



INDEPENDENT CARE HEALTH PLAN

iCare is a wholly-owned subsidiary of Humana

iCare's Skilled Nursing Facilities Claim Guide

Disclaimer:

- This information is provided as a courtesy from *iCare* to assist you in claims submission billing. This is not in the place of the Forward Health and CMS Guidelines. *iCare* relies upon Forward Health and CMS for payment rules and submission requirements.

Skilled Nursing Facility Services (SNF) – Prior Authorization (PA)

- Independent Care Health Plan requires all Skilled Nursing Facilities notify iCare by phone or fax within 24 hours of an admission or on the next business day.
- Forms can be obtained at <http://www.icarehealthplan.org/providers/> under Prior Authorizations>SubAcute Facilities Prior Authorization

Long Term Skilled Nursing Care

- When Medically Necessary *iCare* Medicare covers long-term care placement for 100 days for each benefit period.
 - Medicare benefit period ends when a member is not in SNF for 60 days
- When medically necessary, *iCare* Medicaid covers long-term care placement for up to 90 days. If an *iCare* member requires long-term care, he/she is automatically dis-enrolled from *iCare* after 90 days and continues Medicaid coverage with a Medicaid Fee for Service status.
- The facility is also obligated to notify the Social Security Administration (SSA) office that a member is in long-term care.

Interrupted Stay: Background

- Under PDPM, of the variable per diem adjustment, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay and then readmit the patient in order to reset the variable per diem schedule
- Frequent patient readmissions and transfers represents a significant risk to patient care, as well as a potential administrative burden on providers from having to complete new patient assessments for each readmission
- To mitigate this potential incentive, PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window:
- This type of policy also exists in other post-acute care settings (e.g., Inpatient Rehabilitation Facility PPS)

Interrupted Stay Policy:

- If a patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive calendar days after discharge, then the subsequent stay is considered a continuation of the previous stay:
 - Assessment schedule continues from the point just prior to discharge
 - Variable per diem schedule continues from the point just prior to discharge
- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay:
 - Assessment schedule and variable per diem schedule reset to day 1
- This policy applies not only in instances when a patient physically leaves the facility, but also in cases when the patient remains in the facility but is discharged from a Medicare Part A-covered stay.
 - Example: If a patient in a SNF stay remains in the facility under a Medicaid-covered stay, but returns to skilled care within the interruption window. I

iCare follows CMS and ForwardHealth Claim Processing Guidelines

- PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:
 - Physical Therapy (PT)
 - Occupational Therapy (OT)
 - Speech Language Pathology (SLP)
 - Nursing
 - NTA
- PDPM also includes a “Variable Per Diem (VPD) adjustment” that adjusts the per diem rate over the course of the stay

Skilled Nursing Home Acuity-Based Billing

- Effective 1/1/2022 providers must submit claims using the HIPPS codes in Box 44 (HCPCS/RATE/HIPPS) of the UB-04 claim form
- For non-developmentally disabled (DD) in-house residents, claims must be submitted with the revenue code 0022 and the appropriate HIPPS code for the patient's acuity
- For complete details see ForwardHealth Update No. 2021-22
 - <https://www.forwardhealth.wi.gov/kw/pdf/2021-22.pdf>
- Claims for Vent services should continue to use Rev Code 0946 and the appropriate HIPPS

Claims for Dual Eligible Members

- A dual eligible member has both iCare Medicare and iCare Medicaid coverage.
- Claims are always processed under the primary Medicare benefits.
 - Medicare and Medicaid claims are processed with the same PDPM
- ***Use the M8 disclaimer in Box 80 of the UB04 Form for the following:***
 - Medicare benefits are exhausted
 - Medicare benefits are denied
 - Services are not covered under Medicare

M8 per Forward Health Guidelines

Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance.

For Medicare Part A, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as enrolled in Medicare Part A.
- The member is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).

For Medicare Part B, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as enrolled in Medicare Part B.
- The member is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Clean Claim Guidelines – UB04

 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	Atypical providers excluded i.e., Personal Care Agency, Adult Day Care, Chore Srvc.
57a-57c	Other Provider ID	
58a	Insured's Name	
59a	Relationship to Uninsured	
60a	Insured Identification Number	
67	Primary Diagnosis Code	Box 67A-67Q other diagnosis code - Inpatient Required. The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. Outpatient Required. The hospital enters the full ICD codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.
69	Admitting Diagnosis Code	Inpatient claims only
81a-d	Taxonomy Code	For Electronic Submissions: Loop Number 2000A_BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL, Segment PRV, element PRV02 =PXC, PRV03=value populated

Updated 7/1/2026

UB04 Example

1 Lake Michigan Nursing and Rehab										2		3a PAT. CNTL. #		4 TYPE OF BILL																											
1234 Lake Drive												b. MED. REC. #		21X																											
Milwaukee WI 53201												5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7																									
												12-3456789		01/01/2022		01/31/2022																									
8 PATIENT NAME					a					9 PATIENT ADDRESS					a 5432 River Drive																										
b Jane Doe										b Milwaukee WI 53201					c d e																										
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES 22		23		24		25		26		27		28		29 ACCT STATE		30	
07/23/2022		Female		12/14/2022				3		4				30																											
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 CODE		OCCURRENCE SPAN FROM		OCCURRENCE SPAN THROUGH		36 CODE		OCCURRENCE SPAN FROM		OCCURRENCE SPAN THROUGH		37																					
a		b		c		d		e		f		g		h		i		j		k		l		m		n		o		p		q		r							
38 iCare PO Box 660346 Dallas TX 75222-0346										39 CODE		VALUE CODES AMOUNT		40 CODE		VALUE CODES AMOUNT		41 CODE		VALUE CODES AMOUNT																					
										a 80		\$31.00				#				#																					
										b		#				#				#																					
										c		#				#				#																					
										d		#				#				#																					
42 REV. CD.		43 DESCRIPTION								44 HCPCS / RATE / HIPPS CODE				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																			
1 0022										KGGD6				01/01/2022		31		\$31,000.00		#																					
2																		#		#																					

Therapy Physical, Occupational and Speech

- Medicare and Dual Eligible – Therapies are included in the SNF stay and billed on UB
- Medicaid – Therapies are **payable separately** and **billed on separate HCFA Form**
 - Claims should be submitted with the rendering therapist name and NPI

Claim Submission – Medicaid Therapies

- iCare has determined that Medicaid covered therapy services provided in a skilled nursing facility must be billed in the following manner to be considered for payment.
- Claims must be submitted on a CMS 1500 form.
- The rendering provider on the CMS 1500 form must be a provider qualified to provide therapy service.
- Providers may submit claims for these services under the nursing home NPI, but should refer to the appropriate service areas for more information about covered services, service limitations under the BadgerCare Plus Benchmark Plan, prior authorization guidelines, and claim submission instructions. (ForwardHealth Topic 3215)
- When the rendering provider is employed by, or under contract to, a therapy group, therapy clinic, speech and hearing clinic, or nursing home, the billing provider number of the group, clinic, or nursing home must be indicated on the claim. A performing provider number must be indicated. (ForwardHealth Topic 2765)
- When the rendering provider is employed by or under contract to a rehabilitation agency, the billing provider number of the rehabilitation agency must be indicated on the claim. A rendering provider number should not be indicated (ForwardHealth Topic 2762)
- Claims can contain the services from only one rendering provider per claim form.
- Claims for PT, OT, and SLP services require the referring physician's name and NPI.
- An example of claims with an explanation of the required fields is attached for your reference. More information is available at Forward Health (www.forwardhealth.wi.gov).
- In order for us to process these claims efficiently, please send us a roster of the therapists that will bill under your NPI. Please include the therapist name, credential and NPI number

Transportation

- Non-Emergency transportation is not payable separately.
- Emergency medical transport by an ambulance from a SNF to the Hospital is a covered benefit.
- When the member is release from the hospital back to the SNF ambulance transportation is not a covered benefit

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

Corrected Claims

- When submitting a corrected claim, it is VERY IMPORTANT to include the claim number to be corrected in Box 64 of the UB04 form
 - If submitting corrections for the Medicaid secondary portion without a claim number, the Medicare claim/payment may be adjusted and could cause processing issues or reversals.

See the Corrected Claim Information on our Website:

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

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 Provider ID. 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 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
- 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. 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>

- **CMS PDPM** - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html>
- **SNF PPS** - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS> on the CMS website
 - Chapter 8 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf> on the CMS website
 - Chapters 6 and 7 of the “Medicare Claims Processing Manual” (Publication 100-04) located at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html> on the CMS website
- **SNF QRP** - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting.html> on the CMS website
- **All Available Medicare Learning Network® (MLN) Products** - “MLN Catalog” located at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf> on the CMS website or scan the Quick Response (QR) code
- **Provider-Specific Medicare Information** - MLN publication titled “MLN Guided Pathways: Provider Specific Medicare Resources” booklet located at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_booklet.pdf on the CMS website
- **Medicare Information for Patients** - <https://www.medicare.gov> on the CMS website
- **Medicaid SNF** - [https://www.forwardhealth.wi.gov/OnLineHandbook/BC+/Medicaid/Nursing Home](https://www.forwardhealth.wi.gov/OnLineHandbook/BC+/Medicaid/NursingHome)

GENERAL CONTACT/INDIVIDUAL DEPARTMENT PHONE AND FAX NUMBERS

MAIN NUMBER

414-223-4847 or 800-777-4376

Claims/Appeals/Reconsiderations

Local: 414-231-1029

Fax: 414-231-1094

Out of Area: 877-333-6820

Email: department-providerservices@icarehealthplan.org

Eligibility and Provider Services

Local: 414-231-1029

Fax: 414-231-1094

Out of Area: 877-333-6820

Prior Authorization

Local: 414-299-5539

Out of Area: 855-839-1032

Fax: 414-231-1026

Provider Contracting

414-225-4741

Fax: 414-272-5618