In this document

General information
- Which members does this change affect?
- Who is naviHealth?
- Why are Blue Cross and BCN changing to naviHealth?
- Who will work with the post-acute care provider on coordinating the member’s care?
- How will the naviHealth coordinator interact with the member in the post-acute care setting?
- Will members’ post-acute care benefits change because naviHealth manages these services?
- How can I contact naviHealth after business hours?

Authorizations
- Who should submit authorization requests?
- Should I submit authorization requests directly to naviHealth?
- Where should I submit continued stay requests for admissions on or after June 1?
- How do I access the naviHealth provider portal?
- What documentation should I submit with the authorization request?
- What criteria does naviHealth use to make determinations on authorization requests?
- Who should I call with follow-up questions after submitting an authorization request?
- How can I check the status of a post-acute care request?
- How can I talk to a medical director at naviHealth for a peer-to-peer review?

Skilled nursing facilities
- What is the payment methodology for SNF stays?
- Which assessments are required for Medicare Advantage members admitted to SNFs?
- Why did I receive an administrative denial letter from naviHealth?
- What is the audit and recovery process for SNF claims?
- What happens if the PDPM levels on claims don’t match the levels naviHealth authorized?
General information
Starting June 1, 2019, naviHealth manages post-acute care services for Medicare Plus Blue and BCN Advantage members. naviHealth receives initial, continued stay and retrospective authorization requests for post-acute care submitted by providers for members admitted on or after June 1, 2019. (Authorization requests for admissions prior to June 1 should be submitted as described in “Should I submit authorization requests directly to naviHealth?” on page 5.)

naviHealth reviews each request and makes an approval or denial determination.

This applies to members transitioning from an acute care setting or from any other type of care to one of these care settings:

- Skilled nursing facility
- Inpatient rehabilitation facility
- Long-term acute care hospital

In addition, naviHealth’s care coordinators, who are licensed clinicians, work with post-acute care providers and with members and their families to facilitate utilization management and discharge planning activities. These efforts take place while the member is in the post-acute care setting. The facilities should collaborate with naviHealth on these activities.

Which members does this change affect?
This change affects Medicare Plus Blue and BCN Advantage members, for both in-state and out-of-state post-acute care, with the exception of members in a Special Needs Plan.

Note: These changes do not apply to Blue Cross commercial plans, BCN commercial plans or Blue Cross Complete (Medicaid) members. They also do not apply to the following services: home health care, durable medical equipment, any outpatient service that requires authorization, high-cost drugs and ambulance transportation.
Who is naviHealth?
naviHealth is a national company that focuses on post-acute care management and care transitions designed to improve patient outcomes and help patients discharge to the most appropriate setting, guiding them through their care.

In select locations, naviHealth may place care coordinators (licensed clinicians) onsite. When care coordinators are not onsite, they provide service by telephone.

Why are Blue Cross and BCN changing to naviHealth?
Blue Cross and BCN are transitioning to naviHealth as part of an effort to standardize the management of authorizations for post-acute care for Medicare Advantage members. The change is also expected to provide a more coordinated, patient-focused approach that’s aimed at improving the patient’s physical function and reducing the likelihood of readmission to an acute care setting.

Who will work with the post-acute care provider on coordinating the member’s care?
naviHealth care coordinators, who are licensed clinicians (nurses, physical therapists, occupational therapists and speech pathologists), interact with post-acute care facility staff to obtain information about the patient’s progress in therapy and his or her overall medical condition, and collaborate with facility personnel to promote a safe and comprehensive experience from admission to discharge. naviHealth care coordinators are either onsite at the post-acute care location or are available by phone.
How will the naviHealth coordinator interact with the member in the post-acute care setting?

naviHealth’s onsite care coordinators visit members in post-acute care facilities to explain naviHealth’s role and answer questions about the transition of care during recovery. If a facility does not have a naviHealth care coordinator onsite, naviHealth contacts the member (or his or her family or the person who has the power of attorney) by telephone. With each interaction, the care coordinator introduces himself or herself, using his or her name and licensure and the naviHealth name. The care coordinator explains naviHealth’s relationship with Blue Cross and BCN and reviews the member’s recovery expectations and caregiver requirements, discussing the transition to each care setting. naviHealth care coordinators also participate in discharge planning by attending interdisciplinary team meetings and family care conferences.

Will members’ post-acute care benefits change because naviHealth manages these services?

There will be no changes to members’ benefits and no additional charges to members as a result of naviHealth 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 naviHealth after business hours?

For requests submitted to naviHealth, contact the naviHealth on-call care coordinator at 1-855-851-0843. The on-call coordinator has access to a physician, as needed, and is available as follows:

- Monday through Friday from 7 p.m. to 10 p.m.
- Weekends and Blue Cross corporate holidays from 10 a.m. to 4 p.m.

Authorizations

Who should submit authorization requests?

Here’s who should submit authorization requests for members admitted on or after June 1, 2019:

- The acute care facility, not the post-acute care provider, must submit the request to authorize initial admissions. (This is a change for BCN Advantage authorization requests.)
Note: If the acute care provider is not contracted with the member’s health plan, the post-acute care provider may need to submit the authorization request. Post-acute care providers should always confirm that an authorization request has been submitted and approved when accepting a member for care. If it has not, the post-acute care provider must submit the request. In addition, if the member is moving into post-acute care from somewhere other than an acute care setting, the post-acute care provider must submit the authorization request.

- The post-acute care provider must submit requests for continued stays and retrospective authorization requests and must supply the appropriate discharge information to naviHealth.

Note: The post-acute care provider may submit retrospective authorization requests to naviHealth only for admissions that occur on or after June 1, 2019. (Authorization requests for admissions prior to June 1 should be submitted as described in “Should I submit authorization requests directly to naviHealth?” below.)

Should I submit authorization requests directly to naviHealth?
The process for submitting requests to authorize post-acute care services varies depending on whether the member was admitted before June 1, 2019, or on or after June 1. See the appropriate section below for details.

For members admitted before June 1, 2019

<table>
<thead>
<tr>
<th>BCN Advantage in-state and out-of-state members</th>
<th>Medicare Plus Blue in-state members</th>
<th>Medicare Plus Blue out-of-state members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit to BCN Advantage:</td>
<td>Submit to eviCore healthcare®:</td>
<td>Fax to Medicare Plus Blue:</td>
</tr>
<tr>
<td>• Phone: 1-855-724-4286</td>
<td>o eviCore provider portal at</td>
<td>1-866-464-8223</td>
</tr>
<tr>
<td>• Fax: 1-866-534-9994</td>
<td><a href="http://www.evicore.com">www.evicore.com</a>*</td>
<td></td>
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<tr>
<td></td>
<td>o Phone: 1-877-917-2583</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Fax: 1-844-407-5293</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submit through Allscripts®, now</td>
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<tr>
<td></td>
<td>known as CarePort Care Management.</td>
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<tr>
<td></td>
<td>Follow your current process.</td>
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<td></td>
<td>Note: This also applies to</td>
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<tr>
<td></td>
<td>continued stay and retrospective</td>
<td></td>
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<tr>
<td></td>
<td>authorization requests for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>members admitted prior to June 1,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2019.</td>
<td></td>
</tr>
</tbody>
</table>
For members admitted on or after June 1, 2019

<table>
<thead>
<tr>
<th>Submit to:</th>
<th>Process for submitting requests</th>
</tr>
</thead>
</table>
| naviHealth       | naviHealth provider portal (nH Access™) accessed through the Provider Secured Services home page. Visit <bcbsm.com/providers> and log in to Provider Secured Services. Click the Medicare Advantage Post-Acute Care Authorization link. Enter your NPI. (If you’re having trouble accessing the naviHealth portal using this process, contact the Blue Cross Web Support Help Desk at 1-877-258-3932.)  
Note: Out-of-state providers can access this link by logging in to their home plan's website and selecting an ID card prefix from Michigan, which will take the provider to the Blue Cross Blue Shield of Michigan website.  
• nH Access at <access.navihealth.com>* You must first register with naviHealth for access to their portal.  
• Fax for new authorization requests: 1-844-899-3730  
• Fax for continued stay requests: 1-844-736-2980  
• Fax for discharges: 1-844-729-2951  
• Email for discharges: mid-west_discharge_info@navihealth.com  
• Phone: 1-855-851-0843  
Note: For members who were admitted on or after June 1 but whose requests were submitted prior to June 1, here’s what to do. For in-state Medicare Plus Blue members, submit the request to eviCore. For out-of-state Medicare Plus Blue members, fax the request to Medicare Plus Blue at 1-866-464-8223. For BCN Advantage members, submit the request to BCN Advantage. For all these members, the entity that accepted the authorization request for admission will handle continued stay requests and discharges even after June 1. |
| Allscripts       | Submit through Allscripts, now known as CarePort Care Management. Follow your current process. Refer to the guideline on Submitting Pre-Service Authorization Requests using CarePort Care Management. To access the guideline, visit <navihealth.com/bcbsm/resources/>*, scroll down the page and click Pre-Service Authorization Request Guide. |
Where should I submit continued stay requests for admissions on or after June 1?
Submit continued stay requests as shown in the table below.

<table>
<thead>
<tr>
<th>For authorization number sequence:</th>
<th>For BCN Advantage requests</th>
<th>For Medicare Plus Blue requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>010000xxx</td>
<td>Submit to BCN Advantage:</td>
<td>Fax to Medicare Plus Blue:</td>
</tr>
<tr>
<td></td>
<td>• Phone: 1-855-724-4286</td>
<td>1-866-464-8223</td>
</tr>
<tr>
<td></td>
<td>• Fax: 1-866-534-9994</td>
<td></td>
</tr>
<tr>
<td>Axxxxxxxxx</td>
<td>Not applicable</td>
<td>Submit to eviCore healthcare:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider portal at</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.evicore.com/">www.evicore.com/</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Phone: 1-877-917-2583</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fax: 1-844-407-5293</td>
</tr>
<tr>
<td>3xxxxxx</td>
<td>Submit to naviHealth:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• nH Access at access.navihealth.com <em>(You can also reach the portal through Blue Cross’ Provider Secured Services, using the steps described in “Should I submit authorization requests directly to naviHealth?” on page 5.)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fax for continued stay requests: 1-844-736-2980</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fax for discharges: 1-844-729-2951</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Email for discharges: <a href="mailto:mid-west_discharge_info@navihealth.com">mid-west_discharge_info@navihealth.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Phone: 1-855-851-0843</td>
<td></td>
</tr>
</tbody>
</table>

How do I access the naviHealth provider portal?
If you have access to Provider Secured Services at bcbsm.com, you can click the Medicare Advantage Post-Acute Care Authorization link on the Provider Secured Services welcome page to enter the naviHealth provider portal. (To register for access to Blue Cross’ Provider Secured Services, complete the Provider Secured Access application. Follow the instructions on the form to submit it.)

You can also register for direct access to the naviHealth portal by visiting partners.navihealth.com/partner/nh-access,* scrolling to the “nH Access – Setting Up Your Account” section and clicking the link for the Account Creation Guide. Follow the instructions in the nH Access Account Creation User guide.
After naviHealth creates your account, you’ll receive an email from naviHealth with instructions on how to log in.

While you’re waiting to get direct access to the naviHealth provider portal, you may submit authorization requests to naviHealth as follows:

- Fax for new authorization requests: 1-844-899-3730
- Fax for continued stay requests: 1-844-736-2980
- Fax for discharges: 1-844-729-2951
- Email for discharges: mid-west_discharge_info@navihealth.com
- Phone: 1-855-851-0843

Once you have your login information, you can access the naviHealth portal directly at access.navihealth.com.

What documentation should I submit with the authorization request?
Refer to naviHealth’s Clinical Documentation Submission Requirements to see what documentation is required for each type of authorization request. To access this document, visit navihealth.com/bcbsm/resources/, scroll down the page and click the appropriate Clinical Documentation Submission Requirements link.

What criteria does naviHealth use to make determinations on authorization requests?
naviHealth uses the following criteria:

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

Note: naviHealth applies these criteria in the order in which they are listed.
Who should I call with follow-up questions after submitting an authorization request?

After you submit an authorization request to naviHealth, you can submit questions through nH Access, which you can reach at access.navihealth.com or through Provider Secured Services.

You can also direct follow-up questions to naviHealth during normal business hours by calling 1-855-851-0843. Normal business hours are 8 a.m. to 7 p.m. Monday through Friday.

For requests submitted through Allscripts (now known as CarePort Care Management), follow your normal Allscripts process to contact them with follow-up questions. Refer to the guideline on Submitting Pre-Service Authorization Requests using CarePort Care Management. To access the guideline, visit navihealth.com/bcbsm/resources/, scroll down the page and click Pre-Service Authorization Request Guide.

How can I check the status of a post-acute care request?

If authorization was requested on or after June 1, 2019, you can check the status of an authorization either through nH Access or by contacting naviHealth by phone at 1-855-851-0843.

If authorization was requested prior to June 1, 2019, call as follows:

<table>
<thead>
<tr>
<th>BCN Advantage</th>
<th>Medicare Plus Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call BCN Advantage at 1-855-724-4286.</td>
<td>• For in-state facilities, call eviCore healthcare at 1-877-917-2583.</td>
</tr>
<tr>
<td></td>
<td>• For out-of-state facilities, call Blue Cross at 1-313-448-3619.</td>
</tr>
</tbody>
</table>

How can I talk to a medical director at naviHealth for a peer-to-peer review?

If a peer-to-peer review is needed, contact naviHealth at 1-855-851-0843 and choose option 5 to speak to a naviHealth medical director. You’ll be connected to someone who will take your information and give it to a naviHealth medical director. The medical director will call you back for the peer-to-peer review.
If a post-acute care stay was authorized prior to June 1, 2019, by someone other than naviHealth but the member needs a continued stay or is discharged after June 1, where should I submit the continued stay or discharge information?

Follow the instructions in the table.

<table>
<thead>
<tr>
<th>For authorization number sequence:</th>
<th>BCN Advantage</th>
<th>Medicare Plus Blue</th>
</tr>
</thead>
</table>
| 010000xxx | Submit to BCN Advantage:  
  • Phone: 1-855-724-4286  
  • Fax: 1-866-534-9994 | Fax to Medicare Plus Blue: 1-866-464-8223 |
| Axxxxxxxxx | Not applicable | Submit to eviCore healthcare:  
  • Provider portal at [www.evicore.com](http://www.evicore.com)  
  • Phone: 1-877-917-2583  
  • Fax: 1-844-407-5293 |

If a post-acute care stay was authorized for a specific facility for a member admitted prior to June 1, 2019, but the member moves to another facility after June 1, what needs to happen?

To change the name of the facility on the authorization, follow the instructions in the table.

<table>
<thead>
<tr>
<th>For authorization number sequence:</th>
<th>BCN Advantage</th>
<th>Medicare Plus Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axxxxxxxxx</td>
<td>Not applicable</td>
<td>Call eviCore healthcare at 1-877-917-2583</td>
</tr>
</tbody>
</table>
Can I submit a retrospective authorization request for a post-acute care stay?

Yes. You can submit retrospective requests up to one year post-discharge for both Medicare Plus Blue and BCN Advantage members. Follow the instructions in the table to submit a retrospective authorization request.

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>BCN Advantage</th>
<th>Medicare Plus Blue</th>
</tr>
</thead>
</table>
| Member admission date occurred prior to June 1, 2019, and member is now discharged | Submit to BCN Advantage:  
• Phone: 1-855-724-4286  
• Fax: 1-866-534-9994 | Fax to Medicare Plus Blue:  
1-866-464-8223 |
| Member admission date occurred after June 1, 2019, and member is now discharged | Submit to naviHealth.  
Note: For up to 90 days from the discharge date, you can submit retrospective requests through nH Access or by faxing to naviHealth at 1-844-899-3730, calling naviHealth at 1-855-851-0843 or using Allscripts, now known as CarePort Care Management.  
After 90 days, you must submit retrospective requests either by calling or by faxing naviHealth. | |

How do I submit appeals on denied authorization requests?

Follow the instructions in the denial letter you receive. 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 appeals related to Medicare Plus Blue members, refer to the Medicare Plus Blue PPO Provider Manual. Look in the section titled “Provider dispute resolution process.”

- For additional information on appeals related to 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 provider appeals related to claims, call Provider Inquiry.

If the denial is related to a notice of Medicare noncoverage (for continued stays), the appeal should be submitted to the appropriate quality improvement organization, or QIO.
Note: The facility should send the *Notice of Medicare Non-Coverage* and *Detailed Explanation of Non-Coverage* forms for continued stays managed by eviCore or Blue Cross. For admissions managed by naviHealth, naviHealth will send the forms for discontinuation of care.

## Skilled nursing facilities

### What is the payment methodology for SNF stays?

Medicare Plus Blue and BCN Advantage follow CMS payment methodology for SNFs. As a result, the payment methodology changed from resource utilization group levels to patient-driven payment model levels on Oct. 1, 2019.

- For dates of service through Sept. 30, 2019, naviHealth authorizes RUG levels during the patient’s stay (from preservice through discharge). naviHealth works with SNFs to ensure that the biller submits the appropriate RUG level for reimbursement.

- For dates of service on or after Oct. 1, 2019, naviHealth authorizes PDPM levels during the patient’s stay (from preservice through discharge), which aligns with CMS payment methodology. naviHealth works with SNFs to ensure the biller submits the appropriate PDPM level for reimbursement.

When submitting claims for stays with dates of service starting on or before Sept. 30, 2019, and extending through or beyond Oct. 1, you need to include both the RUG levels and the PDPM levels that naviHealth authorized.

For information about audit and recovery for SNF claims, see “What is the audit and recovery process for SNF claims?” on page 15.

### Which assessments are required for Medicare Advantage members admitted to SNFs?

Here’s some important information about the assessments that are required for Medicare Plus Blue and BCN Advantage members admitted to SNFs on or after June 1, 2019:

- **You must** complete an Omnibus Reconciliation Act, or OBRA, assessment for each member.

- You may opt to complete an additional Prospective Payment System assessment, but you are not required to complete one.
If you complete a PPS assessment:

- No RUG or PDPM level is required, because naviHealth will determine the RUG or PDPM level.

- A RUG or PDPM level included in a PPS assessment may not match the level naviHealth assigns. If the levels don’t match and you enter the RUG or PDPM level from a PPS assessment rather than the naviHealth-assigned RUG or PDPM level, this may cause a claim payment error.

- You must bill using the RUG or PDPM level naviHealth assigns, which you’ll find in the authorization on nH Access™ at access.navihealth.com. (For more information, see “What authorization number should I submit with the claim?” on page 15.)

If you choose not to complete a PPS assessment, there will be no penalties, even if you’re following CMS protocols.

For more information, see the following items on the naviHealth website*:

- The Blue Cross Blue Shield of Michigan and Blue Care Network resources page
- The naviHealth-assigned RUG level for Medicare Advantage Members document
- The Frequently Asked Questions: Claims Processing document
- The PDPM resources page

If you have questions, contact your naviHealth network manager.

**Why did I receive an administrative denial letter from naviHealth?**

BCN Advantage and Medicare Plus Blue members sometimes remain in SNFs for days beyond the service end date on the Notice of Medicare Non-Coverage form. Sometimes the extended stay is due to a provider’s failure either to deliver a completed NOMNC form in a timely manner or to comply with CMS guidelines for responding to requests from Livanta, LLC, the quality improvement organization assigned to Medicare Advantage members in Michigan. This results in days added to the member’s stay that may not be medically necessary.

On behalf of Blue Cross Blue Shield of Michigan, naviHealth will issue an administrative denial for these days if they occur because the SNF provider didn’t handle the NOMNC in accordance with the CMS guidelines. In an administrative denial, the authorization is approved but the reimbursement for the extra days is denied.
Here are some examples of improper handling and delivery of the NOMNC:

- Late delivery of the NOMNC. Members must receive the NOMNC 48 hours prior to the planned discharge date.
  
  Note: naviHealth completes as much of the NOMNC as possible and tells the provider when to issue the NOMNC.

- Failure to fill out the NOMNC in its entirety. All fields in the NOMNC must be completed, including all date and signature fields. For more information, see the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123.*

- Not submitting the requested medical information to the QIO in a timely manner, when the member appealed the service end date with the QIO

Note: To view CMS instructions about appropriate delivery of the NOMNC, see sections 260.2 to 260.4.5 of the CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 2711.*

When SNF providers have repeated difficulties handling the NOMNC according to CMS guidelines, their naviHealth care coordinators will reach out to provide education about CMS guidelines and health plan requirements. If, after receiving education, a SNF provider continues to have difficulties, naviHealth will deliver an administrative denial letter to the provider when members stay beyond the end date stated on the NOMNC.

The administrative denial letter will include details on the specific CMS guideline violations. Blue Cross and BCN will hold the provider responsible for the additional days the member stayed in the SNF. Per CMS guidelines, providers can't bill members for the additional days.

You can find information about CMS guidelines and Medicare Plus Blue and BCN Advantage requirements in the following locations.

- Medicare Claims Processing Manual, Chapter 30*: See section “260.3.6 — Financial Liability for Failure to Deliver a Valid NOMNC.”

- Medicare Plus Blue PPO Manual: See the Utilization Management section. Look under the “Post-acute care skilled nursing, inpatient rehabilitation and long-term acute care facilities” heading.

- BCN Provider Manual: See the BCN Advantage chapter. Look in the “BCN Advantage provider appeals” section.
What is the audit and recovery process for SNF claims?
For claims with dates of service from June 1, 2019, through Dec. 16, 2020, Blue Cross and BCN will review paid SNF claims to ensure that RUG or PDPM levels on the claims match the levels on the authorizations on a quarterly basis. If we find overpayments because RUG or PDPM levels on the claims don’t match levels on the authorizations, we will pursue payment recoveries as necessary.

To ensure that SNF claims reflect the authorized RUG or PDPM level, you should work closely with naviHealth throughout the patient’s stay.

- Prior to discharge, a naviHealth care coordinator will work with your biller to verify that the authorized RUG or PDPM levels are submitted for reimbursement.
- If you have questions about the RUG or PDPM level that naviHealth authorized, contact naviHealth during the patient’s stay to resolve those questions.
- When you submit SNF Medicare Advantage claims, make sure the RUG or PDPM levels on the claims match the levels on the authorization connected to the stay.

For claims with dates of service on or after Dec. 17, 2020, see “What happens if the PDPM levels on claims don’t match the levels naviHealth authorized?” below.

What happens if the PDPM levels on claims don’t match the levels naviHealth authorized?
For dates of service on or after Dec. 17, 2020, Blue Cross and BCN will deny SNF claims when PDPM levels don’t match the levels naviHealth authorized.

Claims

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 have submitted?
Call the member’s plan as follows:

- In-state providers should call Provider Inquiry at 1-800-249-5103.
- Out-of-state providers should call Provider Inquiry at 1-800-676-2583.

The health plans will process all post-acute care claims based on the length of stay and level of service authorized by naviHealth.
Post-acute care services
Frequently asked questions for providers
For Medicare Plus Blue℠ and BCN Advantage℠
Revised April 2021

*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.