



BEHAVIORAL HEALTH and AODA PROVIDER FAQs

Q: When do I need an Authorization?

A: Behavioral Health services that require prior authorization include: Partial hospitalization, Intensive outpatient program, Psychological testing greater than 4 hours, In-home treatment and Community Day Treatment

Q: Where can I find Prior Authorization and Outpatient Notification forms?

A: Prior authorization and outpatient notification forms are available on the iCare provider website at <http://www.icare-wi.org/providers/forms.org> . For assistance please contact iCare behavioral health staff at 414-223-4847.

Q: Do Office Visit (OV) CPT codes require a modifier for outpatient mental health and substance abuse services?

A: Providers should not use modifiers when submitting claims for office visits for outpatient mental health and substance abuse services in the home or community for adults. This will cause the service to deny.

Q: What is iCare' Payer ID number for electronic claims?

A: iCare's Payer ID number is 11695.

Q: Does iCare offer electronic claims submission?

A: Yes, iCare offers electronic claims submission through Claimsnet. For more information please visit <http://www.claimsnet.com/>

Q: What is an Appeal?

A: A Provider Appeal is a formal process for the provider to disagree with or question an iCare claim denial or a reduction in the level of benefits. The provider makes an appeal to iCare to change a claim decision. A provider's formal appeal letter must be marked "APPEAL" and include: Provider's name, Date of service, Date of billing, Date of claim adjudication/EOP date/date of rejection and Provider's name. For more information please see the Provider Reference Manual. The Provider Reference Manual is available at our web site www.icare-wi.org/providers

Q: What is a Reconsideration?

A: Reconsideration is an informal process to request review of processed claims. The provider has 60 days from the date of the EOP to contact *iCare* with an *iCare* Reconsideration request. The request may be made via the phone, in a letter format by mail or by fax for the following situations where the provider feels there was an incorrect denial, underpayment, overpayment, incorrect adjustment or wrong provider payment. . For more information please see the Provider Reference Manual. The Provider Reference Manual is available at our web site www.icare-wi.org/providers

Q: What is the correct way to submit claims for a dual eligible member if I am a provider that is not Medicare certified?

A: A M8 disclaimer should be placed in Box 11 on a HFCA 1500. This is a code used when Medicare never covers the procedure in any circumstance, or the recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the services provided. Here is a link to all the disclaimer codes and descriptions in Forward Health:
<https://www.forwardhealth.wi.gov/WIPortal/OnlineHandbooks/1500HealthInsuranceClaimFormCompletionInstructionsforPhysicianServices.aspx>

Q: What is the correct way to submit claims for a dual eligible member when the service is not covered by Medicare (example: H2012 Code)?

A: The H2012 code is not covered by Medicare. Please use the M8 Disclaimer in Box 11 on the claim.

Q: Can 90834 and 90853 be billed on the same day?

A: Yes, providers are allowed to bill codes 90834 and 90853 on the same day for **Medicaid only.**

Q: Where to locate the appropriate modifier based on the providers credentials?

A: You can locate the appropriate modifier based on the providers credential on the Forward Health website under Max Fee Schedule.

Q: Where can I locate the 1500 Claims submission guidelines?

A: Please reference the *iCare* website and Forward Health Portal
<https://www.forwardhealth.wi.gov/WIPortal/OnlineHandbooks/1500HealthInsuranceClaimFormCompletionInstructionsforPhysicianServices.aspx>