UCare FQHC/RHC Payment Carve-Out Process: Provider Frequently Asked Questions (FAQs)

July 30, 2015

Q. I’m new to the FQHC/RHC process. Where can I find more information on this new process?
A. Please refer to the letter UCare mailed in February 2015 to impacted providers as well as to this follow up UCare Bulletin dated March 3, 2015.

Q. What products are included in the Carve-Out and will be paid the Encounter Rate by DHS?
A. Minnesota Health Care Plan (MHCP) members who have Prepaid Medical Assistance Program (PMAP), MinnesotaCare, MSC+ (non-duals), or UCare Connect (non-duals) are included in the Carve-Out process. This new process does not apply to claims for members who are eligible for Medicare, with the exception of dental services. This means, with the exception of dental services, this process does not apply to claims for individuals enrolled in:
  - UCare Minnesota Senior Health Options (MSHO).
  - UCare Minnesota Senior Care Plus (MSC+) who are eligible for Medicare.*
  - UCare Connect (Special Needs Basic Care) who are eligible for Medicare.*

* Medicare eligibility can be confirmed in MNITS. All MSHO members are Medicare eligible.

Q. Other than those MHCP members eligible for Medicare, are there any other exceptions?
A. Yes, ‘MinnesotaCare Adults without Children’ are also excluded from the Carve-Out. They are identified in DHS MN-ITS by DHS Major Program Code ‘BB’. Effective July 1, 2015, Managed Care Organizations (MCOs) will no longer submit claims for these members to DHS for processing and payment. Minnesota’s authority from CMS does not support DHS making the encounter rate payment to FQHC and RHC providers for members in this program.

Q. Why, after UCare processes a claim, and sends the claim to DHS, does DHS deny a claim and indicate the “Patient cannot be identified as our insured” (CARC 31) and the PMI number = 0000000?
A. The following message was placed in June 2015 by DHS on the DHS-FQRHC-CARVEOUT ListServ:
“It has been brought to our attention some providers are completing the Patient/Dependent Loop in addition to the Subscriber Loop. Since every MHCP recipient can be uniquely identified with our recipient ID (PMI), NEVER send the Patient/Dependent Loop.”

UCare worked with impacted providers in June and July of 2015 to do a one-time clean-up of these claims. Going forward, providers should submit claims information in the Patient/Subscriber loop. If claim information is included in the Dependent loop, UCare will process these claims, but DHS will deny them. If a provider’s claim is denied by DHS for this reason, the provider will then need to send a Void claim to UCare, wait for that to be processed, and then submit an original claim to UCare using the Patient/Subscriber Loop, which UCare will then send to DHS. (See below for further information on how and when to submit Replacement and Void claims for FQHC/RHC processing.)
Q. What could cause some claims to be processed using the Patient/Subscriber Loop and other claims to be processed with the Patient/Dependent Loop?
A. UCare believes identifying someone other than the patient as the responsible party in your Patient Management System/Electronic Health Record system may cause the Subscriber claim line detail to be put in the Dependent Loop. UCare cannot speak to the specifics of your PMS/EHR system, but a pattern we have seen with claims with Subscriber claim line detail in the Dependent Loop is that the patients tend to be children or disabled adults.

Q. Should Replacement claims or Void claims be submitted for FQHC/RHC processing?
A. It varies depending on the scenario. Four examples are listed below for guidance. Although UCare prefers Replacement claims, DHS states they prefer Void claims for FQHC/RHC processing. DHS has also commented that it takes them longer to process Replacement claims over Void claims.

Scenario 1:
FQHC/RHC submits claim to UCare with incorrect site NPI. UCare identifies the claim as belonging to a FQHC/RHC, processes the claim and submits the claim to MHCP. MHCP makes encounter payment on claim. FQHC/RHC realizes their mistake and wants to submit claim with correct site NPI to MHCP.

DHS: “MHCP must receive a void for the MHCP paid claim and then must receive new claim submission. Initial claim must be voided since the NPI is different. Due to Federal Regs, we do not have the authority to replace/change an NPI on a paid claim.”

UCare: As DHS must receive a voided claim, providers need to submit a Void claim (bill frequency 8) to UCare. We will process the void claim and send the claim to DHS with the same bill frequency. Once the provider receives the RA/835 indicating the claim has been voided by UCare, the provider will then need to submit an original claim, with the correct NPI, to UCare.

Scenario 2:
FQHC/RHC submits a claim to UCare. UCare processes the claim and submits the claim to MHCP. MHCP denies the claim due to an internal system issue. MHCP system issue is fixed and FQHC/RHC needs to re-submit the claim.

UCare: As DHS requires a re-submission, providers need to submit a Void claim (bill frequency 8) to UCare. We will process the void claim and send the claim to DHS with the same bill frequency. Once the provider receives the RA/835 indicating the claim has been voided by UCare, the provider can submit a new claim to UCare.

Scenario 3:
FQHC/RHC submits claim to UCare. UCare processes the claim and submits the claim to MHCP. MHCP approves three lines and denies one line. FQHC/RHC wants to correct the one line on the claim.

DHS: Since MHCP approved three lines on the claim, MHCP must receive a Replacement claim with the three approved lines and one corrected line.

UCare: Providers should submit a Replacement claim (billing frequency 7) to UCare. We will process the Replacement claim and send the claim to DHS with the same bill frequency.

Scenario 4:
FQHC/RHC submits claim to UCare. UCare denies all lines back to FQHC/RHC and does not submit the claim to MHCP. FQHC/RHC realizes their mistake and wants to correct the claim.

UCare: Providers should submit a Replacement claim (billing frequency 7) to UCare. We will process the Replacement claim and send the claim to DHS with a bill frequency of 1 (original claim).
Q. On Void and Replacement claims, do I enter DHS’ TCN or UCare’s ICN, to identify which claim is being updated?
A. For claims that were submitted to MHCP from UCare, you will need to enter both DHS’ TCN and UCare’s ICN on Void and Replacement claims.

To submit a replacement or void claim for claims that were submitted to MHCP, enter the Transaction Control Number (TCN – DHS’s claim #) in box 22 or in Loop 2300/REF02 with qualifier ‘F8’ on the 837. Enter UCare’s Internal Control Number (ICN – UCare’s claim #), in box 19 or in Loop 2300/NTE02 with qualifier ‘ADD’.

For claims denied by UCare, that were never submitted to MHCP, enter UCare’s ICN in box 22 or in Loop 2300/REF02 with qualifier ‘F8’ on the 837.

Q. Why did my Replacement claim get denied by UCare for ‘Missing TCN’ when my Original claim was denied by UCare and never submitted to MHCP to get a TCN?
A. This is likely a manual processing error at UCare. Please call UCare’s Provider Assistance Center at 612-676-3300 or 1-888-531-1493 for resolution.

Q. Why is DHS denying my claims for C&TC (completed Child & Teen checkup)?
A. UCare has not properly processed claims with service lines with a $0.00 or $0.01 charge, or a service line with a SL modifier (e.g. no charge – State supplied vaccine), and is making system changes to correct the issue. Until the correction is in place, we are requesting providers to hold these claims because MHCP will deny these claims for not having a completed C&T.

As part of correcting this issue for future claims, UCare will also identify a process for correcting the claims submitted to date.

Q: I received an adjustment from UCare on a claim that was already approved and submitted to DHS. UCare’s RA/835 for the adjusted claim shows a CARC code of ‘16’ and a RARC code of ‘N463’. Those codes aren’t specific enough for me to understand why the claim was adjusted.
A: Although this doesn’t occur frequently, one explanation may be that DHS has corrected/updated the member’s PMI #. When this occurs, all paid claims against the ‘old’ or ‘incorrect’ member’s PMI must be re-processed by the MCO’s. For FQHC/RHC claims, UCare processes an adjustment to void out the claim(s) internally. FQHC/RHC providers will need to submit a corrected, original claim with the member’s new PMI number. This updated claim, with the new PMI number, will be processed by UCare and submitted to DHS for FQHC/RHC processing and payment.

Please call UCare’s Provider Assistance Center at 612-676-3300 or 1-888-531-1493 if you have questions when you don’t understand why UCare adjusted a previously processed claim.

Q. How does UCare make payments on code S0302 for C&TC claims (Completed Child & Teen Checkup) ?
A. Per DHS’ FQHC/RHC guidelines, the S0302 C&T code is excluded from FQHC/RHC Carve-Out processing. This code will continue to be paid by UCare, not DHS, if there is language in your UCare Contract specific to the payment of this code/process. Providers should continue to bill UCare their contracted rate. UCare will retroactively process and pay claims from providers who have billed this code on claims with a date of service (DOS) on or after 01/1/15 per the contractual agreement. The adjustment of these claims will begin sometime in the third quarter of this year and may take several weeks to complete.

Q: Where can I find the copay information to process claim payments?
A. MCOs are required to provide FQHC/RHC Payment Carve-Out claim copay detail to DHS quarterly. DHS will then make gross adjustments that will be reflected on provider RAs with enough detail for providers to process payments within their system. UCare’s RA/835 for providers also contains this information by claim.
Q: **How is FQHC/RHC Provider Based Billing handled under the FQHC/RHC Payment Carve-Out?**

A. For the Professional Fees, the FQHC/RHC should bill those charges on a Professional (1500) form using the FQHC/RHC NPI as the Billing Provider. (The Rendering Provider should be the Doctor/Practitioner proving the service.) This should be done for professional fees generated by FQHC/RHC providers in any setting including emergency room, inpatient, outpatient or clinic settings. UCare then sends these claims to DHS as part of the FQHC/RHC Payment Carve-Out process and DHS will make payment to the FQHC/RHC provider.

Facility Fees should be billed on the Institutional (UB) form using the Hospital’s NPI as the Billing Provider. UCare will pay the Hospital as usual. These will not be processed under the FQHC/RHC Payment Carve-Out process.

Q. **Why have I been paid by both UCare and DHS for Medical Home Health Codes S0280 and S0281? Who should be reimbursed?**

A. Medical Home Health Codes S0280 and S0281 are not supposed to be included in the FQHC/RHC Payment Carve-Out process and should be paid by the MCO’s. However, during the first half of 2015, UCare mistakenly passed some of these claims through this process. As of June 2015, UCare corrected our edits on these claims and this should no longer be an issue for providers.

DHS has mass adjusted these claims and recovered the payments made to providers in error. They also added edits in their system to not pay on these codes going forward if these codes are inadvertently sent as part of the FQHC/RHC process.

Q. **Why are my claims with Global Surgical Codes being denied by MHCP?**

A. DHS has asked providers to hold off on sending in claims with Global Surgical Codes when modifiers 54, 55, and 56 are used. DHS has reviewed the policy and will be updating its manual and making system changes to accommodate the use of these modifiers on claims. DHS has not provided a date when their system updates will be complete and when providers can begin submitting these types of claims for processing.

Comments from DHS: “To receive payment on pre- and post-operative surgical and maternity care services only, submit E&M procedure codes that best describe the level of service for each date of service (DOS). Do not use modifiers 54, 55, or 56 on E&M codes – but other applicable modifiers can be used. Continue to use surgical codes with applicable modifiers, but not for the care surrounding the surgery.”

Q. **Why are my claims that require attachments (e.g. Sterile Consent Forms) being denied by DHS? I faxed the documents to UCare and UCare approved the claim.**

A. DHS is asking providers to fax the document(s) to both the MCO and to DHS. The cover sheet to the MCO should include the MCO’s member ID, and the cover sheet to DHS should include the Medicaid Recipient ID (PMI).

Q. **Who do we call if we have questions regarding this process?**

A. If you have a question on a remittance advice (RA)/835 received from UCare, call **UCare’s Provider Assistance Center at 612-676-3300 or 1-888-531-1493**. When you call UCare’s Provider Assistance Center (PAC) be sure to tell the representative you are calling about a claim related to the FQHC/RHC Payment Carve-Out process.

If you have a question on an RA/835 received from DHS, call **MHCP’s Provider Call Center at 651-431-2700 or 1-800-366-5411**