



Integrated Home Care Services, Inc.

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PROVIDER MANUAL

The IHCS Provider Manual is considered a companion document to the IHCS Provider Services Agreement. The details along with information contained herein provide an operational overview of the IHCS program.

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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 serves as a roadmap 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:

- IHCS Compliance Program Outline
- IHCS HIPAA Privacy Training PPT
- Fraud, Waste, and Abuse (FWA) Training
- Notice of Privacy Practices
- Patient Rights and Responsibilities
- Medicare Sanctioned Part C /Part D General Compliance Training
- FDR Compliance Guide/FDR Affidavit
- Reporting FWA Hotline

Please review these tutorials with your managers and field staff.

IHCS Code of Ethics and Business Conduct

Our goal is to provide patients with high quality Durable Medical Equipment, Home Health, and Home Infusion services based on medical necessity and appropriateness to enhance their activities of daily living. Integrated Home Care and its associated companies are committed to providing quality services, administered by professionals who recognize the patient's needs come first and foremost. Our standards, both personal and professional, reflect and are consistent with the highest of ethics and integrity in mind. At IHCS, we strive for excellence through teamwork.

IHCS MISSION STATEMENT 2024

Go Beyond

To be the trusted ally that helps patients, providers, and plans achieve their care goals in the home.

Our Vision

Unlock the full potential of care in the home.

Our Values

To ensure the highest quality of care in the home, we commit to the following values:

➤ Service with Compassion

We put patients first in everything we do and go beyond just like we do with family.

➤ Accountability

We make bold promises and deliver on our commitments.

➤ Integrity

We promote honesty, integrity and openness in all we do.

➤ Collaboration

We believe in the power of working together.

➤ Innovation

We believe room for improvement always exists.

First Tier, Downstream, and Related Entity (FDR)

IHCS's commitment to compliance includes encouraging our downstream partners to comply with and follow applicable state and federal regulations (Section 423.504, Florida Statutes). IHCS contracts with FDRs to provide administrative or healthcare services to our enrollees; ultimately, IHCS is responsible for fulfilling the terms and conditions with our contract with the Center for Medicare & Medicaid Services (CMS) and meeting the Medicare

and Medicaid program requirements. Therefore, IHCS has developed a process to validate that each contracted FDR and Affiliate generally has met the requirements. Each FDR and Affiliate must complete the FDR Compliance Attestation Form **annually** to confirm compliance with the IHCS's FDR compliance requirements.

Notable: It is the policy of IHCS to perform OIG/SAM/OFAC screening on the **entity** it contracts with, **prior** to its acceptance into the IHCS Network and **monthly thereafter**. It is the incumbent responsibility of the downstream entity itself to perform OIG/SAM/OFAC screenings prior to hire and monthly thereafter, **on its own employees/caregivers**. This is sworn to by the provider in their **FDR Attestation** and verified periodically (via audit) by IHCS. *When performing FDR quarterly audits, the designated IHCS audit representative must ascertain from the provider under review that all OIG/SAM/OFAC screenings show “proof of date of screening” on the printout in order to receiving a passing grade. Selections must be made for both pre-hire and monthly compliance.*

Offshoring

The Centers for Medicare & Medicaid Services (CMS) defines offshore subcontractor as follows: *“The term subcontractor refers to any organization that a Medicaid, Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. Subcontractors include all first-tier, downstream and/or related entities.*

The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of ‘offshore’ include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.”

For new IHCS network providers, if your entity offshores and/ sub-delegates (transfers to another entity) any functions that may contain Patient Health Information (PHI), e.g., Call Center, Credentialing, Billing, Claims, Member Outreach, Network Management, etc., you must report all details to IHCS's Credentialing Department, when possible, prior to the commencement of your contract with the sub-delegated entity. If your entity is an existing network provider that, in the past, had not taken part in offshoring or sub-delegation, but decides midstream to do so, you shall give notice to IHCS's Provider Relations Department, when possible, at least 15 calendar days prior to the instigation of these services.

The IHCS Corporate Compliance Department stands ready to partner with its Network of Home Health, DME and Infusion providers in the compliant execution of their duties to the patients we are privileged to serve.

- **Need help with writing a policy or assistance with understanding a regulation?**
- **Got a HIPAA Privacy concern you need to discuss?**
- **Suspect or know of misconduct, illegal or unethical activities?**

You may reach any of our Compliance staff members via telephone at (954) 381-7954 or via email at compliance@ihscorp.com. All reports made in good faith will be protected from retaliation.

Use of Offshore Vendors

Florida's Electronic Health Records Exchange Act governs the electronic exchange and storage of health records. Healthcare providers and organizations in Florida must follow these rules and regulations when handling electronic health information, with a focus on keeping patients' medical records secure and private. Within the state of Florida, it sets standards for the secure exchange of health information between healthcare providers, facilities, and organizations. Data exchange between states and countries may also be addressed through a health information sharing act. For precise details about the specific provisions and requirements of this act, consult the most recent version of the legislation.

What Does the Florida Electronic Health Records Exchange Act Mean for Medical Providers?

Under Florida's Electronic Health Records Exchange Act¹, medical providers are restricted from storing and exchanging electronic health information about patients. As of July 1, 2023, medical institutions are prohibited from storing specific electronic records overseas or engaging third-party vendors located outside of Canada, the United States, or U.S. territories.

IHCS is committed to establishing protocols for overseeing offshoring and sub-delegation monitoring if needed.

IHCS shall ensure all services provided under this Contract will be performed within the borders of the United States and its territories and protectorates. State-owned Data (data collected or created for or provided by the Agency) will be processed and stored in data centers that are located only in the forty-eight (48) contiguous United States.

¹ §405.051 Florida Electronic Records Exchange Act, 2023

Use of Offshore Vendors

IHCS is committed to establishing protocols for oversight of Offshoring or Sub-delegation activities in the event it is required. Integrated Home Care Services, Inc. does not Offshore or Sub-delegate any of its health plan contracted delegated services. However, should the need occur, IHCS has a policy that will address the compliance measures that would be required.

CMS requires that Medicare contractors or subcontractors obtain written approval prior to performing system functions offshore.

Additionally, should a **network downstream provider** wish to engage in Offshoring, the following enumerated protocols would pertain to your business as part of our vendor compliance monitoring program.

If you are a new Provider...

1. A downstream network provider who engages in Sub-delegation or Offshoring activity must report it to IHCS Credentialing team member when possible, *prior to commencement of their contract. This occurs **during the Credentialing process** and will be identified as such, in MedTrac.*
2. Each provider will be asked to complete an Attestation Statement during their subsequent onboarding training with Provider Relations personnel, indicating what activities have been selected, and presenting a signed Attestation.

If you are an existing Provider...

The provider will comply with all internal oversight as described in bullets one (1) and two (2) as shown above.

All Network providers will also be asked to sign an **Annual Attestation** for any/all sub-delegated or offshoring activities. Attestations are required for offshore entities that receive, process, transfer, handle, store, or access PHI in oral, written, or electronic form.

Note: If a network d/s provider who has not been taking part in Offshoring or Sub-delegation but ***decides mid-stream to do so***, will give notice, when possible, to IHCS at least ***15 calendar days prior to instigation of these services.***

Additional information on any network provider who engages in sub-delegated or offshoring activities may be requested if the need arises.

For any further information on Offshoring or Sub-Delegating, you may reach out to your Provider Relations representative for further guidance.

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
Maria Garron, Director of Home Health Services	(844) 215-4264 Ext 7361
DME	
Nicole Huie, Director of Referrals	(844)215-4264 Ext 7367
Licette Salazar, Manager of Referrals	(844)215-4264 Ext 7526
Damaris Navarro, Manager of Referrals	(844) 215-4264 Ext 7338
Infusion Pharmacy	
Kevin Simas, VP of Pharmacy Services	(844)215-4264 Ext 7489
James Randall, Pharmacy Intake Coordinator	(844)215-4264 Ext 7360
Tanaka Bryant, Pharmacy Intake Coordinator	(844)215-4264 Ext 7475
Katrina Phillip, Pharmacy Operations Team Lead	(844)215-4264 Ext 7416
Claims	
For any questions regarding Claims (Status, Appeals, and Support)	(844)215-4264 Ext 7532 or Select Option 4 ClaimsInquiry@ihcscorp.com
Provider Contracting & Credentialing	
Florida Provider Contracting & Nationwide Credentialing	(844)215-4265 Ext 7534 or Select Option 5 then Option 3 ProviderNetwork.Credentialing@ihcscorp.com
Lazara Barreto, Director of Network Development and Credentialing	(844)215-4264 Ext 7409
National Contracting	
Ferne Dorn, Executive Director – National Providers	(570) 809-1639 – fdorn@ihcscorp.com
Tiesha Williams, Manager – National Providers	(843) 955-7448 – tiwilliams@ihcscorp.com
Katie Slezak, Sr. Network Development Specialist – North Carolina, Pennsylvania, South Carolina	(724) 610-4558 – kslezak@ihcscorp.com
Carrie St. Jean, Sr. Network Development Specialist – Alabama, Ohio, Tennessee	(419) 845-1190 – cjean@ihcscorp.com
John McCormick, Network Account Executive – Arizona, Colorado, Oregon	(956) 402-1095 – jmccormick@ihcscorp.com
Provider Relations	
Provider Relations Department	(844) 215-4264, Option 5, then Option 2 providerservices@ihcscorp.com
Manuel Bustillo, Provider Relations Training Manager	(844) 215-4264 Ext 7662 – mbustillo@ihcscorp.com
Susan Klarner, VP of Network Development	(844) 215-4264 Ext 7817 – sklarner@ihcscorp.com
Patient Financial Accounts	
Customer Service	(844) 215-4264 Ext 7530 or Option 2
Yari San Jorge, Director of Customer Service	(844) 215-4264 Ext 7328
Compliance	
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 ([Sign In ► MedTrac Network Provider Portal \(ihcscorp.com\)](#)) 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

- If it is determined that a patient requires additional services for dates of service beyond the initial authorization, an authorization extension is required for providers to continue services on rental equipment.

- IHCS will perform a clinical review and render a determination (approval or denial).
- Obtaining an authorization extension is the responsibility of the Provider.
- The 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/>.
- Providers are encouraged to submit a request for authorization of continued services at least 72 hours prior to the end of the prior authorization period.
- The Provider Portal identifies the information required to complete the request for an authorization extension. That information includes, but is not limited to, the following:
 1. Initial Order Authorization Number
 2. Patient's Last Name
 3. HCPCS Code and Modifier needing re-authorization.
 4. Updated RX has been received in the case of Oxygen (For all life support, sustaining or patient monitoring equipment, providers must verify with the ordering physician all changes to orders up to and including discontinuation.)

Note:

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

IHCS should be notified immediately of any returned unused equipment or rental equipment returned.

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 ([Sign In ► MedTrac Network Provider Portal \(ihcscorp.com\)](#)) 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

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. As with 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 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:

Home Health/Home Infusion:

- Medicare and Commercial claims are billed on an institutional claim form (837I or UB-04)
 - Medicare claims require a valid and accurate HIPPS code
- Medicaid claims are billed on a professional claim form (837P or CMS-1500)

Durable Medical Equipment:

- All claims are billed on a professional claim form (837P or CMS-1500)

All Claims:

- Patient name, address, relationship to subscriber, gender and date of birth
- Patient Account/Control number
- Insurance subscriber name and ID
- Place of service code
- Primary diagnosis code – [External Cause of Injury codes](#) are not acceptable as the primary diagnosis code. Providers are expected to follow all ICD coding rules
- Billing provider name and NPI if different from billing address
- 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
- 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' and 'To' dates must precede the claim submission date. The date of service 'To' date cannot be a future date.
- Accident Indicator: 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
- Description of miscellaneous code in the line level additional information note segment (NTE*ADD)
- All paper claims must be received on CMS standard red and white forms to accommodate OCR (optical character recognition) scanning.

Institutional Claims: Additional Requirements

- Box 38, the Responsible Party Name and Address, must be populated with the servicing location for Medicare home health claims.
- Valid Bill Type (322-329) IHCS will accept the following 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
- Valid and authorized revenue code
- Home Health Claims: [HIPPS](#) code on all home health claims submitted for Medicare Advantage members.
 - HIPPS code must be valid for the date of service
 - HIPPS code must be applicable for home health services
 - HIPPS code must be billed with revenue code 023, \$0.00 charges and '1' unit
- Attending provider/physician name and NPI – Attending provider NPI must be registered in [PECOS](#) and registered for the applicable service (DME, HHA)
- Description of miscellaneous code in the line level additional information note segment (NTE*ADD)
- All paper claims must be received on CMS standard red and white forms to accommodate OCR (optical character recognition) scanning.
- Value Codes and Value Code Amounts; all submissions must be accurate and billed in accordance with CME guidelines: [Medicare Claims Processing Manual Crosswalk \(cms.gov\)](#)
- Patient Status Code

Professional Claims: Additional Requirements

- Referring provider/physician name and NPI – Referring provider NPI must be active in [NPPES](#)
- Description of miscellaneous code in the line level additional information note segment (NTE*ADD)

Splitting of Claims

Patient coverage is often renewed at the beginning of a calendar year (as of 1/1). To ensure that claims processed invoke the appropriate benefit active for the date of service, expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year.

When the “From” and “Through” years are different, submit a separate claim for each year. (Also known as split-billing), When split billing a claim, make sure that the claim for the first calendar year is submitted first.

In addition, claims spanning more than 50 service lines on a CMS-1500 or 99 service lines on a UB-04 (CMS-1450) must be split into multiple claims.

Conditions Under Which Split Claims May Result

Unless otherwise noted, these situations apply both to claims submitted on paper and claims submitted electronically.

Claim Splitting Conditions	Description of Split
1. Claim with too many line items.	<p>Claim with more line items than can be processed by the health plan's production system.</p> <ul style="list-style-type: none">• For professional claims, claims containing more than 50 claim lines must be split into multiple claims.• For institutional claims, claims containing more than 99 claim lines must be split into multiple claims. <p>Provider Action: Create claims with fewer lines</p>
2. Claim with covered and non-covered dates of services for the member due to eligibility.	<p>A submitted claim has multiple lines of service with different dates. Some lines are for dates under which the member is eligible for coverage by the health plan. Other lines are for dates that the member is not eligible for coverage by the health plan.</p> <p>Provider Action: Make sure the patient is eligible for coverage with the health plan for the full period of the claim.</p>
3. Claim with dates of service that cross a calendar Year.	<p>A submitted claim has lines of service that occurred in different calendar years.</p> <p>Provider Action: Make sure that all services on the claim do not cross different calendar years.</p>
4. Claims with a billed amount of \$100,000 or more.	<p>A submitted claim has a billed amount of \$100,000 or more</p> <p>Provider Action: Make sure that the claim total is less than are for a billed amount less than \$100,000.00</p>

Claims missing required information or containing incorrect required information will be rejected or denied. 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.

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 \(visibiledi.com\)](https://visibiledi.com).

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.

Original claims must be submitted within **75 days from the date of service**. Corrected claims must be submitted with **45 days from initial IHCS processing date**. 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 \(visibiledi.com\)](https://visibiledi.com)

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:

IHCS will only accept original documents for payment consideration that are typed in indelible ink without erasures, strikeouts, whiteout or stickers. All paper claims must be received on CMS standard red and white forms to accommodate OCR (optical character recognition) scanning.

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 organization and service locations on the related authorization form(s).

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 \(visibiledi.com\)](https://ihcs.visibiledi.com) to check status of their claims. After checking the @VisibilEDI portal, any further questions regarding the status of claims, then contact providerservices@ihcscorp.com.

Explanation of Payment (EOP)

An Explanation of Payment (EOP) is issued in connection with each claims for services rendered. The EOP contains detailed explanation of payment and denials for each claim line per claim/invoice.

EOPs are also used to communicate adjustments to claims that have already been processed when it is determined that additional payment will be made on the claim. An adjustment may be made a result of a claims reconsideration request or an appeal. The amount of the adjustment will be detailed by claim line item.

IHCS uses industry standard American National Standards Institute (ANSI) Codes to communicate of 835 transmissions and EOPs. The 835 transmissions and EOPs will have ANSI Claim Adjustment Reason Codes (CARC) and Remittance

Adjustment Reason Codes (RARC) when required. A CARC provides a general explanation for adjustment or denial, and a RARC provides a more detailed description of the basis for the denial.

The CARC and RARC codes and descriptions can be found here:

- CARC: [Claim Adjustment Reason Codes | X12](#)
- RARC: [Remittance Advice Remark Codes | X12](#)

EOPs are available in the ©VisibileDI portal: [IHCS \(visibiledi.com\)](#)

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.

Corrected claims must be submitted with **45 days from initial IHCS processing date**.

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	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 IHCS 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 IHCS 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 837 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@ihscorp.com or providerservices@ihscorp.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 date of service (Frequency Code 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 (Frequency Code 7 and Original 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 (Frequency Code 7 and Original 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@ihscorp.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.

IHCS reserves the right to recoup or adjust payment (or request a refund) for amounts paid for services delivered. This can occur in a number of situations, including but not limited to:

- The patient was not eligible on the date of service
- The patient was determined to have primary coverage through another carrier
- The provider did not bill IHCS timely and IHCS was unable to secure reimbursement from the health plan
- Based upon a post service audit or review, the services did not meet medical necessity criteria, benefit requirements were as not authorized or were otherwise billed incorrectly
- The provider was paid twice for the same service or received more than the allowable amount for the service.

- Recoupments will appear on the IHCS Explanation of Payment (EOP)/835 as a “credit adjustment”. Notification will be sent to the servicing provider advising that an overpayment has occurred. If no appeal is received from the provider within the timeframes indicated below, then we will initiate the recoupment process and deduct the overpayment from future remittances.

Please see the grid below indicating the recoupment timelines for Medicaid, Medicare and Commercial claims.

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

Purpose

The credentialing standards apply to all licensed providers or groups of providers who provide care to the IHCS's Health Plan members. Providers who are certified or registered by the state to practice independently and provide care to IHCS's Health Plan members also are within the scope of the credentialing and re-credentialing standards within the three lines of business of IHCS, namely, DME, Home Health and Infusion Pharmacy.

Committee Attendance

The Credentialing Committee includes participation by the IHCS Medical Director, operational staff, and department leaders to include Network, Compliance, Operations, Home Health, DME, and Infusion. This Committee has the final decisions on applicants and/or providers credentialing and re-credentialing.

Advice from participating committee members, adds validity to credentialing process by including technical knowledge that may not otherwise be available to the Provider Service Corporation during the evaluation of potential providers. In addition, the Committee reviews information such as Credentialing Application, collection and verification of supporting documents and periodic re-credentialing. The Medical Director's advice and accomplished level of expertise plays a vital role in establishing that criteria is met.

Committee Meeting Schedule

The Credentialing Committee generally meets monthly. Ad hoc meetings may also be scheduled to address quality issues, malpractice review and new business requests.

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 surety bond for fifty thousand dollars (\$50,000) or other crime and theft coverage in an amount satisfactory to IHCS.
- 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.

- All documentation has a Primary Source verification with date and time stamping.

A copy of our credentialing application and a checklist of materials are required to be submitted. For questions about our credentialing process, please send an email to our Credentialing Department at Providernetwork.Credentialing@ihcscorp.com or call (954)381-7951 ext. 2534.

Re-Credentialing

IHCS Network Providers are re-credentialed every 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 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 surety 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.

Provider Review

In addition to the information listed in the previous section, the re-credentialing process includes a review of the provider's performance during their participation with IHCS.

This may include but is not limited to:

Satisfaction surveys

- All incidents and follow-up correspondence
- All complaints and follow-up correspondence
- Any correspondence received complimenting the provider's service
- Compliance with IHCS credentialing and other policies
- FDR Compliance (FWA,SAM, OFAC and OIG)

Credentialing Requirements for a New Location

Providers that wish to add a new location must contact the Contracting department in writing to request the addition of the new location. New locations must be credentialed following the initial credentialing process outlined above. IHCS reserves the right to refuse to add new provider locations. Decisions are based on a variety of factors, including satisfaction of our credentialing criteria and the network's needs at the time of the request, subject to applicable law.

Credentialing Requirements for Adding a Service Category

Providers that wish to add a new service category (i.e. DME, infusion) must notify the Contracting Department in writing. New service categories must be credentialed following the initial credentialing process outlined above. Providers must maintain the licensure necessary to provide the new service category. IHCS reserves the right to refuse to add new service categories. Decisions are based on a variety of factors, including satisfaction of our credentialing criteria and the Network's needs at the time of the request, subject to applicable law.

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- ([Sign In ► MedTrac Network Provider Portal \(ihcscorp.com\)](#))
 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.

PROVIDER TERMINATION

Either party may terminate the Provider Agreement, with or without cause, by giving written notice at least one hundred twenty (120) days prior to the expiration of any one (1) year term. Nothing contained in the Agreement shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

IHCS may terminate this Agreement, or any Participating Provider(s), immediately upon written notice to Provider, stating the cause for such termination in the event the Provider's continued participation may adversely affect the health, safety or welfare of any Member, bring IHCS into disrepute, if the Provider fails to meet IHCS's credentialing or re-credentialing criteria, is excluded from participation in any federal health care program, voluntarily or involuntarily seeks protection from creditors through bankruptcy proceedings, engages in or acquiesces to receivership or assignment of accounts for the benefit of creditors or loses its authority to do business.

A nonbreaching party may terminate the Provider Agreement with thirty (30) days prior written notice to the breaching party specifying the alleged breach; provided that the breaching party fails to cure the alleged breach with the thirty (30) day period.

In the event of a termination, Provider must comply with IHCS's post termination continuity of care requirements. Upon termination of the Provider Agreement, Provider shall continue to provide Covered Services to Members receiving services at the time of the notice of termination until such time that IHCS has effectuated an orderly transition of Member's care to another provider. The rates documented in the Provider Agreement will apply to authorized covered services provided during the post termination continuity of care period.

Provider shall provide a detailed list of patients currently on service at the time of the notice of termination, with a description of the services they are receiving (i.e., Prescriptions, Medical Records, Case Summary, Discharge Status) to IHCS. Regardless of the reason for the termination, Provider will maintain a professional attitude to the Members. Provider will refrain from picking up equipment from a Member prior to the Member receiving replacement equipment from another provider.

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 convert 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.

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 requires 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 be denied.

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.

BCBS of South Carolina

BlueCard Benefits FAQ

About:

When a member of a Blue Cross Blue Shield plan has a BlueCard® benefit, they are eligible to receive home care services from an IHCS network provider within the BlueCross BlueShield of South Carolina plan coverage territory. In these instances, BlueCross is known as the “Host” plan and the IHCS network “hosts” the traveling member by providing medically necessary services.

Referral/Order Receipt:

As an IHCS network provider, you may:

1. Be contacted directly by a BlueCard member requiring services.
2. Receive an order/referral directly from a physician for a BlueCard member.
3. Receive an authorization to provide a service from IHCS for a BlueCard member.

In the case of scenarios 1 and 2 above, it is your responsibility to determine member eligibility and/or get prior authorization directly from the member’s home plan. In the case of scenario 3, the IHCS standard referral and authorization process will govern service provision.

Member Eligibility & Authorization:

There are three ways a provider can get prior authorization from a home plan:

- Contact BlueCard by phone at 800-676-BLUE (2583) to speak with a representative from the home plan. Have the member’s three-character prefix ID number ready when you call.
- Go to www.bcbs.com/member-services and enter the member’s prefix information in the “Find My Local BCBS Company”. Then select link for **PROVIDERS** on the home plan’s landing page.

Find My Local BCBS Company

Search with My Member ID Card

Enter the first three characters of the Identification Number from your member ID card.

GO

- Contact the member services phone number on the BlueCard member’s ID card.

Please follow the instructions provided by the home plan for submitting medical documentation needed for prior authorization. If no authorization is required, please document your communication with the home plan — including the representative's name— to avoid erroneous claims denials.

Regardless of whether your claim requires prior authorization, the following information must be shared with IHCS upon receipt of any referral or order for a BlueCard member. If not, the claim will be rejected for Member Not In System.

Required information:

- Member demographics
 - Full Name
 - Phone Number
 - Date of Birth
 - Address
 - Member ID
- Copy of order, referral and/or prescription
- If prior authorization is received, please provide for facilitation with claims adjudication.

Please note you will receive an interim denial from IHCS, pending IHCS receipt of the Home Plan adjudication.

Claims And Payment:

As an IHCS provider, you will submit claims to IHCS for reimbursement regardless of authorization or referral source,. IHCS will work with BlueCross and the member's home plan to adjudicate the claim. You will be subject to standard adjudication policies and procedures. Regardless of authorization, you may be required to supply clinical documentation at the time of claims review. Documentation requested as part of claims processing should always be sent to IHCS and not to the BlueCard home plan.

Member Communications:

Normal patient care communications should transpire as in the ordinary course of business. However, all member questions regarding benefits, payment responsibility and unrelated service-level topics should be sent to the member's home plan.

Concerns:

Difficulties in receiving prior authorization from the home plan should be communicated to the patient and referral/order/prescription source. IHCS will help you escalate concerns accordingly.

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association®.

Cultural Competency and Awareness Training

The Company and its staff, as well as its Provider Network and Relations teams are accountable for providing culturally appropriate patient services.

Cultural Competency training will take place at the time a provider is on boarded and then published in the Provider Manual on the IHCS website.

The Company is committed to meeting the needs of its patients and health plan partners' membership in all their diversity. Integrated has dedicated itself to providing services, programs and policies that are appropriate and accessible to our customers, who encompass a broad range of human differences such as ability and disability, age, educational level, ethnicity, gender, geographic origin, race, religion, sexual orientation, socio-economic class, and values. In order for the Company to accomplish this goal, the Company encourages its provider network to enhance their ability to provide culturally competent services.

DEFINITION:

Cultural competence or culturally competent: (on an individual level) means the ability and the will to respond to the unique needs of an individual patient or family that arise from the patient's culture and the ability to use the person's cultural strengths as resources or tools to assist with the treatment, intervention or helping process.

For IHCS, cultural competence means the ability to provide equal and meaningful access and equal quality to individuals from each cultural and linguistic population served, based on an understanding of each population's distinct needs.

PROCEDURE:

1. The Company, its staff and its Provider Networks can enhance cultural competence with:
 - a. Recruiting and retaining culturally competent personnel – customer service representatives, healthcare technicians, paraprofessionals, and administrators with appropriate skills, knowledge, and attitudes;
 - b. Culturally competent services – interventions and delivery of products, goods, services and treatments proven effective with individuals from the diverse communities likely to be served;
 - c. Culturally competent operations – policies, administrative procedures, and management practices designed to ensure access to culturally appropriate services and competent personnel.
2. The Company recruits and hires trained and culturally skilled and knowledgeable people. Integrated, in partnership with its contractual partners anticipates which cultural communities are likely to be served and then develops the competence to serve them appropriately.
3. If the Company discovers that it lacks the skills in the culture or language of a client, it is incumbent upon the organization and the provider of service (Provider Network) to consult with, or refer to, someone who possesses that skill. (i.e. interpreter, TTY Relay Service, AT&T Language Line).

4. In an emergency, the Network Provider is required to meet the immediate needs of the member/patient and communicate with Integrated and/or the health plan to make a referral for culturally appropriate follow-up.
5. The Company will apply a practical standard that includes providing extraordinary effort to meet the need of a cultural group:
 - a. Whose understanding of health, mental health, illness, or disability is sufficiently different from the mainstream to create a risk of sub optimal service as a result;
 - b. Whose family customs, social patterns, child-rearing practices, and religious values are sufficiently different from the mainstream to create a risk of inaccurately assessing family functioning;
 - c. Whose primary language is not English or whose means of communication is sufficiently different from mainstream as to risk misunderstanding essential elements of the clinical or professional interaction; or
 - d. Whose history of experiencing war or ethnic, racial, social, or class-related discrimination is likely to have produced trauma or stressors beyond the norm.
6. Civil rights guidelines require that the Company (and its Provider Network) augment services or supports when cultural or linguistic factors are contributors to a patient's condition or have a bearing on his or her capacity to effectively participate in his or her care.
7. Legal requirements apply to linguistic competence. Integrated translates documents and provides services in a language other than English when necessary and in order to communicate effectively.

ACCESS BARRIERS

1. The Company will provide meaningful access to services the organization provides for individuals in all cultural and linguistic groups. "Access" refers to the patient's ability to get needed services. For persons with limited English proficiency, meaningful access means effective communication between the organization and the patient.
2. Barriers include the inability to communicate with professionals and support staff in the organization; the inability of the organization to accurately determine a client's needs; failure to obtain authorization for necessary treatment or services; unavailability of needed services; inability of the organization to provide services in a manner that is effective; excessive distance and lack of transportation to services; inability of professionals to establish rapport conducive to effective services or treatment; inability to pay for needed services.

LEGAL AND ACCREDITATION MANDATES

1. Cultural and linguistic competence are required by state and federal law.
2. Accreditation Agencies and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health managed care organizations, have issued standards that require cultural and linguistic competence in health care.

LIABILITY AND FISCAL EFFICIENCY

Providers may be liable under malpractice laws and rules for claims that their failure to bridge communication gaps breached professional standards of service. Further, they may be liable for damages resulting from treatment in the absence of informed consent.

CULTURE, MORE THAN RACE AND ETHNICITY

1. The Company recognizes that culture is more than race or ethnicity.
2. Many groups, such as the poor, homeless, disabled, gay/lesbian/bisexual/transgender, and immigrants/refugees exhibit distinct cultural characteristics, which may present special service delivery issues.
3. Those who are deaf not only often use a distinct language but also manifest a “deaf culture.”
4. Poverty imposes demands that can manifest as distinct worldviews that are cultural in nature. While socio-economic status is independent of race/ethnicity, it has culture-like characteristics for its members and engenders culture-like responses from others.
5. Cultural Awareness of Target Populations
6. Recognizing the member’s Beliefs and Customs
7. Respecting the member’s cultural background
8. Meeting the needs of Economically disadvantaged and culturally diverse populations
9. Working with seniors and people with disabilities
10. Providing Health, Safety and Welfare training materials to employees and downstreams.

DOCUMENTATION:

Customer service representatives, downstream providers, and all IHCS staffers are instructed in the manner by which to document cultural competencies and differences that are to be considered in the coordination and provision of services that respect the cultural and linguistic diversity of the patients.

Appendix

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IHCS

Portal

Provider Guide 2024





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Getting Started

Use the [Provider 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

providersupport@ihscscorp.com



Register as a New User

1. Self-registration is easy. From the [Provider Portal login page](#), click **Register now**.

EDI Transaction Portal

Welcome to the EDI Transaction Portal. Please enter your username and password below to begin using the application. If you have any questions regarding your account, please contact us at (000) 000-0000 or email to support@support.com.

User Name:

Password:

Login **Reset**

If you have lost or forgotten your password, [click here](#)

New users, [click here](#) to register.

2. In **Select Registration Type**, choose **Provider** and click **Next**.

USER SELF-REGISTRATION

- Please complete all requested information. For help click [here](#).

1) SELECT REGISTRATION TYPE:

Next

3. Under **Provider Registration**, enter your email address and the tax number/EIN and click **Find** to bring up the organization. When you have completed all fields, click **Next**.

USER SELF-REGISTRATION

- Please complete all requested information. For help click [here](#).

1) SELECT REGISTRATION TYPE:

2) PROVIDER REGISTRATION

Email

PLEASE ENTER THE TAX #'s (EIN's) FOR REQUESTED ACCESS (comma-delimited): **Find**

SELECT THE ORGANIZATIONS - TAX# - NPI BELOW FOR REQUESTED ACCESS: **Clear**

Next



4. Under **Personal Information**, enter your contact details. Required fields are highlighted in yellow. Click **Next**.

A screenshot of a web form titled "3) PERSONAL INFORMATION". The form has a teal header bar. Below the header, there are input fields for "Last: (Required)", "First: (Required)", and "Middle:". The "Last" and "First" fields are highlighted in yellow. Below these are fields for "Address:", "City:", "State:", and "Zip Code:". The "Address" field is highlighted in yellow. Below these are fields for "Phone:" and "Fax:". The "Phone" field is highlighted in yellow. At the bottom left of the form is a black button with the word "Next" in white text.

5. Under **Login Settings**, validate or update your default username and set a password. Once you have read the **Terms of Use Agreement**, check the box and click **Login**.

Note: Your password must have at least 8 characters, contain both uppercase and lowercase letters, and have at least one number and one special character.

A screenshot of a web form titled "4) LOGIN SETTINGS". The form has a teal header bar. Below the header, there are input fields for "Username" and "Password". The "Username" field contains the text "provider@domain.com". To the right of the "Username" field is a checkbox labeled "Use Email" which is checked. To the right of the "Password" field is a "Password Strength" indicator showing "Good" with a question mark icon. To the right of the "Password Strength" indicator is a "Confirm Password" field containing several asterisks. Below these fields is a checkbox labeled "I have read the Terms of Use Agreement" which is checked. Below the checkbox is a black button with the word "Login" in white text. At the bottom of the form, there is a small line of text: "Registration complete! Your request has been received and will be reviewed by our administrative staff. You will receive an email when your account is activated. Thank you for registering to use our Healthcare Portal!"

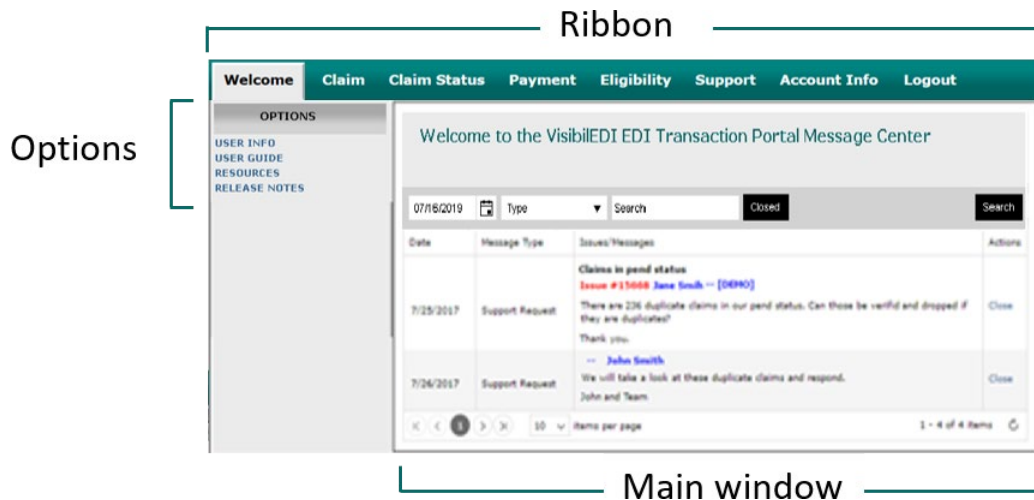
Upon completing registration, you will receive an email indicating that your account request is under review. Once the portal administrator has reviewed and approved your account, you will receive an email confirmation.

Note: If the username you have chosen already exists, if the entered passwords are too weak and/or do not match, or if you have not indicated agreement with *Terms of Use Agreement*, the system will prompt you to correct these issues.



Navigate the Portal

1. Use the **tabs** on the **ribbon** at the top of the screen for your primary navigation.
2. Use **Options** in the left-hand bar to access related pages. Options may change depending upon the tab you select.
3. The **main window** will display information in a grid format. You may see more than one information grid displayed in the main window.



4. Depending upon the tab you select, you may see **Batch Criteria** in the left-hand bar, beneath **Options**. Use Batch Criteria to find and filter information in the main window.



Exploring the Ribbon

Use the following summary to understand what you can do on each tab in the ribbon.




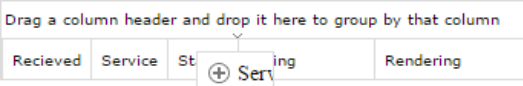


What Is It?	Tab on Ribbon	What You Can Do
Message Center	Welcome	View all your alerts and notifications. Open alerts are displayed by default.
Claim Center	Claim	View and search claims submission history, enter a claim transaction, view claim status, and view claim payment information.
Claim Status Center	Claim Status	View and search claims, claim status, and claim payment details.
Payment Center	Payment	View payment history, search for claim payments, and view payment reports and messages.
Eligibility Center	Eligibility	Submit and review eligibility inquiries.
Support	Support	View, document, and respond to messages related to claims.
Account Info	Account Info	Access and update your account information.
Logout	Logout	Log out of the portal.



Standard Usability Features

The Provider Portal offers familiar buttons, icons, and other navigational elements that make it easy to find and access data and complete tasks.

Usability Feature	What You Can Do
	Navigate through each results page. Navigate between the first and last pages in a list.
	View 10, 20, or 50 records per page. The default is 10. However, the system will remember your preference and apply it to subsequent sessions.
	Change the default sort order in grids by clicking a column heading. An arrow (^ or v) will indicate if a column is sorted in ascending or descending order.
	Change the default column order by clicking and holding a column header and dragging it to a new location between two other columns.



Advanced Usability Features

Sort by Column Header

1. Click and drag a column header to the field. **Drag a column header and drop it here to group by that column.** More than one column header can be used simultaneously to create subgroups.

Service Before: 11/10/2016 Status: Search

Drag a column header and drop it here to group by that column

Received	Service	Status	Billing	Rendering	Tax ID/NPI	Member ID	Member	Billed	Paid
10/14/13	08/18/13	Finalized	THESAPEDCLINIC INC	SMITH, SCOTT	951532715 /	000147308	SMITH, AMY	\$373.00	\$0.00

2. By default, data will be sorted in ascending order. To change the sort order, click ^ or v in the column. To remove a column header from the grouping, click the X.

Service Before: 11/10/2016 Status: Search

^ Billing X ^ Rendering X

Received	Service	Status	Billing	Rendering	Tax ID/NPI	Member ID	Member	Billed	Paid
Billing:									
Rendering: SMITH									
09/03/15	08/24/15	Finalized					SMITH, AMY	\$163.00	\$86.67
Rendering: SMITH									
09/06/15	04/13/15	Processing...					SMITH, AMY	\$402.00	
Billing: PEDIATRIC CLINIC									
Rendering: PEDIATRIC CLINIC									
06/19/14	06/02/14	Finalized	PEDIATRIC CLINIC				SMITH, AMY	\$56.00	\$8.12
05/14/11	04/26/11	Finalized	PEDIATRIC CLINIC				SMITH, AMY	\$98.00	\$39.32

10 items per page 1 - 10 of 100 items

3. To collapse lines of data, click the **collapse icon** ▶ next to the heading. To expand collapsed data, click the **expand icon** ▲.

Service Before: 11/10/2016 Status: Search


^ Rendering X

Received	Service	Status	Billing	Rendering	Tax ID/NPI	Member ID	Member	Billed	Paid	Id
Rendering: SMITH										
Rendering: SMITH										
Rendering: SMITH										
08/25/11	07/29/11	Finalized	PEDIATRIC CLINIC				SMITH, AMY	\$136.00	\$111.00	
08/08/11	07/14/11	Finalized	PEDIATRIC CLINIC				SMITH, AMY	\$375.00	\$287.20	
06/27/11	06/02/11	Finalized	PEDIATRIC CLINIC				SMITH, AMY	\$205.00	\$180.00	

10 items per page 1 - 10 of 100 items





Filter by Column


To filter data by column, click the **filter icon** . The three types of filters are shown below. You can combine up to two search terms. To view results, click **Filter**.

Numbers or Text

Show items with value that:

Is equal to 


And 


Is equal to 


Filter **Clear**


Limited Selection


Show items with value that:

Is equal to 

-Select value- 

And 


Is equal to 


-Select value- 


Filter **Clear**


Date


Show items with value that:

Is equal to 



And 

Is equal to 




Filter **Clear**


Filter by Batch Criteria

With Batch Criteria you can filter data by date range, batch number, or claim status. Find Batch Criteria below Options in the left-hand side bar.


To use Batch Criteria, complete your desired criteria and click **Search**.

BATCH CRITERIA

From: 11/04/2015 

To: 12/03/2015 

Batch:

Status: 

Clear **Search**



Message Center (Welcome)

View all your messages and alerts, including support requests, in the Message Center.

View or Search for an Alert

In the main window you will see the date the message was posted, the message text, and options to close or reopen the alert. Message Center shows open alerts by default.

1. To search for a specific message, set the desired filters and click **Search**:
 - **Date:** Use the default date or enter another date (MM/DD/YYYY). The search will display the history of alerts up to and including the specified date.
 - **Type:** Select one of the following:
 - Message Text:** Enter a keyword to search within the body of an alert.
 - Open/Closed:** Search for open or closed alerts by clicking the corresponding box.
2. To refresh the page and reset the search fields, click **Welcome** on the ribbon.

Options

Message Center options include links to this user guide, Medicare and Medicaid resources, and release notes that show the Provider Portal's latest updates.







Claim Center

In the Claim Center, you can view claim submission history, search claim history, enter and save a claim, and view claim status and claim payment information.

Understanding Batch Views

Depending upon your task in Claim Center, you may have one or more of the following Batch View options.

Batch View	How to Use It
 Download	Click the icon to download a copy of the batch file to your computer. Batch files can be viewed using any text editing program.
 View All Claims	Click the icon to view individual claim details for the file using the portal's claim edit view.
 Claim Messages	Click the icon to view all details related to the batch including error history. This tool is especially useful if you are fixing pended claims.
 Archive	After one year, files are automatically archived. Contact support to request an archived file.



Understanding Claim File Status Messages

Use the following key to understand Claim File Status Messages.

Message	Description
Accepted	The claim file has been accepted by the payer.
Adjusted/Corrected	The claim file was adjusted with another claim submission.
Drop	The claim has been dropped from processing.
Duplicate	The file is a duplicate file/claim/payment.
Errors	There are errors in record that have prevented processing.
Finalized	Remittance received from the payer.
Hold	The claim is being held from processing.
Pend	The claim has been rejected and must be corrected and resubmitted.
Processing	The claim or file is being processed.
Ready for Download	The file is ready for download.
Received	The claim has been received but not yet processed.
Rejected	The entire batch has been pended.
Sent to Receiver	The file has been sent to the payer.
Testing	The file is being used for system processing purposes.
Validated	Data has been validated by the system.



Understanding Claim Submissions

In Claim Submissions, you can upload claim files, view past claim file submissions, and search for claim batches. Read the following information to help you navigate Claim Submissions.

1. In the **Claim Center**, select **Options > Submissions**. The main window will display all the claim file batches you've uploaded in the last thirty days and their status. Results are displayed chronologically, starting with the most recent submission files. To narrow your selections, use Batch Criteria or the filter options.

The screenshot shows the 'Claim Submissions' page. On the left, there's a sidebar with 'OPTIONS' (SUBMISSIONS, DIRECT ENTRY, PENDED CLAIMS (711), SEARCH) and 'BATCH CRITERIA' (Batch, From, To, Status). The main area displays a table of batches with columns: Upload Date, Batch, File Name, Organization, Count, Charges, Status, and Batch Views. The table shows 6 rows of data. At the bottom, there are pagination controls showing '1 - 6 of 6 items'.

2. To view or edit a batch, click the **claim messages icon** . Two grids will appear in the main window:

- a. **Upper grid:** This grid displays batch details, including the number of Pends (in red) and the number of Accepted claims (in blue). Click the blue and red numbers to link to all claims in that specific category. For instance, clicking a number in the Pends column will redirect you to a work list and claim detail view for pended claims.

Organization	Rec	Val	Pends	Held	Drop	Sent	Acc	Fin	Total	Total Billed
Submitter(s)										
CLAIM SUBMITTER			12				35		47	\$7,957.37
Receiver(s)										
PAYER			12				35		47	\$7,957.37

- b. **Lower grid:** This grid provides a count of claims by message type: Accepted, Rejected, and Informational. The display defaults to Rejected. Use the Message Type dropdown to select a different message type or select View All to see all claim messages.

MESSAGE TYPE: Rejected Active Pend		
Message Type	Message	Count
Rejected	Receiver Response - 30201 - I-Referring Physician NPI is Required	26
Rejected	Receiver Response - 25001 - I-Medically Unlikely Error	20

Click the **message text** to see a work list and claim detail view for claims in that batch with that error message.

MESSAGE TYPE: View All Active Pend		
Message Type	Message	Count
Rejected	Receiver Response - 30201 - I-Referring Physician NPI is Required	26
Rejected	Receiver Response - 25001 - I-Medically Unlikely Error	20
Rejected	Receiver Response - 228 - Type of bill for UB claim.	12



Related

[Understanding Claim File Status Messages](#)

Upload a Claim File

Upload claim files on the Claim Submissions page. You can also view past claim file submissions from this page.

1. In the **Claim Center**, select **Options > Submissions**. Results are displayed chronologically starting with the most recent submission files.

The screenshot shows the 'Claim Submissions' page. On the left, there's a sidebar with 'OPTIONS' (SUBMISSIONS, DIRECT ENTRY, PENDING CLAIMS (711), SEARCH) and 'BATCH CRITERIA' (Batch, From: 04/01/2019, To: 10/14/2019, Status: dropdown, Clear, Search). The main area has a 'Claim Submissions' header and a table with columns: Upload Date, Batch, File Name, Organization, Count, Charges, Status, and Batch Views. The table contains 6 rows of data, all with 'Accepted' status. At the bottom, there are pagination controls showing '1 - 6 of 6 items'.

Upload Date	Batch	File Name	Organization	Count	Charges	Status	Batch Views
9/5/2019	859350	Export-9-5-2 019.txt	Demo	15	\$5,659,588.31	Accepted	
8/26/2019	849933	Export-8-6-2 019.txt	Demo	93	\$5,727,129.03	Accepted	
7/3/2019	796638	Export-7-3-2 019.txt	Demo Healthplan	56	\$3,615,725.26	Accepted	
6/7/2019	772913	Export-6-7-2 019.txt	Demo	30	\$8,469,607.08	Accepted	
5/7/2019	746001	Export-5-7-2 019.txt	Demo Healthplan	42	\$6,028,962.70	Accepted	
4/4/2019	720736	Export-4-4-2 019.txt	Demo	8	\$4,262,490.90	Accepted	

2. Choose **Select Files** to view a list of claim submissions. If desired, use either **Batch Criteria** or the **Column Filters** to narrow the file selections.

The screenshot shows the 'Claim Submissions' page with a 'Select files...' button visible.

3. Navigate to the claim file that you want to upload and select **Open** to submit your file. **Only .txt files may be uploaded**. Once the progress indicator reaches 100%, your upload is complete.
4. Click the **refresh icon** to see the file. **Status** will appear as **Processing**.

The screenshot shows the 'Claim Submissions' page with a table containing one row of data. The status is 'Processing...'. The table has columns: Upload Date, Batch, File Name, Organization, Count, Charges, Status, and Batch Views.

Upload Date	Batch	File Name	Organization	Count	Charges	Status	Batch Views
8/2/2018	208821	test_upload_file.txt	Claim Submitter			Processing...	

View Entered Claims with Batch Views

As claims get entered, a new daily batch is created in Claim Submissions for each billing organization. All claims created for that billing organization will be added to this batch within a 24-hour period.



To view individual claims and track claim status, use Batch Views. When a claim passes the validation process, it is sent to the designated payer. If there are errors, the claim will pend. The provider must correct the issues before the claim can be submitted to the payer.

View and Resolve Pended Claims

View and resolve pended claims on the Pended Claims page. You can also view past claim file submissions. Pended claims should be resolved daily.

To access Pended Claims, in the **Claim Center** select **Options > Pended Claims**. All pended claims will appear in the search results.

The screenshot shows the 'Pended Claims' interface. On the left, there are 'Error Filters & Search Results' including filters for 'Payer Filter', 'Prepend Filter', and 'Response Filter'. The 'SEARCH RESULTS' section lists several pended claims. The main area displays 'Basic Claim Details' for a specific claim, including patient and subscriber information. Below this are 'Claim View Tabs' for Patient, Payers, Providers, Facility, Detail, and Other. The 'Status' is 'Pend - Claim rejected. Please correct error and save changes to resubmit'. At the bottom is a 'Message Grid' showing a rejected message with details like 'Invalid Facility NPI'.

To resolve pended claims, review messages within the grid with the 'Rejected' Message Type, make the necessary changes to the claim, and save. If it is not clear to you what needs to be corrected, refer to industry standard billing guidelines and billing instructions provided by the payer. If it is still unclear what needs to be fixed, contact the [support center](#) team for help.

Error Filters & Search Results

Use the Error Filters to narrow pended claims. Each filter displays the count of claims in each pend bucket based on any other filter criteria already in place (such as a specific payer).

Claims may have more than one error. Reference the Message Grid to ensure all errors have been corrected before saving and resubmitting a claim.

This screenshot shows the 'PENDED CLAIMS (263)' section. It includes a 'SEARCH RESULTS' table with columns for 'Submit Date', 'Oldest First', and 'Count'. A green arrow points from the 'SEARCH RESULTS' section to a 'Prepend Filter' dropdown menu. The dropdown menu lists various error categories and their counts, such as 'ValPATGENDER -- (5208)', 'UnbalancedCOBPD -- (4444)', 'MissingRenderingNPI -- (3394)', 'HoldDuplicateClaims -- (1067)', 'MissingSBR09 -- (1563)', 'ValSubscriberAddress -- (1535)', 'MISSING BILLING NPI -- (1344)', 'MissingPrimaryPayerInfo -- (1317)', and 'ValRevCodeLen -- (1127)'. A text box explains: 'Each filter displays the count of claims for a specific error category.'



Filter Option	Description
Biller Filter	Filter by a specific plan.
Filter by Payer	Filter by a specific destination.
Prepend Filter	Displays pends resulting from a preset business rule. These pended claims have not been sent to the destination.
Response Filter	Displays messages provided by the destination on claims sent to them. These messages can communicate acceptance or rejection.

Basic Claim Details

Claim Details in the upper section of the main window provides a fixed reference for essential claim information. Using the Action menu, you can Save, Drop, or Hold a claim.

Note: When using Drop or Hold, always enter a reason into the Message Grid.

Welcome Claim Claim Status Payment Eligibility Support Account Info Logout	<div> <div>OPTIONS</div> <div> SUBMISSIONS DIRECT ENTRY PENDED CLAIMS (58) </div> </div> <div> <div> <div>Patient: DEMO STRUBEN</div> <div>Subscriber: DEMO STRUBEN</div> <div>Provider: DEMO CLINIC LLC</div> </div> <div> <div>Account #: 1652928</div> <div>SVC Date: 05/13/2018</div> <div>Payer: HEALTH SHARE/CAREOREGON</div> </div> <div> <div>Subscriber #: NH601LSL</div> <div>Billed: 227.00</div> <div>Claim #: 54427719</div> </div> <div> <div>Save PC</div> <div>Action: Save ▼</div> </div> </div>
--	---

Action	Description
Save	Once you have corrected a pended claim, select Save from the Action menu and then click Save . The claim status will change to Received.
Drop	When a claim should not be processed, select Drop from the Action menu and click Save . The claim will be dropped from further processing and will not be sent to any destination. The claim will remain in the system for reference.
Hold	Select Hold from the Action menu and click Save . Claim status will change to Hold and will not be processed further.
Validate	To revalidate claim data, select Validate from the Action menu and click Save . Claim status will change to Validate and will be sent to the destination.



Claim View Tabs

Use the Claim View tabs to view in depth detail about the claim.



Tab	Description
Patient	Contains patient, subscriber information.
Payers	Contains current and primary payer, primary subscriber information.
Providers	Contains applicable rendering, billing, and referring provider information.
Facility	Contains facility and ambulance information, where applicable.
Detail	Contains claim detail/line-level data.
Other	Contains other claim data such as Auth ID, Submitter Claim ID, and ICN.
Payment	Contains payment data from the Health Plan Payer.



Message Grid

A message grid detailing claim history appears at the bottom of each claim. All messages are displayed by default. Click **Show Active** to see only Active messages.

Add Message			
Informational		09/26/2016	4:45 PM
		Save Message	Show Active
Message Type	Message	Date	
Rejected	Missing Subscriber ID	06/28/2016	
Rejected	Subscriber Name information is invalid	06/28/2016	

Most messages are loaded automatically by the system.

- Validation messages provide details regarding why a claim pended.
- Informational messages provide details about the batch the claim was submitted in, when it was sent to the payer, and if the claim has been accepted.

To provide additional background around a claim, click **Add Message**.

If a message is no longer relevant, click the **trash icon** to make the message inactive. All inactive messages can be viewed by clicking **Show All**.

Related

[Understanding Claim File Status Messages](#)



Search Claims

Perform a basic or advanced search based on criteria related to a specific claim. Use Search to track history of submissions and acceptance by the payer.

1. In the **Claim Center**, select **Options > Search**. You can search two ways.

Basic search: Complete the desired fields and click **Search**.

Advanced search: Click **Advanced**. Complete the desired fields and click **Search**. To return to the basic search, click **Basic**.

2. View search results in the left-hand portion of the screen. To export search results to Excel, click **Export**. To update your search, click **Revise Search** to return to the search window.

Related

[Advanced Usability Features](#)



Submit a Claim Inquiry

Inquiry allows you to submit a support ticket to the Health Plan Claims Support Team while viewing a claim in the Claims Center.

1. To submit an inquiry while viewing a claim, click **Inquiry**. A pop-up window containing claim details will appear.

Welcome Provider 7/31/2017 11:19 AM Inquiry

Welcome	Claim	Support	Account Info	Logout
---------	-------	---------	--------------	--------

OPTIONS
SUBMISSIONS
PENDING CLAIMS (263)
SEARCH
--Billor Filter--
--Payer Filter--
--Prepend Filter--
--Response Filter--

Patient:	SMITH, JANE	Account #:		Subscriber #:		Save Claim
Subscriber:	SMITH, JANE	SVC Date:		Billed:		Action:
Provider:		Payer:		Claim #:	32669069	Save

Patient	Payers	Providers	Facility	Detail	Other	Payments
PATIENT						
Last	First	Middle	DOB	Sex	Relationship	
SMITH	JANE					

2. Provide relevant information in the **Issue Entry window** and click **Submit**. The Inquiry will post to the Support Issue History page for response by the Health Plan Claims Support Team.

ISSUE ENTRY - Please provide enough detail to analyze and resolve the issue.

SUBJECT
Do NOT include private or sensitive information (PHI) in the subject line. It may be displayed in the recipient's personal non-secure email inbox.

Inquiry on Claim# 144963410; Patient Account# 1446900

DESCRIPTION
Claim Date of Service: 9/2/2016
Billing Provider Name: Demo Clinic
Billed Amount: 196.00
Member ID: BJ92243X

Submit **Cancel**



Claim Status Center


In the Claim Status Center, you can view and search claims, claim status, and claim payment details.


Perform an Online Inquiry

Use Online Inquiry to see if a claim has been received, processed, or paid.

1. In the **Claim Status Center**, select **Options > Online Inquiry**. By default, the last 100 claims are displayed. No claim information will be displayed until you perform a search.
2. To search claim status, enter criteria into the available fields (described below) and click **Search**. Results are displayed in chronological order starting with the most recent claims. To refresh the page and reset the search fields, click **Online Inquiry** under **Options**.
3. To view claim/payment details, click the **information icon**



Field	How to Use
Service before	Click the calendar icon or set date in MM/DD/YYYY format.
Status	Use the dropdown to search claims that are In Process or Finalized.
Member Last	Enter at least 3 characters of member's last name. 
Member ID	Enter at least 3 characters of member's ID number.
Account/Claim No	Enter at least 3 characters of the patient or claim number/ICN.
Provider	Use the dropdown to select a provider.

Online Claim Status Inquiry
Back 

PAYER: Visibiledi **EFT/CHECK NO:** 089559 **DATE:** 09/30/15 **AMOUNT:** \$ 238.29
BILLING PROVIDER: CLINIC **RENDERING PROVIDER:** SMITH, SCOTT

PROVIDER_ID	DATE	PROC_MOD	BILLED	ALLOWED	COPAY/DED	COINS	GRP/RC_AMT	PAID
Name: SMITH, REX	HIC:	PAT #:	ICN:	E				
08/27/15	99214	210.00	196.60	25.00 PR-3	0.00	13.40 CO-45	171.60	
TOTALS:		210.00	196.60	25.00	0.00	13.40	171.60	
PT RESP: \$ 25.00						NET	171.60	

GLOSSARY:

- 3 Co-payment Amount
- 45 Charges exceed your contracted/ legislated fee arrangement.
- CO Contractual obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
- PR Patient Responsibility. Amount that may be billed to a patient or another payer.

DATE	PROCEDURE	MESSAGE
08/27/15	PROC CODE: 99214	OFFICE/OUTPATIENT VISIT, EST
09/14/15	I : -	Claim Received for product - Accessibiledi. Batch # 217900
09/30/15	A : -	Line 1:
09/30/15	I : 3 -	Line 1: Co-payment Amount
09/30/15	I : 45 -	Line 1: Charges exceed your contracted/ legislated fee arrangement.

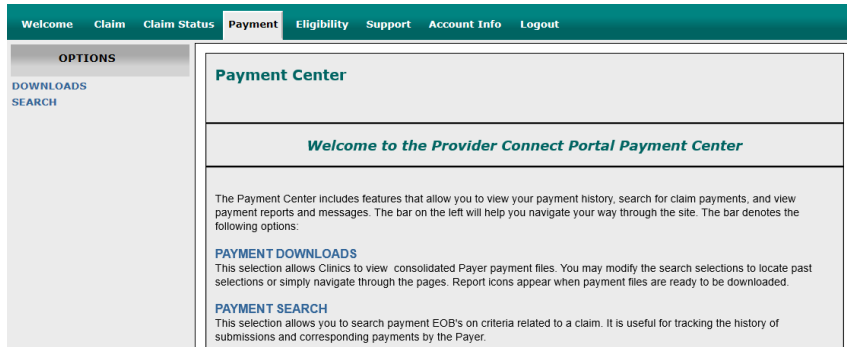
Related

[Advanced Usability Features](#)




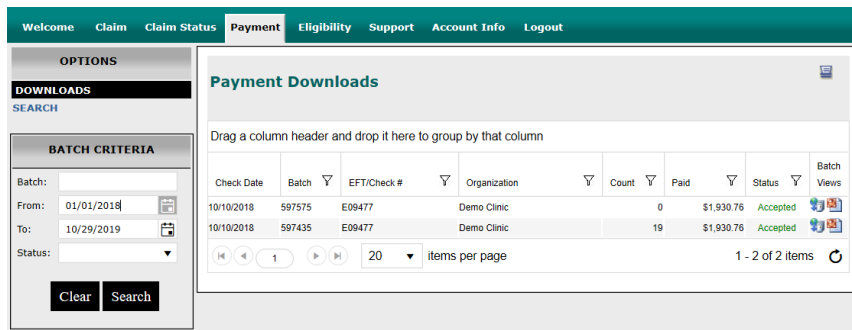
Payment Center

In the Payment Center, you can view payment history, search for claim payments, and view payment reports and messages.




View Payment Downloads and Search for Payments

To view payer payment files, from the **Payment Center**, select **Options > Downloads**. The payments from the last thirty days are displayed by default. A **download icon**  will appear if a payment file is ready for download.



There are two ways to search: using **Batch Criteria** in the left-hand bar or using **Payment Search** under **Options**.

Search Using Batch Criteria

1. Use Batch Criteria to search by batch number, time period, or status. Claim status options include: Accepted or Ready for Download. Once you have set your Batch Criteria, click **Search**.
2. You can then filter and sort claims in the main window.
 - Select the **download icon**  to view or download the x12 835 file from the payer.



- Select the **message icon** to view and print the Payment File Batch Summary.

Payment File Batch Summary									
Payer Name		Billing Name		Check/EFT No:		Date	Count	Amount	
HEALTH ALLIANCE		CLINIC		00015		9/30/2015	441	\$45,771.59	
Batch Totals:								\$45,771.59	
HEALTH ALLIANCE		CLINIC						REMITTANCE	
CHECK/EFT #: 00015		PAGE #: 1 OF 62						NOTICE	
								10/1/2015	
								PROV PD	
		SERV DATE	PROC MOD	BILLED	ALLOWED	COPAY/DED	COINS	GRP/RC-AMT	PROV PD
Name: 20111120			HIC:		PAT #:		ICN:		
10/24/2014		99213		\$165.00	\$0.00			\$165.00 CO-29	\$0.00
\$0.00		Claim Totals		\$165.00	\$0.00	\$0.00	\$0.00	\$165.00	\$0.00
PT RESP:									\$0.00
Name: 20111120			HIC:		PAT #:		ICN:		
10/24/2014		99213		\$165.00	\$0.00			\$165.00 CO-29	\$0.00
\$0.00		Claim Totals		\$165.00	\$0.00	\$0.00	\$0.00	\$165.00	\$0.00
PT RESP:									\$0.00
									NET

Note: To reset search criteria, click **Clear**.

Use Payment Search

Simple Search

Set search criteria using the available fields which include check number, check amount, account/claim number, member ID, and/or date range. Click **Search**.

Payment Search

EFT/Check #: Amount:
Account/Claim #: Member ID:
EFT/Check Date: From: 10/01/2015 To: 10/31/2015

Drag a column header and drop it here to group by that column

Status	Account	DOS	Trans Date	Payer ICN	Member ID	Member Name	Billed	Paid	Patient Resp	Short Amt.
--------	---------	-----	------------	-----------	-----------	-------------	--------	------	--------------	------------

items per page

No items to display

Advanced Search

Select **Advanced** to search by Billing Tax ID number and Name or by Payer ID number and Name. Set your search criteria and click **Search**.

Payment Search

EFT/Check #: Amount:
Account/Claim #: Member ID:
EFT/Check Date: From: 09/17/2019 To: 10/16/2019

Billing Tax ID: Name:
Payer ID: Name:

Drag a column header and drop it here to group by that column

Status	Account	DOS	Trans Date	Payer ICN	Member ID	Member Name	Billed	Paid Amt	Patient Resp	Short Amt.
--------	---------	-----	------------	-----------	-----------	-------------	--------	----------	--------------	------------

items per page

No items to display

Note: To reset search criteria, click **Clear**.

Related

[Understanding Batch Views](#)

Eligibility Center

In the Eligibility Center, you can submit and review eligibility inquiries.

Submit Eligibility Verification Inquiry

1. From the **Eligibility Center**, select **Options > Online Inquiry**.

2. To check patient eligibility, complete the **Service Date** and **Payer** fields and **one of these required fields**: Member ID or Member Last and First name and Date of Birth.

- Click **Search**. Patient eligibility information will be displayed in Results.

Eligibility Online Inquiry

Please select a Payer and enter either Member ID or Last, First, and DOB

Service Date: 01/03/2018

Payer: [Dropdown]

Member ID: [Text]

Last: [Text]

First: [Text]

MI: [Text]

DOB: [Text]

Search **Clear**

RESULTS

John Smith is eligible for the entered date of service.

PATIENT DEMOGRAPHICS

First	MI	Last	SUFF	DOB	Sex	SSN	Address	City	State	Zip
John		Smith		01/03/1980	M	123-45-6789	123 Main St	Anytown	CA	90210

PAYER INFORMATION

Payer Name	Payer Type	Payer Plan	Member ID	Group ID	Employer Name
ABC Insurance	Commercial	ABC Plan	123456789	987654321	ABC Corp

Eff Date	Term Date	Relationship	Subscriber First Name	Last Name
01/03/2018	12/31/2018	Subscriber	John	Smith

Plan Details	Address	City	State	Zip
ABC Plan	123 Main St	Anytown	CA	90210

PRIMARY CARE PHYSICIAN

PCP Name	Eff Date	Phone #
Dr. John Doe	01/03/2018	123-456-7890

INSURANCE BENEFIT SUMMARY

Benefit	Service	Period	In Network	Remaining	Out Of Network	Remaining
Co-insurance	Medical Services	01/03/2018 - 12/31/2018	\$100	\$100	\$0	\$0
Co-payment	Prescription Services	01/03/2018 - 12/31/2018	\$10	\$10	\$0	\$0
Deductible	Medical Services	01/03/2018 - 12/31/2018	\$1000	\$1000	\$0	\$0
Deductible	Prescription Services	01/03/2018 - 12/31/2018	\$500	\$500	\$0	\$0
Out of Pocket (Stop Loss)	Medical Services	01/03/2018 - 12/31/2018	\$5000	\$5000	\$0	\$0
Out of Pocket (Stop Loss)	Prescription Services	01/03/2018 - 12/31/2018	\$2500	\$2500	\$0	\$0

Support Center

The Support Center consolidates issue history related to claims into a single location. You can view, document, and respond to support-related messages 24/7.

Welcome **Claim** **Claim Status** **Payment** **Eligibility** **Support** **Account Info** **Logout**

OPTIONS

- ISSUE HISTORY (0)
- ENTER ISSUE
- USER GUIDE

Support Center

Welcome to the Provider Connect Portal Support Center

The Support Center includes features that allow the user to enter and respond to support messages, receive responses, and track the resolution of an issue in a secure manner. By utilizing the Support Center, the user documents each issue and consolidates issue history into one location for easy 24/7 reference for themselves and the customer service / support departments. The bar denotes the following options:

ISSUE HISTORY
This selection allows the user to view and search support issue history. From this page the user can edit a previously submitted issue, reply to an issue, or close an issue. When editing or replying to an issue, a user can change the priority or due date of an issue or reassign the issue to a different individual as appropriate.

ENTER ISSUE
This selection allows the user to enter a new issue. The user can set the issue category and assign the appropriate support type / individual and priority. Use the Issue Text field to describe the issue being sure to provide enough detail for the customer service / support departments to analyze and resolve the issue. Once an issue has been submitted, it will appear in the user's Issue History.

View, Search, and Manage Support Issues

View, Search and Export Support Issues

- From the **Support Center**, select **Options > Issue History**.

From here you can view Issues/Messages, including the subject line, issue number, message text, creation date, assigned support party, issue category, and priority, along with relevant actions you can take.

Replies appear directly beneath the parent message in chronological order. Replies are easily distinguished as they do not have a subject line or issue number.

2. To narrow the list of issues, set the available filters. To filter for a specific issue, enter the issue number into the **Search** field. To search on a specific key word or phrase, enter the key word or phrase into the **Subject** field. Click **Search**.
3. To download a report of issues from your current search to Excel, click **Export**.

Note: All messages will be marked “unassigned” by default. The Portal Administrator will assign priority and support party.

Actions	Issues/Messages	Created
Reply Close	Support Inquiry on Status Issue #68059 Provider	10/9/2018 2:02 PM
Reply Close	Inquiry to Support 1 Issue #68056 Provider	10/9/2018 1:56 PM

Manage Support Issues

1. From the **Support Center**, select **Options > Issue History**.
2. Choose one of the following **Actions**:
 - Click **Reply** to respond to the parent or related Issue/Message.
 - Click **Close** to close out the issue record.

Account Info

From the Account Info page, you can update your user information and login settings. You can also view your current account privileges and request access to additional organizations.

Update Account Info and Login Settings

1. From **Account Info**, select **Options > User Info**.
2. Update the appropriate fields and click **Save**.

Note: Due to HIPAA regulations, the account must be registered with your first AND last name.

The screenshot shows the 'Account Info' page with a teal header bar containing links: Welcome, Claim, Claim Status, Payment, Eligibility, Support, Account Info, and Logout. A left sidebar has 'OPTIONS' and 'USER INFO' (selected). The main content area is divided into three sections:

- USER INFORMATION:** Fields for Last: (Demo), First: (Provider), Middle: (), Email Address: (support@healthplan.com), Title: (), Address: (), City: (), State: (), Zip Code: (), Phone: (), and Fax: ().
- LOGIN SETTINGS:** Fields for Username: (ProviderDemo), Password: (), Password Strength: (Empty), and Confirm Password: (?).
- ACCOUNT PRIVILEGES:** A table showing user type (Provider) and a list of roles/privileges with their corresponding organization, tax ID, and NPI.

A 'Save' button is located at the bottom of the form.

Role/Privilege	Organization	Tax ID	NPI
Upload Claims	Demo Clinic - 123456789 - 1234567809	123456789	1234567809
Claim Submissions	Demo Clinic - 123456789 - 1234567809	123456789	1234567809
Edit Claims	Demo Clinic - 123456789 - 1234567809	123456789	1234567809
Payment Downloads	Demo Clinic - 123456789 - 1234567809	123456789	1234567809
Eligibility Online Inquiry	FANNO CREEK CLINIC LLC - 841192683 - 1609876705	841192683	1609876705
Claim Status Inquiry	Demo Clinic - 123456789 - 1234567809	123456789	1234567809
Eligibility Submissions	Demo Clinic - 123456789 - 1234567809	123456789	1234567809

Account and Password Expiration

All user accounts will become inactive after 90 days of inactivity. To reactivate your account, contact the portal administrator listed on the login page.

User passwords expire every 180 days. Upon login, you will be prompted to enter a new password. You may not reuse any of your previous six passwords.

Related

[How Do I Recover My Password?](#)

Account Privileges

Account Privileges is read-only and shows your current account access level. Each designation under Role/Privilege indicates the type of access that you have.

Role/Privilege	Type of Access
Upload Claims	Access to Claims Submissions and the Upload Claims feature
Edit Claims	View and manage pending claims
Payment Downloads	Access to Payment Downloads and Search
Eligibility Only Inquiry	Access to Payment Downloads and Search
Claim Status Inquiry	Access to Claim Status Online Inquiry

Organization Requests

To request access to an additional organization, go to Account Info > Organization Request.

1. Enter the Tax ID in the first field and click **Find**.
2. Select the provider description and corresponding NPI in the second field, then click **Submit**.

OPTIONS

USER INFO

ORGANIZATION REQUEST

REQUEST ADDITIONAL ACCESS

PLEASE ENTER THE TAX #'s (EIN's) FOR REQUESTED ACCESS (comma-delimited):

Find

SELECT THE ORGANIZATIONS - TAX# - NPI BELOW FOR REQUESTED ACCESS:

If you are unable to locate your organization, please contact the THA Help Desk at (503) 844-8104 or THA.CustomerService@tuality.org.



Clear

Submit

You will receive an email when your request has been approved.


Frequently Asked Questions

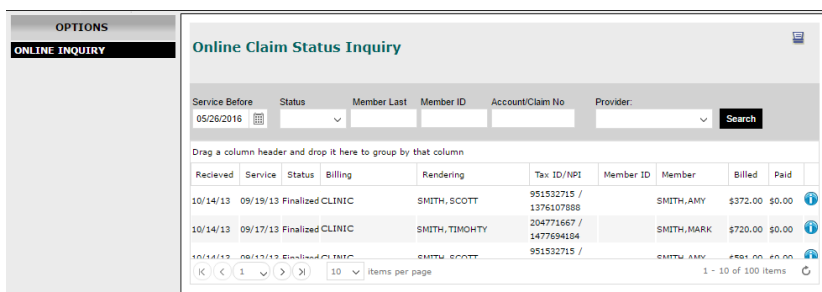
How Do I Print a Screen?

1. Click the **print icon** .
2. Select **Print** in the upper right-hand corner to open a print dialogue screen. Select your printer and desired settings and click **Print**.
3. After printing, click the **print icon**  to return to the normal page view.



Note: When in print view, you cannot use the browser back button to return to the normal page view.

How Do I Print a Single Claim Record?

1. Click the **information icon**  next to the claim record you wish to print to bring up the Online Claim Status Inquiry window.



Received	Service	Status	Billing	Rendering	Tax ID/NPI	Member ID	Member	Billed	Paid
10/14/13	09/19/13	Finalized	CLINIC	SMITH, SCOTT	951532715 / 1376107088		SMITH, AMY	\$372.00	\$0.00
10/14/13	09/17/13	Finalized	CLINIC	SMITH, TIMOTHY	204771667 / 1477694104		SMITH, MARK	\$720.00	\$0.00

2. Click the **print icon**  in the upper right-hand corner to open a print dialogue screen. Select your printer and desired settings and click **Print**.
3. To return to the normal page view, click **Back** or the **print icon** .
4. To return to Claim Status Online Inquiry, click **Back** once more.

How Do I Recover My Password?

1. From the portal login screen, click **Recover Password**. Enter your username and email address and click **Submit**.

Note: If you input your email address as your username at registration, it will need to be entered in both fields.

2. You will receive an automated email with a link that will allow you to enter a new password. Follow the instructions and use the link to create a new password.

Note: Your password must have at least eight characters, contain both uppercase and lowercase letters, and have at least one number and one special character. You may not reuse any of your last six passwords.

3. You will be redirected to the login page where you can enter your username and new password.

Why Can't I See My Claims?

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.

How Do I Troubleshoot a Pended Claim?

To troubleshoot a Pended Claim, use the following steps:

1. Review the Pend Claim Status Message to determine root cause, such as missing or incorrect data.
2. Correct data within the portal. If needed, correct and upload source documentation. If there are further issues, contact the account manager.
3. Save and submit the claim for processing.

Related

[View and Resolve Pended Claims](#)



Billing & Claims Guide

2024

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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

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.
- Provider NPI:
 - CMS 1500 and UB-04: Referring provider name and NPI must be valid and registered in NPPES ([NPPES NPI Registry \(hhs.gov\)](https://nppes.hhs.gov))
 - UB-04: Attending provider name and NPI must be valid, registered in NPPES ([NPPES NPI Registry \(hhs.gov\)](https://nppes.hhs.gov)) and registered in PECOS ([Home Page - Centers for Medicare & Medicaid Services Data \(cms.gov\)](https://www.cms.gov/medicare/medicaid-support/data-mgmt/pecos))

- 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:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-L to service line below (24E)										22. DISPOSITION CODE										ORIGINAL REF. NO.																																							
A. R69																																																											
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE										C. CHARGE CODES, SERVICES, OR SUPPLIES										D. DIAGNOSIS POINTER										E. CHARGES										F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.									
01 02 20 01 02 20										S5130										A										25 50 6										1234567890																			

- 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:

25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT?										28. TOTAL CHARGE										29. AMOUNT PAID										30. Rsvd for NUCC Use									
123456789																														YES NO										\$ 25 50										\$																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #																																																	
Signature on file										05/05/2020																				John Doe Home Health										1112 NE 222 Ave										Ocala FL 33755-1234																			
SIGNED										DATE										a.										b.										a. 1234567890										b. 1234567890																			

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

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

25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT?										28. TOTAL CHARGE										29. AMOUNT PAID										30. Rsvd for NUCC Use									
																														YES NO										\$										\$																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #																																																	
																				Billing NPI										Billing Taxonomy																																							
SIGNED										DATE										a. NPI										b. NPI										a. NPI										b. NPI																			

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

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

- Patient status code for bill type 322 and 323 must be 30
- 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. Acceptable value codes are 61 and 85 for home health claims.
- 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.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: R69
 24. A. DATE(S) OF SERVICE: 01/02/20
 B. PLACE OF SERVICE: S5130
 C. PROVIDER'S SERVICES, OR SUPPLIES: A
 25. PRIOR AUTHORIZATION NUMBER: H-201912345458
 26. CHARGE: 25 50 6
 27. RENDERING PROVIDER ID #: 1234567890

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:

25. FEDERAL TAX I.D. NUMBER: 123456789
 26. PATIENT'S ACCOUNT NO.:
 27. ACCEPT ASSIGNMENT? YES
 28. TOTAL CHARGE: \$25.50
 29. AMOUNT PAID: \$0
 30. Resvd for NUCC Use: 999
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: Signature on file
 32. SERVICE FACILITY LOCATION INFORMATION: John Doe Home Health, 1112 NE 222 Ave, Ocala FL 33755-1234
 33. BILLING PROVIDER INFO & PH #: 555-1111

- **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

- VisibiliEDI 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

- 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 the claim was rejected	If the original claim was submitted and denied	If the corrected claim still denies due to billing error
<ul style="list-style-type: none"> • Correct error that caused the rejection • Submit as an original claim within 75 days of DOS [Frequency 1] 	<ul style="list-style-type: none"> • Correct error that caused the denial • Submit as a corrected claim within 45 days of EOP [Frequency 7 and ICN] 	<ul style="list-style-type: none"> • If a corrected claim denies for a different reason, i.e. duplicate, paid at a different rate, please contact Provider Relations at ProviderServices@ihcs corp to request assistance for next step e.g. Submit a corrected claim or Claims Reconsideration Spreadsheet to initiate a reconsideration project

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

Splitting of Claims

Patient coverage is often renewed at the beginning of a calendar year (as of 1/1). To ensure that claims processed invoke the appropriate benefit active for the date of service, expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year.

When the "From" and "Through" years are different, submit a separate claim for each year. (Also known as split-billing), When split billing a claim, make sure that the claim for the first calendar year is submitted first.

In addition, claims spanning more than 50 service lines on a CMS-1500 or 99 service lines on a UB-04 (CMS-1450) must be split into multiple claims.

Conditions Under Which Split Claims May Result

Unless otherwise noted, these situations apply both to claims submitted on paper and claims submitted electronically.

Claim Splitting Conditions	Description of Split
1. Claim with too many line items.	<p>Claim with more line items than can be processed by the health plan's production system.</p> <ul style="list-style-type: none"> For professional claims, claims containing more than 50 claim lines must be split into multiple claims. For institutional claims, claims containing more than 99 claim lines must be split into multiple claims. <p>Provider Action: Create claims with fewer lines</p>
2. Claim with covered and non-covered dates of services for the member due to eligibility.	<p>A submitted claim has multiple lines of service with different dates. Some lines are for dates under which the member is eligible for coverage by the health plan. Other lines are for dates that the member is not eligible for coverage by the health plan.</p> <p>Provider Action: Make sure the patient is eligible for coverage with the health plan for the full period of the claim.</p>
3. Claim with dates of service that cross a calendar Year.	<p>A submitted claim has lines of service that occurred in different calendar years.</p> <p>Provider Action: Make sure that all services on the claim do not cross different calendar years.</p>
4. Claims with a billed amount of \$100,000 or more.	<p>A submitted claim has a billed amount of \$100,000 or more</p> <p>Provider Action: Make sure that the claim total is less than are for a billed amount less than \$100,000.00</p>

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 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@ihscorp.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@ihscorp.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.

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 \(b2clogin.com\)](https://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, VisibiliEDI, 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	RESPIRE 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 ticket 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.

Integrated Home Care Services 2024

Quick Reference Guide

IHCS Website	<p>On the IHCS website you can learn who we are, who we serve, connect to MedTrac and access provider resources such as the IHCS Provider Manual, Billing and Claims Manual, Portal Guide, Provider Communication, Provider Education and Training materials, Compliance information, instructional videos, product manuals and other pertinent information. Be sure to check the IHCS website often for important updates.</p> <p>www.ihcscorp.com</p>
Authorizations	<p>All Home Health, Durable Medical Equipment and Home Infusion services require an authorization from IHCS prior to providing services. 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.</p> <p>For Authorizations (Status, Re-authorization Requests or Add-on Services please contact us at:</p> <p>(844) 215-4264 Ext 7533</p>
Credentialing	<p>IHCS is delegated for credentialing/re-credentialing. IHCS Network Providers are re-credentialled every two to three years (as determined by applicable law or plan requirements).Credentialing department can be reached by calling: (844)215-4265 Ext 7534 or Select Option 5 then Option 3 or emailed at ProviderNetwork.Credentialing@ihcscorp.com</p>
Provider Relations	<p>The IHCS Provider Relations Group is here to support our contracted network. Please connect with us should you have questions or concerns or need access to one of our portals. Provider Relations can be reached by calling: (844) 215-4264, Option 5, Option 2, or via email:</p> <p>Provider Relations: Providerservices@ihcscorp.com Medtrac Portal Access & Training: Providertraining@ihcscorp.com VisibilEDI Access: Providerservcies@ihcscorp.com Password Reset: PR-PasswordSupport@ihcscorp.com</p>
Claims	<p>3. 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.</p> <p>4. 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</p>

	<p>location must be in Box 32a. Any claims not in this standard format will be denied or rejected.</p> <p>For any questions regarding claims (Status, Appeals, Support): (844)215-4264 Ext 7532 or Select Option 4</p> <p>ClaimsInquiry@ihscorp.com</p>
Customer Service	<p>The IHCS Customer Service Group can be reached by calling: (844) 215-4264 Ext 7530 or Option 2</p>
MedTrac Portal	<p>MedTrac is the IHCS proprietary information system that provides a complete picture of the homecare ecosystem.</p> <p>MedTrac Login (ihscorp.com)</p>
Netsmart/EVV Portal	<p>For Florida Medicaid members covered by Simply Healthcare®: EVV Evv Dashboard (4tellus.net)</p>
Visibiledi Portal	<p>Use the Provider Portal to view claims, claim status messages, claims payments, and check eligibility. You can access the portal 24 hours a day, seven days a week.</p> <p>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 providersupport@ihscorp.com</p> <p>IHCS (visibiledi.com)</p> <p>Please direct questions about payments to: EOP@ihscorp.com</p>

Provider User Guide to Monitor Visit Verification Method



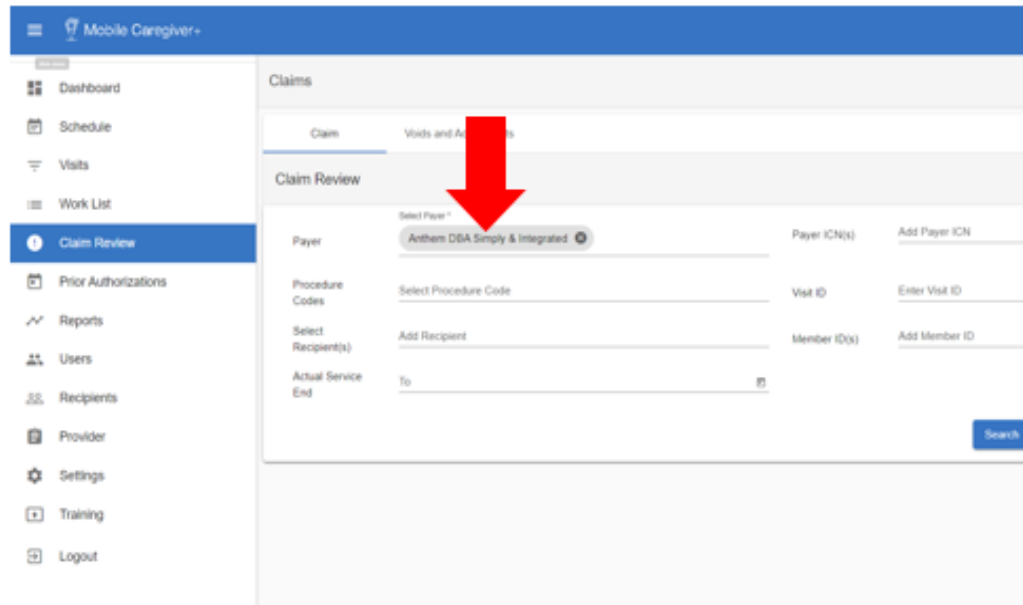
Netsmart

www.ntst.com

11100 Nall Avenue
Overland Park, KS 66211
800.842.1973

Instructions: The following user guide provides instructions on viewing the visit verification method captured in Netsmart Mobile Caregiver+.

1. Log onto your Netsmart Mobile Caregiver+ Provider Portal and select the **Claim Review** tab in the Main Menu.
2. Under the **Payer** drop down menu, select **Anthem** then click **Search**.



The screenshot shows the 'Claim Review' form in the Netsmart Mobile Caregiver+ Provider Portal. The left sidebar contains a navigation menu with options: Dashboard, Schedule, Visits, Work List, Claim Review (selected), Prior Authorizations, Reports, Users, Recipients, Provider, Settings, Training, and Logout. The main content area is titled 'Claims' and has tabs for 'Claim' and 'Visits and Authorizations'. The 'Claim Review' tab is active. The form includes fields for 'Payer' (with a dropdown menu showing 'Anthem DBA Simply & Integrated'), 'Payer ICN(s)', 'Add Payer ICN', 'Procedure Codes', 'Select Procedure Code', 'Visit ID', 'Enter Visit ID', 'Select Recipient(s)', 'Add Recipient', 'Member ID(s)', 'Add Member ID', and 'Actual Service End'. A red arrow points to the 'Select Payer' dropdown menu.

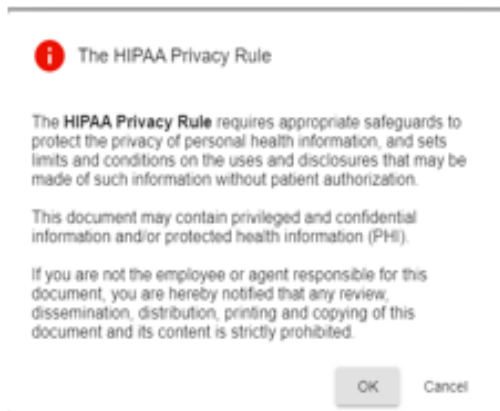
3. Select the visits by clicking on the empty box to the left of the recipient's name. You may select a single visit to view the verification method used for that single visit, or you may bulk select all visits.

Search List							
<input checked="" type="checkbox"/>	Row	Recipient First Name	Visit ID	Member ID	Status ↓	Procedure Codes/Mode	Diagnosis Code
<input checked="" type="checkbox"/>	1 BERRY	DELLA	2410768797	1111110006	RELEASED	H2019 (BA)	F840
<input checked="" type="checkbox"/>	2 HARRISON	IONY	3945773573	1111110009	RELEASED	H2014 (BA)	F88
<input checked="" type="checkbox"/>	3 BERRY	DELLA	-	1111110006	RELEASED	H2019 (BA)	F840,F88

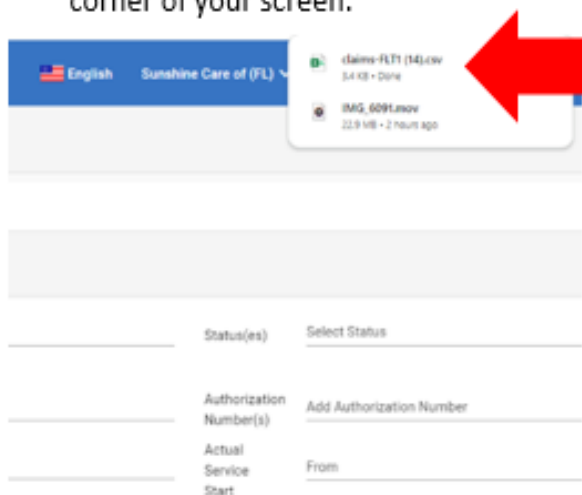
4. Select the option to **Export**.

A HIPAA Privacy notice will appear on your screen.

5. Click **OK** to acknowledge receipt of the message.



6. Your claim data will export into an Excel spreadsheet. To view the Excel spreadsheet, click on the Excel document that has downloaded in the top right corner of your screen.



7. Columns T and AC of the Excel spreadsheet contain the visit verification method for both the clock in and clock out portion of the visit. This is denoted by the **Start Verified Method** and **End Verified Method**.