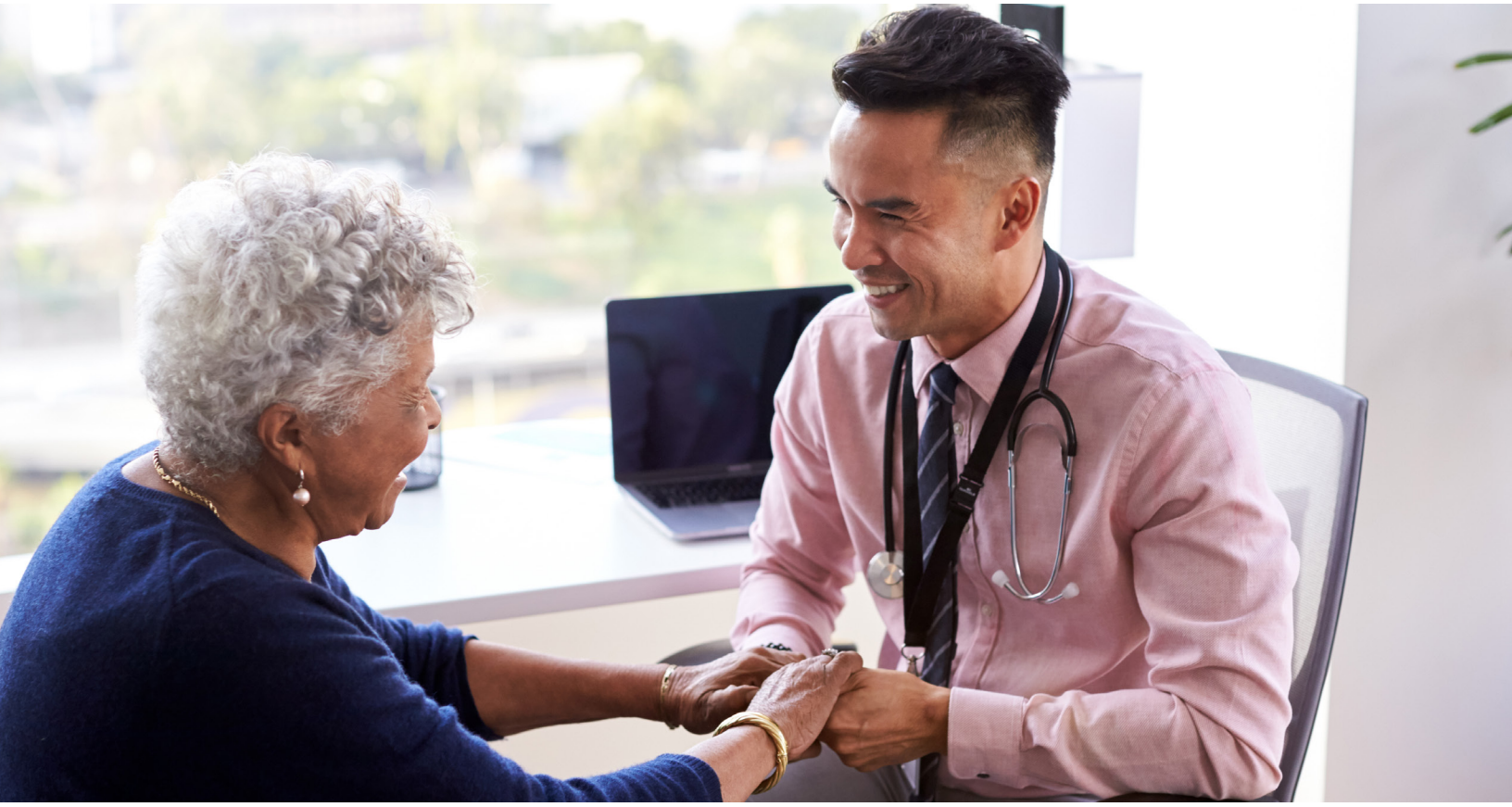
iCare
INDEPENDENT CARE HEALTH PLAN

Provider BULLETIN

December 2022 | *i*Care is a wholly-owned subsidiary of Humana.



Maximum Out of Pocket Limit — Center for Medicare and Medicaid Services (CMS) Contract Year 2023 Policy and Technical Changes

CMS released the final rule effective 1/1/2023 which revises Medicare Advantage (MA) Part C programs to implement changes of communications in part, related to Maximum Out of Pocket (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, or 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 Wisconsin Department of Health Services/ForwardHealth. Dual *i*Care members will not be responsible for copayments, coinsurance 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.

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EVV Hard Launch May 1, 2023

Based on data provided by Wisconsin Department of Health Services (DHS) and our claim data, 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, it is highly encourage 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 ProviderRelationsSpecialist@iCareHealthPlan.org

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

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