INFORmed

A newsletter for Providers of Independent Care Health Plan

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Help spread the word!
Please forward this email to others in your organization who need this information.

EVV Hard Launch May 1, 2023

Based on data provided by the Wisconsin Department of Health Services (DHS) and our claims, we have identified multiple EVV data errors due to span billing. The units billed within a span MUST be evenly divisible by the number of days. If you are not able to do this, we encourage providers to bill each date of service separately. As a reminder, once DHS commits to hard launch of EVV, if your EVV data does not match your claim data, payment will be denied. If you have any questions or would like claim data examples, please contact us by email.

Detail Span Billing (*i*Care follows DHS billing guidelines)

EVV has not changed existing fee-for-service span billing policy; however, EVV edits will help to enforce this existing policy after hard launch. Provider agencies should check with their HMO, MCO, or IRIS FEA regarding detail span billing requirements.

Per current fee-for-service policy, span dates may only be billed when the same services are provided for the same number of units for each date of service.

The procedure code, revenue code, modifier, and units billed must all be the same for each date included in the date span. Unless the EVV units for every day in the date span are identical, DHS encourages provider agencies to bill each DOS separately to avoid denials.

To calculate units billed per day, the total units in the date span will be divided by the days in the span. If the units billed per day are greater than the calculated EVV units for any date in the date span, the detail will post an explanation of benefits message and deny. For example, if a provider agency bills for 15 units for three days, there must be at least five EVV units for each of the three days in the date span. If the EVV units were captured as six units on Monday, five units on Tuesday, and four units on Wednesday, the date span detail would deny because Wednesday does not have at least five EVV units.

DHS will not deny a claim detail if the EVV units are greater than units billed.

Source: https://www.forwardhealth.wi.gov/kw/pdf/2021-26.pdf

Provider Certification for Substance Use Disorder Facilities

As of October 1, 2022, ForwardHealth announced certification changes for substance abuse disorder (SUD) facilities, including the new allowable certification for adult residential integrated behavioral health stabilization services.

The ForwardHealth update focuses on the certification for currently enrolled SUD facilities that provide one of the following services:

- Outpatient Services
- Substance abuse day treatment services
- Residential SUD services
- Services through an opioid treatment program

For additional information, please review this attachment.

¡Care Medicare Policy and Technical Changes for Contract Year 2023: Notification of Maximum Out-of-Pocket Limit

The Centers for Medicare and Medicaid Services (CMS) released the final rule, effective January 1, 2023, which advises Medicare Advantage (MA) Part C programs to implement changes of communication practices for members and providers related to Maximum Out-of-Pocket or MOOP.

The MOOP limit in an MA plan (after which the plan pays 100 percent of MA costs) is calculated based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid. This also includes when the cost-sharing is not paid because of state limits on the amounts paid for Medicare cost-sharing and dual eligible individuals' exemption from Medicare cost-sharing.

While enrolled, *i*Care dual eligible members are cost-share protected by the Wisconsin Department of Health Services/ForwardHealth. Dual *i*Care members will not be responsible for co-payments, co-insurance or deductibles and cannot be balance billed, even if a provider chooses not to bill *i*Care. *i*Care members will be notified when their MOOP has been met and a copy of the notification will be sent to the provider.

Questions? Please email *i*Care or call Customer Service at 1-800-777-4376.

Make a Strong Flu Shot and COVID Vaccine Recommendation

As a health care provider, your strong recommendation makes a difference in whether your patients get a flu shot or the COVID–19 booster. Every office visit is an opportunity to remind your patients that the flu and COVID shots help protect them from serious illness and complications. Don't miss this critical opportunity to keep your patients safe and healthy.

More Information:

- CMS Flu Shot webpage
- CDC Seasonal Influenza Vaccination Resources for Health Professionals
- Vaccines.gov
- Flu Shots: information for your patients

2023 Medicare Member Documents

Please review our document library for our Medicare materials, including health education brochures, plan documents like the Provider/Pharmacy directories, Summary of Benefits, Evidence of Coverage, Comprehensive Formulary, and more.

Your Role in Keeping Member Contact Information Current

When checking Medicaid eligibility and/or verifying member contact information upon appointment check-in, if you notice discrepancies or the member reports they have a new address, phone number or other life event change (marriage, divorce, new resident in the home, etc.), please encourage the member to update their information with DHS by using the MyACCESS app, on MyACCESS.com or by calling their local agency. Please remind them to also contact their MCO Customer Service to report these changes.

Supportive Home Care and Residential Care Providers: It is Imperative to Complete *i*Care's Monthly Survey

*i*Care contracted Supportive Home Care and Residential Care providers receive a monthly email from our Network Development department. This email includes a link to a form to report to *i*Care either your current capacity to accept new referrals, or current or upcoming vacancies (depending on your provider type).

Every month any previous information submitted is deleted and replaced with the most up-to-date information received. So, it is imperative you watch for the email and take a few moments to complete the survey.

If you do not receive the email and believe you should, please contact us so we may research and update your contact information, if necessary. Thank you.

Fraud, Waste, and Abuse

Do you suspect that someone is committing or has committed any form of Fraud, Waste or Abuse (FWA)? To report FWA directly or anonymously, please do one of the following:

- Fill out the electronic form
- Call the Humana Ethics Help Line at 1-877-584-3539 (1-877-5-THE-KEY).
- Visit the Humana Ethics Help Line reporting web site

Learn more about *i*Care's Compliance Program, which includes Fraud, Waste and Abuse information.

News Briefs

NVA Reminder

To avoid payment delay, claims submission and benefit coverage inquiries for vision services by Optometrists are to be submitted to National Vision Administrators, LLC. For more information, call NVA at 1-888-287-0116 or visit https://www.e-nva.com/nva/content/home/providers/why-join-us.xhtml

Provider Reference Manual

These documents are a provider's primary resource to efficiently conduct transactions related to *i*Care members. Please download and save a copy for your reference.

- Medicaid/Medicare Reference Manual
- Family Care Partnership Manual

As updates occur to these documents, versions will be posted to our provider web page (scroll down half way on this page and click on the appropriate button), sent out through a INFORmed News Brief (email blast), and also included in this e-newsletter.

Provider Demographic/Affiliation Changes

Has any of your information changed? We strive to keep our records and our provider directories current not only to better serve our members, but also to remain compliant with DHS and CMS requirements. To update your information, please use the forms on our web site:

- The Demographic Change Form is for name, TIN, phone number or physical or billing address changes.
- The Affiliation Change Form is for adding or removing providers associated with a contracted provider group.

Please note: Organizations with delegated credentialing agreements should submit regular provider and facility rosters by email.

iCare Launched a New Provider Portal

iCare's Provider Portal is active! If you haven't registered for access, it's easy to do so using your TIN, NPI and most recent check number. The iCare Provider Portal Reference Guide provides further information and outlines functionalities.

If you have checks with 20 or more claims processed, you will need to register with a PIN. To request a PIN, click here. In your email, include the provider's name, TIN and NPI. You can also use this email to contact us with questions or concerns. Click on "reply-to" to send your message. Upon receipt by iCare, your question will be routed to the appropriate department.

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