PCW Institutional Outpatient Claim Submission via iCare Provider Portal

Log on to iCare Provider Portal  Provider Portal

From the menu on the left side select Claims, next select create claim, (see screen shot 1)

Next select member name (enter member last name , first name, date of birth or member Medicaid id) click on search, (This will bring up the members name) verify your member is correct, click next

Claim Type (Required) select Institutional Outpatient Claim, click next.

Provider Information
Select the claim type, provider name, and the service address.
Select Claim Type (Required) = Institutional Outpatient Claim

Type of Bill
Click next, Facility Type (Required) – 32 Home Health Services

**Frequency** 4 – options
01 – Admit through Discharge
02 – First Interim Claim
03 – Continuing Interim Claim
04 – Last Interim Claim

**Statement From Date and Statement To Date**
MM/DD/YYYY through MM/DD/YYYY

**Admission Details**
**Admission Date** (the date the member started care) enter MM/DD/YYYY

**Admission Hour**
Select Admission time 00 to 18

**Type of Admission**
Select Options 1 to 9

**Admission Sources**
Select Options 0 to 9 or C to F

**Discharge Details**
Discharge Date (the though date on claim) enter MM/DD/YYYY
Discharge Hour (Required)
Select Discharge time 00 to 18

Discharge Status (Required)
Select Options 0 to 11 or 30

Select the ICD type & primary Diagnosis Code to enter service details.

ICD Type (Required)
Select – ICD 10

Primary Diagnosis Code (Required)
Enter valid IDC10 for the member

POA Indicator (*not a required field)
Present on Admission (POA) – means the primary diagnosis was present at the time admission occurs
Select Yes, No, Unknown, Clinically Undetermined or Exempt

Accept Assignment check box
indicate whether you agree (or is required by law) to accept the Medicare-approved amount as full payment for covered services

Service Line 1
Date of Service From Date and Date of Service To Date
MM/DD/YYYY through MM/DD/YYYY

Revenue Code
Enter - room and board Rev (example: 0570)

CPT/HCPCS
Enter valid code, must be a 5 digit/character code.
  •  T1019

Enter Modifiers
Example, U3 or KX

Units (Required)
Enter – number of units/days

Unit Type (Required)
Select unit type = Days

Charge (Required)
Calculate – Rev code rates x number of days – Enter Charge amount

Click + Add Service Line to submit additional charges

**Once the fields are complete on each service line, click View Estimate**

Next

Confirm Claims Service Line is correct. Next Submit Claim

Please be sure to review your claim to ensure accuracy. Any corrected claims will need to be submitted on the hard copy UB04 claim form.

**Corrected Claims**

Follow the above instructions to submit a claim. But, use the following Frequency in the Statement Summary

Frequency 06 – adjustment of a prior claim (make changes to a paid claim)
Frequency 07 – Replacement of a prior claim (make changes to a denied claim)
Search by:

- Member ID
- Member Name
- Subscriber ID

Member ID: 440297

Member Information:
- Group ID: TZSPONSOR000114
- Age: 30
- Status: Eligible

Address:
C/O WCS, 3734 W WISCONSIN AVE, MILWAUKEE, WI 53208

Select the claim type, provider name, and service address.

- Claim Type: Institutional Outpatient Claim
**Service Details (Required)**

Select the ICD type & primary Diagnosis Code to enter service details.

<table>
<thead>
<tr>
<th>ICD Type</th>
<th>(Required)</th>
<th>Primary Diagnosis Code</th>
<th>(Required)</th>
<th>POA Indicator</th>
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<tbody>
<tr>
<td>ICD-10</td>
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<td>202</td>
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</table>

**Service Line 1**

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<thead>
<tr>
<th>Data of Service From</th>
<th>(Required)</th>
<th>Date of Service To</th>
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<tbody>
<tr>
<td>04/18/2023</td>
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<td>04/18/2023</td>
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</tbody>
</table>

Enter KX Modifier for Live In Workers ONLY
<table>
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<tr>
<th>NDC Code</th>
<th>Units</th>
<th>Unit Type</th>
<th>Charge</th>
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Select unit type:
- Units
- Minutes
- Days

Additional columns and fields may exist but are not visible in the image.