

# **Provider Network News**

# Wrap Payment Process and Methodology

To align with Texas Health and Human Services (HHSC), contract and direction to Federally Qualified Health Centers (FQHC) Wrap Payment methodology, PCHP will initiate claims system modifications for FQHC claims. Payments to PCHP contracted FQHC providers for services rendered to Medicaid clients must be equal to the federal established prospective payment system (PPS) encounter rate. To ensure accurate claims processing and claims reimbursement the following claim billing elements are required.

#### **FQHC Claim Billing Requirements:**

- FQHC claims must be submitted on CMS 1500 claim form
- POS must be 50
- Box 24J Requires Rendering provider NPI/Taxonomy code
- Box 33 Requires Billing provider's name and address
  - o 33a Billing taxonomy 261QF0400X
  - o 33b Billing NPI
- 32 Service Facility location of service
  - o 32a Location of services facility NPI
  - o 32b Services facility taxonomy code
- Must bill T1015 on the first line of the claim as the indicator of FQHC Wrap Around Payment
  - o T1015 must be billed with applicable modifiers such as AH, AJ, AM, SA, TD, TE, TH, U1, U2 or U7 (EP modifier must be used for THSTEPS in addition to the required modifiers)
  - o T1015 charge amount must be the difference between the contracted rate of \$70.00 less the PPS.
  - o T1015 must be followed by the applicable E&M procedure code for the sevices provided with applicable modifiers and charge amount \$70.00. Case Management services must be reported with HCPC G9012 and applicable modifiers G2 or U3 in addition to T1015.
    - Example of Medical claim
      - T1015 AM charge amount is PPS rate \$147.22 less contracted rate \$70.00 = \$77.22
      - 99212 AM charge amount = contracted rate \$70.00
    - Example of Case Management
      - T1015 U2: \$77.22
      - G9012 U2: \$70.00
    - Reimbursement
      - FQHCs are paid an all-inclusive rate per visit for payable services except for Long-Acting Reversible Contraception (LARC) procedure codes J7297, J7298, J7300, J7301 and J7307, \*postpartum procedure code 59430, and Obstetric delivery services procedure codes 59409, 59612, 59514, 59620
        - \*Effective 02/01/2024, postpaturm is reimbursed as part of Wrap Around for CHIP Perinate members only
      - Example of reimbursement
        - T1015:AM charge amt \$77.22
        - 99212:AM charge amount \$70.00 = \$70.00
      - Total claim payment = full PPS \$147.22



### **1. Acute Care Visit**

EALTH INSURANCE CLAIM FORM		
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MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA. OTHER	1a. INSURED'S I.D. NUMBER (For Program in tham 1)
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PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
Y STATE	8. RESERVED FOR NUCC USE	CITY STATE
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	YES NO	MM DO YY M F
ESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (Bate)	5. OTHER CLAIM ID (Designated by NUCC)
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ESERVED FOR NUCCUSE	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
ISURANCE PLAN NAME OR PROGRAM NAME	10d. CLAM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
	and the second second second second	YES NO If yes, complete items 9, 9a, and 9d.
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#### 2. THSTEPS

HEALTH INSURANCE CLAIM FORM	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	
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a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)	CITY STATE ZIP CODE TELEPHONE (Indude Area Code) ( ) 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BRITH b. OTHER CLAIM ID (Designated by NUCC) b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENERIT PLAN?
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (Sate)	b. OTHER CLAIM ID (Designated by NUCC)
C. RESERVED FOR NUCCUSE C. OTHER ACCIDENT?	C INSURANCE PLAN NAME OF PROGRAM NAME
YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	YES NO Byes, complete items 9, 9a, and 93.
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14. DATE OF CUPRENT ILLNESS, INJURY, & PREGNANCY (LMP) 15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
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17. NAME OF REFERRING PROVIDER OR OTHER BOURCE 178.	18. HOGPITALIZATION DATES RELATED TO CURRENT SERVICES
17.b. NPI 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	PROM TO 20. OUTSIDE LAB? & CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate AL to service line below (24E) ICD ind	22. REPLEMISSION ORIGINAL REF. NO.
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apply to this bill and are made a part thereof.) 111 ONE STREET	111 ONE STREET
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NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-12)



# 3. Postpartum for CHIP Perinate

EALTH INSURANCE CLAIM FORM			
ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			
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MEDICARE MEDICAID TRICARE CHAMPVA (Modicared) (Minicardd) (2040/204) (Menter Olif)	(IOW)	1a. INSURED'S I.D. NUMBER (For Pro	gram is Barn 1)
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ISURANCE PLAN NAME OF PROGRAM NAME 10d. CI	LAM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
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PATEINTS CR AUTHORIZED PERSON'S SIGNATURE I authorize the release o b process this claim. I also request payment of government benefits either to mysell solow.		payment of medical benofits to the undersigned physic services described below.	ian or supplier for
	DATE	SIGNED	
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NAME OF REFERRING PROVIDER OR OTHER BOURCE 178.		18. HOSPITALIZATION DATES RELATED TO CURRENT MM OD YY NM FROM TO	DD YY
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INCLUDING DEGREES OR CREDENTIALS ABC TX HEALTH CEN		ABC TX HEALTH CENTER	
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NUCC Instruction Manual available at: www.nucc.org-PLEASE PRINT OR TYPE



## 4. Postpartum for Medicaid Members

ALTH INSURANCE CLAIM FORM		
IOVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/1		
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	Self Spouse Child Other	
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THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOVMENT? (Current or Previous)	N NOUREN'S DATE OF BRTH BEX
ESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIMID (Designated by NUCC)
	YES NO	
SERVED FOR NUCCUSE	C. OTHER ACCIDENT?	E. INSURANCE PLAN NAME OR PROGRAM NAME
SURANCE PLAN NAME OR PROGRAM NAME	10d. CLAM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	The common course (congrated by the cost	YES NO J/yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize the process this claim. Laiso request payment of government torvetits either context.		payment of medical benefits to the undersigned physician or supplier for services described below.
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IGNED	OTHER DATE	BIGNED
M I DD I VY	MAL MM DO YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
AME OF REFERRING PROVIDER OR OTHER BOURCE 1	8.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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# 5. LARC Services

ALTH INSURANCE CLAIM					
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(Medicare#) 🔄 (Medicaid#) 🔄 (ID#/DoD#)	(Member IDA) (IDA	#) (10#) (10#) (10#)			
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		YES NO			
SURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIN	I CODES (Designated by NUCC)	d. IS THERE ANOTHER HEAL		
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ATIENT'S OR AUTHORIZED PERSON'S SIGNATU	RE I authorize the release of an	y medical or other information necessary	payment of medical benefits		
i process this claim. I also request payment of govern slow.	ent tenens einer to myser or t	o ne party who accepts assignment	services described below.		
KINED		ATE	SIGNED		
ATE OF CURRENT ILLNESS, INJURY, or PREGN	NCY (LMP) 15. OTHER DAT	E IN DO INV	16. DATES PATIENT UNABLE	TO WORK IN CU	REENT OCCUPATION
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B		D. L	23. PRIOR AUTHORIZATION I	UMBER	
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IGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE FACILITY LCC		3. BILLING PROVIDER INFO		
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pply to this bill and are made a part thereof.)	111 ONE STREET		111 ONE STREET		
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