iCare Guide for Skilled Nursing Facilities
CLAIMS PROCESSING OVERVIEW
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/](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.
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
January 2022 – 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

- 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
- **It is imperative to 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 Skilled Nursing (SNF) UB-04 GUIDELINES

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<th>Box</th>
<th>Description</th>
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<tr>
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<td>6</td>
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<td>Required for Rural Health or Federally Qualified Clinics</td>
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<td>9e</td>
<td>Patient Address</td>
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## Revenue Codes

- **MEDICARE**: 019C and 018X for leave of absence. **Please Note**: Claims should NOT be billed with revenue codes 0110-0129. These are not allowed.
- **DUAL ELIGIBLE**: Box 42 - E002 (Same line box 44 five (5) digit Medicare HIPPS code) - Second Line - 012X Room & Board
- **MEDICARE**: The required three (3) digit code
- **NFHCARE**: The required five (5) digit code
- **DUAL ELIGIBLE**: In order to avoid the companion claim (Medicaid claim) from denying, the Medicaid RU5-46 code needs to be included on the R & B line. (See Example)

## HIPPS/RU5 Codes

- **MEDICARE**: The required three (3) digit code
- **DUAL ELIGIBLE**: The required five (5) digit code

## Service Date

Required for Rural Health

## Service Units

Total units should equal the total confinement days

## 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 on claim** with Revenue Codes 0022 must be zero.

## SIC

<table>
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<td>SIC 60</td>
<td>Benefits</td>
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## SIC 18a

- **ELECTRONIC SUBMISSIONS**: Loop N04# 2000A_BILLING/PAY-TO PROVIDER
- **HIERARCHICAL LEVEL**: Segment, PRIV, element, PRIV2, PRIV3, value populated
- **PAPER SUBMISSIONS**: 837TAXonomy
UB04 Example
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
  PO Box 660346
  Dallas, TX 75222-0346

- **Long-Term Care Services**
  Independent Care Health Plan
  PO Box 224255
  Dallas, TX 75222-4255

- *i*Care 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 *i*Care in the payer drop down box on the registration form to avoid paying any set-up or submission fees for your *i*Care 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
Additional Information

- Open ended authorizations will appear on the Portal with an end date the day after the admit date
  - iCare will manually review claims in these cases and apply the appropriate authorization
- If Medicare benefits have been exhausted, submit claim with M8 modifier in Box 80 to expedite Medicaid processing
- If charges are billed on line 1 0022, the claim will deny
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
- **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
- **Medicare Information for Patients** - https://www.medicare.gov on the CMS website
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 you 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.
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