Coordinated Home Care Program Section

2017

Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, copayments, coinsurance and deductibles, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member’s policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any.
Coordinated Home Care Program
The BCBSIL Coordinated Home Care (CHC) Program is a program designed to help members maximize their benefits for home health care, when such benefits are available under the member’s health benefit coverage. The program may be initiated by an inpatient facility to facilitate the early discharge of its patients into a program of home care. Such home care should be provided by an independently contracted participating provider which may be a hospital’s duly licensed home health department or by other duly licensed home health agencies with which the inpatient facility may have referral arrangements. The covered person must require skilled nursing services on an intermittent basis under the direction of the covered person’s physician. The program includes, but is not limited to, skilled nursing services by or under the supervision of a registered professional nurse, the services of physical, occupational and/or speech therapists and necessary medical supplies.

General Benefit Coverage Criteria
In order for services to be eligible for benefits under the CHC program, in most situations, the member must:
- Be under the care of a physician
- Have an active written treatment plan and orders from the physician
- Require skilled nursing services on an intermittent basis
- Receive care from a licensed home health agency
- Be recertified for continued care needed periodically by the attending physician

Exceptions to the General Benefit Coverage Criteria
- Some benefit plans require a prior hospital or skilled nursing facility stay.
- Benefit plans requiring a prior inpatient facility stay may have different requirements as to the time the first coordinated home care visit must occur.
- Benefits for any Covered Service are limited to that which is set forth in the member’s policy certificate and/or benefits booklet and/or summary plan description.

Eligibility and benefits should be determined electronically via the provider’s preferred third-party vendor portal, or by calling the BCBSIL Provider Telecommunications Center (PTC) at 800-972-8088 to utilize the automated Interactive Voice Response (IVR) phone system.

Listed below are some of the multi-payer vendors that providers may wish to utilize to conduct electronic transactions. Registration is required prior to utilizing an independent third-party vendor. In some cases there may be a fee for services. Providers should contact the vendor(s) directly for information or assistance.

Availity™
Providers may visit the Availity website to register or learn more about Availity’s products and services. Providers also may contact Availity Client Services at 800-282-4548 for assistance.

Experian Health
Providers may enroll online via the BCBSIL Provider website by going to the E-Commerce Connections page, under Electronic Commerce in the Claims and Eligibility section of our Provider website. For additional information on Experian Health, providers may visit the Experian Health website.

Services normally considered eligible for benefits:
- Intermittent (one to two hours per visit) skilled nursing services by a registered nurse or a licensed practical nurse. Intermittent visits are not continuous care as rendered in private duty nursing. See Private Duty Nursing Note below.
- Physical, Occupational and Speech therapy
- Medical Social Services
- Medical supplies
Services not normally considered eligible for benefits:

- Services of a home health aide
- Private duty nursing (private duty nursing is defined as follows: Skilled nursing care provided in the patient’s home on a one-to-one basis by an actively practicing RN or LPN under the direction of the attending physician.)
- Rental or purchase of Durable Medical Equipment (DME)

- **PHARMACEUTICALS, including but not limited to Specialty Pharmacy Drugs, Infused Drugs, Total Parenteral Nutrition (TPN) and Enterals Note:** all pharmaceuticals, including, but not limited to, specialty pharmacy drugs, infused drugs, total parenteral nutrition (TPN) and enterals, which are Covered Services pursuant to the Covered Person's Coverage Agreement ("Pharmaceuticals"), must be billed by the dispensing pharmacy to BCBSIL on a CMS-1500 claim form with appropriate Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDCs) and units where appropriate.

- **Private Duty Nursing:** Private duty nursing is **not** a CHC benefit. However, some BCBSIL members may be eligible for private duty nursing under their benefit plan. Benefit coverage for private duty nursing is subject to the terms, conditions, limitations and exclusions of the member’s health benefit plan. The provider must submit an electronic eligibility and benefits request or call the PTC at 800-972-8088 to verify if private duty nursing is a benefit. Private duty nursing must be billed under a National Provider Identifier (NPI) number using the CMS-1500 claim form.

- **Custodial care services** (services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed) are not covered.

Discharge Planning Guidelines

When a member is discharged from an inpatient setting to coordinated home care setting, the transition of care must comply with the following guidelines:

- Obtain the physician’s orders, plan of treatment and other pertinent documentation.
- The agency’s utilization review (UR) staff should ensure that the member care being received meets the program criteria.
- Confirm eligibility and benefits electronically via a third-party vendor portal, or by calling the BCBSIL PTC.
- Obtain prior authorization/pre-certification as required.

Prior Authorization/Pre-certification

Prior Authorization/Pre-certification for CHC is required by most benefit plans. Since members receiving CHC services have generally been discharged from an inpatient facility hospital, and planning for CHC services is part of inpatient discharge planning, some case management may be performed by the BCBSIL Medical Management Department. Please refer to the Contacts and Resources section of this manual for information and procedures on prior authorization/pre-certification.

Electronic Benefit Pre-certification (iExchange®) or Request, Verify or Obtain Pre-certifications

iExchange is our online tool that supports direct submission and provides online approval of benefits for inpatient admissions and select outpatient services 24 hours a day, seven days a week. iExchange is available to the independently contracted physicians, professional providers and facilities that participate in BCBSIL networks within Illinois via a Web-based application. For more information about iExchange, visit the Education and Reference Center/Provider Tools section of our website.

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HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, BlueCare Direct℠ and Blue FocusCare℠ Pre-certification

The HMO member’s Primary Care Physician (PCP) must authorize all home care referrals and must refer the member to a CHC provider within the independently contracted HMO network. A CHC provider that wishes to participate contractually as an HMO provider must have an executed agreement and meet all credentialing requirements which include current accreditation from a nationally recognized accrediting organization (Joint Commission, ACHC or CHAP) and licensed by the state as a Home Health Care Agency.

Billing Requirements

CHC bills must be submitted in the UB-04 format either electronically or on the paper claim form. The following data elements are specific to CHC. For complete details, providers should reference the UB-04 Data Specifications Manual, available from the National Uniform Billing Committee.

<table>
<thead>
<tr>
<th>Form Locator 4 Type of Bill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st digit: Type of facility (3 = home health)</td>
<td></td>
</tr>
<tr>
<td>2nd digit Bill classification (2)</td>
<td></td>
</tr>
<tr>
<td>3rd digit: Frequency</td>
<td></td>
</tr>
</tbody>
</table>

**Examples:**
- 321 for admit through discharge cycle billing
- 322 for 1st claim
- 323 for continuing claim
- 324 for last claim
- 325 for late charges
- 327 for replacement of prior claim

<table>
<thead>
<tr>
<th>Form Locator 6 Statement Covers Period</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date for period of services (Continuing services should be billed at 30-day intervals, i.e., calendar months)</td>
<td></td>
</tr>
</tbody>
</table>

**Exceptions:**
Submit only one claim if the entire billing cycle is less than 40 days

<table>
<thead>
<tr>
<th>Form Locator 15 Source of Admission</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A code indicating the source of this admission (1 = physician referral)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form Locator 17 Patient Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status code. Must be consistent with the Bill Type in Form Locator 4 (01 = discharge, 30 = still patient)</td>
<td></td>
</tr>
</tbody>
</table>

Institutional claims may be submitted electronically via the ANSI 837I transaction. Information on electronic Claim Submission is available in the Claims and Eligibility section of the BCBSIL Provider website. Providers may also contact the Electronic Commerce Center at 800-746-4614 for assistance.

**Note:** This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.

**Mailing Address for Paper Claims**
Blue Cross and Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112
### Coordinated Home Care (CHC) Billing Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Service Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>270</td>
<td>Medical Supplies</td>
<td>99341</td>
<td>020117</td>
<td>75.00</td>
</tr>
<tr>
<td>551</td>
<td>Skilled Nursing Visit</td>
<td>99349</td>
<td>020117</td>
<td>200.00</td>
</tr>
</tbody>
</table>

**Total:** 1475.00
Blue Cross Secondary Billing
On the next page is an example of a claim where Blue Cross is secondary to another insurance carrier. It is a discharge claim, due to the Type of Bill in Form Locator 4 (324), and the Patient Status (01) in Form Locator 17.

Form Locator 39
Value Code A3 identifies other insurance and the dollar amount paid by the insurance primary to Blue Cross

Form Locator 50
Identifies payer information by line item:
Line A indicates Aetna is primary
Line B indicates Blue Cross is secondary

Form Locator 58
Identifies the insured’s name:
Line A indicates the insured’s name for Aetna
Line B indicates the insured’s name for Blue Cross
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