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

Clinical documentation requirements

For Medicare Plus Blue℠ and BCN Advantage℠

June 2022

CareCentrix® manages prior authorizations for home health care services for Medicare Plus Blue and BCN Advantage members.

When submitting prior authorization requests to CareCentrix for home health care services, include the following documentation:

Type of request	Required information and documentation to support medical necessity	
All prior authorization requests	• Patient first and last name • Patient date of birth • Patient home address • Patient servicing address	• Patient phone number with area code • Subscriber ID • Home health agency name • Home health agency phone number
Initial prior authorization requests	In addition to the information in the "All prior authorization requests" row, initial prior authorization requests must include: • Services required • Physician/allowed practitioner orders or plan of care (signature isn't required) • Start-of-care date • Primary diagnosis (may reflect up to three diagnoses) The plan of care provides information that helps determine medical necessity. If you don't provide the plan of care, you may provide other documentation (such as hospital discharge summary / orders) to support medical necessity; this documentation must identify the following: • Services/treatment the patient requires • Disciplines that will deliver the services • Frequency and duration of requested services • Medical equipment and/or supplies required for home health services • Outline of expected goals for each discipline	
Continued services / re-authorization requests	In addition to the information in the "All prior authorization requests" row, continued services / re-authorization requests must include: • The most current clinical notes to support medical necessity for each discipline requested • Notification of change in ordering physician, if applicable • Physician / allowed practitioner orders or plan of care (signature isn't required) CareCentrix reviews each case for medical necessity every 30 days. When a second 30-day authorization is required within a 60-day certification period, you need to supply only recent nursing and/or therapy notes. Skilled nursing and therapy notes should describe patient status, treatments / skilled services provided, progress toward goals, ongoing need and next steps. For additional details on what clinical notes should include, refer to *Medicare Benefit Policy Manual, Chapter 7 – Home Health Services** on the **cms.gov** website.	

Additional clinical documentation to be submitted prior to the end of each episode of care:

- Comprehensive OASIS assessment
- **For Medicare Plus Blue members who receive services in Michigan:** HIPPS code. Submit to CareCentrix through the HomeBridge® portal or by calling 1-833-409-1280.

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