Post-Acute and Home Health Care

Frequently Asked Questions

Q1: Which members will eviCore healthcare manage for the Post-Acute and Home Health Care programs?

A1: eviCore healthcare will manage Prior Authorizations for BlueCross BlueShield Minnesota (Blue Cross) members who are enrolled in the following programs:

- Medicare Advantage

Q2: Which Post-Acute Care services require Prior Authorization?

A2: Services requiring Prior Authorization are:

- Skilled Nursing Facility admissions
- Critical Access Hospitals – (Medicare Swing Bed)
- Inpatient Rehabilitation Facility admissions
- Long-term Acute Care admissions
- Home Health Care services

Q3: How do providers check the eligibility and benefits of a member?

A3: Eligibility and benefits should be verified on **https://www.availity.com/** before every service request. Providers are encouraged to check online. If providers do not have online access, they may also call the Interactive Voice Response automated telephone system at 800-262-0820. To access more information about checking eligibility and benefits by phone, go to **providers.bluecrossmn.com** and under "What's Inside", select "Education Center" then select "Blueline, an automated voice response system". You can request to have a summary of the member's benefits faxed to you as an option through Blueline.

Q4: How does a provider initiate a Prior Authorization request or a length of stay extension?

A4: A Prior Authorization can be initiated via:

- Online through Availity at **https://www.availity.com/**
- Fax PA request form with clinical information to: PAC 888-738-3916 Home Health 866-506-3087
- Phone: Call 844-224-0494 for all request types; then follow appropriate prompts based on inquiry

Q5: What is the process to check the Prior Authorization status for a member?

A5: The web portal is available 24/7 and is the quickest way to check existing case status. To access the portal, please visit Availity at **https://www.availity.com/** You may also call eviCore healthcare at 844-224-0494, then follow appropriate prompts to check on the Prior Authorization status and request a fax confirmation letter.

Q6: What are the hours of operation?

A6: Our hours of operation are:

- Monday through Friday, 7am – 6pm CST
- Saturday: 8am – 4pm CST
- Sundays and Holidays: 8am – 1pm CST
- 24 Hour on-call coverage for urgent needs

  Note: The eviCore after hours number is the same as the call center. Phone 844-224-0494, then follow the appropriate prompts, based on inquiry.

Q7: Who is responsible to submit the initial Post-Acute Care Prior Authorization requests?
A7: The hospital is responsible for submitting Post-Acute Care admission requests for members discharging from the hospital. Post-Acute Care Facilities are responsible for submitting the initial Prior Authorization request for members admitting directly from the community.

Q8: What are the Prior Authorization requirements?
A8: The requirements are outlined on our Prior Authorization (PA) request forms. To ensure the Prior Authorization process is as quick and efficient as possible, we highly recommend submitting pertinent clinical information to substantiate medical necessity for the type of service being requested.

Q9: Where can I find the PA request forms?
A9: A link to the PA forms is available at: **www.bluecrossmn.com**
Post-Acute care Prior Authorization forms are also available on our implementation web site: **www.evicore.com/healthplan/bluecrossmn**

Q10: What criteria does eviCore healthcare utilize to Prior Authorize Post-Acute and Home Health Care Admissions?
A10: eviCore may utilize a number of resources in reviewing Prior Authorization requests, including, but not limited to; the applicable benefit plan document, McKesson IQ Guidelines and Medicare Benefit Policy Manuals & Clinical Findings.

Q11. When will I receive the Prior Authorization outcome from eviCore healthcare?
A11: Once all required information is submitted to eviCore, outreach will be made to providers with a determination within 1 to 2 business days.

Q12: How will the Prior Authorization determinations be communicated to the providers?
A12: eviCore Prior Authorization approvals may be communicated in the following ways:

- Information can be viewed and printed on demand from the eviCore Web Portal, available 24/7 via **www.availity.com**. There is a single sign on process for Blue Cross providers.
- Written notification in the form of a letter will be faxed to the referring provider and mailed to the member.
- An outbound call will be placed to the requesting provider by one of our clinical support specialists.

Q13: How can the servicing provider confirm that the Prior Authorization number is valid?
A13: Providers can confirm that the Prior Authorization is valid by logging into the eviCore Post-Acute Care Web Portal via **www.availity.com**. Single sign on process for Blue Cross providers is available 24/7 and the quickest way to check existing case status. To request a fax letter with the Prior Authorization number, please call eviCore healthcare at 844-224-0494, then follow appropriate prompts to speak with a customer service specialist.

Q14: How many days does eviCore authorize for each PAC level of service requested?
A14: eviCore healthcare will provide Prior Authorizations by facility type in the following ways:

PAC Facility Type	Initial	Concurrent
Skilled Nursing Facility	3 business days	7 calendar days
Inpatient Rehab	5 calendar days	7 calendar days
Long Term Acute Care	5 calendar days	7 calendar days

Q15: How many days does eviCore authorize for each HHC level of service requested?

A15: The initial authorization for HHC services will be provided in the following ways:

- Skilled Nursing, PT: Up to 8 visits in 60 days
- Home Health Aide: Up to 80 hours in 60 days
- Social Worker, OT, ST: Approvals based on medical necessity

The number of visits approved for concurrent HHC services will be approved based on medical necessity.
Note: Once authorized, the initial visit should occur within a 7 day time frame to allow time for the nurse or therapist to go into the home and complete their evaluations. If additional days are needed during the first 60 days, providers should submit supporting documentation for the request to eviCore and our Medical Director will review for medical necessity.

Q16: When does the initial Prior Authorization approval expire?

A16: The initial Prior Authorization expires 7 days from the date of issue to allow early initiation of hospital discharge planning and reduce LOS. If the patient is not admitted to a PAC facility or HHC agency within this time frame, a new prior approval is required.

Q17: How will a provider be informed about the number of PAC days or HH visits/hours being authorized?

A17: The number of PAC days or HH visits/hours being authorized will be communicated at the same time the Prior Authorization determination and authorization details are communicated.

Q18: What is the process if an admission to a Post-Acute Care facility or an extension of days does not meet clinical criteria?

A18: If a Post-Acute Care admission or length of stay extension does not meet clinical criteria in accordance with the member's health benefit plan, eviCore healthcare will reach out telephonically for additional clinical or to offer a clinical consultation prior to a denial.

Q19: How do I obtain the denial rationale for a DENC (Detailed Explanation of Medical Non-coverage)?

A19: Requests for the denial rationale may be sent to eviCore at: DENCRationaleRequests@evicore.com. eviCore will email the rationale within 4 hours of receipt. If the request is received after 5pm CST M-F, eviCore will respond by 9am CST the next day, Tues-Sat. If the request is received after 4pm CST Sat, eviCore will respond by 9am CST the next business day. To eliminate time constraints by e-mail, providers may call eviCore at 844-224-0494 to request the denial rationale to be dictated by phone.

Q20: What is the appeal process if a provider or member disagrees with the decision to deny?

A20: Once a service has been denied, members and providers must file an appeal to have the request re-reviewed. Medicare members requesting to appeal a denial for initial PAC or HHC services or to appeal the decision to end skilled care in an IRF or LTAC facility should contact eviCore via phone at 844-224-0494 (Monday through Friday 7-5 CST) or fax to 866-699-8128. The turnaround time after an Appeal has been requested by the member is up to 72 hours for an expedited appeal and up to 30 days for a standard appeal. Medicare members have up to 60 calendar days to file an appeal.

Members requesting to appeal the eviCore decision to end skilled care in a SNF or HHC agency should follow the Quality Improvement Organization (QIO) process as outlined on the NOMNC.

Q21: What is the requirement for members admitted to a Post-Acute Care facility after being discharged to home from an acute care facility?
A21: In the event that the medical condition or diagnosis has changed since being discharged from the acute care facility, the member will need an evaluation from a physician for medical clearance. A re-evaluation by PT/OT/ST may also be required, depending on the situation.

Q22: Who should request Prior Authorizations for Post-Acute Care admissions for patients needing placement after being discharged home from the acute care setting?
A22: The Post-Acute Care facility, Home Health Agency or PCP can initiate a Prior Authorization request in this situation. The member will require a physician's order along with medical clearance.

Q23: Can a patient be admitted to a Post-Acute Care facility directly from the emergency room or outpatient setting?
A23: Yes, this is considered a Community PAC admission. The Medicare 3 day inpatient stay requirement is waived for BCBSMN MA Members. Skilled Nursing Facilities may accept members directly for Community PAC Admissions and are responsible to submit the clinical details supporting the Admission. For these cases, eviCore will authorize (3) business days with the submission of the clinical information.

Q24: What if a Prior Authorization is issued to a facility and the patient or family wants to change the facility at the last minute?
A24: The hospital should contact eviCore with any change to the accepting Post-Acute Care facility. We will then update the authorization in our system. It is very important to update eviCore healthcare of any changes to the accepting Post-Acute Care facility in order for claims to be correctly processed for the facility that receives the member.

Q25: If a patient is in a Post-Acute Care facility and is transferred to the hospital for observation, does the facility have to get a new authorization in order for the patient to return?
A25: If the member leaves the facility for less than 24 hours, a new authorization is not required. The hospital should call eviCore healthcare to confirm the authorization status.

Q26: Does eviCore approve cases retrospectively if no authorization was obtained before the admission?
A26: Retrospective requests must be initiated within 14 days following the date of service. Please have all clinical information relevant to your request available when you contact eviCore healthcare.

Q27: How do out of network providers obtain an authorization?
A27: Out of network providers are required to go through eviCore healthcare for pre-certification on Post-Acute Care requests.

Q28: How do I determine if a provider is in network?
A28: Participation status can be verified by visiting www.bluecrossmn.com
Providers may also contact eviCore healthcare at 844-224-0494. eviCore receives a provider file from BlueCross BlueShield Minnesota with all independently contracted participating providers.

Q29: Who will manage the concurrent stay review for a BCBSMN Medicare Advantage member that is already in a PAC facility or currently receiving HHC services prior to January 1, 2019?
A29: eviCore will manage dates of service beginning on January 1, 2019 for a BCBSMN Medicare Advantage member that is currently receiving PAC or HHC services prior to January 1, 2019.

Q30: What recourse does the SNF have if the IP hospital facility does not submit the initial PA request?
A30: For the first 30 days of the program, the PAC Facility may submit the request to eviCore. After Feb 1, 2019, hospitals are responsible to submit the initial Prior Authorization request directly to eviCore.

Q31: Where do providers submit claims?
A31: All claims will continue to be filed directly to BlueCross BlueShield Minnesota**.**

Q32: What is the process to submit a program related question or concern?
A32: For program related questions or concerns, please email: **clientservices@evicore.com.**

Q33: Where can providers find additional information?
A33: For more information and reference documents, please visit our implementation site:
www.evicore.com/healthplan/bluecrossmn