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* will now grant authorizations for personal care services for up to 1 year at a time to better align with ForwardHealth.
  - Members who receive upwards of at least 3 hours per day of care will receive shorter authorizations per *iCare* discretion.
  - This does NOT mean that providers are required to submit more frequent PCSTs. The shortened authorization is simply to allow care management team more opportunities to connect with their members.
- Please visit [https://www.icarehealthplan.org/Prior-Authorization.htm](https://www.icarehealthplan.org/Prior-Authorization.htm) for further information on PA request’s less than 1 year and other requirements.
Personal Care Services– Prior Authorization (PA) Cont.

- Agency will send iCare PA form, PCST, 485 plan of care and pertinent physician notes to the iCare PA department for review.
  - **If caregiver lives with member, iCare will require form f02717**
- iCare will confirm allocation with a third-party assessment and either issue a full approval or full/partial denial after clinical review
- iCare does not authorize any services rendered prior the date of the independent assessment.
- This process will be repeated on an annual basis

- PA form’s and additional details can be found on our website: [https://www.icarehealthplan.org/Prior-Authorization.htm](https://www.icarehealthplan.org/Prior-Authorization.htm)
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 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 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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Required Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1019</td>
<td>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)</td>
<td>None</td>
</tr>
<tr>
<td>T1019</td>
<td>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)</td>
<td>U3 — Travel time</td>
</tr>
<tr>
<td>99509</td>
<td>Home visit for assistance with activities of daily living and personal care (per visit)</td>
<td>TD — Registered Nurse</td>
</tr>
</tbody>
</table>
# Clean Claim Guidelines

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name and Address</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Bill Type</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax ID</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period</td>
<td>From and Through Dates of Claim</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>9a-e</td>
<td>Patient Address</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>Required Inpatient, Home Health and SNF</td>
</tr>
<tr>
<td>14</td>
<td>Admission Type</td>
<td>Inpatient claims only</td>
</tr>
<tr>
<td>15</td>
<td>Admission Source</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Discharge Status</td>
<td>Not required for rural health or federally qualified clinics.</td>
</tr>
<tr>
<td>10-28</td>
<td>Condition Codes</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Accident State</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Revenue Codes</td>
<td>If Revenue code of 0023, 0023, 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Code</td>
<td>Required based on Type of Bill</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Service Units</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Total/Line Item Charges</td>
<td>Negative Amount: Claim will reject &quot;No Dollar Amount&quot;. Total Charges must equal the sum of the line item charges or claim will reject &quot;Total charge does not match line charge totals&quot;. Total charges with claim with Revenue Codes 0022, 0023, 0024 may be zero.</td>
</tr>
<tr>
<td>49</td>
<td>Unlabeled</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>57a-57c</td>
<td>Other Provider ID</td>
<td></td>
</tr>
<tr>
<td>58a</td>
<td>Insured's Name</td>
<td></td>
</tr>
<tr>
<td>59a</td>
<td>Relationship to Uninsured</td>
<td></td>
</tr>
<tr>
<td>60a</td>
<td>Insured Identification Number</td>
<td></td>
</tr>
</tbody>
</table>
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.
For More Information

ForwardHealth Website Link: https://www.forwardhealth.wi.gov/WIPortal/
CMS Website Link: https://www.cms.gov

ForwardHealth/Personal Care Handbook:

Centers for Medicare and Medicaid Information:
https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html
• 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.
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 Personal Care Worker

**Note** if you have an NPI for other business i.e., Home Health do not use the NPI for Personal Care claims. This will delay your claim or cause claim denials.

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