INDEPENDENT CARE HEALTH PLAN

*i*Care Guide for Long-Term Care
Claims Processing Overview

Reviewed: December 2020

Long-Term Care Overview on Services and Claims

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

Abbreviations

- LTC – Long-Term Care
- FCP – Family Care Partnership
- AODA – Alcohol and Other Drug Abuse
- PERS – Personal Emergency Response System
- IDT – Interdisciplinary Team
- DOS – Date of Service
- EOP – Explanation of Payment
- SDS – Self Directed Supports

Definition of LTC Services

- Long-Term Care Services include a broad range of health, personal care, and supportive services. These services include assistance with activities (ex: dressing, bathing and toileting), instrumental activities (ex: medication management and housework), and health maintenance tasks.
- These services are meant to assist or improve the Member's quality of life.

Long-Term Care Services

- Adaptive Services (general and vehicle)
- Adult Day Care
- AODA Services
- Assessment and Case Planning
- Case Management
- Alternative Treatments
- Communication Aids/Interpreter Services
- Community Support Programs
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Durable Medical Equipment
- Financial Management Services
- Home Health Care Services
- Home Modifications
- Housing Counseling

Eligible LTC Services

- Services rendered will be provided to *i*Care FCP Members through our network of contracted providers.
- All LTC services **MUST** be authorized through the IDT **PRIOR** to services being rendered.
- The service request will outline the specific services and rate of reimbursement authorized.
- For all **Emergency** situations, the Provider is required to contact the IDT as soon as possible.
- Professional LTC services include
  - Supportive Home Care
  - Attendant Care
  - Respite Care, etc.

Requesting Services

- Services can be requested by Members, Guardians or Providers.

- The IDT needs the following information:
  - Member Name & Date of Birth
  - Description of services to be provided and the HCPCS code
  - Units and frequency of service(s)
  - Dates of Service
  - Service Location

- Questions regarding service requests should be directed to the Member's Care Manager.

SR Date and Claim Dates

- If an SR is approved with an end date in the middle of a month, providers need to bill per the SR dates in order for the claim system to pick up the SR and apply the unit counts appropriately.
  - The claim system cannot apply two SR's to one claim.
- Example:
  - SR is approved for 1/6/2020 through 3/6/2020. The next SR is approved for 3/7/2020 through 6/7/2020.
  - The March claim must be billed as two claims, 3/1-3/6/2020 and 3/7/2020-3/31/2020 (or beyond) in order for them to process correctly and apply the appropriate PA/SR and units.

Electronic Visit Verification (EVV)

- iCare will not require Live-in Workers to use EVV
  - Submit claims with the KX modifier to bypass EVV requirements
  - Live in worker status must be verified by the provider agency annually.
- All supportive care services will require an EVV to match the services submitted on the claim
- EVV can be updated at anytime to match the claim. If a claim denial occurs prior to the update, a request for review can be submitted within the Review/Reopen Guidelines found here: https://www.icarehealthplan.org/Claims/Claims-Processing.htm (Claim Review/Adjustment Guidelines)
- Please see our EVV Guide for additional details: https://www.icarehealthplan.org/Education/Resources.htm

Claim Submission

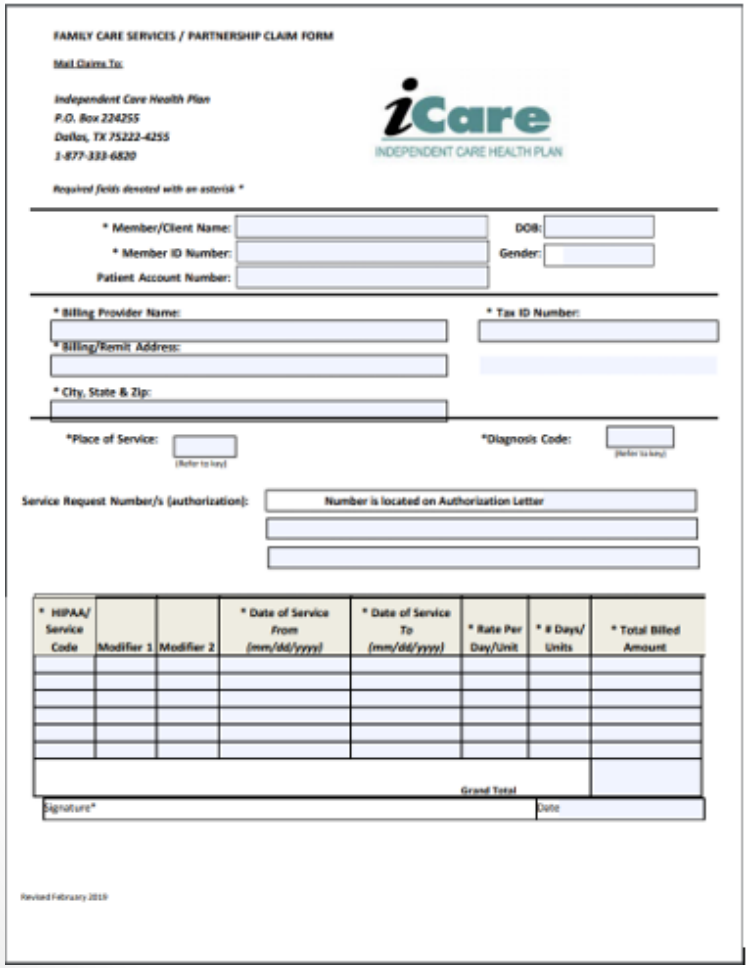
- LTC claims are submitted either on the LTC Professional or LTC Residential claim forms.
- Medicare/Medicaid services are submitted on either the CMS 1500 or UB04 claim forms.

NOTE: Any Medicaid claims related to a Family Care Partnership member may not submit review/reopening request. Providers will need to submit a corrected claim or a formal appeal.

https://www.icarehealthplan.org/Claims/Claims-Processing.htm

LTC Professional Claim Form

www.icarehealthplan.org/providers



FAMILY CARE SERVICES / PARTNERSHIP CLAIM FORM

Mail Claims To:

Independent Care Health Plan
P.O. Box 224255
Dallas, TX 75222-4255
1-877-333-6820

iCare
INDEPENDENT CARE HEALTH PLAN

*Required fields denoted with an asterisk **

* Member/Client Name:
DOB:
* Member ID Number:
Gender:
Patient Account Number:

* Billing Provider Name:
* Tax ID Number:
* Billing/Remit Address:
* City, State & Zip:

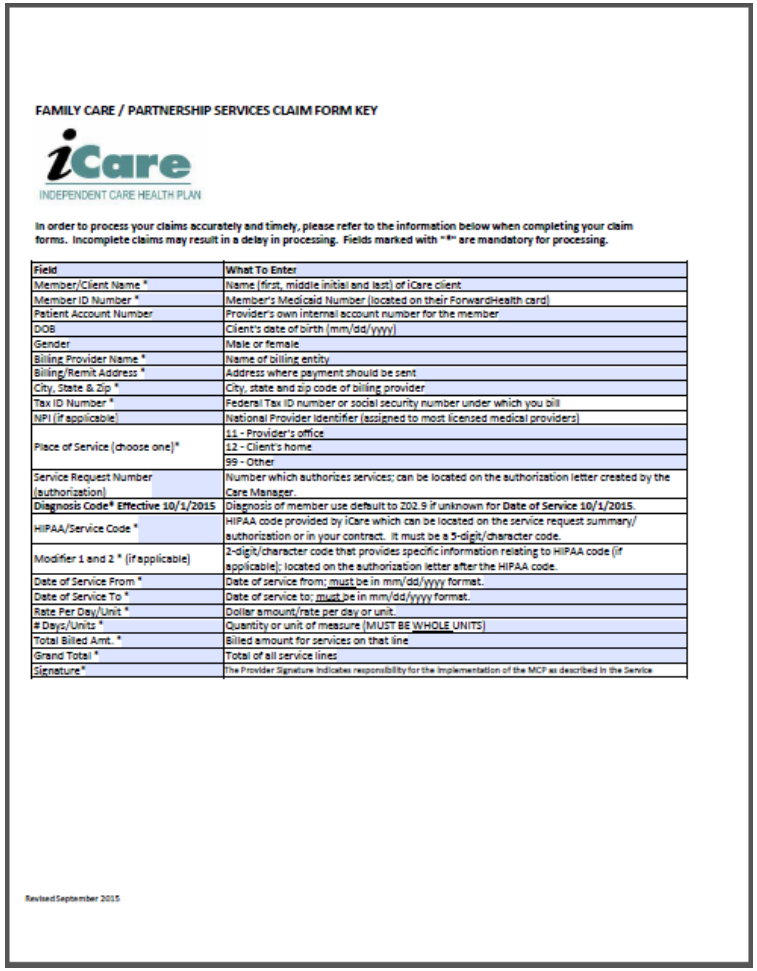
*Place of Service:
(Refer to key)
*Diagnosis Code:
(Refer to key)

Service Request Number/s (authorization):
Number is located on Authorization Letter

* HIPAA/ Service Code	Modifier 1	Modifier 2	* Date of Service From (mm/dd/yyyy)	* Date of Service To (mm/dd/yyyy)	* Rate Per Day/Unit	* # Days/ Units	* Total Billed Amount
				Grand Total			

Signature*
Date

Revised February 2019



FAMILY CARE / PARTNERSHIP SERVICES CLAIM FORM KEY

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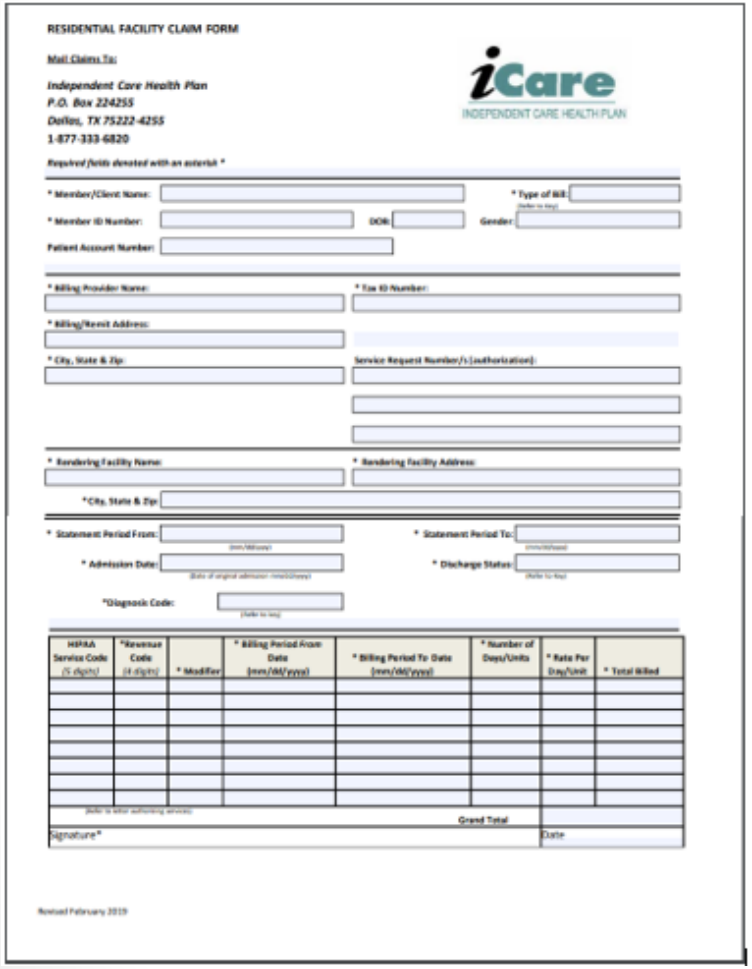
In order to process your claims accurately and timely, please refer to the information below when completing your claim forms. Incomplete claims may result in a delay in processing. Fields marked with "*" are mandatory for processing.

Field	What To Enter
Member/Client Name *	Name (first, middle initial and last) of iCare client
Member ID Number *	Member's Medicaid Number (located on their ForwardHealth card)
Patient Account Number	Provider's own internal account number for the member
DOB	Client's date of birth (mm/dd/yyyy)
Gender	Male or female
Billing Provider Name *	Name of billing entity
Billing/Remit Address *	Address where payment should be sent
City, State & Zip *	City, state and zip code of billing provider
Tax ID Number *	Federal Tax ID number or social security number under which you bill
NPI (if applicable)	National Provider Identifier (assigned to most licensed medical providers)
Place of Service (choose one)*	11 - Provider's office 12 - Client's home 99 - Other
Service Request Number (authorization)	Number which authorizes services; can be located on the authorization letter created by the Care Manager.
Diagnosis Code* Effective 10/1/2015	Diagnosis of member use default to Z02.9 if unknown for Date of Service 10/1/2015.
HIPAA/Service Code *	HIPAA code provided by iCare which can be located on the service request summary/ authorization or in your contract. It must be a 5-digit/character code.
Modifier 1 and 2 * (if applicable)	2-digit/character code that provides specific information relating to HIPAA code (if applicable); located on the authorization letter after the HIPAA code.
Date of Service From *	Date of service from; must be in mm/dd/yyyy format.
Date of Service To *	Date of service to; must be in mm/dd/yyyy format.
Rate Per Day/Unit *	Dollar amount/rate per day or unit.
# Days/Units *	Quantity or unit of measure (MUST BE WHOLE UNITS)
Total Billed Amt. *	Billed amount for services on that line
Grand Total *	Total of all service lines
Signature*	The Provider Signature indicates responsibility for the implementation of the MCP as described in the Service

Revised September 2015

LTC Residential Claim Form

www.icarehealthplan.org/providers



RESIDENTIAL FACILITY CLAIM FORM

Mail Claims To:

Independent Care Health Plan
P.O. Box 224255
Dallas, TX 75222-4255
1-877-333-6820

iCare
INDEPENDENT CARE HEALTH PLAN

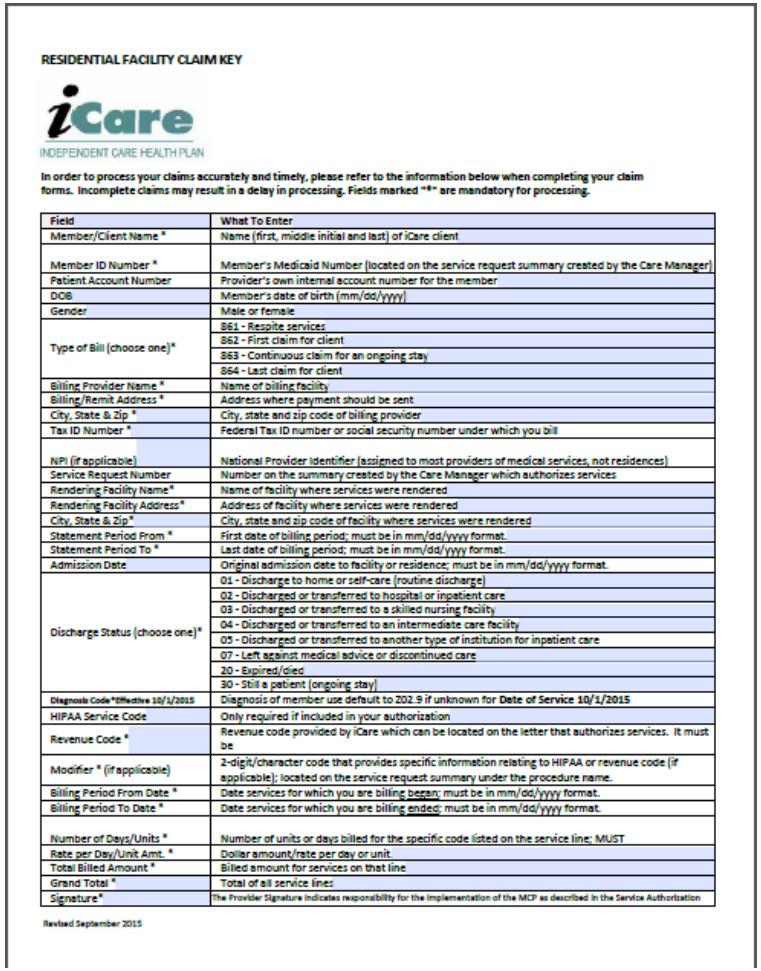
*Required fields denoted with an asterisk **

* Member/Client Name:
* Type of Bill:
* Member ID Number:
DOB:
Gender:
Patient Account Number:
* Billing Provider Name:
* Tax ID Number:
* Billing/Remit Address:
* City, State & Zip:
Service Request Number/s (authorization):
* Rendering Facility Name:
* Rendering Facility Address:
*City, State & Zip:
* Statement Period From:
* Statement Period To:
* Admission Date:
* Discharge Status:
*Diagnosis Code:

HIPAA Service Code (5 digits)	*Revenue Code (4 digits)	* Modifier	* Billing Period From Date (mm/dd/yyyy)	* Billing Period To Date (mm/dd/yyyy)	* Number of Days/Units	* Rate Per Day/Unit	* Total Billed
					Grand Total		

Signature*
Date

Revised February 2015



RESIDENTIAL FACILITY CLAIM KEY

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In order to process your claims accurately and timely, please refer to the information below when completing your claim forms. Incomplete claims may result in a delay in processing. Fields marked "*" are mandatory for processing.

Field	What To Enter
Member/Client Name *	Name (first, middle initial and last) of iCare client
Member ID Number *	Member's Medicaid Number (located on the service request summary created by the Care Manager)
Patient Account Number	Provider's own internal account number for the member
DOB	Member's date of birth (mm/dd/yyyy)
Gender	Male or female
Type of Bill (choose one)*	861 - Respite services 862 - First claim for client 863 - Continuous claim for an ongoing stay 864 - Last claim for client
Billing Provider Name *	Name of billing facility
Billing/Remit Address *	Address where payment should be sent
City, State & Zip *	City, state and zip code of billing provider
Tax ID Number *	Federal Tax ID number or social security number under which you bill
NPI (if applicable)	National Provider Identifier (assigned to most providers of medical services, not residences)
Service Request Number	Number on the summary created by the Care Manager which authorizes services
Rendering Facility Name*	Name of facility where services were rendered
Rendering Facility Address*	Address of facility where services were rendered
City, State & Zip*	City, state and zip code of facility where services were rendered
Statement Period From *	First date of billing period; must be in mm/dd/yyyy format.
Statement Period To *	Last date of billing period; must be in mm/dd/yyyy format.
Admission Date	Original admission date to facility or residence; must be in mm/dd/yyyy format.
Discharge Status (choose one)*	01 - Discharge to home or self-care (routine discharge) 02 - Discharged or transferred to hospital or inpatient care 03 - Discharged or transferred to a skilled nursing facility 04 - Discharged or transferred to an intermediate care facility 05 - Discharged or transferred to another type of institution for inpatient care 07 - Left against medical advice or discontinued care 20 - Expired/died 30 - Still a patient (ongoing stay)
Diagnosis Code*Effective 10/1/2015	Diagnosis of member use default to 202.9 if unknown for **Date of Service 10/1/2015**
HIPAA Service Code	Only required if included in your authorization
Revenue Code *	Revenue code provided by iCare which can be located on the letter that authorizes services. It must be
Modifier * (if applicable)	2-digit/character code that provides specific information relating to HIPAA or revenue code (if applicable); located on the service request summary under the procedure name.
Billing Period From Date *	Date services for which you are billing began; must be in mm/dd/yyyy format.
Billing Period To Date *	Date services for which you are billing ended; must be in mm/dd/yyyy format.
Number of Days/Units *	Number of units or days billed for the specific code listed on the service line; MUST
Rate per Day/Unit Amt. *	Dollar amount/rate per day or unit.
Total Billed Amount *	Billed amount for services on that line
Grand Total *	Total of all service lines
Signature *	The Provider Signature indicates responsibility for the implementation of the MCP as described in the Service Authorization

Revised September 2015

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 *i*Care.
- Providers are to submit all claims for services rendered where *i*Care Medicare is primary or *i*Care Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

Frequently Asked Questions

- Do all LTC services require service request/authorization?
  - Yes, Service Requests are required for all services and must be received before services are rendered.
- Can LTC claims be submitted electronically?
  - LTC Professional claims may be submitted through the provider portal. LTC Residential claims may **NOT** be submitted through the provider portal; rather mailed to our PO Box in Dallas, TX.
- Why is my claim denying?
  - Claims can deny for many reasons. It is very important to make sure that you are comparing the claim to the service request on file.
  - Things to check on the service request are rate per day or rate per unit.
  - **Was the correct HCPCS/Revenue Code and modifier (if applicable) used?**
  - Is the date span within the service request timeframe?
  - **Do the claim's line-item totals and grand total calculate**?

iCare Provider Portal Access

Your time is valuable.

This portal provides you with access to current member eligibility information, claims status and authorization status at your convenience.

A PIN letter containing your unique PIN number is provided by *i*Care and is required to access the Provider Portal. You can request a PIN number by emailing the completed Portal Access Request Form to netdev@icarehealthplan.org.

The iCare Portal User Guide provides step by step instructions for registration and outlines existing functionalities. If you have any questions, please contact ProviderOutreach@icarehealthplan.org.

https://www.icarehealthplan.org/Provider/Provider_Portal.htm

*i*Care Contact Information

Customer Service-Milwaukee Office
(Monday-Friday 8:00-5:00)

Provider Local: 414-231-1029
Out of Area: 1/877-333-6820
Email:
providerservices@icarehealthplan.org

iCare Dane County Office
1-800-777-4376

Prior Authorization
Local: 414-299-5539
Out of Area: 855-839-1032
Fax: 414-231-1026

Interdisciplinary Team
414-231-4847

Member Rights Specialist
414-231-1076
Fax: 414-231-1026

Pharmacy
1-800-910-4743
1-877-333-6820

Provider Contracting
414-225-4741
FAX: 414-272-5618