iCare Guide for Personal Care Worker (PCW)
CLAIMS PROCESSING OVERVIEW

Reviewed: February 2021

Disclaimer

- This information is provided as a courtesy from *i*Care to assist you with claims 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.

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 *i*Care 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 for further information on **PA request's less than 1 year and other requirements**

Personal Care Services– Prior Authorization (PA) Cont.

- Agency will send *i*Care PA form, PCST, 485 plan of care and pertinent physician notes to the *i*Care PA department for review.
  - **If caregiver lives with member, *i*Care will require form f02717**
- *i*Care will confirm allocation with a third-party assessment and either issue a full approval or full/partial denial after clinical review
- *i*Care 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

PCW Services – Continuity of Care

- Personal Care Agencies (PCA) can submit claims for reimbursement of services for *i*Care 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 *i*Care. Once a contract is executed *i*Care contract rates apply.

Electronic Visit Verification (EVV)

- *i*Care 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

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 *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.

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

To access the portal, click here: Provider Portal.

*i*Care 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)