

HOME HEALTH CARE FACILITY

GENERAL INFORMATION

I. BCBSM's Home Health Care Facility Programs

Traditional

Participation in Blue Cross Blue Shield of Michigan's (BCBSM) Traditional program is on a formal basis only. Services provided by a non-participating Home Health Care (HHC) facility are not reimbursed to either the facility or the member.

The following information applies to facilities that want to participate in BCBSM's network for members enrolled in our Traditional product. BCBSM members who have the HHC benefit are eligible to receive care from a participating HHC provider. Please note that members enrolled in BCBSM's non-Medicare PPO products (e.g., Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO etc.) use the BCBSM Traditional network *unless* a separate network for HHC services has been established for those members. Members of other Blue Cross Blue Shield (BCBS) Plans also use the Traditional network when receiving services in Michigan. Members must have a benefit for HHC services and services must meet the member's benefit criteria to be payable.

BCBSM's HHC program provides benefits for eligible members living at home with needed medical, nursing, and ancillary treatments. An HHC facility uses coordinated planning, evaluation and follow-up procedures to provide physician-directed nursing and other professional and ancillary services to patients at home.

In general, home health care, when provided by a participating HHC facility, is a benefit when the patient meets the following requirements:

- has a valid and active BCBSM contract that provides for home health care benefits
- is ineligible for Medicare home health care benefits
- requires services by a BCBSM participating HHC facility
- is referred by a physician who signs a detailed written plan of treatment for the facility
- has a medical condition that requires the level and intensity of care defined in the BCBSM Home Health Care manual or other published BCBSM documents
- complies with the plan of care described by the physician and the agency
- is sufficiently confined to his or her home so that he or she cannot, without great difficulty, obtain required services such as in a physician's office or hospital outpatient department.

Home Health Care facilities should verify members' eligibility and benefit coverage *before* providing services. Predetermination for home care services may be required by select customer groups.

Medicare Advantage PPO

Facilities that are Medicare certified as HHC facilities are eligible to apply for affiliation 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, HHC facilities are not required to participate in the Traditional network but must meet all of the same requirements for Traditional participation.

Medicare Supplemental

Patients who have primary coverage through Medicare may also have Medicare Supplemental coverage through BCBSM. This benefit, if available to the patient, may provide coverage for payment of applicable Medicare deductibles and/or copayments. In general, the effective date of a facility's participation in the BCBSM Medicare Supplemental program coincides with the effective date of the facility's Medicare certification as a Home Health Care agency. This date most likely will be different than the facility's Traditional or MA PPO program participation effective dates. All HHC facilities that are approved for participation in our Traditional program are approved for Medicare Supplemental payments.

Qualified HHC facilities may be eligible to obtain a BCBSM facility code for the billing of covered Medicare Supplemental services even if the facility elects *not* to participate with BCBSM in our Traditional program. Facilities that make this election must complete this application, however, the only attachments the facility must submit are: the IRS documents, and proof of the facility's Medicare certification. 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. Although participation in BCBSM's Traditional or MA PPO network is not required to obtain a Medicare Supplemental code, a Medicare Supplemental facility code is required to be eligible for out-of-network reimbursement for the MA PPO network.

II. BCBSM's Home Health Care Facility Qualification Requirements for Traditional and MA PPO Network

In order to participate with BCBSM in the Traditional and/or Medicare Advantage PPO network a HHC facility must, at minimum, have and maintain the following:

- current Medicare certification as a home health care agency
- full accreditation, generally three years, as a home health care agency/facility by:
 - the Community Health Accreditation Program, Inc. (CHAP)
 - the Joint Commission
 - the Accreditation Commission for Health Care (ACHC)
 - the Commission on Accreditation of Rehabilitation Facilities (CARF)
- Staffing requirements: the facility has a multi-disciplinary staff composed of all of the following:
 - a nursing administrator or coordinator who is a Michigan licensed registered nurse and who directs the activities of nurses, therapists, and other staff members
 - a business office manager who handles the business and financial aspects of the program
 - a physician coordinator, licensed as a physician (MD/DO) in Michigan, who serves as a consultant, advisor, and a liaison between the facility and the medical community
 - registered nurses, licensed in Michigan
 - Michigan licensed therapists or Michigan registered social workers, as appropriate to the services provided by the facility

b. General requirements include:

- The facility must provide skilled nursing covered services and one other professional type of therapy such as physical, speech, nutritional, occupational therapies or medical social services.
- The facility must meet BCBSM's Evidence of Necessity requirements, as applicable.
- The facility has an absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review.
- The facility has an absence of fraud and illegal activities.
- The facility has written policies and procedures that meet generally acceptable standards for home health care services to assure the quality of patient care, and the facility demonstrates compliance with such policies and procedures.
- Maintains adequate patient and financial records.

Note: It is BCBSM's policy to recredential participating providers every 2-3 years to verify continued compliance with all qualification requirements.

III. Home Health Care Facility Reimbursement – Traditional Network

Participating Freestanding and Hospital Based Home Health Care Facilities must bill BCBSM for covered services and accept BCBSM's payment as payment in full, except for any applicable copayments and/or deductibles that are the member's responsibility.

Reimbursement is made only for covered services provided by a participating HHC facility's approved sites(s). For each covered service, BCBSM will pay the facility the lesser of billed charges or the BCBSM approved amount per revenue code, less any deductible or copayment for which the member is responsible.

IV. Home Health Care Facility Reimbursement - Medicare PPO

Reimbursement for HHC facilities that participate in the MA PPO network is made at the BCBSM Payment Rate(s) for the applicable service, less any applicable member copayments or deductibles. Reimbursement is currently the same as Medicare but is subject to change via the contract amendment process.

V. The BCBSM Participation Agreements

The applicable Traditional and/or MA PPO HHC facility participation agreement(s) are available on the bcbsm.com HHC 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 participation agreements are 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 HHC 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 outlined in this application. The facility must be ready for the on-site review at the time of submitting 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.

A separate BCBSM facility code is assigned to each approved and contracted location that is considered the "primary" location by CMS. Approved branch locations use the same facility code as the primary location when submitting claims to BCBSM.

Participating HHC facilities must bill BCBSM on a UB-04 claim form or its electronic equivalent. BCBSM no longer accepts facility paper claims (with some exceptions). Facilities that would like more information about internet claims submission or who wish to bill electronically 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 or MA PPO programs or that are eligible to receive Medicare Supplemental payments from BCBSM must notify BCBSM *immediately* of any change in the facility's ownership, tax identification number, CMS certification number, NPI, addition/deletion of branch locations, address, telephone number, etc.

Multiple Locations

A separate application must be completed for each primary location. If the facility has one or more CMS approved branch locations, please include that information in the application package. Each site must meet all qualifications in order to be approved. One BCBSM provider facility code and contract is applied for each approved primary site. It includes the associated approved branch locations for billing purposes.