# Provider Onboarding Training

2025

# Purpose

- Review our end-to-end workflow of getting the right care at the right time, and then getting your claims paid on time and accurately.
- Orient you to the tools and reference materials to support your work
- Share best practices
- Resources & Support

# Agenda

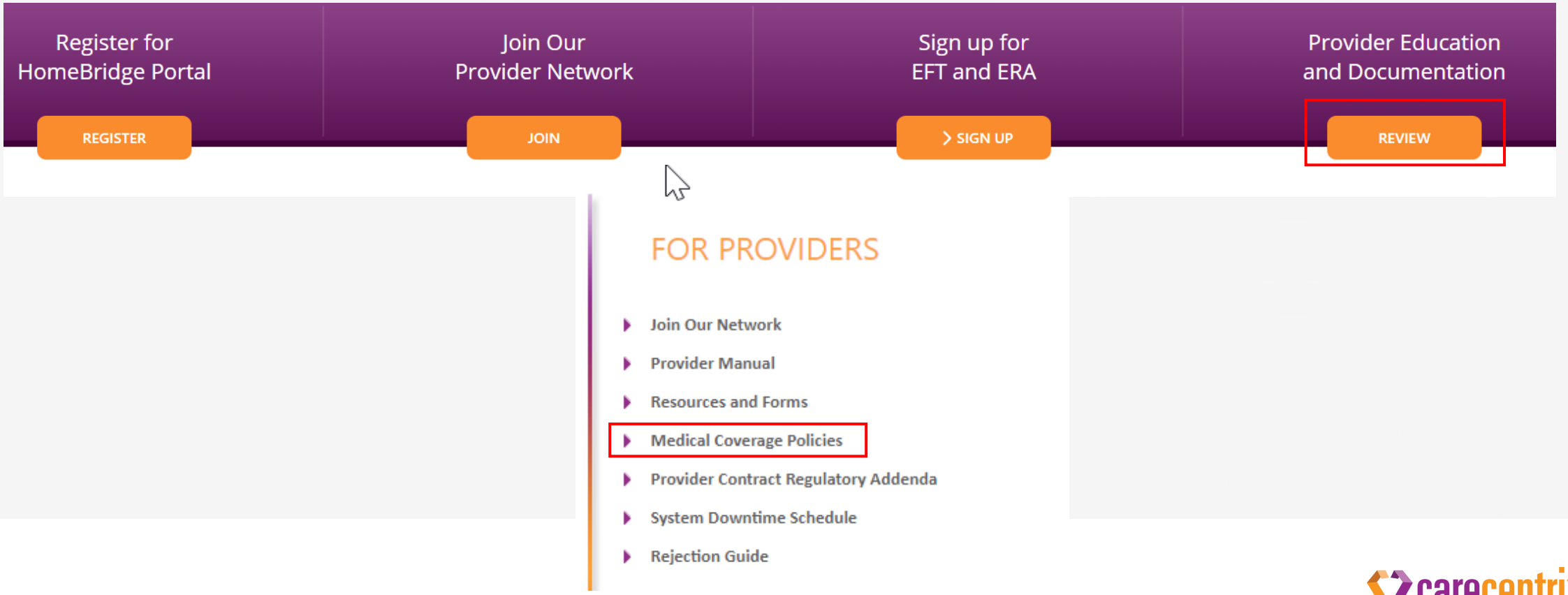
1. Registration/Authorization Process
2. Claim Submission & Payment
3. Out-of-State Blues Plan
4. Medicare Advantage
5. Additional Resources/Information
6. Contact Information

# Registration & Authorization Process

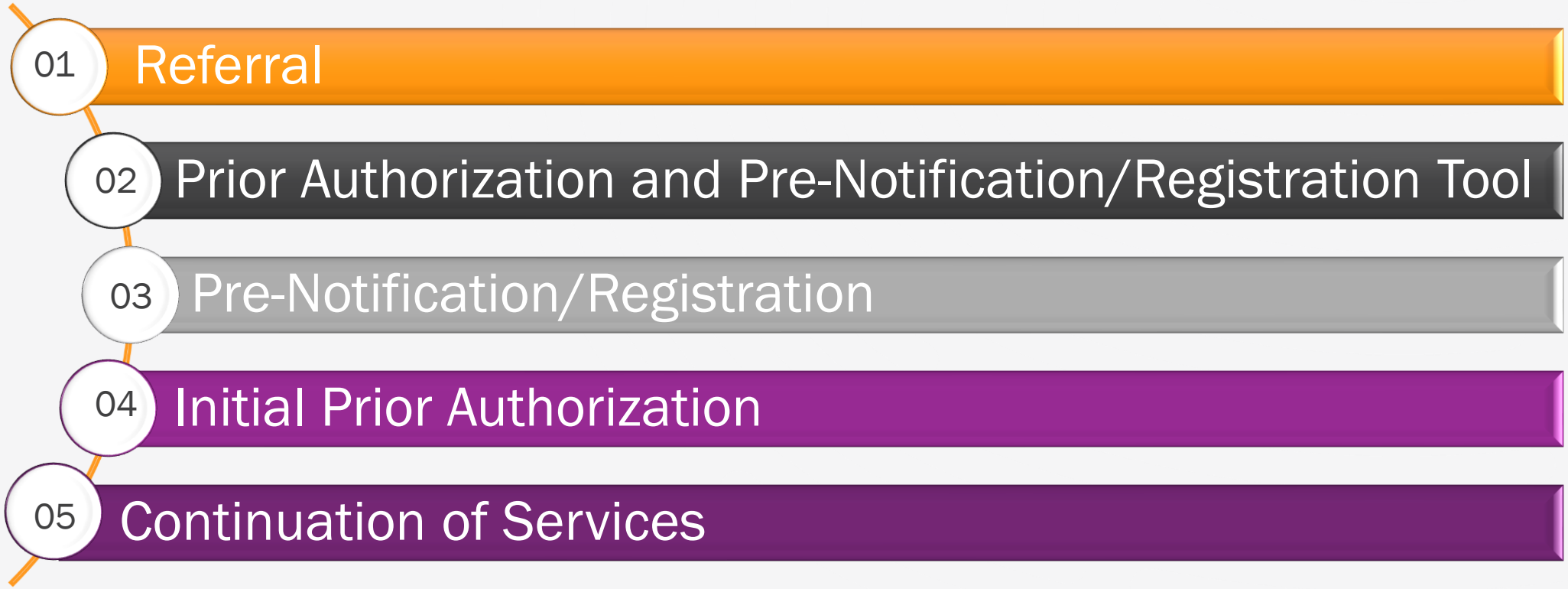
Criteria for Health Care Decisions

# Criteria for Health Care Decisions

The utilization review criteria that CareCentrix applies in making determinations on prior authorization requests can be found on **HomeBridge®.**



# Registration & Authorization Process



# Registration & Authorization Process

## Eligibility & Benefits: General Overview

### What?

Prior to service, providers must verify with the Health Plan:

- Eligibility & Benefits

Always obtain the Call Reference Number from the Health Plan even if they say it is not necessary.

### Why?

The Health Plan manages the patient's eligibility and benefits. Therefore:

- Payment of services rendered is subject to:
  - The patient's eligibility and coverage on the date of service
  - The medical necessity of the services rendered
  - The applicable payor's payment policies

### How?

Providers are expected to verify eligibility and benefits by:

- Calling the number listed on patients' insurance card
- Health Plan's website

# Registration & Authorization Process

## Care Coordination Workflow: When you receive the Request for services

Provider receives request for service and confirms services are medically necessary

Provider completes eligibility & benefits check.

Provider reviews the Prior Authorization and Pre-notification/ Registration tool. Does the code require Registration and/or Prior authorization?

Yes

No

**Registration/Authorization is required for most services provided to CareCentrix patients**

**Note:** Edits can not be made to an authorization once a claim has been submitted.
Registration/Authorization of services is not a guarantee of payment.

Provider enters request into HomeBridge

CareCentrix performs review (if prior auth is required)

CareCentrix Service Registration Form (SRF)

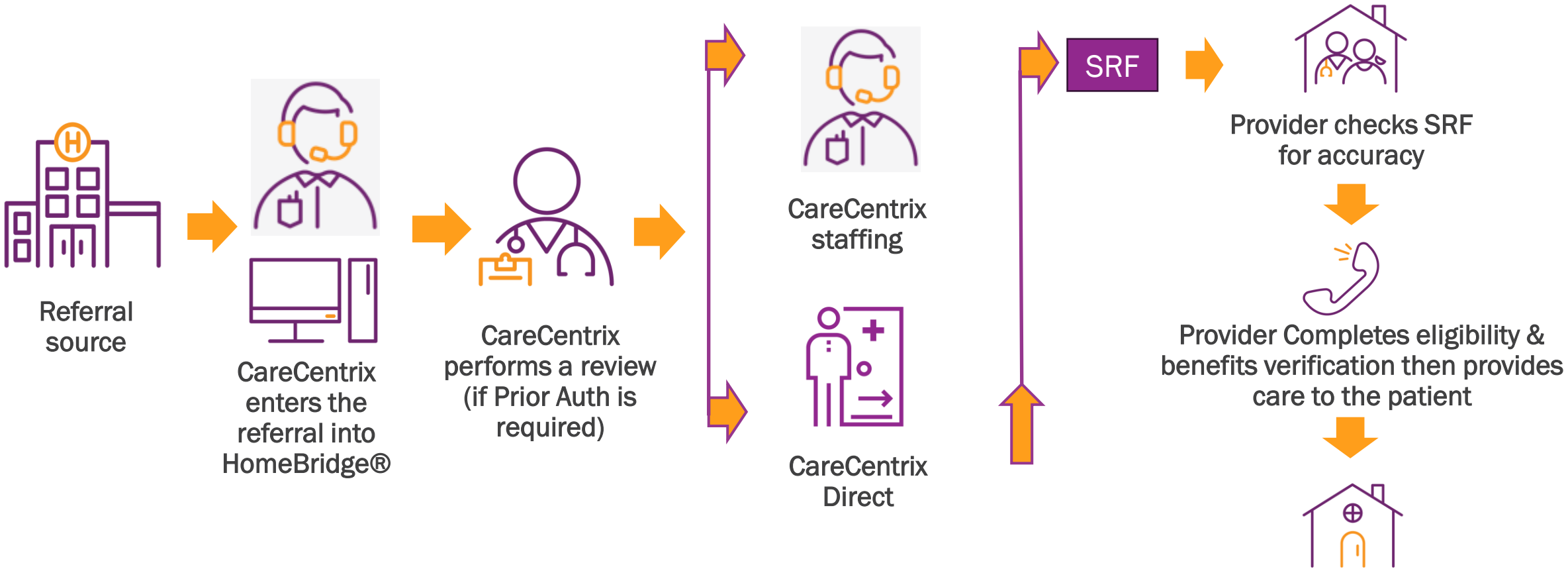
Provider checks SRF for accuracy

Provider then provides care to patient

# Registration & Authorization Process

## Care Coordination Workflow: When CareCentrix has the referral

Note: SRF will be issued when CareCentrix staffs a case with a provider even when the code is NOT on the prior authorization tool. Always check the prior authorization tool and pre-notification/registration tool to confirm if reauthorization is necessary.

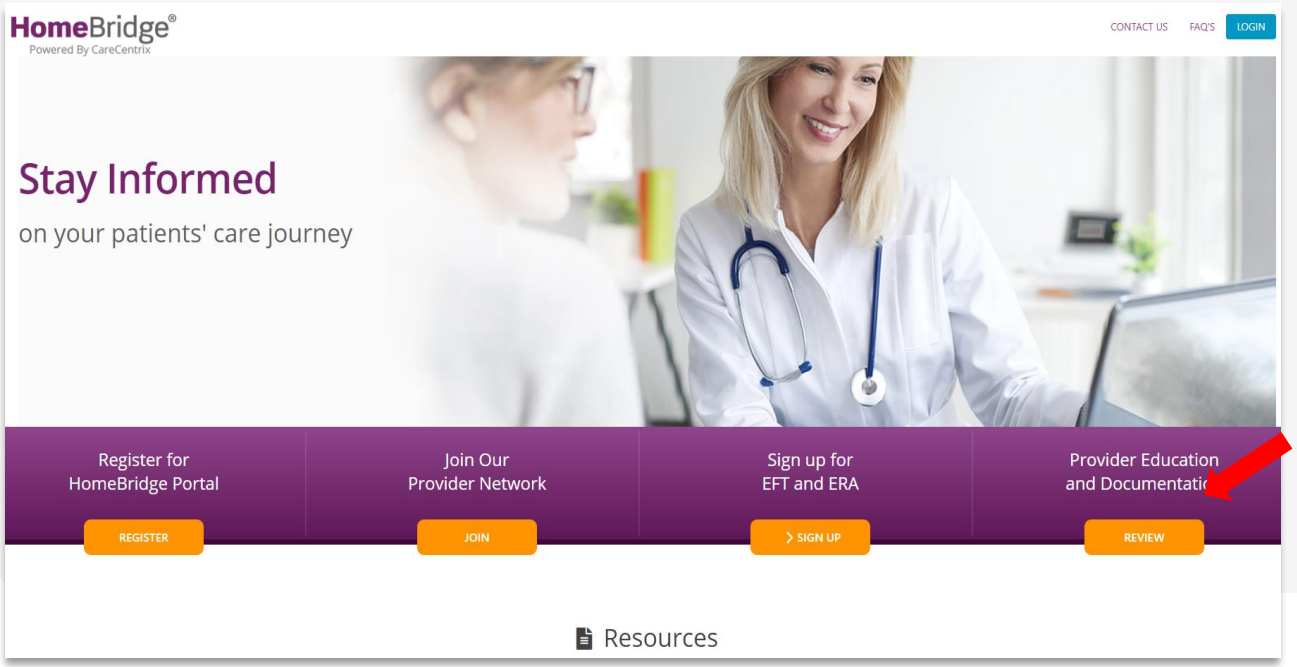


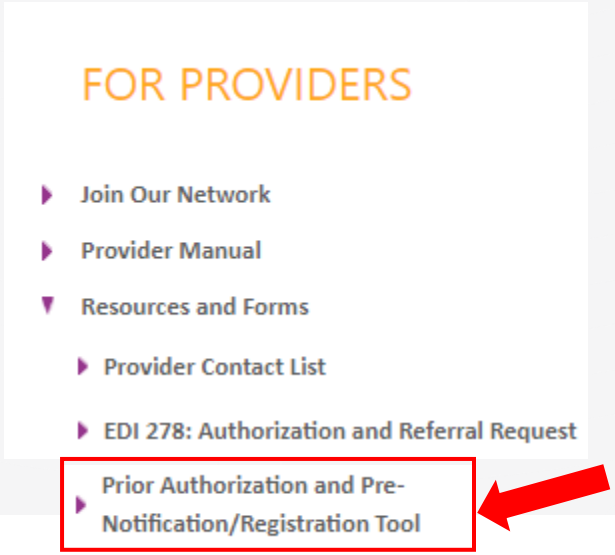

Edits cannot be made to an authorization once a claim has been submitted.

# Registration & Authorization Process

## HomeBridge

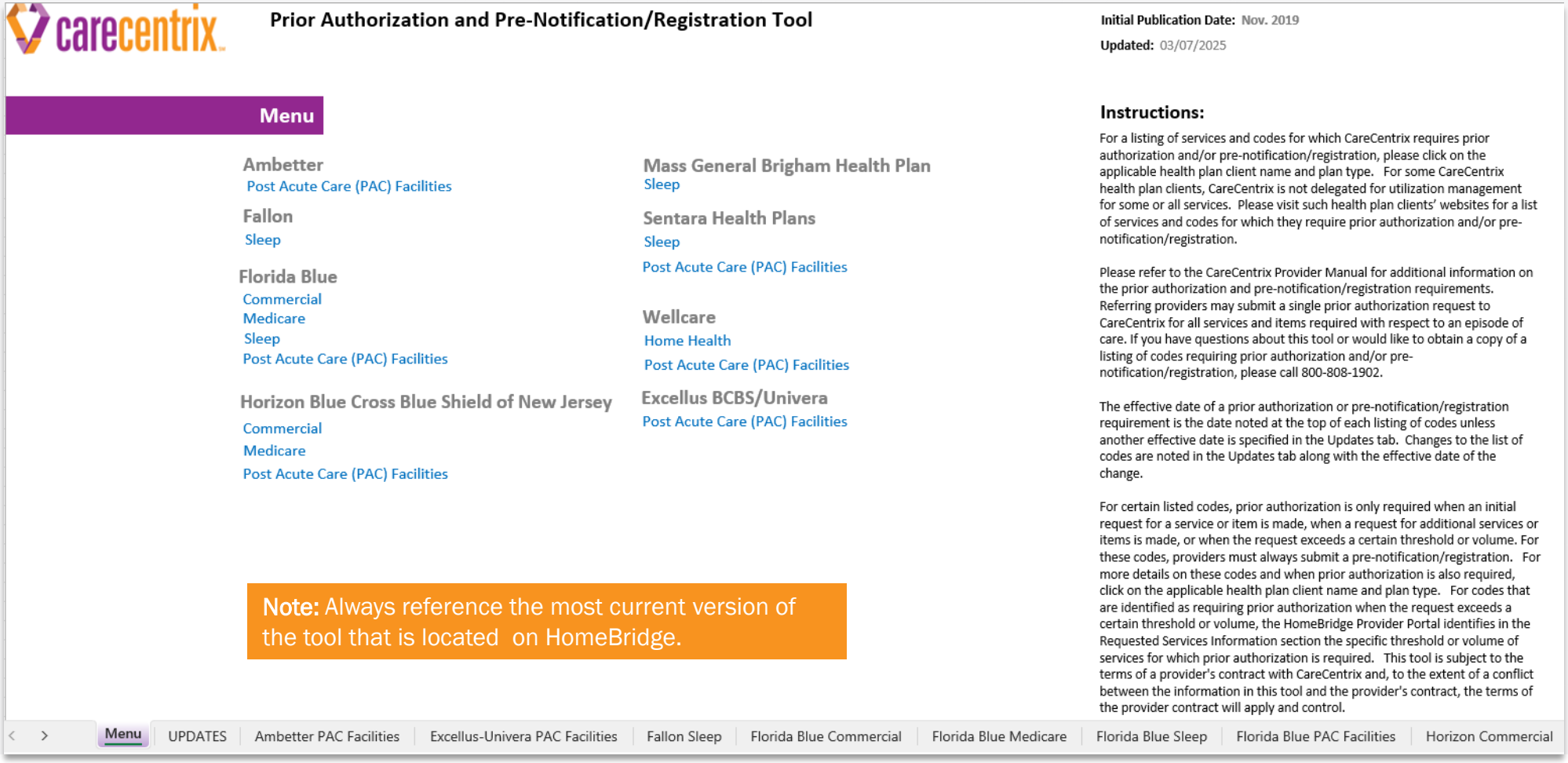
Registration and reference materials can be found on HomeBridge at: www.carecentrixportal.com under Provider Education and Documentation

# Registration & Authorization Process

## Prior Authorization and Pre-Notification/Registration Tool



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**Prior Authorization and Pre-Notification/Registration Tool**

**Initial Publication Date:** Nov. 2019

**Updated:** 03/07/2025

**Menu**

**Ambetter**
Post Acute Care (PAC) Facilities

**Fallon**
Sleep

**Florida Blue**
Commercial
Medicare
Sleep
Post Acute Care (PAC) Facilities

**Horizon Blue Cross Blue Shield of New Jersey**
Commercial
Medicare
Post Acute Care (PAC) Facilities

**Mass General Brigham Health Plan**
Sleep

**Sentara Health Plans**
Sleep
Post Acute Care (PAC) Facilities

**Wellcare**
Home Health
Post Acute Care (PAC) Facilities

**Excellus BCBS/Univera**
Post Acute Care (PAC) Facilities

**Instructions:**

For a listing of services and codes for which CareCentrix requires prior authorization and/or pre-notification/registration, please click on the applicable health plan client name and plan type. For some CareCentrix health plan clients, CareCentrix is not delegated for utilization management for some or all services. Please visit such health plan clients' websites for a list of services and codes for which they require prior authorization and/or pre-notification/registration.

Please refer to the CareCentrix Provider Manual for additional information on the prior authorization and pre-notification/registration requirements. Referring providers may submit a single prior authorization request to CareCentrix for all services and items required with respect to an episode of care. If you have questions about this tool or would like to obtain a copy of a listing of codes requiring prior authorization and/or pre-notification/registration, please call 800-808-1902.

The effective date of a prior authorization or pre-notification/registration requirement is the date noted at the top of each listing of codes unless another effective date is specified in the Updates tab. Changes to the list of codes are noted in the Updates tab along with the effective date of the change.

For certain listed codes, prior authorization is only required when an initial request for a service or item is made, when a request for additional services or items is made, or when the request exceeds a certain threshold or volume. For these codes, providers must always submit a pre-notification/registration. For more details on these codes and when prior authorization is also required, click on the applicable health plan client name and plan type. For codes that are identified as requiring prior authorization when the request exceeds a certain threshold or volume, the HomeBridge Provider Portal identifies in the Requested Services Information section the specific threshold or volume of services for which prior authorization is required. This tool is subject to the terms of a provider's contract with CareCentrix and, to the extent of a conflict between the information in this tool and the provider's contract, the terms of the provider contract will apply and control.

**Note:** Always reference the most current version of the tool that is located on HomeBridge.

Menu | UPDATES | Ambetter PAC Facilities | Excellus-Univera PAC Facilities | Fallon Sleep | Florida Blue Commercial | Florida Blue Medicare | Florida Blue Sleep | Florida Blue PAC Facilities | Horizon Commercial



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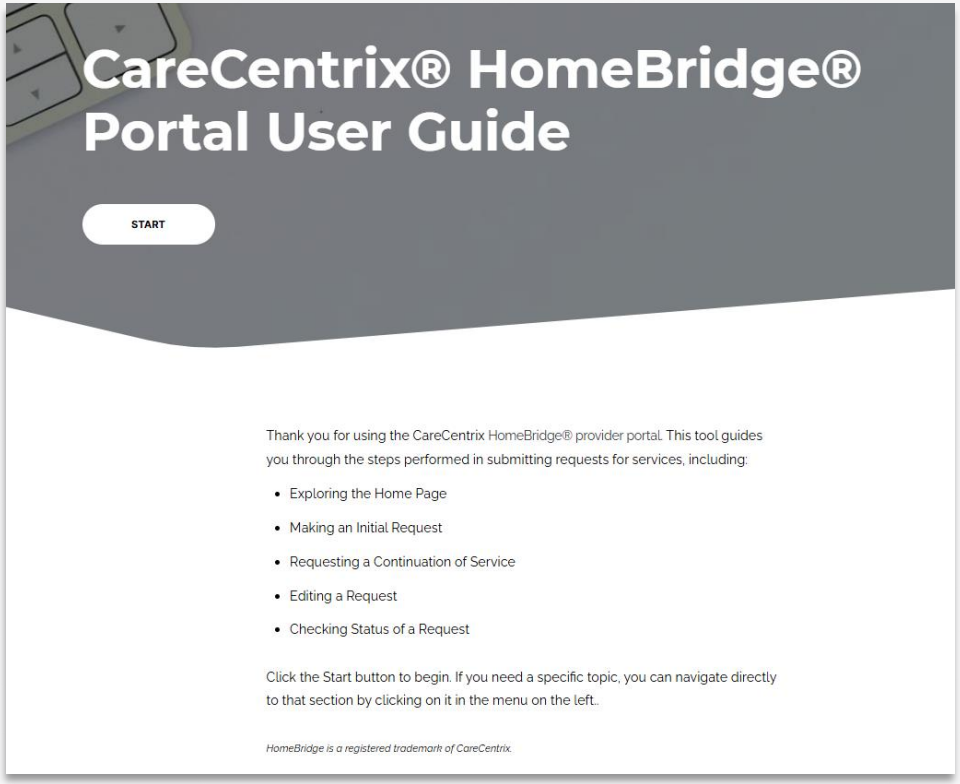
# Registration & Authorization Process

## Overview

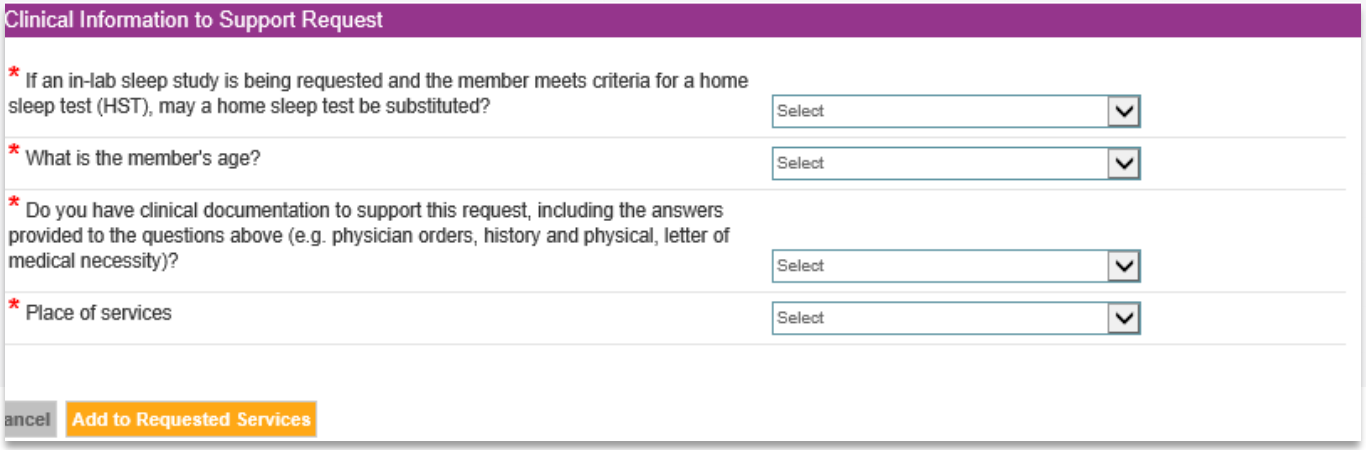
- Always verify the patients benefits and eligibility with the plan prior to rendering services.
- To determine if you must register services with CareCentrix prior to providing the service, review the Prior Authorization & Pre-Notification/Registration Tool
- Submit a request via HomeBridge if Prior Authorization/Registration is required
- For Instructions on making an Initial Request please review the HomeBridge Portal User Guide



# Registration & Authorization Process

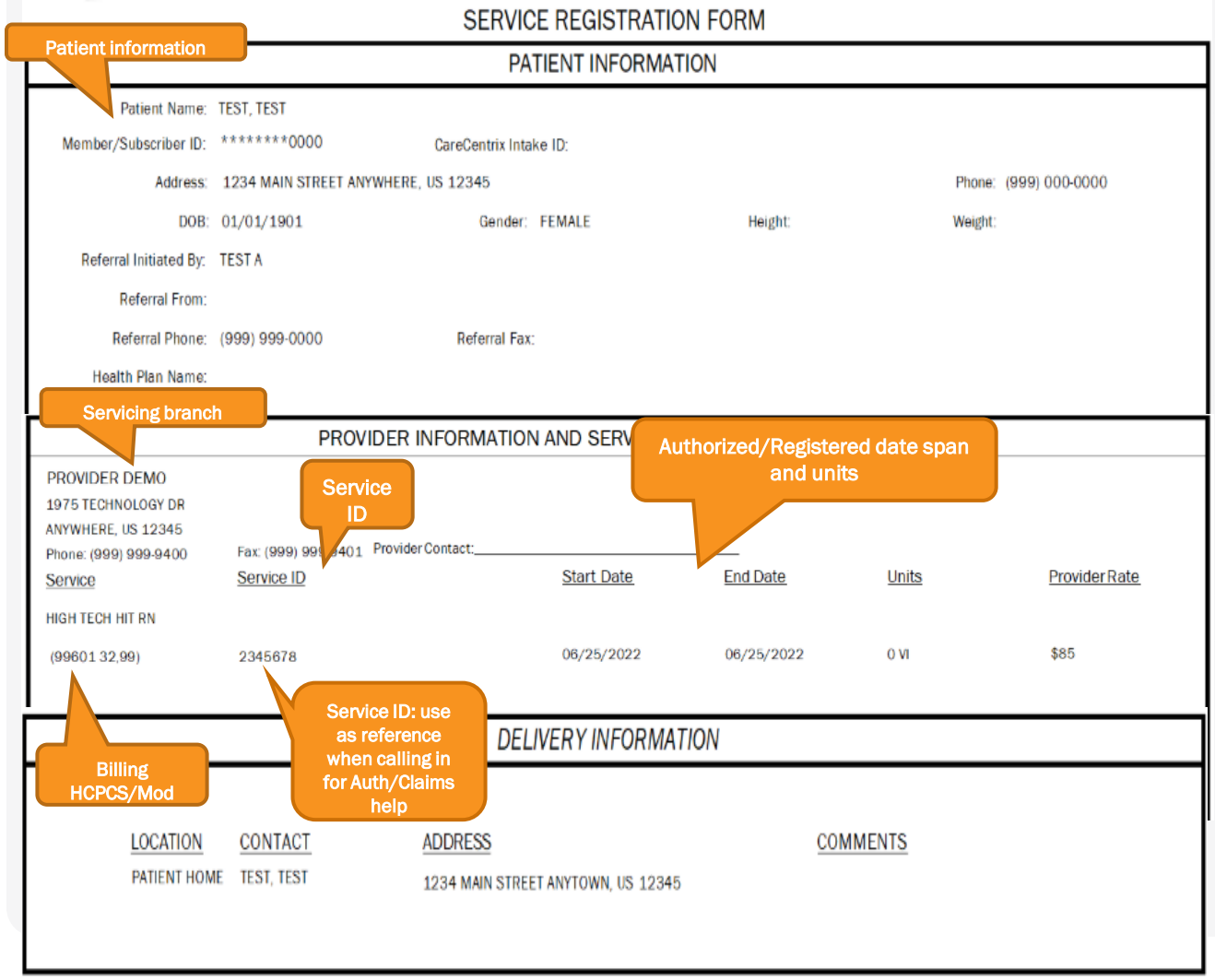
## Status and Timely Processing Tips

- Verify registration/authorization status in HomeBridge.
- The time frame in which the provider receives the registration/authorization will vary based on the services requested and the patient's plan. (ex. health plan authorization & clinical review)
- Enable faster processing of registration/authorization requests by attaching all supporting documentation when submitting the request.
    - Physician's Orders
    - History & Physical
    - Clinical Notes
    - Accurate completion of the HomeBridge questions associated with the service
- This screenshot is an example of some of the clinical questions that are asked to support the request.



# Registration & Authorization Process

## Service Registration Form (SRF)




- Any discrepancies between the information on the Service Registration Form and the claim form may lead to rejections and denials.
- If you submitted the request through HomeBridge, it is your responsibility to fix any discrepancies by submitting an **Authorization Edit** request. For Instructions on Editing a Request in HomeBridge please review the HomeBridge Portal User Guide.
- If the Patient Information on the SRF varies from what is on their ID card, refer to page 7 of the Provider Manual on how to contact the CareCentrix Care & Service Center and we will make the change.

# Registration & Authorization Process

## Service Request Types (Use of “Urgent”)

Only mark **“Urgent”** if it meets the criteria below.

1. A request where the application of time periods for making non-urgent care determinations could:
    a. Seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function
    b. Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request
2. A request that meets the urgent care definition mandated under applicable law or accrediting body requirements.

# Registration & Authorization Process

## “At Risk” Start of Care (SOC)

Only ordering physicians can change orders or the start of care date.

01 Contact the patient’s ordering physician to discuss any necessary changes in the Start of Care and obtain agreement.

02 Communicate SOC changes with the patient directly.

03 Once agreement obtained from the physician, changes to SOC date on the SRF can be submitted via HomeBridge, if necessary.

# Claim Submission & Payment

Claim Requirement/Clean Claim Guidelines

Rejections & Denials

Timely Filing

Claim References

Checking the Status of a Claim

# Claim Submission and Payment

## Timely Filing

**The claim timely filing limit is specified in your contract. Typically, you have 60 days from the date of service to submit your claim** (or as specified by applicable law).

- A clean claim must be received and accepted within the timely filing period.
- Rejected claims are not proof of timely filing.
- The timely filing requirement applies to both original and corrected claims (no additional time is allotted for void and replace claims).

# Claim Submission and Payment

## Claim Submission Options - Electronic Data Submission (EDI)

See appendix for clean claim requirements and more information on rejection remediation.


**Our Clearinghouses include:**
**WAYSTAR** 1-844-692-9782 (www.waystar.com)
**AVAILITY** 1-800-AVAILITY (www.availity.com)
**CHANGE HEALTHCARE** 1-866-369-8805 (www.changehealthcare.co)

- There is no CareCentrix EDI registration for claims submission.
- EFT/ERA enrollment IS required with CareCentrix to receive direct deposits for claim payments and Electronic Remittance Advices (835's). EFT/ERA support email: ERAITenrollment@CareCentrix.com
- CareCentrix EDI support email: EDIsupport@carecentrix.com

# Claim Submission and Payment

## EDI Payor ID's 837 submission to CareCentrix

| Payor ID | Payor Description |
|---|---|
| 11346 | CCX – Fallon & Mass General Bringham Health Plan |
| 11347 | CCX – Florida Blue |
| 11348 | CCX – Horizon Blue Cross Blue Shield New Jersey |
| 11349 | CCX – Blue Cross Blue Shield Michigan |
| 11350 | CCX – WellCare |
| 11345 | CCX - All Plans |

Reference the CareCentrix 837 Companion Guide for more EDI information

EDI questions email: EDIsupport@Carecentrix.com

# Claim Submission and Payment

## Claim Billing Guidelines

**CLAIM TYPE:** Ensure you are billing on the **correct claim transaction type** or paper form. Use the chart below for reference.

| Line of Business | All Other Health Plans | Horizon |
|---|---|---|
| HIT | 837p or CMS-1500 | Claims for factor drugs: 837i or UB-04<br>All other home infusion claims: 837p or CMS-1500 |
| HH | 837i or UB-04 | |
| PDN | 837i or UB-04 | |
| DME | 837p or CMS-1500 | |
| O&P | | |

EDI questions email: EDIsupport@Carecentrix.com

# Claim Submission and Payment

## Claims Process: Claim Billing Guidelines

| Guideline | Description | Example |
|---|---|---|
| HCPCS & Modifiers | Services must be billed with the HCPCS and modifiers in the order exactly as they are specified in your contracted fee schedule. | Fee Schedule contains: S9379 KP SC<br>• Bill: S9379 KP SC<br>• Do NOT Bill: S9379 SC KP<br>• Do NOT Bill: S9379 KP SC XX |
| National Drug Code (NDC): | Always include the following for any drug billed:<br>NDC (11 characters, no hyphens)<br>Unit/Basis of Measure<br>Drug Quantity | If billing on paper, enter the NDC and associated information as follows with no spaces or delimiters:<br>• N4<br>• followed by the 11-digit NDC (no hyphens)<br>• followed by the Unit of Measure (F2, GR, ML, UN or ME)<br>• followed by the quantity, using a decimal to represent any fractional units with no more than 2 digits to the right of the decimal<br>Example: N412345678910ML3.25 |
| One Claim | It is a best practice to bill all services or supplies given to the patient on the same day on one claim. | Patient receives an antibiotic (Vancomycin) in their home for 90 minutes. If possible, a single claim should be billed with three lines reflecting:<br>• J3370 – Medication<br>• 99601 – Nursing<br>• S9501 – Per Diem |

Clean Claims Requirements can be found in your Provider Manual.
The Provider Manual is located in HomeBridge.

# Claim Submission and Payment

## Claims Process: Claim Billing Guidelines

| Guideline | Description | Example |
|---|---|---|
| Same Services Same Day | Identical services performed for a patient on the same day with the same HCPCS and modifiers must be billed on the same claim line with multiple units. | INFUSION- Two nursing visits were performed on the same day – both units must be billed on one claim line<br><br>PDN- all hours on that day need to be on the same line |
| Per Diem Units | Units billed for a per diem service should be aligned with the total number of days in the date of service date range. | For a date of service range of 1/2/21 to 1/7/21<br>• 6 units would be expected because there are six days in the date range |
| Fractional Billing: | HCPCS codes must be billed in whole units of 1 or greater.<br>Any partial units billed must be rounded up or down to the nearest whole number. Partial units will not be accepted.<br><br>NDC quantities, however, may be submitted in fractional units up to 2 decimal points. | A nurse spends 2 hours and 38 minutes in the home. The provider rounds up to 3 hours and bills<br>• 99601 with 1 unit (1st 2 hours)<br>• 99602 with 1 unit (each additional hour) |

Clean Claims Requirements can be found in your Provider Manual.
The Provider Manual is located in HomeBridge.

# Claim Submission and Payment

## Claims Process: Claim Billing Guidelines

| Guideline | Description | Details |
|---|---|---|
| Coordination of Benefits | When a patient has coverage under more than one insurance plan, their benefits must be coordinated by the provider.<br><br>• Bill the primary plan first (do not include secondary plan information)<br><br>• After receiving the primary payor's Explanation of Payment (EOP), bill the secondary plan<br><br>• When billing CareCentrix for the secondary claim, include all information regarding the primary plan and their payment including:<br>  • Other (Primary) Insurance Plan Name<br>  • Other (Primary) Insurance Subscriber Name<br>  • Other (Primary) Insurance Subscriber ID<br>  • Other (Primary) Insurance Payment Amount(s)<br>  • Other (Primary) Insurance adjustments | EDI claim: Include all primary plan and payment details, including any adjustments in Loops 2320 or 2430.<br><br>Paper claim: Include a copy of the Primary Insurance Explanation of Payment (EOP), and abide by the following rules for a professional claim:<br>  • The Secondary's subscriber and plan information should be in Boxes 1, 4, 7 and 11.<br>  • The Primary's information should be in Box 9 (a thru d).<br>  • Box 24 – should match the primary total service line charge amount<br>  • Box 28 – should match the primary total billed charges<br>  • Box 29 – leave blank<br><br>If Medicare is primary, do not submit the secondary claim to CareCentrix. Medicare will send the secondary claim to the appropriate health plan through their cross-over process. |

Failure to comply with these guidelines as noted may result in a claim rejection.

# Claim Submission and Payment

## Claims Process: Corrected Claims/Reconsiderations/Appeals

| Request Type | Definition/Action | Timely Filing |
|---|---|---|
| Corrected Claim | Request to correct claim information due to provider billing error. | Corrected claims must be received within the original timely filing timeframe (unless otherwise indicated in your Provider Agreement or Manual) |
| Reconsiderations | Request to evaluate claim outcome as claim determination is different from what was expected and provider unable to reconcile the discrepancy.<br><br>Submit a request for claim reconsideration including any supporting documentation. | 45 days from the EOP or as required by applicable law |
| Appeal | Request to submit an appeal only after claim reconsideration is upheld.<br><br>Submit a request for appeal including any supporting documentation. | 30 days from the Reconsideration response or as required by applicable law |

# Claim Submission and Payment

## Claims Process: Corrected and Voided Claim Scenarios

| Billing Error Scenarios | EDI | Paper CMS-1500 | Paper UB-04 |
|---|---|---|---|
| **Voided a claim filed in error** | Submit Frequency Code 8 (Void transaction) | • Submit a claim with "**VOID**" stamped in the top right corner or in **Box 19**.<br>• **Box 22** must contain the frequency code **8** and the original CareCentrix claim ID. | • Submit a claim with "VOID" stamped in the top right corner or in **Box 60**.<br>• The frequency code (**the third digit in box 4**) should be **8**.<br>• **Box 64** must contain the original CareCentrix claim ID. |
| **Claim correction to add or remove a line – OR- to modify service information**<br>• **HCPCS / Modifier**<br>• **Dates of Service**<br>• **Diagnosis** | Submit Frequency Code 7 (Void/Replace transaction)<br><br>Include CareCentrix Claim ID in the Payor Claim Control Number segment (Loop 2300 REF*F8.) | • Submit a claim with "**CORRECTED CLAIM**" stamped in the top right corner or in **Box 19**.<br>• **Box 22** must contain the frequency code **7** and the original CareCentrix claim ID. | • Submit a claim with "VOID" stamped in the top right corner or in **Box 60**.<br>• The frequency code (**the third digit in box 4**) should be **8**.<br>• **Box 64** must contain the original CareCentrix claim ID. |
| **Claim correction to modify patient demographics**<br>• **Patient Name**<br>• **Date of Birth**<br>• **Subscriber ID Number**<br>• **Person Code**<br><br>**-OR- Claim correction to modify Billing or Rendering provider NPI** | Submit Frequency Code 8 (Void transaction).<br><br>Submit a Frequency Code 1 (Original transaction) with the correct patient demographics | • Submit a claim with "**VOID**" stamped in the top right corner or in **Box 19**.<br>• **Box 22** must contain the frequency code **8** and the original CareCentrix claim ID.<br>• Submit a new claim with correct patient demographics | • Submit a claim with "VOID" stamped in the top right corner or in **Box 60**.<br>• The frequency code (**the third digit in box 4**) should be **8**.<br>• **Box 64** must contain the original CareCentrix claim ID.<br>• Submit a new claim with correct patient demographics |

# Claim Submission and Payment

## HomeBridge: Education and documentation

Quick Tips on the Claim Reconsideration and Appeals Process

A short eLearning tutorial of the claim rejection and denial process outlines the next steps on how to proceed with your claim. Select the corresponding button applicable to your claim status.

**Rejected Claim**
If your claim has been rejected, click for recommended next steps.

Rejected

**Denied Claim**
If your claim has been denied, click for recommended next steps.

Denied

**Reconsideration**
If you disagree with a claim denial and wish to complete a Claim Reconsideration Form, click to see next steps.

Reconsideration

**Appeal**
If your reconsideration is upheld and you would like to submit an appeal, click for next steps.

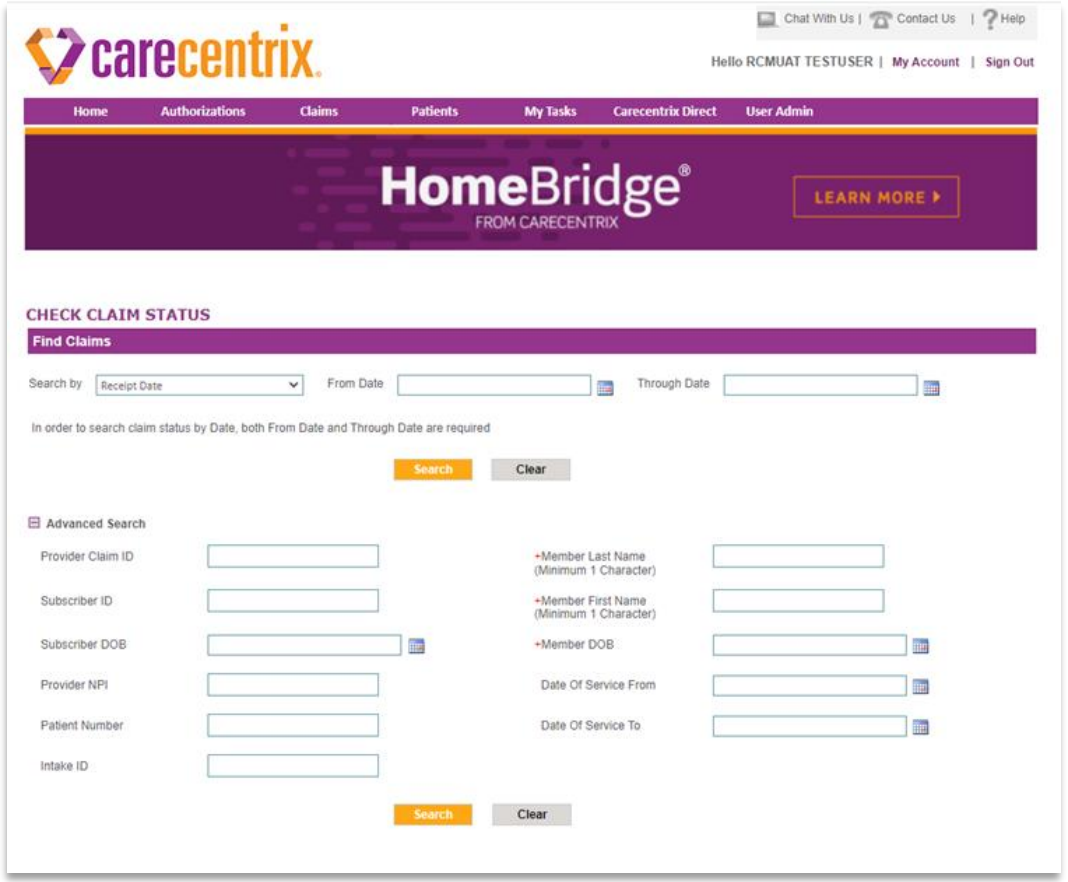
Appeal

# Claim Submission and Payment

## HomeBridge: Claims Support

Once you are logged into HomeBridge, you can:

- Check Claim Status
  - View Claim Replica
  - View Claim Acknowledgement
  - View Claim Remittance Advice
  - View Claim Status History
- Submit Claim Inquiry, Appeal, or Reconsideration



# Out-of-State Blues Plan

Overview

Identification of Plans

Tips for Blue Cross Blue Shield of New Jersey (Horizon)

Ancillary Claims

Additional Training

# Out-of-State Blues Plan

## Out-of-State Blues Plan: Overview

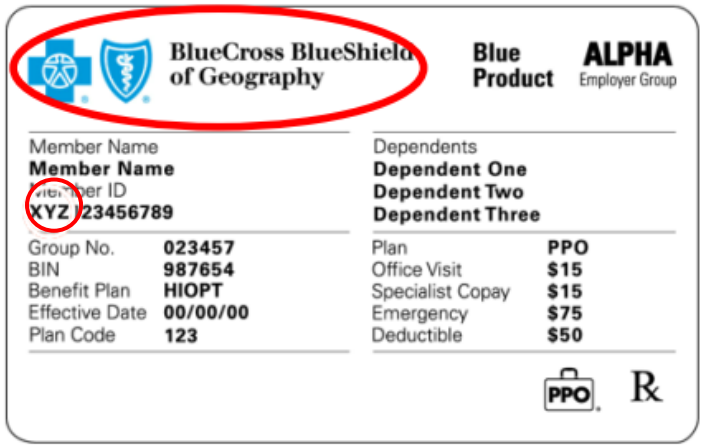
Out-of-State Blues Plan is a national program that enables Blue Cross Blue Shield patients to obtain health care services while traveling or living in another Blues Plan's service area.

**Home Plan** – The Blues Plan in the state where the group/contract is headquartered and is responsible for:

- Eligibility and benefit information
- Prior authorization for requested services
- Issues Explanation of Benefits (EOBs) to the patient

**Host Plan** – Blues Plan in the state away from the patient's home where services are rendered and is responsible for:

- Processing all claim and adjustment requests and will transmit them to the appropriate BCBS home plan




The 3-character prefix generally identifies both the home plan, product and group.

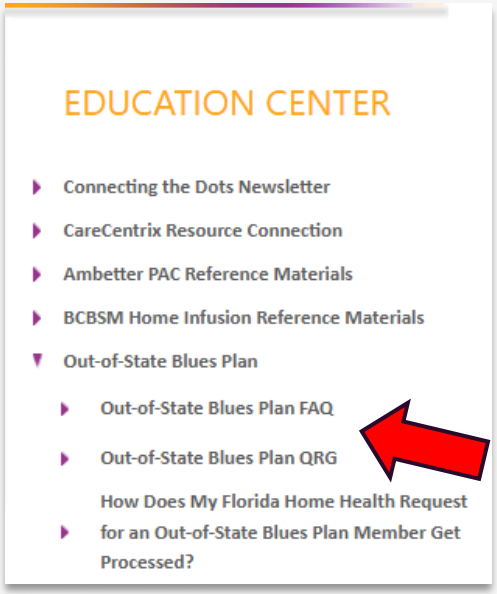
Review Out-of-State Blues Plan educational materials at the Education Center in HomeBridge

# Out-of-State Blues Plan

## Authorization

Utilization Review: Prior-Authorization/Pre-Authorization

- Providers are responsible for obtaining prior authorization for services from the Home Plan prior to performing the service.
- Providers may also contact the patient's Home Plan on the patient's behalf.
- You can do so by calling Out-of-State Blues Plan at 1.800.676.BLUE (2583) and ask to be transferred to the utilization review area.
- Frequently Asked Questions (FAQ) and Quick Review Guide (QRG) for Out-of-State Blues Plan can be found on HomeBridge under Education Center



# Out-of-State Blues Plan

## Claims

### Submit all Out-of-State Blues Plan claims to CareCentrix:

- The host plan should send the claim to the patient's home plan within the required timeframe.
- The patients home plan should respond back to the host plan within the required timeframe.

### Submit all reconsiderations to CareCentrix:

- The patient's Home Plan has within the required timeframe to respond to the host plan from the date the request is received, according to Blue Cross Association Guidelines.

### Submit all appeals to CareCentrix:

- The patient's home plan must respond to the host plan within the required timeframe with the action that will be taken according to Blue Cross Association Guidelines.

# Out-of-State Blues Plan

## Claims

Durable/Home Medical Equipment & Supplies, and Specialty Pharmacy providers.

File claims for these providers as follows:

| | Durable/Home Medical Equipment & Supplies (D/HME) | Specialty Pharmacy |
|---|---|---|
| Bill Claim to: | The plan where equipment and/or supplies were shipped to or purchased at a retail store. | The plan and state where Ordering Physician is located. |

DME claims must be submitted based on the patient's and provider's location per table below. DME Claims Filing Supersedes Contiguous Counties. For example:

| | Member lives in NJ/FL and equipment purchased in DME office. | Member lives outside of NJ/FL and equipment purchased in DME office. | Member lives outside of NJ/FL and equipment shipped to patient's home. |
|---|---|---|---|
| Provider located in NJ | Bill CareCentrix and Local Plan BlueCard | Bill CareCentrix and Local Plan BlueCard | Bill to local Blue's Plan (not CareCentrix) |
| Provider located in NJ/FL | Bill CareCentrix and Local Plan BlueCard | Bill CareCentrix and Local Plan BlueCard | Bill to local Blue's Plan (not CareCentrix) |

# Out-of-State Blues Plan

## Claims

| Where to Verify Out-of-State Blues Plan Eligibility and Benefits, Submit Authorization Requests and Claims | | | |
|---|---|---|---|
| **Florida Service Area** | | | |
| **Service Type:** | **Verify Eligibility and Benefits with:** | **Submit Authorization Request with:** | **Submit Claims with:** |
| **Home Infusion** | **Home Plan** | **Home Plan** | **CareCentrix** |
| **Home DME** | **Home Plan** | **Home Plan** | **CareCentrix** |
| **O+P** | **Home Plan** | **Home Plan** | **CareCentrix** |
| **Home Health Care** | **Home Plan** | **CareCentrix or Home Plan**** | **CareCentrix** |
| **CareCentrix will contact the home plan on the home health provider's behalf to request authorization when required when the request is submitted to CareCentrix via the CareCentrix HomeBridge® provider portal.<br><br>**IMPORTANT NOTE:** Home health providers may instead contact the home plan directly to request authorization when required. However, if you plan to request authorization from the home plan on a regular basis, please notify your Provider Relations contact to prevent duplication of efforts. Claims must be submitted to CareCentrix in either option. | | | |
| **Horizon New Jersey Service Area** | | | |
| **Service Type:** | **Verify Eligibility and Benefits to:** | **Submit Authorization Request to:** | **Submit Claims to:** |
| **Home Infusion** | **Home Plan** | **Home Plan** | **CareCentrix** |
| **Home DME** | **Home Plan** | **Home Plan** | **CareCentrix** |
| **O+P** | **Home Plan** | **Home Plan** | **CareCentrix** |
| **Blue Cross Blue Shield of Michigan Service Area** | | | |
| **Service Type:** | **Verify Eligibility and Benefits to:** | **Submit Authorization Request to:** | **Submit Claims to:** |
| **Home Infusion** | **Home Plan** | **Home Plan** | **CareCentrix** |

# Out-of-State Blues Plan

## Claims

Authorizations for Out-of-State Blues Plan are given by the patient's home plan per example below.

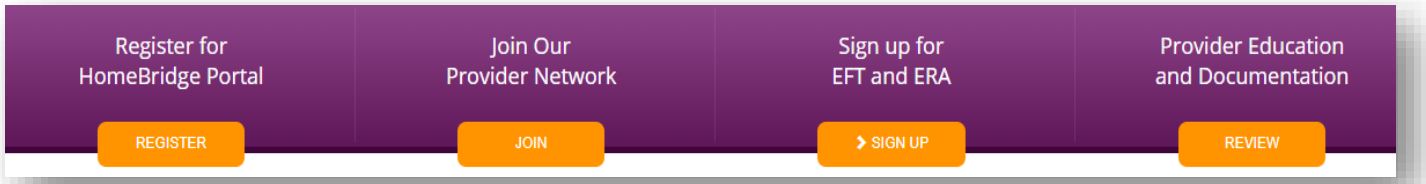
**Example:**

Patient has BCBS of Michigan plan but lives in Florida and needs DME. The authorization for the DME was approved by BCBS of Michigan. The DME was delivered to the patient's home in Florida.

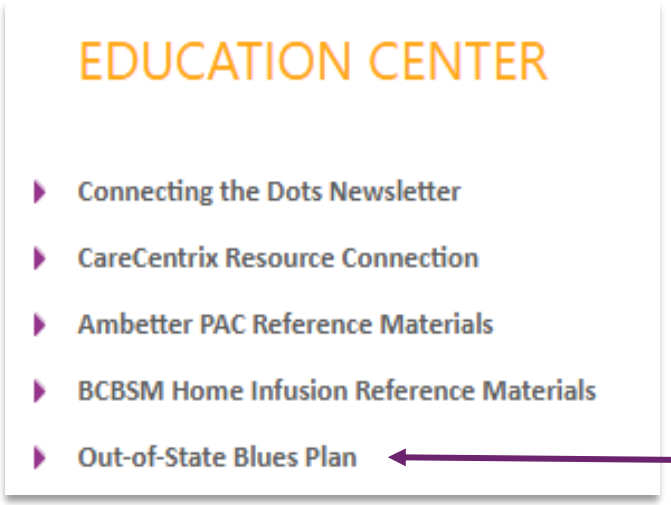
Where should you submit the claim?

**Submit the claim to CareCentrix.**

# Out-of-State Blues Plan




Access the Education Center from the home page of HomeBridge.




Click to open Out-of-State Blues Plan section under the Education Center.

# Medicare Advantage

Notice of Medicare Non-Coverage (NOMNC)

NOMNC Exceptions

Claim Guidelines

Medicare Requirements for Services Terminating under SNF, HH, CORF

# Medicare Advantage (MA)

## Notice of Medicare Non-Coverage (NOMNC) Requirements for Home Health Services only

- The NOMNC letter is a **Centers for Medicare and Medicaid Services (CMS)** approved member letter that a provider must deliver to a Medicare Advantage member receiving covered SNF or HH services in certain situations when all services are terminating to inform the member of his or her appeal rights.
- Providers are required  to be trained on CMS NOMNC process and delivery requirements.
- Providers complete the form according to NOMNC instructions.
- CareCentrix may audit your records to ensure NOMNC requirements are met.
- Additional Resources
    - NOMNC training is available in the Education Center of HomeBridge.

# Medicare Advantage

## Claim Guidelines

### HIPPS Code

Bill CMS HIPPS code on the first line of the claim,

- Listing Unit Value = 1
- Billed Amount = $0.00

**For Out-of-State Blues Plan Medicare Advantage patients only:**
FL Blue confirmed Treatment Authorization Code (TAC) is no longer required. A Medicare claim for THH services where the earliest date of service is on or after 1/1/2020 will NOT require TAC.

- In Box 39, include Value Code 61 and the Core-Based Statistical Area (CBSA) codes.

# Resources & Support

# Resources & Support

## Transition of Care

- If a patient is already receiving service with another Provider, a member of The CareCentrix Member Transition Team will have already advised the patient of the change and obtained agreement.
- Contact the Transition Team for Rent to Purchase medical equipment.
- Rent to Purchase Equipment is DME equipment that rents up to the purchase price for that piece of equipment and then becomes patient owned.
- Examples of Rent to Purchase Equipment:
  - CPAP
  - BILEVAL PAP
  - Wheelchairs
  - Hospital Beds

**Transition Team: 866.776.4617**

# Resources & Support

## Responsibility of Patient Expense Collection

The responsibility of collecting Patient Expenses is based on the patient's payor.

### What this means:

- Providers may not bill the patient for covered services.
- Providers may not bill the patient for non-covered services, unless, in advance of the provision of such services, the patient **agrees in writing** to accept the financial responsibility for such services.
- **Please refer any patients requesting an OOP estimate to the patient's health plan's cost estimator**
- Patients should be directed to the CareCentrix Patient Services Team for questions on their CareCentrix bills.
- For additional information please see: Patient Financial Responsibility

The grid below shows when providers are expected to collect the patient responsibility

| Payor | Provider | CareCentrix |
|---|---|---|
| Mass General Bringham® Health Plan | | √ |
| BlueCross® Blue Shield® of Michigan | | √ |
| Horizon® Blue Cross® Blue Shield® of New Jersey<br>Braven HealthSM | | √ |
| Fallon Health® | | √ |
| Florida Blue | | √ |
| Sentara® Health Plans | | √ |
| Walmart Specialty Pharmacy | | √ |
| Wellcare® | √ | |

**Patient Services Team : 800.808.1902**

# Additional Resources: Credentialing Department

- Notify CareCentrix immediately of changes to provider demographic information or other information submitted with the provider application
- Send written notice immediately but no later than within 7 days of any such change to CareCentrix Credentialing Department at Contract.Department@carecentrix.com
- Re-credentialing occurs every 2-3 years depending on state regulations

## Contact for the following informational changes:

- Address(es) including remit to address
- Telephone number(s) and/or fax numbers(s)
- Name of key organizational contact(s)
- Name(s) of key local operations contact(s)
- Tax Identification Number
- Days/hours of operations
- Service/product capabilities
- Populations serves (adults, children, geriatric)
- Service area
- Accreditation status, including revocations.
- New malpractice actions
- Licensing status, including sanctions
- Liability insurance coverage
- Change in business structure or ownership.
- Closure of operations/business site
- Changes in the ability to accept new patients

# Additional Resources: CareCentrix Dedicated Contacts

CareCentrix provides you with a dedicated Contracting and Provider Relations Contact to answer your specific questions.

| Provider Relations | Contracting |
|---|---|
| • Primary contact for notification of temporary closures or impact to service delivery | • Answer question regarding your contract or fee schedule |
| • Primary contact for service or support needed post-contracting | • Update your coverage area |
| • Assist with general questions or inquires related to:<br>○ Working with CareCentrix<br>○ Service Registration/authorization<br>○ Portal assistance<br>○ ERA/EFT<br>○ Claims | • Add/remove codes from your contract, including amendments for new implementations |
| • If you are experiencing increased claim denials or need additional assistance, reach out to establish a regular touch point | • Add/remove locations to your contract |

*Access our contact look up tool here

# Additional Resources: HomeBridge Registration

## How do I register for the portal?

A member of your organization can register for HomeBridge by following the HomeBridge provider portal registration guide. Once a request has been entered, a confirmation email will be sent to both your organization's portal administrator and the requestor. Portal information is also included in your "Welcome to the Network!" Email.

## What is a portal administrator – and what do they do?

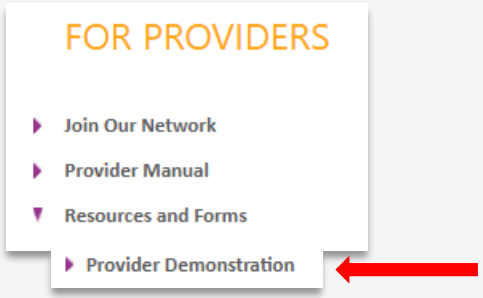
Portal administrators are individuals from your company identified during the contracting and credentialing phase to:

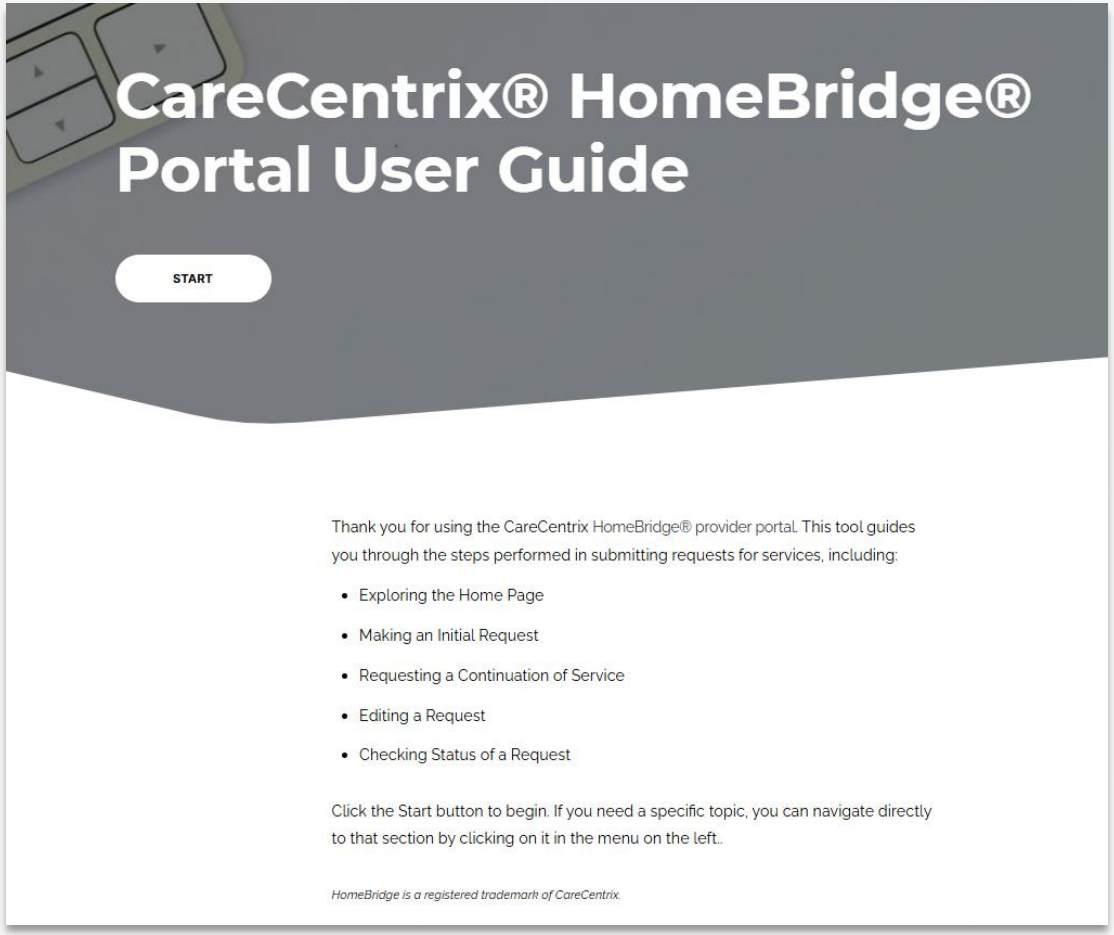
- Manage all registered portal accounts for their organization.
- Register additional users from your organization that need access to HomeBridge.

# Additional Resources: HomeBridge Portal User Guide

The CareCentrix HomeBridge Portal User Guide provides comprehensive portal training at your convenience. This tool guides you through the steps performed in submitting requests for services including:

- Making an Initial Request
- Requesting a Continuation of Services
- Editing a Request
- Checking Status of a Request

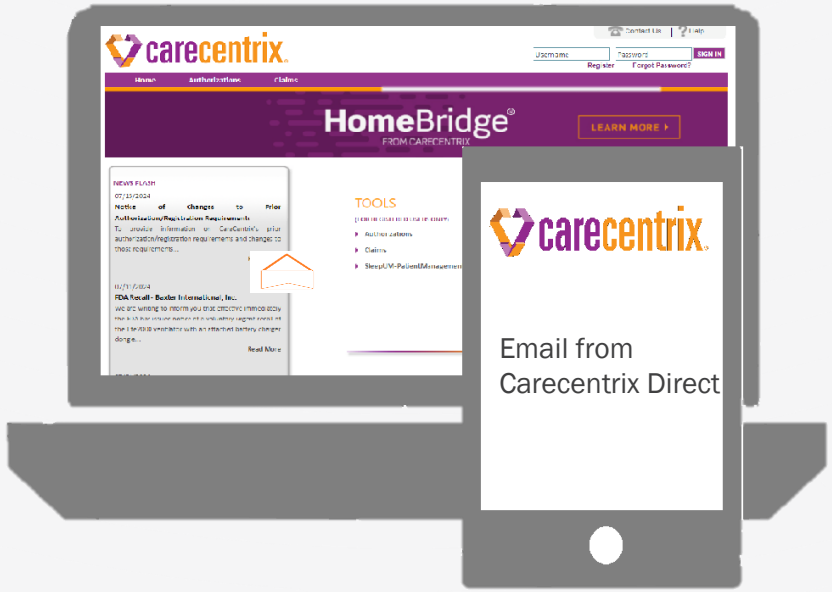


# Additional Resources: CareCentrix Direct

## CareCentrix Direct

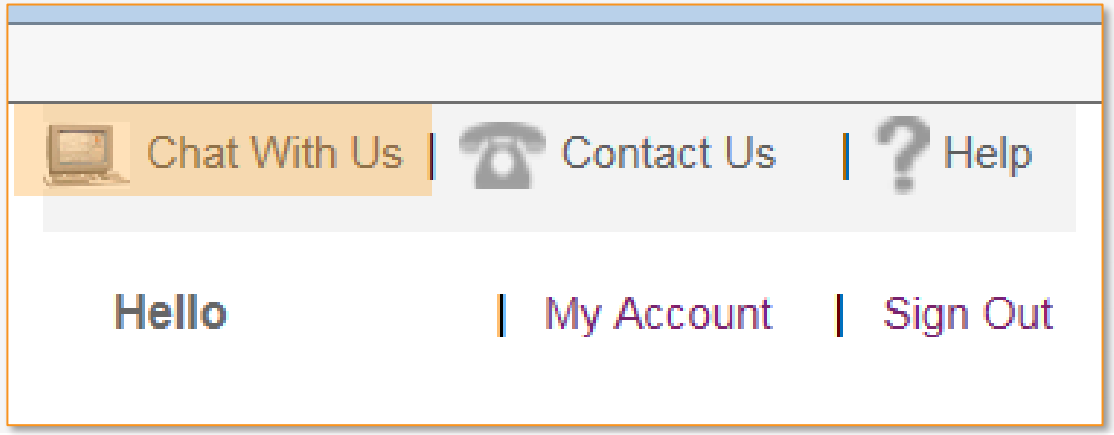
- CareCentrix Direct is an essential service we provide to increase efficiency for our contracted providers through automated referrals that are delivered via email or HomeBridge directly to you!
  - Home Health: The Cross Street field may include the type of services the patient requires, frequency (3x weekly, daily, etc.) and duration.
  - DME: The Cross Street field may include frequency and any DME specific details (i.e., 4-wheel walker with extra-large seat). For certain HCPCS codes, the “Requested Brand” field may populate if the patient requests a specific brand.
  - Manage the CareCentrix Direct user list (For further information on CareCentrix Direct please review the CareCentrix Direct Training and FAQ.



# Additional Resources: Chat

## Chat With Us


After logging into HomeBridge, select the "Chat With Us" link in the upper right-hand corner of your screen to begin the online chat process for existing authorizations.



# Additional Resources: Chat cont.

## Chat With Us

**Important!**
This application can be used for inquiries relating to existing authorizations. You will need to enter the Patient's CareCentrix Intake ID and Date of Birth.

**Important!**
This application will not support any inquiries relating to claims or claim status.

**Important!**
Only one chat session can be used at a time.

If you have a claims related inquiry or require claims assistance, please contact the Claims Support Team at 877-725-6525.

Please continue to use the self-service functionality available on carecentrixportal.com to create new intakes, submit authorization requests and check on authorization status.





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# Additional Resources: Provider Communications

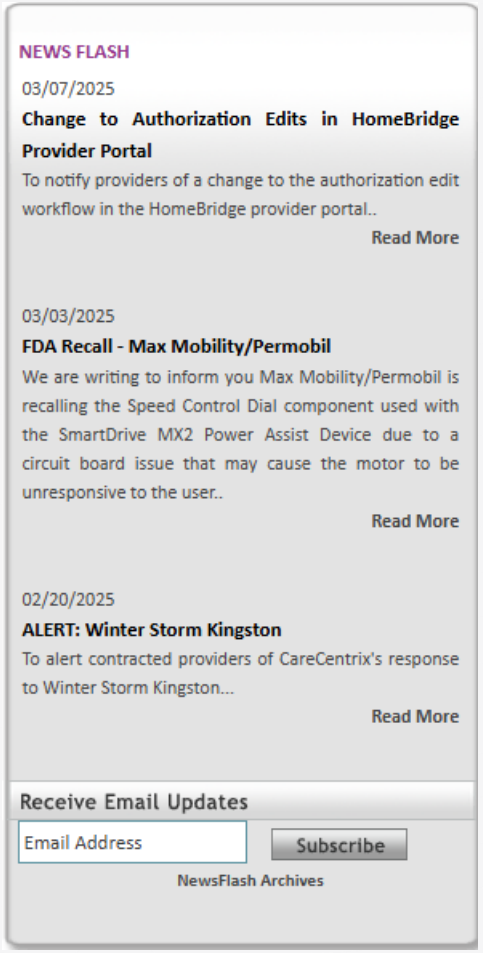
## CareCentrix Newsflashes & Communications

Examples of CareCentrix Communications:

- Newsflashes
  - Most newsflashes can also be viewed in the “Newsflash Archive” on HomeBridge
- Onboarding information
- Information regarding new implementations
- A quarterly newsletter titled “Connecting the Dots" and more

- Communications will be sent from ProviderInfo@CareCentrix.com. Be sure to mark it as a “SAFE” contact in your email system

- If you wish to add or edit the list of contacts from your organization that should receive these, please email your dedicated Provider Relations contact



# Educational Material

Anywhere you see this logo and click it, it will bring you to a resource library full of documents meant to guide you through certain processes in an easy-to-read way

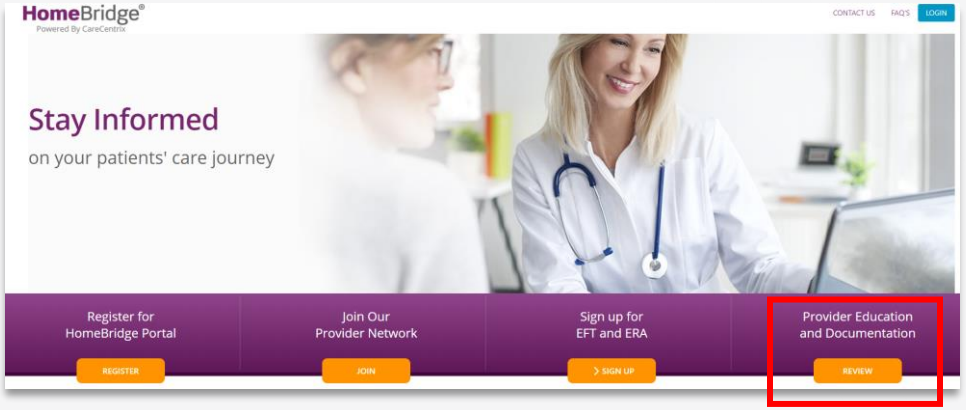
CARECENTRIX®
RESOURCE CONNECTION

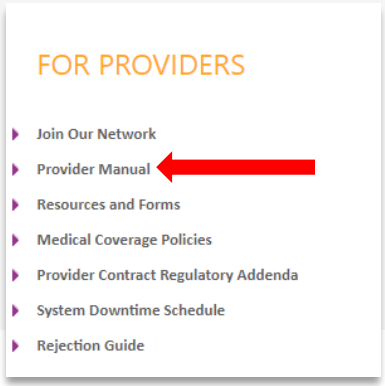
Our quarterly newsletter “Connecting the Dots” is an actionable source to find out the latest process updates, helpful reminders, new resource documents, market news, and more

# Contact Us

# Contact Us

Service Registration/Pre-Notification and Prior Authorization Request, Claims/Payments, HomeBridge and any other provider inquiry see the Provider Manual.




| Contact Method | Phone Number / URL Link |
|---|---|
| HomeBridge | For authorization inquiries or request: carecentrixportal.com/ProviderPortal<br><br>For portal support: portalinfo@carecentrix.com |
| **Days and Hours of Operation** | |
| *Monday – Sunday: 8am to 11pm ET<br><br>(except New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Day after Thanksgiving and Christmas)<br><br>*May vary based on Client and Product | |
| *After Hours, Memorial Day, Independence Day, Labor Day, Thanksgiving and Day after Thanksgiving and Christmas:<br><br>CareCentrix on call clinical staff will be available for urgent authorization requests. Callers should follow the prompts to leave a message. On-call nurses are notified of the inquiry and will return the call within 30 minutes.<br><br>*May vary based on Client and Product | |

# Thank You

## Questions?

For questions, please use this tool to reach out to a Provider Relations contact or for Key Contacts reference the Provider Manual.

# Appendix

- Professional Clean Claim Requirements
- Institutional Clean Claim Requirements
- Claims Process: Paper Claim Submissions
- Best practices for Paper Claim Billing
- CMS –1500 Form
- CMS–1500 Continued
- UB-04 Institutional Claim Form
- Rejection Resources
- Education and Documentation- Claim Submission and Documentation

# Claims Process

# Claim Submission and Payment

## Professional Clean Claim Requirements

- Patient Name, Address, Relationship to subscriber, Gender, Date of Birth
- Patient Account/Control Number
- Insurance subscriber name/ID
- Place of Service
- Primary Diagnosis Code
- Billing Provider Name, Address, Tax ID, NPI
- Rendering Provider Name & Address
- Referring Provider Name & NPI
- HCPCS and Modifiers
- Total Charge amount of each claim service line
- Number of Invoiced units for each claim service line
- NDC Code, NDC unit of measure, NDC quantity (if drug is billed)
- Date of Service (FROM and TO Required)
- Patient's Condition
- Other Insurance Information: Subscriber Name, ID, Plan Name, Date of Birth, and Relationship to subscriber
- Coordination of benefits/primary EOP information for secondary claims
- Description of miscellaneous code in the line level additional information note segment

# Claim Submission and Payment

## Institutional Clean Claim Requirements

- Patient Name, Address, Relationship to subscriber, Gender, Date of Birth
- Patient Account/Control Number
- Insurance subscriber name/ID
- Type of bill (Example 032)
- Primary Diagnosis Code
- Billing Provider Name, Address, Tax ID, NPI
- Attending Provider Name, NPI
- Rendering Provider Name, Address
- Service Facility Location Name, Address, NPI
- HCPCS and Modifiers Combination
- Total Charge amount of each claim service line
- Number of Invoiced units for each claim service line
- For Medicare Advantage plans and traditional home health services, a HIPPS line must be billed
- NDC code, NDC unit of measure, NDC quantity if drug is billed
- Date of Service
- Patient's condition
- Other Insurance Information:  Subscriber Name, ID, Plan Name, Date of Birth, and Relationship to subscriber
- Coordination of benefits/primary EOP information for secondary claims
- Description of miscellaneous code in the line level additional information note segment (NTE*ADD)

# Claim Submission and Payment

## Claims Process: Paper Claim Submissions

Mail both CMS 1500 Professional Claim Forms and UB-04 Institutional Forms to the following addresses:

| Regular Mail: | Federal Express, UPS and Certified Mail: |
|---|---|
| CareCentrix Claims<br>PO Box 30722-3722<br>Tampa, FL 33630 | CareCentrix Claims c/o ImageNet<br>10004 N Dale Mabry Highway<br>Suite 106<br>Tampa, FL 33618 |

# Claim Submission and Payment

## Best practices for Paper Claim Billing

- Use industry standard red forms only (no copies) on 20–22-pound weight paper
- Use black ink only
- USE ALL CAPITAL LETTERS
- Use 10, 11, or 12 point font sizes
- Use Arial or Tahoma font (NO script or stylized fonts)
- **DO NOT** use dot matrix printers
- **DO NOT** hand write any data on the paper claim
- Ensure that all the text is WITHIN the empty spaces of boxes provided and NOT touching the lines
- **Box 22** on a CMS 1500 must contain the frequency code and **the original CareCentrix claim ID** when correcting or voiding a claim
- **Box 64** on a UB-04 must contain the original CareCentrix claim ID when correcting or voiding a claim
- When billing a frequency 7 claim, please make sure that "**CORRECTED CLAIM**" is typed, stamped or handwritten, either at the top of the form or in Box 19 on a CMS 1500 form or Box 60 on a UB-04
- When billing a frequency 8 claim, please make sure that "**VOID**" is typed, stamped or handwritten, either at the top of the form or in Box 19 on a CMS 1500 form or Box 60 on a UB-04
- Ensure that when billing multiple page claims they're stapled together and include a page count, ie 1 of 3, 2 of 3, 3 of 3 at the top of your claim

# Claim Submission and Payment

## CMS –1500 Form

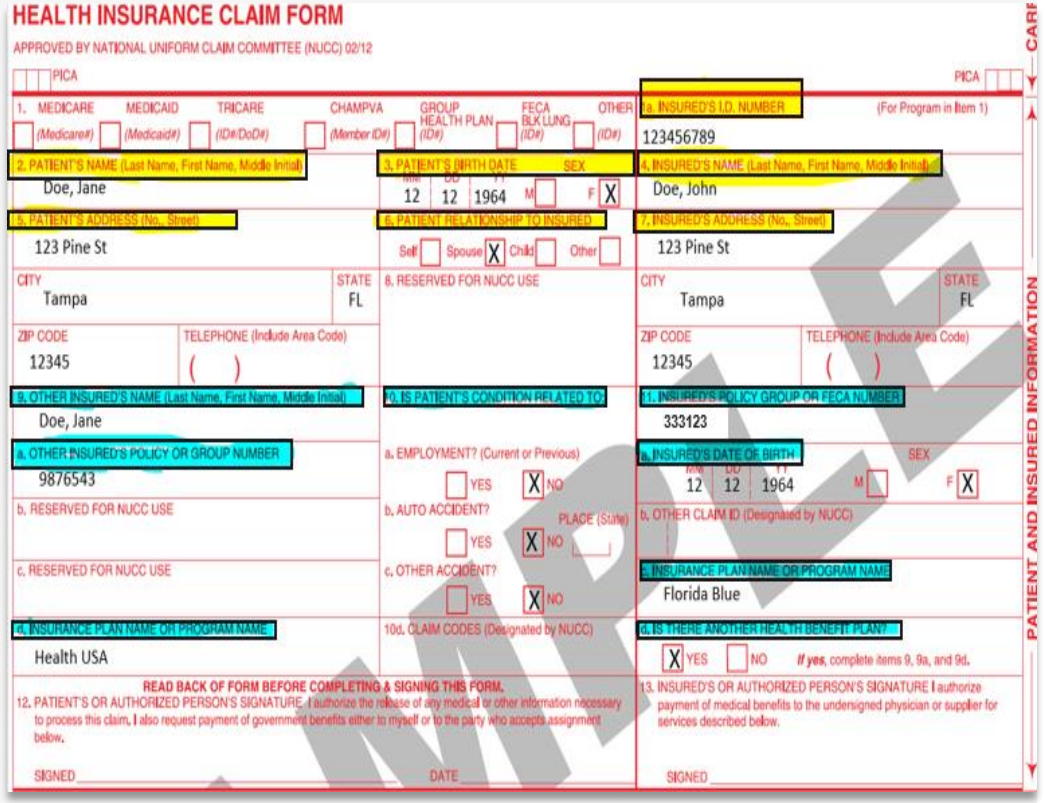
### Yellow

- Box 1a: Subscriber ID – **without the 2-digit person code**
- Box 2: Patient Name (Last, First)
- Box 3: Date of Birth & Gender
- Box 4: Insured's Name (Last, First)
- Box 5: Patient's Address
- Box 6: Check the appropriate Relationship to Subscriber
- Box 7: Insured's Address

### Blue

**The following boxes should only be populated if this is a secondary claim. Otherwise, they should be left blank.**

- Box 9: Other Insured's Name - **If this is a secondary claim, this should contain the NAME of the subscriber for the primary plan**
- Box 9a: Other Insured's Policy or Group Number – **If this is a secondary claim, this should contain the subscriber ID for the primary plan**
- Box 9d: Other Insurance Plan Name - **If this is a secondary claim, this should contain the primary plan name**
- Box 10a-c: Patient's Condition
- Box 11: Other Insurance Group Number - **If this is a secondary claim, this should contain the primary insurance group number**
- Box 11a: Other Insured's Date of Birth, Gender - **If this is a secondary claim, this should contain the primary subscriber's information**
- Box 11c: Other Insurance Plan Name or Program Name – **If this is a secondary claim, this should contain the name of the primary insurance health plan**
- Box 11d: - **This should be checked if this is a secondary claim**

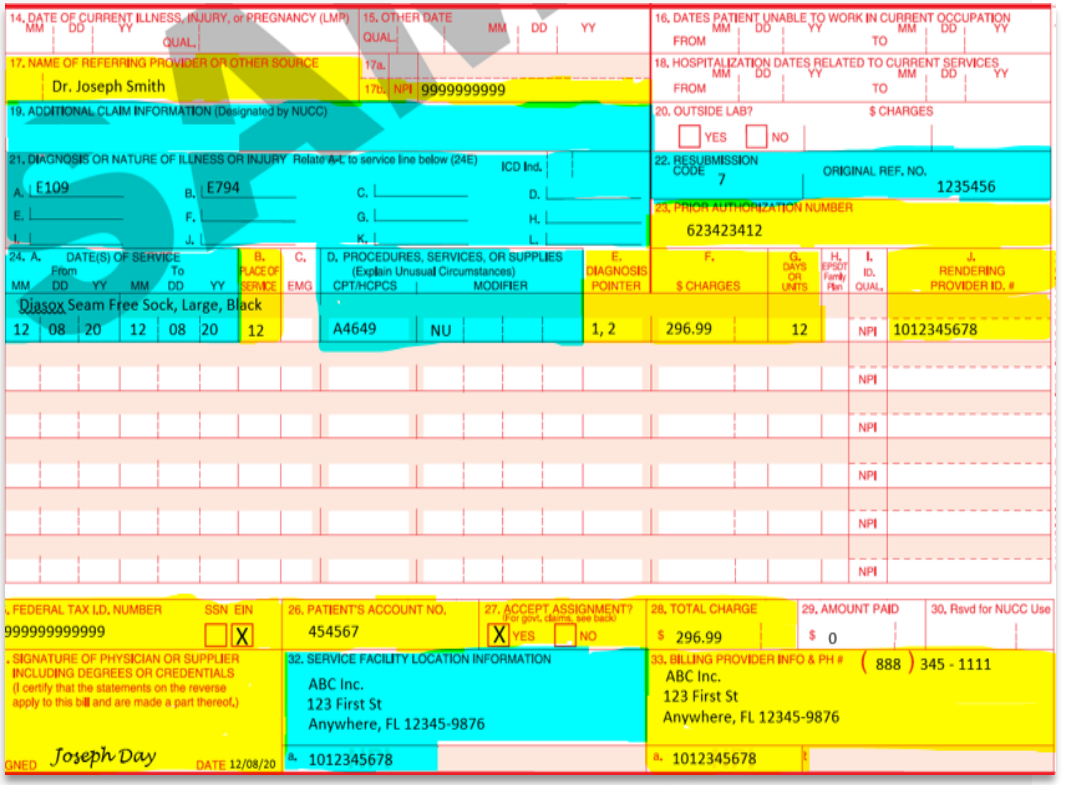


# Claim Submission and Payment

## CMS –1500 Continued

### Yellow

- Box 17: Referring Provider Name
- Box 17b: Referring Provider NPI
- Box 23: Authorization Number
- Box 24B: Place of Service
- Box 24E: Diagnosis Pointer(s)
- Box 24F: Total Charge amount for service line
- Box 24G: Number of invoiced units for service line
- Box24J: Rendering Provider NPI – This must be populated if Rendering provider is not the Billing provider.
- Box 25: Billing provider's Federal Tax ID Number
- Box 26: Provider's Patient Account/Control Number
- Box 27: Indicate Accept Assignment
- Box 28: Total Charge Amount for all service lines combined
- Box 31: Provider Signature, date
- Box 33: Billing Provider Name, Address
- Box 33a: Billing Provider NPI




### Blue

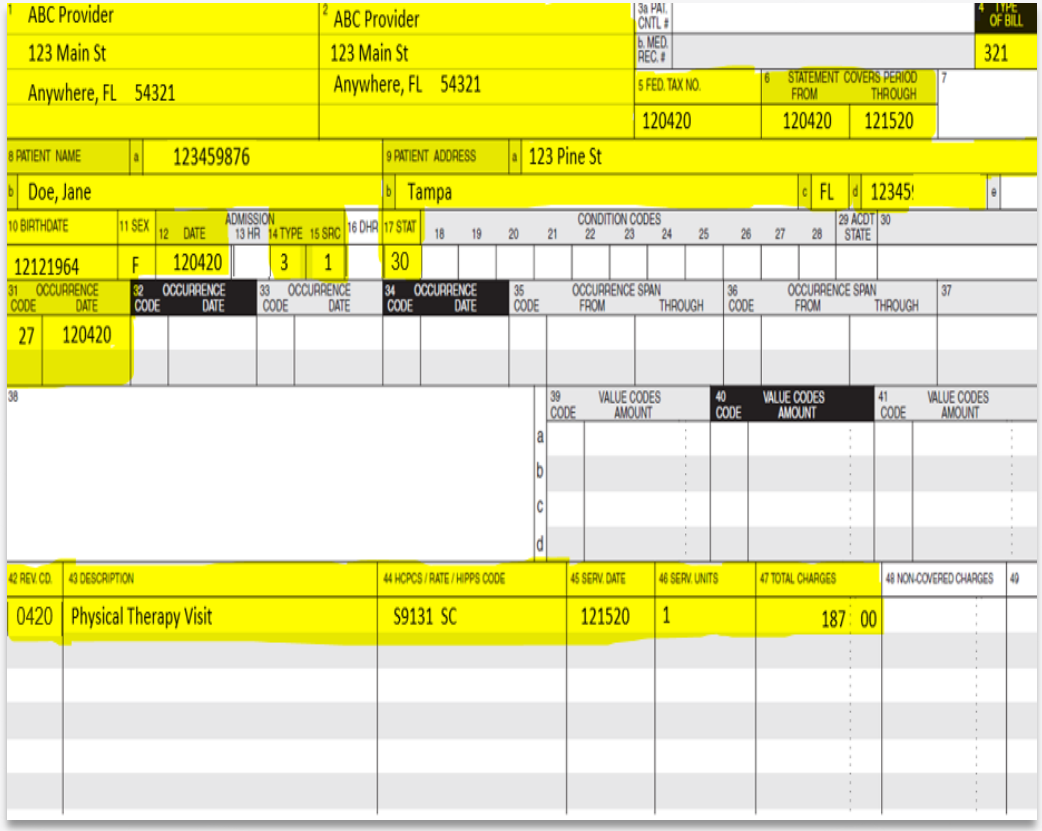
- Box 19: Additional Claim Information **(if applicable)**
- Box 21: Diagnosis Code - **Do not include decimal points**
- Box 22: **Frequency code of 7 (Corrected Claim) or 8 (Void) and the CareCentrix Claim Number of the original claim**
- Box 24A: **Put the Date of Service range in the white, lower half of the line**
- **Also, in Box 24A (in the upper, shaded peach half of the line, send the following if applicable:**
  - **If a Miscellaneous HCPCS is being billed, place the specific description of the service being billed**
  - **If a drug is being billed, place the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Unit of Measure Qualifier, followed by the NDC Quantity.**
- Box 24D: HCPCS and Modifier Combination – **Again, this must match a HCPCS and modifier combination in the provider's contracted fee schedule and the health plan's fee schedule.**
- Box 32: Services Facility Name and Address - This should contain the Rendering provider's name and address if it is different than the Billing Provider's Name and Address in
- Box 32a: Service Facility NPI – This is the Rendering Provider's NPI if different from the Billing provider's NPI. *6

# Claim Submission and Payment

## UB-04 Institutional Claim Form

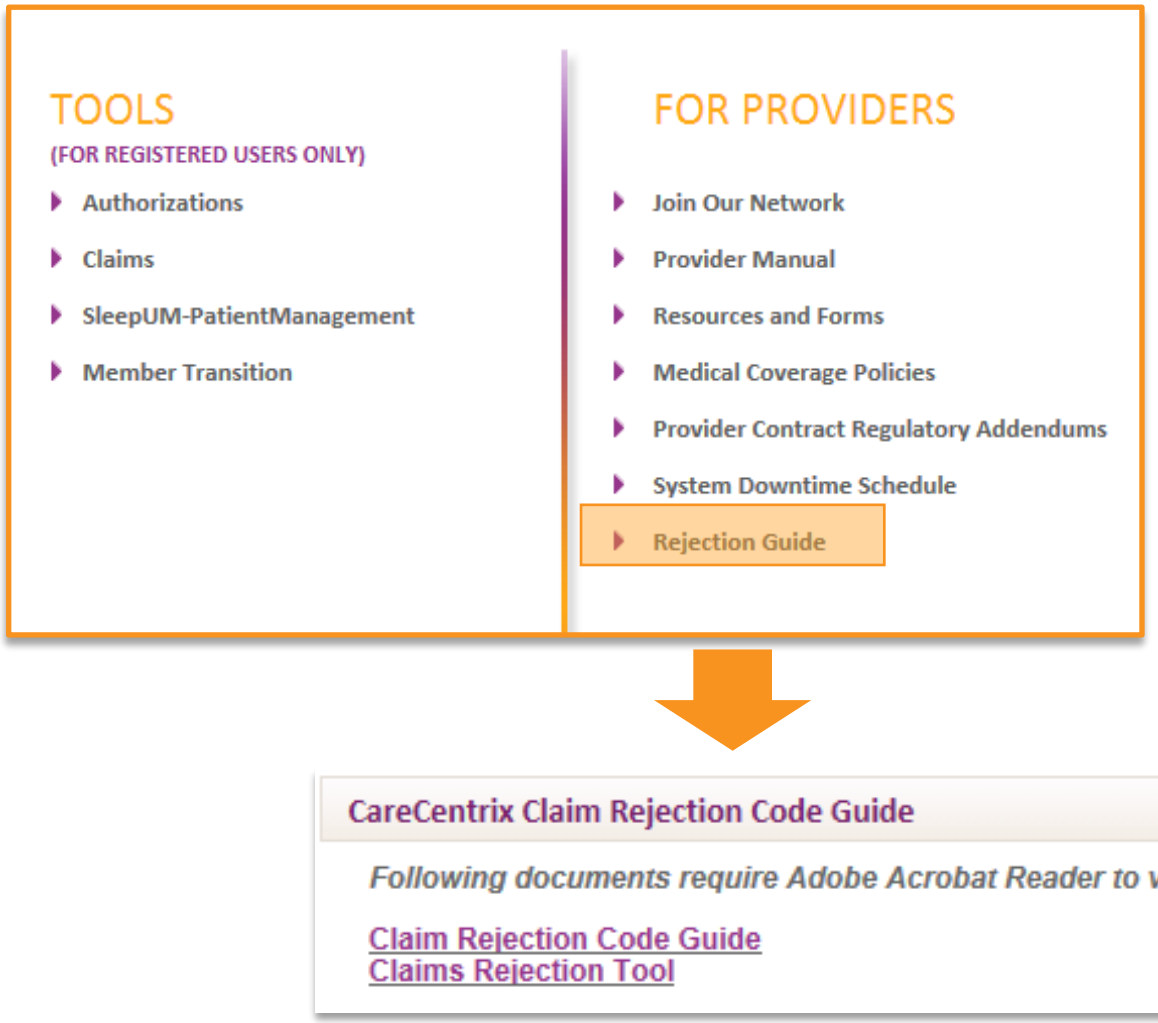
### Yellow

- Make sure you also fill in the following required fields:
- Box 1:  Provider Name and Address (no PO Boxes)
- Box 2: Pay to Name and Address
- Box 4: Type of Bill
- Box 5: Billing provider's Federal Tax ID Number
- Box 6: Statement date range (From and through date)  - these should align with the oldest and newest dates of service included in this claim.
- Box 8a: Subscriber ID
- Box 8b: Patient Name –Last Suffix, First Middle (ex: Jones III, David Jordan)
- Box 9a-d: Patient Address
- Box 10: Patient's Date of Birth MMDDYYYY format
- Box 11: Patient's Gender (M or F)
- Box 12: Admission Date MMDDYY format
- Box 14: Admission Type Code
- Box 15: Source of Admission Code
- Box 17: Patient Status
- Box 31: Occurrence Code and Date of Occurrence if applicable
- Box 42: Revenue Code
- Box 43: Service Description
- Box 44: HCPCS and Modifiers
- Box 45: Date of Service
- Box 46: Units
- Box 47: Total charge for service line
- Please note – If your claim is for home health services for a Medicare Advantage patient, then a HIPPS line is also required!



# Claim Submission and Payment

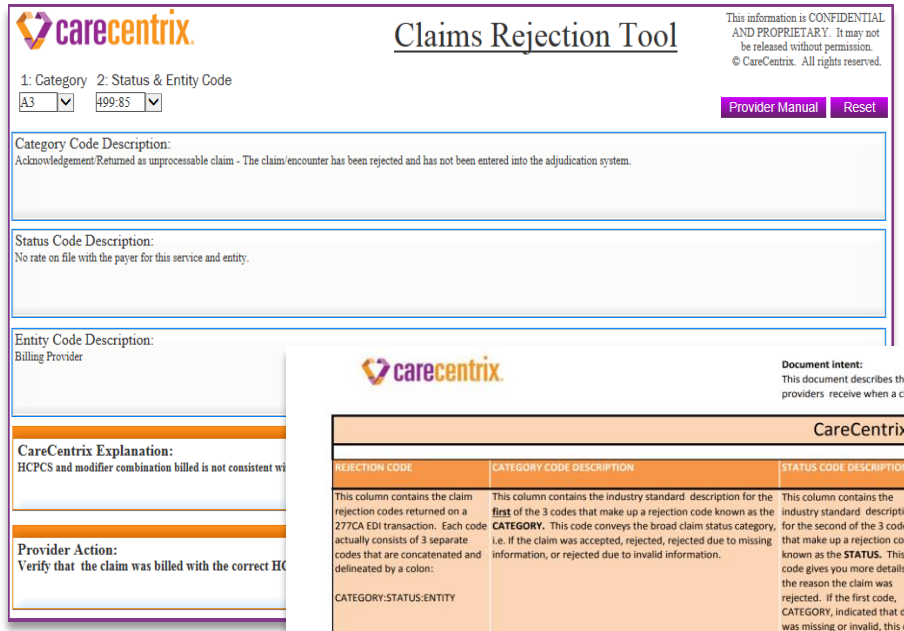
## Rejection Resources

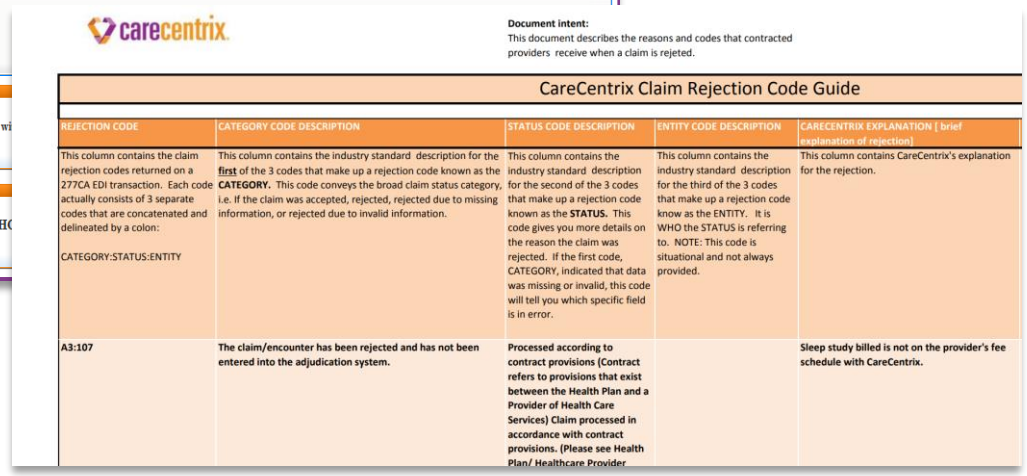


# Claim Submission and Payment

## HomeBridge: Education and documentation

Claim Submission and Rejections




**Claims Rejection Tool** – Outlines provider actions required if a claim is rejected when received by CareCentrix.

**Please Note:** This tool does not contain rejections by the patient's health plan.

**CareCentrix Claim Rejection Code Guide** – Describes common rejection reasons and codes that providers receive when a claim is rejected