INDEPENDENT CARE HEALTH PLAN

*i*Care is a wholly-owned subsidiary of Humana

*i*Care Guide for Mental/Behavioral Health and Substance Abuse
CLAIMS PROCESSING OVERVIEW

Updated: December 2025

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.

MH/BH and AODA Authorization

MH/BH and AODA services which require prior notification or authorization include:

- Inpatient hospitalization
- Partial hospitalization
- Intensive outpatient program
- Psychological testing greater than 4 hours
- In-home treatment
- Community day treatment
- Crisis stabilization

- Prior authorization and outpatient notification forms are available on the *i*Care provider website at http://www.icare-wi.org/providers/forms.aspx or can be obtained from an *i*Care behavioral health staff member at 1-855-893-0476.

Prior Authorization Cont.

- Please refer to Prior Authorization Procedure Specific Listing on the *i*Care website: http://www.icarehealthplan.org/ for services that require prior authorization.

MH/BH and AODA Medicaid Coverage

- Visit ForwardHealth Online Handbook @ https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for claim and benefit information on
  - Adult Mental Health Day Treatment
  - Behavioral Health Treatment Benefit
  - Child/Adolescent Day Treatment, Health Check “other services”
  - Community Recovery Services
  - Community Support Program
  - Comprehensive Community Services
  - Crisis Intervention
  - In-Home Mental Health and Substance Abuse Treatment Services for Children

MH/BH and AODA Medicare Coverage

*i*Care follows CMS coverage and claim guidelines

https://www.cms.gov/files/document/medicare-mental-health.pdf

MH/BH and AODA Claims and Coverage Cont.

- Outpatient Mental Health
- Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults
- Outpatient Substance Abuse
- Substance Abuse Day Treatment

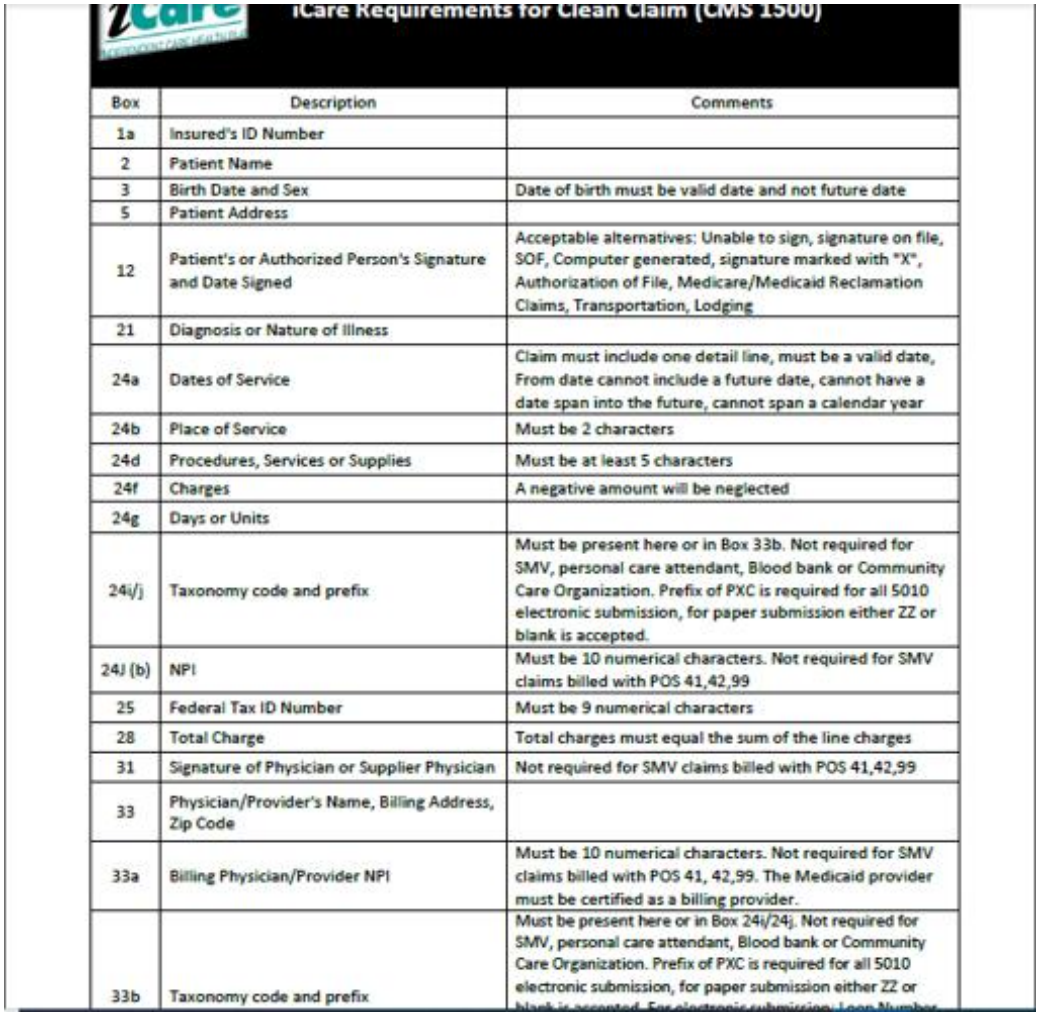
Opioid Treatment Program (OTP) Billing:

Proper Billing for OTP Weekly bundles HCPCS codes G2067–G2073 and G2075 and Take Home Medication Codes G2078 and G2079

- Date of Service = the first date of care for that week. Do not span "From" and "To" dates. Do not cross months on one claim.
- Units of Service – 1 (HCPCS description includes 7 days)

- Visit https://www.medicare.gov/coverage/mental-health-care-outpatient for Outpatient Medicare benefits and coverage
- Visit https://www.medicare.gov/coverage/mental-health-care-inpatient for Inpatient Medicare benefits and coverage
- Medicare Substance Abuse: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf

Clean Claim Guidelines – HCFA



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.

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
- *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

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 to speak with a live agent

*i*Care Provider Portal Access

- Your time is valuable. *i*Care's Provider Portal allows you to view prior authorizations, service requests, verify eligibility and view claim information for the *i*Care 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. *i*Care 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 your will need to request a PIN to register.**
- If you do not receive your PIN, please contact *i*Care at ProviderRelationsSpecialist@*i*CareHealthPlan.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 ***i*Care Portal User Guide** provides step by step instructions for registration and outlines functionalities. If you have any questions, please contact ProviderOutreach@*i*CareHealthPlan.org or ProviderRelationsSpecialist@*i*CareHealthPlan.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@*i*CareHealthPlan.org or ProviderRelationsSpecialist@*i*CareHealthPlan.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