



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

Post-acute care services

Frequently asked questions for providers

For Medicare Plus BlueSM and BCN AdvantageSM

Revised February 2024

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General information

Home & Community Care (formerly known as naviHealth, Inc.) manages post-acute care services for Medicare Plus Blue and BCN Advantage members. They make authorization determinations on initial, continued stay and retroactive requests for post-acute care services.

Home & Community Care reviews each request and either approves it or denies it.

Providers need to submit authorization requests to Home & Community Care for Medicare Advantage members who are transitioning from an acute care setting or from any other type of care to one of these care settings:

- Skilled nursing facility
- Inpatient rehabilitation facility
- Long-term acute care hospital

In addition, Home & Community Care’s care coordinators, who are licensed clinicians, work with post-acute care providers and with members and their families to facilitate utilization management and discharge planning activities. These efforts take place while the member is in the post-acute care setting. The facilities should collaborate with Home & Community Care on these activities.

Which members does this change affect?

This change affects Medicare Plus Blue and BCN Advantage members, for both in-Michigan and outside-of-Michigan post-acute care, with the exception of members in a Special Needs Plan.

Note: These changes do not apply to Blue Cross commercial plans, BCN commercial plans or Blue Cross Complete (Medicaid) members. They also do not apply to the following services: home health care, durable medical equipment, any outpatient service that requires prior authorization, high-cost drugs and ambulance transportation.

Who is Home & Community Care?

Home & Community Care is a national company that focuses on post-acute care management and care transitions. Their goal is to improve patient outcomes and help patients discharge to the most appropriate setting, while guiding them through their care.

In select locations, Home & Community Care may place care coordinators (licensed clinicians) onsite. When care coordinators are not onsite, they provide service by telephone.

Why did Blue Cross and BCN contract with Home & Community Care to manage post-acute care services?

Blue Cross and BCN transitioned these services to Home & Community Care as part of an effort to standardize the management of authorizations for post-acute care for Medicare Advantage members. Home & Community Care's management helps to provide a more coordinated, patient-focused approach that's aimed at improving the patient's physical function and reducing the likelihood of readmission to an acute care setting.

Who works with the post-acute care provider to coordinate the member's care?

Home & Community Care care coordinators, who are licensed clinicians (nurses, physical therapists, occupational therapists and speech pathologists), interact with post-acute care facility staff to:

- Obtain information about the patient's progress in therapy and his or her overall medical condition.
- Collaborate with facility personnel to promote a safe and comprehensive experience from admission to discharge.

Home & Community Care care coordinators are either onsite at the post-acute care location or are available by phone.

How do Home & Community Care coordinators interact with members in the post-acute care setting?

Home & Community Care's onsite care coordinators visit members in post-acute care facilities to explain Home & Community Care's role and answer questions about the transition of care during recovery.

If a facility does not have a Home & Community Care care coordinator onsite, Home & Community Care contacts the member (or his or her family or the person who has the power of attorney) by telephone. With each interaction, the care coordinator introduces himself or herself, using his or her name and licensure and the Home & Community Care name.

The care coordinator explains Home & Community Care's relationship with Blue Cross and BCN and reviews the member's recovery expectations and caregiver requirements, discussing the transition to each care setting. Home & Community Care care coordinators also participate in discharge planning by attending interdisciplinary team meetings and family care conferences.

How can I contact Home & Community Care after business hours?

For requests submitted to Home & Community Care, contact the Home & Community Care on-call care coordinator at 1-855-851-0843. The on-call coordinator has access to a physician, as needed, and is available as follows:

- Monday through Friday from 7 p.m. to 10 p.m.
- Weekends and Blue Cross corporate holidays from 10 a.m. to 4 p.m.

How do I access Home & Community Care documents related to this program?

To access Home & Community Care documents, you must first register for the Home & Community Care Partner Resources website for Blue Cross and BCN. To register:

1. Go to the [registration page](#).*
2. Enter your name and email address.
3. Click *Submit*.

You'll receive an email message from Home & Community Care that will include:

- A link to the Home & Community Care Partner Resources website
- Your username, which matches the email address you entered on the registration page
- A temporary password

It may take several hours for the email message to arrive.

After you receive the email message, you can access the Home & Community Care documents by going to partners.navihealth.com/partner/bcbsm* and logging in. The first time you log in, you'll be prompted to change your password.

Note: You'll find references to documents that are available through the Home & Community Care Partner website throughout this document.

Authorizations

Who should submit prior authorization requests?

Here's who should submit prior authorization requests for post-acute care services:

- The acute care facility, not the post-acute care provider, must submit the request to authorize initial admissions.

Note: If the acute care provider isn't contracted with the member's health plan, the post-acute care provider may need to submit the prior authorization request. Post-acute care providers should always confirm that a prior authorization request has been submitted and approved when accepting a member for care. If it has not, the post-acute care provider must submit the request. In addition, if the member is moving into post-acute care from somewhere other than an acute care setting, the post-acute care provider must submit the prior authorization request.

- The post-acute care provider must submit requests for continued stays and retroactive authorization requests and must supply the appropriate discharge information to Home & Community Care.

Note: The post-acute care provider may submit retroactive authorization requests to Home & Community Care.

The preferred method for submitting prior authorization requests to Home & Community Care is to enter the requests in Home & Community Care's Access provider portal.

As a reminder, prior authorization isn't a guarantee of payment.

How do I register for access to Home & Community Care's Access provider portal?

To use Home & Community Care's Access provider portal to submit prior authorization requests and to complete other tasks, you must follow these steps to register for direct access to Access:

1. Go to partners.navihealth.com/partner/nh-access*
2. Scroll to the "Access – Setting Up Your Account" section.
3. Follow the instructions in the *Access account creation guide*.

After Home & Community Care creates your account, you'll receive an email from Home & Community Care with instructions on how to log in.

While you're waiting to get direct access to the Home & Community Care Access provider portal, you may submit authorization requests to Home & Community Care by fax or phone, as outlined in "How do I submit prior authorization requests?" on page 6.

Once you have your login information, you can access Home & Community Care's Access portal directly at access.navihealth.com* or through our provider portal.

How do I submit prior authorization requests?

To submit prior authorization requests, do the following.

| Submit to | Process for submitting requests |
|----------------------------------|--|
| <p>Home & Community Care</p> | <ul style="list-style-type: none"> • Online through the Access provider portal, which you can access as follows: <p>Important: You must register for access to Home & Community Care’s Access provider portal. To learn how to register, see “How do I register for access to Home & Community Care’s Access provider portal?” on page 5.</p> <p>Michigan providers</p> <ul style="list-style-type: none"> ○ Through access.navihealth.com*. ○ Through our provider portal. To do this, log in to availability.com*, click <i>Payer Spaces</i> in the menu bar, click the BCBSM and BCN logo, and then click the <i>Home & Community Care Portal</i> tile in the Applications tab. This opens the Access login screen. <p>Non-Michigan providers</p> <ul style="list-style-type: none"> ○ Non-Michigan providers who aren’t registered with Availity®: Access Home & Community Care’s Access provider portal through access.navihealth.com*. ○ Non-Michigan providers who are registered with Availity: You can access the login page for the Home & Community Care provider portal by logging in to your local plan's website and selecting an ID card prefix from Michigan. This will take you to the Pre-Service Review for Out-of-Area and Local Members screen, where you can click the <i>Home & Community Care</i> link to access the login page. • Fax for new authorization requests: 1-844-899-3730 • Fax for continued stay requests: 1-844-736-2980 • Fax for discharges: 1-844-729-2951 • Email for discharges: mid-west_discharge_info@navihealth.com • Phone: 1-855-851-0843 |
| <p>CarePort Care Management</p> | <p>Submit through CarePort Care Management (formerly Allscripts).</p> <p>Follow your current process. Refer to the guideline on Submitting Pre-Service Authorization Requests using CarePort Care Management. To access the guideline, go to partners.navihealth.com/partner/bcbsm*, log in, scroll down the page and click <i>Pre-Service Authorization Request Guide</i>.</p> <p>Note: For information about registering for the Home & Community Care Partner Resources website, see “How do I access Home & Community Care documents related to this program?” on page 4.</p> |

What documentation should I submit with prior authorization requests?

Refer to Home & Community Care’s Clinical Documentation Submission Requirements to see what documentation is required for each type of authorization request.

To access this document, go to partners.navihealth.com/partner/bcbsm,* log in, scroll down the page and click the appropriate *Clinical Documentation Submission Requirements* link.

Note: For information about registering for the Home & Community Care Partner Resources website, see “How do I access Home & Community Care documents related to this program?” on page 4.

What criteria does Home & Community Care use to make determinations on prior authorization requests?

Home & Community Care uses the following criteria:

- CMS National Coverage Determinations and Local Coverage Determinations, within the appropriate jurisdictions
- InterQual[®] criteria

Who should I call with follow-up questions after submitting a prior authorization request?

After you submit a prior authorization request to Home & Community Care, you can submit questions through the Access provider portal, which you can access at access.navihealth.com* or through our provider portal (availity.com*).

You can also direct follow-up questions to Home & Community Care during normal business hours by calling 1-855-851-0843. Normal business hours are 8 a.m. to 7 p.m. Monday through Friday.

For requests submitted through CarePort Care Management (formerly Allscripts), follow your normal CarePort Care Management process to contact them with follow-up questions.

Refer to the guideline on Submitting Pre-Service Authorization Requests using CarePort Care Management. To access the guideline, go to partners.navihealth.com/partner/bcbsm,* log in, scroll down the page and click *Pre-Service Authorization Request Guide*.

Note: For information about registering for the Home & Community Care Partner Resources website, see “How do I access Home & Community Care documents related to this program?” on page 4.

How can I check the status of a post-acute care prior authorization request?

You can check the status of a prior authorization request through Home & Community Care's Access provider portal or by contacting Home & Community Care by phone at 1-855-851-0843.

How can I talk to a medical director at Home & Community Care for a peer-to-peer review?

If a peer-to-peer review is needed, contact Home & Community Care at 1-855-851-0843 and choose option 5 to speak to a Home & Community Care medical director.

You'll be connected to someone who will take your information and give it to a Home & Community Care medical director. The medical director will call you back for the peer-to-peer review.

Can I submit a retroactive authorization request for a post-acute care stay?

Yes. You can submit retroactive requests to Home & Community Care up to one year post-discharge for both Medicare Plus Blue and BCN Advantage members.

You have up to 90 days from the discharge date to submit retroactive requests as follows:

- Through Home & Community Care's Access provider portal
- By faxing to Home & Community Care at 1-844-899-3730
- By calling Home & Community Care at 1-855-851-0843
- Using CarePort Care Management (formerly Allscripts)

After 90 days, you must submit retroactive requests either by calling or faxing Home & Community Care.

How do I submit appeals on denied authorization requests?

The Medicare Plus Blue and BCN Advantage Grievance and Appeals units handle requests to appeal denials of both prior and retroactive authorization requests.

To submit an appeal, follow the instructions in the denial letter. If you haven't received the denial letter yet, you can request a copy by calling Home & Community Care at 1-855-851-0843 or by submitting a request through the Access provider portal.

If you're submitting a fast, or expedited, appeal, you'll get the fastest response from us by doing the following:

1. Including all current and relevant medical documentation to ensure your appeal can be processed in a timely manner.

2. Faxing it to the number listed on the denial letter. (The fax numbers are also listed below.)
3. On the fax cover sheet, indicating that you're requesting a fast, or expedited, appeal.

Within 72 hours, we'll send a fax to inform you of our determination. See "Can I transfer the patient as soon as the appeal is approved?" on page 9 for additional information.

To appeal an adverse determination, submit the appeal to the appropriate Grievance and Appeals unit as outlined in the following table:

| Coverage | Details |
|--------------------|---|
| Medicare Plus Blue | <ul style="list-style-type: none"> • Fax it to 1-877-348-2251. • Call the Provider Inquiry number listed below. <p>For additional information on appeals related to Medicare Plus Blue members, refer to the Medicare Plus Blue PPO Provider Manual. Look in the section titled "Providing notices of appeal rights and responding to appeals."</p> <p>To inquire about the status of an appeal, call Provider Inquiry at 1-866-309-1719.</p> |
| BCN Advantage | <ul style="list-style-type: none"> • Fax it to 1-866-522-7345. • Call the Provider Inquiry number listed below. <p>For additional information on appeals related to BCN Advantage members, refer to the BCN Advantage chapter of the <i>BCN Provider Manual</i>. Look in the section titled "BCN Advantage provider appeals."</p> <p>To inquire about the status of an appeal, call Provider Inquiry at:</p> <ul style="list-style-type: none"> • Facility providers: 1-800-249-5103 • Professional providers: 1-800-344-8525 |

Note: For provider appeals related to claims, call Provider Inquiry.

If the denial is related to a *Notice of Medicare Noncoverage*, or *NOMNC*, (for continued stays), the appeal should be submitted to the appropriate quality improvement organization, or QIO. The *NOMNC* includes the name of the QIO and detailed instructions about how to appeal.

Note: Home & Community Care will send the *Notice of Medicare Non-Coverage* and *Detailed Explanation of Non-Coverage* forms for discontinuation of care.

Can I transfer the patient as soon as the appeal is approved?

Once you receive a fax from us stating that an appeal has been approved, you can immediately transfer the member to a post-acute care facility.

Although Home & Community Care will provide an authorization number later, don't wait for that number to transfer the patient. The fax you received serves as proof of the approval.

Post-acute care providers should accept the transfer based on the faxed notification stating that we approved the appeal.

Skilled nursing facilities

What is the payment methodology for SNF stays?

Medicare Plus Blue and BCN Advantage follow CMS payment methodology for SNFs.

Home & Community Care authorizes PDPM codes during the patient's stay (from preservice through discharge), based on medical necessity review and their proprietary Predict functional assessment.

Home & Community Care authorizes the first four digits of the PDPM code based on the associated case mix groups, or CMGs. The provider is responsible for assigning the appropriate fifth digit. Home & Community Care works with SNFs to ensure the biller submits the appropriate PDPM codes for reimbursement.

Which assessments are required for Medicare Advantage members admitted to SNFs?

Here's some important information about the assessments that are required for Medicare Plus Blue and BCN Advantage members admitted to SNFs:

- You must submit physical therapy, occupational therapy, speech therapy and nursing assessments for each member to Home & Community Care within 48 hours of admission to a skilled nursing facility. Home & Community Care uses these assessments to:
 - Complete the Predict functional assessment
 - Create and deliver the Predict outcome report to the member and the SNF in a timely manner
- You must complete an Omnibus Reconciliation Act, or OBRA, assessment for each member.
- You may opt to complete an additional Prospective Payment System assessment, but you are not required to complete one.

If you complete a PPS assessment:

- No PDPM code is required, because Home & Community Care will determine the PDPM code.

Note: Home & Community Care authorizes the first four digits of the PDPM code based on the associated case mix groups, or CMGs. The provider is responsible for assigning the appropriate fifth digit.

- A PDPM code included in a PPS assessment may not match the code Home & Community Care assigns. If the code doesn't match and you enter the PDPM code from a PPS assessment rather than the Home & Community Care -assigned PDPM code, this may cause a claim denial or payment error.
- You must bill using the PDPM code Home & Community Care assigns, which you'll find in the authorization on Home & Community Care's Access provider portal at access.navihealth.com.* (For more information, see "What authorization number should I submit with the claim?" on page 15.)

If you choose not to complete a PPS assessment, there will be no penalties, even if you're following CMS protocols.

For more information, see the following on the Home & Community Care website*:

- The [Home & Community Care Partner site](#)

Note: For information about registering for the Home & Community Care Partner Resources website, see "How do I access Home & Community Care documents related to this program?" on page 4.

- The [PDPM resources](#) page

If you have questions, contact your Home & Community Care provider network manager.

Note: For SNF interrupted stays, the completion of new patient assessments is optional.

What clinical documents or assessments are needed for Home & Community Care to calculate the CMG level?

By day seven of a member's stay, you must submit the following items to Home & Community Care so they can calculate the case mix group, or CMG, level:

- PHQ-9 assessment
- Medication Administration Record, or MAR / Treatment Administration Record, or TAR
- Discharge planning assessment
- Physician and nursing notes
- Physical, occupational and speech therapy notes

Home & Community Care will calculate the CMG level within two days of receiving clinical documentation and assessments. They'll use the CMG level to generate patient-driven payment model, or PDPM, codes, which are used for billing.

Can I request a reassessment of the CMG level?

After Home & Community Care has calculated the CMG level, you can submit requests to reassess CMG levels. **Be sure to request the reassessment prior to discharging the member from skilled services.** Send the clinical documentation required for the reassessment to Home & Community Care as soon as possible.

Clinical documentation for the reassessment of CMG levels includes — but isn't limited to — information from the most recent history and physical, transfer documents, physician progress notes, discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and diagnostic reports.

Home & Community Care will use the clinical documentation to determine whether to change the CMG level. you must identify where the supporting documentation appears within the clinical documentation. If Home & Community Care determines that the CMG level should change, they'll change it retroactive to the day of admission.

You can use the *Request for a Reassessment of the CMG Level* worksheet to ensure that you submit comprehensive clinical documentation to support the request. You can find this worksheet:

- By requesting it from your assigned Home & Community Care care coordinator.
- Through the Home & Community Care Provider Resources website for Blue Cross and BCN at <https://partners.navihealth.com/partner/bcbsm>*. For information about registering for the Home & Community Care Partner Resources website, see "How do I access Home & Community Care documents related to this program?" on page 4.

Note: The decision to change a CMG level may require review of the request by a Home & Community Care medical director.

What happens if the PDPM codes on claims don't match the codes Home & Community Care authorized?

Blue Cross and BCN will deny SNF claims when PDPM codes don't match the codes Home & Community Care authorized.

To ensure that SNF claims reflect the authorized PDPM code, you should work closely with Home & Community Care throughout the patient's stay as follows:

- Prior to discharge, your biller should work with a Home & Community Care care coordinator to verify that the authorized PDPM codes are submitted for reimbursement.

- If you have questions about the PDPM code Home & Community Care authorized, contact Home & Community Care during the patient's stay to resolve those questions.
- When you submit SNF claims for Medicare Advantage members, make sure the PDPM codes on the claims match the codes on the authorization for the stay.

Reminders:

- For dates of service from June 1, 2019, through Dec. 16, 2020, Blue Cross and BCN reviewed paid SNF claims to ensure that the RUG or PDPM codes on the claims matched the codes on the authorizations. If we found overpayments because the RUG or PDPM codes on the claims didn't match the codes on the authorizations, we pursued payment recoveries as necessary.
- For dates of service on or after Dec. 17, 2020, we deny SNF claims when PDPM codes don't match the codes Home & Community Care authorized.

When is a SNF stay considered an interrupted stay?

Per Centers for Medicare & Medicaid Services guidance, a skilled nursing facility interrupted stay occurs when a patient is discharged from a SNF and is readmitted to the same SNF within three consecutive days. When this occurs:

- The readmission or subsequent stay is considered a continuation of the previous stay.
- One claim must be submitted for both stays.
- The completion of new patient assessments is optional.
- The variable per diem isn't reset.

For more information, see the "Interrupted Stay Policy" section of the Medicare Learning Network[®] document titled [SNF PPS: Patient Driven Payment Model*](#).

How does Home & Community Care handle authorizations for SNF interrupted stays?

If a patient who is receiving skilled services leaves a SNF for the emergency department, for an observation stay or for an acute-care hospital inpatient stay and:

- Returns to the same SNF **before two midnights have passed**, Home & Community Care will use the original prior authorization number.
- Returns to the same SNF **after two or more midnights have passed**, Home & Community Care will create a new authorization number.

For information about submitting claims for SNF interrupted stays, see "How do I submit claims for SNF interrupted stays?" on page 15.

Why did I receive an administrative denial letter from Home & Community Care?

BCN Advantage and Medicare Plus Blue members sometimes remain in SNFs for days beyond the service end date on the *Notice of Medicare Non-Coverage* form.

Sometimes the extended stay is due to a provider's failure either to deliver a completed *NOMNC* form in a timely manner or to comply with CMS guidelines for responding to requests from Livanta, LLC, the quality improvement organization assigned to Medicare Advantage members in Michigan. This results in days added to the member's stay that may not be medically necessary.

On behalf of Blue Cross or BCN, Home & Community Care will issue an administrative denial for these days if they occur because the SNF provider didn't handle the *NOMNC* in accordance with the CMS guidelines. In an administrative denial, the authorization is approved but the reimbursement for the extra days is denied.

Here are some examples of improper handling and delivery of the *NOMNC*:

- Late delivery of the *NOMNC*. Members must receive the *NOMNC* 48 hours prior to the planned discharge date.

Note: Home & Community Care completes as much of the *NOMNC* as possible and tells the provider when to issue the *NOMNC*.
- Failure to fill out the *NOMNC* in its entirety. All fields in the *NOMNC* must be completed, including all date and signature fields. For more information, see the [Form Instructions for the Notice of Medicare Non-Coverage \(NOMNC\) CMS-10123](#).*
- Not submitting the requested medical information to the QIO in a timely manner, when the member appealed the service end date with the QIO

Note: To view CMS instructions about appropriate delivery of the *NOMNC*, see sections 260.2 to 260.4.5 of the [CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 2711](#).*

When SNF providers have repeated difficulties handling the *NOMNC* according to CMS guidelines, their Home & Community Care care coordinators will reach out to provide education about CMS guidelines and health plan requirements. If, after receiving education, a SNF provider continues to have difficulties, Home & Community Care will deliver an administrative denial letter to the provider when members stay beyond the end date stated on the *NOMNC*.

The administrative denial letter will include details on the specific CMS guideline violations. Blue Cross and BCN will hold the provider responsible for the additional days the member stayed in the SNF. Per CMS guidelines, providers can't bill members for the additional days.

You can find information about CMS guidelines and Medicare Plus Blue and BCN Advantage requirements in the following locations.

- [Medicare Claims Processing Manual, Chapter 30](#)*: See section “260.3.6 — Financial Liability for Failure to Deliver a Valid NOMNC.”
- [Medicare Plus Blue PPO Provider Manual](#): See the Utilization Management section. Look under the “Post-acute care skilled nursing, inpatient rehabilitation and long-term acute care facilities” heading.
- *BCN Provider Manual*: See the [BCN Advantage](#) chapter. Look in the “BCN Advantage provider appeals” section.
- [Medicare Managed Care Appeals & Grievances](#)* webpage at **cms.gov**
- [Beneficiary Notices Initiative \(BNI\)](#)* webpage at **cms.gov**

How do I submit claims for SNF interrupted stays?

When submitting claims for SNF interrupted stays:

- You must submit only one claim for both stays.
- Submitting authorization numbers on Medicare Plus Blue and BCN Advantage claims for post-acute care stays is **optional**. If you choose to include an authorization number on the claim, include the prior authorization number for the initial SNF stay.
- If Home & Community Care assigns a different patient-driven payment model, or PDPM, code for the subsequent stay:
 1. Include a claim line for the original dates of service and PDPM code.
 2. Include a separate or new claim line for the subsequent dates of service and the second PDPM code.

Claims

What authorization number should I submit with the claim?

Submit the authorization number provided with the authorization approval.

See “How does Home & Community Care handle authorizations for SNF interrupted stays?” on page 13 for additional information.

Who should I call with questions about claims I have submitted?

Call the member's plan as follows:

- Michigan providers should call Provider Inquiry at 1-800-249-5103.
- Non-Michigan providers should call Provider Inquiry at 1-800-676-2583.

The health plans will process all post-acute care claims based on the length of stay and level of service authorized by Home & Community Care.

Reminders:

- Providers are responsible for billing appropriately.
- Claims for unauthorized services and procedures are subject to denial.
- Prior authorization isn't a guarantee of payment.

*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.

Availity[®] is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Home & Community Care is an independent company that manages authorizations for post-acute care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.