INDEPENDENT CARE HEALTH PLAN

*i*Care Guide for Physical, Occupational and Speech Therapy

Claims Processing Overview

Reviewed: August 2019

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.

Abbreviations

- Abbreviations
  - PT – Physical Therapy
  - OT – Occupational Therapy
  - SLP – Speech, Language and Pathology Therapy
  - PA – Prior Authorization

PT, OT and ST – Prior Authorization

- Prior Authorization is required for **ALL** outpatient therapy services including PT, OT and SLP.
- *i*Care authorizes outpatient therapy by number of visits; however, the CPT codes that the provider anticipates billing MUST be listed on the prior authorization request form in order to complete the clinical review and determine medical necessity.
- Comprehensive information about the member helps to establish the functional potential of the member and forms the basis for determining whether the member will benefit from the requested services. Please submit the Prior Authorization Request form along with the completed therapy evaluation, plan of care, and signed physicians prescription for review to determine if the service is medically necessary.
- Outpatient therapy will be authorized based on medical necessity. Services that are medically necessary are defined under Wis. Admin. Code § DHS 101.03(96m). The provider is responsible to assure that the services provided are covered under the Medicare or Medicaid benefit, whichever applies.

PT, OT and ST – Prior Authorization

- An approved PA request will be backdated to the initial date of the evaluation if the PA request is received within 14 calendar days of the initial therapy evaluation. *i*Care will not retro authorize any authorization requests submitted beyond the 14 calendar days of the initial evaluation.
- Continuing therapy requests may be requested when the member's need for therapy services is expected to exceed the maximum allowable treatment days authorized.
- For continuing therapy requests, prior authorization must be obtained. PA requests for ongoing therapy will not be backdated. To request additional visits, please submit the completed Prior Authorization Request form, as well as clinical documentation to support medical necessity for ongoing therapy services.

PT, OT and ST – Prior Authorization

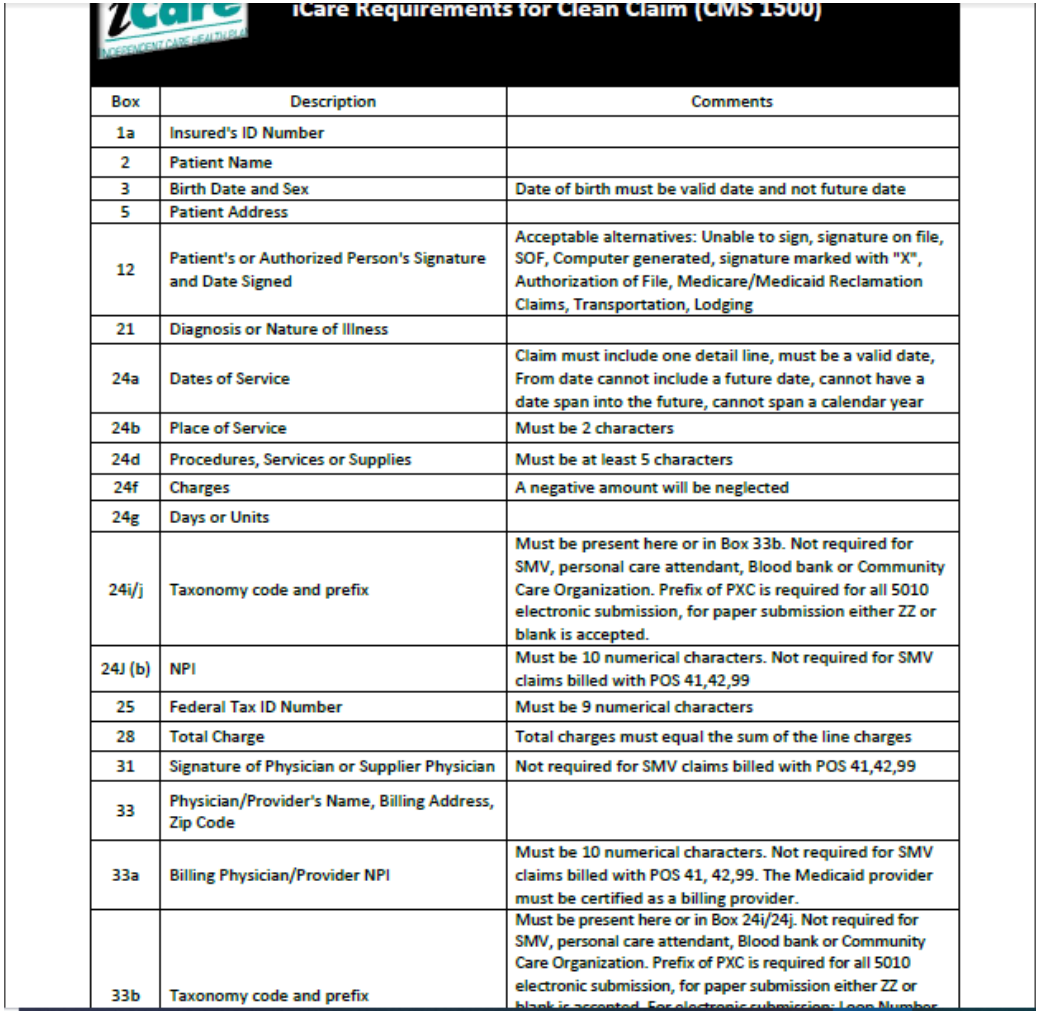
- PA requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the start date given.
- An approved request means that the requested service, not necessarily by code, was approved. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned start and end dates.
- All claims for services are subject to the coverage and medical necessity guidelines provided by Medicare and Medicaid.
- Medicare Guidelines for Outpatient Physical and Occupational Therapy Services can be found here.
- Medical Guidelines can be found here.

Therapy Codes and Modifiers

- CPT codes are required on all outpatient therapy claims submitted on the CMS 1500 claim form.
  - Claims or adjustments received without a valid CPT code will be rejected
- CMS and ForwardHealth websites have all applicable CPT codes and modifiers for all therapy codes.
  - CMS - https://www.cms.gov/medicare/medicare.html
  - ForwardHealth https://www.forwardhealth.wi.gov/WIPortal/
    - Please access ForwardHealth's online handbook for detailed Therapy information.

Clean Claim Guidelines

CMS 1500



iCare Requirements for Clean Claim (CMS 1500)

Box	Description	Comments
1a	Insured's ID Number	
2	Patient Name	
3	Birth Date and Sex	Date of birth must be valid date and not future date
5	Patient Address	
12	Patient's or Authorized Person's Signature and Date Signed	Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging
21	Diagnosis or Nature of Illness	
24a	Dates of Service	Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year
24b	Place of Service	Must be 2 characters
24d	Procedures, Services or Supplies	Must be at least 5 characters
24f	Charges	A negative amount will be neglected
24g	Days or Units	
24i/j	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99
25	Federal Tax ID Number	Must be 9 numerical characters
28	Total Charge	Total charges must equal the sum of the line charges
31	Signature of Physician or Supplier Physician	Not required for SMV claims billed with POS 41,42,99
33	Physician/Provider's Name, Billing Address, Zip Code	
33a	Billing Physician/Provider NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider.
33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number

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	
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.

Frequently Asked Questions

Q: When do I need an Authorization?
A: Prior authorization is required for all outpatient therapy services including PT, OT, and SLP

Q: Where can I find Prior Authorization and Outpatient Notification forms?
A: Prior authorization and outpatient notification forms are available on the iCare provider website at https://www.icarehealthplan.org/Forms/ProviderForms.aspx

Q: Does iCare offer electronic claims submission?
A: Yes, iCare offers electronic claims submission through Claimsnet. For more information please visit http://www.claimsnet.com/

Q: What is iCare' Payer ID number for electronic claims?
A: iCare's Payer ID number is 11695.

Q: What is the correct way to submit claims for a dual eligible member if I am a provider that is not Medicare certified?
A: An M8 disclaimer should be placed in Box 11 on a HCFA 1500. This is a code used when Medicare never covers the procedure in any circumstance, or the recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the services provided.

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