UNDERSTANDING FQHC/RHC WRAPAROUND

Updated: 10/8/2018
OBJECTIVES

In this webinar, we will discuss...

• An overview of the FQHC/RHC Wraparound Process
• Identified Errors
• What it means to be a Gatekeeper
AN OVERVIEW OF FQHC/RHC WRAPAROUND PROCESS
OVERVIEW

FQHC/RHC WRAPAROUND

On October 1, 2015, a new, automated FQHC/RHC Wraparound process was implemented to ensure more timely reconciliations of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) payments made by the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) health plans to the fully enrolled FQHCs and RHCs within the health plan's network. Wraparound payments are based on accepted encounter data received from a health plan and sent directly to the FQHC/RHC by the Florida Medicaid Management Information System (FLMMIS).
SUBMISSION PROCESS

1. Fully Enrolled FQHC/RHC submits claim to health plan.

2. Health plan ensures that the data received from the provider is accurate, sufficient, and compliant.

3. Health plan pays FQHC/RHC provider.

4. Health plan submits the encounter to Florida Medicaid.

5. FQHC/RHC encounter adjudication occurs with the following conditions:
   - If the encounter adjudicates in a paid status, and meets the wraparound eligibility requirements, then the provider will receive a wraparound payment, and this encounter will be included on the provider’s Wraparound Report.
   - If the encounter adjudicates in a paid status, and it does not meet the wraparound eligibility requirements, then the provider will not receive a wraparound payment, and the encounter will no be included on the provider’s Wraparound Report.
   - If the encounter adjudicates in a denied status then the provider will not be included on the provider’s Wraparound Report.
How can health plans verify if the FQHC/RHC is authorized for wraparound payments?

The provider data presented on the encounter must meet all of the following criteria in order to successfully process.

Billing provider requirements (loop 2010AA of the X12 837):
1. Provider must be **fully enrolled**.
2. Provider must be enrolled as provider type 68 (Federally Qualified Health Center) or provider type 66 (Rural Health Clinic).
3. Provider must be enrolled as a group.

Rendering provider requirements (loop 23108 of the X12 837):
1. Provider must be fully enrolled.
2. Provider must be enrolled as an individual (for example, physician, dentist, ARNP).
FQHC/RHC Wraparound Eligibility Requirements

AN OVERVIEW OF THE FQHC/RHC WRAPAROUND PROCESS

Which providers are eligible for the wraparound payment?

Health plans should reference the Provider Master Listing (PML) in order to identify fully enrolled FQHC and RHC providers that are authorized for wraparound payments. This resource offers a current listing of all providers and is updated on a daily basis, Monday through Friday.

Plans must review the below columns of the PML to determine provider eligibility for wraparound payments. Utilizing a filter functionality within the PML will further aid the plans in locating eligible providers.

1. Column D (Provider Type Code) must reflect a provider type of 66 (RHC) or 68 (FQHC).
2. Column F must contain an N, which signifies a fully enrolled provider.
3. Columns W and X will indicate whether the provider is fully enrolled for the dates of services billed.
FQHC/RHC Wraparound Eligibility Requirements
AN OVERVIEW OF THE FQHC/RHC WRAPAROUND PROCESS

What claim types will be considered for this program?
Only Physician (837P) and Dental (8370) encounter X12 types will be considered.

What services does the wraparound program allow?
A full listing of FQHC services procedure codes can be found in Appendix A of the Federally Qualified Health Center Services Coverage and Limitations Handbook. RHC services procedure codes are located in Appendix A of the Rural Health Clinic Services Coverage and Limitations Handbook.

Both handbooks are available online at http://mymedicaid-florida.com. Select Provider Services and then Handbooks under the Support menu.

The health plan will receive denials if the encounter contains services that are not allowed for the FQHC or RHC provider types.
FQHC/RHC Wraparound Eligibility Requirements

AN OVERVIEW OF THE FQHC/RHC WRAPAROUND PROCESS

What places of service are permissible for FQHC and RHC encounters?
The encounter must include an appropriate place of service (POS) in order for it to successfully process. The system will accept a POS 50 or 71 when billing services for an FQHC (provider type 68); POS 72 is acceptable when billing for an RHC (provider type 66).
FQHC/RHC Wraparound Eligibility Requirements
AN OVERVIEW OF THE FQHC/RHC WRAPAROUND PROCESS

How does the plan correctly report the plan paid price?

In order for FLMMIS to accurately calculate the provider's wraparound amount, the encounter must include a 09 in the CN101 segment, and the CN102 must include payment made by the plan to the FQHC or RHC provider. It is very important to note that if the encounter is rejected or if the plan-paid amount is not correctly completed, then the provider will either not receive a wraparound payment or will receive an incorrect wraparound payment.

Please note that when CN101 is 09, the sum of all SVD02 data elements should equal the amount in CN102.

For more information on successfully processing encounters containing plan-paid amounts, health plans can refer to the EDI companion guides.
IDENTIFIED ERRORS
IDENTIFIED ERRORS

The following are common errors identified in FQHC/RHC Encounter Data submitted to the Agency for Health Care Administration (Agency) by the health plans, during the month of October 2015.

These denials and/or billing errors impacted wraparound eligibility and affected the provider’s wraparound payment.
IDENTIFIED ERRORS

Scenario 1
CARC 170/RARC N95 – No Contract for Billed Procedures:

In this example, a professional encounter was billed under provider type 66 (RHC).

The procedure code on the encounter is 93000. This procedure code is not billable under provider type 66.

This encounter adjudicated in a denied status, and the wraparound payment was not issued to the provider.
IDENTIFIED ERRORS

Scenario 1 continued

A full listing of RHC services procedure codes are located in Appendix A of the Rural Health Clinic Services Coverage and Limitations Handbook.

The RHC handbook is available online at http://mymedicaid-florida.com. Select Provider Services and then Handbooks under the Support menu.

APPENDIX A
RURAL HEALTH CLINIC FEE SCHEDULE

CLINIC SERVICES
(Billed with the Clinic Services Provider Number)

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION OF SERVICES</th>
<th>MAXIMUM FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99385</td>
<td>Adult Health Screening, new patient, age 21-39 yrs.</td>
<td>Cost based</td>
</tr>
<tr>
<td>99386</td>
<td>Adult Health Screening, new patient, age 40-64 yrs.</td>
<td>Cost based</td>
</tr>
<tr>
<td>99387</td>
<td>Adult Health Screening, new patient, age 65 yrs. and over</td>
<td>Cost based</td>
</tr>
<tr>
<td>99395</td>
<td>Adult Health Screening, established patient, age 21-39 yrs.</td>
<td>Cost based</td>
</tr>
<tr>
<td>99396</td>
<td>Adult Health Screening, established patient, age 40-64 yrs.</td>
<td>Cost based</td>
</tr>
<tr>
<td>99397</td>
<td>Adult Health Screening, established patient, 64 yrs. and over</td>
<td>Cost based</td>
</tr>
</tbody>
</table>
**IDENTIFIED ERRORS**

**Scenario 2**
CARC 170/RARC N95 – No Contract for Billed Procedure:

- In this example, a professional encounter was billed under provider type 68 (FQHC).
- The procedure codes on the encounter were 90471 and 90472. Both procedure codes are not billable under provide type 68.
- This encounter adjudicated in a denied status, and the wraparound payment was not issued to the provider.
IDENTIFIED ERRORS

Scenario 2 continued

A full listing of RHC services procedure codes are located in Appendix A of the Rural Health Clinic Services Coverage and Limitations Handbook.

The RHC handbook is available online at http://mymedicaid-florida.com. Select Provider Services and then Handbooks under the Support menu.

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</tbody>
</table>
IDENTIFIED ERRORS

Scenario 3
CARC 96/RARC M79 – Plan Paid Zero for Non-Capitated Claim:

In this example, a professional encounter that was billed with provider type 68 (FQHC).

The CN101 segment was not equal to 05, and a plan paid amount of zero was indicated.

This encounter received a denial, and the wraparound payment was not issued to the provider.
IDENTIFIED ERRORS

Scenario 3 continued

How does the plan correctly report the plan paid price?

In order for FLMMIS to accurately calculate the provider's wraparound amount, the encounter must include a 09 in the CN101 segment, and the CN102 must include payment made by the plan to the FQHC or RHC provider. It is very important to note that if the encounter is rejected or if the plan-paid amount is not correctly complete, then the provider will either not receive a wraparound payment or will receive an incorrect wraparound payment.

Please note that when CN101 is 09 then the sum of all SVD02 data elements should equal the amount in CN102.
IDENTIFIED ERRORS

Scenario 4
CARC 208 – Multiple Service Locations for Billing Provider:

This example is a denied encounter that was billed with provider type 68 (FQHC).

The billing provider has multiple NPI crosswalks. The NPI crosswalk provided on the encounter did not map uniquely to one Medicaid Provider ID.

The encounter received a denial, and the wraparound payment was not issued to the provider. The provider should have included the unique NPI crosswalk that directly corresponds to the Medicaid ID that has a provider type of 68.
**IDENTIFIED ERRORS**

**Scenario 4 continued**

The PML displays the provider's unique NPI crosswalk, which makes a one-to-one match to their fully enrolled provider type 68.

<table>
<thead>
<tr>
<th>Florida Medicaid Provider ID</th>
<th>Florida Medicaid Provider Name</th>
<th>Provider Type Code</th>
<th>Primary Specialty Code</th>
<th>Encount only N</th>
<th>FFS</th>
<th>Registered Provider Y</th>
<th>Provider =</th>
<th>IDENTIFIED ERRORS</th>
<th>Provider NPI</th>
<th>Crosswalk NPI</th>
<th>Crosswalk Taxonomy</th>
<th>Effective Date</th>
<th>Crosswalk End Date</th>
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</table>
Scenario 5
CARC 206 – Individual/Billing Provider (Group/NPI Number(s) Billed incorrectly or Not on File

In this example, a professional encounter that was billed with provider type 68 (FQHC).

The NPI information provided on the encounter did not map to a provider in FLMMIS.

This encounter received a denial, and the wraparound payment was not issued to the provider.
IDENTIFIED ERRORS

Scenario 6
CARC 16/RARC N290 – Treating Provider Number Not on File
CARC 16/RARC MA81 – Missing Provider Number:

This example is a dental encounter that was billed with provider type 68 (FQHC).

The Rendering provider NPI information, supplied on the encounter, did not map to any providers in FLMMIS.

This encounter received a denial, and the wraparound payment was not issued to the provider.
IDENTIFIED ERRORS

Scenario 7
CARC 177 – Recipient Ineligible for Date of Service:

This example is a professional encounter that was billed for date of service 10/10/2015, provider type 66 (RHC).

The recipient does not have Medicaid coverage for the date of service billed.

This encounter received a denial, and the wraparound payment was not issued to the provider.
IDENTIFIED ERRORS

Scenario 8
Health plan indicated incorrect capitation information on the FQHC/RHC encounter:

Health plan has a non capitated relationship with the FQHC/RHC provider, but mistakenly listed a 05 in the CN1 segment and the $0 as the monetary amount, which indicates a capitated relationship.

While the encounter received a paid status, a wraparound payment was not issued to the provider. Providers that have a capitated relationship with the health plan currently are not eligible to receive wraparound payment via the automated process.

The health plan must adjust the paid encounter to reflect a 09 in the CN1 segment and the appropriate plan-paid amount. Once corrected, the provider will receive a wraparound payment, if they are eligible.
 IDENTIFIED ERRORS

Scenario 8 continued
Health plan indicated incorrect capitation information on the FQHC/RHC encounter, resulting in Provider Overpayment:

Health plan has a non capitated relationship with the FQHC/RHC provider, but mistakenly listed a 05 in the CN1 segment and the $0 as the monetary amount, which indicates a capitated relationship.

While the encounter received a paid status, a wraparound payment was not issued to the provider. Providers that have a capitated relationship with the health plan currently are not eligible to receive wraparound payment via the automated process.

The health plan must adjust the paid encounter to reflect a 09 in the CN1 segment and the appropriate plan-paid amount. Once corrected, the provider will receive a wraparound payment, if they are eligible.
WHAT DOES IT MEAN TO BE A GATEKEEPER?
Understanding FQHC/RHC Wraparound

GATEKEEPER
WHAT DOES IT MEAN?

The Agency expects health plans to act as Gatekeepers, and therefore highly encourages health plans to implement front-end editing, and not accept provider submissions that contain invalid and/or incorrect provider NPI information, ineligible Medicaid recipient information, and any other data that is non-compliant with Medicaid policy.

The following are examples of errors that are preventable and can be deterred through effective gatekeeping and/or by implementing front end edits.

- CARC 208 – Multiple Service Locations for Billing Provider
- CARC 177 – Recipient Ineligible for Date of Service
- CARC 16/RARC N290 – Treating Provider Number Not on File
- CARC 16/RARC MA81 – Missing Provider Number
- CARC 206 – Individual/Billing Provider (Group)/NPI Number(s) Billed Incorrectly or Not on File.
GATEKEEPER
WHAT DOES IT MEAN?

A Gatekeeper is expected to do the following:

- Collect and submit encounter data in accordance with industry best practices.
- Can be counted on to fulfill the encounter data submission requirements of the Contract.
- Keep sufficient information about its providers in order to ensure that those providers can be recognized as participating providers for plan selection and encounter data acceptance purposes.
- Participate in Agency-sponsored workgroups directed at improving encounter data quality and operations.
- Give the Agency sufficient information to prove that the Gatekeeper’s providers are recognized in FL MMIS, as either actively enrolled Medicaid providers or as Managed Care Plan registered providers.
- Ensure that participating network providers and non-participating providers who provide services to Managed Care Plan enrollees can be accurately identified.
TIP SHEET

Helpful Resources:

The FQHC/RHC Wraparound Tip Sheet provides information about submitting encounters that will be used in the automated FQHC/RHC Wraparound process.

Download the FQHC/RHC Wraparound Tip Sheet by navigating to the Florida public Web Portal then selecting Managed Care Support.
Helpful Resources:

DXC Technology (DXC) is here to help!

The Florida Encounter Support Team is available to assist with resolving your encounter-related concerns. Please contact the Health Plan Support team at healthplan.support@dxc.com for additional assistance or to schedule an onsite or virtual plan meeting.
QUESTIONS?
SUMMARY

In this webinar, we discussed...

• An overview of the FQHC/RHC Wraparound Process

• Identified Errors

• What it means to be a Gatekeeper
Thank you.