Blue Cross Blue Shield Blue Care Network of Michigan

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

# Home health care

## Frequently asked questions for providers

**For Medicare Plus Blue℠ and BCN Advantage℠**

April 2021

*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 will 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.

Note: CareCentrix will begin accepting requests for prior authorizations on May 28, 2021.

CareCentrix will authorize and support 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, including those from InterQual® and the Centers for Medicare & Medicaid Services, and clinical documentation to make medical necessity utilization management decisions
- Validate appropriate utilization and enhanced quality of care across home health services
- As needed, assist with coordinating member transitions from hospital to home

Providers will be required to obtain 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 will provide training, tools and support to the provider network so all are prepared to request prior authorization for home health services from CareCentrix.

After the program launch and 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 will interact 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.

## Will members' home health care benefits change because CareCentrix manages these services?

No, there won't be 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 request: carecentrixportal.com/ProviderPortal<br>• 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, including most holidays
- **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 now 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 and how do I submit prior authorization requests to CareCentrix?

In accordance with CMS guidelines, initial prior authorization requests should be submitted within five days after the initial evaluation is conducted.

For continuation of services, CareCentrix recommends the 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.

Submit requests as follows:

| Method of submission | Process for submitting |
|---|---|
| CareCentrix HomeBridge® portal — through Blue Cross and BCN's Provider Secured Services<br><br>Note: If you don't already have access to Provider Secured Services, complete the Provider Secured Access Application and fax it to the number on the form. | Access the CareCentrix HomeBridge portal through Blue Cross and BCN's Provider Secured Services. To do this:<br>1. Log in to bcbsm.com as a provider.<br>2. In the Provider Secured Services welcome page, click the link to access the CareCentrix HomeBridge portal.<br>3. Enter your National Provider Identifier.<br><br>This will take you to the CareCentrix HomeBridge portal.<br><br>If you're having trouble accessing the CareCentrix HomeBridge portal using this process, contact the Blue Cross and BCN Web Support Help Desk at 1-877-258-3932.<br><br>**Note for out-of-state providers:** You can access Blue Cross and BCN's Provider Secured Services by logging in to your local plan's website and selecting an ID card prefix from Michigan. This will take you to the Blue Cross Blue Shield of Michigan website where you can complete steps 2 and 3 above to access the CareCentrix HomeBridge portal. |
| CareCentrix HomeBridge portal — direct access | Go to carecentrixportal.com/ProviderPortal.*<br><br>You must register with CareCentrix to use this method. |
| By fax | 1-877-245-4891<br><br>Include a fax coversheet, required member information and supporting clinical documentation. |
| By phone | 1-833-409-1280 |

## What documentation should I submit with home health care prior authorization requests?

You must provide the following information when you submit requests. Unless otherwise noted, these requirements apply to Medicare Plus Blue and BCN Advantage.

| Type of request | Details |
|---|---|
| Initial prior authorization requests | • Patient name, date of birth, home address, servicing address, phone number<br>• Subscriber ID<br>• Home health agency name<br>• Home health agency phone number<br>• Services required<br>• Start of care date<br>• Primary diagnosis (may reflect up to three diagnoses)<br>• Physician/allowed practitioner orders if no rendering provider is identified<br>• Plan of care<br>• Start of care Outcome and Assessment Information Set, or OASIS, assessment |
| Continuation of services requests | • Patient name, date of birth, home address, servicing address, phone number<br>• Subscriber ID<br>• Most recent OASIS assessment<br>• Signed plan of care<br>• Most current clinical notes to support request for each discipline<br>• Notification of change in ordering physician, if applicable<br>• **For Medicare Plus Blue members (in-state providers only):** Completion of HIPPS questionnaire available on portal |

## 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 Provider Secured Services, you can access the CareCentrix HomeBridge portal through the Provider Secured Services welcome page as outlined in “When and how do I submit prior authorization requests to CareCentrix?” on page 5. If you don’t have access to Provider Secured Services, complete the Provider Secured Access Application and fax it to the number on the form.

Alternatively, you can register for direct access to the CareCentrix HomeBridge portal as follows.

Note: If you already have access to the CareCentrix HomeBridge portal and are a contracted Blue Cross or BCN provider, CareCentrix will automatically update your portal access so you can submit requests for Medicare Plus Blue and BCN Advantage members. If you have questions regarding your access, contact portal support at portalinfo@carecentrix.com.

1. Go to carecentrixportal.com/ProviderPortal.*
2. Click the *Register* button.
3. Select one of the following user types:
   - Facility
   - Ordering Physician
   - Other Non-Contracted CareCentrix Provider (for providers not participating in the CareCentrix network)
4. Select **BCBSM** from the *Health Plan* field.
5. Complete the registration form. If you’re a provider with multiple locations, you’ll be able to select only one provider location during registration. To register other locations, contact CareCentrix at portalinfo@carecentrix.com.

When you complete the registration form, you’ll receive an email to confirm that CareCentrix received your registration request. CareCentrix will notify you when you can access the portal and provide a temporary password. You’ll need to set up your permanent password and security questions before you can use the HomeBridge portal.

Once you have access to the portal, you can submit requests directly through the CareCentrix HomeBridge portal at carecentrixportal.com/ProviderPortal.*

In the meantime, you can submit prior authorization requests to CareCentrix by phone or fax as outlined in "When and how do I submit prior authorization requests to CareCentrix?" on page 5.

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

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

- CMS National and Local Coverage Determinations within the appropriate jurisdictions
- InterQual®

In the event of a conflict between the sources listed, CareCentrix will apply the sources in the order in which they are listed above.

## 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 only if homebound status is in question.

## How long will the prior authorization approval be valid?

For Medicare Plus Blue members who receive services in state, authorizations will be valid for 30 days from start of care.

For all BCN Advantage members and for Medicare Plus Blue members who receive services out of state, approved authorizations will include start and end dates. The start and end dates are based on the provider's requested service dates.

## What authorization information will I receive from CareCentrix?

CareCentrix will provide the following information with home health care authorizations:

- **For all members:** Service Registration Form, or SRF, that outlines the approved service (CPT code/revenue code), dates of service, number of units per discipline and episode ID or authorization ID per discipline
- **For Medicare Plus Blue members who receive services in state:** HIPPS code for each 30 day period, in addition to the information listed above.

## How do I inquire about a prior authorization request?

All authorization statuses are available on the CareCentrix HomeBridge portal at carecentrixportal.com/ProviderPortal.*

You may also call CareCentrix with follow-up questions at 1-833-409-1280. For more information, see "How can I contact CareCentrix during business hours, after hours and on holidays?" on page 4.

## What is the turnaround time for prior authorization requests?

Turnaround time 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.** next business day, unless a peer-to-peer discussion is requested or insufficient information is provided with the request.<br>With a peer-to-peer discussion or insufficient information, CareCentrix will make a determination within 14 calendar days. |

| Type of request | Expected turnaround time |
|---|---|
| **Expedited or urgent** initial prior authorization requests and requests for continued services | • Requests received **before 4 p.m.**** will be processed the same day, unless a peer-to-peer discussion is requested<br>• Requests received after **4 p.m.**** will be processed by 4 p.m.** the next calendar day, unless a peer-to-peer discussion is requested<br>When peer-to-peer discussions are requested, CareCentrix will make a determination within 72 hours. |
| **Post-service request** | Within 14 calendar days |

**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 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 see authorizations for multiple home health care agencies?

In both the CareCentrix HomeBridge portal and Blue Cross and BCN's e-referral system, portal users with logins that are associated with a parent home health care agency can view all authorizations that are associated with both the parent and subsidiary home health care agencies.

Referring providers and portal users who aren't associated with multiple 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.

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

If absolutely necessary, you can submit retroactive authorization requests up to 90 days post-discharge for both Medicare Plus Blue and BCN Advantage members.

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, phone or fax.<br>Note: For up to 90 days from the discharge date, you can submit retroactive authorization requests through CareCentrix.<br>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 requests, the discussion must be requested and completed within 24 hours. For expedited requests, the discussion must be requested and completed 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 rendering 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 15.

## 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 Provider 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 the Medicare Plus Blue or the BCN Advantage Grievance and Appeals unit, as appropriate. For post-service provider appeals related to claims, call the BCBSM Provider Inquiry team.

If the denial 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 (QIO).

### 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. In addition, assessments are required for each discipline that is ordered.

### If I need to add visits to an existing 30-day authorization and the LUPA threshold has been met, do I need to submit a request to CareCentrix?

Yes. All requests for additional services — regardless of the LUPA threshold — require providers to submit prior authorization requests to CareCentrix.

The simplest way to place a submission is through the CareCentrix HomeBridge portal, which you can access through Blue Cross and BCN's Provider Secured Services or through direct access. For more information, see "When and how do I submit prior authorization requests to CareCentrix?" on page 5.

## 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, claims may be denied.

### What authorization number should I submit with the claim?

Submit the authorization number provided with the authorization approval.

### 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
  - Professional providers: Call Provider Inquiry at 1-800-344-8525.
  - Facility providers: 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.

*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.



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