iCare
INDEPENDENT CARE HEALTH PLAN

PROVIDER BULLETIN

2020 | ISSUE 5

Place of Service (POS) and Modifier Reminder – Telehealth Billing

Medicaid

GT Modifier should be used with POS 02 when an allowable provider is performing and allowable telehealth service

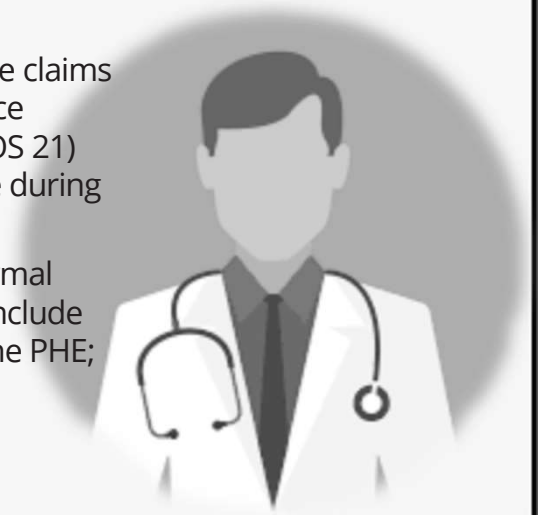
95 Modifier should be used with the provider's POS when telehealth service is temporarily allowable due to the Shelter in Place order

Please see ForwardHealth for further details on this topic:
https://www.forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_billing.html.spage

Medicare

If you are offering telehealth services as part of the PHE, those claims should be submitted with the POS from where the face-to-face service is normally performed (e.g., office POS 11, hospital POS 21) and include modifier 95 to identify this as a telehealth service during the PHE; this is the preferred method for submission..

If you are offering telehealth services as you would under normal circumstances, you may continue to bill your POS as 02 and include modifier 95 to identify that the service was provided during the PHE; which will be paid at the facility fee schedule rate.



See NGS News and Alerts COVID 19

Personal Care Agencies, LTC Providers and FEA's - EVV Update

- The soft Launch of EVV will be November 2
  - iCare will not deny claims for missing or inaccurate information during soft launch
  - iCare will communicate with providers when errors are identified
    - If you are not currently in communication with Provider Relations, please send your contact information to providerrelationsspecialist@icarehealthplan.org
  - iCare will not require EVV for Live-In workers
    - Claims should be submitted with KX modifier to bypass EVV requirements
- **IMPORTANT**: If you are not a Medicaid-enrolled agency (and we anticipate many supportive home care agencies are not), you will need to request a provider agency ID through the ForwardHealth portal. Please refer to page 18-19 of the following ForwardHealth Update for instructions on how to request a provider agency ID: ForwardHealth Update 2020-31, "Implementation of Electronic Visit Verification for Personal Care and Supportive Home Care Services"
- EVV Training of the Sandata system is available via DHS, please visit https://www.dhs.wisconsin.gov/evv/training.htm to sign up
- Please check DHS website regularly for updates: https://www.dhs.wisconsin.gov/evv/index.htm

Electronic Claim Submission

*i*Care is partnered with one of the nation's leading claims clearinghouse, SSI Claimsnet, to allow electronic claims submission. Save time and reduce costs as you increase office productivity and eliminate costly delays in reimbursement.

To register with SSI Claimsnet for electronic claims submission via the Internet, https://products3.ssigroup.com/ProviderRegistration/register Select *i*Care in the payer drop down box on the registration form to avoid paying any set-up or submission fees for your *i*Care claims through SSI Claimsnet.

Providers who do not have an NPI, please enter 9999999999 in the *required field

*i*Care's EDI payer ID code is 11695. Registration can be done on-line, and you can immediately take advantage of on-line claims submission, real-time error reporting and payor updates.

Please submit questions to Helpdesk_Dallas@ssigroup.com or call 800-356-0092.

ForwardHealth Billing Reminders When Submitting Claims for Vaccinations

- See the COVID-19: ForwardHealth Provider News and Resources Portal page

Reminder: Mental Health/Substance Abuse Travel Code

- When billing 99082 for travel the Place of Service should be 99

iCarehealthplan.org

Please be sure to visit our website which has many resources related to Claims, Prior Authorizations, Education, the Provider Portal and more.

Prior Authorization Reminders

- Please continue to properly utilize our Prior Authorization request form found on our website: https://www.icarehealthplan.org/Prior-Authorization.htm.
- When completing this form, we ask you to observe the Center for Medicare Services (CMS) definition for an "urgent" request.
    - CMS defines urgency as "when the treatment requested is required to prevent imminent, serious deterioration in the member's health or threatens to jeopardize the members ability to regain maximum function."
- Any request that does not meet this requirement should be marked standard. Standard requests have a 14-day processing time however iCare will do its best to process your requests faster.
- Utilize the check boxes on the Prior Authorization form to delineate level of urgency. This allows us to quickly and correctly identify your request when it comes in.
- *Example*

Member Information			
Member Name:		**DOB:**	
Member ID#:		**Phone:**	
Service Type:	☐ Elective/Routine (14-day turnaround time)	☐ Expedited/Urgent* (72-hr. turnaround time)	