

**Indiana Health Coverage Programs  
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)  
Medicaid Managed Care Supplemental Payment Automation  
Effective July 1, 2021  
Frequently Asked Questions (FAQs)**

**Automation Process**

**Q: What is the FQHC/RHC Medicaid managed care supplemental payment automation?**

A: Currently, FQHC and RHC Medicaid managed care supplemental (“wrap-around” or “wrap”) payments are based upon a monthly wrap request form that is prepared by the provider and submitted to Myers and Stauffer for processing. For dates of service on or after July 1, 2021, the state’s Medicaid Management Information System (CoreMMIS) will process the Medicaid managed care wrap payments automatically based upon claims transmitted by the Medicaid managed care entities (MCEs) to CoreMMIS. Please see the Indiana Health Coverage Programs (IHCP) bulletin, BT02144 for additional information.

**Q: How often will wrap payments be processed by CoreMMIS?**

A: Wrap payments will be processed by CoreMMIS on a weekly schedule based upon the encounter data received from the MCEs.

**Q: Which Medicaid managed care programs are included in the wrap payment automation?**

A: The Medicaid managed care wrap payment automation includes the Hoosier Healthwise (HHW), Hoosier Care Connect (HCC), and Healthy Indiana Plan (HIP) programs.

**Q: When will the Medicaid managed care wrap payment automation process be implemented?**

A: The Medicaid managed care wrap payment automation CoreMMIS go-live date for medical and behavioral health claims is July 1, 2021, and the anticipated CoreMMIS go-live date for dental claims is August 25, 2021. This change is effective for all claims with dates of service on or after July 1, 2021.

**Q: What services does the Medicaid managed care wrap automation process include?**

A: The Medicaid managed care wrap automation process includes all Medicaid covered services provided by FQHC and RHC providers, except for services provided in an inpatient hospital or outpatient hospital setting and services provided to Medicare/Medicaid dual eligible members.

**Q: Traditional Medicaid Fee-for-Service (FFS) dental claims were previously included in the historical wrap payment process. Will the FFS dental claim payments also be automated?**

A: Yes, payments for Indiana Medicaid FFS dental claims will be automated for claims with dates of service on or after July 1, 2021.

**Q: How has the Medicaid managed care wrap payment automation process been tested to ensure cash flow to the FQHC/RHC is not negatively impacted?**

A: CoreMMIS was tested using various test scenarios and test claims.

**Q: How will retroactive changes to the prospective payment system (PPS) rate be processed, e.g. PPS rate changes resulting from the establishment of the final PPS rate or a change in scope of service?**

A: For PPS rate changes impacting claims with dates of service before July 1, 2021, the current wrap request and year-end settlement process will be utilized. For PPS rate changes impacting claims with dates of service on or after July 1, 2021, the wrap payment will be made through the automated process.

**Q: If a monthly wrap request is not submitted to Myers and Stauffer for dates of service prior to July 1, 2021, how will the wrap payment be received?**

A: Year-end reconciliations will be performed for dates of service prior to July 1, 2021. If monthly wrap requests are not submitted to Myers and Stauffer, the encounters will be included in the year-end reconciliation.

**Q: Will year-end reconciliations be necessary for dates of service on or after July 1, 2021?**

A: The year-end reconciliation process (in the current format) will not be necessary for dates of service on or after July 1, 2021. On-going monitoring of the automated system for accuracy and completeness may be implemented for dates of service on or after July 1, 2021.

**Q: Each year, the IHCP publishes a list of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes that represent an FQHC or RHC encounter. The list is updated annually, effective January 1, for the addition and/or removal of encounter codes. How will providers receive payment for the new encounter codes when the recognition of encounter code changes occurs after January 1?**

A: Gainwell Technologies will mass adjust claims with dates of service retroactive to January 1 of each year for the addition of the new encounter codes for the year.

**Q: Due to dental claim form billing restrictions, global dental procedure codes require the actual number of encounters incurred be reported manually. How will wrap payments for global dental procedure codes be processed?**

A: Myers and Stauffer will identify Medicaid FFS and Medicaid managed care dental claims billed with a global dental procedure code. On an annual basis, Myers and Stauffer will contact providers to identify the appropriate number of additional encounters in order to calculate a settlement payment for the provider.

**Q: Dental claims are submitted to Envolve Dental and/or DentaQuest. Will the MCEs submit the dental claims to Gainwell on behalf of Envolve Dental and/or DentaQuest?**

A: Yes. The MCEs will transmit the dental claims to CoreMMIS.

## **T1015 and D9999 Procedure Codes**

### **Q: What is the T1015 procedure code?**

A: The T1015 procedure code is the procedure code that prompts CoreMMIS to process the wrap payment for medical and behavioral health claims. The T1015 procedure code must be included on each Medicaid managed medical and behavioral health care claim for dates of service on or after July 1, 2021. However, the T1015 procedure code should not be included on claims in which the service was not rendered by an eligible practitioner as listed in the IHCP Federally Qualified Health Centers and Rural Health Clinics Provider Reference Module.

### **Q: What is the D9999 procedure code?**

A: The D9999 procedure code is the procedure code that prompts CoreMMIS to process the wrap payment for dental claims. The D9999 procedure code must be included on each Medicaid managed care dental claim for dates of service on or after July 1, 2021. However, the D9999 procedure code should not be included on claims in which the service was not rendered by an eligible practitioner as listed in the IHCP Federally Qualified Health Centers and Rural Health Clinics Provider Reference Module.

### **Q: Should the D9999 procedure code be included on Medicaid FFS dental claims?**

A: Yes. The D9999 procedure code is the procedure code that prompts CoreMMIS to process the PPS rate payment for dental claims. The D9999 procedure code must be included on each Medicaid FFS claim for dates of service on or after July 1, 2021.

### **Q: Can more than one claim per member, per date of service be filed using the T1015 and/or the D9999 procedure code?**

A: Reimbursement for FQHCs and RHCs is limited to one encounter per member, per date of service, unless the primary diagnosis code differs. If the primary diagnosis code differs, each distinct and qualifying encounter should be billed on a separate claim.

### **Q: What if the T1015 or the D9999 procedure code is not included on the Medicaid managed care claim?**

A: If the T1015 or D9999 procedure code is not included on the Medicaid managed care claim, the MCE will pay the claim in accordance with the MCE's fee schedule, and the wrap payment will not be remitted to the provider. In order to receive the wrap payment, the original claim should be voided and a replacement claim should be submitted to the MCE that includes the T1015 or D9999 procedure code.

### **Q: Have the MCEs confirmed their systems are ready to accept the T1015 and D9999 procedure code?**

A: Yes, the MCEs have confirmed their systems are ready for this change.

### **Q: When billing the T1015 and D9999 procedure code, what should be the amount of the billed charge associated with these procedure codes?**

A: It is not necessary to include a billed charge for the T1015 and D9999 procedure codes. The MCEs will pay the T1015 and D9999 procedure code detail lines at \$0, regardless of the associated billed charge.

**Q: Should the T1015 and D9999 procedure codes be included on claims for dates of service prior to July 1, 2021?**

A: No. Providers should not include the T1015 and D9999 procedure codes on claims with dates of service prior to July 1, 2021.

**Q: Should the T1015 and D9999 procedure codes be included on claims that do not include a valid encounter code from the FQHC/RHC Valid Encounter Code Listing?**

A: Yes. Providers should include the T1015 or the D9999 procedure code on all claims, except for claims in which the services were not rendered by an eligible practitioner as listed in the IHCP Federally Qualified Health Centers and Rural Health Clinics Provider Reference Module.

**Q: Are there any requirements regarding which claim detail line should include the T1015 or D9999 procedure codes?**

A: No. The T1015 or D9999 procedure code can be included on any detail line of the claim.

**Q: If the D9999 procedure code is added to dental claims with dates of service on or after July 1, 2021 before the anticipated CoreMMIS go-live date of August 25, 2021, will the claims be denied or rejected by the MCE?**

A: The D9999 procedure code will not be denied by the MCE prior to the CoreMMIS go-live date of August 25, 2021. However, the wrap payment will not be calculated and remitted to the provider until the anticipated CoreMMIS go-live date of August 25, 2021. All Medicaid FFS and Medicaid managed care claims with dates of service between July 1, 2021 and the anticipated go-live date of August 25, 2021 will be reprocessed by Gainwell Technologies for purposes of calculating and remitting the wrap payment to the provider.

## **Wrap Payments and Wrap Report**

**Q: How will wrap payments be communicated to the FQHCs and RHCs?**

A: FQHCs and RHCs will receive a provider remittance advice entitled, 'Wrap Around Services Expenditures' ("wrap report") each week. The wrap report will include information regarding the MCE, the claim, the recipient, and the wrap payment.

**Q: Will the wrap payment be calculated for each patient so that payments can be posted directly to each patient's account?**

A: Yes. The wrap payments will be calculated on a per-claim basis.

**Q: Will the Indiana Medicaid recipient identification number be included on the wrap report?**

A: Yes. The wrap report will include the Indiana Medicaid recipient identification number.

**Q: Will the MCE recipient identification number be included on the wrap report?**

A: No. The wrap report will not include the MCE recipient identification number.

**Q: Will the wrap report be separated by clinic billing provider (i.e. service location)?**

A: Yes. The wrap report will include a separate section for each clinic billing provider.

**Q: Will the wrap report include the MCE and third party payer amounts?**

A: This field will be added to the wrap report at a future date.

**Q: Can FQHCs and RHCs request additional fields be included on the wrap report?**

A: Yes. The state will consider additional fields requested by the FQHCs and RHCs for inclusion on the wrap report.

**Q: Will the wrap report be available via 835 remittance advice transactions?**

A: The wrap report will be included as part of the remittance advice.

**Q: Will the wrap report be available in Excel format?**

A: No. The wrap report is not available in Excel format.

**Q: Will the MCE denied claims be included on the wrap report?**

A: MCE denied claims will not be included on the wrap report.

## **Other**

**Q: Indiana Medicaid will require Anthem to use the Indiana Medicaid recipient identification number on the Anthem remittance advices in the future. When will this change be effective?**

A: For HCC, Anthem began reporting the Indiana Medicaid recipient identification number on remittance advices issued on or after April 1, 2021. Anthem is in the process of implementing this change for the HHW and HIP programs.

**Q: The CMS 1500 claim form includes a rendering provider identification number field (field J). Should a rendering provider national provider identifier (NPI) be included in this field?**

A: The CMS 1500 claim form should be completed in accordance with each MCE's billing guidelines regarding the inclusion of the rendering provider identification number in this field.

**Q: If a wrap payment is not calculated for a claim, will the reason the wrap payment was not calculated be communicated to the provider?**

A: Yes. Three new explanation of benefit (EOB) codes have been added to CoreMMIS to notify providers when a wrap payment is not calculated. Please see IHCP bulletin BT202144 for a listing and description of the wrap automation EOB codes.

**Q: If an MCE adjusts a claim, and the adjustment results in a recoupment of a previously issued wrap payment, will the recoupment be communicated to the provider?**

A: Yes. Two new accounts receivable (A/R) codes have been added to CoreMMIS to notify providers when a wrap payment has been recouped. Please see IHCP bulletin BT202144 for a listing and description of the wrap automation A/R codes.

**Q: If CoreMMIS does not process the MCE claim and/or calculate the wrap payment correctly, will providers have the ability to edit the claim in CoreMMIS?**

A: No. Providers will not be able to edit the MCE claim in CoreMMIS. If CoreMMIS does not correctly calculate the wrap payment, please contact Gainwell Technologies.