iCare Vision Claims Processing Overview
Disclaimer:

- This information is provided as a courtesy from iCare to assist you with claims submission and billing. This does not replace Forward Health and CMS Guidelines. iCare relies upon Forward Health and CMS for payment rules and regulations for claim submission.
National Vision Administrators (NVA)

Effective January 1, 2019 iCare’s Medicare and Medicaid optometry provider network is administered by NVA.

- **NVA Responsibilities:**
  - Recruit and maintain an adequate provider network of optometrists.
  - Process all covered medical and routine optometry claims based on member benefits.
  - Optometry claims submitted directly to iCare will deny indicating all optometry claims must be submitted to NVA.
  - NVA will not process claims from providers outside of the NVA network.
  - It is the provider’s responsibility to check member eligibility and network status prior to rendering services.
Medicare (Plans 001 / 007 / 009 / 011)

- Medicare Standard Benefit:
  - Medical vision exams by an optometrist covered by NVA
  - Hardware – coverage for one pair of eyeglasses or contact lenses after cataract surgery covered by NVA
  - Medical vision exams/procedures by an ophthalmologist covered by iCare

- iCare Enhanced Benefit:
  - $450 per calendar year to be used toward glasses (lenses, frames, enhancements), cosmetic contacts, and contact fitting
    - Members may use non-NVA provider and submit receipts to NVA for reimbursement
    - Cost above $450 is the Member’s responsibility

- Medicare does not cover routine vision exams
Medicaid
BadgerCare Plus, SSI, and Family Care Partnership

- Vision Services covered by NVA:
  - Routine and Medical optometry
  - Medicaid approved hardware
  - Medically necessary contacts (PA required through NVA)

- **Note:**
  - When Medicare is primary all medical optometry will be covered by Medicare (NVA).
  - Ophthalmology claims are processed by iCare
  - Medicaid Benefit cannot be used in conjunction with iCare’s Medicare Enhanced Benefit ($450 toward lenses/frames/contacts).
Prior Authorization

• Optometry providers: refer to NVA for all Prior Authorization requirements prior to rendering services.

• Ophthalmology providers: refer to iCare’s website to confirm if a Prior Authorization is required prior to rendering services.
  • https://www.icarehealthplan.org/Prior-Authorization.htm
Member Payment for Covered Services

ForwardHealth Topic #86

- Under state and federal laws, a Medicaid-enrolled provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

- If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid enrollment.

- ForwardHealth Portal: [https://www.forwardhealth.wi.gov/WIPortal/](https://www.forwardhealth.wi.gov/WIPortal/)
Clean Claim Guideline

Optometry claims billed to NVA; Ophthalmology claims billed to iCare

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Insured's ID Number</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Birth Date and Sex</td>
<td>Date of birth must be valid date and not future date</td>
</tr>
<tr>
<td>5</td>
<td>Patient Address</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Signature and Date Signed</td>
<td>Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with “X”, Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness</td>
<td></td>
</tr>
<tr>
<td>24a</td>
<td>Dates of Service</td>
<td>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</td>
</tr>
<tr>
<td>24b</td>
<td>Place of Service</td>
<td>Must be 2 characters</td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, Services or Supplies</td>
<td>Must at least 5 characters</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>A negative amount will be neglected</td>
</tr>
<tr>
<td>24g</td>
<td>Days or Units</td>
<td></td>
</tr>
<tr>
<td>24i</td>
<td>Taxonomy code and prefix</td>
<td>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.</td>
</tr>
<tr>
<td>24i (b)</td>
<td>NPI</td>
<td>Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number</td>
<td>Must be 9 numerical characters</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Total charges must equal the sum of the line charges</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Physician</td>
<td>Not required for SMV claims billed with POS 41,42,99</td>
</tr>
<tr>
<td>33</td>
<td>Physician/Provider’s Name, Billing Address, Zip Code</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>Billing Physician/Provider NPI</td>
<td>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.</td>
</tr>
<tr>
<td>33b</td>
<td>Taxonomy code and prefix</td>
<td>Must be present here or in Box 24/24a. 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 2310A-BILLING PROVIDER NAME, Segment PRV, ElementPRV02-PXC, ElementPRV03-value populated taxonomy code</td>
</tr>
</tbody>
</table>

Updated 5/8/2015- Paper Claims must signed and dated
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 ophthalmology 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.

• NVA contracted providers/optometrists must refer to their contract with NVA for claims guidelines.
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.

For NVA Portal information, please contact NVA's Provider Line:
National Vision Administrators, LLC
1-888-287-0116
www.e-nva.com
GENERAL CONTACT/INDIVIDUAL DEPARTMENT PHONE AND FAX NUMBERS

iCare 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

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