LTC Residential 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 Inpatient Claim**, click **next**.

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

Type of Bill
Click next , Facility Type (Required) 21- Inpatient skilled nursing
*note this facility type with the closet match to a residential facility for UB04 submissions

Frequency 3 – options
01 – Admit through Discharge
02 – First Interim Claim
03 – Continuing Interim Claim
04 – Last Interim Claim

When entering the above Facility Type and Frequency, they will be converted as follows for residential facility/AFH

21 01 will be: 861 – Respite Services
21 02 will be: 862 – First claim for Client
21 03 will be: 863 – Continuous claim for Client
21 04 will be: 864 – Last claim for Client

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

Admission Details
Admission Date (the date the member came to your facility) enter **MM/DD/YYYY**

Admission Hour
Select – admission time = **00**

Type of Admission

Select – 9 – Information Not Available

Admission Sources
Select – 9 – Information Not Available

Discharge Details
Discharge Date (the though date on claim) enter **MM/DD/YYYY**

Discharge Hour (Required)
Select – discharge time = **00**

Discharge Status (Required)
Select – discharge status = 30 – Still patient

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

ICD Type (Required)
Select – ICD 10

Primary Diagnosis Code (Required)
Enter – Z02.9

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: 0120)

CPT/HCPCS (previously referred to as HIPAA)
Enter the code that is approved on your Service Request, it must be a 5 digit/character code.

- If a CPT/HCPCS is not provided, use only the Revenue code

Modifier

- Enter a comma between modifiers when entering more than one modifier.

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

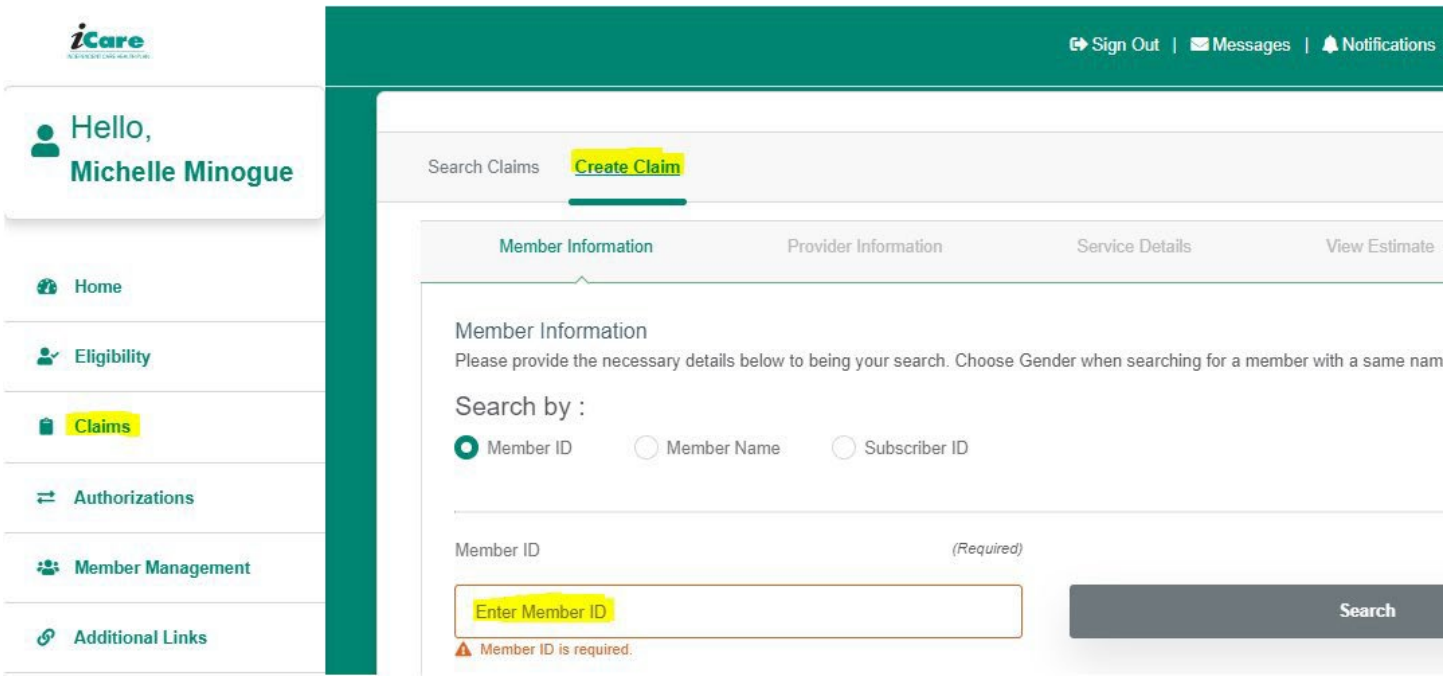
Please be sure to review your claim to ensure accuracy. Any corrected claims will need to be submitted on the hard copy LTC Residential Claim form.

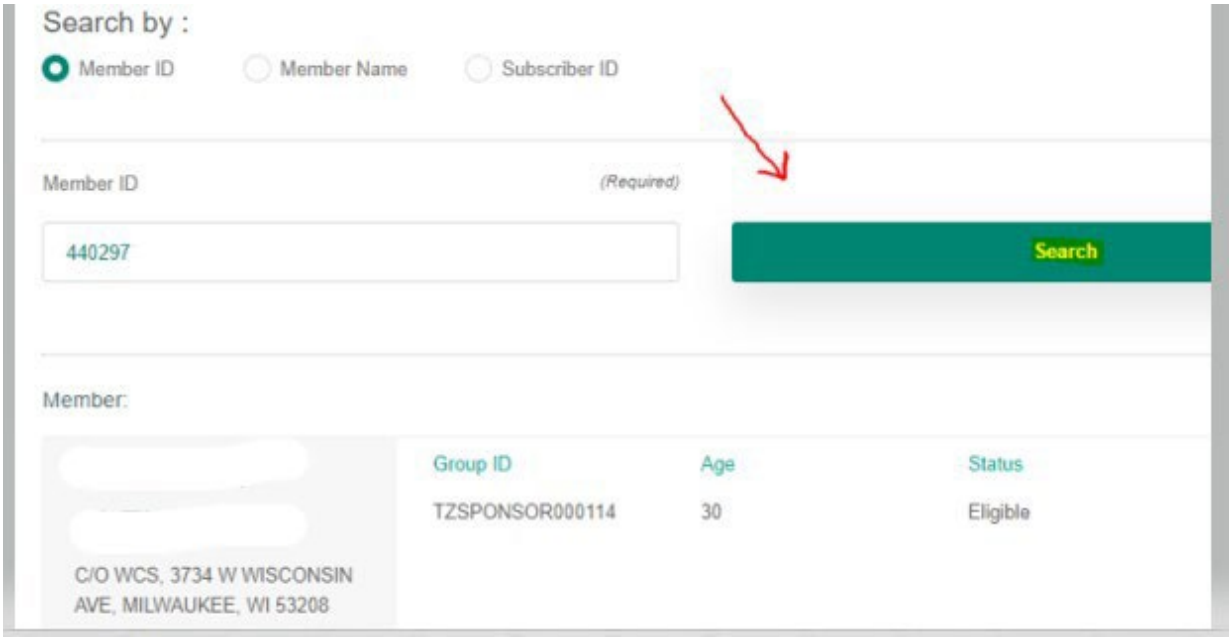
Corrected Claims

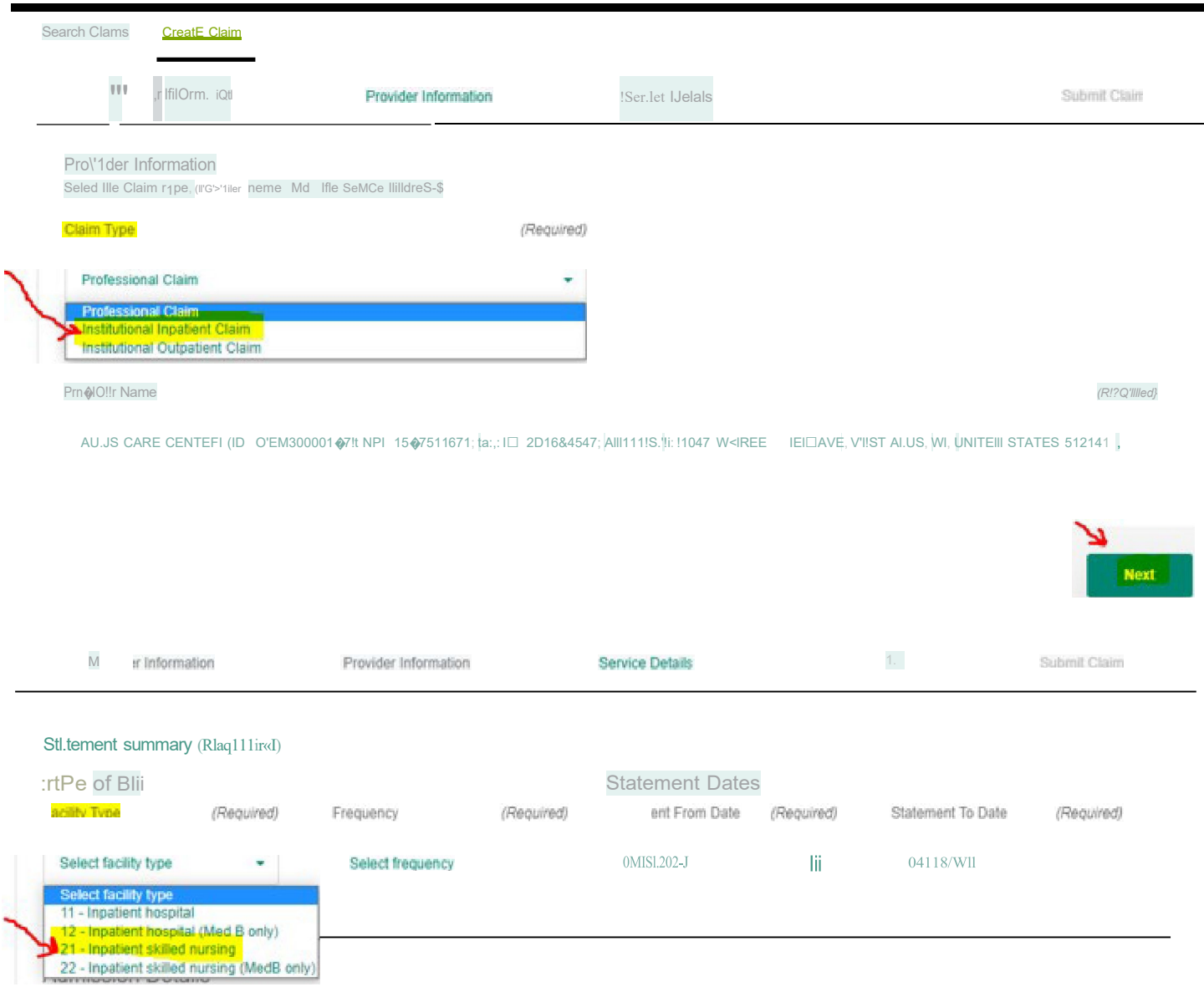
Follow the above instructions to submit a claim. But, use the following Frequency in the Statement Summary

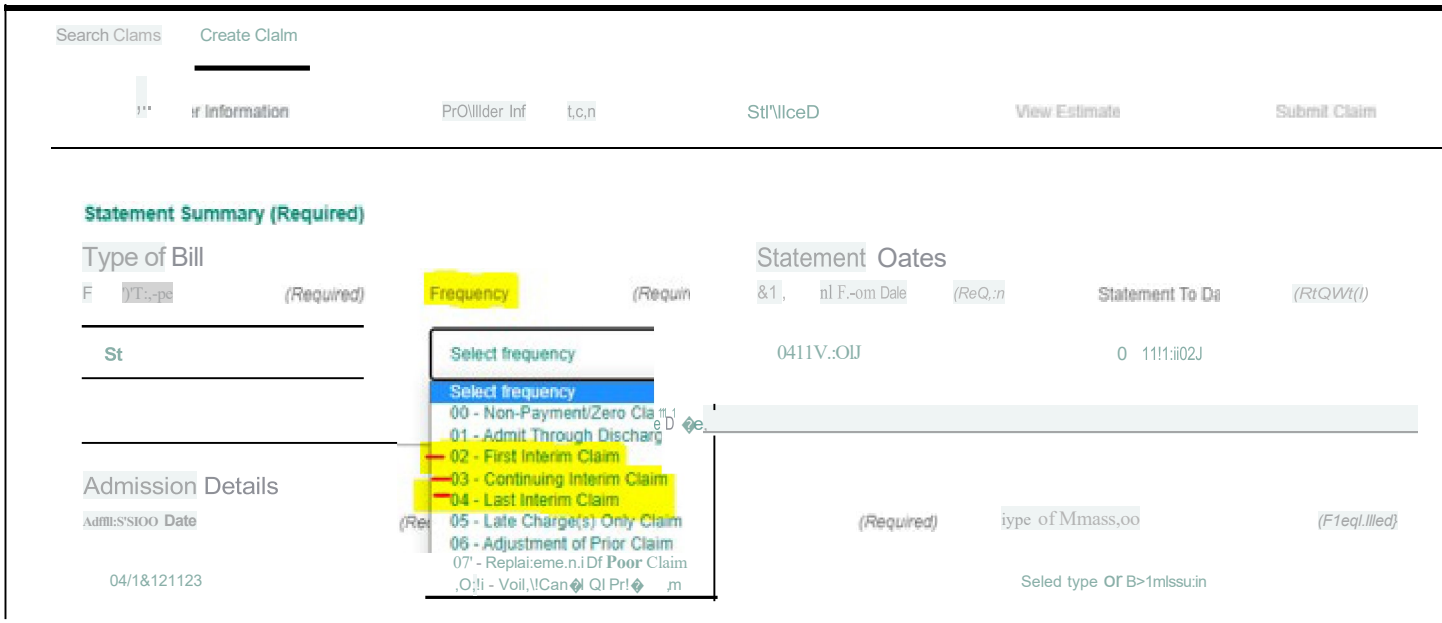
Frequency 06 – adjustment of a prior claim (make changes to a paid claim)
Frequency 07 – Replacement of a prior claim (make changes to a denied claim)

Screen Shot 1






Search Clams
CreatE Claim
Provider Information
Submit Claim
Pro\'1der Information
Claim Type
(Required)
Professional Claim
Professional Claim
Institutional Inpatient Claim
Institutional Outpatient Claim
Next
Provider Information
Service Details
Submit Claim
Stl.tement summary
Statement Dates
Frequency
(Required)
Statement To Date
(Required)
Select facility type
Select frequency
Select facility type
11 - Inpatient hospital
12 - Inpatient hospital (Med B only)
21 - Inpatient skilled nursing
22 - Inpatient skilled nursing (MedB only)



Statement summary (Required)

Type of Bill

Facility Type *(Required)*: 21 - Inpal!ient skilled nursing

Frequency *(Required}*: 02 - First Interim Claim

Statement Dates

Statement From Date *(Required)*: 04/18/2023

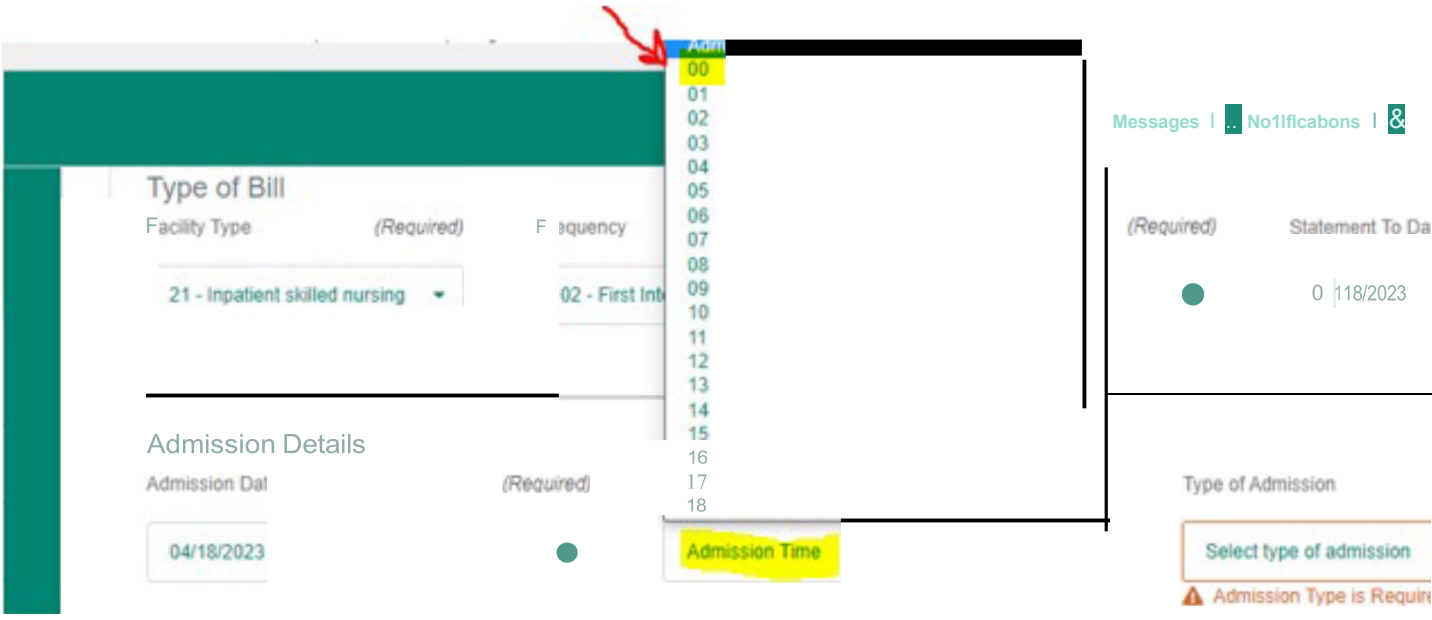
Statement To Date *(Required)*: 04/18/2023

Admission Details

Admission Date *(Required)*: 0411812023

Admission Hour *(Required)*: 17

Type of Admission: Select type of admission


Type of Bill
Facility Type
(Required)
21 - Inpatient skilled nursing
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Messages
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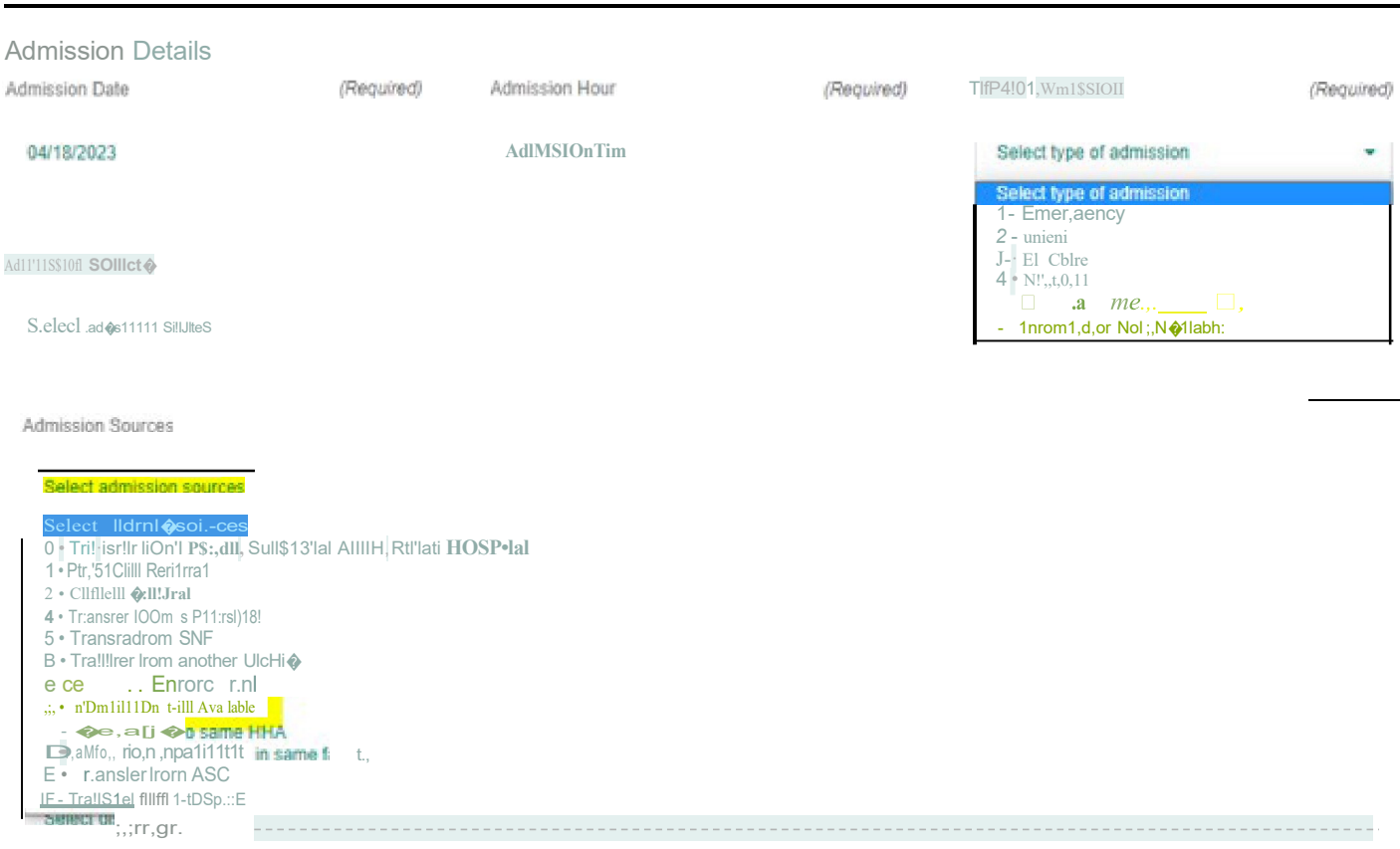
(Required)
Statement To Da
0 118/2023
Admission Details
Admission Dat
(Required)
04/18/2023
Admission Time
Type of Admission
Select type of admission
Admission Type is Require


Admission Details
Admission Date
(Required)
04/18/2023
Admission Hour
(Required)
AdlMSIOnTim
Select type of admission
Select type of admission
1- Emer,aency
2 - unieni
J- El Cblre
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Admission Sources
Select admission sources
Select lldrnl soi.-ces
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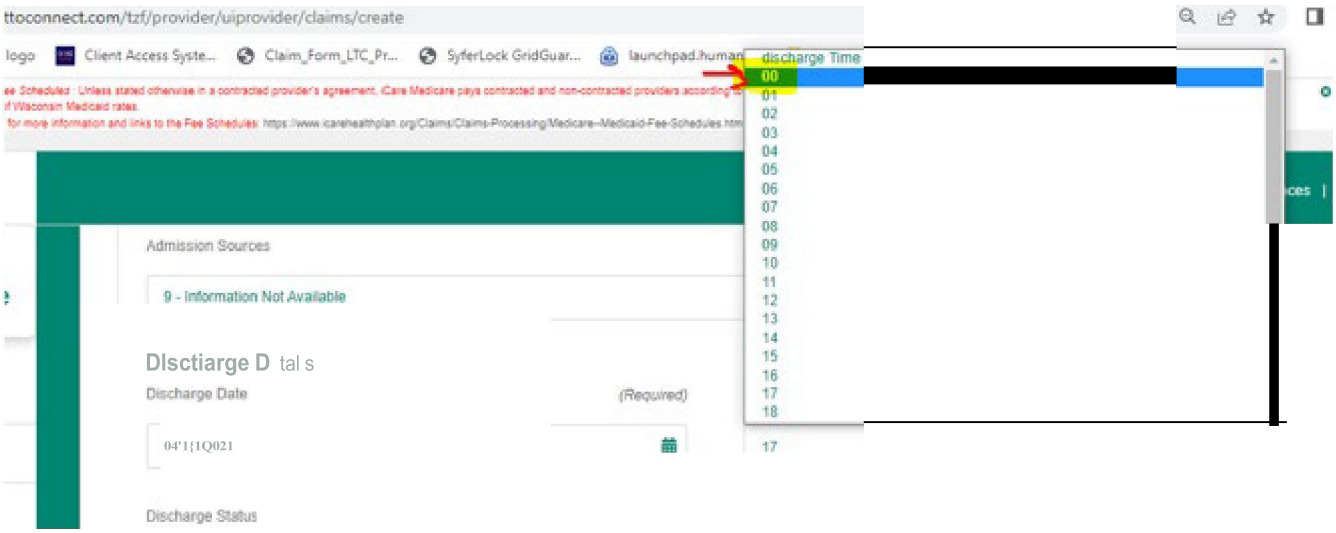
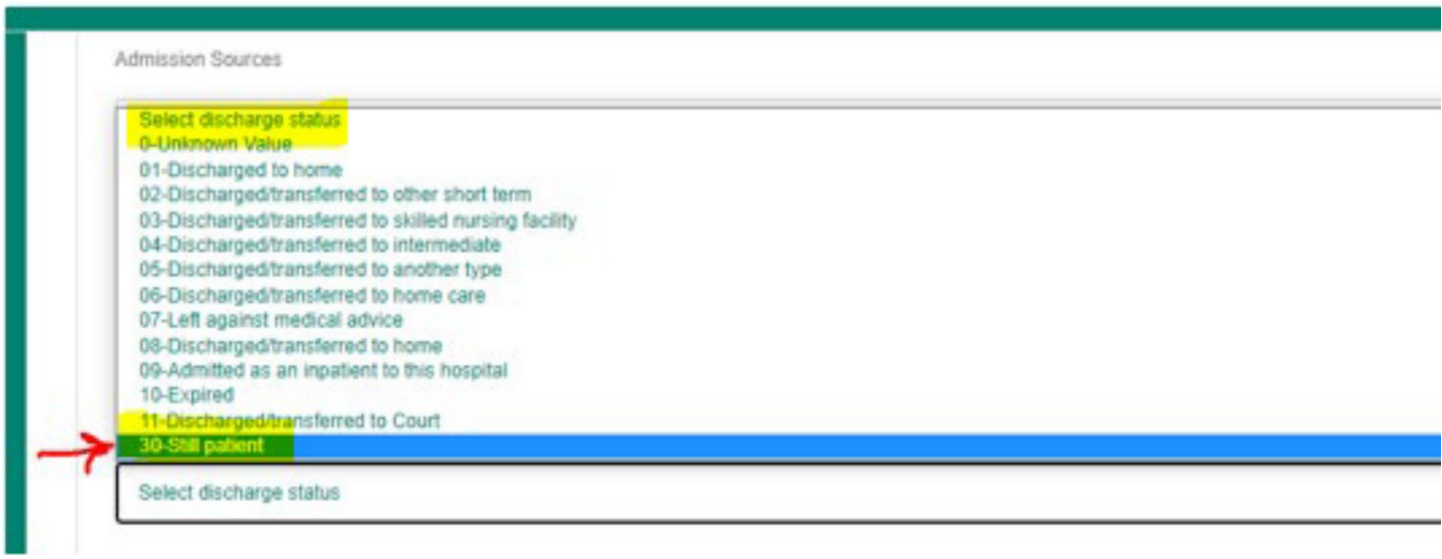
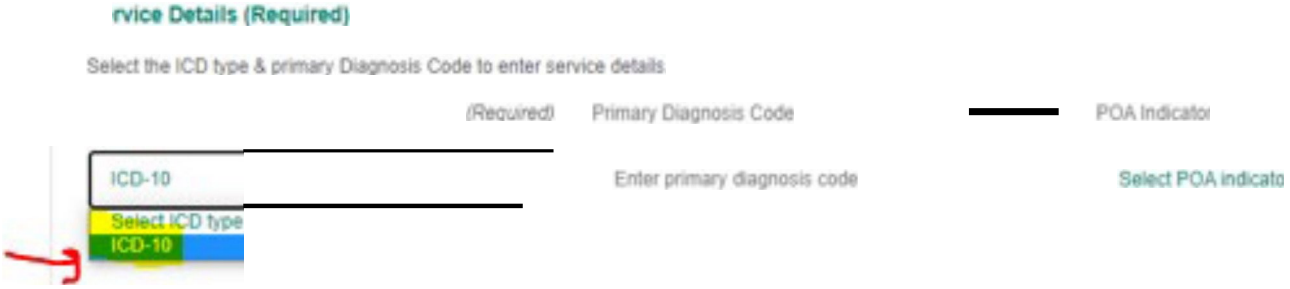
Discharge Details

Discharge Da e (Required) Discharge Hour

04/1812023 iii 17







Service Details (ReQuired}

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

ICDType	(Required)	Pri aIY. Diagnosis Code	(Required)	POA Indicalor
ICD-10		Z02.9		Select POA tndicator

Service Line 1

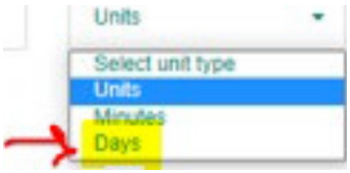
Date of Service From	(Required)	Date of Service To
0 I&I.2023		04/18/2023

Revenue Code	CPT/HCPCS	Modifiers
Enter Revenue Code Q	Enter CPT / HCPCS Q	Enter modifiers

Revenue Code	CPT/HCPCS	Modifiers
0120 Q	Enter CPT / HCPCS Q	Enter modifiers

NOC Code	Units	Regu1redl	Unit Type	(Required)	Charge	(Required)	Amt
Enter NDC code Q			Units	...	$0.00		Z

NDC Code	(Required)	Unit Type	(Required)	Charge	(Required)
Enter NDC code		Units		0	



NOC Code	Units	(Re.quired)	Unit Type	(Required)	Charge	(Required	An
Enter NOC code	1		Units				

Claims Service Line

Service Date(s)	Revenue Code	Charged	Allowed	Plan Discount	Copay	Coinsurance	Deductible	Member Responsibility	F F
04118J2023-04118J2023	0120	51.00	$0.00	$1.00	$0.00	$0.00	$0.00	$0.00	

CPT Description

0120-Room & Board - Semi-private [Two Beds