PROVIDER MANUAL

Integrated Home Care Services, Inc.

3700 Commerce Parkway
Miramar, FL 33025
Phone: (844) 215-4264
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Brought to you by the IHCS Provider Relations and Compliance Team as part of our commitment to Vendor Delegation Training and Management

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Introduction

Thank you for your participation with Integrated Home Care Services, Inc. (IHCS). Our goal is to provide quality services to the members enrolled in the Health Plans with which we contracted. This Provider Manual is intended to serve as a guide for you and your staff with information related to claims submissions, authorizations, compliance policies, protocols, and procedures. The guidelines outlined in this Provider Manual are designed to assist you in providing caring and responsive service to the members enrolled in the Health Plans we are contracted with to service. We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact our Provider Relations Department.

Company Information, Mission, Vision and Values

Integrated Home Care Services, Inc. (IHCS) is a for profit, Florida health care quality improvement, medical cost management and health information technology company providing a wide range of effective and efficient solutions for our health plan clients. Services include care coordination, utilization review, and quality improvement, provision of home medical services inclusive of home health, durable medical equipment/supplies and pharmacy home infusion. IHCS is committed to assisting our downstream providers to embrace quality standards, Medicare and Medicaid compliance to maximize and improve the quality of care provided to our patients/recipients.

Integrated Home Care Services Compliance and FWA Programs

Compliance is everyone's business and Integrated Home Care Services, Inc. expects the same diligence and dedication from its provider network in these important endeavors.

In order to share our commitment to compliance with you, please visit our website at www.ihcscorp.com to review the following program tutorials and informational trainings for you and your staff to enjoy! Please review these programs with your managers and field staff. They are:

- IHCS Compliance Program Outline
- IHCS HIPAA PowerPoint
- Reporting Fraud Waste and Abuse Hotline
- Patient Rights and Responsibilities
- Medicare sanctioned Part C and Part D General Compliance Training
- FDR Affidavit and Training

CONTACT INFORMATION

MedTrac Portal	
Portal Access & Training	providertraining@ihcscorp.com
Authorization Requests or Inquiries	
Initial Authorization Requests	(844) 215-4264 Ext 7533 / Fax: (844)215-4265
For Authorization Status, Re-Authorization Requests or Add-On Services	(844) 215-4264 Ext 7533
Home Health Services	
Maritza Perez, UM Home Health Manager	(844)215-4264 Ext 7417
Grisel Ibanez, LPN, UM Case Manager	(844)215-4264 Ext 7354
Grace Iglesias, Lead Referral Coordinator	(844)215-4264 Ext 7351
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Nicole Huie, Director of Referrals	(844)215-4264 Ext 7367
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Tanaka Bryant, Pharmacy Intake Coordinator	(844)215-4264 Ext 7475
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For any questions regarding Claims (Status, Appeals, and Support)	(844)215-4264 Ext 2532 or Select Option 3 ClaimsInquiry@ihcscorp.com
Provider Contracting & Credentialing	
Florida Provider Contracting & Nationwide Credentialing	(844)215-4265 Ext 7534 or Select Option 4 Option 2 ProviderNetwork.Credentialing@ihcscorp.com
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Provider Relations	
Provider Relations	(844) 215-4264, Option 4, Option 1 – providerservices@ihcscorp.com
Vonnessa Ruffin, Manager of Provider Relations	(844) 215-4264 Ext 7675 – vruffin@ihcscorp.com

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Donna Gale, VP of Compliance	(844) 215-4264 Ext 7494
Mark Gilchrist, Director of Compliance	(844) 215-4264 Ext 7495

Performance Standards

As a participant of Integrated Home Care Services (IHCS) Provider Network, you are required to:

- Provide high quality, compassionate care to patients.
- Provide written notices regarding changes in your organization. These changes must be submitted to Integrated Home Care Services, Inc. within a timely manner as required in your Provider Service Agreement and this Provider Manual.
- Maintain 24-hour on-call coverage 7 days per week, respond to patient and/or IHCS within 30 minutes of call, including weekends, evenings, and holidays, unless otherwise specified by contract.
- Submit Claims for authorized services and/or products to IHCS at least monthly and within the timely filing timeframe. Claims must be submitted to the designated address for claims or via the portals.
- Shall not submit Claims to the primary Health Plan for services/products unless directed to do so by IHCS in writing;
    - No patient/member will be sent a bill for the covered services or for services in which payment was denied due to failure to comply with the Provider Service Agreement or this Provider Manual. Not otherwise bill the patient/member for any covered services;
- Provider shall collect deductibles, co-payments and/or co-insurance from patients as identified and instructed by Integrated Home Care Services. At no time shall Provider collect any monies due from AvMed Health Plan Members. Providers shall not collect any monies from patients without consent from Integrated. Providers are paid for authorized covered services in accordance with their rates found in the Provider Service Agreement, less any applicable deductibles, co-payments and/or co-insurance due from patients.
- Provider will promptly return any overpayments received for services provided to Integrated Home Care Services per the Provider Service Agreement.
- Provider agrees not to charge the member where payments were denied for services that were deemed not medically necessary.
- Provider agrees not to charge the patient for such services in advance of provision of the service unless the member agrees in writing to accept the financial responsibility.
- Provider shall submit medical records, quality assessment, quality improvement, clinical outcomes, program evaluation, and other reports **upon request** of IHCS's personnel and cooperate fully with any audits conducted by IHCS. Requested records must be provided to IHCS at no charge to Integrated and within the timeframes requested.

NOTE: If Provider fails to provide records within the requested timeframe in order to substantiate services billed, payments on the claims that are in subject of the record request may be reversed and recovered through fund request or offset.

The Provider shall also:

- Participate in Integrated Home Care Services, Inc. Quality Improvement initiatives as requested.
- Notify patients of FDA recalls affecting them and facilitate the repair, replacement and/or resolution of the recall according to the guidelines issued by the manufacturer in the FDA notification.
- Adhere to all other principles, practices and procedures found in the Provider Service Agreement, IHCS's Provider Manual, and the contractual relationships between IHCS and its Health Plan customers.

For the most up-to-date policies, procedures, or provider operations, please visit our website at www.ihcscorp.com .

Report any Incidents that may occur with a Health Plan Member relating to Compliance/Quality or FWA using the mandated IHCS form in accordance with F.S. 395.0197. (1) A facility shall, as a part of its administrative functions, establish an internal and external risk management program that includes all of the following components: (a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients. ***PURSUANT TO F.S 395.0197***

Utilization Management Program

The UM Program seeks to:

- Coordinate the delivery of care that is aligned with State and Federal Regulatory guidelines.
- Promote the efficient Utilization of services/resources.
- Monitor patterns of Utilization over time to reduce variations in UM decision-making and delivery of care.
- Improve continuity of care and patient outcomes through effective case management.
- Enhance physicians and patient satisfaction by facility access, enhancing awareness of medical necessity and appropriateness of services.

IHCS's Utilization Management Process

Utilization Management is the evaluation of the appropriateness, medical necessity and efficiency of healthcare services according to established criteria or guidelines under the provisions of the patient's benefit plan. Providers (Home Health Agency/Ordering Provider) and Members may request the Clinical Review Criteria/Policies used to make the UM Decision. The request can be made by phone at 1-844-215-4264 ext. 7533. When Integrated Home Care Services, Inc. is responsible for conducting a review of the medical necessity of a proposed service, the following is our standard medical necessity definition:

- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and
- Not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage.

Utilization Management Responsibilities

Providers have the following Utilization Management responsibilities:

- Provide and maintain appropriate documentation to establish the existence of medical necessity.
- Obtain authorization prior to beginning services/products. Services/products performed without authorization may be denied for payment, and any such denial of payment is not billable to the patient by the Provider.
- Verify the information on the Authorization Form (service codes, HCPCS, modifier, number of units, start and stop date, Provider name and location) upon receipt. While the Integrated UM staff work to assure the accuracy of the information on the Authorization Form, mistakes can occur. Should you identify an error, call IHCS within 24 hours to correct the error.
- Notify IHCS immediately if, when the services or equipment is delivered, the diagnosis is determined to be different from the diagnosis information obtained from Integrated.
- Notify IHCS if the services ordered will not meet the needs of the patient. You may be asked to assist in identifying alternatives and discussing with Integrated and the ordering physician.
- Participate in case conferences.
- Respond to all requests for contact from Integrated within 24 hours.
- Respond to all requests for contact from the Health Plan case manager within one business day. IHCS will act as a liaison when a Health Plan case manager requests information. Providers should not initiate contact with a Health Plan case manager unless directed to do so by IHCS.
- If requested by IHCS, provide assessment reports, progress reports, organization forms or other organization documents within 48 hours of request.
- Verify all initial physician orders with the physician and obtain physician orders for additional services/products as necessary.
- Provide all other documentation and records, which may be requested by IHCS from time to time, within the time frames set forth in the request.

All services authorized and provided by IHCS have a Utilization Management determination.

Coordination of Authorization and Home Health Services

- A primary referral source, a physician, hospital or skilled nursing facility; discharge planner, other Provider, etc., contacts Integrated with the referral. Initial orders/referrals must be faxed to IHCS at (844)215-4265 for processing.
- IHCS will provide your initial referral authorization.
- IHCS will call your agency and coordinate services needed by the member and if you are able to provide such services, the **Subcontractor Notice** will be sent to your fax. This **Subcontractor Notice** is the authorization for services and is an alert for you to go to the MedTrac Portal and retrieve the orders.
- The MedTrac Portal is discussed later in this manual. MedTrac is the tool by which IHCS uses to give referrals and obtain supportive clinical information.

IHCS Receives Referral from Referral Source

The required information generally includes, but is not limited to, the following:

1. Patient's First and Last Name
2. Patient's Date of Birth
3. Patient's insurance company and insurance Subscriber ID number
4. Patient's physical address (not PO Box) including zip code
5. Patient's phone number
6. Patient gender
7. Diagnosis
8. Face sheet, if recently discharged from hospital or other inpatient setting
9. Ordering and primary physician first and last name, full address and telephone number
10. History and Physical
11. Signed physician orders for services for which authorization is being requested; orders must be complete.

Reauthorization Responsibilities: Home Health

- A re-authorization or concurrent review is **required** to continue services.
- Obtaining a re-authorization is the responsibility of the Provider.
- Providers must submit requests for re-authorization at least 48 hours prior to the expiration of the authorization.
- Provider must submit clinical status and objective reasons for re-authorization prior to authorization expiration.
- Re-authorization is requested via the MedTrac Provider Portal at https://apps.ihcscorp.com/MedTrac/ or via Fax to IHCS (844)215-4265.
- The Provider Portal identifies the information required in order to complete your request for re-authorization. That information includes, but is not limited to, the following:
    1. Intake ID
    2. Patient's Last Name
    3. HCPCS Code and modifier needing re-authorization
    4. Number of requested visits/units, start and stop date of requested authorization
    5. Medical necessity for the service requested
    6. Physician orders for all services for which authorization is requested for (current POC or order)
    7. Supporting documentation for the authorization being requested
- If the Provider does not submit all of the required information, the request will not be accepted by Integrated.
- Providers are responsible for checking eligibility and benefits with the member's health plan at the beginning of each month.

Authorization Extension Responsibilities: DME

- An authorization extension is required for providers to continue services on rental equipment.
- Obtaining an authorization extension is the responsibility of the Provider.
- Provider must first close out the initial order in the IHCS MedTrac Portal and submit the proof of delivery to include the patient's signature prior to submitting a request for an auth extension.
- Authorization extension is requested via the MedTrac Provider Portal at https://apps.ihcscorp.com/MedTrac/.
- The Provider Portal identifies the information required in order to complete your request for an authorization extension. That information includes, but is not limited to, the following:

    1. Intake ID
    2. Patient's Last Name
    3. HCPCS Code and Modifier needing re-authorization
    4. Updated RX has been received in the case of Oxygen

Note:

If the Provider does not submit all the required information, the request will not be accepted by Integrated. Providers are responsible for checking eligibility and benefits with the member's health plan at the beginning of each month.

Re-authorization Responsibilities: Infusion Pharmacy

- A re-authorization or authorization extension is **required** to continue services.
- Obtaining a re-authorization is the responsibility of the Provider.
- Providers must submit requests for re-authorization at least 48 hours prior to the expiration of the authorization.
- Provider must submit new/continuation prescription to continue therapy.
- Reauthorization is requested via the MedTrac Provider Portal at https://apps.ihcscorp.com/MedTrac/ or via Fax to IHCS (844)215-4265.
- The MedTrac Provider Portal identifies the information required in order to complete your request for re-authorization. That information includes, but is not limited to, the following:

1. Patient's First and Last Name
2. Insurance ID number
3. Continuation/New RX Date of Service Range
4. HCPC per diem request – to included HCPC units
5. Physician orders/prescription for all drug infusion services for which authorization is requested for (current POC or order)
6. Supporting documentation for the authorization being requested (e.g. signed delivery ticket, new prescription).
7. If the Provider does not submit all of the required information, the request will not be accepted by Integrated.
8. Providers are responsible to check eligibility and benefits with the member's health plan at the beginning of each month.

Notice of Medicare Non-Coverage (NOMNC)
Compliance with CMS Notice of Medicare Non-Coverage Requirement

N O M N C

Providers **are required to comply** with applicable state and federal laws. With respect to Medicare patients who are discharged from home health care, CMS requires Providers to timely issue a Notice of Medicare Non-Coverage (NOMNC) to the patient**.** The following are some steps Providers should take to ensure compliance with this NOMNC requirement:

- Prior to discharging a patient from home health services, determine whether the patient is a Medicare Advantage member.

- If the patient is a Medicare Advantage member, provide the patient with a NOMNC letter at least 48 hours prior to discharge. **Please note:** The patient or the patient's authorized representative must sign and date the notice.

- Utilize the approved CMS NOMNC letter template and complete the template letter as directed by CMS.

- Providers are required to upload the NOMNC into the MedTrac Portal if a NOMNC is issued to a member. The required NOMNC fields are audited for compliance.

Providers will be periodically audited for compliance with this very important Medicare requirement. Failure to comply may result in corrective action being imposed.

Provider Billing and Claims Payment Guidelines

General Claims

All claims are processed based on the authorization issued. For all plans, providers are responsible for confirming eligibility and benefits with the member's health plan for ongoing or add-on services. Failure to do so could lead to claim rejections and denials. It is imperative to check eligibility and benefits to ensure the member's plan has not changed.

To expedite payment of claims, the Provider should match the billable services against the authorization and your contracted Provider crosswalk. Claims for services, date of service or units that do not exactly match the authorization may be rejected or denied in part or in whole. Alternatively, if the Provider bills for a higher level of service, equipment or supply than the level authorized, payment may be made in accordance with the rate associated with the authorized service, equipment or supply, and Provider will accept that rate as payment in full. Claims will be paid based on the lower of the Provider's usual billed charge or the contracted/negotiated rate.

Authorization of services is not a guarantee of payment. Payment of services rendered is subject to the patient's eligibility and coverage on the date of service, the medical necessity of the services rendered, coverage requirements, the applicable payer's payment policies, including, but not limited to, applicable payer's claim coding and bundling rules, IHCS's claim coding and bundling rules and compliance with the Provider's contract with IHCS.

By submitting a claim for payment to IHCS, the Provider is certifying that it has met the above requirements, that the service has been rendered, and that it has a record of all necessary documentation to support the foregoing. Claims that are not submitted within the time frames set forth in the Provider Agreement and in accordance with the requirements of the Provider Agreement, this Provider Manual, and the applicable health plan may be denied.

Clean Claim Requirements

Claims must be submitted electronically or on standard paper claim forms (CMS 1500 or UB-04). Home Health Providers must submit claims on an 837I or UB-04. Our required clean claim data elements for both electronic and paper claims include the following:

- Medicare Members are billed on a UB-04 and Medicaid Members are billed on a HCFA
- Patient's name, Subscriber ID number (including any prefix and/or suffix as appropriate), Address, Relationship to Subscriber, Gender, and Date of Birth
- Insurance name, group name and group number
- Subscriber name, address, and gender
- Place of service code
- Primary diagnosis code(s)

- External cause of injury codes are not acceptable as the primary diagnosis. Refer to the following website for a complete list of external cause of injury diagnosis codes: 2022 ICD-10 Index of External Cause of Injuries (icd10coded.com). All submitted diagnosis codes must be valid for the date of service and coded to the highest specificity.
- Rendering Provider's name, service location, and billing address
- Rendering Provider's National Provider Identifier (NPI) number, Federal Tax ID number, Medicaid ID number (Medicaid network Providers only), and Taxonomy Code
- Referring provider/Physician name and NPI number(837P)
- Attending provider/physician name and NPI number(837I)
- Individual line level charge for each service
- Number of invoiced units for each claim line
- Authorized procedure (HCPC/CPT) code(s) and modifiers (when applicable). Prescription/Injectable Drugs: NDC code, description, unit of measure, and units
- Date(s) of Service: The date of service 'From' date must precede the claim submission date. The date of service 'Through' date cannot be a future date. Whether the patient's condition is related to employment, auto accident or other accident
- Other insurance information, when applicable. If other insurance, then include other insured's name, date of birth, other insurance carrier name, group or policy number)
- Coordination of benefits information for secondary claims (Explanation of Payment from Primary Carrier), when applicable
- Service authorization number
- Revenue Code (Institutional Claims 837I, UB04)
- HIPPS code on all home health claims submitted for Medicare Advantage members. HIPPS code must be valid for the date of service.
- When billing with a miscellaneous code a description is required.
- All paper claims, UB04/CMS1500 must be received in red and white
- Institutional Claims (UB04, 837I): Box 38, the Responsible Party Name and Address, must be populated with the servicing location for Medicare home health claims. This change is effective 2/1/22 in our system and all claims will need to have this info in order to process.

Claims missing required information or containing incorrect required information may not be processed. Paper claims without correct or required information may be returned. The Provider will be informed of the information that is missing or incorrect. The clearinghouse with corresponding reasons for the rejection may reject electronic claims submitted without correct or required information. Incomplete claims must be resubmitted by the Provider to IHCS to ensure a complete (clean) claim is received by IHCS within the original timely filing timeframe as specified below subject to applicable law.

With regard to services delivered, the claim must include a description of the service provided (i.e. "RN visit" or "CPAP rental") as well as the relevant HCPCS, CPT or revenue code and applicable modifier(s) found on the IHCS Service Authorization Form or the billing crosswalk (located at https://apps.ihcscorp.com/medtrac). Claims without a description of the service provided will be returned.

Billing Codes

Only contracted procedure codes and authorized services will be allowed for payment. Providers must submit only those procedure codes detailed on the contract, Letter of Agreement or Authorization received. Services not authorization will be denied accordingly.

Example: If the authorization contained a revenue code and modifier, then the claim must contain a revenue code and modifier.

All Medicare home health claims must contain a valid HIPPS code per CMS mandate. Only one HIPPS code is to be entered on a claim. The HIPPS code rate reported always as zero. The HIPPS code must be billed with revenue code of 0023. The HIPPS score service date must be equal to the first service date pertaining to the HIPPS code. It is the agency's responsibility to research other CMS rules regarding HIPPS code to ensure accurate claim filing. Inaccurate specification of HIPPS codes will result in claim denials. If any of the criteria outlined here is missing or incomplete, then the claim will be denied.

Integrated Home Care Services, Inc. reserves the right to update, modify, and/or clarify HCPCS codes in accordance with federal, state, or other regulatory bodies. It is the Provider's responsibility to check the IHCS portal regularly for updates to HCPCS codes, descriptions, and the IHCS billing crosswalk. The current billing crosswalk can be found at IHCS (visibiledi.com).

Home Health Institutional Claims:

Original claims must be submitted within 75 calendar days from the rendered date services. Claims rejecting for invalid bill type must be corrected and resubmitted. Rejected claims are not registered in the IHCS system as received and therefore should not be resent as a corrected claim (frequency code 7).

If the claim was previously accepted and denied, then a corrected claim is required if the bill requires correction and reprocessing. Corrected claims must be submitted with a frequency 7 as reflected in the bill type 327.

IHCS will accept on the following Home Health Services bill types:

- 322- Initial/First Claim
- 323- Interim/Continuing Claim
- 324- Interim/Last Claim
- 327- Adjustment/Corrected/Replacement Claim
- 328- Void/Cancel Prior RAP/Claim
- 329- Final Claim for Episode

Timely Filing

Clean claims must be filed at the address designated by Integrated within the period described in the corresponding Provider Agreement or within the period 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. Note that Integrated may pay some claims that were not submitted timely to Integrated if we believe there may still be time to timely bill and receive payment from the Health Plan. However, please be aware that if the Payer does not pay the claim in full, integrated may later deny the claim for failure to timely file and recoup the prior payment. All claims must be submitted **75 days from the date of service**. In the case of paper claims, they must be mailed to:

Integrated Home Care Services, Inc.
3700 Commerce Parkway
Miramar, FL 33025

Providers are encouraged to bill using the Provider Portal located at:

IHCS (visibiledi.com)

IHCS will only accept original documents for payment consideration that are typed in indelible ink without erasures, strikeovers, whiteout or stickers. Dot matrix printers should not be used when typing information onto paper claims forms. Claims with handwritten information will be rejected. In addition, it is important that the name of the Provider organization and service location on the claim match the Provider name on the related authorization form(s).

Claims submitted without all required information may be rejected or denied.

1. Electronic EDI Claims:
   If you are using practice management software (Availity) to submit claims electronically, your system needs to be set up with the **payer ID IHCS1.** All Medicare claims sent to Availity shall be sent in 837i format.

2. Paper Claims:
   Must be submitted on the Professional 1500 HCFA Claim Form Version 02/12, any claims submitted on 1500 Version 08/05 will be rejected as of April 1, 2014. (Please review CMS changes for further detail) Copies of the form cannot be used for submission. Data must be typed, not handwritten. Authorization number must include any hyphens (entire auth #- 123456-1-1234) Box 23. NPI # of rendering location must be in Box 32a. Any claims not in this standard format will be denied/rejected.

Provider Payment

The Provider Agreement rate is payment in full for covered services and is all-inclusive. Provider is not entitled to receive additional compensation for covered services, including but not limited to, compensation for copies of records, sales tax, reports, or other services contemplated by the Provider Agreement. No billing to the patient or Health Plan of the difference between the negotiated or contracted rate and the Provider's list price

is permitted. If Provider's billing system is unable to support billing at the contracted rate, the difference between the contract rate and Provider's list price must be adjusted off Provider's accounts receivable. Doing so can help the Provider avoid repeated claims inquiries and in addition, when billing for custom equipment, the claim must reflect the full rate, the discount as negotiated, and the net price. Provider must attach to the claim the manufacturer's specification sheet for the equipment. For custom equipment, you may be instructed to complete two claims, if required, for specific IHCS Health Plan contracts. Provider shall not be paid for services rendered without proof of delivery submitted to IHCS.

With respect to applicable sales tax, as indicated above, your network contract rate is inclusive of any applicable sales tax. It is your obligation to 1) calculate and identify on your claim that portion of your contract rate that is attributable to applicable sales tax; and 2) remit the applicable sales tax amount to the appropriate regulatory authority.

Reimbursement Status

Providers should utilize the Provider Portal at IHCS (visibiledi.com) to check their claim's reimbursement status.

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

Corrected claims replace the original claim. If the corrected claim is not submitted timely (within 45 days of the original claim processing date), then the corrected claim will be denied as exceeding timely filing. This will result in an overpayment.

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.

Payment Differences

If you receive a payment from IHCS that is different from what you expected, you should first try to understand the difference and reconcile the discrepancy. If you cannot reconcile the discrepancy and wish to request a reconsideration, you must submit a request for reconsideration in writing through our Claim Reconsideration Form by emailing claimsinquiry@ihcscorp.com or providerservices@ihcscorp.com.

Reconsiderations and Grievances

Provider Grievances and Administrative IHCS has a comprehensive process for resolving appeals and grievances. An appeal is a request for IHCS to review an adverse action or denied claim, having provided documentation supporting the request for reconsideration. Appeal requests must be submitted in writing.

If the claim was rejected:

1. Correct error that caused rejection
2. Submit as an original claim within 75 days of DOS (Freq 1)

If the original claim was submitted and denied:

1. Correct error that caused denial
2. Submit as a corrected claim within 45 days of EOP (Freq 7 and ICN)

If corrected claim still denies due to billing error:

1. Re-submit a corrected claim to correct the billing error within 45 days of last EOP (Freq 7 and ICN)

If corrected claim denies for a different reason i.e., duplicate, authorization, units exceeded, paid at a different rate, you must contact the Provider Relations department at providerservices@ihcscorp.com to request a Claims Reconsideration Spreadsheet to initiate a claims reconsideration project.

Reconsideration must be received by IHCS within 45 calendar days of the provider's receipt of the explanation of payment (EOP). We will communicate the results of our review of your Reconsideration in writing, which may include payment and an explanation of payment.

Requesting a Claims Reconsideration as described in the Billing Guidelines section or as contractually agreed, providers can request a review and possible adjustment of a previously processed claim within 45 days of the Explanation of Payment (EOP) date on which the original claim was processed.

Appeal requests must be submitted in writing within one of the following timeframes:

- **45 days** from receipt of the EOP
- **45 days** from receipt of EOP from other insurance

The reconsideration must include additional relevant information and documentation to support the request. Requests received beyond the 45-day appeal request filing limit will not be considered.

When submitting a provider appeal, please contact ProviderServices@ihcscorp.com for the Claims Reconsideration Spreadsheet.

Reconsiderations/Corrected Claims may also be sent via USPS mail to:

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

A **grievance** is any expression of dissatisfaction about any action or inaction by IHCS other than an Adverse Action. Grievances should be reported to IHCS Provider Relations Department via email at ProviderServices@ihcscorp.com.

Dispute Resolution

If the Provider is not satisfied with the resolution of the appeal, the Provider may request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute within 60 days of the date of the appeal decision letter. If the matter is not resolved within 60 days of the Provider's written request for such negotiation, the Provider may submit the matter for resolution in accordance with the dispute resolution process outlined in the Provider's contract with IHCS. The right to submit the matter for dispute resolution will be waived if the matter is not submitted for dispute resolution within 120 days of the date of the appeal decision letter or within the time required by applicable law if applicable law requires a time longer than such 120-day period. Please note that, if changes are required to the original claim, in lieu of submitting an appeal, Providers should submit a corrected claim in accordance with our corrected claim process.

Retrospective Claims Review

Paid claims can be subject to retrospective audits and Providers have the obligation to maintain and make available documentation to support the medical necessity of services rendered and billed. Such documentation must be made available to IHCS and/or the applicable Health Plan at no cost to IHCS or the Health Plan and within the timeframes requested. Integrated Home Care Services, Inc. may recover any payment for services determined not to meet medical necessity or benefit requirements, including recovery through recoupment.

Note: Please see the grid below indicating the recoupment timelines for Medicaid, Medicare and Commercial claims. If IHCS does not receive a response within the specified timeframes, we will initiate the recoupment process and deduct the overpayment from future remittances.

Business	Provider Appeal Timeline	Recoupment Process
Medicare	60 Days	After the 60 days of the date of the Letter
Medicaid	45 Days	After the 45 days of the date of the Letter
Commercial	35 Days	After the 35 days of the date of the Letter

Restriction on Balance Billing

IHCS Network Providers may not bill a patient or that patient's insurance company (if the insurance company is an IHCS client) during the reconsideration or appeals process or for a balance remaining after a decision has been made on an IHCS Network Provider appeal.

Provider Complaints

IHCS maintains a provider complaint system that permits a provider to dispute IHCS's policies and Procedures, or any aspect of the administrative functions, including proposed actions and claims. IHCS has a copy of the provider complaint system policies and procedures in its handbook. The IHCS Complaint system policy and

procedures, includes distribution of the provider complaint system policies, to include claims issues, to out of-network providers upon request. IHCS will distribute a summary of these policies and procedures, the summary will include information about how the providers may access the full policies and procedures on the IHCS website. The summary will include details on how the downstream providers may obtain a hard copy from IHCS at no charge. IHCS allows Providers 45 calendar days to file a written complaint for issues not pertaining to claims. The Provider Relations Department is responsible for investigating each complaint using applicable statutory, regulatory, contractual provisions.

Provider Complaints are received, documented, and processed through the Provider Relations Department. It is the role of the Provider Relations Representative to follow Provider Relations Complaint process in responding to all Provider Complaints. The Compliance Department may assist in such investigations. When the Complaint has been identified as a quality concern, the Complaint will be investigated by the Compliance Department.

For more information on the Provider Complaint System, please contact the IHCS Provider Relations Department (844)215-4264 or providerservices@ihcscorp.com.

Provider Credentialing and Re-Credentialing

Credentialing

Our credentialing process requires, but is not limited to, the following:

- Completed IHCS Credentialing Application. The application must contain a current signature of the CEO, Administrator or other appropriate designated representative, attesting that all information provided in conjunction with the application is true, correct, and complete.
- Copies of current licensure as required by applicable law.
- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate and a copy of a current fidelity bond for fifty thousand dollars ($50,000) or other crime and theft coverage in an amount satisfactory to Integrated.
- Claims/Malpractice History for the last Five (5) years.
- Copies of current accreditation or certification. If not accredited, provider must provide a copy of the most recent State or Federal Survey or Inspection Report and the approval letter from the State regarding the Emergency Action Plan.

Re-Credentialing

IHCS Network Providers are re-credentialed every two to three years (as determined by applicable law or plan requirements). However, a Provider's credentialing status may be evaluated by IHCS at any time during the two to three year credentialed period, including when a Provider adds a new service category, or malpractice or quality of care/service issues are brought to the Committee's attention. In addition, if a Provider adds or acquires a new location, subsidiary or affiliate, that location or entity must be credentialed.

The standard re-credentialing process begins approximately six (6) months before the credentialing anniversary. Our re-credentialing process requires, but is not limited to, the following:

- Completion of IHCS's re-credentialing application
- Copies of current licensure.
- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate a copy of current fidelity bond for fifty thousand dollars ($50,000) or other crime and theft coverage in an amount satisfactory to Integrated.
- Claims/Malpractice History for the last three (3) years.
- Copies of current accreditation or certification. If not accredited, provider must provide a copy of the most recent State or Federal Survey or Inspection Report and the approval letter from the State regarding the Emergency Action Plan.

IHCS Provider Portals

Integrated Home Care Services, Inc. works with three (3) separate portals. Below you will find the names, link and use of each portal.

1. MedTrac- (https://apps.ihcscorp.com/MedTrac)
    1. Obtain clinical information for initial referrals such as Physician Orders, Patient Demographics, and History & Physical.
    2. Request Re-Authorization
    3. Edit an authorization request
    4. Submit clinical documentation for UM purpose
    5. Documenting the Start of Care (SOC) date
    6. Documenting the Discharge Date
    7. Documenting NOMNC date
    8. Documenting Delay of Services Date and/or any important notes

2. VisibilEDI – IHCS (visibiledi.com)
    1. Submit claim(s)
    2. Look up claim(s)
    3. Submit a claims inquiry*
    4. Enroll in EDI (Electronic Claims Submission)

For access, login credentials, and training on the portals, please submit a request via email to:

MedTrac Portal Access & Training	**Providertraining@ihcscorp.com**
VisibilEDI Access	**Providerservices@ihcscorp.com**
Password Reset	**PR-PasswordSupport@ihcscorp.com**

Reporting and Investigating Patient Complaints and Grievances

Integrated Home Care Services, Inc. (*IHCS*) is committed to resolving all patient and provider Complaints, quality of care concerns and including allegations of fraud, waste or abuse, hereafter referred to collectively for the purpose of this narrative as "Complaints". IHCS has established a standard process to ensure that all Complaints are received, documented and reconciled in accordance with law and regulations, accreditation standards, contractual obligations and respect for patients. IHCS monitors and analyzes Complaints to identify opportunities to improve the product and services provided. IHCS will report Complaints received to the designated payer as required by each contract and report 99% of such notices within 7 business days for standard Complaints and 24 hours for urgent Complaints.

Complaint

Any expression of dissatisfaction with products and/or services to IHCS, a health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of IHCS, providers or health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process described in this Policy. [FL Medicaid Medical Assistance Program (FL MMA): A complaint not resolved by close of business on the day following receipt of the complaint must be classified as a grievance.]

Grievance

Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, orally or in writing, to either IHCS, a health plan, provider, or facility. An expedited grievance may also include a complaint that a health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration period.

1. Provider employees who receive Complaints or other expressions of dissatisfaction with a product or service provided by their agency will promptly report the event to his/her supervisor. The supervisor will report the Complaint to an Integrated Supervisor who will document the Complaint in the Complaints and Grievances Share Point Site.
2. The employee and his/her supervisor who receive the initial call will also verbally respond to the patient in real time (i.e., while the patient or caller is on the telephone, or by a return

telephone call) and make every reasonable effort to reconcile the concern and address any outstanding service items. The employee will document such efforts in the patient's electronic medical record under Patient Notes, if applicable, and record the resolution and appropriate Tier in the Grievances and Appeals SharePoint Site.

3. Complaints may also be received directly from a health plan customer. Each health plan customer will be directed to deliver all provider and member/patient Complaints to a Company lead account manager. The lead account engagement employee will immediately report the Complaint to the Referrals department. The Referrals representative will document the Complaint in the Complaints and Grievances Share Point Site. A Referrals Representative employee and his/her supervisor will verbally respond to the patient in real time (i.e., by a return telephone call/e-mail) and make every reasonable effort to reconcile the concern and address any outstanding service items. The Referrals Representative will document such efforts in the patient's electronic medical record under Patient Notes, if applicable, and record the resolution and appropriate Tier in the Grievances and Appeals SharePoint Site.

4. Complaints documented in the Complaints and Grievances Share Point Site will send an email notification to the Referrals Representative (for Member Complaints), the Chief Compliance Officer, Clinical Division, or the designated Compliance representative, and the lead account manager for Complaints initiated by the health plan.

    a. The lead account manager will provide written or secure email notice to the health plan customer that a Complaint has been received (FL MMA: All notices of receipt of a complaint will be provided to the health plan no later than close of business on the day following receipt of the complaint. A complaint not resolved by close of business the day following receipt of the complaint shall be labeled as a "grievance".)

    b. The Referrals Representative will investigate and provide a response to the designated Compliance representative verbally, or in writing and will document the investigation results in the patient /member's electronic medical record. The designated Compliance representative will ensure that a written response is prepared and provided to the lead account manager for the health plan customer. The lead account manager will provide the written response to the health plan. After a response has been provided the designated Compliance representative will close the Complaint in the Complaints and Grievances SharePoint Site.

    c. IHCS will respond to Complaints within the period required by the applicable health Plan customer. Absent a specific health plan requirement, IHCS will respond to 99% of urgent and open service Complaints within 24 hours and 99% of standard Complaints within 7 business days.

d. Any Complaint that appears to be the result of process failure, gross negligence, fraud/waste/abuse, quality of care, or potential litigation, must be forwarded to the Chief Compliance Officer for reconciliation and formal response as soon as reasonably possible, but no later than 24 hours after receiving the Complaint.

5. In the event that a Complaint involves a patient/member who has not received care and patient safety or quality of care concerns is evident, the lead account manager for the health plan or the Referral Representative will provide a timeline and pertinent information to the Line of Business (LOB) leader so they can take necessary steps to expedite care to the patient. Each LOB will provide an escalation list to the account managers and the Referrals Representative Representatives.

6. When deviations in process, failure to follow policy/protocol or policy/protocol is ineffective, the Referrals Representative will notify the business leader to initiate process review and/or employee counseling. At the same time, the Department of Compliance will be notified. The appropriate designee will facilitate appropriate referrals to the Quality Improvement Chairperson(s) and monitoring of corrective actions will be reported through the QM Program.

7. The Compliance Officer or his/her designee monitors all reported concerns and Complaints received. All formal written responses must be reviewed by Compliance prior to submission.

8. Members/Patients have the right to notify any external patient quality control organization with concerns or dissatisfaction they experienced with any service or product provided by IHCS.

9. The Compliance Department monitors and measures all Complaints received. The data is aggregated no less than quarterly to identify potential adverse trends and opportunities for improvement. The Compliance Department reports the Complaint metrics to the applicable Clinical Operations Quality Management Committees and Clinical Division Leadership.

10. The PI/QI Committee reviews the Complaint data to ensure that IHCS is meeting its operational performance metrics. In the event that any Complaint category reaches or exceeds 1% of the total volume of services provided by any LOB in a given reporting period, immediate interventions may be imposed by the CEO/COO and General Manager with the Compliance Officer, and Clinical Division.

11. When operational performance does not meet Company expectations, an internal corrective action plan may be initiated by the LOB. The Compliance Department will support each corrective action plan and may independently issue corrective action plans for significant operational performance challenges.

12. All new Provider employees should be oriented to this policy during their new hire process, not to exceed 90 days from the date of hire, and annually thereafter.

Frequently Asked Questions

Q: Does IHCS issue retro authorizations?
A: IHCS does not issue retro authorizations.

Q: What happens if a patient's insurance terminates during care?
A: The Provider must check eligibility every month and ask the patient if he or she has changed Health Plans. Should this occur, the Provider must contact the new Health Plan and ask for an authorization. The new Health Plan as a Continuity of Care should reimburse the services.

Q: Can I verify eligibility on the IHCS Provider Portal?
A: No, eligibility must be checked with the individual plan.

Q: Is the IHCS authorization a guarantee of payment?
A: No, authorization is not a guarantee of payment. Providers must verify eligibility at the time services are being rendered.

Q: How can I view the Explanation of Payments in the portal?
A: You must login to the VisibilEDI portal; select the "Payment" tab at the top. Next, you will select "Payment Download" and all EOP will download. It will take 12-14 business days to view/download your most recent EOP. You can also email EOP@ihcscorp.com for assistance.

Q: How do I know if I have been issued an authorization? Do I receive a notification?
A: All providers will receive a subcontractor notice, which will alert you of the authorization in the portal. However, we strongly encourage all providers to login to MedTrac on a daily basis, to review their referrals.

Q: I have recently moved or updated my contact information. Whom do I notify to update information in your system?
A: Please submit an email to ProviderNetwork.Credentialing@ihcscorp.com to request a Provider Demographic Change Form.

Q: How do I reset my portal password?
A: You may reset your password to the MedTrac and VisibilEDI portal by selecting "Forgot password"/"Reset" on the home page. An email with the password reset link will be sent to the email address registered to the account. You may also email to PR-PasswordSupport@ihcscorp.com for assistance.

Q: How do I covert a claim to an 837 TXT format in VisibilEDI?
A: Claims cannot be converted to an 837 TXT document in VisibilEDI. Please contact your billing software company.

HHC/Infusion

Q: Why can't IHCS provide visits for the whole certification period?
A: IHCS must review all services; the frequency of the review is up to the Nurse who reviews the concurrent request. The Nurse must make sure that Medical Necessity is met.

Q: What is the purpose of Home Therapy?
A: The purpose of Home Therapy is to teach and train a home exercise program and to advance the member to an Outpatient facility if needed.

Q: Is Transportation offered?
A: IHCS or our contracted Providers do NOT provide transportation. The PCP coordinates transportation to the MD offices if the Health Plan offers that service.

Q: How long does it take the Health Plan to make a determination if the case has to be escalated for determination?
A: For Medicare Expedited requests, the Health Plan has 72 hours to make a determination and 14 days for Routine requests. For Medicaid Expedited requests, the Health Plan has 48 hours to make a determination and 7 days for Routine requests.

Q: What is a NOMNC?
A: A NOMNC is the Notice of Medicare Non-Coverage. This is a CMS requirement to be issued to the patient 48 hours prior to discharge from Home Health services. The NOMNC is only required for Medicare patients.

Q: Where do I find the NOMNC form?
A: The pre-filled NOMNC form is provided along with your approval notification from IHCS. This form must be signed and dated by the patient and must be uploaded into the MedTrac portal.

Q: Am I required to enter the date of the patient's start of care (SOC) and discharge date from Home Health services?
A: Yes, you are required to update the SOC and discharge date in the MedTrac portal.

Q: What happens if you are unable to start the patient's care?
A: If you have accepted the referral and are unable to proceed with SOC, IHCS must be notified immediately by calling the Home Health Department and by adding a note on the MedTrac authorization. This is considered a Delay in Care and we must notify the Health Plan.

Q: Does IHCS call a provider and coordinate locations for servicing the patient prior to issuing them the order?
A: Yes, we will call the agency to see if they have the staff to service our member and are within the location range.

Q: What if a patient cancels services or refuses service before start of care date? Do we NTUC *(Not Taken Under Care)* or does Provider have access to NTUC in portal? What is the procedure?
A: The Provider can NTUC in the Portal, but IHCS needs to be notified as the referral source that the member has refused via a phone call to IHCS.

Q: On a case-by-case basis, does IHCS make special discretions to issue any retro authorizations for auth extensions and or concurrent requests? – *Example:* If it is Friday and the Provider does not hear back from IHCS until Monday, can they perform services even though they have not received the authorization from IHCS?
A: If the member is requiring Skilled Care and there is Medical Necessity, please continue to see the member and we will give you the authorization, especially for *Wound Care, Diabetics and IV's.*

Q: What is the limit of Concurrent/New Auth Extension requests that IHCS will authorize?
A: Each patient record is reviewed and authorization is given pending Clinical Necessity.

Q: What is the difference between a New Auth Extension request and a Concurrent request?
A: A New Auth is the initial referral that we issue the Provider with a bout of visits to service the member according to the MD orders. The Concurrent request is continued visits/services that the member needs and the Provider is requesting.

Q: What happens when a Physician will not sign the Plan of Care?
A: The Provider must call IHCS and speak to a Representative from Home Health and they will get the Health Plan involved to assist in getting the POC signed.

Q: Can an LPN sign verbal orders?
A: No, we must have an RN signature.

Q: Can a follow up request for Home Health be faxed to IHCS?
A: No, all Concurrent requests must be submitted via the MedTrac Portal.

Q: Can I call IHCS to ask questions regarding Home Health?
A: Yes, we welcome calls to the Home Health Department with your questions; see the contact list for names and extensions.

Q: How do I find a patient in the MedTrac portal?
A: To view new referrals, you must select the "New Orders Queue" tab. To view accepted/completed cases, you must select "Home Health Admissions" tab.

Q: How do I submit a concurrent request?
A: Go to the Home Health Admission tab in the MedTrac Portal, locate the patient and ensure that their status is *Active*, locate the green button with the arrow under concurrent next to the patients name to submit the concurrent request.

Q: How do I submit an authorization request through the portal?
A: Under the Home Health Administration tab once the patient is active, click the green arrow under concurrent and create the reauthorization/concurrent request.

DME

Q: I need to add additional users and/or manage users, who do I contact?
A: The new MedTrac DME portal allows users with Portal Admin designation to add, manage, and edit Standard Portal User accounts. Contact your Portal Admin for assistance.

Q: What If I do not have a delivery receipt and/or do not upload a delivery receipt into the new DME portal?
A: This is a mandatory new portal function. If NO delivery ticket is uploaded, the Provider will not be able to close out the order. If claims are submitted *prior* to the Delivery Receipt being uploaded and the order being closed out the authorization will not be valid and the claim will deny.

Q: After I upload the Delivery Receipt, what is my next step?
A: After uploading the Delivery Receipt, you must close out the order by selecting the UPDATE DELIVERY OUTCOME button.

Q: Once I complete transitioning into the new DME MedTrac Portal, will I still have access to the old MedTrac DME Portal?
A: No, once you have fully transitioned to the new portal, your access to the old MedTrac portal will be cancelled/closed.