Billing & Claims Orientation

- 2023 –

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TIMELY FILING

Clean claims must be filed at the address designated by Integrated within the time frame described in the corresponding Provider Agreement or within the period of time required by applicable law if longer.

Claims received by Integrated after the filing deadline may be denied, and Providers cannot bill the patient for such services.

All claims must be submitted 75 days from the date of service.

Corrected claims must be submitted within 45 days of payment.

Paper claims must be mailed red/white to:

Integrated Home Care Services, Inc.
Attention: Claims Department
3700 Commerce Parkway
Miramar, FL 33025

Claim Submission Guidelines

Updated: December 15, 2022

All Claims

- Utilize only approved claim forms:
  - OMB-0938-0997 CMS 1500 claim form or 837P Electronic format
  - OMB-0938-0997 UB-04 claim form or 837I Electronic format
- Verify member eligibility before submission. Claims for ineligible members will be rejected.
- Total charges on claims must equal the total of all individual claim lines submitted.
- Diagnosis codes must be ICD-10 compliant and valid for the date of service billed.
- Corrected Claims:
  - CMS-1500: Corrected claims must include submission frequency code 7 and the original claim number in the 'Original Ref. No' field
  - UB-04: Correct claims must be submitted with bill Type 327 and the original claim number in Box 64
- Procedure codes must be valid for the date of service billed.
- Integrated Authorization number must be included on the claim. Ensure the authorization number includes any hyphens and is complete:
  Examples:
  - **Home Health:** H-202201600101
  - **Home Infusion:** I-202201600101, T-202201600101 (transitional care)
  - **DME:** D-202201600101
- Submit only one authorization per claim.
- Each date of service must be on a single line. Do not bill date ranges on the claim line.
- Provider NPI:
  - CMS 1500 and UB-04: Referring provider name and NPI must be valid and registered in NPPES (NPPES NPI Registry (hhs.gov))
  - UB-04: Attending provider name and NPI must be valid, registered in NPPES (NPPES NPI Registry (hhs.gov)) and registered in PECOS (Home Page - Centers for Medicare & Medicaid Services Data (cms.gov))

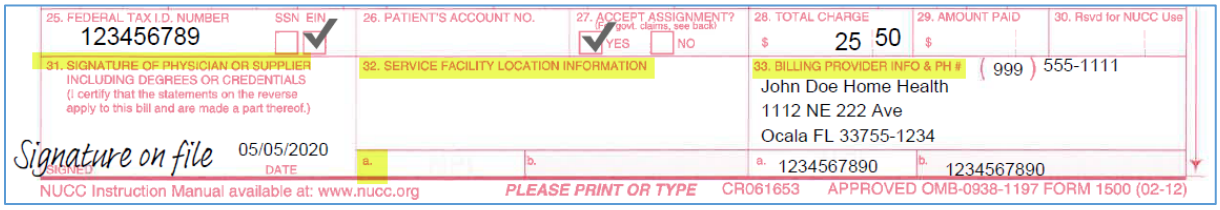
Medicaid Home Health Claims

- Submit claims using CMS1500 claim form or 837P format if billing electronically.
- Diagnosis pointers in Box 24E must correlate to diagnosis code(s) in Box 21 and must be valid for the date of service.

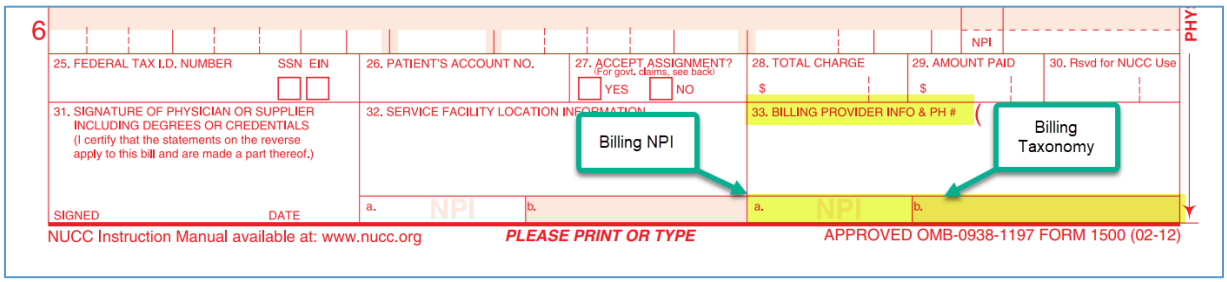
Example:

- Rendering Provider NPI must be in Box 32A and ***rendering location in Box 32 (2310C for 837P)***. It is very important that Box 32 (2310C for 837P) be populated with the address ***where the services were rendered***. The address must contain the zip code +4.
- Box 31 must have a signature or state 'Signature on File'.
- Box 33 must have the physical address listed on the AHCA PML file including the zip code+4. PO Box addresses are not permitted.

Example:



- Box 33a must have the billing provider NPI. Box 33b must have the billing provider Taxonomy code.



Medicare Home Health Claims

- Submit claims using UB-04 (CMS-1450) or 837I format if billing electronically.

- Acceptable Bill Types:

Code	Usage
322	Interim; First claim for the patient
323	Interim continuing claim
324	Interim last claim
327	Corrected claim
328	Void of original claim

  Claims will an invalid bill type will be rejected for correction and resubmission.

- Condition codes are two digits and are reported in boxes 18 through 28.

- Value codes and their associated value amounts are required in boxes 39a through 39d.

- Medicare requires a HIPPS (level of service) line to be reported as a service line. The HIPPS line must be included with a valid HIPPS code for the date of service using Revenue (REV) code 0023.
  Valid HIPPS codes are located on the CMS website: HIPPS Codes | CMS

  - Electronic claim submissions must include 'HP' in the Product/Service ID Qualifier field on the HIPPS line.
  - HIPPS Line must be populated with units equal to one (1).

- Statement dates, to and from, are reported in Box 6 and must coincide with the first and last dates of service on the claim.

- Principal diagnosis, Box 67 is required. Other Diagnosis Codes, Boxes 67A-Q, are reported when applicable.

- Servicing location, Box 38 (2310E for EDI 837I), is required. This field is be populated with the address of the servicing location for Medicare home health services. The address must contain the zip code +4.

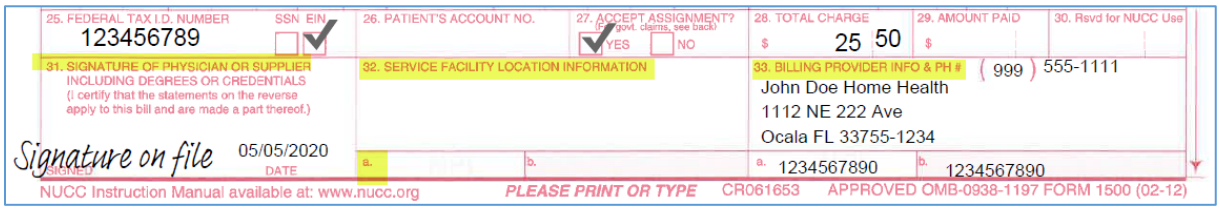
DME and Home Infusion Claims

- Submit claims using CMS1500 claim form or 837P format if billing electronically
- Diagnosis pointers in Box 24E must correlate to diagnosis code(s) in Box 21 and must be valid for the date of service.

Example:

- Rendering Provider NPI must be in Box 32A and rendering location in Box 32.
- Box 31 must have a signature or state 'Signature on File'
- Box 33 must have the physical address listed on the AHCA PML file including the zip code+4; PO Box addresses are not permitted.

Example:



- **DME Claims:** Delivery Ticket/Invoice must be uploaded to the MedTrac Portal. A copy of the delivery ticker or invoice should be included with paper claims.

Additional Information

- VisibilEDI claim number assignment may take 24 to 48 hours.
- Timeframe for claim processing:

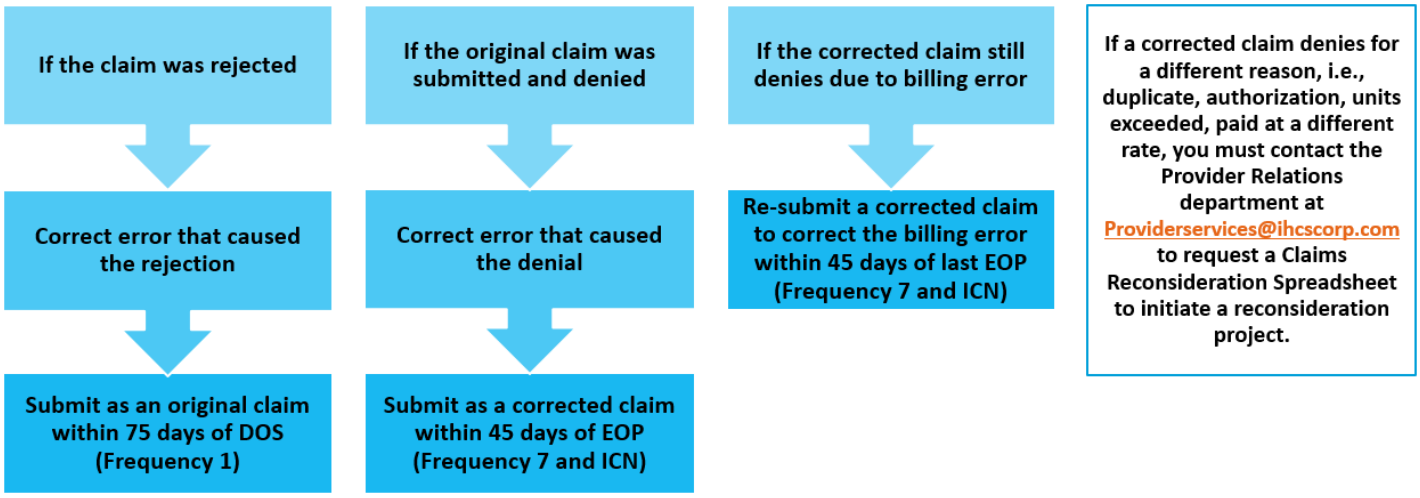
Claim Type/Product	Timeframe for Processing
Electronic Medicaid Claims	7-10 Days
Electronic Medicare Claims	20 Days
Electronic Commercial Claims	
Paper Medicaid Claims	20 Days
Paper Medicare Claims	30 Days
Paper Commercial Claims	

- Providers billing for clients who have another health plan as primary, Coordination of Benefits (COB) provisions apply:
    - The provider must submit the claim with a copy of the Explanation of Payment (EOP) from the primary health plan.
    - If the service is covered by the primary carrier, then IHCS will allow the member responsibility after the primary carrier, up to the contracted amount.
    - If the service is excluded by the primary carrier, then the provider is required to obtain authorization through the secondary carrier.

CLAIMS REFERENCE LINKS

- Home Health Medicare Billing Codes Sheet (Home Health & Hospice) (cgsmedicare.com)
- **HIPPS Codes:** HIPPS Codes | CMS
- **1500 Claims Reference Manual:** https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42
- **CMS Claims Reference for UB-04 (CMS-1450):** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf
- **NPPES NPI Registry:** https://npiregistry.cms.hhs.gov/
- **PECOS Registry:** https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
- **NPI Ordering and Referring PECOS Lookup:** https://data.cms.gov/
- **X12 CARC/RARC Codes:** https://x12.org/codes/claim-adjustment-reason-codes
- **X12 Companion Guide for Professional Claims:** https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/5010a1837bcg.pdf
- **X12 Companion Guide for Institutional Claims:** https://www.cms.gov/medicare/billing/electronicbillingeditrans/downloads/5010a2837acg.pdf
- **External Cause of Injuries:** https://icd10coded.com/cm/injuries/

CORRECTED CLAIMS & RECONSIDERATIONS



If submitted on paper, the corrected claim must include clearly visible markings that indicate the claim has been corrected.

After receipt of your completed request for reconsideration, we will research your concern and respond to you as soon as possible. If the request for reconsideration is resolved in your favor, the claim will be adjusted and an explanation of payment (EOP) issued.

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.

When correcting a CMS-1500 or UB-04 claim, **resubmit all original lines and charges as well as the corrected or additional information.**

Claim Frequency Codes		
Code	**Description**	**Filing Guidelines**
7	Replacement of a Prior Claim Use to replace an entire claim (all but identify information)	File the claim in its entirety, including all services for which you are requesting reprocessing
8	Void/Cancel of Prior Claim Use to entirely eliminate a previously submitted claim for a specific provider, patient and 'statement covers period'	File the claim in its entirety. Include all charges that were on the original claim

Paper Corrected Claims:

When correcting UB-04 Institutional claims, use bill type xx7, Replacement of Prior Claim and include the original claim number in Box 64 'Document Control Number'.

When correcting CMS-1500 Professional claims, use Frequency code 7, Replacement of Prior Claim in Box 22 'Resubmission Code' along with the original claim number in the 'Original REF NO' field.

Electronic (EDI) Corrected Claims:

The 837 Implementation Guides refer to the Nation Uniform Billing Data Element Specifications Loop 3400 CLM05-4 for explanation and usage. In the 847 formats, the codes are called 'claim frequency codes'. Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim.

When submitting claims noted with claim frequency code 7 or 8, the original claim number, also referred to as the Document Control Number (DCN) must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The DCN can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original DCN, adjustment requests will generate a submission error and the claim will reject. IHCS only accepts claim frequency code 7 to replace a prior claim or 8 to void a prior claim.

PECOS

Background:

Provider Enrollment, Chain, and Ownership System or PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage their Medicare enrollment information. CMS developed PECOS because of the Patient Protection and Affordable Care Act. This regulation requires all physicians who order or refer a patient for home healthcare services or supplies to be enrolled with Medicare. The PECOS requirement became effective July 6, 2010.

All Medicare attending providers are required to be registered in PECOS. For home healthcare claims, the attending provider must be registered as Home Health in PECOS. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in a given claim. PECOS enrollment is required when an institutional claim contains any services other than non-scheduled transportations services.

The Home Health Agency enters the name and the National Provider Identifier (NPI) of the attending physician who signed the plan of care. The attending physician cannot be the Home Health Agency.

It is important providers keep their PECOS up-to-date. Anytime the there is a change related to the provider information, please make sure the information is updated within 30 days of the event.

The attending provider's NPI and first four (4) characters must match an active value in the PECOS database provided by CMS in order for IHCS to process the submitted claims. If the attending provider on the claim does not correlate with the PECOS database, then the claim will be rejected. Please make sure your registration matches all specialties.

EFT ENROLLMENT

Integrated Home Care Services is encouraging providers to sign up and have access to EFT deposits.

What is EFT?

An electronic funds transfer, or EFT, is the electronic message used by our company to approve a financial institution to electronically transfer funds to a provider's account to pay for the services they rendered.

There are many benefits associated with using EFTs including receiving payments faster. Signing up for EFT means, you do not have to wait for the check to arrive in the mail or worry about a lost check.

To enroll in EFT please email EFT@ihcscorp.com

For providers that currently have a registered MedTrac user ID, we can enable EFT function under your MedTrac ID.

Please contact us at EFT@ihcscorp.com and provide us with your MedTrac username.

For new MedTrac users, please select **EFT PERMISSIONS** when completing your MedTrac IT Access Form.

VisibilEDI

We encourage you to submit claims electronically via our clearinghouse, VisibilEDI. On VisibilEDI you will be able to:

- Submit and look up claims status
- View payments
- Submit a claims inquiry/support ticket
- Search for and view EOP

Please click on the link below to sign up for VisibilEDI:

https://visibiledi.com/ihcs/Login.aspx

IHCS Payer ID is IHCS1

You can use VisibilEDI as long as you can create the 837EDI (837P for Medicaid and 837I for Medicare). You may use your preferred clearinghouse, but still have access to VisibilEDI in order to see your EOP and claim status.

Once you have registered on VisibilEDI, please contact us at Providerservices@ihcscorp.com so that we may activate your account.

Paper claims (Medicaid CMS 1500 and Medicare UB04) can be submitted to IHCS along with the supporting paperwork/notes or timesheets to:

Integrated Home Care Services
Attention: Claims Department
3700 Commerce Parkway
Miramar, FL 33025

Use the Health Plan Portal to view claims, claim status messages, payments, and check eligibility. You can access the portal 24 hours a day, seven days a week.

To log out, click Logout on the ribbon. The system will automatically log you out after 30 minutes of inactivity.

Get Support

For questions or support, email us any time or call us Monday through Friday from 8:30 AM to 5:30 PM EST.
(844) 215-4264 option 4
providerservices@ihcscorp.com

Please review the attached VisibilEDI User Guides for information on submission, uploading, downloading, claim file status, navigating the portal, viewing and resolving pended claims, searching for and viewing EOPs, and much more.

VISIBILEDI FREQUENTLY ASKED QUESTIONS

Q: How do I find my payments in the portal?

A: Refer the provider to the User Guide within the portal to navigate the Payments modules. But if the provider is unable to locate a payment from the Payment Downloads tab:

1. On the Payment Downloads tab, ensure they have expanded the date range in the left navigation to cover the appropriate date span for the payments in question. If they still do not find the record…
2. Obtain the Check/EFT # from them and look it up yourself. a. On the Payment Downloads tab, expand the date range in the left navigation, then click on the filter option in the EFT/Check column and enter the check # and click Search. If you can locate it…
3. Check the provider's account to see if they are linked to all necessary provider organizations. Payments are linked to IHCS vendor records based on Tax ID and Billing NPI. If the provider's user account is not linked to the record with the matching Tax ID and Billing NPI, associated payment records will not be visible to them.
4. If you cannot locate the payment from the Downloads module, locate the check # from the appropriate inbound batch (in to VisibilEDI from IHCS) in the Payment Submissions module. Payments must be in Exported status. If the record is in any other status, submit a ticket within the Support Center.

Q: What if IHCS's Payer ID isn't available in my software or through my clearinghouse?

A: Submit a ticket to your software vendor or clearinghouse to have Payer ID IHCS1 added. You should mention in the ticket that IHCS's clearinghouse is VisibilEDI.

Q: How do I submit a replacement claim?

A: If the original claim was submitted electronically: find the claim in the portal. If it is in 'Accepted' status, make the necessary changes then go to the 'Other' tab, change the frequency ID to '7', enter the ICN if it is not present, and click save.

If the original was submitted via paper the provider can submit a Frequency ID of 7 on the resubmission via their Clearinghouse or claims management system.

Q: Why Can't I See My Claims?

A: Access to certain features of the portal such as Online Inquiry, Payment Submissions and Downloads, and Eligibility are directly linked to the privileges associated with your account. Missing privileges or inaccurate data can prevent you from accessing the appropriate information. Contact your Portal Administrator to troubleshoot your access privileges.

Q: How Do I Troubleshoot a Pended Claim?

A: To troubleshoot a Pended Claim, use the following steps:

Review the Pend Claim Status Message to determine root cause, such as missing or incorrect data.

Correct data within the portal. If needed, correct and upload source documentation. If there are further issues, contact the account manager.

Save and submit the claim for processing.

EVV: NETSMART

FOR FLORIDA MEDICAID PROVIDERS ONLY

Integrated Home Care Services, a third party administrator, has a process in place to be compliant with Electronic Visit Verification compliance monitoring to strengthen the integrity of Medicaid Managed health care plan programs that we are contracted to provide services for while also providing transparency for consumers. It bridges the gap between States, Payers, Providers and Caregivers.

Section 409.9132, Florida Statutes (F.S.), directs the Agency for Health Care Administration (Agency) to competitively procure a Vendor to operate an Electronic Visit Verification (EVV) Program of home health services provided through the fee-for-service delivery system. The EVV Program must verify the utilization and delivery of home health services (home health visits, private duty nursing, and personal care services) using technology that is effective for identifying delivery of the service and deterring fraudulent or abusive billing for the service. Also, the EVV Program must provide an electronic billing interface and require the electronic submission of claims for home health services. Home health agency providers who render services through the fee-for-service delivery system must register and create an EVV Dashboard profile for their home health agency in the AHCA EVV system to be able to schedule services or submit claims for reimbursement. Providers may create one initial EVV System Administrator account by going to: NetsmartCONNECT Sign in (b2clogin.com)

Note: The Florida Agency for Health Care Administration (Agency) has contracted with Centric Consulting, LLC (Vendor), to implement the AHCA Electronic Visit Verification (EVV) Program for home health providers furnishing services through the fee-for-service delivery system. The AHCA EVV Program is powered by Tellus, LLC technology and uses the Tellus EVV software to verify the utilization and delivery of home health services (home health visits, private duty nursing, and personal care services) Also, the AHCA EVV Program will provide an electronic billing interface and require the electronic submission of claims for home health services.

1. Claims requiring EVV need to be submitted through the NETSMART/TELLUS Simply EVV Vendor.

2. Upon verification of the EVV by NETSMART/TELLUS, the EVV vendor sends the claim information through IHCS' clearinghouse, VisibilEDI, and subsequently to IHCS.

3. Upon receipt of the electronic claims and time for processing, the IHCS Claims Examiner recognizes and differentiates these claims by an identifier "EVV" on the assigned claim ID number. This will preclude the examiner from looking for the physical notes/timesheets on the billed services.

4. Upon quality assurance verification that all data is acceptable, claims are adjudicated and reimbursed.

LIST OF SERVICES AND CODES REQUIRING EVV:

PRODUCT	DESCRIPTION OF SERVICE	SIMPLY
LTSS	ATTENDANT CARE SERVICES	S5125
LTSS	HOMEMAKER SERVICE	S5130
LTSS	ADULT COMPANION CARE	S5135
LTSS	RESPITE IN HOME	S5150
LTSS	INTERMITTENT & SKILLED (LPN)	T1003
LTSS	INTERMITTENT & SKILLED (RN)	T1002
LTSS	PERSONAL CARE	T1019
MMA	PERSONAL CARE BY HOME HEALTH AIDE	S9122
MMA	PERSONAL CARE BY RN	S9123
MMA	PERSONAL CARE BY LPN	S9124
MMA	HOME HEALTH AIDE	T1021
MMA	RN SERVICES	T1030
MMA	LPN SERVICES	T1031

Visit notes requirements: Private Duty Nurses – S9122, S9123 and S9124

Visit notes are not required: Companion Services – only time sheets are required.

Example HCPC code: S5135, T1019, S5130, S5150

Note: All visit notes need to be available upon IHCS request

Skilled services requiring visit notes:

- RN – Registered Nurse
- LPN – Licensed Practical Nurse

EVV Claims & Healthy Kids

FL Healthy Kids ARE EXCLUDED from the EVV Compliance requirements and are not submitted to NETSMART

Claims for FL Healthy Kids must be submitted directly to IHCS

Please contact NETSMART/TELLUS if you require assistance: **(833) 483-5587** or by opening a service ticke directly with NETSMART/TELLUS at www.mobilecaregiverplus.com

If you experience any technical, submission, or authorization issues with Netsmart/Tellus, you MUST open a Service Ticket/CS # with them directly and contact Provider Relations immediately with the Service Ticket/CS #.

Once you have provided us with your Service Ticket/CS #, a member of the Provider Relations team will contact Netsmart/Tellus to help expedite a resolution.

PLEASE NOTE: *While undergoing Integration/Implementation/Training with Netsmart, claims should be submitted directly to IHCS to avoid timely filing issues.*

Please contact Cynthia Leon, EVV/PDN Provider Relations Specialist at cleon@ihcscorp.com for assistance.