iCare Guide for Skilled Nursing Facilities
CLAIMS PROCESSING OVERVIEW

Revised 6/24/2020

Disclaimer:

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

Skilled Nursing Facility Services (SNF) – Prior Authorization

- Independent Care Health Plan requires that all Skilled Nursing Facilities notify *i*Care 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 *i*Care 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, *i*Care Medicaid covers long-term care placement for up to 90 days. If an *i*Care member requires long-term care, he/she is automatically dis-enrolled from *i*Care 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.

Difference between RUG and PDPM (SNF PPS)

- RUG-IV consists of two case-mix adjusted components:
  - Therapy: Based on volume of services provided
  - Nursing: The nursing Case-Mix Index (CMI) does not currently reflect specific variations in non-therapy ancillary (NTA) utilization

- 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

Interrupted Stay: Background

- Given the introduction, 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

Clean Claim Guidelines – UB04

iCare Skilled Nursing (SNF) UB-04 GUIDELINES

Box	Description	Comments
1	Provider Name and Address	
4	Bill Type	
5	Federal Tax ID	
6	Statement Covers Period	Not required for Bill type 322 or 323
8b	Patient Name	
9a-e	Patient Address	
10	Date of Birth	
11	Patient Sex	
12	Admission Date	Required for Inpatient, Home Health, and SNF claims
14	Admission Type	*Inpatient claims only*
15	Admission Source	
17	Discharge Status	Not required for Rural Health or Federally Qualified Clinics
35		Not required
42	Revenue Codes	⇨ **MEDICAID:** 019X and 018X for leave of absence. *PLEASE NOTE: *Claims should **NOT** be billed with revenue codes 0110-0129. These are non-covered.* ⇨ **MEDICARE:** • First line - Box 42- Rev 0022 (Same line Box 44 five (5) digit Medicare HIPPS code) • Second line – 012X Room & Board ⇨ **DUAL ELIGIBLE:** • First line – Box 42- Rev 0022 (Same line Box 44 five (5) digit Medicare HIPPS code) • Second line - 019X Room-Board ▪ *PLEASE NOTE: Claims submitted without this information will be denied. (See Example)*
44	HIPPS/RUGS Codes	⇨ **MEDICAID:** The required three (3) digit code ⇨ **MEDICARE:** The required five (5) digit code ⇨ **DUAL ELIGIBLE:** In order to avoid the companion claim (Medicaid claim) from denying, the Medicaid RUGS-48 code needs to be included on the R & B line. *(See Example)*
45	Service Date	Required for Home Health
46	Service Units	Total units should equal the total confinement days
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 on claim with Revenue Codes 0022 must be zero.
49	Unlabeled	
56	NPI	
57a-c	Other Provider ID	Required for ESRD claims
58a	Insured's Name	
59a	Relationship to Uninsured	
60a	Insured Identification No#	
67	Primary Diagnosis Code	Box 67a-67Q other diagnosis code Present on Admission Indicator
69	Admitting Diagnosis Code	Inpatient claims only
80	Remarks	Disclaimer M7-M8
81a-d	Taxonomy Code	⇨ **ELECTRONIC SUBMISSIONS:** Loop N0# 2000A_BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL, Segment PRV,element PRV02-PXC, PRV03=value populated ⇨ **PAPER SUBMISSIONS:** B3Taxonomy

Claim Submission Examples

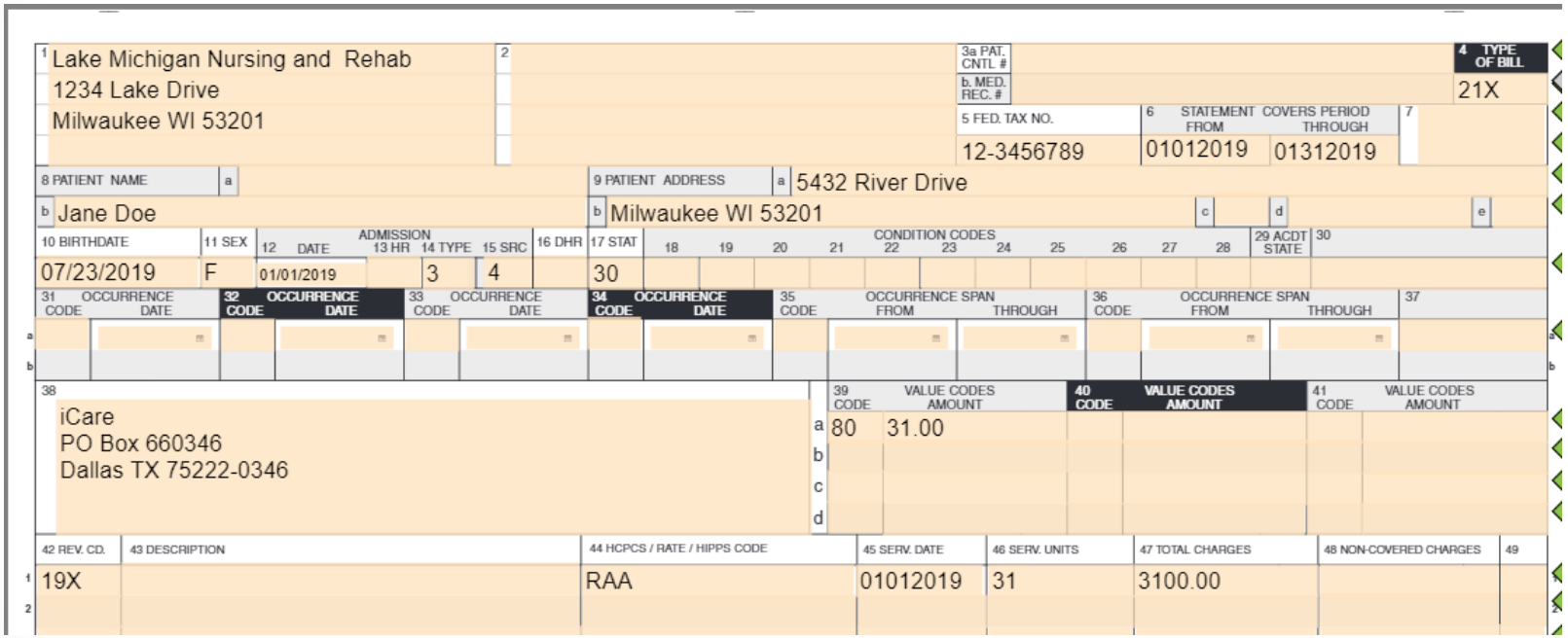
- Example 1 – Medicaid only Room and Board should be submitted with a 19X (or 18X for leave of absence) Rev Code in Box 42 and a 3 digit RUGS code in box 44

- Example 2 – Medicare only Room and Board should be submitted with a 0022 Rev Code in Box 42 and a 5 digit HIPPS code in box 44 on line 1 with $.00 billed
- 12X should be submitted with charges on line 2

- Example 3 – Dual Eligible (Medicare and Medicaid) should be submitted with 0022 Rev Code in Box 42 and Medicare HIPPS code in Box 44 on same/first line(s) and 19X Rev Code in Box 42 and Medicaid RUG code in Box 44 on same, second line/s.

  - See next two slides for Claim examples

Medicaid UB04 Example



1 Lake Michigan Nursing and Rehab
1234 Lake Drive
Milwaukee WI 53201

2

3a PAT. CNTL #
b. MED. REC. #

4 TYPE OF BILL: 21X

5 FED. TAX NO.: 12-3456789

6 STATEMENT COVERS PERIOD: FROM 01012019 THROUGH 01312019

7

8 PATIENT NAME
a
b Jane Doe

9 PATIENT ADDRESS
a 5432 River Drive
b Milwaukee WI 53201
c
d
e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
07/23/2019	F	01/01/2019		3	4		30													

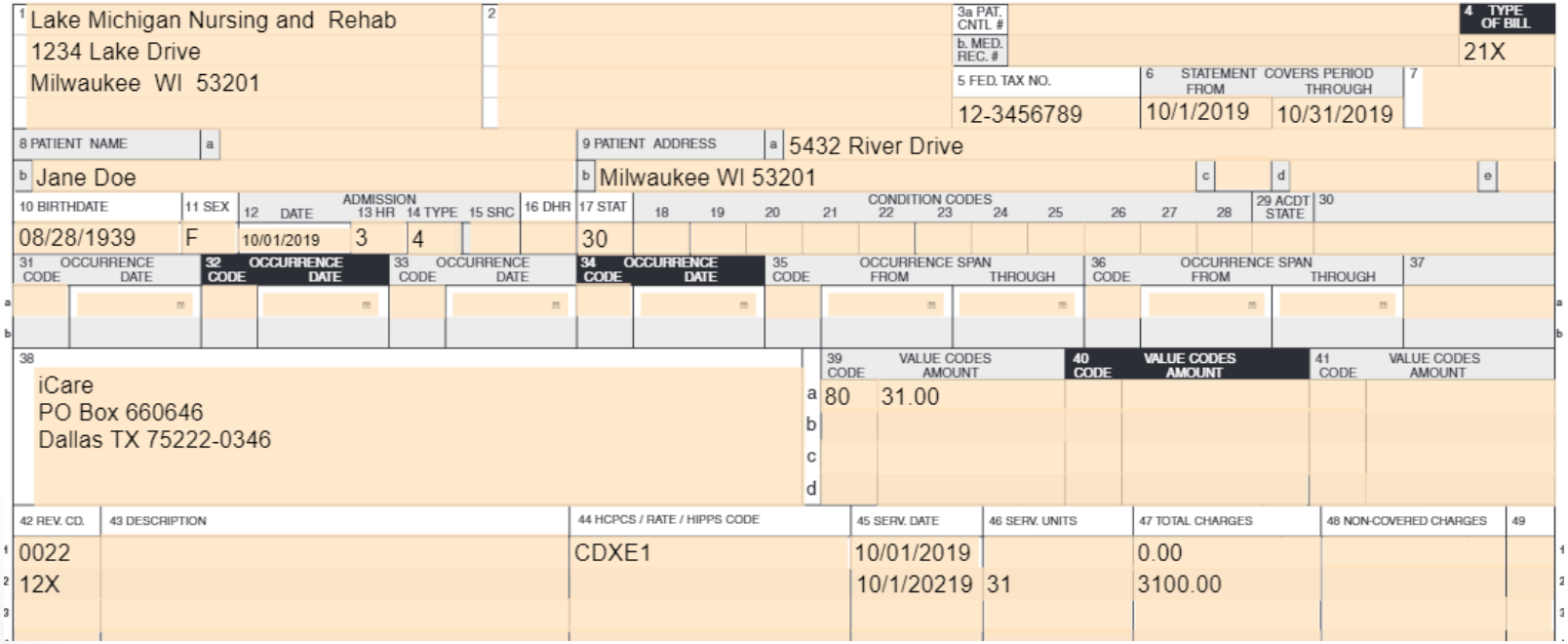
31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a														a
b														b

38
iCare
PO Box 660346
Dallas TX 75222-0346

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 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	19X		RAA	01012019	31	3100.00		
2								

Medicare UB04 Example



1		2		3a PAT. CNTL #		4 TYPE OF BILL
Lake Michigan Nursing and Rehab 1234 Lake Drive Milwaukee WI 53201				b. MED. REC. #		21X
			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
			12-3456789	10/1/2019	10/31/2019	

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 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
08/28/1939	F	10/01/2019	3	4			30													

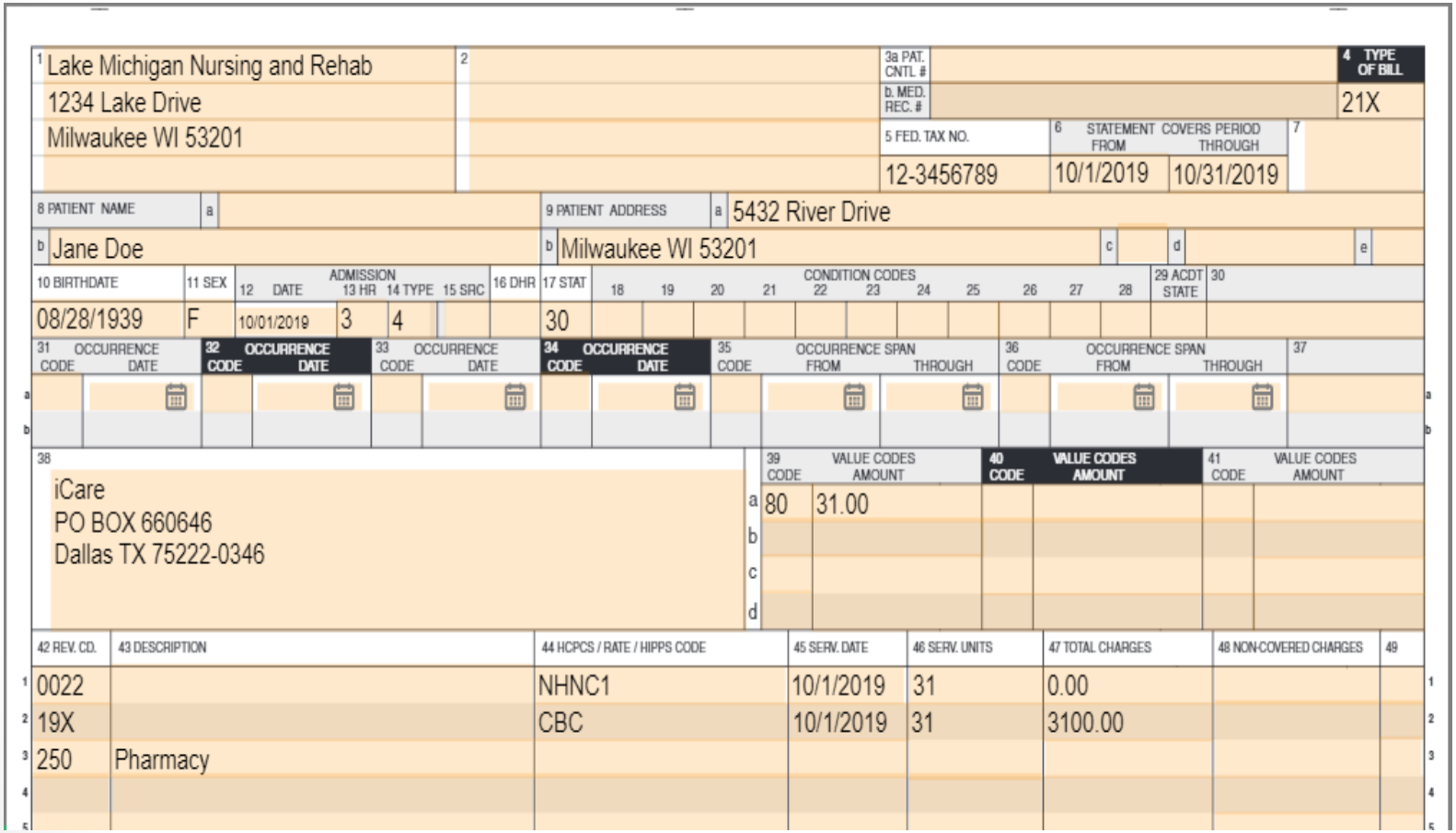
31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a														a
b														b

38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
iCare PO Box 660646 Dallas TX 75222-0346	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
0022		CDXE1	10/01/2019		0.00		
12X			10/1/20219	31	3100.00		

Dual Eligibility UB04 Example

* If Medicare benefits are denied or exhausted, follow the Medicaid Claim example



1 Lake Michigan Nursing and Rehab 1234 Lake Drive Milwaukee WI 53201	2	3a PAT. CNTL # b. MED. REC. #		4 TYPE OF BILL	21X
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
		12-3456789	10/1/2019	10/31/2019	

8 PATIENT NAME		9 PATIENT ADDRESS				
a		a	5432 River Drive			
b Jane Doe		b Milwaukee WI 53201		c	d	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08/28/1939	F	10/01/2019	3	4			30													

	31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a															a
b															b

38		39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
iCare PO BOX 660646 Dallas TX 75222-0346	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		NHNC1	10/1/2019	31	0.00			1
2	19X		CBC	10/1/2019	31	3100.00			2
3	250	Pharmacy							3
4									4
5									5

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

Claim Submission – Medicaid Therapies

- *i*Care 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

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.

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
  - 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>OnLine Handbook>BC+/Medicaid>Nursing Home

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@icare-wi.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@icare-wi.org.

To access the portal, click here: Provider Portal.

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: 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