# Table of Contents

Introduction ........................................................................................................................................... 4  
Company Information, Mission, Vision and Values .................................................................................. 4  
Integrated Home Care Services Compliance and FWA Programs ............................................................... 5  
Contacts ................................................................................................................................................ 6  
Performance Standards .............................................................................................................................. 7  
Utilization Management Program ............................................................................................................ 7  
  IHCS’s Utilization Management Process .................................................................................................... 9  
  Utilization Management Responsibilities.................................................................................................. 10  
Coordination of Authorization and Home Health Services ........................................................................ 12  
  IHCS Receives Referral from Referral Source ......................................................................................... 12  
Reauthorization Responsibilities ................................................................................................................ 13  
  Home Health ....................................................................................................................................... 13  
  Authorization Extension Responsibilities DME ............................................................................................ 14  
  Re-authorization Responsibilities Infusion Pharmacy .................................................................................. 15  
Notice of Medicare Non-Coverage (NOMNC) .......................................................................................... 16  
Provider Billing and Claims Payment Guidelines ..................................................................................... 17  
  General Claims .................................................................................................................................... 17  
  Clean Claim Requirements ..................................................................................................................... 17  
  Billing Codes ....................................................................................................................................... 19  
Timely Filing ............................................................................................................................................ 19  
Provider Payment .................................................................................................................................... 20  
Reimbursement Status .............................................................................................................................. 21  
Corrected Claims ..................................................................................................................................... 21  
Payment Differences ............................................................................................................................... 21  
Appeals and Reconsiderations .................................................................................................................. 21  
Appeals and Grievances ........................................................................................................................... 22  
Dispute Resolution ................................................................................................................................... 22  
Retrospective Claims Review .................................................................................................................... 23
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restriction on Balance Billing</td>
<td>23</td>
</tr>
<tr>
<td>Provider Complaints</td>
<td>23</td>
</tr>
<tr>
<td>Provider Credentialing and Re-Credentialing</td>
<td>25</td>
</tr>
<tr>
<td>Credentialing</td>
<td>25</td>
</tr>
<tr>
<td>Re-Credentialing</td>
<td>25</td>
</tr>
<tr>
<td>IHCS Provider Portals</td>
<td>27</td>
</tr>
<tr>
<td>Reporting and Investigating Patient Complaints</td>
<td>28</td>
</tr>
<tr>
<td>Complaint</td>
<td>28</td>
</tr>
<tr>
<td>Grievance</td>
<td>28</td>
</tr>
<tr>
<td>Frequently Asked Questions</td>
<td>32</td>
</tr>
</tbody>
</table>
Introduction

Thank you for your participation with Integrated Home Care Services, Inc. (IHCS). Our goal is to provide quality services to the members enrolled in the Health Plans we are contracted with. This provider manual is to serve as a guide for you and your staff with information related to claims submissions, authorizations, policies and procedures. It is intended to serve as a guide for you and your staff with information related to claims submissions, authorizations, compliance policies and protocols. The guidelines outlined in this Provider Manual are designed to assist you in providing caring, responsive service to the members enrolled in the Health Plan’s we are contracted with to service. We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact our Provider Relations Department.

Company Information, Mission, Vision and Values

Integrated Home Care Services, Inc. (IHCS) is a for profit, Florida health care quality improvement, medical cost management and health information technology company providing a wide range of effective and efficient solutions for our health plan clients. Services include care coordination, utilization review, and quality improvement, provision of home medical services inclusive of home health, durable medical equipment/supplies and pharmacy home infusion. IHCS is committed to assisting our downstream providers to embrace quality standards, Medicare and Medicaid compliance to maximize and improve the quality of care provided to our patients/recipient.
Integrated Home Care Services Compliance and FWA Programs

Compliance is everyone’s business and Integrated Home Care Services, Inc. expects the same diligence and dedication from its provider network in these important endeavors.

In order to share our commitment to compliance with you, please visit our website at www.ihcscorp.com to review the following program tutorials and informational trainings for you and your staff to enjoy! Please review these programs with your managers and field staff. They are:

- IHCS Compliance Program Outline
- IHCS HIPAA PowerPoint
- Reporting Fraud Waste and Abuse Hotline
- Patient Rights and Responsibilities
- Medicare sanctioned Part C and Part D General Compliance Training
- FDR Affidavit and Training
## Contacts

### Portal Support

<table>
<thead>
<tr>
<th>Support</th>
<th>Send an email to <a href="mailto:ProviderServices@ihcscorp.com">ProviderServices@ihcscorp.com</a></th>
<th>(844) 215-4264 Ext 7534 or email <a href="mailto:ProviderServices@ihcscorp.com">ProviderServices@ihcscorp.com</a></th>
</tr>
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<tbody>
<tr>
<td>Register for the Provider Portals</td>
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<tr>
<td>Support</td>
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<tr>
<td>Authorization Requests or Inquiries</td>
<td>(844) 215-4264 Ext 7533</td>
<td>(844) 215-4264 Ext 7533</td>
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### Home Health Services

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Maritza Perez, UM Home Health Manager</td>
<td>(844)215-4264 Ext 7417</td>
</tr>
<tr>
<td>Grisel Ibanez, LPN, UM Case Manager</td>
<td>(844)215-4264 Ext 7354</td>
</tr>
<tr>
<td>Grace Iglesias, Lead Referral Coordinator</td>
<td>(844)215-4264 Ext 7351</td>
</tr>
<tr>
<td>Maria Garron, Director of Home Health Services</td>
<td>(844) 215-4264 Ext 7361</td>
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### DME

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Nicole Falconer, Director of Referrals</td>
<td>(844)215-4264 Ext 7367</td>
</tr>
<tr>
<td>Licette Salazar, Manager of Referrals</td>
<td>(844)215-4264 Ext 7526</td>
</tr>
<tr>
<td>Aracelys Lopez, Supervisor of Referrals</td>
<td>(844)215-4264 Ext 7316</td>
</tr>
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### Infusion Pharmacy

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Jiselle Arrieta, Pharmacy Intake Specialist</td>
<td>(844)215-4264 Ext 7359</td>
</tr>
<tr>
<td>Jennifer De La Rosa, Pharmacy Intake Specialist</td>
<td>(844)215-4264 Ext 7360</td>
</tr>
<tr>
<td>Karen Hitchen, VP of Pharmacy Services</td>
<td>(844)215-4264 Ext 7489</td>
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### Claims

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<tr>
<th>Name</th>
<th>Phone Number</th>
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<tr>
<td>For any questions regarding Claims (Status, Appeals and Support)</td>
<td>(844)215-4264 Ext 7532 or Select Option 3</td>
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### Provider Relations/Provider Contracting/Credentialing

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Provider Network</td>
<td>(844)215-4265 Ext 7534 or Select Option 4 you may also send an email to <a href="mailto:ProviderNetwork.Credentialing@ihcscorp.com">ProviderNetwork.Credentialing@ihcscorp.com</a></td>
</tr>
<tr>
<td>Lazara Barreto, Manager of Provider Network</td>
<td>(844)215-4265 Ext 7409</td>
</tr>
<tr>
<td>Zaira Krasick, Manager of Provider Relations</td>
<td>(844)215-4265 Ext 7675</td>
</tr>
<tr>
<td>Natalie Delgado, Credentialing Coordinator</td>
<td>(844)215-4265 Ext 7366</td>
</tr>
</tbody>
</table>

### Patient Financial Accounts

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Customer Service</td>
<td>(844)215-4264 Ext 7530 or Select Option 2</td>
</tr>
<tr>
<td>Yari San Jorge, Director of Customer Service</td>
<td>(844)-215-4264 Ext 7328</td>
</tr>
</tbody>
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### Compliance

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Donna Gale, VP of Compliance</td>
<td>(844)215-4264 Ext 7494</td>
</tr>
<tr>
<td>Mark Gilchrist, Director of Compliance</td>
<td>(844)215-4264 Ext 7495</td>
</tr>
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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 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 and respond to patient and/or Integrated 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 member will be sent a bill the patient/member for covered services or for services in which payment was denied due to failure to comply with the Provider Service Agreement or this Provider Manual. Not otherwise bill the patient/member for any covered services;

- Provider shall collect deductibles, co-payments and/or co-insurance from patients as identified and instructed by Integrated Home Care Services. At no time shall Provider collect any monies due from AvMed Health Plan Members. Providers shall not collect any monies from patients without except consent of Integrated. Providers are paid for authorized services in accordance with their rates found in the Provider Service Agreement, less any applicable deductibles, co-payments and/or co-insurance due from patients.
- Provider will promptly return any overpayments received for services provided to Integrated Home Care Services per the Provider Service Agreement.
- Provider agrees not to charge the member where payments were denied for services that were deemed not medically necessary.

- Provider agrees to not 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 impacting 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 it’s 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. 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 utilization management 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 are delivered, the diagnosis is determined to be different than 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 1 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 also an alert to go to the MedTrac Portal and retrieve the orders. The MedTrac Portal is discussed later in this manual; note it 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. If recently discharged from hospital or other inpatient setting, face sheet
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 reauthorization or concurrent review is **required** to continue services.
- Obtaining a re-authorization is the responsibility of the Provider
- Providers must submit requests for re-authorization at least 48 hours prior to the expiration of the authorization.
- Provider must submit clinical status and objective reasons for re-authorization prior to authorization expiration.
- Re-authorization is requested via the MedTrac Provider Portal at [https://apps.ihscorp.com/medtrac](https://apps.ihscorp.com/medtrac) or via Fax to IHCS (844)215-4265.
- The Provider Portal identifies the information required in order to complete your request for reauthorization. That information includes, but is not limited to, the following:
  1. Intake ID
  2. Patient’s Last Name
  3. HCPCS Code and modifier needing reauthorization
  4. Number of requested visits/units, start and stop date of requested authorization
  5. Medical necessity for the service requested
  6. Physician orders for all services for which authorization is requested for (current POC or order)
  7. Supporting documentation for the authorization being requested
- If the Provider does not submit all of the required information, the request will not be accepted by Integrated.
- Providers are responsible to check eligibility and benefits with the member’s health plan at the beginning of each month.
Authorization Extension Responsibilities DME

- An authorization extension is required for providers to continue services on rental equipment.
- Obtaining an authorization extension is the responsibility of the Provider.
- 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
- The Provider Portal identifies the information required in order to complete your request for an authorization extension. That information includes, but is not limited to, the following:
  1. Intake ID
  2. Patient’s Last Name
  3. HCPCS Code and Modifier needing reauthorization
  4. Updated RX has been received in the case of O2

**Note:**
If the Provider does not submit all the required information, the request will not be accepted by Integrated. Providers are responsible to verify eligibility and benefits with the member’s health plan at the beginning of each month.
Re-authorization Responsibilities Infusion Pharmacy

- A reauthorization 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 [https://apps.ihscorp.com/medtrac](https://apps.ihscorp.com/medtrac) or via Fax to IHCS (844)215-4265.
- The Provider Portal identifies the information required in order to complete your request for reauthorization. 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 include HCPC units
  5. Physician orders/prescription for all drug infusion services for which authorization is requested for (current POC or order)
  6. Supporting documentation for the authorization being requested (e.g. signed delivery ticket, new prescription).
  7. If the Provider does not submit all of the required information, the request will not be accepted by Integrated.
  8. Providers are responsible to check eligibility and benefits with the member’s health plan at the beginning of each month.
Notice of Medicare Non-Coverage (NOMNC)

Compliance with CMS Notice of Medicare Non-Coverage Requirement

Providers are required to comply with applicable state and federal laws. With respect to Medicare patients who are discharged from home health care, CMS requires Providers to timely issue a Notice of Medicare Non-Coverage (NOMNC) to the patient. The following are some steps Providers should take to ensure compliance with this NOMNC requirement:

- Prior to discharging a patient from home health services, determine whether the patient is a Medicare Advantage member.

- If the patient is a Medicare Advantage member, provide the patient with a NOMNC letter at least 48 hours prior to discharge. Please note that the patient or the patient’s authorized representative must sign and date the notice.

- Utilize the approved CMS NOMNC letter template and complete the template letter as directed by CMS.

- Providers are required to populate in the MedTrac Portal if a NOMNC is issued to a member and the date issued. The required NOMNC fields that are audited quarterly 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
Claims are processed based upon authorization. For all plans, providers are responsible for confirming eligibility and benefits with the member’s health plan for ongoing or add-on services. Failure to do so could lead to claim rejections and denials. It is imperative to check eligibility and benefits to ensure the member’s plan has not changed.

To expedite payment of claims, the Provider should match the billable services against the authorization and your contracted Provider crosswalk. Claims for services, date of service or units that do not exactly match the authorization may be rejected or denied in part or in whole. Alternatively, if the Provider bills for a higher level of service, equipment or supply than the level authorized, payment may be made in accordance with the rate associated with the authorized service, equipment or supply, and Provider will accept that rate as payment in full. Claims will be paid based on the lower of the Provider’s usual billed charge or the contracted/negotiated rate.

Authorization of services is not a guarantee of payment, and payment of services rendered is subject to the patient’s eligibility and coverage on the date of service, the medical necessity of the services rendered, coverage requirements, the applicable payer’s payment policies, including, but not limited to, applicable payer’s claim coding and bundling rules, IHCS’s claim coding and bundling rules and compliance with the Provider’s contract with IHCS.

By submitting a claim for payment to IHCS, the Provider is certifying that it has met the above requirements, that the service has been rendered and that it has a record of all necessary documentation to support the foregoing. Claims that are not submitted within the time frames set forth in the Provider Agreement and in accordance with the requirements of the Provider Agreement, this Provider Manual and the applicable health plan may be denied.

Clean Claim Requirements
Claims must be submitted electronically or on standard paper claims forms (CMS 1500 or UB-04). Home Health Providers must submit claims on an 837I or UB-04. Our required clean claim data elements for both electronic and paper claims include the following:

- Patient’s name, Subscriber ID number (including any prefix and/or suffix as appropriate), Address, Relationship to Subscriber, Gender, and Date of Birth
- Insurance name, group name and group number
- Subscriber name, address, and gender
- Place of service code
- Primary diagnosis code(s)
• V codes will not be accepted as the primary diagnosis code and Provider is expected to follow all ICD coding rules
• Rendering Provider’s name, service location, and billing address
• Rendering Provider’s National Provider Identifier (NPI) number, Federal Tax ID number, Medicaid ID number (Medicaid network Providers only), and Taxonomy Code
• Referring Provider’s/Physician’s name and NPI number(837P)
• Attending Provider’s/physician’s name and NPI number(837I)
• Individual line level charge for each service
• Number of invoiced units for each claim line
• Integrated Home Care Services, Inc.’s HCPCS/ CPT code(s) and modifier combination
• NDC codes, NDC description, NDC unit of measure, and NDC units (i.e. prescription drugs)
• Date of Service (FROM and to required; FROM date must be before the claim receipt date and before or equal to the to date)
• Whether the patient’s condition is related to employment, auto accident or other accident
• Other insurance information (if other insurance, include other insured’s name, Date of Birth, other insurer’s name, group or policy number)
• Coordination of benefits information for secondary claims (Explanation of Payment from Primary Carrier)
• Service authorization number
• Revenue Code (Institutional Claims)
• HIPPS code on all home health claims submitted for Medicare Advantage members
• Description of miscellaneous code

Claims missing required information or containing incorrect required information may not be processed. Paper claims without the correct required information may be returned, and the Provider will be informed of the information that is missing or incorrect. Claims submitted electronically without correct required information may be rejected by the clearinghouse with corresponding reasons for the rejection. Such incomplete claims must be resubmitted by the Provider to IHCS so that a complete or clean claim is received by IHCS within the original timely filing timeframe as specified below subject to applicable law.

With regard to services delivered, the claim must include a description of the service provided (i.e. “RN visit” or “CPAP rental”) as well as the relevant HCPCS, CPT or revenue code and applicable modifier(s) found on the IHCS Service Authorization Form or the billing crosswalk (located at https://apps.ihcscorp.com/medtrac). Claims without a description of the service provided will be returned.
Billing Codes
Only contracted procedure codes and authorized services will be paid. Provider must only use procedure codes and HCPC codes that are detailed on the contract, Letter of Agreement or Authorization received. Services will use the relevant Medicare G-code set on the authorization which contain revenue codes and modifiers. The claim must match the exact billing code set found on the authorization; otherwise it will be denied.

Example: If the authorization contained a revenue code and modifier, the claim shall contain a revenue code and modifier. If the authorization for did not include a revenue code, please contact your IHCS home health liaison to correct the authorization.

All Medicare home health claims shall contain a HIPPS code per CMS mandate. Only one HIPPS score shall be entered on a claim, otherwise the claim will be denied. The HIPPS code rate shall always be zero; otherwise the claim will be denied. The HIPPS code shall have a revenue code of 0023; otherwise the claim will be denied. The HIPPS score service date shall be the first service date pertaining to the HIPPS code. It is the agency’s responsibility to research other CMS rules regarding HIPPS code to ensure accurate claim filing. Inaccurate specification of HIPPS codes will result in claim denials.

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 regularly check the IHCS portal for updates to HCPCS codes, descriptions, and the IHCS billing crosswalk. The current billing crosswalk can be found at: https://www.visibledi.com/ihcs/.

Timely Filing
Clean claims must be filed at the address designated by Integrated within the time frame described in the corresponding Provider Agreement or within the period of time required by applicable law if longer. Claims received by Integrated after the filing deadline may be denied, and Providers cannot bill the patient for such services. Note that Integrated may pay some claims that were not submitted timely to Integrated if we believe there may still be time to timely bill and receive payment from the Health Plan. However, please be aware that, if the Payer does not pay the claim in full, integrated may later deny the claim for failure to timely file and recoup the prior payment. All claims must be submitted 75 days from the date of service. 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:

https://www.visibiledi.com/ihcs/

IHCS will only accept original documents for payment consideration that are typed in indelible ink without erasures, strikeovers, whiteout or stickers. Dot matrix printers should not be used when typing information onto paper claims forms. Claims with handwritten information will be rejected. Also, it is important that the name of the Provider organization and service location on the claim match the Provider name on the related authorization form(s).

Claims submitted without all required information may be rejected or denied.

1. **Electronic EDI Claims:**
   If you are using practice management software (Availity) to submit claims electronically, your system needs to be set up with the **payer ID IHCS1** All nursing claims must have nursing and therapy notes attached. All Medicare claims sent to Availity shall be sent in 837i format.

2. **Paper Claims:**
   Must be submitted on the Professional 1500 HCFA Claim Form Version 02/12, any claims submitted on 1500 Version 08/05 will be rejected as of April 1, 2014. (Please review CMS changes for further detail) Copies of the form cannot be used for submission. Data must be typed not handwritten. Authorization number must include any hyphens (entire auth #-123456-1-1234) Box 23. NPI # of rendering location must be in Box 32a. Any claims not in this standard format will be denied / rejected.

**Provider Payment**

The Provider Agreement rate is payment in full for covered services and is all inclusive. Provider is not entitled to receive additional compensation for covered services, including but not limited to, compensation for copies of records, sales tax, reports, or other services contemplated by the Provider Agreement. No billing to the patient or Health Plan of the difference between the negotiated or contracted rate and the Provider’s list price is permitted. If Provider’s billing system is unable to support billing at the contracted rate, the difference between the contract rate and Provider’s list price must be adjusted off Provider’s accounts receivable. Doing so can help Provider avoid repeated claims inquiries and in addition, when billing for custom equipment, the claim must reflect the full rate, the discount as negotiated, and the net price. Provider must attach to the claim the manufacturer’s specification sheet for the equipment. For custom equipment, you may be instructed to complete 2 claims, if required for specific IHCS Health Plan contracts. Provider shall not be paid for services rendered without proof of delivery submitted to IHCS.
With respect to applicable sales tax, as indicated above, your network contract rate is inclusive of any applicable sales tax. It is your obligation to 1) calculate and identify on your claim that portion of your contract rate that is attributable to applicable sales tax; and 2) remit the applicable sales tax amount to the appropriate regulatory authority.

Reimbursement Status
Providers should utilize the Provider Portal at https://www.visibiledi.com/ihcs/ to check their claim’s reimbursement status.

Corrected Claims
If you receive a denial from IHCS and you agree with the denial, you can correct the issue identified in the denial and resubmit the claim as a corrected claim. If submitted on paper, the corrected claim must include clearly visible markings that indicate the claim has been corrected. Please note that corrected claims must be received by IHCS within the original timely filing timeframe in order to be payable.

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 which can be found on our Provider portal at https://www.visibiledi.com/ihcs/.

Appeals and Reconsiderations
Appeals must be received by IHCS within 30 calendar days of the provider’s receipt of the explanation of payment. Our Appeals Unit will endeavor to complete the review of your appeal within 30 calendar days of the date the Appeals Unit receives all information necessary to review your appeal. We will communicate the results of our review of your Appeal in writing which may include payment and an explanation of payment.

If the claim was rejected or denied: Rejected claims can be resubmitted without submitting a reconsideration request. If the original claim has been altered in response to the denial. Only original claims that do not require changes in response to the denial should be submitted as a claim’s reconsideration request. Claims requiring correction to address the issue causing the denial, should be submitted as corrected claims. Your request for reconsideration must be received by IHCS at the designated address within 45 days after the date of our explanation of payment, or within the period of time permitted by applicable law if longer.

After receipt of your completed request for reconsideration, we will research your concern and respond to you as soon as possible. If the request for reconsideration is resolved in your favor, the claim will be adjusted and an explanation of payment (EOP) issued. If it is not resolved in
your favor, you will be advised to submit an appeal in writing using our Appeal Form which can be found on our Provider portal at https://apps.ihcscorp.com/medtrac/.

**Appeals and Grievances**

Provider Grievances and Administrative IHCS has a comprehensive process for resolving appeals and grievances.

An appeal is a request IHCS review an adverse action or denied claim, having provided documentation supporting the request for reconsideration. Appeal requests must be submitted in writing.

A grievance is any expression of dissatisfaction about any action or inaction by IHCS other than an Adverse Action. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of IHCS or failure to respect the member’s rights. Grievances should be reported to IHCS Provider Relations Department via email at ProviderServices@ihcscorp.com.

Requesting an Administrative Appeal

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 30 days of the Explanation of Payment (EOP) date on which the original claim was processed. If the provider is not satisfied with the decision, an appeal can be submitted to Integrated Home Care Services Claims Department.

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

- **30 days** from receipt of the EOP
- **30 days** from receipt of EOP from other insurance
- **30 days** from the date of the claim adjustment letter

The appeal must include additional relevant information and documentation to support the request. Requests received beyond the 30-day appeal request filing limit will not be considered.

When submitting a provider appeal, please use the Request for Claim Review Form.

Appeals may be sent via USPS mail to:

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

**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 period required by applicable law if applicable law requires a time period 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.

**Note:** Please see the grid below indicating the recoupment timelines for Medicaid, Medicare and Commercial claims. If IHCS does not receive a response within the specified timeframes, we will initiate the recoupment process and deduct the overpayment from future remittances.

<table>
<thead>
<tr>
<th>Business</th>
<th>Provider Appeal Timeline</th>
<th>Recoupment Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>60 Days</td>
<td>After the 60 days of the date of the Letter</td>
</tr>
<tr>
<td>Medicaid</td>
<td>45 Days</td>
<td>After the 45 days of the date of the Letter</td>
</tr>
<tr>
<td>Commercial</td>
<td>35 Days</td>
<td>After the 35 days of the date of the Letter</td>
</tr>
</tbody>
</table>

**Restriction on Balance Billing**

IHCS Network Providers may not bill a patient or that patient’s insurance company (if the insurance company is an IHCS client) during the reconsideration or appeals process or for a balance remaining after a decision has been made on an IHCS Network Provider appeal.

**Provider Complaints**

IHCS maintains a provider complaint system that permits a provider to dispute IHCS’s policies and Procedures, or any aspect of the administrative functions, including proposed actions and claims. IHCS has a copy of the provider complaint system policies and procedures in its handbook. The IHCS Complaint system policy and procedures, includes distribution of the provider complaint system policies, to include claims issues, to out of-network providers upon request. IHCS will distribute a summary of these policies and procedures, the summary will include information about how the providers may access the full policies and procedures on the IHCS website. The summary will include details on how the downstream providers may obtain a hard copy from IHCS at no charge. IHCS allows providers 45 calendar days to file a written complaint for issues not pertaining to claims. The Provider Relations Manager is responsible to investigate each complaint using applicable statutory, regulatory, contractual provisions.
Provider Complaints are received, documented and processed through the Provider Relations Department. It is the role of the Provider Relations Representative to follow Provider Relations Complaint process in responding to all Provider Complaints. The Compliance Department may assist in such investigations. When the Complaint has been identified as a quality concern, the Complaint will be investigated by the Compliance Department.

For more information on the Provider Complaint System please contact the IHCS Provider Relations Department (844)215-4264 EXT 7534
Provider Credentialing and Re-Credentialing

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 fidelity 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 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.

Re-Credentialing
IHCS Network Providers are re-credentialed every two to 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 two to three year credentialed period, including when a Provider adds a new service category, or malpractice or quality of care/service issues are brought to the Committee’s attention. In addition, if a Provider adds or acquires a new location, subsidiary or affiliate, that location or entity must be credentialed.

The standard re-credentialing process begins approximately six (6) months before the credentialing anniversary. Our re-credentialing process requires, but is not limited to, the following:

- Completion of IHCS’s re-credentialing application
- Copies of current licensure.
- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate; a copy of current fidelity 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.
IHCS Provider Portals

Integrated Home Care Services, Inc. works with three (3) separate portals. Below you will find the names, link and use of each portal.

   1. Obtain clinical information for initial referrals such as Physician Orders, Patient Demographics, 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

   1. Submit claim(s)
   2. Look up claim(s)
   3. Submit a claims inquiry*
   4. Enroll in EDI (Electronic Claims Submission)

3. FTP – (http://edi.ihcscorp.com)
   1. Upload clinical documentation for Claims purposes
   2. Upload the Delivery Tickets/Work Orders for Claims purposes

For access, login credentials and training on the portals, please submit a request via email to 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, either orally or in writing, to 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 time frame.

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 SharePoint 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 SharePoint 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’s/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 time frame 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.

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. Appropriate referrals to the Quality Improvement Chairperson(s) will be facilitated by the appropriate designee 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
Home Health/ DME / Infusion

Q: Does IHCS issue retro authorizations?
A: IHCS may issue a retro authorization up to 48 hours prior to the submission of the request into the portal

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: Transportation to the MD offices are coordinated by the PCP 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 happens if a patient’s insurance terminates during care?
A: The Provider must check eligibility every month and also 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 services should be reimbursed by the new Health Plan as a Continuity of Care.

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 verbal orders be signed by an LPN?
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: Can I obtain orders from the MD offices directly and provide the equipment and then obtain the auth after?
A: No, orders must be faxed to IHCS and the auth needs to be issued prior to item(s) being delivered.

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

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: After the 10/13-months rental period does IHCS own the equipment?
A: Yes, for rental items after the 10/13 months rental period the ownership is passes to Integrated Home Care Services.

Q: What is the purpose of home infusion therapy?
A: The purpose of home infusion therapy is to provide continued IV therapy in the patient home when the patient no long requires in an acute care setting such as a Hospital/Skilled Nursing Facility (SNF).
Frequently Asked Questions
Provider Relations/ Provider Portal

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 patient’s name to submit the concurrent request.

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. To reset your password on the FTP portal, you must submit a request via email to ProviderServices@ihcscorp.com.

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 covert a claim to an 837 TXT format in the VisibilEDI?
A: Claims cannot be converted to an 837 TXT document in VisibilEDI. Please contact your billing Software company.

Q: I have tried to reset my password online and have not received the password reset email. Who do I contact?
A: Please send an email to ProviderServices@ihcscorp.com.

Q: Where do I upload the delivery tickets in MedTrac?
A: Providers do not have the ability to upload Delivery Tickets in MedTrac at this time. All Delivery Tickets must be uploaded in the FTP portal.

Q: How do I submit an authorization request through the portal?
A: under the Administration tab once the patient is active, Click the green arrow under concurrent and create the reauthorization request.

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: 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.

Q: How can I verify if IHCS received the claim(s) submitted in the portal?

A: You must login to the VisibilEDI portal and select “Claim” at the top. Several options will appear on the left hand side, click on “Submissions” and under “Batch Criteria” enter the batch number and click on “Search”.

Q: I’ve recently moved or updated my contact information. How do I update my information in your system or who do I notify at IHCS?

A: Please submit an email to ProviderNetwork.Credentialing@ihscorp.com with the information being updated and effective date.