Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Post-acute care services for Medicare Advantage members

Frequently asked questions for providers

For Medicare Plus Blue℠ and BCN Advantage℠

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General information

WellSky® manages prior authorizations for post-acute care services for Medicare Plus Blue and BCN Advantage members for stays that start on or after Jan. 5, 2026. This includes requests for initial and continued stays and for retroactive requests.

Health care providers need to submit prior authorization requests to WellSky for our Medicare Advantage members who are 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, WellSky's care coordinators, who are licensed clinicians, work with acute and 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 transitioning from the acute care to the post-acute care facility and while the member is in the post-acute care setting. The facilities should collaborate with WellSky on these activities.

Which members does this change affect?

This change affects Medicare Plus Blue and BCN Advantage members for post-acute care stays in Michigan and outside of Michigan.

Note: The post-acute care prior authorization program through WellSky doesn't affect Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial or Blue Cross Complete (Medicaid) members. In addition, the program doesn't apply to the following services: home health care, durable medical equipment, outpatient services that require prior authorization, high-cost drugs and ambulance transportation.

What's changing and what's staying the same?

For stays that start before Jan. 5, 2026, Blue Cross and BCN Utilization Management manages prior authorization requests for post-acute care stays for Medicare Plus Blue and BCN Advantage members.

Here's a summary of what's changing and what's staying the same.

What's changing

- WellSky will manage prior authorization requests for post-acute care.
- Acute care providers will have access to lists of high-performing post-acute care facilities through CarePort solutions.

What's staying the same

- Prior authorization will continue to be required for post-acute care stays:
  - WellSky will use Centers for Medicare & Medicaid Services criteria and InterQual® criteria to make decisions on prior authorization requests.
  - Providers must submit clinical documentation.
  - Blue Cross and BCN will continue to manage appeals.
- Peer-to-peer reviews — WellSky will offer peer-to-peer reviews.
- Claims — Continue to submit claims to Blue Cross and BCN.
- Care management — WellSky, Blue Cross or BCN will reach out to members and their caregivers.
- Member view into the prior authorization process — Members will be able to view the status of prior authorization requests through their BCBSM member accounts.

What is WellSky and what is the PAC Advance initiative?

WellSky is a health care technology company that's leading the movement for intelligent, coordinated care. Through the PAC Advance initiative, WellSky aims to deliver a fully integrated, post-acute care episode management program that facilitates high-quality, end-to-end post-acute care management.

WellSky's next-generation software, analytics and services power better member outcomes and improved provider and member experiences across the post-acute care continuum.

Why did Blue Cross and BCN contract with WellSky to manage post-acute care services?

Blue Cross and BCN are transitioning these services to WellSky as part of an effort to standardize the management of authorizations for post-acute care for Medicare Advantage members. WellSky's management will help 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 works with the post-acute care provider to coordinate the member's care?

WellSky will:

- Make decisions on prior authorization requests and coverage.
- Conduct mid-stay progress checks.
- Provide onsite liaisons at high-volume post-acute care facilities. At lower-volume facilities, liaisons will be available by phone.

How can I contact WellSky after business hours?

For requests submitted to WellSky, contact the WellSky PAC Advance team by calling 1-855-739-0742. The on-call coordinator has access to a physician, as needed, and is available as follows:

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

How do I access WellSky documents related to this program?

To access WellSky documents, see:

- The Post-Acute Care page on **authorizations.bcbsm.com** — Provides access to Blue Cross and BCN's communications related to post-acute care.
- WellSky's Provider Resource Center for Blue Cross and BCN at **ProviderResourceCenter.com/bcbsmi*** — This resource provides access to WellSky documents related to post-acute care, including:
  - Forms for faxing prior authorization requests
  - Quick reference guides about submitting prior authorization requests for initial stays and for continued stays

- For acute care facilities: Detailed information about using CarePort to submit prior authorization requests and discharge information

Authorizations

Who should submit prior authorization requests?

Here's who should submit prior authorization requests for post-acute care services:

Note: Except for community referrals and concurrent reviews, prior authorization requests must originate from the acute care setting.

Requester	Submits
Acute care providers and primary care providers	Initial prior authorization requests for the following levels of care: • Skilled nursing • Inpatient rehabilitation • Long-term acute care To help the WellSky clinical team understand the transition plan as early as possible, acute care providers should submit a prior authorization request immediately after making the decision to refer the patient for post-acute care services. This enables WellSky to help identify quality in-network post-acute care providers and alternate transitions of care.
Skilled nursing facilities	• Initial prior authorization requests for community referrals • Prior authorization requests for concurrent reviews
Inpatient rehabilitation facilities	• Initial prior authorization requests for community referrals • Prior authorization requests for concurrent reviews

Where should I submit continued stay requests for post-acute care stays that started before Jan. 5, 2026, and continue beyond Jan. 5, 2026?

For post-acute care stays that started before Jan. 5, 2026, continue to submit continued stay requests to Blue Cross or BCN through the e-referral system.

If you're experiencing temporary technological problems that prevent you from accessing the e-referral system, such as a power or internet outage, fax requests to WellSky at 1-877-673-8784 using the appropriate form. WellSky will forward the request to Blue Cross or BCN.

Use these links to access the forms:

- SNF/acute IPR assessment form

- LTACH assessment form

We're updating the fax instructions that appear on page 1 of each form to include the new fax number.

Important:

- Starting Jan. 5, 2026, don't fax requests for Medicare Advantage members to Blue Cross or BCN at 1-866-796-3713. We're discontinuing this fax line.
- Starting Jan. 5, 2026, use the above forms only in these situations:
  - When submitting continued stay requests for stays that started before Jan. 5.
  - When submitting retroactive authorization requests for stays that started before Jan. 5

If you have questions, send them to UMMedicarePACCA@bcbsm.com.

For Michigan providers: What do I need to do to submit prior authorization requests through the WellSky provider portal?

Staff members need to do one of the following:

- **If you already have direct access to the WellSky portal:** WellSky can update your portal access to include Medicare Plus Blue and BCN Advantage members. To make this request, email WellSky at PACAdvanceSupport@wellsky.com.
- **If you don't have access to the WellSky portal:** Follow the steps in the document titled Register to access the WellSky provider portal through Availity Essentials to obtain your AKA ID through Availity Essentials™ and register with WellSky.

Notes:

- Acute care hospitals that submit prior authorization requests through WellSky CarePort Care Management don't need to register for the WellSky portal.
- For large organizations, managers can email PACAdvanceSupport@wellsky.com to begin the process of submitting a list of users to register with WellSky. Use the *Provider portal – new team submission template* to enter information for each person in your organization who needs access to the WellSky portal. You can find the template on the WellSky Provider Resource Center for Blue Cross and BCN.*

For non-Michigan providers: How do I submit prior authorization requests through the WellSky provider portal?

Non-Michigan providers must register for direct access to the WellSky provider portal to submit prior authorization requests electronically. To do this:

1. Go to the WellSky PAC Advance Provider Portal login page.*
2. Click the *Need an Account? Sign Me Up* link.
3. Complete all fields.
4. Read the information below the fields.
5. Mark the *I'm not a robot* checkbox.
6. Click *Sign Up*.

After receiving confirmation from WellSky that you've been approved for access, go to the WellSky provider portal login page to log in.*

Important: Michigan providers should read the section above, titled "For Michigan providers: What do I need to do to submit prior authorization requests through the WellSky provider portal?"

How do I submit prior authorization requests?

Starting Jan. 5, 2026, you can submit prior authorization requests to WellSky as follows. The methods that are noted as preferred have faster turnaround times.

Submission method	Details
Preferred method: Through the WellSky provider portal — for Michigan providers	**Access the WellSky portal through Blue Cross and BCN's provider portal.** To do this: 1. Complete the steps in the document titled Register to access the WellSky provider portal through Availity Essentials. 2. After receiving confirmation from WellSky that you've been approved for access, log in to Blue Cross and BCN's provider portal (availity.com*). 3. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. 4. Click the *WellSky Provider Portal* tile in the Applications tab. If you're having trouble accessing the WellSky portal using this process, contact Availity® Client Services at 1-800-AVAILITY (282-4548). If you're having trouble while working in the WellSky portal, contact WellSky by calling 1-855-739-0742 or emailing PACAdvanceSupport@wellsky.com.
	If you have direct access to the WellSky provider portal: Sign in to the WellSky PAC Advance portal.*
Preferred method: Through CarePort Care Management	CarePort Quick reference guides are available on WellSky's Provider Resource Center for Blue Cross and BCN.* See the acute care hospital provider resources.

Submission method	Details
Non-Michigan providers	Non-Michigan providers can submit prior authorization requests in the following ways: • By logging in to your local plan's website and entering the member's enrollee ID from their member ID card. This will open the Pre-Service Review for Out-of-Area and Local Members screen. • By registering for direct access to the WellSky provider portal — See For non-Michigan providers: How do I submit prior authorization requests through the WellSky provider portal? for details. • By fax — See the "By fax" row below for details.
By fax	Using the fax cover sheet and the appropriate form, fax the request to WellSky at 1-877-673-8784. To find these items, go to WellSky's Provider Resource Center for Blue Cross and BCN and select your provider type. Be sure to include the required documentation.*
By phone	Call WellSky at 1-855-739-0742. Be prepared to provide the necessary details to a representative.

What documentation should I submit with prior authorization requests?

The WellSky PAC Advance clinical team uses an evidence-based approach to evaluate the most appropriate medically necessary care for each member. This evaluation requires submission of legible medical records pertinent to the services requested.

If the medical records or information provided doesn't provide sufficient information to understand the individual's current clinical status or is illegible, medical necessity can't be established and will result in a denial.

The table below outlines the elements that are commonly required to establish medical necessity. If there is additional information that will help to establish medical necessity, we encourage you to provide it.

Type of request	What to submit
Initial prior authorization request	• Face sheet / basic member information • History and physical • Post-acute care initial / admission evaluation (community referrals are allowed only without prior hospitalization) • Physical, occupational and speech therapy evaluations, if applicable and available • PT, OT, ST progress notes — Should be dated within the past 24 to 48 hours

Type of request	What to submit
	• Progress notes • Discharge summary, if applicable and available Note: If a discharge summary isn't available, submit information about the patient's home setup and prior living situation. • Caregiver availability
Concurrent review and subsequent prior authorization request	• Face sheet / basic member information • Progress notes or therapy notes for all disciplines • Discharge plan and applicable updates

What's the difference between a referring provider and a refer-to provider?

The **referring provider** is the health care provider or organization that submits the prior authorization request.

The **refer-to provider** is the health care provider or organization that receives the request to provide services and will deliver care.

In some cases, the same organization is both the referring and the refer-to provider. This typically occurs when the refer-to provider receives a referral from or clinical information about the patient from an external health care provider, from a community-based referral or from another source. Based on the referral, the refer-to provider assesses the patient's needs and submits a prior authorization request, if appropriate.

What criteria does WellSky use to make determinations on prior authorization requests?

WellSky uses the following criteria:

- Centers for Medicare & Medicaid Services regulations
- InterQual® criteria

For more information, see the Clinical Guideline Transparency page on **wellsky.com**.*

How long does it take to receive a decision on a prior authorization request?

You'll receive determinations on requests within the following time frames:

- **For requests received by 4 p.m.:** WellSky will make a determination or request additional information that day.
- **For requests received after 4 p.m.:** WellSky will make a determination or request additional information the next day.

Providing complete information when you submit the request will result in the fastest turnaround time. If WellSky asks for additional information, you should submit it as soon as possible.

How long are prior authorizations valid?

Approved authorizations are valid for five calendar days from the date on which you're notified of the approval. This means the referring provider has five days to discharge the patient to the approved level of care. Here's how this works:

- If the member **is admitted** to a post-acute care facility within five calendar days, the authorization period starts on the date of the admission. The number of days for which treatment is approved is stated on the authorization.
- If the member **isn't admitted** to a post-acute care facility within five calendar days, the authorization will expire. You'll need to submit a new prior authorization request and provide updated documentation.

Who should I call with follow-up questions after submitting a prior authorization request?

You can direct follow-up questions to the WellSky PAC Advance team during normal business hours by calling 1-855-739-0742 or emailing PACAdvanceSupport@wellsky.com. Normal business hours are 7 a.m. to 7 p.m. Monday through Friday.

For requests submitted through CarePort Care Management, follow your normal CarePort Care Management process for follow-up questions.

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

You can check the status of a prior authorization request through the WellSky provider portal or by calling WellSky at 1-855-739-0742.

Can I request an extension of or additional days for a post-acute care stay?

If a member requires additional care beyond the time period on the initial authorization, submit a prior authorization request to request an extension or a concurrent review. You'll need to include updated clinical information. For additional information, see:

- "For Michigan providers: What do I need to do to submit prior authorization requests through the WellSky provider portal?" on page 6
- "For non-Michigan providers: How do I submit prior authorization requests through the WellSky provider portal?" on page 6
- "What documentation should I submit with prior authorization requests?" on page 8

WellSky will conduct progress checks for members midway through the initially authorized time frame to assist with the extension and concurrent review process.

What will happen if WellSky doesn't approve a prior authorization request?

If WellSky doesn't approve a prior authorization request, you'll receive a written notification that includes:

- The reasons the request wasn't approved
- Member appeal rights

To request the specific guideline WellSky used to make the determination, see the determination letter or contact the WellSky PAC Advance team as follows:

- Call 1-855-739-0742
- Email PACAdvanceSupport@wellsky.com

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

WellSky offers proactive peer-to-peer reviews prior to services beginning and before issuing an adverse determination. To do this, WellSky calls the requesting provider and leaves a message with a person or in a secure voicemail stating that they're calling on behalf of Blue Cross or BCN regarding a member's prior authorization determination. WellSky will provide callback information for the WellSky Clinical Services team.

WellSky will meet with mid-level providers for peer-to-peer reviews.

For peer-to-peer reviews that are offered in advance of issuing an adverse determination, WellSky will issue the denial if the provider is unable to meet within the required time frame.

Can I submit a retroactive authorization request for a post-acute care stay?

Yes. You can submit retroactive requests for up to one year post-discharge for both Medicare Plus Blue and BCN Advantage members.

Information about submitting retroactive authorization requests for post-acute care stays that start before Jan. 5, 2026

Submit retroactive authorization requests for stays that started before Jan. 5, 2026, to Blue Cross or BCN through the e-referral system. We'll accept retroactive requests through Jan. 4, 2027.

If you're experiencing temporary technological problems that prevent you from accessing the e-referral system, such as a power or internet outage, fax requests to WellSky at 1-877-673-8784 using the appropriate form. WellSky will forward the request to Blue Cross or BCN.

Use these links to access the forms:

- SNF/acute IPR assessment form
- LTACH assessment form

We're updating the fax instructions that appear on page 1 of each form to include the new fax number.

Important:

- Starting Jan. 5, 2026, don't fax requests for Medicare Advantage members to Blue Cross or BCN at 1-866-796-3713. We're discontinuing this fax line.
- Starting Jan. 5, 2026, use the above forms only in these situations:
  - When submitting continued stay requests for stays that started before Jan. 5.
  - When submitting retroactive authorization requests for stays that started before Jan. 5

If you have questions, send them to UMMedicarePACCA@bcbsm.com.

Does prior authorization guarantee payment?

Prior authorization doesn't guarantee payment. Claims submitted for these services will also be subject, but not limited to, the following:

- Member eligibility at the time services were provided
- Benefit limitations and/or exclusions
- Appropriateness of codes billed
- Medical necessity review, if prior authorization wasn't obtained before services were provided

How do I submit appeals on denied authorization requests?

The Medicare Plus Blue and BCN Advantage Grievance and Appeals units handle requests to appeal denials of both prior and retroactive authorization requests.

To submit an appeal, follow the instructions in the denial letter. If you haven't received the denial letter yet, you can request a copy by calling WellSky at 1-855-739-0742 or by logging in to the WellSky provider portal.

If you're submitting a fast, or expedited, appeal, you'll get the fastest response from us by doing the following:

1. Including all current and relevant medical documentation to ensure your appeal can be processed in a timely manner.
2. Faxing it to the number listed on the denial letter. (The fax numbers are also listed below.)

3. On the fax cover sheet, indicate that you're requesting a fast, or expedited, appeal.

Within 72 hours, we'll send a fax to inform you of our determination. See "Can I transfer the patient as soon as the appeal is approved?" on page 13 for additional information.

To appeal an adverse determination, submit the appeal to the appropriate Grievance and Appeals unit as outlined in the following table:

Coverage	Details
Medicare Plus Blue	• Fax it to 1-877-348-2251. • Call the Provider Inquiry number listed below. 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 "Providing notices of appeal rights and responding to appeals." To inquire about the status of an appeal, call Provider Inquiry at 1-866-309-1719.
BCN Advantage	• Fax it to 1-866-522-7345. • Call the Provider Inquiry number listed below. 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." To inquire about the status of an appeal, call Provider Inquiry at: • Facility providers: 1-800-249-5103 • Professional providers: 1-800-344-8525

Note: For provider appeals related to claims, call Provider Inquiry.

If the denial is related to a *Notice of Medicare Noncoverage*, or *NOMNC*, (for continued stays), the appeal should be submitted to the appropriate quality improvement organization, or QIO. The *NOMNC* includes the name of the QIO and detailed instructions about how to appeal.

Note: WellSky will send the *Notice of Medicare Non-Coverage* and *Detailed Explanation of Non-Coverage* forms for discontinuation of care.

Can I transfer the patient as soon as the appeal is approved?

Once you receive a fax from us stating that an appeal has been approved, you can immediately transfer the member to a post-acute care facility.

Although WellSky will provide an authorization number later, don't wait for that number to transfer the patient. The fax you received serves as proof of the approval.

Post-acute care providers should accept the transfer based on the faxed notification stating that we approved the appeal.

Skilled nursing facilities

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:

- You must submit physical therapy, occupational therapy, speech therapy and nursing assessments for each member to WellSky within 48 hours of admission to a skilled nursing facility.
- You may opt to complete an additional Prospective Payment System assessment, but you are not required to complete one.

If you have questions, contact your WellSky provider network manager.

Note: For SNF interrupted stays, the completion of new patient assessments is optional.

When is a SNF stay considered an interrupted stay?

Per Centers for Medicare & Medicaid Services guidance, a skilled nursing facility interrupted stay occurs when a patient is discharged from a SNF and is readmitted to the same SNF within three consecutive days. When this occurs:

- The readmission or subsequent stay is considered a continuation of the previous stay.
- One claim must be submitted for both stays.
- The completion of new patient assessments is optional.
- The variable per diem isn't reset.

For more information, see the "Interrupted Stay Policy" section of the Medicare Learning Network® document titled SNF PPS: Patient Driven Payment Model.*

How does WellSky handle authorizations for SNF interrupted stays?

If a patient who is receiving skilled services leaves a SNF for the emergency department, for an observation stay or for an acute-care hospital inpatient stay and:

- Returns to the same SNF on the day of discharge (before midnight), WellSky will use the original prior authorization number.

- Returns to the same SNF one or more days after the discharge date, WellSky will create a new authorization number.

For information about submitting claims for SNF interrupted stays, see “How do I submit claims for SNF interrupted stays?” on page 16.

Why did I receive an administrative denial letter from WellSky?

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 or BCN, WellSky 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: WellSky 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 FFS & MA NOMNC/DENC page on **cms.gov**.*

- 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, WellSky will reach out to provide education about CMS guidelines and health plan requirements. If, after receiving education, a SNF provider continues to have difficulties, WellSky 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 Provider 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.
- Medicare Managed Care Appeals & Grievances webpage at **cms.gov***
- Beneficiary Notices Initiative (BNI) webpage at **cms.gov***

How do I submit claims for SNF interrupted stays?

When submitting claims for SNF interrupted stays:

- You must submit only one claim for both stays.
- Submitting authorization numbers on Medicare Plus Blue and BCN Advantage claims for post-acute care stays is **optional**. If you choose to include an authorization number on the claim, include the prior authorization number for the initial SNF stay.

Claims

What authorization number should I submit with the claim?

Submit the authorization number provided with the authorization approval.

See "How does WellSky handle authorizations for SNF interrupted stays?" on page 14 for additional information.

Who should I call with questions about claims I have submitted?

Call the member's plan as follows:

- Michigan providers should call Provider Inquiry at 1-800-249-5103.

- Non-Michigan 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 WellSky.

Reminders:

- Providers are responsible for billing appropriately.
- Claims for unauthorized services and procedures are subject to denial.
- Prior authorization isn't a guarantee of payment.

*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.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Tango and WellSky® are independent companies that review member health care services for appropriateness and medical necessity on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.