
    c. If the physician / allowed practitioner wants to discuss the case, they must request a peer-to-peer discussion by completing step 2 below. For standard prior authorization requests, the discussion must be requested within 1 business day of receiving notification of the intent to deny. For expedited requests, the discussion must be requested by 5 p.m. the same day.
    d. If the peer-to-peer discussion isn't requested within the timeframe listed above, CareCentrix will issue the denial.
2. Peer-to-peer discussion: Prior to CareCentrix making a final determination:
    - The ordering physician / allowed practitioner requests a peer-to-peer discussion by contacting CareCentrix at 1-833-409-1280 and following the prompts to request a peer-to-peer discussion.

- If the request for the discussion is made and the discussion occurs prior to CareCentrix issuing the denial, the reviewer may change the denial recommendation and approve the request.
- If the peer-to-peer discussion isn't requested in a timely manner, CareCentrix will issue a denial. A peer-to-peer discussion may still occur, but it won't result in an overturning of the denial. To request that the denial be overturned, the provider must submit an appeal.

3. Denial decision: If CareCentrix denies the authorization request, the ordering physician, member and servicing provider will be notified by oral or written notification in accordance with CMS guidelines. For additional information about CMS guidelines, see the CMS document titled "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance."*

For information about the appeals process, see "How do I submit appeals for denied authorization requests?" on page 16.

How can I talk to a medical director at CareCentrix for a peer-to-peer discussion?

If a peer-to-peer discussion is needed, contact CareCentrix as soon as possible by calling 1-833-409-1280 and following the prompts to request an appointment for the discussion.

If the peer-to-peer discussion occurs prior to CareCentrix issuing a denial, the medical director may change the denial recommendation and approve the request. A peer-to-peer discussion cannot overturn an adverse determination that has been already been issued.

How do I submit appeals for denied authorization requests?

To submit an appeal, follow the instructions in the denial letter.

The appeal process is not changing. Appeals of denied authorization requests are handled by the Grievance and Appeals units at Medicare Plus Blue and BCN Advantage.

- For additional information on the appeals process for Medicare Plus Blue members, see the Medicare Plus Blue PPO Manual. Look in the section titled "Provider dispute resolution process."

- For additional information on the appeal process for BCN Advantage members, refer to the BCN Advantage chapter of the *BCN Provider Manual*. Look in the section titled "BCN Advantage provider appeals."

Note: Member appeals are handled by either Medicare Plus Blue's or BCN Advantage's Grievance and Appeals unit, as appropriate. For post-service provider appeals related to claims, call Blue Cross and BCN's Provider Inquiry.

If the appeal is related to a Notice of Medicare Non-Coverage (NOMNC) for continued stays, the appeal should be timely submitted to the appropriate Quality Improvement Organization, or QIO.

When is a NOMNC required, and what is the process for submitting it to CareCentrix?

A Notice of Medicare Non-Coverage, or NOMNC, is required when a home health agency determines that a skilled service is no longer needed. The home health agency will generate the NOMNC and deliver it to the member and obtain the member's signature.

When CareCentrix determines that a skilled service is no longer medically necessary, CareCentrix will generate the NOMNC and fax it to the home health agency. The home health agency will then deliver it to the member and obtain the member's signature.

Whether generated by the home health agency or by CareCentrix, the NOMNC must be delivered to the member at least two calendar days before Medicare-covered services end or by the second-to-last day of service if care isn't being provided daily.

Once signed by the member, the home health agency should fax the NOMNC to CareCentrix at 1-877-246-5875.

Which assessments are required for members admitted to home health care?

A completed OASIS assessment is required for Medicare Advantage members who are admitted to home health care. The assessment should be submitted to CareCentrix prior to the end of the episode of care. An assessment is required for each discipline that is ordered.

To submit an OASIS assessment, do one of the following:

- Upload it as a separate document when you submit the prior authorization request. Don't include it within the medical record.

- Fax it to CareCentrix at 1-877-414-1087.

For Medicare Plus Blue members who receive services in state
Whenever possible, you should submit a HIPPS code when you submit an authorization request. This will ensure that a HIPPS code is associated with the authorization request for each episode of care. **You must include the HIPPS code on the claim for home health care services**.

Note: CareCentrix can make an authorization determination even if you don't include a HIPPS code with an authorization request.

How do I submit a HIPPS code to CareCentrix?

How you submit a HIPPS code depends on whether you know the HIPPS code when you submit the authorization request.

- Submit the HIPPS code with the authorization request
- If you don't know the HIPPS code when you submit the request, submit it later

Regardless of how you submit it, the HIPPS code that you submit on a claim must match the HIPPS code you provided to CareCentrix.

Submit the HIPPS code with the authorization request
When submitting the authorization request in the CareCentrix HomeBridge portal, answer yes to the question "Do you have the current HIPPS code?" You'll then be prompted to answer these questions:

- What is the primary diagnosis?
- What is the HIPPS code for this requested time period?

CareCentrix validates that the primary diagnosis code you enter maps to the clinical category designated in the second position of the HIPPS code. If it doesn't map, HomeBridge will display this message:

> "Primary Diagnosis does not match the Clinical Grouping in the HIPPS code provided. Please review and update the Primary Diagnosis code and/or HIPPS Code entered and confirm they are accurate."

If you click OK, HomeBridge will take you back to the main page so you can review and update your entries.

You can confirm the HIPPS code either on the Service Registration Form or on the Authorization Status screen in the HomeBridge portal.

If you don't know the HIPPS code when you submit the request, submit it later
If you don't know the HIPPS code when you submit the request through the HomeBridge portal, answer no to the question "Do you have the current HIPPS code?" to submit the request without the HIPPS code. CareCentrix will send a *Service Registration Form* that doesn't include the HIPPS code.

Important: Once you've determined the appropriate HIPPS code, you must return to the HomeBridge portal and complete an Authorization Edit to add the HIPPS code using the HIPPS template.

After you've provided the HIPPS code, you can confirm it on the Authorization Status screen in the HomeBridge portal or by calling CareCentrix at 1-833-409-1280.

In addition, CareCentrix monitors authorizations for missing HIPPS codes. If you don't submit the HIPPS code by day 25 of the episode of care, CareCentrix will make two attempts to call you.

- When CareCentrix contacts you and you supply the HIPPS code, CareCentrix will update the authorization to include the HIPPS code.
- If you contact CareCentrix to provide a HIPPS code after the 30-day episode of care has ended and you provide the necessary information, CareCentrix will update the authorization to include the HIPPS code.

In either case, you'll be able to find the HIPPS code on the Authorization Status screen in the HomeBridge portal. (If you don't have access to the portal, call CareCentrix; see "How can I contact CareCentrix during business hours, after hours and on holidays?" on page 5 for details.)

How do I request a change to a HIPPS code?

To request a change to a HIPPS code, go to the HomeBridge portal and complete an Authorization Edit using the HIPPS template or call CareCentrix at 1-833-409-1280.

A CareCentrix representative will review the request to ensure the clinical documentation supports the change.

If I need to add visits to an existing 30-day episodic authorization for Medicare Plus Blue members receiving services in state and the LUPA threshold has been met, do I need to submit a request to CareCentrix?

You don't need to submit a request for additional visits for a discipline that CareCentrix approved on the current authorization.

If I need to add a discipline to an existing 30-day episodic authorization for Medicare Plus Blue members receiving services in state and the LUPA threshold has been met, do I need to submit a request to CareCentrix?

You don't need to submit a request to add disciplines to an existing 30-day episodic authorization that has already been approved by CareCentrix as long as it has met the LUPA threshold. However, you will need to add the new discipline to the authorization request for the next 30-day period.

Notes:

- For Medicare Plus Blue members receiving services outside of Michigan, follow the guidelines for your local Blue Cross plan. If your local plan uses a fee-for-service payment methodology for home health care services, you'll need to submit authorization requests for additional disciplines that haven't been authorized by CareCentrix.
- For BCN Advantage members, home health care services use a fee-for-service payment methodology, so you need to submit authorization requests for additional disciplines that haven't been authorized by CareCentrix.

Claims

Will CareCentrix process claims for Blue Cross and BCN?

No. Home health agencies will continue to submit claims, claims questions and appeals to Blue Cross Blue Shield of Michigan or Blue Care Network.

If providers do not obtain prior authorization for home health care services from CareCentrix, Blue Cross and BCN may deny those claims.

What episode ID or authorization number should I submit with the claim?

We recommend that you include an authorization number or episode ID on claims, but it's not required for a claim to pay. If you choose to include the episode ID or authorization number:

- For Medicare Plus Blue members who receive services in Michigan, include the episode ID on the claim. We recommend including the episode ID because multiple authorization numbers can be 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.

What do I need to include on each claim to help ensure that it matches the authorization?

The information that's required on claims varies depending on the member's coverage and CMS claims/billing methodology. The resulting payment methodology determines which information is required on claims.

At minimum, you must include the following information:

Members	Payment methodology	Data to include on claims
Medicare Plus Blue members who receive services in state	Episodic payment methodology	• Date range • HIPPS code that matches the CareCentrix authorization
Medicare Plus Blue members who receive services out of state	Based on the reimbursement guidelines for your local Blue Cross plan	Based on the reimbursement guidelines for your local Blue Cross plan
BCN Advantage — All members	FFS payment methodology	• Date range • CareCentrix-authorized HCPCS and revenue codes — See "Which revenue codes should I include on claims?" below. • Units for all disciplines

As shown above, all claims for services provided to Medicare Plus Blue members in Michigan must include a HIPPS code. For more information, see "How do I submit a HIPPS code to CareCentrix?" on page 18.

Which revenue codes should I include on claims?

See the following table to determine which HCPCS codes are associated to revenue codes by discipline:

Service	HCPCS code	Associated revenue codes
Home health aide	• **G0156:** Home health aide	0570, 0571, 0572, 0579

Service	HCPCS code	Associated revenue codes
Medical social services	• **G0155:** Medical social worker	0560, 0561, 0562
Occupational therapy	• **G0152:** Occupational therapist • **G0158:** Occupational therapist assistant • **G0160:** Occupational therapist, establish or deliver occupational therapy maintenance program	0430, 0431, 0432, 0434
Physical therapy	• **G0151:** Physical therapist • **G0157:** Physical therapist assistant • **G0159:** Physical therapist, establish or delivery physical therapy maintenance program	0420, 0421, 0422, 0424, 0429
Skilled nursing	• **G0299:** RN visit • **G0300:** Licensed vocational nurse/LPN visit • **G0162:** RN, for management and evaluation of the care plan • **G0493:** RN clinical assessment, initial • **G0494:** LPN, for the observation and assessment of patient condition • **G0495:** RN, training / education of a patient or family member • **G0496:** Practice nurse, training / education of a patient or family member	0550, 0551, 0552
Speech therapy	• **G0153:** Speech therapist • **G0161:** Speech language pathologist, establish or deliver speech language pathology maintenance program	0440, 0441, 0442, 0444

Who should I call with questions about claims I've submitted?

If you have questions about a claim, call the appropriate number below.

- **Medicare Plus Blue:** Call 1-866-309-1719.
- **BCN Advantage:** Call Provider Inquiry at 1-800-249-5103.

The health plans will process home health care claims based on the length of stay and level of service authorized by CareCentrix.

What do I do for outlier payments?

You should continue to follow the standard process as established by Blue Cross and BCN.

Should I submit a RAP or an NOA for episodes of care with start dates on or after Jan. 1, 2022?

For episodes of care starting on or after Jan. 1, 2022, home health agencies no longer need to submit Requests for Anticipated Payment, or RAPs. Instead, the home health agency must notify Medicare systems of each home health care admission by submitting a Notice of Admission, or NOA, within five days of the start-of-care date.

If a home health agency doesn't submit an NOA within five days of the start-of-care date, the agency will be penalized through a reduction to the payment amount. However, Blue Cross is waiving the five-day penalty for untimely NOA submissions until further notice. We expect to implement the five-day penalty at a later date and will provide advance notice of this change.

We'll accept HIPPS code 1AA11 on the NOA, but the HIPPS code on the final claim must:

- Match the level of care provided
- Match the HIPPS code on the CareCentrix authorization

This requirement is in keeping with standard billing processes and is in alignment with the Centers for Medicare & Medicaid Services requirements. For more information, see the following resources:

- Medicare Claims Processing Manual Chapter 10 – Home Health Agency Billing*
- The *Claims Submission Data Elements* section of the Submitting a Final Claim under the Home Health Patient-Driven Groupings Model page on the **cgsmedicare.com** website*

Where can I find additional information about submitting claims for services provided to Medicare Plus Blue members?

See the document titled Medicare Plus Blue home health care claims: Frequently asked questions for providers.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.

CareCentrix is an independent company that manages the authorization of home health care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

EDRC 1499_BCBSM 042021