Blue Cross Blue Shield of Michigan

LONG-TERM ACUTE CARE HOSPITAL (LTACH)

GENERAL INFORMATION

I. BCBSM's LTACH Program(s)

Traditional

Participation in Blue Cross Blue Shield of Michigan's (BCBSM) Long-Term Acute Care Hospital (LTACH) Traditional program is on a formal basis only. Services provided in a non-participating LTACH may *not* be reimbursed by BCBSM to either the facility or the member.

The following information applies to facilities that want to participate in BCBSM's LTACH network for members enrolled in our Traditional product. Members who have the LTACH benefit are eligible to receive care at a participating LTACH. Please note that members enrolled in non-Medicare PPO and Point of Service products (e.g., Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO, Blue Choice POS, etc.) use the BCBSM Traditional network *unless* a separate network for LTACH services has been established for those members. Such members must have a benefit for LTACH services, and services must meet the members benefit criteria to be payable (e.g., all LTACH cases must be approved/authorized by BCBSM prior to providing services to the member). Member benefits and eligibility should always be verified with BCBSM before providing services.

Medicare Advantage PPO

Facilities that are Medicare certified as Long-Term Acute Care Hospitals are eligible to apply for participation in the BCBSM Medicare Advantage PPO network which became effective January 1, 2010 for individual and group customers. To participate in the MA PPO network, LTACHs are not required to participate in the Traditional network but must have and maintain all of the same requirements for Traditional participation.

Medicare Supplemental

Patients for whom Medicare is primary may also have Medicare Supplemental coverage through BCBSM. This benefit, if available to the patient, may provide coverage for payment of applicable Medicare deductibles, copayments and/or for days of care in excess of those paid for by Medicare. In general, the date on which the LTACH is eligible to receive Medicare Supplemental payments (using BCBSM's facility code) will be the same as the effective of the facility's Medicare certification as an LTACH. This date could be different than the facility's effective date for participation in BCBSM's Traditional or MA PPO programs. However, due to claims filing limitations, BCBSM will generally not assign a BCBSM Medicare Supplemental facility code with a retroactive effective date that exceeds a two year period.

Qualified LTACHs are eligible to obtain a BCBSM facility code for the billing of covered Medicare Supplemental services even if the facility does not qualify for or elects *not* to participate with BCBSM in our Traditional or MA PPO programs. LTACHs that make this

election must complete an application. However, the only attachments these LTACHs must submit are: the IRS documents, the facility license, proof of Medicare certification, and proof of accreditation.

II. BCBSM's LTACH Qualification Requirements for Traditional and MA PPO Networks

In order to participate with BCBSM as a Long-Term Acute Care Hospital in the Traditional or MA PPO Programs the facility must, at minimum, have and maintain the following:

- licensure by the state of Michigan as an acute care hospital
- Medicare certification as a Long-Term Acute Care Hospital (i.e., facilities do not qualify for BCBSM Traditional or MA PPO participation during the six-month Medicare qualifying period for LTACH status from Medicare)
- full accreditation (three or four years) by at least one national accreditation organization approved by BCBSM such as but not limited to, the Joint Commission, or the American Osteopathic Association (AOA)
- compliance with an applicable state Certificate of Need (CON) requirements
- a transfer agreement with an acute care hospital
- a governing body that is legally responsible for the conduct of the LTACH
- demonstration that the facility conducts program evaluation and utilization review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components
- an absence of fraud and/or other illegal activities
- has a financial structure that follows generally accepted accounting principles and practices
- has written policies and procedures that meet generally accepted standards to assure the quality of patient care and is able to demonstrate compliance with such policies and procedures
- an absence of inappropriate utilization or practice patterns as identified through valid subscriber complaints, medical necessity audits, peer review, and utilization management

III. Traditional Network Reimbursement

Reimbursement is made only for covered services provided by an LTACH that is approved and contracted with BCBSM. Reimbursement is limited to the lesser of the billed charge or the BCBSM all inclusive per-diem maximum payment level indicated on the Rate Schedule for the level of service/tier preauthorized by BCBSM for each day of care.

IV. Medicare Advantage PPO Network Reimbursement

Reimbursement for LTACHs in the MA PPO network is made at the BCBSM Payment Rate(s) for the applicable service, less any applicable member copayments or deductibles. For out-of-network providers, payment is made at CMS rates but the member is subject to additional out-of-network copayments and deductibles.

V. The BCBSM Participation Agreements

The applicable Traditional and/or MA PPO LTACH participation agreement(s) are available on the bcbsm.com LTACH home web page. The Traditional agreement is also available as a link in the participation chapter of the provider manual on web-DENIS for those providers that

already have web-DENIS access. The Traditional participation agreement is on file with the Michigan Office of Financial and Insurance Regulation (OFIR). The payment rates and the terms and provisions of the Traditional and MA PPO agreements are not negotiable.

The applicable participation agreement signature documents for each BCBSM network/program being requested on the application are available on the LTACH home web page and must be completed, signed and returned with a completed facility application form.

NOTE: This is general information only and is subject to change without notice.

After we review the application and accompanying documentation, we may contact the designated representative of the facility to set up an appointment for an on-site visit. The on-site visit includes a review of a sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as described in this application. The facility should be ready for the on-site review at the time it submits the application.

If the facility is approved for Traditional and/or MA PPO program participation, the appropriate notification will be sent. If the facility is not approved, we will send notification in writing indicating the reason(s) for the denial.

The facility may not submit claims and is not eligible for reimbursement unless and until the application for participation is approved by BCBSM and BCBSM has issued a signed letter of approval to the facility for the networks requested. The effective date for the approved networks will be indicated in the approval letter sent to the facility. Effective dates are not retroactive to the date the application was submitted or received.

With the implementation of National Provider Identifiers (NPI) BCBSM crosswalks the claims from the facility's NPI to the assigned BCBSM LTACH facility code (BCBSM's internal identifier) for claims processing. Therefore BCBSM recommends obtaining one NPI (in accordance with federal guidelines) for each location and provider type. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty codes).

Upon completion of the application and contracting process, the facility will receive a welcome package with information on how to sign up for electronic billing and access to web-DENIS, BCBSM's web- based information system for providers. Through web DENIS the facility will have access to provider manuals, newsletters (e.g., The Record), and patient data such as contract eligibility and benefits. It is the LTACH's responsibility to be familiar with and adhere to all BCBCM billing and benefit requirements. It is also the responsibility of the LTACH to ensure the facility's billing department (or billing agency) is compliant with all of BCBSM's billing requirements.

Participating LTACHs must bill BCBSM on a UB-04 claim form or the institutional electronic claim format. BCBSM no longer accepts facility paper claims (with some exceptions). Facilities that would like more information about electronic billing should contact BCBSM's Electronic Data Input (EDI) Helpline at (800) 542-0945 for electronic billing information after their BCBSM facility code has been received.

Facilities that participate in the Traditional and/or MA PPO programs or receive Medicare Supplemental payments from BCBSM must notify BCBSM *immediately* of any change in the facility's ownership, tax identification number, NPI, CMS certification number, Medicare certification status, address, telephone number, etc.

Multiple Locations/NPI

If the facility is applying for participation (or an ownership change) for more than one location, each location must meet all requirements in order to be approved. A separate BCBSM provider code is issued for each approved location with a separate NPI. A separate application must be submitted for each location.