Revised March 2026

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.

Integrated Home Care Services, Inc.

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Assessing and Reviewing Provider's Performance

As a home care benefit administrator, we work on behalf of our health plan partners that require compliance with performance metrics that we at **Integrated Home Care Services** (**IHCS)** must adhere to along with managing the performance metrics of our contracted network of providers. **IHCS** has implemented a strategic and systematic approach in reviewing and assessing our contracted provider's performance to ensure that every provider meets the contract terms and criteria specified in the **IHCS Provider Agreement** and the **IHCS Provider Manual**. This assessment process monitors key metrics such as start-of-care for home health providers and timely delivery for DME providers. Other metrics monitored include quality of care, patient outcomes, cost, and compliance with **IHCS** administrative processes, claims submission procedures, use of **IHCS** portals and systems and member and health plan complaints.

Define Performance Objectives and Expectations

This systematic real-time oversight of performance metrics allows **IHCS** to identify potential issues early and take corrective action that when indicated. When we can share results with **IHCS** providers, we have the opportunity to foster transparency with the providers in our network and to promote collaboration through feedback mechanisms.

The guiding principle for the provider performance management program is to recognize **IHCS** providers for offering quality services to our members while enhancing the member experience. Providers with higher performance measures that support our goal of providing the right care at the right time and in the right place build the intended partnership with **IHCS** and they will be recognized with continued and potentially more referrals.

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 2026

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@ihcscorp.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 Act[1], 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 - eight (48) contiguous United States.

§405.051 Florida Electronic Records Exchange Act, 2023

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.

[1] *§405.051 Florida Electronic Records Exchange Act, 2023*

CONTACT INFORMATION

Customer Service	
Customer Service	(844) 215-4264 Ext 2530
Authorization Requests or Inquiries	
Initial Authorization Requests Fax	(844) 215-4265
Home Health Call Center	(844) 215-4264 Ext 2533
DME Call Center	(844) 215-4264 Ext 2531
Pharmacy	(844) 215-4264 Ext 2562
Claims	
For any questions regarding Claims (Status, Appeals, and Support)	(844) 215-4264 Ext 2532 ClaimsInquiry@ihcscorp.com
Provider Contracting & Credentialing	
Florida Provider Contracting & Nationwide Credentialing	(844) 215-4264 Ext 2534 ProviderNetwork.Credentialing@ihcscorp.com
Network Development Department (states outside Florida)	ProviderNetworkSupport@ihcscorp.com
Provider Relations	
Provider Relations Department	(844) 215-4264 Ext 2546 Providerservices@ihcscorp.com
MedTrac Portal Access & Training	(844) 215-4264 Ext 2546 Providertraining@ihcscorp.com
Compliance	
Compliance	(954) 381-7954 Compliance@ihcscorp.com

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.
- 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 documentation and objective reasons to support medical necessity 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).

- 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, skilled visit notes)
    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 is not a guarantee of payment.
- Providers are required to submit Notice of Medicare Non-Coverage (NOMNC) CMS-10095 to the patient no later than two days before the termination of services. This notice fulfills the CMS requirement 42 CFR 422.62(b)(1) and (2).
- All completed/signed NOMNC's **must be uploaded** to the patients record in MedTrac upon discharge from home care services.
- Providers are required to promptly notify members receiving home care services if any visits will be missed, with every effort possible made by the provider to reschedule those visits.

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.

Health, Welfare, and Safety Training 2026

IHCS requires this training for all subcontractors/downstream providers supporting Integrated's health plan contractual obligations in servicing their respective Medicaid or Medicare patients. This training requirement is based on each Health Plan's applicable contractual and regulatory obligations within their state of domicile.

It presents a general overview that addresses the identification and reporting of suspected types of Abuse, Neglect and Exploitation that may be encountered during the arranging for, and/or the providing of, home care services on behalf of IHCS.

Please review this tutorial located on our website in the 'Provider Education & Training' section under the resources tab ------ https://ihcscorp.com/resource-center/

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 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. The CMS NOMNC is a standardized notice. Therefore, you may not re-write, re-interpret, or re-insert non-OMB approved language into the body of the notice except where indicated. Please note that the CMS form number and the OMB control number must be displayed on the notice.
- 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 members' 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 members' 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.

Sequestration:

- Integrated Home Care Services (IHCS) will use the same sequestration reductions as those imposed by the Centers for Medicare & Medicaid Services (CMS). All providers are reimbursed using a fee schedule and will have the 2% sequestration reduction applied the same way it would be applied by CMS. This reduction applies to all MA plans.

Clean Claim Requirements

Claims must be submitted electronically via 837I, 837P or on standard paper claim forms (CMS 1500 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
    - Medicare institutional claims for Home Health services require Q codes
    - HCPC codes beginning with 'T' must be billed on a professional claim form (837P or CMS-1500)
- Medicaid claims are billed on a professional claim form (837P or CMS-1500)

Private Duty Nursing Billing:

- As per AHCA guidelines, it is the provider's responsibility to bill 50% of their contracted rate when servicing multiple patients in the same residence. If the provider is billing their full rate and an overpayment is made, the provider is required to notify IHCS of the overpayment and return the funds. IHCS will no longer be manually reducing payments to providers. Please use the attached link as reference: Private Duty Nursing Services Fee Schedule October 1 2024.pdf

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: Providers are expected to follow all ICD-10 coding rules
    - External Cause of Injury codes are not acceptable as the primary diagnosis code.
    - Manifestation ICD-10 Codes are not acceptable as the primary diagnosis code.
- Servicing Provider's name, service location, and billing address
- Servicing Provider's National Provider Identifier (NPI) number, Federal Tax ID number, Medicaid ID number (Medicaid network Providers only), and Taxonomy Code
- Billing provider name, address and NPI
- Individual line level charge for each service and claim total charges. The sum of all claim lines combined must be equal total charges billed.
- Number of billed 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 there is any 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
- 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 the 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)

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)

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 may be returned.

Per guidelines associated with 837P (Professional), the maximum allowed diagnosis codes are 12 per claim submission. Please confirm that your billing system is capable of properly submitting claims in the case there are more than 12 diagnosis codes (by stopping at 12 and immediately generating a second claim with the remainder, up to 24).

CPT 99499 for Supplemental Diagnosis Code Submission

If a Provider needs to report more than 12 professional diagnosis codes, subsequent claims should be submitted.

If there are more than 12 diagnoses, Providers can submit a second claim using CPT code 99499 and bill a $0 charge on the additional claim. Providers can include the additional diagnosis codes that went beyond the maximum codes allowed from the original claim on the new claim. This will allow up to 24 total diagnoses.

If appropriate, Providers can submit remaining diagnoses on a third claim using CPT code 99499 with modifier 25 and bill a $0 on an additional claim. This will allow up to a maximum of 36 total diagnoses between the three claims.

Using CPT code 99499 enables Providers to submit all documented claim diagnosis codes, where diagnosis truncation has been identified.

Guidelines for submitting 99499 claims

- All ICD-10 codes must be supported in the documentation of a face-to-face visit
- The 99499 claim should only be used when there is a primary claim with a primary service
- 99499 claims should only be used when the Provider-submitted primary claim contains the maximum of 12 diagnosis codes; if the maximum number of diagnosis codes was not submitted on the primary claim, use the corrected claim process to submit additional diagnoses instead of a 99499 claim
- The Member name, billing Provider, rendering Provider, and Date of Service must match the primary claim
- No other services should be billed on the claim with 99499
- 99499 claims are not corrected or replacement claims, so frequency codes 6 or 7 would not be needed
- Multiple units of 99499 are billable on same DOS when used appropriately with modifier 25
- Bill 99499 claims with zero-dollar ($0.00) charge

Split 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.	Claim with more line items than can be processed by the health plan's production system. • 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. **Provider Action**: Create claims with fewer lines
2. Claim with covered and non-covered dates of services for the member due to eligibility.	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. **Provider Action:** Make sure the patient is eligible for coverage with the health plan for the full period of the claim.
3. Claim with dates of service that cross a calendar Year.	A submitted claim has lines of service that occurred in different calendar years. **Provider Action:** Make sure that all services on the claim do not cross different calendar years.
4. Claims with a billed amount of $100,000 or more.	A submitted claim has a billed amount of $100,000 or more **Provider Action:** Make sure that the claim total is less than are for a billed amount less than $100,000.00

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 authorized 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).

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 in a timely manner to Integrated if we believe there may still be time to 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 within **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)

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.**

2. Paper Claims:
   IHCS will only accept original documents for payment consideration that are typed in indelible ink without erasures, strikeovers, 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 the 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. The 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. The 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 contracted rate that is attributable to applicable sales tax; and 2) remit the applicable sales tax amount to the appropriate regulatory authority.

Reimbursement Status

Providers should utilize the Provider Portal at IHCS (visibiledi.com) to check 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 claim 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 because of a claim 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 on 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 within **45 days from the 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 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 overpayment and recoupment efforts will be initiated.

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 be rejected. 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 PRClaimsSupport@ihcscorp.com or providerservices@ihcscorp.com.

Reconsiderations and Grievances

IHCS maintains a comprehensive process for addressing and resolving appeals and grievances. An appeal is a formal request for IHCS to review an adverse action or a denied claim, accompanied by supporting documentation for reconsideration. All 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@ihcscorp.com to request a Claims Reconsideration Spreadsheet to initiate a claims reconsideration project.

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

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

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

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

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

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

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

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

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

Dispute Resolution

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

Retrospective Claims Review

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

IHCS reserves the right to recoup or adjust payment (or request a refund) for the amounts paid for services delivered. This can occur in several 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 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.

Copayment, Coinsurance or Deductible

When the Member's plan has a co-payment, coinsurance or deductible, IHCS shall pay the Provider the lesser of the amounts described in the Agreement or Provider's charges, less any applicable copayments, co-insurance, or deductibles that the Member is responsible for. The Provider is responsible for collecting all copayments, coinsurance, and deductibles from the Member directly unless health plan requirements deem otherwise. However, if it is determined that the provider has overcharged the patient share of cost, it is the provider's responsibility to reimburse the member. If a copayment, co-insurance or deductible applies, this will be detailed in the Explanation of Payment "EOP" that you received from IHCS.

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 the 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 Ext. 2546 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 four (4) 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 two (2) 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	**Providerservices@ihcscorp.com**

Reporting and Investigating Patient Complaints and Grievances

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

Complaint

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

Grievance

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

1. Provider employees who receive Complaints or other expressions of dissatisfaction with a product or service provided by their agency will promptly report the event to his/her supervisor. The supervisor will report the Complaint to an Integrated Supervisor who will document the Complaint in the Complaints and Grievances Share Point Site.

2. The employee and his/her supervisor who receive the initial call will also verbally respond to the patient in real time (i.e., while the patient or caller is on the telephone, or by a return telephone call) and make every reasonable effort to reconcile the concern and address any outstanding service items. The employee will document such efforts in the patient's electronic medical record under Patient Notes, if applicable, and record the resolution and appropriate Tier in the Grievances and Appeals SharePoint Site.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Frequently Asked Questions

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

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

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

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

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

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

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

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

HHC/Infusion

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

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

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

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

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

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

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

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

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

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

Q: On a case-by-case basis, does IHCS make special discretions to issue any retro authorizations for auth extensions and or concurrent requests? – *Example:* If it is Friday and the Provider does not hear back from IHCS until Monday, can they perform services even though they have not received the authorization from IHCS?
A: If the member 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:

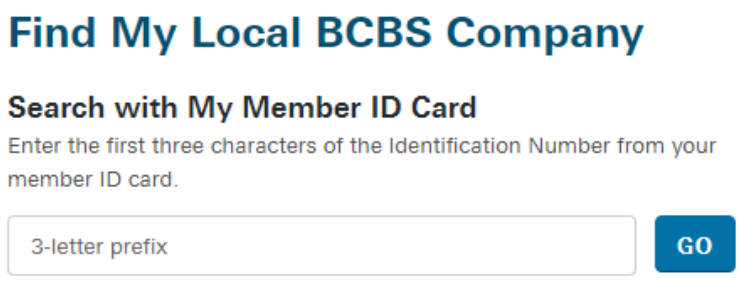
1. Be contacted directly by a BlueCard member requiring services.
2. Receive an order/referral directly from a physician for a BlueCard member.
3. Receive an authorization to provide a service from IHCS for a BlueCard member.

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.



- 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®.

BCBS Diabetic Supplies

Please note that diabetic supplies are now included for all BCBS Lines of Business as of April 2025. Should you have any questions, please reach out to your contracting representative or our Provider Relations department at 844-215-4264 ext. 2542.

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 ember/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' 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.

RECORDS: AUDITS AND RETENTION

Maintenance of Records: IHCS Providers agrees to retain all contracts, books, documents, papers, and other records related to the provision of services to Beneficiaries and/or as related to Provider's obligations under the Provider Agreement for a period of not less than ten (10) years from the end of an applicable IHCS Provider agreement including a Medicaid Contract or Medicare Contract; or date of completion of any audit, whichever is later.

IHCS Providers shall maintain records of services, service providers, charges, dates of services and all other commonly required information elements for services provided to Beneficiaries, including without limitation, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services

IHCS Providers agree to abide by all federal and state laws and IHCS Contracted Health Plan requirements regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, ensure that medical information is released only in accordance with applicable state or federal law, or pursuant to court orders or subpoenas; and maintain all Beneficiary records and information in an accurate and timely manner.

Emergency Preparedness / Disaster Recovery

Integrated Home Care Services (IHCS) is committed to supporting, educating, and partnering with our patients, health plans and provider partners to ensure the health, safety, and well-being of everyone before, during and after an emergency occurrence such as severe weather event. To create awareness and preparedness for all, these readiness tips are shared with you to provide details to support our Network providers in the implementation of their Emergency Preparedness responsibilities when called upon.

OXYGEN PATIENTS:
It is essential for your patients on supplemental oxygen to prepare and ensure that an emergency back-up oxygen system is in place to last at least 48 hours. The oxygen concentrator used daily will not operate in the event of a power outage.

EVACUATION:
Patients who live in an evacuation zone or reside in a mobile home and have received orders to evacuate, should do so immediately. This is for their safety and the safety of first responders. When evacuating, patients must take all their necessary medical equipment, medications, and emergency supplies with them. Make sure you are made aware of where your patients will be evacuating to so we may support you in providing ongoing services after an emergency event.

MEDICAL NEEDS SHELTERS:
A Medical Needs Shelter is a type of program that provides shelter for individuals who do not require hospitalization but do require a greater level of care than a General Population Shelter. These shelters are staffed by medical personnel and have back-up electricity for limited lighting and essential medical equipment functionality. Your Emergency Plan should include this information.

DELIVERIES:
During certain severe weather events or other emergencies, network vendors will continue making deliveries. However, once city/state warnings are issued deliveries may be suspended. Deliveries should only resume after Emergency Management Officials have given the "All Clear". This is to ensure the safety of our network provider associates and your compliance with Emergency Management Guidance.

In addition to your Emergency Management Plan, IHCS recommends you have a Disaster Recovery Plan (DRP). This is a detailed document that outlines how your organization will respond effectively to an unplanned incident and resume business operations**.** DRP's help ensure that businesses like ours are prepared to face many different types of disasters, including power outages, ransomware and malware attacks, natural disasters and much more. A DRP is considered a subset of business continuity, explicitly focusing on ensuring that the IT systems that support our critical business functions are operational as soon as possible after a disruptive event occurs. Typically, disaster recovery involves securely replicating and backing up critical data and workloads to a secondary location or multiple locations—disaster recovery sites. A disaster recovery site can be used to recover data from the most recent backup or a previous point in time. Organizations like ours can also switch to using a DR site if the primary location and its systems fail due to an unforeseen event until the primary one is restored.

Appendix

IHCS Portal

Provider Guide 2026

Revised: December 2025

Table of Contents

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

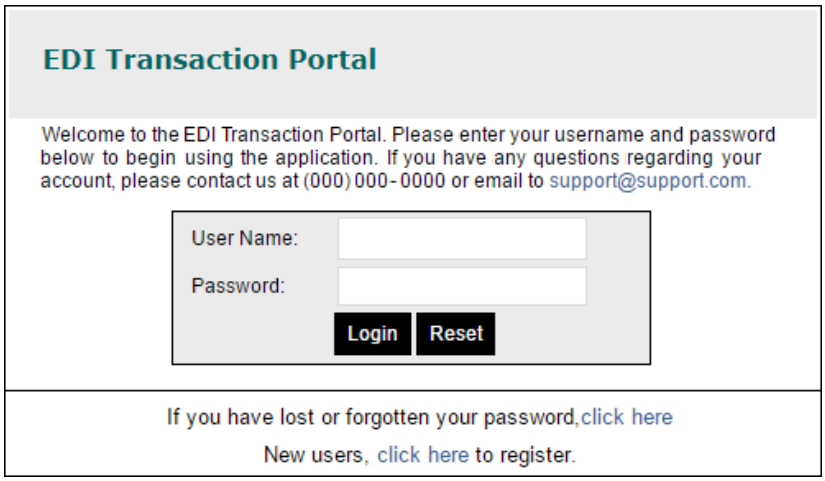
For questions or support, email us any time or call us Monday through Friday from 8:30 AM to 5:30 PM EST.

(844) 215-4264 Ext. 2546

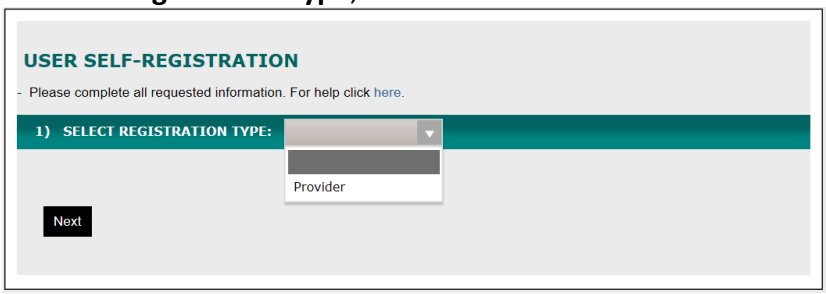
providerservices@ihscscorp.com

Register as a New User

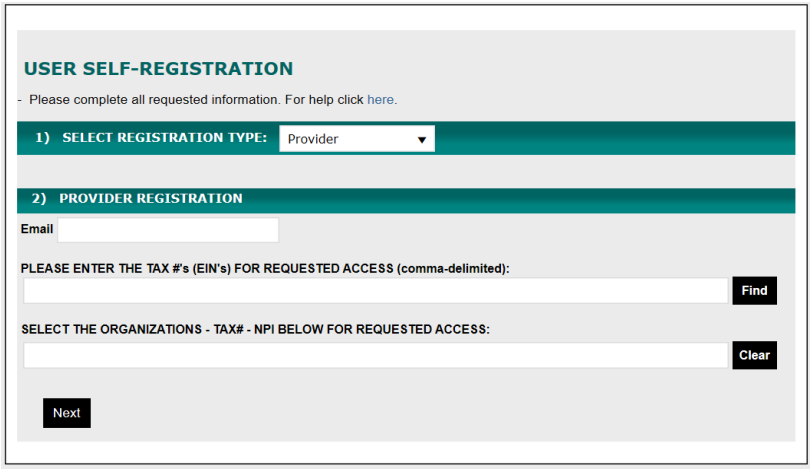
1. Self-registration is easy. From the **Provider Portal login page**, click **Register now**.



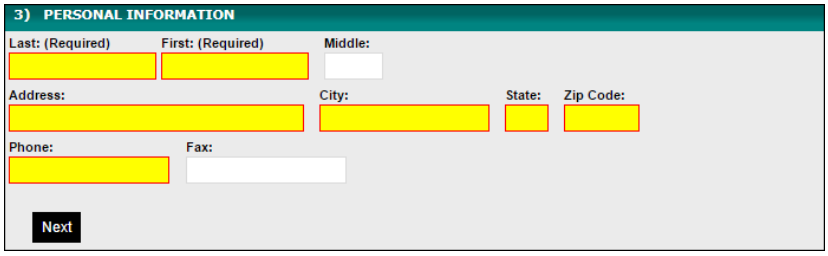
2. In **Select Registration Type**, choose **Provider** and click **Next**.



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**.

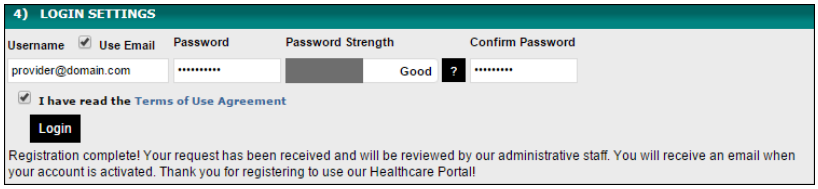


4. Under **Personal Information**, enter your contact details. Required fields are highlighted in yellow. Click **Next.**



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.

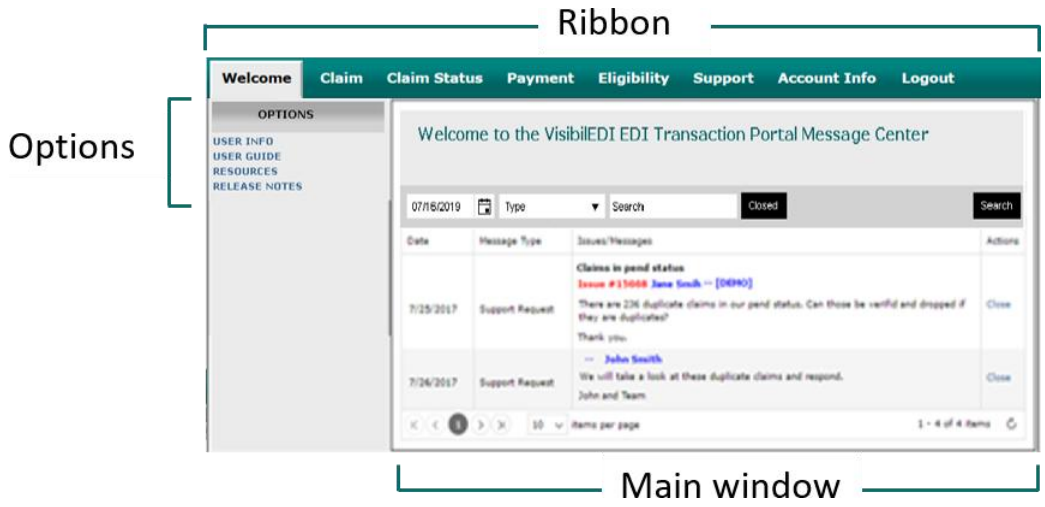


Upon completing registration, you will receive an email indicating that your account request is under review. Once the portal administrator has reviewed and approved your account, you will receive an email confirmation.

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.

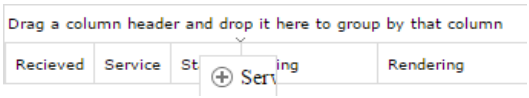
Exploring the Ribbon

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

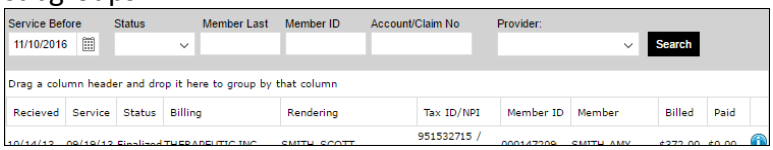
The Provider Portal offers familiar buttons, icons, and other navigational elements that make it easy to find and access data and complete tasks.

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 ˅) 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.

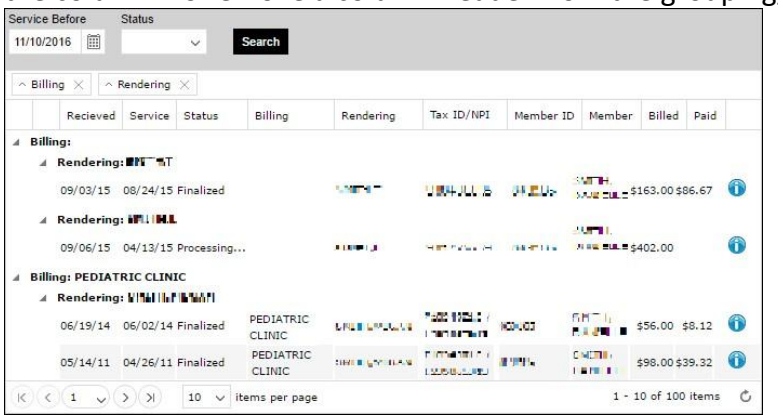
Advanced Usability Features

Sort by Column Header

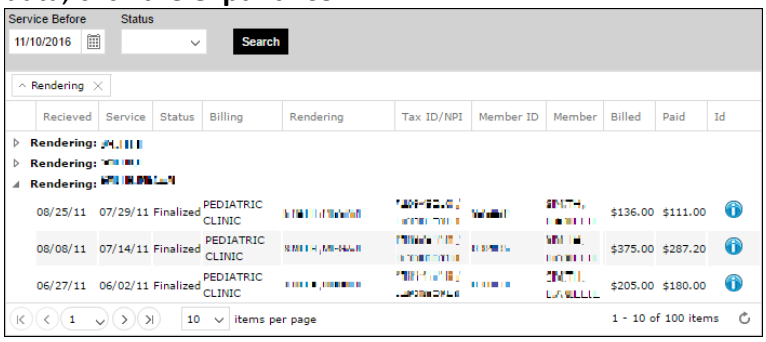
1. Click and drag a column header to the field. **Drag a column header and drop it here to group by that column**. More than one column header can be used simultaneously to create subgroups.



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



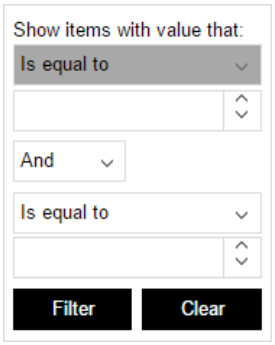
3. To collapse lines of data, click the **collapse icon** ▷ next to the heading. To expand collapsed data, click the **expand icon** ◢.



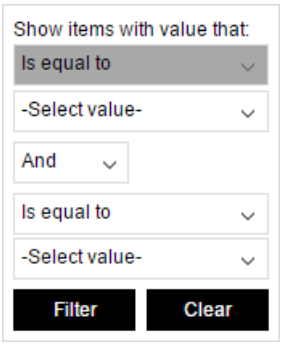
Filter by Column

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**.

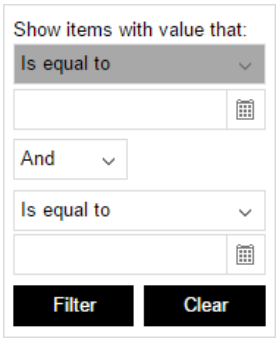
Numbers or Text



Limited Selection



Date



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.

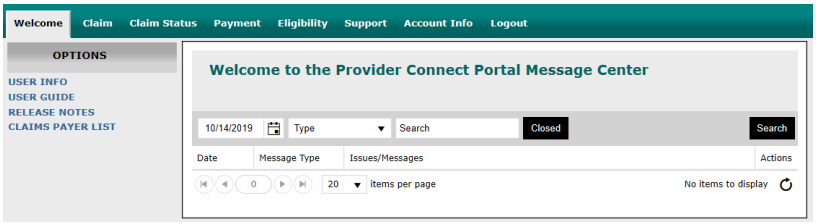
To use Batch Criteria, complete your desired criteria and click **Search**.

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.



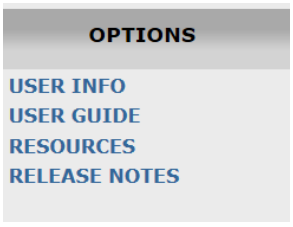
1. To search for a specific message, set the desired filters and click **Search**:
   - **Date:** Use the default date or enter another date (MM/DD/YYYY). The search will display the history of alerts up to and including the specified date.
   - **Type:** Select one of the following:

     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

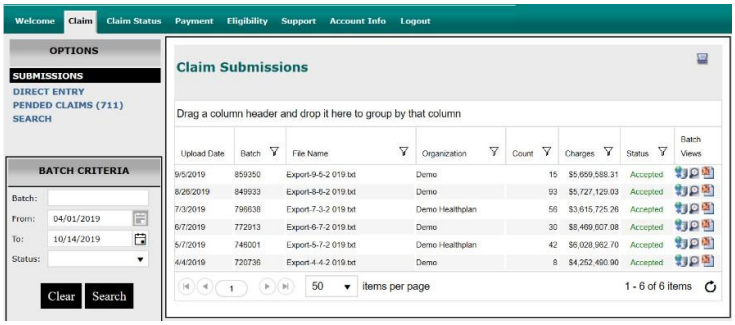
Use the following key to understand Claim File Status Messages.

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

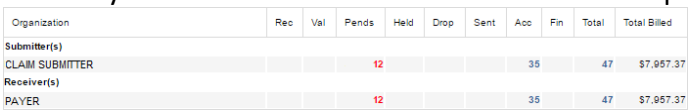
In Claim Submissions, you can upload claim files, view past claim file submissions, and search for claim batches. Read the following information to help you navigate Claim Submissions.

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.



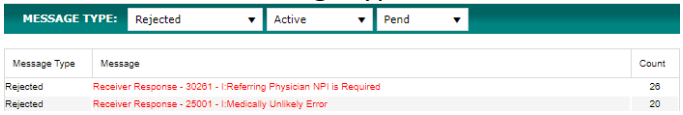
2. To view or edit a batch, click the **claim messages icon**  **.** Two grids will appear in the main window:

   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

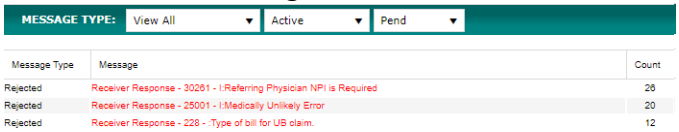
   b. **Lower grid:** This grid provides a count of claims by message type: Accepted, Rejected, and Informational. The display defaults to Rejected. Use the Message Type dropdown to select a different message type or select View All to see all claim messages.



MESSAGE TYPE: Rejected | Active | Pend

Message Type	Message	Count
Rejected	Receiver Response - 30261 - 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 - 30261 - 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

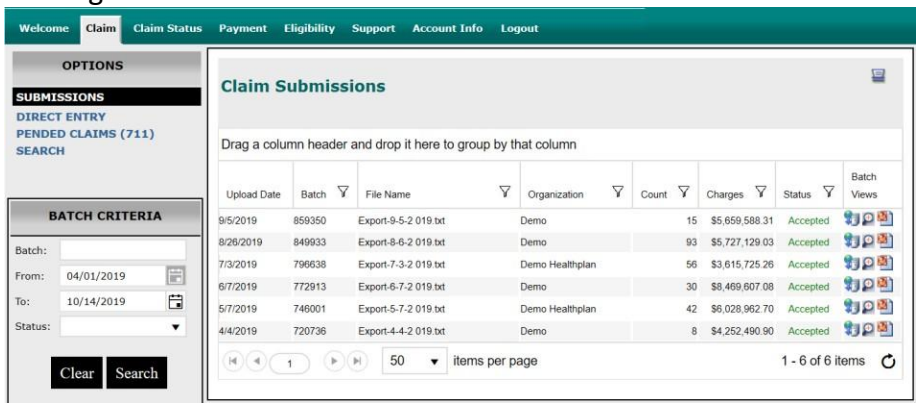
Related

[Understanding Claim File Status Messages]

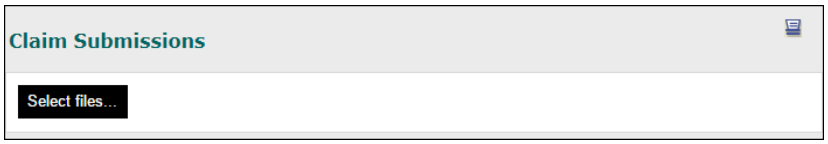
Upload a Claim File

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.



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.



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**.

View Entered Claims with Batch Views

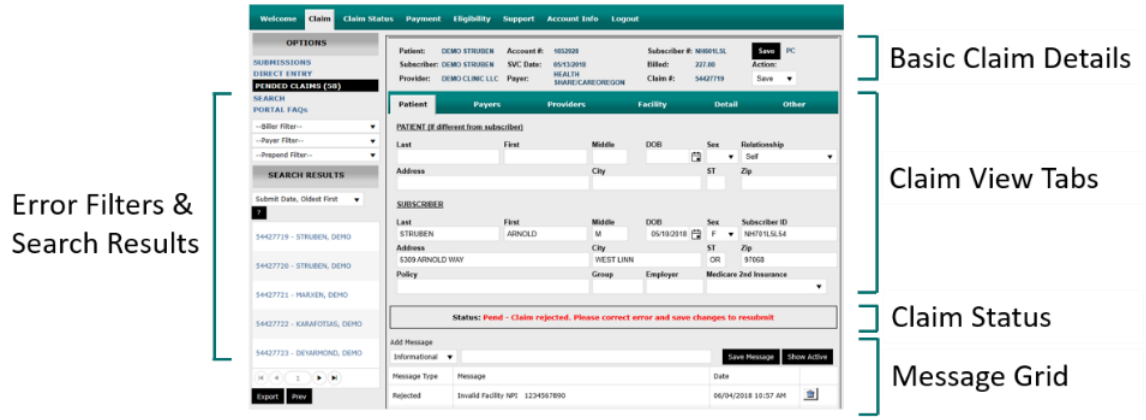
As claims get entered, a new daily batch is created in Claim Submissions for each billing organization. All claims created for that billing organization will be added to this batch within a 24-hour period.

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.

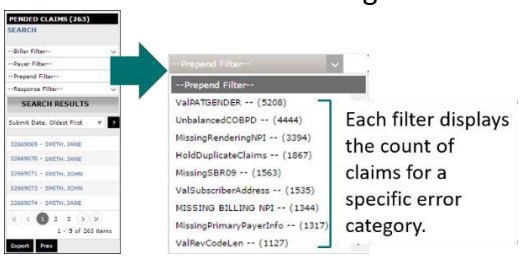


To resolve pended claims, review messages within the grid with the 'Rejected' Message Type, make the necessary changes to the claim, and save. If it is not clear to you what needs to be corrected, refer to industry standard billing guidelines and billing instructions provided by the payer. If it is still 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.



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.

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.

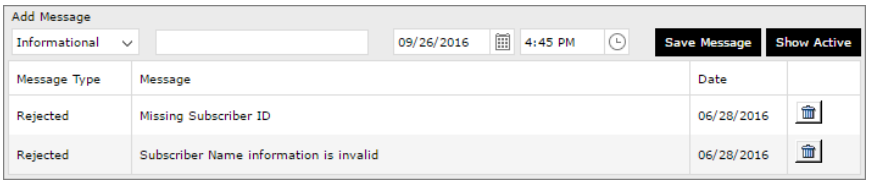
Claim View Tabs

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.



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**.

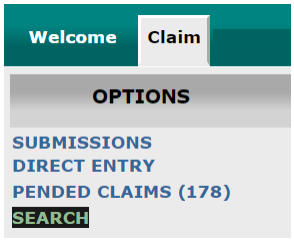
Related

Understanding Claim File Status Messages

Search Claims

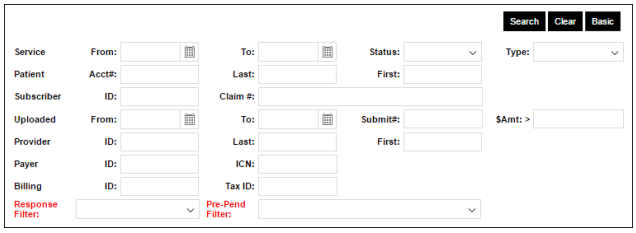
Perform a basic or advanced search based on criteria related to a specific claim. Use Search to track history of submissions and acceptance by the payer.

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

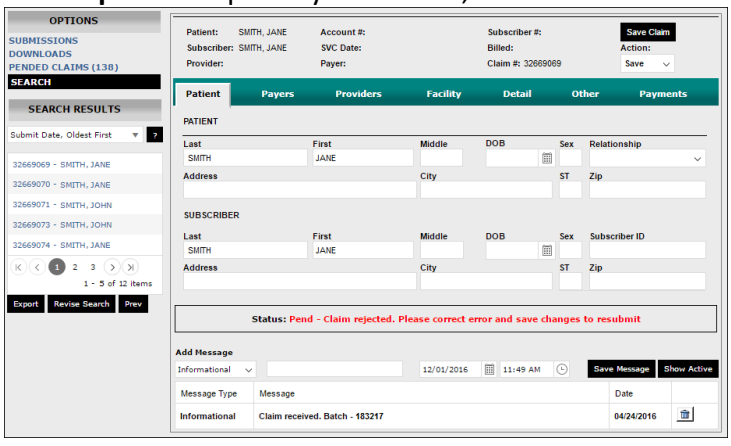


Basic search: Complete the desired fields and click **Search**.

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.



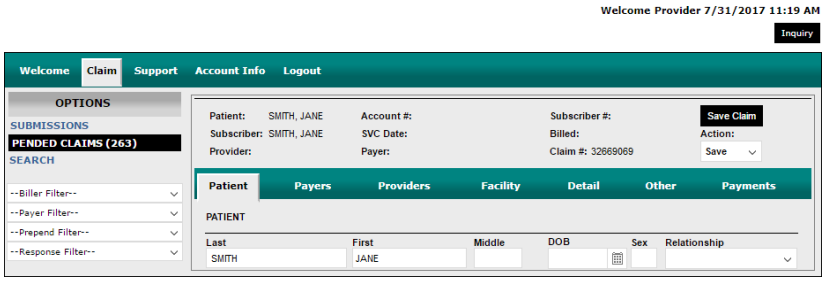
Related

[Advanced Usability Features]

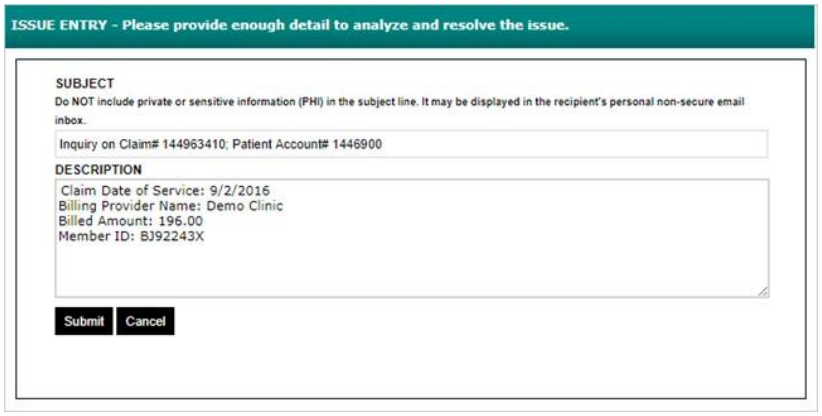
Submit a Claim Inquiry

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.

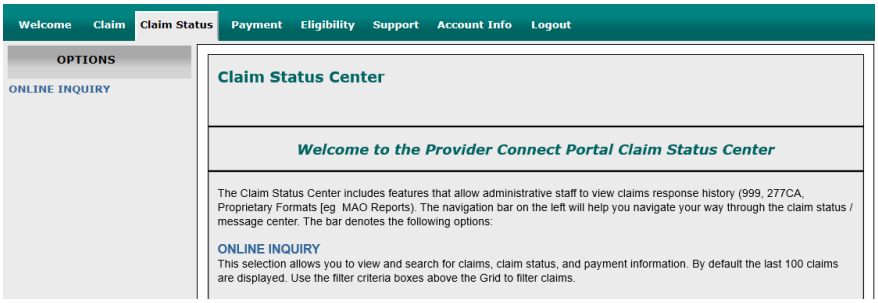


2. Provide relevant information in the **Issue Entry window** and click **Submit**. The Inquiry will post to the Support Issue History page for response by the Health Plan Claims Support Team.



Claim Status Center

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

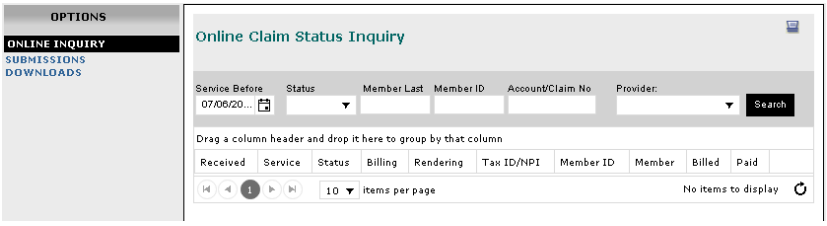


Perform an Online Inquiry

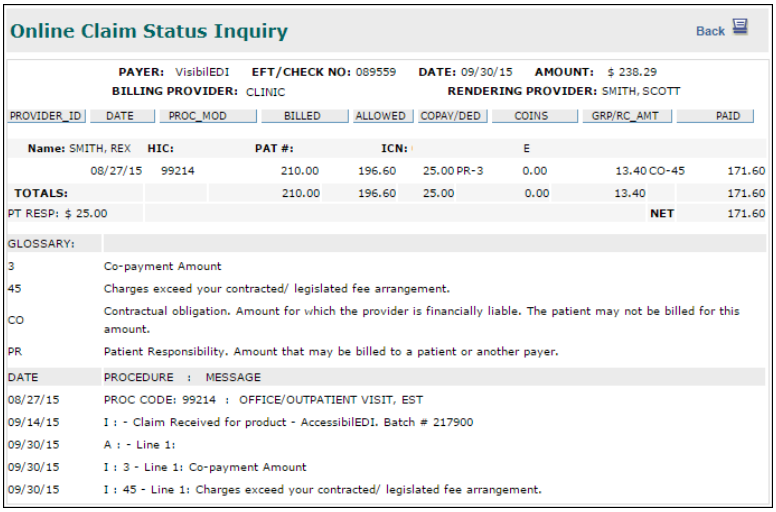
Use Online Inquiry to see if a claim has been received, processed, or paid.

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.

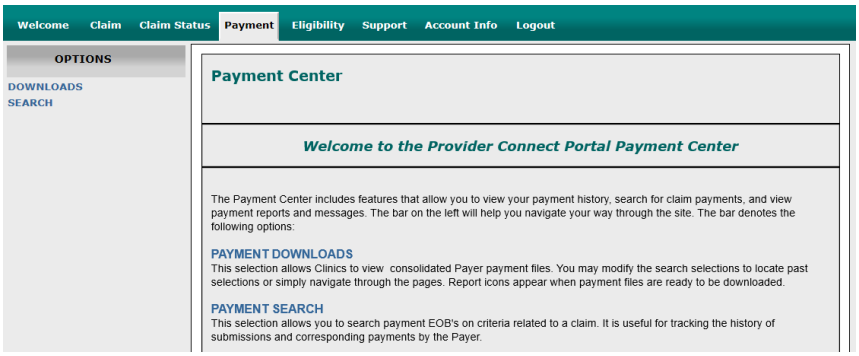
DATE	PROCEDURE : MESSAGE
08/27/15	PROC CODE: 99214 : OFFICE/OUTPATIENT VISIT, EST
09/14/15	I : - Claim Received for product - AccessibilEDI. Batch # 217900
09/30/15	A : - Line 1:
09/30/15	I : 3 - Line 1: Co-payment Amount
09/30/15	I : 45 - Line 1: Charges exceed your contracted/ legislated fee arrangement.

Related

[Advanced Usability Features]

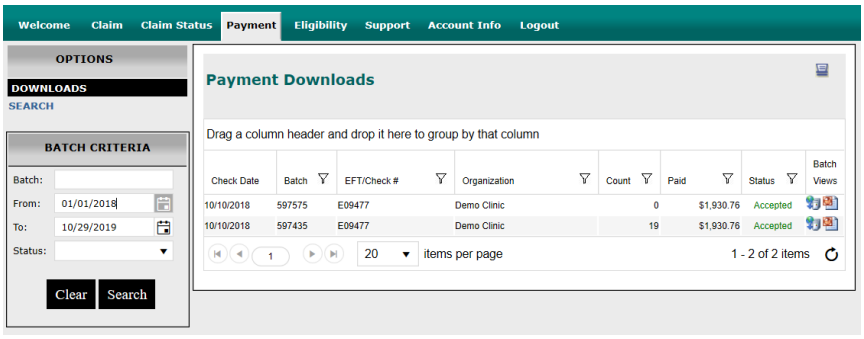
Payment Center

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.

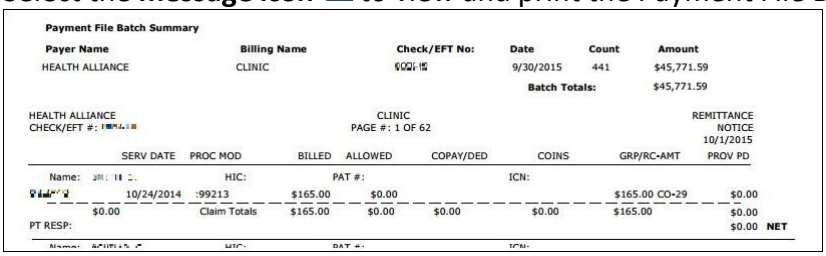


There are two ways to search: using **Batch Criteria** in the left-hand bar or using **Payment Search** under **Options**.

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.

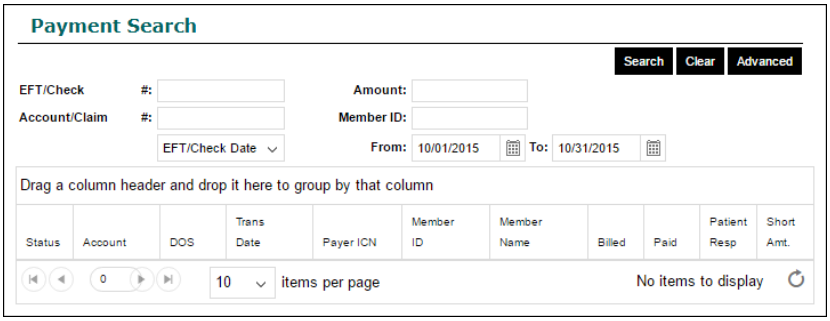


Note: To reset search criteria, click **Clear**.

Use Payment Search

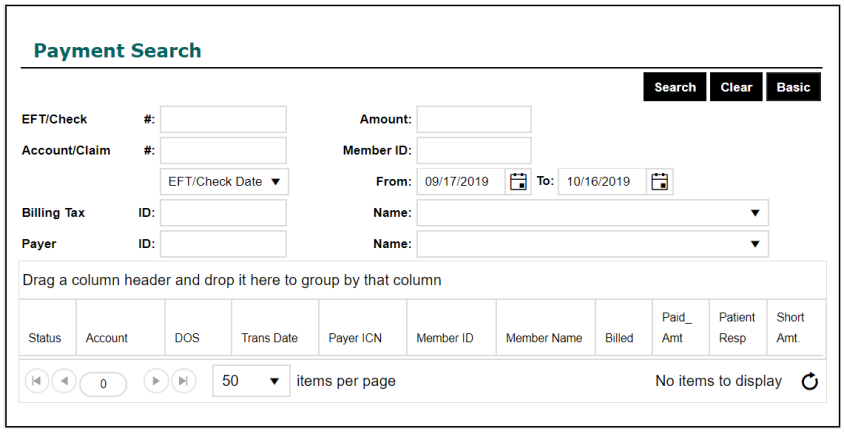
Simple Search

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



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**.



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

Related

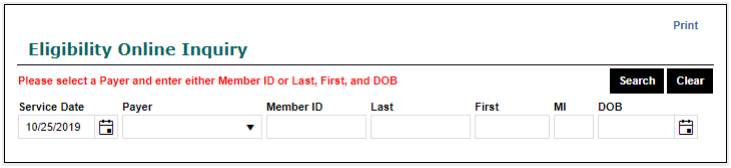
[Understanding Batch Views]

Eligibility Center

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

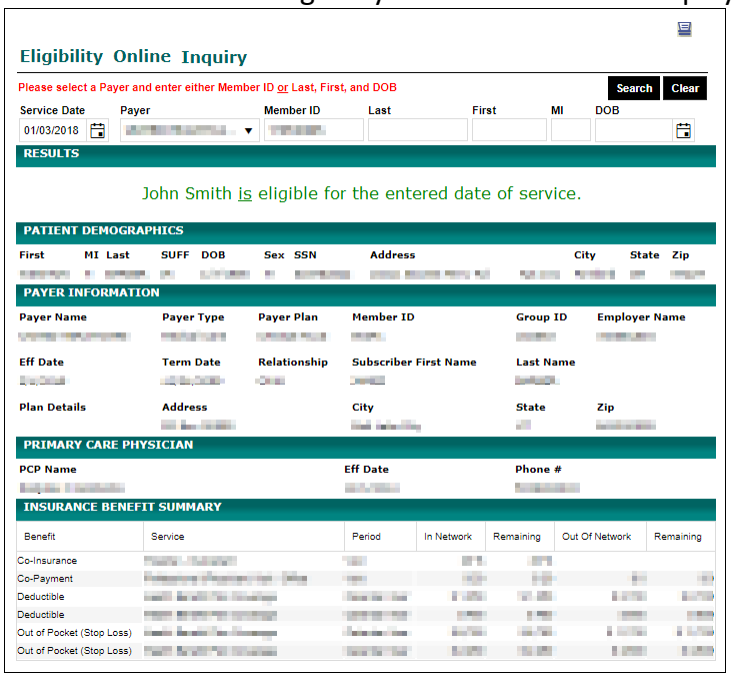
Submit Eligibility Verification Inquiry

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



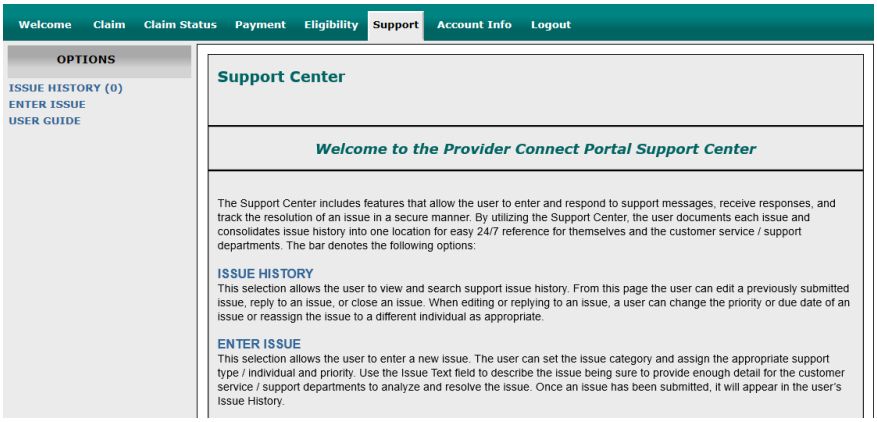
2. To check patient eligibility, complete the **Service Date** and **Payer** fields and **one of these required fields**: Member ID or Member Last and First name and Date of Birth.

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



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.



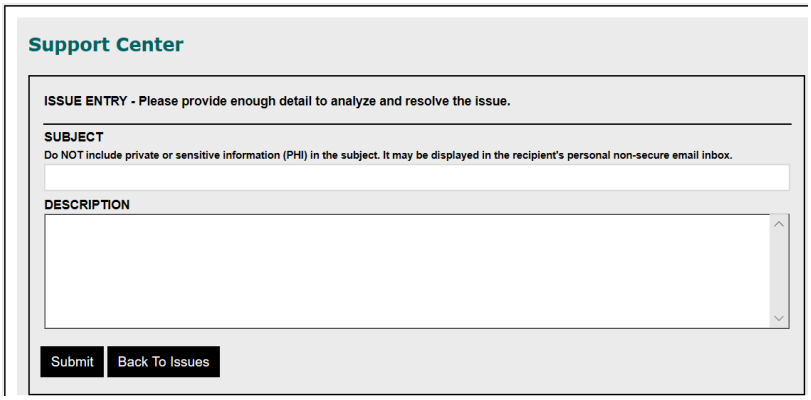
View, Search, and Manage Support Issues

View, Search and Export Support Issues

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

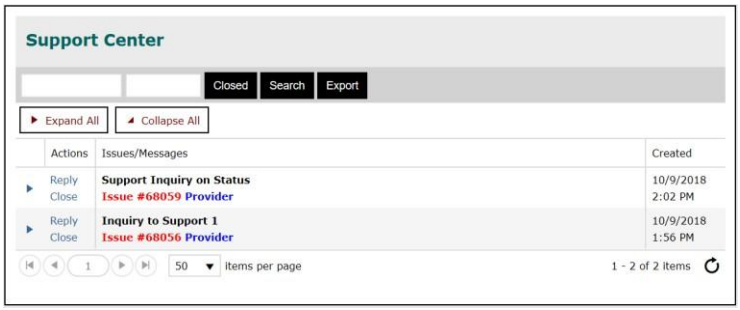
From here you can view Issues/Messages, including the subject line, issue number, message text, creation date, assigned support party, issue category, and priority, along with relevant actions you can take.

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.



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.

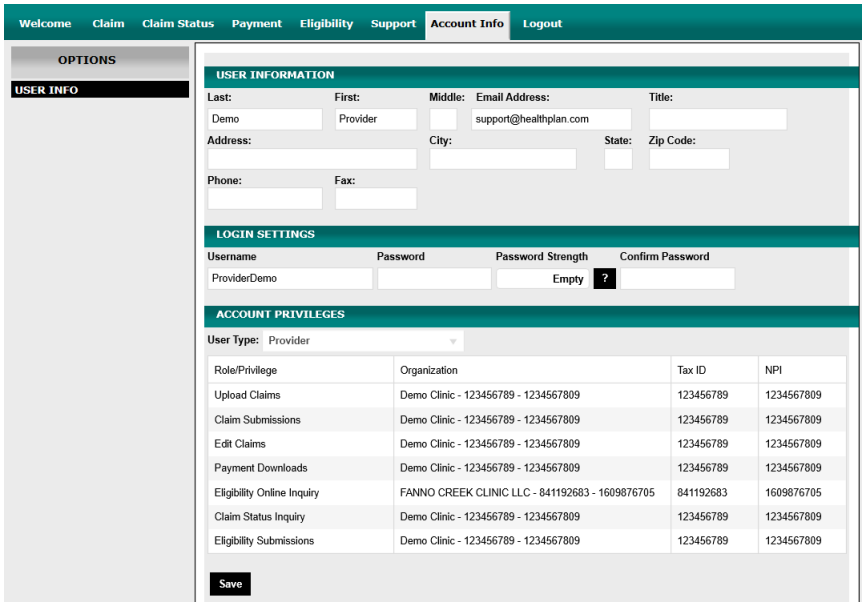
Account Info

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.



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

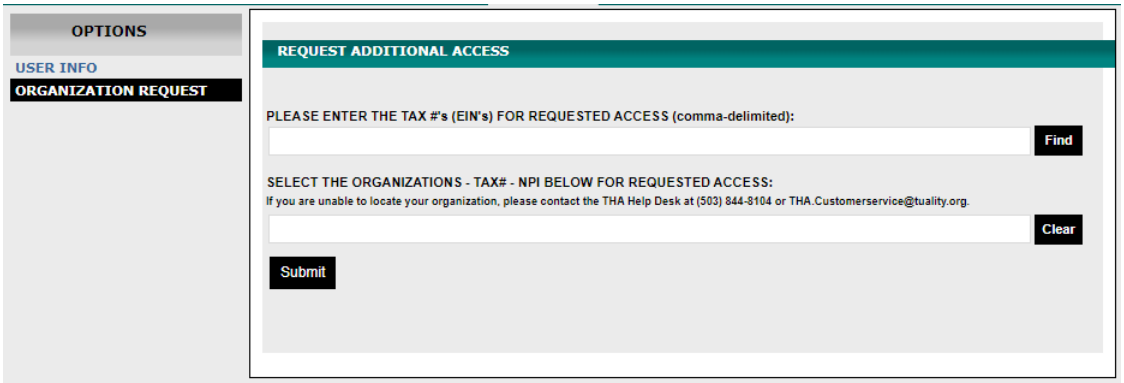
Account Privileges is read-only and shows your current account access level. Each designation under Role/Privilege indicates the type of access that you have.

Role/Privilege	Type of Access
Upload Claims	Access to Claims Submissions and the Upload Claims feature
Edit Claims	View and manage pended 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.



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

Frequently Asked Questions

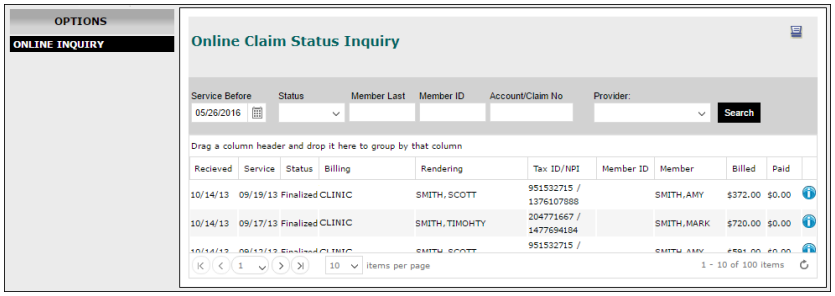
How Do I Print a Screen?

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.



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