



Integrated Home Care Services 2026 Billing Quick Reference Guide

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.
Clean Claim Requirements	Claims must be submitted electronically via 837I, 837P or on standard paper claim forms (CMS 1500 or UB-04). For full breakdown of requirements, please reference pages 14-16 of the IHCS Provider Manual.



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. Please reference page 17 of the IHCS Provider Manual for full breakdown.
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.
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 IHCS 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. Claims submitted without all required information may be rejected or denied.



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. 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. For full claim frequency code details, please refer to page 19 of the IHCS Provider Manual.
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.