



iCare Guide for Hospice
CLAIMS PROCESSING OVERVIEW

Disclaimer:

- This information is provided as a courtesy from *iCare* to assist you with claims submission and billing. This does not replace Forward Health and CMS Guidelines. *iCare* relies upon Forward Health and CMS for payment rules and regulations for claim submission.

Hospice Services – Prior Authorization

- Hospice services must be requested in 60 day increments
- Ongoing services must be requested and will continue to require an updated signed physician's order/plan of care. For ongoing services, all PA requests are required to be submitted within 14 days after the expiration date of the previous authorization.
- *iCare* will not retro authorize any services submitted after the 14th day.

Please see our website for procedure specific list and forms

- <https://www.icarehealthplan.org/Prior-Authorization.htm>

Medicaid Services

- Hospice Services are provided to members based on the following categories of hospice care
 - Routine Care, with per diem rate for less than 8 hours of care per day
 - Continuous Care, with an hourly rate for 8 to 24 hours of care per day
 - Inpatient Respite Care, hospital or Skilled Nursing Facility (SNF) meeting SNF staffing, hourly and environmental requirements
 - General Inpatient Care, Hospital or SNF
 - Other Functions; PT, OT, SLP DME/DMS Drugs for pain relief or symptom control
 - See ForwardHealth On-Line Handbook for further information

Medicaid Services Cont.

- Hospice Services when in SNF
 - The Hospice reimburses the SNF for Medicaid SSI Members SNF Room and Board
 - iCare reimburses the SNF for Medicaid Family Care Partnership members SNF Room and Board
 - Submit claims with Rev Code 169 to be reimbursed 95% of RUG rate
- See ForwardHealth On-Line Handbook for further information


Medicaid Service Cont.

- iCare is requiring providers to submit the Notification of Hospice Benefit Election Form F-01008 when requesting prior authorization (PA) for hospice services. If the F-01008 form is not included, the PA will be denied for lack of information.
- Per ForwardHealth (Update 2015-64), MCOs will require their providers to submit to the MCO Form F-01008 Notification of Hospice Benefit Election. The MCO will forward the form to DXC at the address indicated on the form. DXC will put a hospice lock-in segment on file for the member to allow Code T2042 to price for encounters in the same manner as it does fee-for-service.
- The form can be found on the DHS website:
<https://www.dhs.wisconsin.gov/library/f-01008.htm>

Medicare Services

- Services covered by the *iCare* Medicare plan include Hospice Care
- The first election is for a 90-day period. An individual may elect to received coverage for two 90-day periods, and an unlimited number of 60-day periods.
- Hospice Notice of Election statement is required to be filed within 5 calendar days after hospice election to CMS

Clean Claim Guidelines – UB04

|  iCare Requirements for Clean Claim (UB-04) | | |
|---|-------------------------------|---|
| Box | Description | Comments |
| 1 | Provider Name and Address | |
| 4 | Bill Type | |
| 5 | Federal Tax ID | |
| 6 | Statement Covers Period | From and Through Dates of Claim |
| 8b | Patient Name | |
| 9a-e | Patient Address | |
| 10 | Date of Birth | |
| 11 | Patient Sex | |
| 12 | Admission Date | Required Inpatient, Home Health and SNF |
| 14 | Admission Type | Inpatient claims only |
| 15 | Admission Source | |
| 17 | Discharge Status | Not required for rural health or federally qualified clinics. |
| 18-28 | Condition Codes | |
| 29 | Accident State | |
| 42 | Revenue Codes | If Revenue code of 0022, 0023, 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing |
| 44 | HCPCS/Rate | Required based on Type of Bill |
| 45 | Service Date | |
| 46 | Service Units | |
| 47 | Total/Line Item Charges | Negative Amount: Claim will reject for "No Dollar Amount". Total Charges must equal the sum of the line item charges or claim will reject "Total charge does not match line charge totals". Total charges with claim with Revenue Codes 0022, 0023, 0024 may be zero. |
| 49 | Unlabeled | |
| 56 | NPI | |
| 57a-57c | Other Provider ID | |
| 58a | Insured's Name | |
| 59a | Relationship to Uninsured | |
| 60a | Insured Identification Number | |

Claims Filing Limits

- Timely filing limits for all providers is 120 days from the date of service, unless otherwise agreed upon and included in the Provider's service agreement with *iCare*.
- Providers are to submit all claims for services rendered where *iCare* Medicare is primary or *iCare* Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

iCare follows CMS and ForwardHealth Claim Guidelines:

ForwardHealth Website Link:

<https://www.forwardhealth.wi.gov/WIPortal/>

CMS Website Link: <https://www.cms.gov>

ForwardHealth/Home Health Handbook:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx>

Centers for Medicare and Medicaid Information:

<https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html>

iCare Provider Portal Access

- Your time is valuable. *iCare's* Provider Portal allows you to view prior authorizations, service requests, verify eligibility and view claim information for the *iCare* members you serve.
- **Getting Started**
- Registration can be completed with information already at your disposal using your TIN (Tax ID Number), NPI and most recent check number. Use the Facility/Group name as listed on your Explanation of Payment. *iCare* can also generate a one-time PIN, you can request a one-time PIN via the request button below. **If you have checks with more than 20 claims processed your will need to request a PIN to register.**
- If you do not receive your PIN, please contact *iCare* at ProviderRelationsSpecialist@iCareHealthPlan.org for additional assistance.
- If an organization chooses to assign roles for the employees, the Office Manager will need to create a user account for the users within your organization. Office Managers can set up additional users individually and invite them to register or you can create user accounts in bulk via spreadsheet upload.
- The ***iCare Portal User Guide*** provides step by step instructions for registration and outlines functionalities. If you have any questions, please contact ProviderOutreach@iCareHealthPlan.org or ProviderRelationsSpecialist@iCareHealthPlan.org
- Use care when entering your password in the Provider Portal. If the incorrect password is attempted 3 times, your account will be locked. If you are not able to reset your own password or retrieve your forgotten password, email ProviderOutreach@iCareHealthPlan.org or ProviderRelationsSpecialist@iCareHealthPlan.org. Include your Username and your password will be reset within 24 hours.

GENERAL CONTACT/INDIVIDUAL DEPARTMENT PHONE AND FAX NUMBERS

MAIN NUMBER

414-223-4847 or 800-777-4376

Claims/Appeals/Reconsiderations

Local: 414-231-1029

Fax: 414-231-1094

Out of Area: 877-333-6820

Email: providerservices@icarehealthplan.org

Eligibility and Provider Services

Local: 414-231-1029

Fax: 414-231-1094

Out of Area: 877-333-6820

Prior Authorization

Local: 414-299-5539

Out of Area: 855-839-1032

Fax: 414-231-1026

Provider Contracting

414-225-4741

Fax: 414-272-5618