LTC Residential Claim Submission via iCare Provider Portal

Log on to iCare Provider Portal Provider Portal

From the menu on the left side select **Claims**, next select **create claim**, (see screen shot 1)

Next select **member name** (enter member last name , first name, date of birth or member Medicaid id) click on **search**, (This will bring up the members name) verify your member is correct, click **next**

Claim Type (Required) select **Institutional Inpatient Claim**, click **next**.

Provider Information
Select the claim type, provider name, and the service address.
Select Claim Type (Required) = **Institutional Inpatient Claim**

Type of Bill
Click next , Facility Type (Required) 21- Inpatient skilled nursing
*note this facility type with the closet match to a residential facility for UB04 submissions

Frequency 3 – options
01 – Admit through Discharge
02 – First Interim Claim
03 – Continuing Interim Claim
04 – Last Interim Claim

When entering the above Facility Type and Frequency, they will be converted as follows for residential facility/AFH

21 01 will be: 861 – Respite Services
21 02 will be: 862 – First claim for Client
21 03 will be: 863 – Continuous claim for Client
21 04 will be: 864 – Last claim for Client

Statement From Date and Statement To Date
MM/DD/YYYY through **MM/DD/YYYY**

Admission Details
Admission Date (the date the member came to your facility) enter **MM/DD/YYYY**

Admission Hour
Select – admission time = **00**

Type of Admission

Select – 9 – Information Not Available

Admission Sources
Select – 9 – Information Not Available

Discharge Details
Discharge Date (the though date on claim) enter **MM/DD/YYYY**

Discharge Hour (Required)
Select – discharge time = **00**

Discharge Status (Required)
Select – discharge status = 30 – Still patient

Select the ICD type & primary Diagnosis Code to enter service details.

ICD Type (Required)
Select – ICD 10

Primary Diagnosis Code (Required)
Enter – Z02.9

POA Indicator (*not a required field)
Present on Admission (POA) – means the primary diagnosis was present at the time admission occurs
Select Yes, No, Unknown, Clinically Undetermined or Exempt

Accept Assignment check box
indicate whether you agree (or is required by law) to accept the Medicare-approved amount as full payment for covered services

Service Line 1
Date of Service From Date and Date of Service To Date
MM/DD/YYYY through **MM/DD/YYYY**

Revenue Code
Enter - room and board Rev (example: 0120)

CPT/HCPCS (previously referred to as HIPAA)
Enter the code that is approved on your Service Request, it must be a 5 digit/character code.

- If a CPT/HCPCS is not provided, use only the Revenue code

Units (Required)

Enter – number of units/days

Unit Type (Required)
Select unit type = Days

Charge (Required)
Calculate – Rev code rates x number of days – Enter Charge amount

Click **+ Add Service Line** to submit additional charges

Once the fields are complete on each service line, click View Estimate

Next
Confirm Claims Service Line is correct. Next Submit Claim

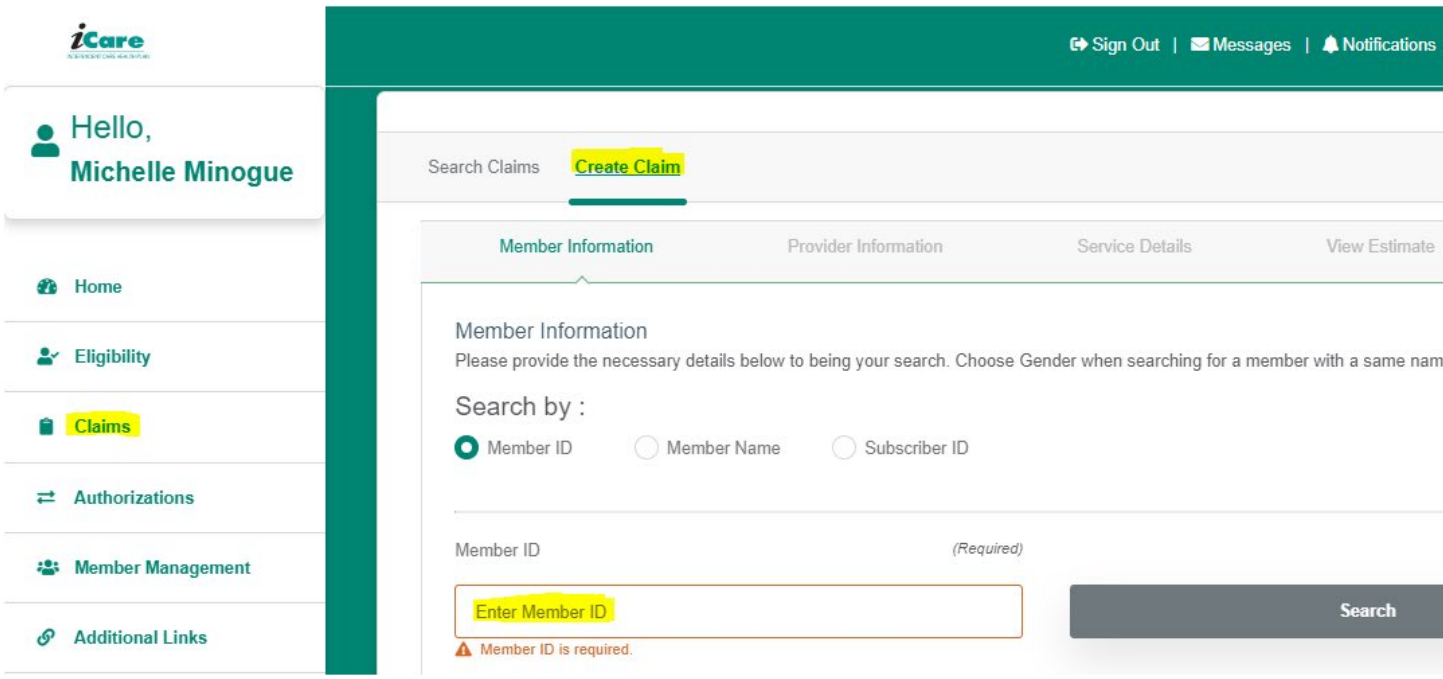
Please be sure to review your claim to ensure accuracy. Any corrected claims will need to be submitted on the hard copy LTC Residential Claim form.

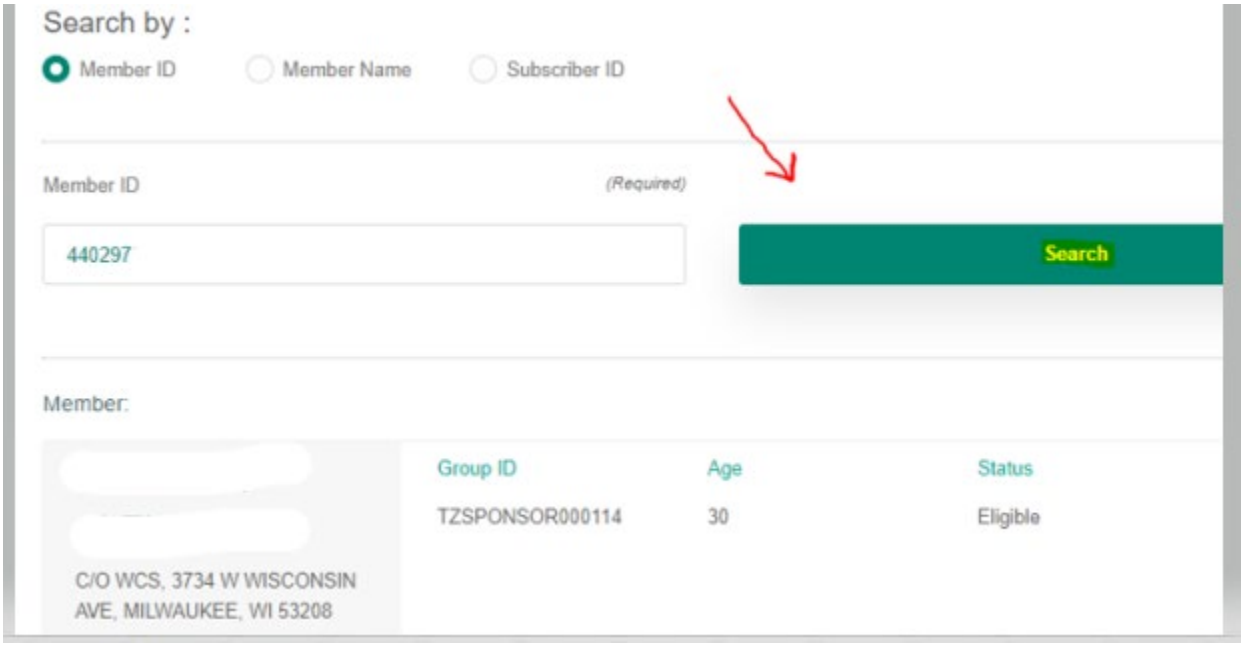
Corrected Claims

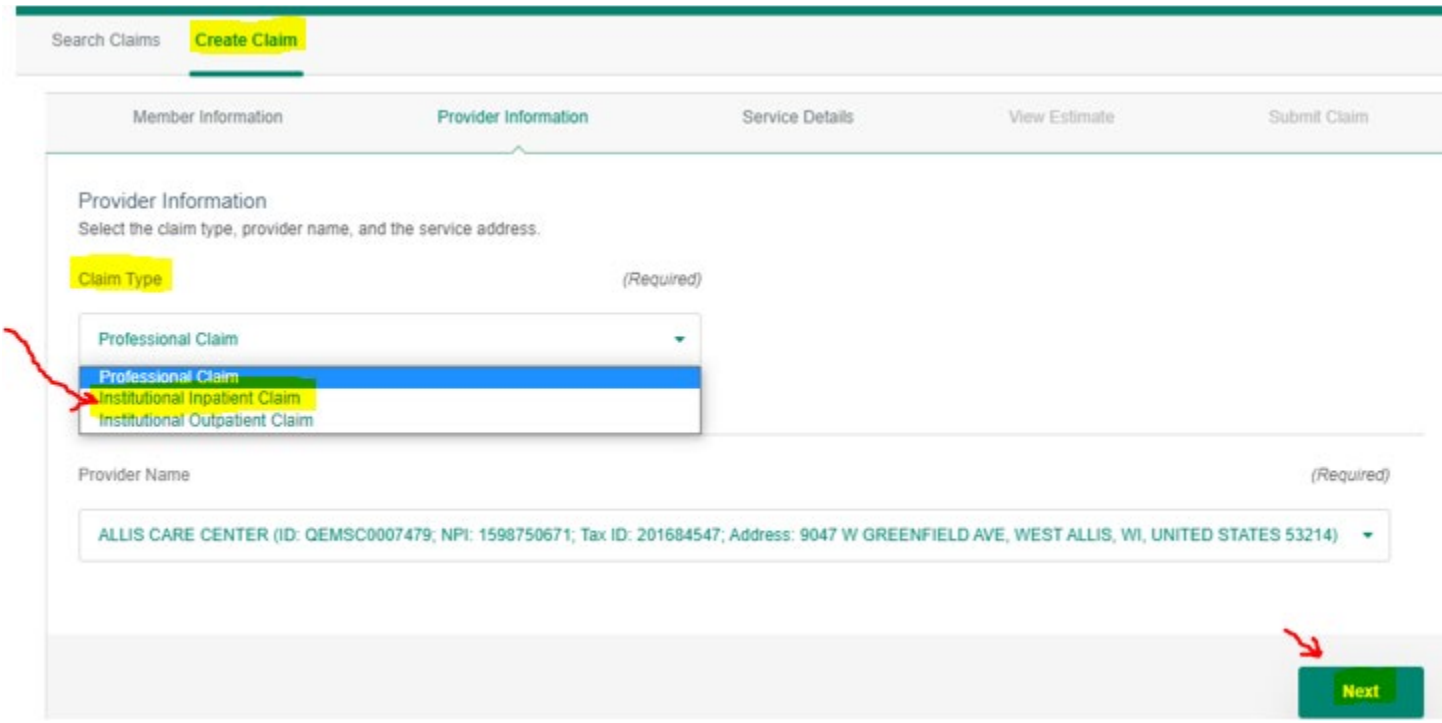
Follow the above instructions to submit a claim. But, use the following Frequency in the Statement Summary

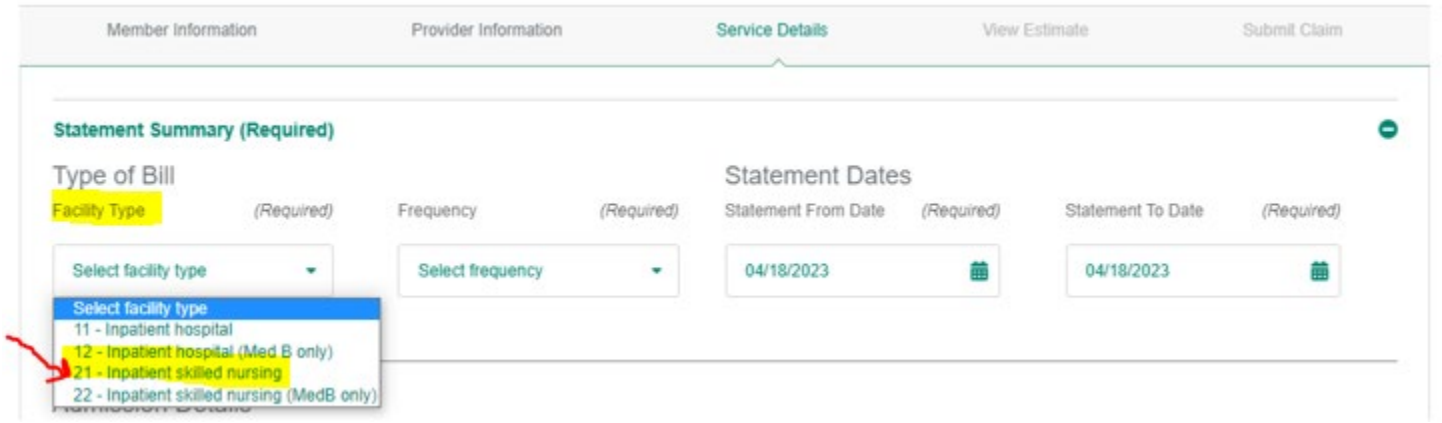
Frequency 06 – adjustment of a prior claim (make changes to a paid claim)
Frequency 07 – Replacement of a prior claim (make changes to a denied claim)

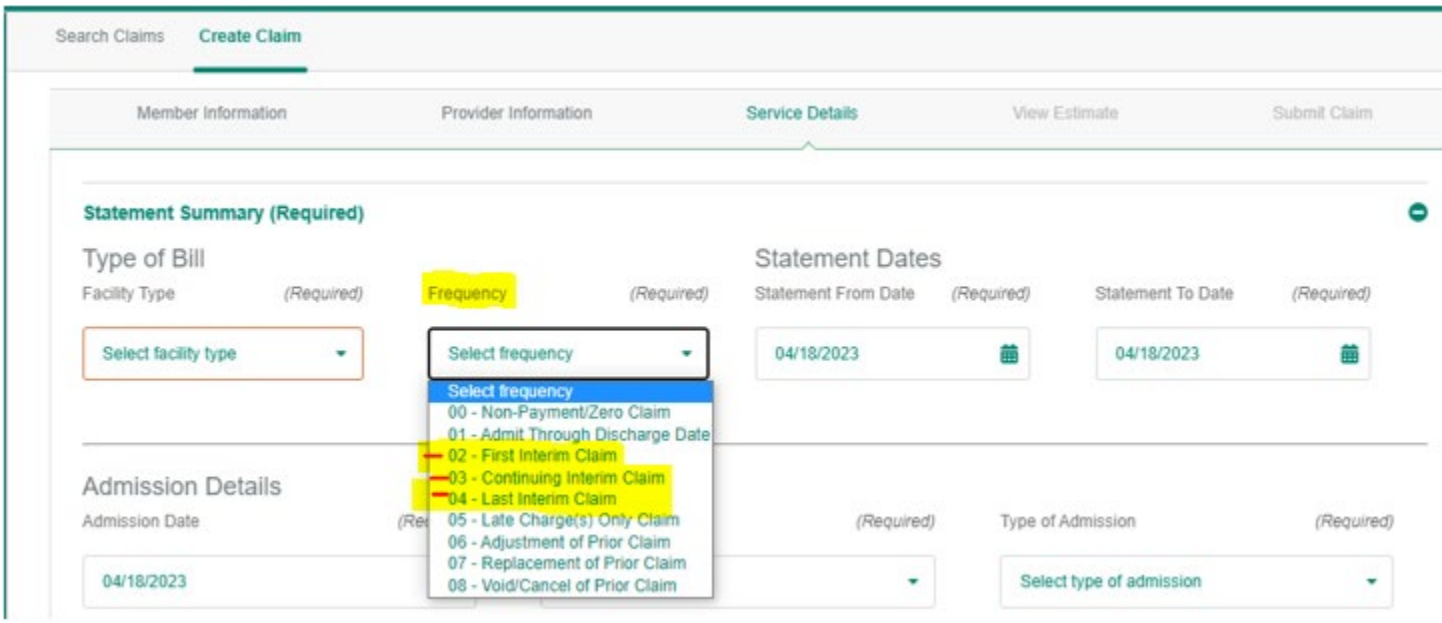
Screen Shot 1

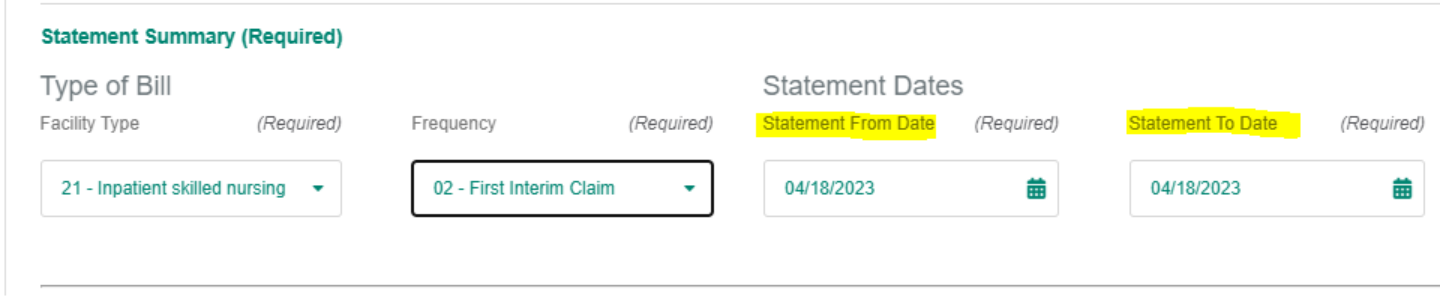


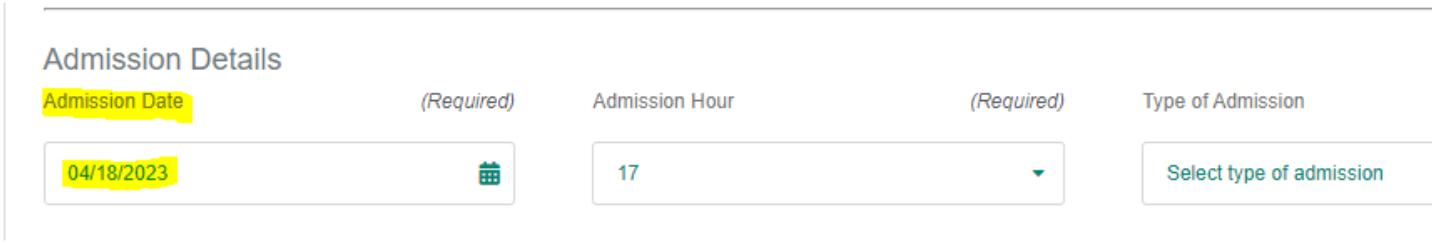


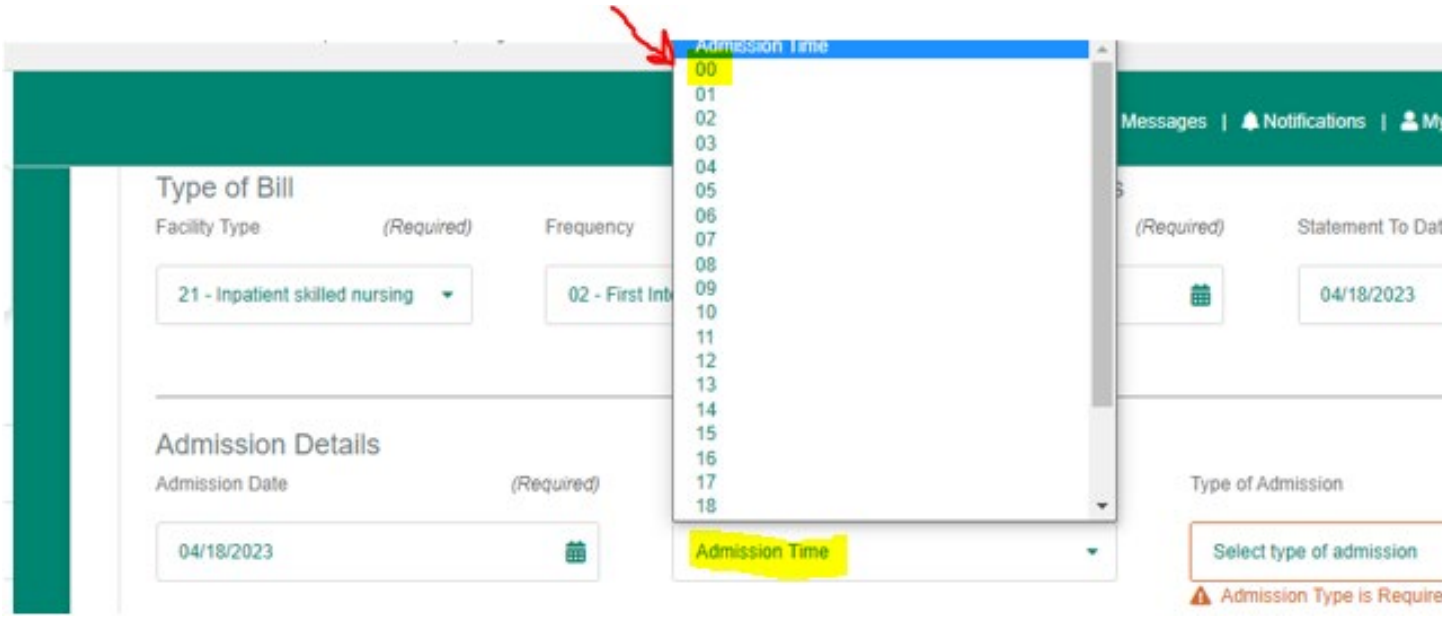

Search Claims
Create Claim
Member Information
Provider Information
Service Details
View Estimate
Submit Claim
Provider Information
Select the claim type, provider name, and the service address.
Claim Type
(Required)
Professional Claim
Professional Claim
Institutional Inpatient Claim
Institutional Outpatient Claim
Provider Name
(Required)
ALLIS CARE CENTER (ID: QEMSC0007479; NPI: 1598750671; Tax ID: 201684547; Address: 9047 W GREENFIELD AVE, WEST ALLIS, WI, UNITED STATES 53214)
Next

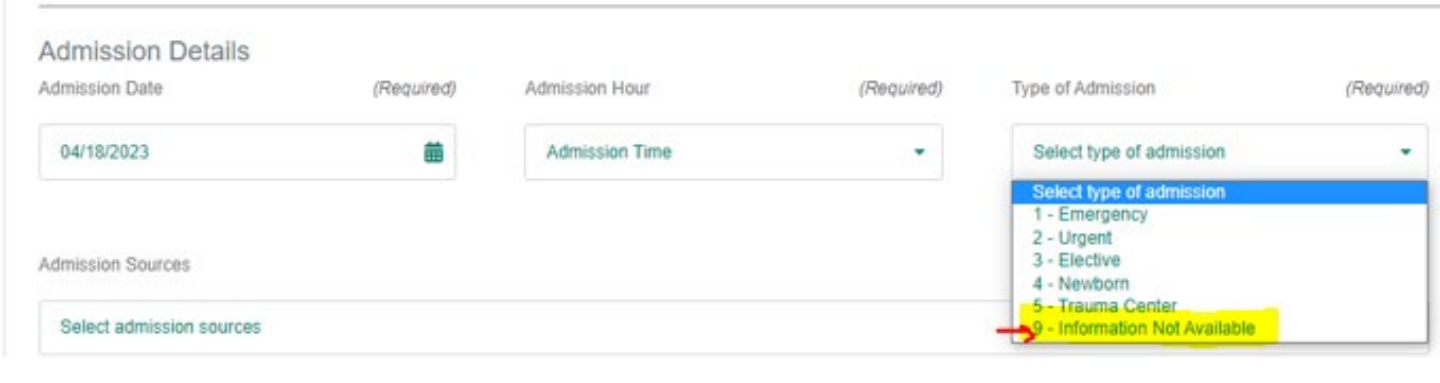

Member Information
Provider Information
Service Details
View Estimate
Submit Claim
Statement Summary (Required)
Type of Bill
Facility Type
(Required)
Frequency
(Required)
Statement Dates
Statement From Date
(Required)
Statement To Date
(Required)
Select facility type
Select frequency
04/18/2023
04/18/2023
Select facility type
11 - Inpatient hospital
12 - Inpatient hospital (Med B only)
21 - Inpatient skilled nursing
22 - Inpatient skilled nursing (MedB only)

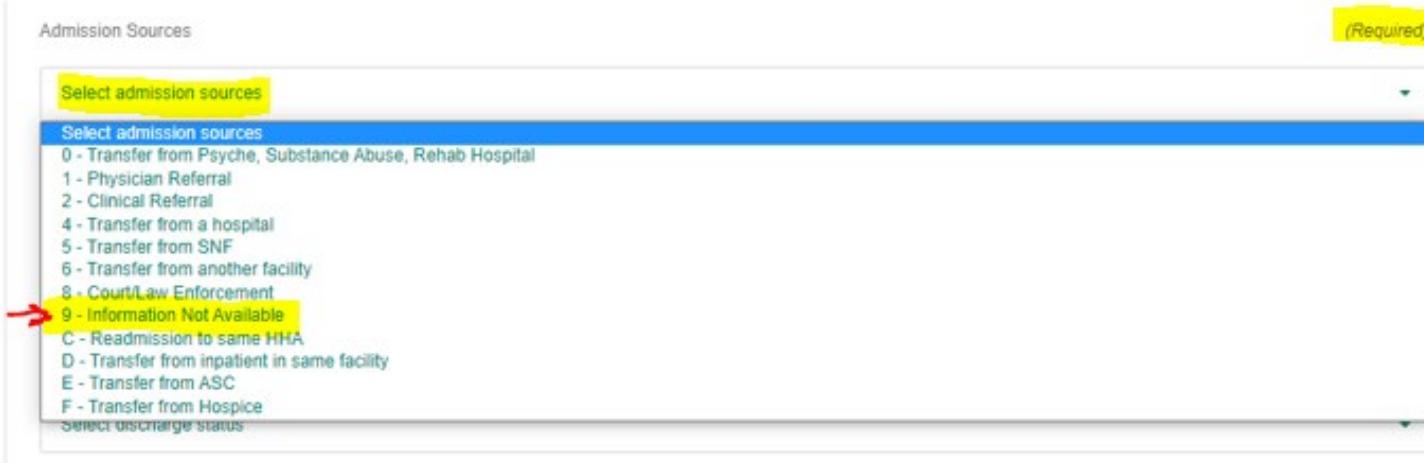

Search Claims
Create Claim
Member Information
Provider Information
Service Details
View Estimate
Submit Claim
Statement Summary (Required)
Type of Bill
Facility Type (Required)
Frequency (Required)
Statement Dates
Statement From Date (Required)
Statement To Date (Required)
Select facility type
Select frequency
04/18/2023
04/18/2023
Select frequency
00 - Non-Payment/Zero Claim
01 - Admit Through Discharge Date
02 - First Interim Claim
03 - Continuing Interim Claim
04 - Last Interim Claim
05 - Late Charge(s) Only Claim
06 - Adjustment of Prior Claim
07 - Replacement of Prior Claim
08 - Void/Cancel of Prior Claim
Admission Details
Admission Date
(Required)
Type of Admission (Required)
04/18/2023
Select type of admission


Statement Summary (Required)
Type of Bill
Facility Type (Required)
Frequency (Required)
Statement Dates
Statement From Date (Required)
Statement To Date (Required)
21 - Inpatient skilled nursing
02 - First Interim Claim
04/18/2023
04/18/2023


Admission Details
Admission Date (Required)
Admission Hour (Required)
Type of Admission
04/18/2023
17
Select type of admission


Admission Time
00
01
02
03
04
05
06
07
08
09
10
11
12
13
14
15
16
17
18
Messages | Notifications | My
Type of Bill
Facility Type (Required)
Frequency
(Required)
Statement To Dat
21 - Inpatient skilled nursing
02 - First Int
04/18/2023
Admission Details
Admission Date (Required)
Type of Admission
04/18/2023
Admission Time
Select type of admission
Admission Type is Require


Admission Details
Admission Date (Required)
Admission Hour (Required)
Type of Admission (Required)
04/18/2023
Admission Time
Select type of admission
Select type of admission
1 - Emergency
2 - Urgent
3 - Elective
4 - Newborn
5 - Trauma Center
9 - Information Not Available
Admission Sources
Select admission sources


Admission Sources
(Required
Select admission sources
Select admission sources
0 - Transfer from Psyche, Substance Abuse, Rehab Hospital
1 - Physician Referral
2 - Clinical Referral
4 - Transfer from a hospital
5 - Transfer from SNF
6 - Transfer from another facility
8 - Court/Law Enforcement
9 - Information Not Available
C - Readmission to same HHA
D - Transfer from inpatient in same facility
E - Transfer from ASC
F - Transfer from Hospice

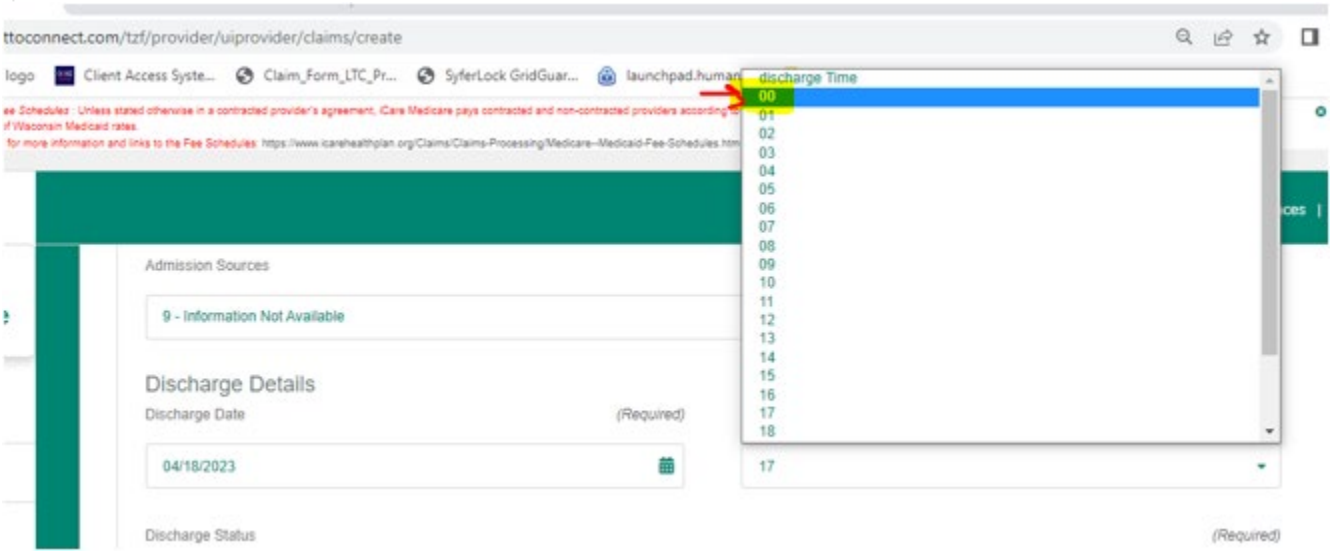
Discharge Details

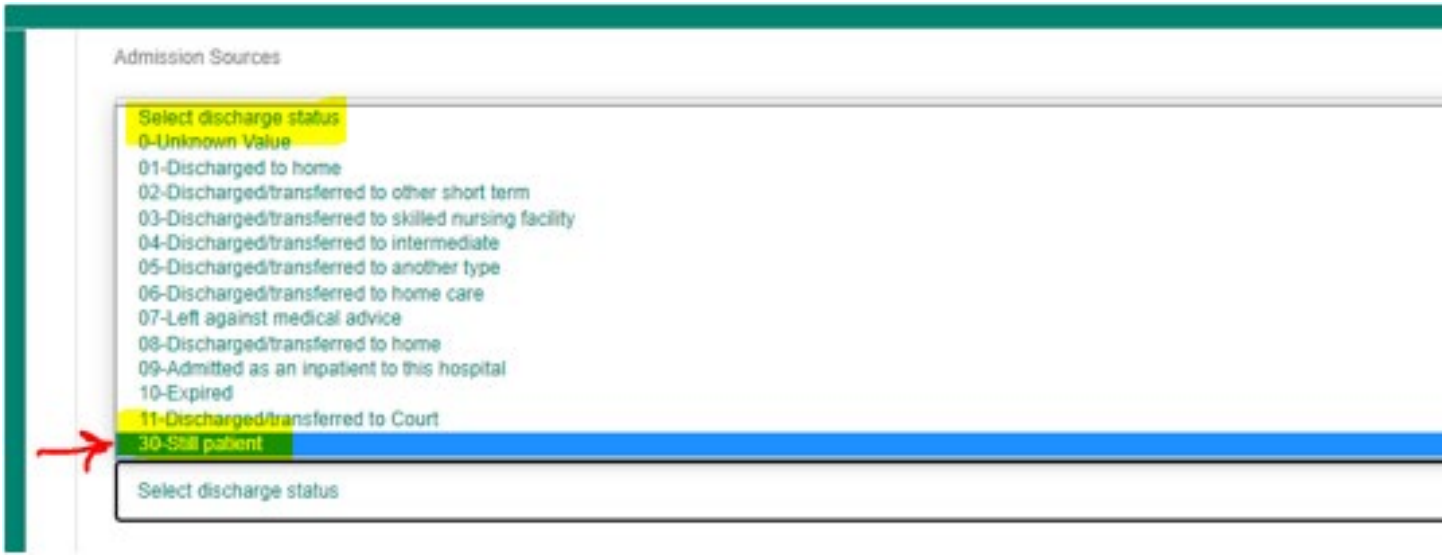
Discharge Date *(Required)*

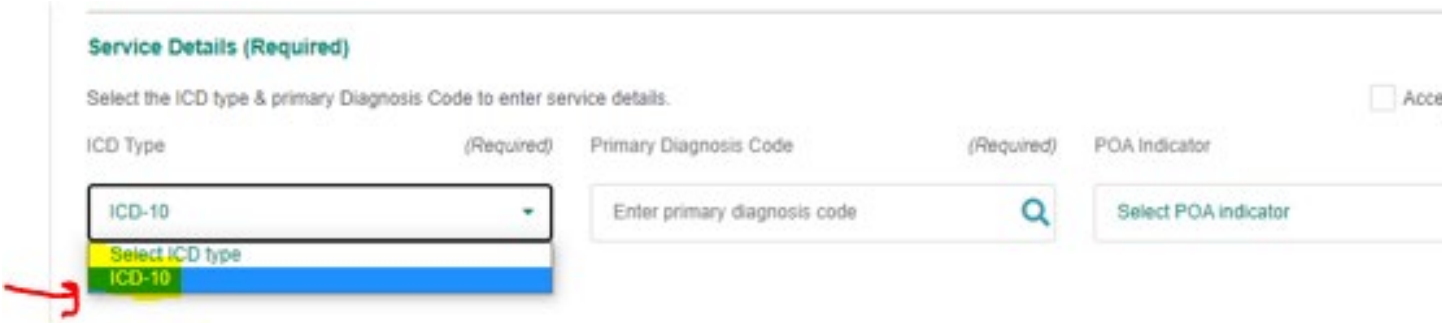
04/18/2023

Discharge Hour

17







Service Details (Required)

Select the ICD type & primary Diagnosis Code to enter service details.

ICD Type *(Required)* | Primary Diagnosis Code *(Required)* | POA Indicator

ICD-10 | Z02.9 | Select POA indicator

Service Line 1

Date of Service From *(Required)* | Date of Service To

04/18/2023 | 04/18/2023

Revenue Code | CPT / HCPCS | Modifiers

Enter Revenue Code | Enter CPT / HCPCS | Enter modifiers

Revenue Code | CPT / HCPCS | Modifiers

0120 | Enter CPT / HCPCS | Enter modifiers

NDC Code | Units *(Required)* | Unit Type *(Required)* | Charge *(Required)* | Amb

Enter NDC code | 1 | Units | $ 0.00

NDC Code | Units *(Required)* | Unit Type *(Required)* | Charge *(Required)* | Ambula

Enter NDC code | 1 | Units | $ 0.00 | Zip

Select unit type
Units
Minutes
Days

NDC Code | Units *(Required)* | Unit Type *(Required)* | Charge *(Required)* | An

Enter NDC code | 1 | Units | $ 1.00

Claims Service Line

Service Date(s)	Revenue Code	Charged	Allowed	Plan Discount	Copay	Coinsurance	Deductible	Member Responsibility	P
04/18/2023-04/18/2023	0120	$1.00	$0.00	$1.00	$0.00	$0.00	$0.00	$0.00	

CPT Description

0120-Room & Board - Semi-private (Two Beds)