



INDEPENDENT CARE HEALTH PLAN

iCare is a wholly-owned subsidiary of Humana

iCare Guide for Personal Care Worker (PCW)
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.

Personal Care Services - Definition

- §DHS 107.112, covered personal care services are medically-oriented activities related to assisting a Member with ADL necessary to maintain the Member in their place of residence in the community.
- Personal care services are covered when provided by a Medicaid-enrolled personal care provider to a Member enrolled in BadgerCare Plus or Medicaid according to policies and procedures.
- Covered services are required to have written orders of a physician and a written plan of care. All covered personal care services must be supervised by an RN supervisor. The services must be medically necessary and be provided by individuals who are trained in a manner that is in compliance with licensing and certification requirements.

Personal Care Services– Prior Authorization (PA)

- *iCare* requires all initial Personal Care Worker (PCW) referrals in the SSI or BadgerCare+ programs, that request three or more hours per day, to include a personal needs assessment prior to submitting the Prior Authorization.
- This personal needs assessment must be conducted by Holistic Home Health Care or Independence First for selected *iCare* SSI or BadgerCare+ enrollees residing in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha Counties.
- Contact information and Referral Forms can be found on our website:
<https://www.icarehealthplan.org/Prior-Authorization/Prior-Authorization-Documents/Personal-Care-Worker-PCW1.htm>

Personal Care Services– PA Cont.

- ***ForwardHealth requires persons who are requesting authorization for Personal Care (PC) service to complete and submit the Personal Care Screening Tool (PCST) form. Please see the instructions prior to completing the PCST form.***

PCW Provider Guide and Referral Process

PCW Provider Guide

PCW Referral Process

iCare PCW Prior Auth Form & Checklist

PCW PA Fillable Request Form

PCW Provider Fillable Checklist

DHS Personal Care Screening Tool (PCST) Form & Instructions

PCST Fillable Form

PCST Instructions

EVV Form (f02717) Live-In Worker Identification

EVV Fillable Form

- These documents and others can also be found on the [Prior Authorization Main Page](#) or [Prior Authorizations Documents](#) page.

Personal Care Services– PA

Cont.

- *i*Care does not require EVV for live-in caregivers. However, the provider must supply a completed EVV Live-In Worker Identification form, F-02717, at the time of authorization for all live-in workers. Failure to submit required documentation will result in a denial of authorization for a live-in worker.

PCW Services – Continuity of Care

- Personal Care Agencies (PCA) can submit claims for reimbursement of services for *iCare* members before being contracted under 90-day Continuity of Care at FFS rates.
 - However, the provider must be certified with ForwardHealth/State of WI Medicaid.
- After 90 days, PCA's must be credentialed and contracted with *iCare*. Once a contract is executed *iCare* contract rates apply.

Electronic Visit Verification (EVV)

- iCare **will** require Live-in Workers to use EVV for BadgerCare+ and Medicaid SSI
- iCare **will not** require Live-in Workers to use EVV for Medicaid Family Care Partnership
 - Submit claims with the KX modifier to bypass EVV requirements
 - Live in worker status must be verified by the provider agency annually.
- All personal 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 complete details:
<https://www.icarehealthplan.org/Education/Resources.htm>

PCW Codes and Modifiers

- Personal care providers are required to use the **appropriate** CPT or HCPCS procedure code from the following table that describes the service performed.
- The Modifiers providers are required to use with the procedure codes are listed
 - Use KX for Live-In Care Workers

Procedure Code	Description	Required Modifier
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	None
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	U3 — Travel time
99509	Home visit for assistance with activities of daily living and personal care (per visit)	TD — Registered Nurse

Clean Claim Guidelines

 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.

Claims Submission

- Medicare/Medicaid Covered Services
Independent Care Health Plan
P.O. Box 280
Glen Burnie, MD 21060-0280
- Long-Term Care Services
Independent Care Health Plan
P.O. Box 670
Glen Burnie, MD 21060-0670
- *iCare* is partner with the claims clearinghouse, SSI Claimsnet, to allow electronic claims submission.
- To register with SSI Claimsnet for electronic claims submission via the Internet, click [here](#). Select *iCare* in the payer drop down box on the registration form to avoid paying any set-up or submission fees for your *iCare* claims through SSI Claimsnet

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Electronic Funds Transfer (EFT) Enrollment*i*Care has joined the InstaMed Network to deliver your payments as free electronic remittance advice (ERA) and electronic funds transfer (EFT).

[Sign up now](#) to receive *i*Care payments as direct deposits!

ERA/EFT is a convenient, paperless and secure way to receive claims payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions. Additional benefits include:

- Accelerated access to funds with direct deposit into your existing bank account
- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow — ERAs can also be routed to your existing clearinghouse

You have two simple options to register for free ERA/EFT from InstaMed:

- Online: visit www.instamed.com/eraeft
- Phone: call us at [\(866\) 945-7990](tel:(866)945-7990) to speak with a live agent

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.

For More Information

ForwardHealth Website Link:

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

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

ForwardHealth/Personal Care Handbook:

<https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx>

Centers for Medicare and Medicaid Information:

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

iCare Contact Information

Customer Service-Milwaukee Office

(Monday-Friday 8:00-5:00)

Member Local: 414-223-4847

Out Of Area: 1-800-777-4376

Provider Local: 414-231-1029

Out of Area: 1/877-333-6820

Email:

providerservices@icarehealthplan.org

iCare Dane County Office

1-800-777-4376

Inpatient Admissions Notification

414-225-4760

FAX: 414-231-1075

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

Frequently Asked Questions

Below is information on some of the fields for Personal Care claims which need to be completed

Box 4 – Type of Bill

32X: Home Health — Services under a plan of treatment.

321: Inpatient admit through discharge claim.

322: Interim bill — first claim.

323: Interim bill — continuing claim.

324: Interim bill — final claim.

34X: Home Health — Services not under a plan of treatment.

341: Inpatient admit through discharge claim.

342: Interim bill — first claim.

343: Interim bill — continuing claim.

344: Interim bill — final claim.

Box 15 – Admission Source

1 – Physician Referral

2 – Clinical Referral

3 – HMO Referral

4 – Transfer from Hospital

5 – Transfer from SNF

6 – Transfer from another HealthCare Facility

7 – Emergency Room

9 – Information Not Available

Box 17 – Patient Discharge Status

01 – Discharge to Home/Self Care

02 – Discharged/Transferred to short term Inpatient Care

30 – Still Patient

Frequently Asked Questions

Below is information on some of the fields for Personal Care claims which need to be completed

Box 42 – Rev Code 570 – Personal Care

Box 44 – HCPCS/Rate/HIPPS

Box 46 – Units, enter number of visits for each Date of Service. Indicate whole units to the nearest 15 minutes (15 minutes = 1 Unit)

Detail Line 23:

Page _ of _ Enter Current page in the first blank and total number of pages in second blank
Creation Date not Required

Totals – Enter the total of all charges of the claim here. If there are multiple pages, enter the total charge of the claim only on the last page of the claim

Box 56 – NPI is NOT required for atypical providers, i.e., personal care agencies. Claims will be returned as unclean. See iCare's Clean Claim Guidelines.

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

****Note****

If you are contracted for both personal care services and LTC/Waiver services continue to use the NPI to differentiate the claims for payment purposes.

Box 67 – Primary Diagnosis, must be ICD10 formatted (period not required for processing)