FREQUENTLY ASKED PROVIDER QUESTIONS & INFORMATION

I have a question about claims. Who should I contact?

- Provider Relation Coordinators can be reached at 1.844-283-2884; Mon-Fri 8:00 a.m. – 12:00 p.m., 1:00 p.m. - 5:00 p.m. or via email at ProviderService@icirclecny.org
- Please note, inquiries pertaining to claim status/assistance via phone or email are limited to a maximum of 5-individual claim inquiries per call/per day. If additional claims need to be reviewed with iCircle staff, you may be asked to fill out our claim-inquiry grid so as to assist with the appropriate review.

How can I schedule transportation for a member?

- Please contact Member Services at 1.844.694.2273 8:00 a.m. - 5:00 p.m.
- iCircle MLTC will cover non-emergent, medically necessary transportation services

How do I become a provider?

- Visit our website at https://www.icirclecny.org/ and complete the appropriate Credentialing Application.
- New Provider contracting is dependent on iCircle's current provider network adequacy and the reputation & offered services of the entity who is requesting to become an iCircle provider.

Where can I submit my claims?

- Paper claims can be submitted to:
  - iCircle Care
    P.O. Box 1320
    Webster, NY 14580
    ATTN: Claims Department
- Electronic claims can also be submitted via Clearinghouse - VisibilEDI
  - Clearinghouse: Visibiledi
  - Payer Name: iCircle
  - Payer ID: ICRCL
- iCircle's Provider Portal also allows providers the ability to submit claims directly through the portal-entry.
- iCircle MLTC does not accept claims via email or any other method other than the above.

I have questions about a member's vision benefits.

- iCircle MLTC partners with **Davis Vision** for our member's vision benefits. Providers may contact Davis Vision at 1.800.773.2847 for iCircle MLTC members, or may work in conjunction with the member's iCircle Care Manager.

I have questions about a member's dental benefits.

- iCircle MLTC partners with **DENTAQUEST** for our member's dental benefits. Providers may contact DentaQuest at 1.855.343.7343 for iCircle MLTC members, or may work in conjunction with the member's iCircle Care Manager.

How long will it take for my clean claim to process?

- Electronic claims are typically processed within 30 days of receipt.
- Paper claims are typically processed within 45 days of receipt.

What information is needed for Corrected Claim Submissions?

- For CMS 1500 Corrected claims, valid resubmission code should be entered into Box 22, with the Original Claim (Reference) number to show what claim is being corrected.
- For UB04 Corrected claims, valid resubmission code should be references as the 3rd digit in the bill-type, along with Original Claim (Reference) number in Box 64.
- For Additional assistance with Corrected Claims, Please contact our Provider Network Team.

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I've never submitted a health insurance claim before, what do I do?

- If you provided an MLTC covered service and are not a medical facility you will need complete a **CMS 1500** form and appropriately submit it to iCircle MLTC. The form can be purchased here: http://bookstore.gpo.gov
- Most of the information needed to complete this form will be found on the authorization that you received from iCircle, as well as the instructions found on the form itself.
- If you have additional submission questions, we encourage you to call our Provider Network Team at 1.844-283-2884; or via email at ProviderService@icirclecny.org.
- While iCircle representatives are not allowed to directly assist in the creation / data-entry for any individual claim, our team will assist with any questions you may have about the claim-submission process & requirements.

I have questions about the iCircle Authorization, who do I contact?

- New Requests can be discussed with the member's care management team by calling 1-844-424-7253.
- Authorization Revision, please use the form found on our website and email it to Authrevisionreq@iCirclecny.org
- It is important to note that providers are required to review all information within an authorization **prior** to servicing iCircle members and especially prior to billing for said services. Such review should include confirmation of appropriate service codes & units, provider information, member information, and any other pertinent information that relates to the servicing of the member and the billing of the service.
- Diagnosis coding that is provided on authorizations may include a general-diagnosis code that is considered "Non-Billable" according to NYS DOH standards, which iCircle follows in this regard. In these situations, the provider is expected to determine the appropriate, specific diagnosis code that IS billable, as providers are the entities who have the direct-interaction / servicing component for iCircle MLTC members. For questions about diagnosis coding, we encourage outreach to the member's Clinical Team via the methods above.
- iCircle MLTC Providers are responsible for ensuring that any authorized service code is active/within their executed iCircle MLTC Contract / Fee Schedule in order to ensure proper processing of claims. Likewise, providers should ensure the effective dates for any authorization are relevant for each individual date of service that is being submitted on a claim with the utilized authorization number.

What Documents are needed when submitted a claim for a skilled nursing stay?

- If a member is considered long-term placement in a skilled-nursing facility, and iCircle MLTC is considered the primary insurer; upon authorization of those services, the iCircle representative should request the NOMNC / 3559 documents from the servicing provider. Such documents must be filled out in their entirety to include (but not limited to) Effective dates, Medicare Term Date (as applicable), etc.
- In the event the member that resides at a skilled-nursing facility has a primary insurance / active Medicare, the provider should submit the primary remit/EOB to show the secondary amount that iCircle is responsible to pay.

We received a change to our rate, what happens now?

- iCircle will pay up to the Charge Amount on the Claim **or** the Contracted rate (whichever is lower) for clean-claims.
- In the event a provider's rate **increases** and the effective date of the increase coincides with claims that were previously processed, the provider will be responsible for submitting a corrected claim with the updated charge amount in order to receive additional reimbursement.
- If the new rate is equal to, or lower than the previous charge amount on a claim, the provider need only notify iCircle of the new rates, and iCircle will reprocess claims as appropriate.

FREQUENTLY ASKED PROVIDER QUESTIONS & INFORMATION

How do I access iCircle's Provider Portal?

- To register for iCircle's Provider Portal, providers can go to the following link and follow the instructions within; https://visibiledi.com/iCircle/Account/Register
- Providers can have multiple staff accounts associated with their portal access, and can access more than one provider-entity information on the portal, by choosing the appropriate Tax ID & Billing NPI(s) associated with their facility.
- Access to multiple billing entities will require the registrant to first register for only 1 entity, then upon approval by an iCircle representative, they can request access to additional provider-entities through their approved account.
- Items that are included/accessible by providers via our portal include; Copies of iCircle EOP's, Provider Payment Details (Check Numbers, amounts, dates, etc.), Claim Status, Patient Eligibility, Downloadable ERA's, and the option to submit claims directly through the portal (X12 837 format required).
- At this time, access to iCircle's member authorizations are NOT included on the Provider Portal.

Additional iCircle Claim & Contract Information;

- All Claims submitted to iCircle MLTC for services rendered MUST have a "Through-date" on the claim, even in the event the service was only 1-day span. In the event the service was for 1 specific date, the provider should put that date in both the "From" and "To" areas of the claim that pertain to the Date of Service.
- In the event a provider submits a claim utilizing a specific claim type (CMS-1500 or UB04), but realizes they need to submit the claim via the alternate claim-type, the provider may submit said claim(s) revisions as ORIGINAL claim submissions (no corrected claim information needed on the claim) to which the claim will process as if received as an original submission (all timely filing aspects still apply).
- iCircle MLTC Providers are responsible for ensuring any changes to their information including (but not limited to) the below are updated within iCircle's network by submitting a Provider-Demographic-Change-Form (Found on iCircle's Website). Depending on the information being adjusted/changed, an iCircle representative may reach out to you for additional documentation as needed.
    - NPI / Tax ID Information
    - Servicing / Billing Address Changes
    - Legal Entity Name or DBA Name
    - Service offerings (service codes as applicable to the contracted fee schedule)
    - Servicing Counties being covered by the Provider
    - Phone / Fax / Email Informational Changes
    - Operating / Office Hours
- Providers classified as "atypical" (Not having NPI) should utilize the following taxonomy codes when submitting electronic claims;
    - Non-Emergent Medical Transportation – 343900000X
    - Home Delivered Meals – 332U00000X
    - Contractor (Independent such as Home-Modifications) – 171WH0202X

How do I submit a referral to iCircle MLTC?

- Enrollment into iCircle MLTC is completely voluntary. Prospective members who wish to enroll must meet the following eligibility Requirements;
    - 18 Years of Age or Older & Actively reside in one of iCircle's Covered Counties
    - Must have Active Medicaid (Or be Medicaid Eligible)
    - Must meet NYS Requirements for being capable of returning to, or remaining in, the home and community without jeopardy to member's health and safety at the time of enrollment
    - Must have a medical-need for at least 1 of the following services for 120 days or more per year; Nursing Services in the Home, Therapies in the Home (PT, OT, ST), Home Health Aide Services, Adult Day Health Care, Private Duty Nursing, Consumer-Directed Personal Assistance.
- For a current form to utilize, providers can obtain iCircle's Referral Form via our website, and may inquire with our enrollment department at any time for questions/assistance as needed; 1-844-424-7253

FREQUENTLY ASKED PROVIDER QUESTIONS & INFORMATION

What is a Front-end Rejection (see definition below)? Why was my claim sent back?

- Claims with missing or incorrect information that prevent iCircle from processing will be sent back to the provider without being entered into the system. The provider will receive a letter advising them of the reason for the rejection (if submitted via paper) or through their clearinghouse (if submitted electronically). After correcting the information, the claim may be sent back to iCircle as an original claim.
- It is important to note, in the event a claim is "Rejected", the claim will not be entered in any way into iCircle's claim-system, and as such the timely filing component for original claim submissions remains open as it pertains to normal timely filing expectations.
- Claims may be rejected due to White-out / handwritten information being utilized on the claim. Providers should always attempt to type claim information if submitting via paper.

How do I file an appeal for a denied claim?

- To file an appeal, you'll need to complete an appeal form & supply all necessary documentation.
  - Appeals must include sufficient reasoning to overturn any previous claim / payment decision.
  - Appeal submissions are NOT a guarantee that a previous claim determination will be overturned.
  - Assistance with understanding appeals can be obtained by contacting the Provider Network Team.
- If you have a large number of denied claims or errors that you need assistance on, one of our designated Provider Relation Representatives can assist you to ensure you send all needed information for our internal review.
- Please note, in the event a provider contacts a member of iCircle's Provider Network Team to dispute a claim result, the standard timely filing of appeals is still applicable, provider must include any/all supporting documentation within their inquiry, and provider may be asked to supply additional documentation as determined needed by the iCircle representative.

What is your timely filing limit?

- Original, Primary claims have **120 days from the last date of service** to be submitted to iCircle.
- Secondary Insurance Claims have **120 days from receipt of the primary EOB (which also must be submitted to iCircle MLTC for consideration of secondary coverage).**
- Corrected claims (see definition below) have **12 months from the date of service.**
- Claim Appeals (see definition below) must be submitted no later than **90 days from date of denial/payment**
- To submit a Corrected Claim, or an Appeal, the original claim must have been fully processed and included on an iCircle MLTC EOP to your organization.

Corrected	• **Definition**: A corrected claim is a claim that requires changes be made to the original claim previously processed (a corrected claim is NOT a rejected claim). For rejected claims please see Front-end Rejection. • **Example**: An error with the way the original claim was billed (i.e., # of units billed, date of service, diagnosis, procedure codes, modifiers, bill amount)
Front-end Rejection	• **Definition**: A front-end rejection is a claim that has been rejected and needs to be resubmitted (meaning it is not recorded in our system). • **Example**: Provider receives a rejection letter identifying the reason for rejection. (i.e., claim not on file, invalid claim number, NPI not on file, W-9 not on file, whiteout was used on claim). New claim submission is required.
Appeals	• **Definition**: An appeal is a type of dispute you make when you want a reconsideration of a decision (determination) that was made regarding a service. • **Example**: All denials (i.e., authorization related denials, rate issues and timely filing).

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How do I contact certain iCircle Departments?

- General Phone / Enrollment Inquiries; 1-844-iCircle (424-7253) TTY: 711
- General Email; Info@iCirclecarecny.org
- Enrollment Email; Enrollment@iCirclecarecny.org
- Mailing Address; iCircle Services – 860 Hard Rd. Webster, NY 14580
- Website; https://www.icirclecny.org/

The General Phone and Email for iCircle can be utilized for any item or discussion that is needed and all calls / emails will be forwarded and/or escalated to appropriate staff internally. For quicker responses, we encourage iCircle Providers to utilize the below contact methods depending on the inquiry-type.

- Provider Network Phone; 1-844-283-2884
- Provider Network Email; ProviderService@iCirclecny.org

The Provider Network Phone & Email can be utilized to assist with any & all Claim/Payment Information, General Provider Questions, Onboarding information, Networking Opportunities, etc.
Our dedicated PR Team is willing and able to provide general iCircle educational sessions as well as iCircle brochures & informational documents to your staff if desired.
Our Provider Network Team will involve additional iCircle departments as needed, depending on the inquiry.

- Provider Contracting Email; Contracts@iCirclecny.org

iCircle's Provider Contract & Credentialing Team can assist with any contractual-related inquiries / requests, and may involve additional iCircle departments as needed, depending on the inquiry.

- Authorization Revision Requests; Authrevisionreq@iCirclecny.org

Providers who need an authorization adjusted or revised can utilize the Revision email, but must also include the Authorization Revision Request Form, which is found on our general website in the Provider Resource section. Please note, this email should not be utilized to request NEW authorizations for new services. To request a new service authorization, please contact the Care Manager or Member Care Associate directly via the Member Care Assistance Phone line.

- Member Care Assistance Phone; 1-844-MY-iCARE (694-2273)
- Member Complaints / Appeals Phone; 1-855-775-3778 ; Fax: 1-888-519-2816

iCircle's Member Service Staff and Individual Care Management Staff can be reached via the above "Member Care Assistance Phone".

During the course of a provider or member inquiry, iCircle staff may provide you with direct contact information to expedite the request. Please note, that staff may change throughout time, and we always encourage providers and members to utilize the general group emails / phone lines outlined above to ensure your inquiry is responded to as efficiently as possible. It is against iCircle policy to give out our full staff contact list including direct email and direct phone lines for this purpose, and to prevent our staff from receiving unwarranted emails or calls that should be directed to a different department. Rest assured, by contacting one of the above emails or calling one of the above phone lines, your inquiry will be sent to the correct staff to provide assistance.