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

Quick reference guide

For Medicare Plus Blue℠ and BCN Advantage℠

Revised July 2022

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

<table>
<tr><th>Information</th><th colspan="3">Details</th></tr>
<tr><td>Submitting prior authorization requests</td><td>Through the HomeBridge® portal:
Accessed through Blue Cross and BCN's provider portal (availity.com*)
Direct access at carecentrixportal.com/ProviderPortal.*</td><td>By fax: 1-877-245-4891
Include a cover sheet, required member information and supporting clinical documentation.</td><td>By phone:
1-833-409-1280</td></tr>
<tr><td>Any questions or issues, including those related to prior authorizations and the HomeBridge portal</td><td colspan="3">Phone: 1-833-409-1280
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 requests. Follow the prompts to leave a message. CareCentrix on-call nurses will respond within 30 minutes.
Fax: 1-877-245-4891 — You can fax anytime, but we'll retrieve faxes only during normal business hours.</td></tr>
<tr><td rowspan="2">Information and documentation required for prior authorization requests</td><td colspan="3">In addition to the specific requirements listed for initial and continued services prior authorization requests below, all prior authorization requests must include:
Patient first and last name
Patient date of birth
Patient home address
Patient servicing address
Patient home telephone number with area code
Subscriber ID
Home health agency name
Home health agency phone number</td></tr>
<tr><td colspan="2">Initial prior authorization requests must be submitted within five days after the initial evaluation is conducted and must include:
Services required
Start-of-care date
Primary diagnosis (may reflect up to three diagnoses)
Physician/allowed practitioner orders, if a servicing provider isn't identified
Plan of care
Start-of-care OASIS assessment</td><td>Continued services prior authorization requests should be submitted at least 72 hours prior to an authorization expiration date and must include:
Most recent OASIS assessment
Signed plan of care
Most current clinical notes to support medical necessity for each discipline requested
Notification of change in ordering physician, if applicable
Medicare Plus Blue (in-state providers only): HIPPS code</td></tr>
<tr><td>Turnaround time for prior authorization requests</td><td colspan="3">Turnaround times are the same for initial requests and requests for continued services.
Standard requests will be processed by 4 p.m.** of the next business day, unless a peer-to-peer discussion is requested or insufficient information is provided with the request.
With a peer-to-peer discussion or insufficient information, CareCentrix will make a determination within 14 calendar days.</td></tr>
</table>

Information	Details
Turnaround time for prior authorization requests, cont.	• **Expedited or urgent requests will be processed as follows:** ○ Requests received **before 4 p.m.**** will be processed the same day, unless a peer-to-peer discussion is requested ○ 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 When peer-to-peer discussions are requested, CareCentrix will make a determination within 72 hours. • **Post-service requests:** Within 14 calendar days
Intent-to-deny and peer-to-peer discussions	If CareCentrix determines that services do not meet medical necessity criteria and recommends a denial decision, these are the next steps prior to denying a request: 1. CareCentrix notifies the ordering physician/allowed practitioner of the intent to deny via a courtesy fax and phone call. 2. If the physician/allowed practitioner would like to discuss the case, they must contact CareCentrix as soon as possible to request a peer-to-peer discussion. Call CareCentrix at 1-833-409-1280 and follow the prompts to request an appointment. ○ For **standard** prior authorization requests, the discussion must be requested and completed within 24 hours. ○ For **expedited or urgent** prior authorization requests, the discussion must be requested and completed by 5 p.m. the same day. If the peer-to-peer discussion isn't requested within the time frame listed above, CareCentrix will issue the 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.
Appeals process	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. If the denial is related to a Notice of Medicare Non-Coverage, or NOMNC, for continued stays, the appeal should be submitted timely to the appropriate Quality Improvement Organization, or QIO.
Claims	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 don't obtain prior authorization for home health care services from CareCentrix, claims may be denied.

*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.

**Based on the local time zone of the requesting provider.

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