Researching Supplemental (WRAP) – KYHealthNet

FQHC, RHC & CCBHC – MCO Encounters

Overview: The Department for Medicaid Services (DMS) made changes to KYHealthNet to help Federally Qualified Health Center (FQHC), Rural Health Center (RHC) and Certified Community Behavioral Health Center (CCBHC) providers to lookup both encounters and supplemental (WRAP) claims. This document will provide some tips to assist the provider billing staff in tracking reasons for missing WRAP payments for claims submitted to managed care organizations (MCOs).

Definitions:

Threshold Edit (Failed encounter) – An MCO encounter must pass a series of edits and audits (threshold edits) to be accepted by the Kentucky Medicaid Management Information System (MMIS). An MCO encounter that failed a threshold edit will not trigger a WRAP payment. Threshold encounters are purged from KYMMIS periodically and will only appear in KYHealthNet for a short amount of time.

Encounter Patient Account Number (PAN) – The value displayed in KYHealthNet as Encounter Patient Account Number is the MCO ICN assigned to the encounter. It is not the provider's Patient Account Number. This number may not match the ICN number associated with the remittance advice for the provider claim. This number is used by the MCO to research the encounter submitted to MMIS.

Medical Record Number (MRN) – The medical record number on an encounter is the provider's Patient Account Number that the provider sent to the MCO on the electronic claim. To assist providers with auto-posting of the WRAP payment, MMIS moves the MRN submitted on the encounter to the Patient Control Number (CLP01) on the WRAP remittance advice. This is the same information in Box 26 on a paper claim.

MMIS ICN: Understanding the MMIS ICN helps in unlocking time and events. The ICN follows a specific pattern to track claims and encounters in MMIS. ICN numbers starting with 7 are MCO encounters and ICN numbers starting with 8 are supplemental claims.

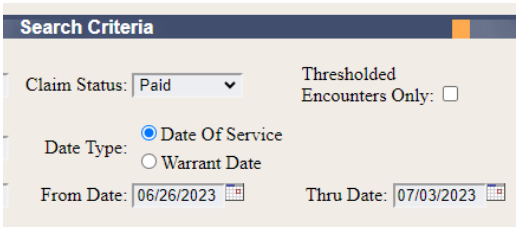
- First and Second Digits: Type of claim and submission source
  - 75 = Original Encounter (an encounter that has not been previously accepted)
  - 76 = Adjusted Encounter (used to replace a previously accepted encounter)
  - 77 = Voided Encounter (used to void or cancel a previously accepted encounter)
  - 85 = Supplemental Claim (WRAP claim)
  - 86 = Adjusted Supplemental claim
  - 87 = Voided Supplement claim
  - 88 = Mass Adjustment to Supplemental claim
- Third and Fourth Digits: Year encounter received by MMIS
  - 23 = Year 2023

- Fifth – Seventh Digits: Julian date encounter received by MMIS
  - 001 = represents January 1 and 031 represents January 31st
  - Online Julian calendar for 2023: https://www.calendarlabs.com/templates/2023/2023-yearly-julian-calendar-04.pdf
- Remaining Digits: Sequential for within the batch

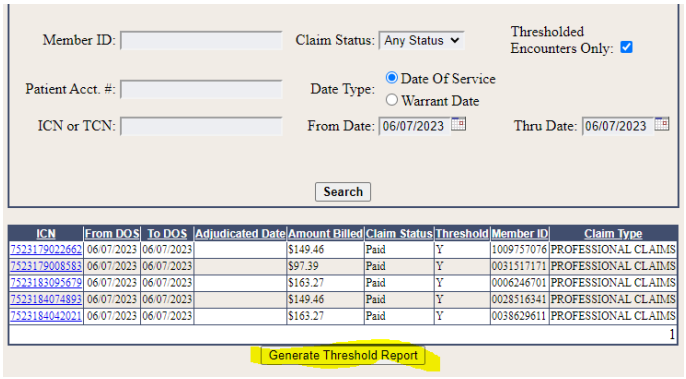
TIMELINE:

Reconciling Supplemental Payments should occur between 30 - 45 calendar days from the date the claim was paid by the MCO. KYHealthNet will show accepted and threshold encounters. *NOTE: If reconciliation has not been completed before 90 days, KYHealthNet Claims Inquiry lookup may not have all the threshold encounters.*

- Day 1: Date of MCO payment for services
- Day 38: Accepted encounter should be in KYHealthNet.
  - KYHealthNet Tip - Claim Inquiry link, select Claim Status equals Paid and Date Type by Date of Service (*limit days because the system can only return 500 lines*)
    - After results appears, click on Member ID to sort by Member

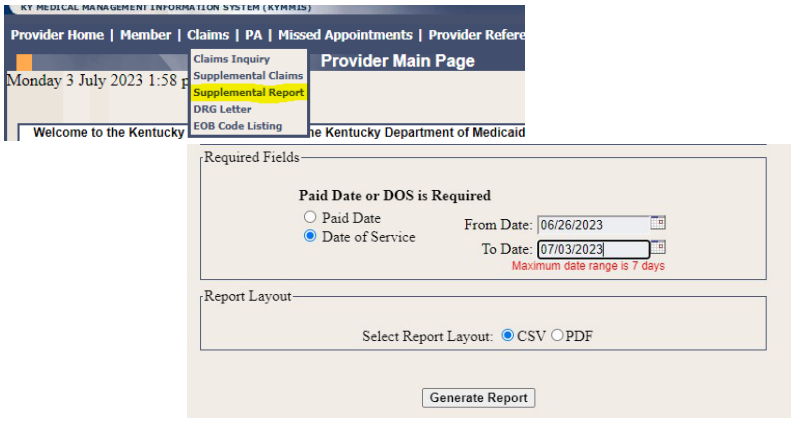


  - KYHealthNet Tip – Checking "Threshold Encounters Only" box will show the MCO Encounters that have errors. Clicking "Generate Threshold Report" will provide as .csv file to share with MCOs



  - PROVIDER NOTE: If the provider received payment from the MCO for a claim, there should be a paid encounter in the MMIS system within 30 days. If not, contact the MCO.

- Day 45: Supplemental Report can be run to see all the WRAP payments. (Use Chrome browser)
    - Providers should run the report by Date of Service to match back to practice management systems daily charges.



Communicate to MCO – Provider questions about missing WRAP payments or threshold encounters should be submitted via email and include the *Supplemental Claims Inquiry Spreadsheet* of the payments in question. It is important to include the date of Provider EOB and remittance information. Table 1 provides a list of information needed to assist in researching.

Email Subject Line: **FQHC/RHC Action Required**

DMS Contact Information:

DMS WRAP Workgroup - DMSWrapquestions@ky.gov

MCO Contact Information:

Aetna
- KYProviderRelations@aetna.com

Anthem
- AnthemKY-WRAPInquiry@anthem.com

Humana
- KYMCDPR@humana.com

Passport by Molina
- Meredith.Norris@molinahealthcare.com,
- Della.Whitworth@molinahealthcare.com

Wellcare
- ky_providerrelations@wellcare.com

UnitedHealthCare
- angela.mcgraw@uhc.com
- Unlock the power of chat - UnitedHealthcare (uhcprovider.com)

Table: 1 – Supplemental Claims Inquiry Spreadsheet *(requested columns)*

Member Information
Member Medicaid ID
Member Name
Provider Information
Billing NPI
Rendering NPI
Billing Taxonomy
Billing Tax ID
Claim Information
MCO Claim # (from MCO explanation of benefits)
DMS MCO Encounter ICN # (found in KYHealthNet)
Date of Service
MCO Paid Amount
MCO Paid Date
Other Insurance (Third Party Liability) if applicable
Other Insurance Payer Type (Commercial, Medicare, Workers Comp, Other Liability)
Other Insurance Primary, Secondary
Other Payer COB Paid Amount
Other Payer COB Coinsurance and Deductible
Issue (No Wrap Payment, Wrap Payment Underpaid, or Wrap Payment Overpaid)

Understanding Claims Summary screen –

Other things to consider while researching -

Why did I not receive my expected amount on the WRAP payment?

- ✶ TPL amount paid and/or MCO paid amount greater than per diem.
- ✶ Medicare crossover claim did not include a coinsurance or deductible.
  - Medicare Advantage claims should have payer type 16
  - Medicare Part A claims should have payer type MA
  - Medicare Part B claims should have payer type MB

Why do I keep getting my WRAP payment recouped and repaid?

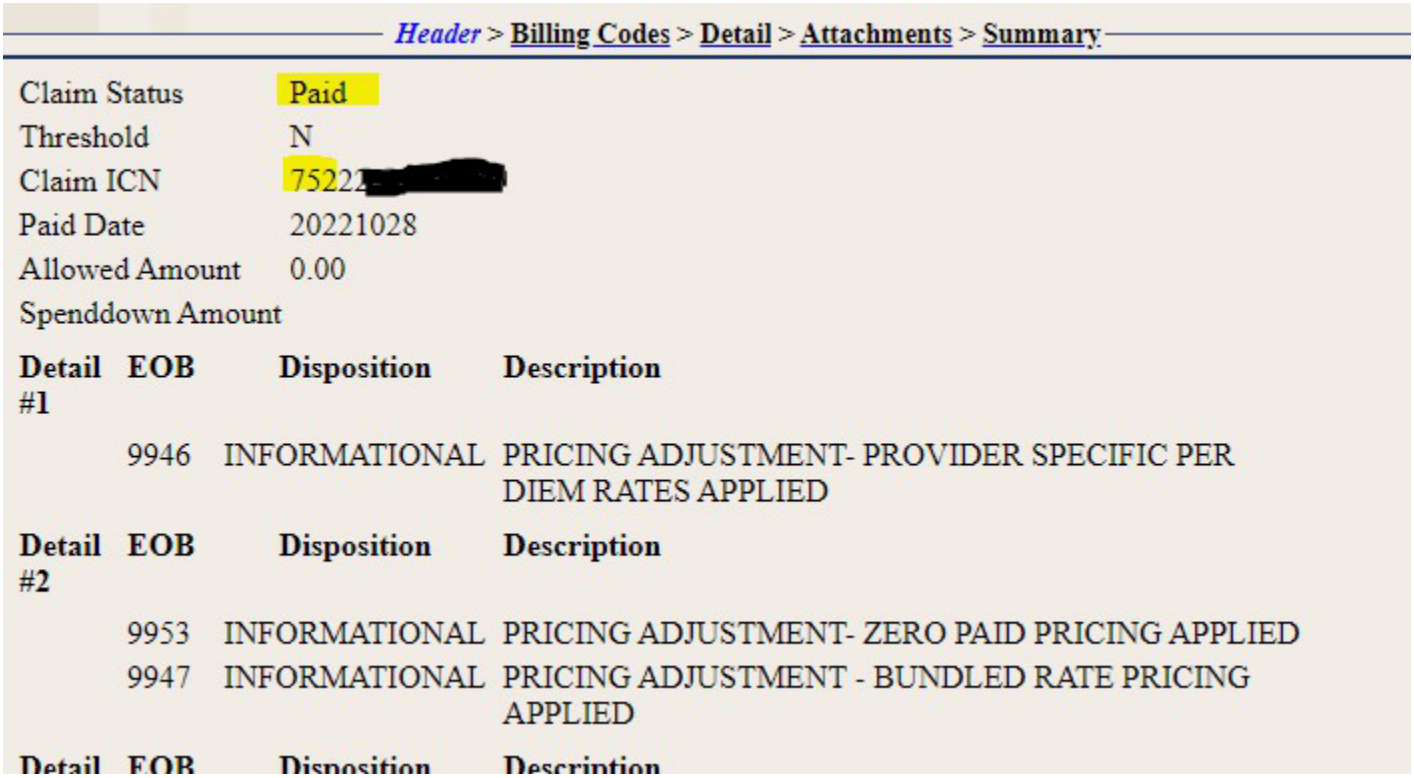
- ✶ If an encounter is submitted with additional charges or an encounter is submitted as an adjustment, the original supplemental payment will be recouped and a new supplemental claim will be calculated.

MMIS Steps in Calculating Supplemental (WRAP) Payment –

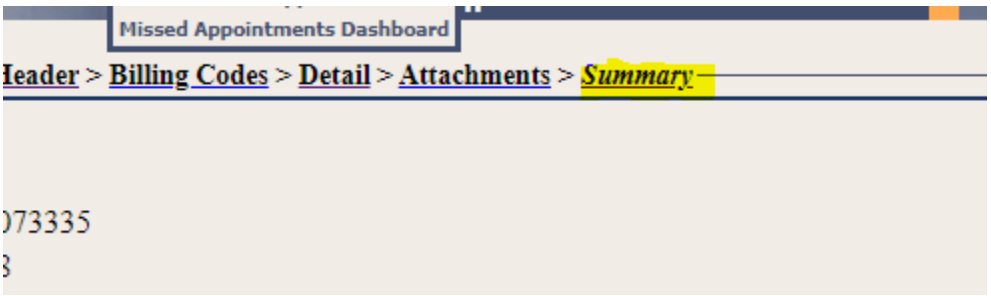
1. Does the claim include at least one procedure code that would trigger a WRAP payment? (NOTE: Contact DMS with questions as to whether codes are considered "pay procedures" or not.)
   a. If yes, MMIS generates a supplemental claim
2. Are there <u>multiple paid encounters</u> for this member and date of service with different dates of submission?
   a. If yes, all claims/encounter are used in the calculation of WRAP. Recoupment of previous WRAP payment will occur if subsequent paid encounters are received. A new WRAP supplemental payment will be calculated.
3. Does the member have <u>other insurance</u> (TPL) that would be responsible for paying medical claims?
   a. If yes, all other payment information is used to calculate per diem including MCO payment information
4. Does this member have <u>Medicare</u> and were the claims/encounters paid by Medicare?
   a. If yes, other payer type code must be MA, MB or 16 to indicate Medicare payer amounts.

My claim says, "PAID" why didn't I receive a WRAP?

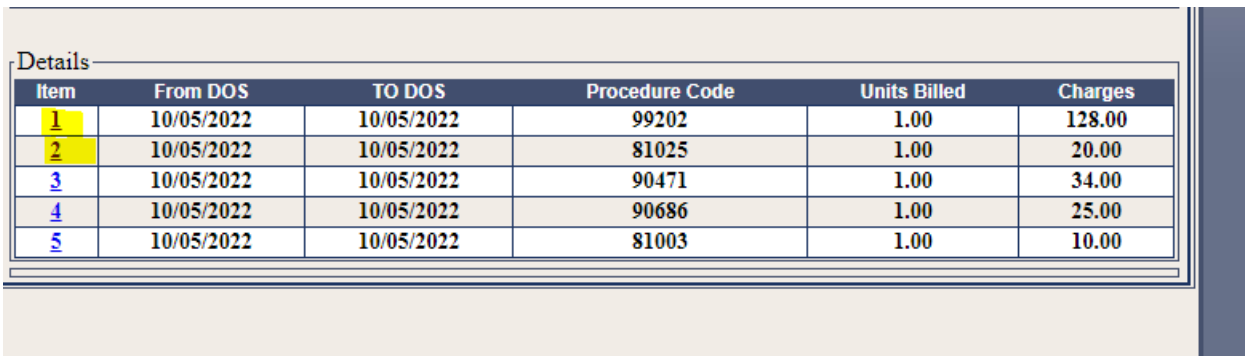
You've not received a WRAP. You've checked the Claim Status under "Header" and it says, "Paid" indicating it was Paid by MCO. (NOTE: The ICN will begin with "75" if you did not receive a wrap payment.)



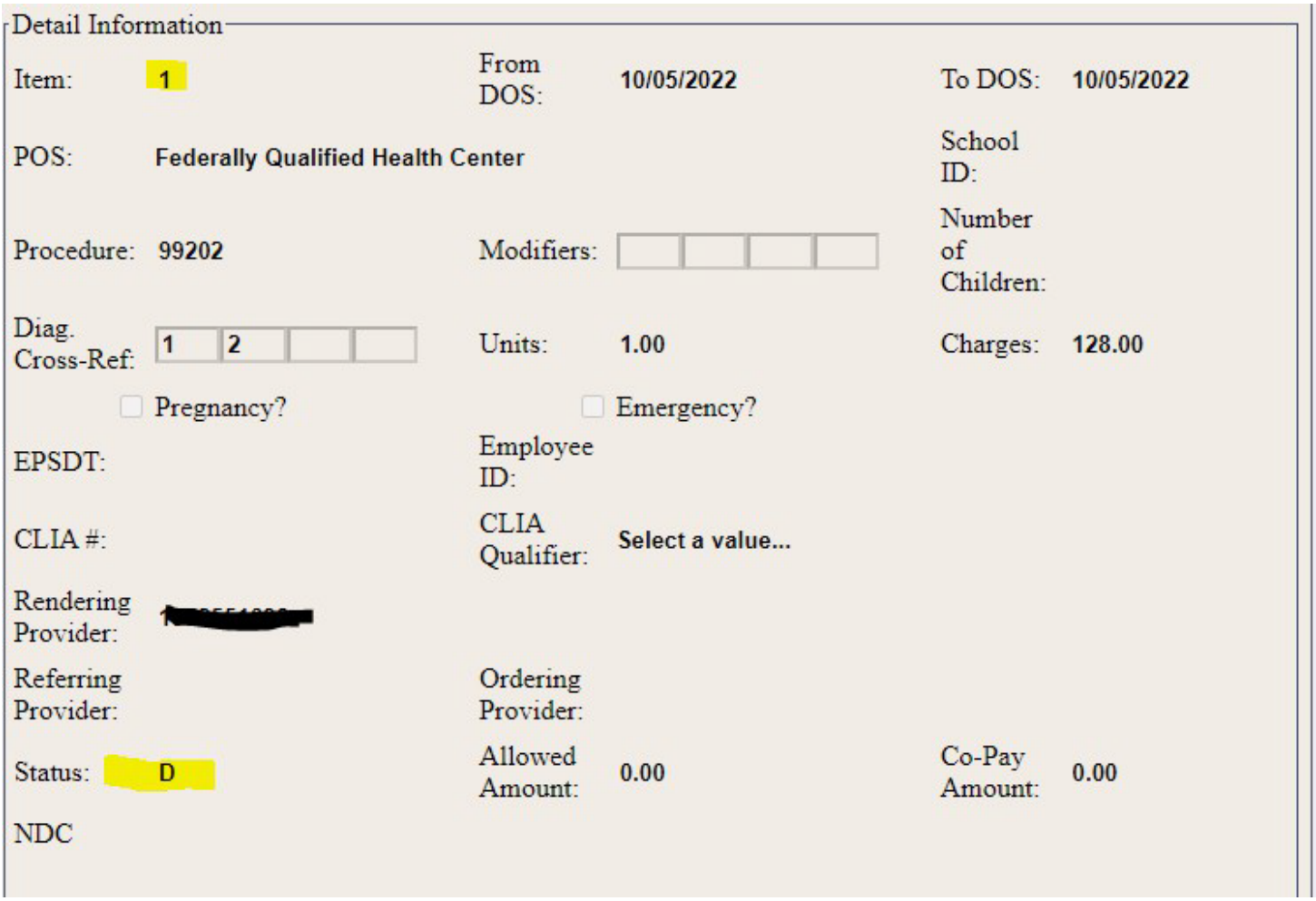
Check the status of the "Detail line" of the encounter by clicking on "Summary".



Then choose which detail line to open for further information.



This example shows the Status of this "Detail Line" in the encounter to be "D" for DENIED. This was denied at the MCO level and DMS has no information from the MCO telling why it was denied. The provider should reach out to the MCO for more information.



Another example shown below is the status "P" but "Allowed amount" is $0.00.
DMS considers the detail line to fall into the category of "ZEROPD" Pricing Indicator. DMS does not issue a wrap for a "ZEROPD" Pricing Indicator.

Detail Information

Item:	2	From DOS:	10/05/2022	To DOS:	10/05/2022
POS:	Federally Qualified Health Center			School ID:	
Procedure:	81025	Modifiers:		Number of Children:	
Diag. Cross-Ref:	1 2	Units:	1.00	Charges:	20.00
	Pregnancy?		Emergency?		
EPSDT:		Employee ID:			
CLIA #:		CLIA Qualifier:	Select a value...		
Rendering Provider:	19[redacted]				
Referring Provider:		Ordering Provider:			
Status:	P	Allowed Amount:	0.00	Co-Pay Amount:	0.00
NDC					