Rural Health Clinic TennCare Quarterly Wrap Around Reporting

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Becoming a Tennessee Rural Health Clinic

Step	Detail of Step
1.	Pass the RHC State Inspection to become a RHC.
2.	Continue billing MCOs in the same manner as before.
3.	Receive Medicare Tie-In Notice from CMS Atlanta Regional Office.
4.	Submit request within the TennCare portal to change provider type to 'Rural Health Clinic' (see next slide for information).
5.	Submit a Letter of Acknowledgement of Visit Count Accuracy to Maya Angelova and receive average PPS rate for neighboring clinics with similar caseloads.
6.	File the 1st TennCare Quarterly Wrap Around Report to Maya Angelova.
7.	Expect to receive 1st settlement check in about 6 – 8 weeks from report submission.

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Becoming a Tennessee Rural Health Clinic

- Website to enroll in TennCare online:
  - http://pdms.tenncare.tn.gov/Account/Login.aspx
  - Once the CMS approval letter is received, it will need to be uploaded to the registration with a notation on the upload that the facility registration needs to be changed to Provider Type: Rural Health Clinic.
  - TennCare will have to change the provider type for you and then the registration will be submitted back. Once changed to RHC, you will have a 'Licenses & Classifications' page that would need to be filled out and the CMS letter would be uploaded to that section.
  - After you have received the CMS approval certificate letter and have uploaded to the registration, please advise Provider Registration that this document has been uploaded and you are ready to submit. TennCare can only update the Provider Type when the registration is under TennCare Provider Review.

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TennCare Provider Enrollment Contact

Provider Registration
Bureau of TennCare - Provider Services
310 Great Circle Road
Nashville, TN 37243
(800) 852-2683
Provider.Registration@tn.gov
tn.gov/hcfa
tn.gov/tenncare

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Why is the TennCare Quarterly Wrap Around Report Important?

- Once you become a Rural Health Clinic, MCOs will not change the rate that they pay you for visits. The way you receive your enhanced TennCare RHC rate is to prepare this quarterly report.
  - Example:

Paid Visits	MCO Payment per Visit	Total Payments from MCO	TennCare RHC Rate per Visit	TennCare Settlement Due
1,000	$50	$50,000	$125	$75,000

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When is the TennCare Quarterly Wrap Around Report Due?

Reporting Period (Claims Paid Date)	Due Date
January 1st – March 31st	April 30th
April 1st – June 30th	July 31st
July 1st – September 30th	October 31st
October 1st – December 31st	January 31st

- NOTE: TennCare Quarterly Wrap Around Reports must be filed in order to receive the settlement to your enhanced RHC rate. Currently, TennCare will accept reports past the due date, but that could change that at any time.

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Report ONLY Paid Claims for the Quarter

- Visits and claims paid in January – March will be reported on the Q1 TennCare Quarterly Wrap Around Report.

- On the Q2 report, visits from 1st and 2nd quarter that were paid during the 2nd quarter will be reported.
  - The 1st and 2nd quarter visit totals will be on separate columns of the report.

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Report ONLY Paid Claims for the Quarter

FQHC/RHC Cumulative Report of TennCare Visits and Payments

Name of Provider: Sample Clinic — Original Filing
Provider Number: XX-XXXX
NPI Number: XXXXXXXXXX
Period: Q2-2021

Core Services (1)

Submitted	Q1-2021	Q2-2021	
Q1-2021	394		
Q2-2021	418	513	931
Cumulative Totals	812	513	

Core Services (2)

Submitted	Q1-2021	Q2-2021	
Q2-2021	$ 26,234		
	$ 24,743	$ 31,110	$ 55,854
Cumulative Totals	$ 50,977	$ 31,110	

(1) Include only covered visits paid by MCOs. Denied claims must be excluded.

(2) Include fee for service payments for all services provided to TennCare enrollees, with the exception of cross-over claims.
This includes monies received from commercial insurers for TennCare enrollees and all patient liability amounts.
Also include capitation or other special lump-sum payments from MCOs for which there is such an arrangement.

I certify that this form is true and correct

Name _____ Title _____ Date _____

For reimbursement please email form to: Clinics@cot.tn.gov and Maya.Angelova@cot.tn.gov

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Counting Visits

- TennCare visits are face-to-face encounters with a Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, or Licensed Professional Counselor – some common examples include:
  - Office Visits
    - CANNOT include Nurse-Only Visits (99211)
  - Nursing Home Visits
  - Physicals
  - Maternity Visits
  - Behavioral Health Visits
    - *IF the clinic included behavioral health in their initial scope of practice.*

- PLEASE NOTE: What constitutes as a visit for TennCare does not always constitute a RHC Medicare visit and cannot be billed as such (i.e., physicals).

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Counting Visits

- In most cases, TennCare will limit the number of visits that a clinic can claim to one visit per patient per day.
  - Pediatrics will be allowed to count both a sick and well visit on the same day.
  - You will be allowed to count both sick and behavioral health visit on the same day if:
    - The clinic included behavioral health in their initial scope of service.

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Counting Visits

PATIENT: [redacted]

SUBSCRIBER ID: [redacted]
MEMBER ID:
SERVICING PROV NPI:
COB PRIMARY INS:

SUBSCRIBER NAME: [redacted]
INTEREST AMOUNT:
SERVICING PROV NM:
POLICY NUMBER:

PROMPT PAY DISC: [redacted]
PCP NUMBER:
COVERAGE DATE:

CLAIM NUMBER: [redacted]
REMIT DETAIL:
PCP NAME:

PATIENT ACCOUNT: [redacted]
PRODUCT DESC.:

BILLING NPI:
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
10/10/19 - 10/10/19	billing code 99393 POS/ Bill Type 11	1	$240.00	$190.16	$49.84			$0.00	$0.00	$49.84	$0.00			CO45
10/10/19 - 10/10/19	billing code 99213-25 POS/ Bill Type 11	1	$120.00	$85.88	$34.12			$0.00	$0.00	$34.12	$0.00			CO45
10/10/19 - 10/10/19	billing code 96110-59 POS/ Bill Type 11	1	$30.00	$26.08	$3.92			$0.00	$0.00	$3.92	$0.00			CO45
10/10/19 - 10/10/19	billing code 96127 POS/ Bill Type 11	1	$15.00	$12.47	$2.53			$0.00	$0.00	$2.53	$0.00			CO45
10/10/19 - 10/10/19	billing code 96160-59 POS/ Bill Type 11	1	$50.00	$47.74	$2.26			$0.00	$0.00	$2.26	$0.00			CO45
10/10/19 - 10/10/19	billing code 87880-QW POS/ Bill Type 11	1	$50.00	$42.50	$7.50			$0.00	$0.00	$7.50	$0.00			CO45
10/10/19 - 10/10/19	billing code 87804-QW POS/ Bill Type 11	1	$90.00	$82.50	$7.50			$0.00	$0.00	$7.50	$0.00			CO45
10/10/19 - 10/10/19	billing code 87804-59, QW POS/ Bill Type 11	1	$90.00	$82.50	$7.50			$0.00	$0.00	$7.50	$0.00			CO45
10/10/19 - 10/10/19	billing code 85018-QW POS/ Bill Type 11	1	$20.00	$18.45	$1.55			$0.00	$0.00	$1.55	$0.00			CO45
	CLAIM NUMBER: 19K799499700 SUBTOTAL:		$705.00	$588.28	$116.72			$0.00	$0.00	$116.72	$0.00			

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Counting Payments

- "The amount received should include all monies received for services including lab services provided to TennCare enrollees, excluding cross-over claims. This includes monies received from commercial insurers for TennCare enrollees and all patient liability amounts. Also include capitation or other lump-sum payments from MCOs for which there is such arrangement."

- Julie Rogers, CPA, CISA

  Assistant Director

  Tennessee Comptroller of the Treasury

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Counting Payments

- When counting payments, you must include all payments for core services, as well as ancillary services – even if there is no “visit” associated with the service (i.e., labs, x-rays, etc.).
- All payments must be included including patient co-pays and payments from third party insurance payers.

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Counting Payments

SERVICE DATE(S)	SERVICE/ REVENUE CODE(S)	COUNT/ DAYS	POS	CHARGE	ALLOWED	DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CONTRACTUAL DIFFERENCE	TPP	PROV RESP AMOUNT	EXPL/ANSI CODE(S)	INSURED'S RESP AMOUNT	EXPL/ANSI CODE(S)	NET PAID
PATIENT NAME: [redacted]					MEMBER ID: [redacted]			STATE/ALT ID: [redacted]		DRG#: [redacted]				
PATIENT ACCOUNT#:					CLAIM NUMBER:			TOB:		RECEIVED DATE:				
SERVICE PROVIDER NAME:					SERVICE PROVIDER ID:			AUTH#:		EXPL CD:				
10/01/19 10/01/19	36415	1	11	10.00	1.35	0.00	0.00	0.00	0.00	8.65	G22 45	0.00		1.35
TOTAL:				10.00	1.35	0.00	0.00	0.00	0.00	8.65		0.00		1.35
INTEREST														0.00
TOTAL NET PAID														1.35

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Counting Payments

PATIENT: [redacted]

SUBSCRIBER ID: [redacted]
MEMBER ID:
SERVICING PROV NPI:
COB PRIMARY INS:

SUBSCRIBER NAME:
INTEREST AMOUNT:
SERVICING PROV NM:
POLICY NUMBER:

PROMPT PAY DISC:
PCP NUMBER:
COVERAGE DATE:

CLAIM NUMBER:
REMIT DETAIL:
PCP NAME:

PATIENT ACCOUNT:
PRODUCT DESC.:
BILLING NPI:
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	DISCOUNT AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
12/07/17 - 12/07/17	billing code 99214-25 POS/ Bill Type 11	1	$125.00	$74.32		$50.68			$50.68	$0.00	$0.00	$0.00			CO45
12/07/17 - 12/07/17	billing code 87880-QW POS/ Bill Type 11	1	$40.00	$34.63		$5.37			$0.00	$0.00	$5.37	$0.00			CO45
CLAIM NUMBER: 18A221478600 SUBTOTAL:			$165.00	$108.95		$56.05			$50.68	$0.00	$5.37	$0.00			

Processed Claim

Patient Name: [redacted] AGP Member ID: [redacted] Acct: [redacted] State/Alt Member ID: [redacted]
Claim Number: [redacted] Servicing Provider: [redacted] Servicing NPI: [redacted] DRG#:
Claim Comment: TOB: Auth#:

#	Dates of Service	LC	Diag #	Rev	Proc/Mod	Day/Cnt	Charge	Allowed	Disallowed	Co-Pay	TPP		Payment	Explain Codes
1	11/01/17 - 11/01/17	11	J020		99213 25	1	$112.00	$46.97	$65.03	$.00	$27.27		$19.70	019
2	11/01/17 - 11/01/17	11	J020		87880 QW	1	$40.00	$5.56	$34.44	$.00	$3.23		$2.33	019
					Service Line(s) Sub Total(s):		$152.00	$52.53	$99.47	$.00	$30.50		$22.03	

Total-Interest: $.00 Total-Prompt Pay Discount: $.00 Claim Total: $22.03

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Visit and Payment Summary

Type of Visit	Visit	Payment
Office Visits	Count +	Count +
Nursing Home Visits	Count +	Count +
Physicals	Count +	Count +
Behavioral Health Visits	Count +	Count +
Nurse-only Visits, Labs, X-Rays, etc.	Do NOT Count	Count +

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Visit and Payment Summary

PATIENT: [redacted]

SUBSCRIBER ID: [redacted]
MEMBER ID:
SERVICING PROV NPI:

SUBSCRIBER NAME: [redacted]
INTEREST AMOUNT:
SERVICING PROV NM:

PROMPT PAY DISC: [redacted]
PCP NUMBER:

CLAIM NUMBER: [redacted]
REMIT DETAIL:
PCP NAME:

PATIENT ACCOUNT: [redacted]
PRODUCT DESC.: TN Dual SNP Full Coverage
BILLING NPI: [redacted]
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
10/09/19 - 10/09/19	billing code 99214-25 POS/ Bill Type 11	1	$125.00	$32.49	$92.51			$0.00	$1.85	$90.66	$0.00			CO45, CO253
10/09/19 - 10/09/19	billing code 99408 POS/ Bill Type 11	1	$40.00	$40.00				$0.00	$0.00	$0.00	$0.00		M80	CO234
10/09/19 - 10/09/19	billing code 80305-QW POS/ Bill Type 11	1	$20.00	$14.71	$5.29			$0.00	$0.00	$5.29	$0.00			CO45
CLAIM NUMBER: 19K713847200 SUBTOTAL:			$185.00	$87.20	$97.80			$0.00	$1.85	$95.95	$0.00		M80	

NOTE: Medicare Crossover is when Medicare is primary and TennCare is secondary. This type of payer mix is completely excluded from the TennCare Quarterly Wrap Around Report (NO Visit and NO Payment).

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Completing the Report

- Every TennCare remittance should be sorted by MCO and then reviewed for visits and payments by quarter.

- On the Excel spreadsheet (accumulation logs), you can summarize the EOB information in the following columns: RA/Check #, RA Date, # of visits by quarter, and payment amounts by quarter – see template.

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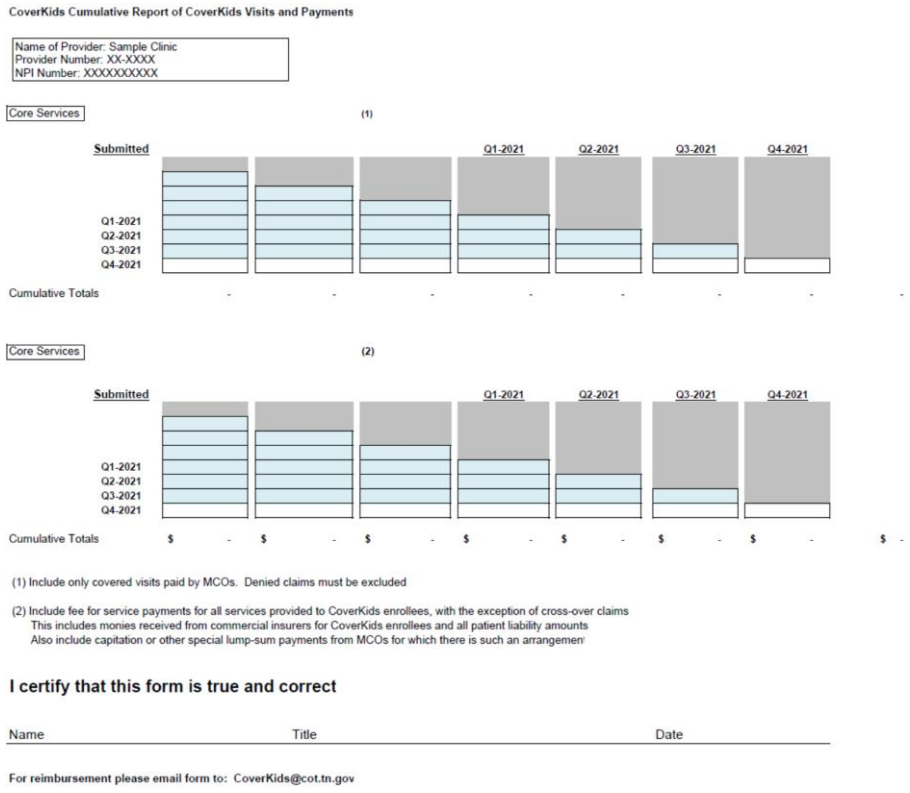
TennCare Quarterly Wrap Around Report - CoverKids

- The following form must be completed and emailed to CoverKids@cot.tn.gov.



CoverKids Cumulative Report of CoverKids Visits and Payments

Name of Provider: Sample Clinic
Provider Number: XX-XXXX
NPI Number: XXXXXXXXXX

Core Services (1)

Submitted	Q1-2021	Q2-2021	Q3-2021	Q4-2021
Q1-2021				
Q2-2021				
Q3-2021				
Q4-2021				
Cumulative Totals	-	-	-	-

Core Services (2)

Submitted	Q1-2021	Q2-2021	Q3-2021	Q4-2021
Q1-2021				
Q2-2021				
Q3-2021				
Q4-2021				
Cumulative Totals	$ -	$ -	$ -	$ -

(1) Include only covered visits paid by MCOs. Denied claims must be excluded

(2) Include fee for service payments for all services provided to CoverKids enrollees, with the exception of cross-over claims
This includes monies received from commercial insurers for CoverKids enrollees and all patient liability amounts
Also include capitation or other special lump-sum payments from MCOs for which there is such an arrangemen

I certify that this form is true and correct

Name Title Date

For reimbursement please email form to: CoverKids@cot.tn.gov

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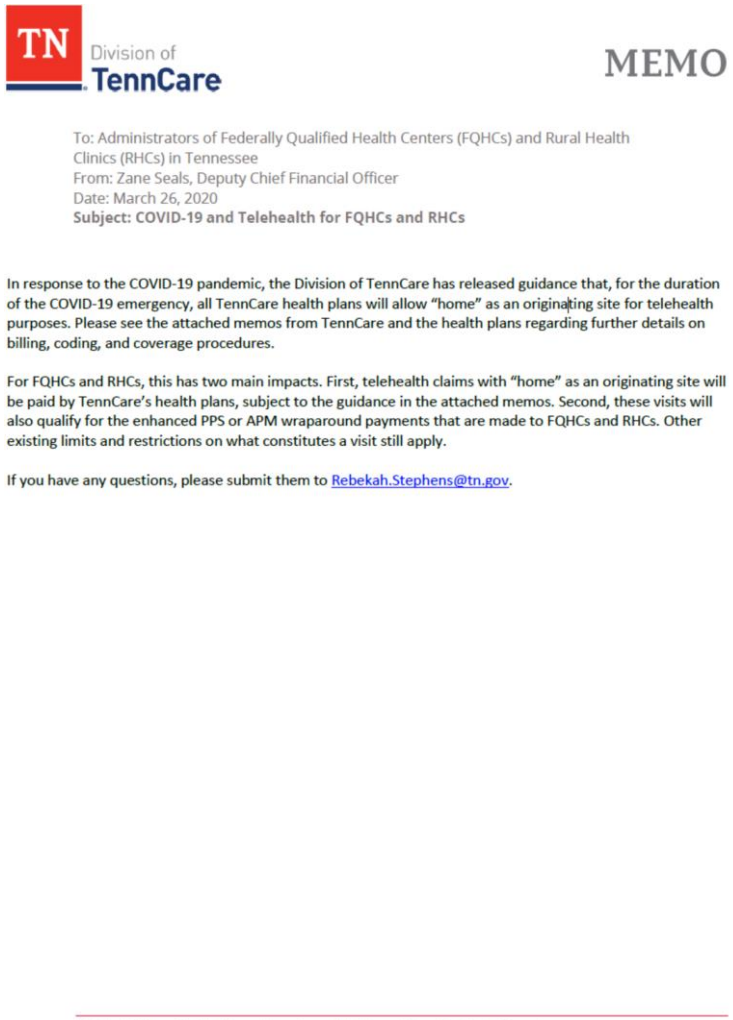
TennCare Quarterly Wrap Around Report Changes

- In March 2020, TennCare announced approval to allow “home” as an originating site for telehealth purposes in response to the COVID-19 pandemic.



TN Division of TennCare

MEMO

To: Administrators of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in Tennessee
From: Zane Seals, Deputy Chief Financial Officer
Date: March 26, 2020
Subject: COVID-19 and Telehealth for FQHCs and RHCs

In response to the COVID-19 pandemic, the Division of TennCare has released guidance that, for the duration of the COVID-19 emergency, all TennCare health plans will allow “home” as an originating site for telehealth purposes. Please see the attached memos from TennCare and the health plans regarding further details on billing, coding, and coverage procedures.

For FQHCs and RHCs, this has two main impacts. First, telehealth claims with “home” as an originating site will be paid by TennCare’s health plans, subject to the guidance in the attached memos. Second, these visits will also qualify for the enhanced PPS or APM wraparound payments that are made to FQHCs and RHCs. Other existing limits and restrictions on what constitutes a visit still apply.

If you have any questions, please submit them to Rebekah.Stephens@tn.gov.

Division/Office • First Address Line • Second Address Line • City, State Zipcode
Tel: 615-000-1234 • Fax: 615-000-1234 • tn.gov/agency

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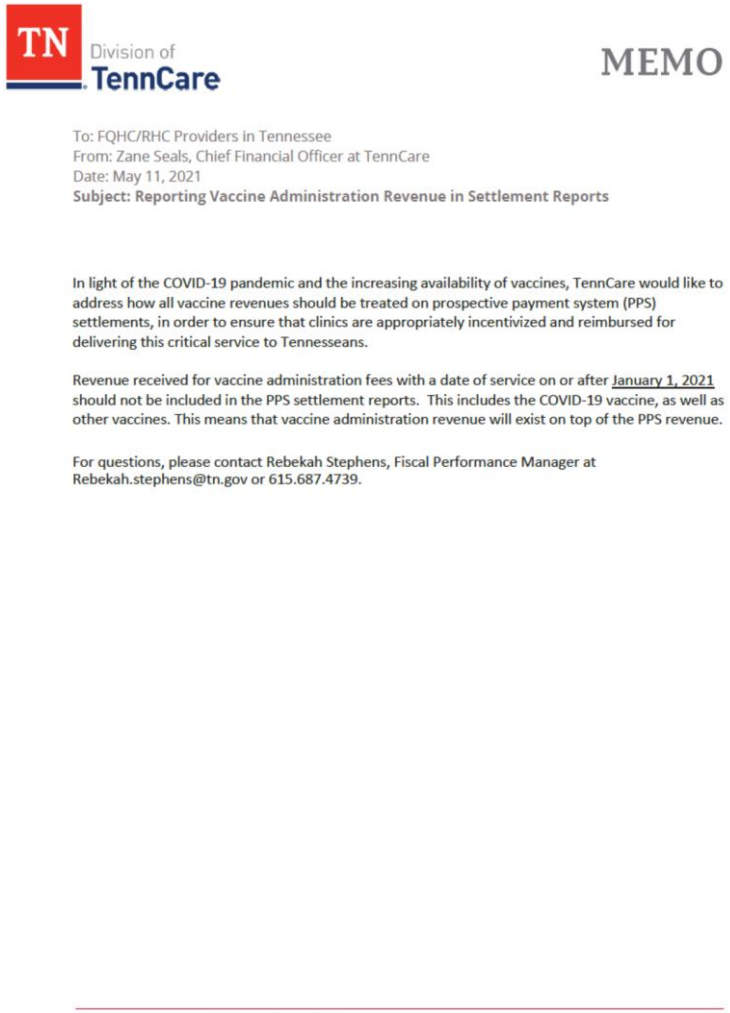
TennCare Quarterly Wrap Around Report Changes

- In May 2021, TennCare announced that revenue received for vaccine administration fees with a DOS on or after **January 1, 2021** should not be included in the PPS settlement reports.



TN Division of TennCare

MEMO

To: FQHC/RHC Providers in Tennessee
From: Zane Seals, Chief Financial Officer at TennCare
Date: May 11, 2021
Subject: Reporting Vaccine Administration Revenue in Settlement Reports

In light of the COVID-19 pandemic and the increasing availability of vaccines, TennCare would like to address how all vaccine revenues should be treated on prospective payment system (PPS) settlements, in order to ensure that clinics are appropriately incentivized and reimbursed for delivering this critical service to Tennesseans.

Revenue received for vaccine administration fees with a date of service on or after January 1, 2021 should not be included in the PPS settlement reports. This includes the COVID-19 vaccine, as well as other vaccines. This means that vaccine administration revenue will exist on top of the PPS revenue.

For questions, please contact Rebekah Stephens, Fiscal Performance Manager at Rebekah.stephens@tn.gov or 615.687.4739.

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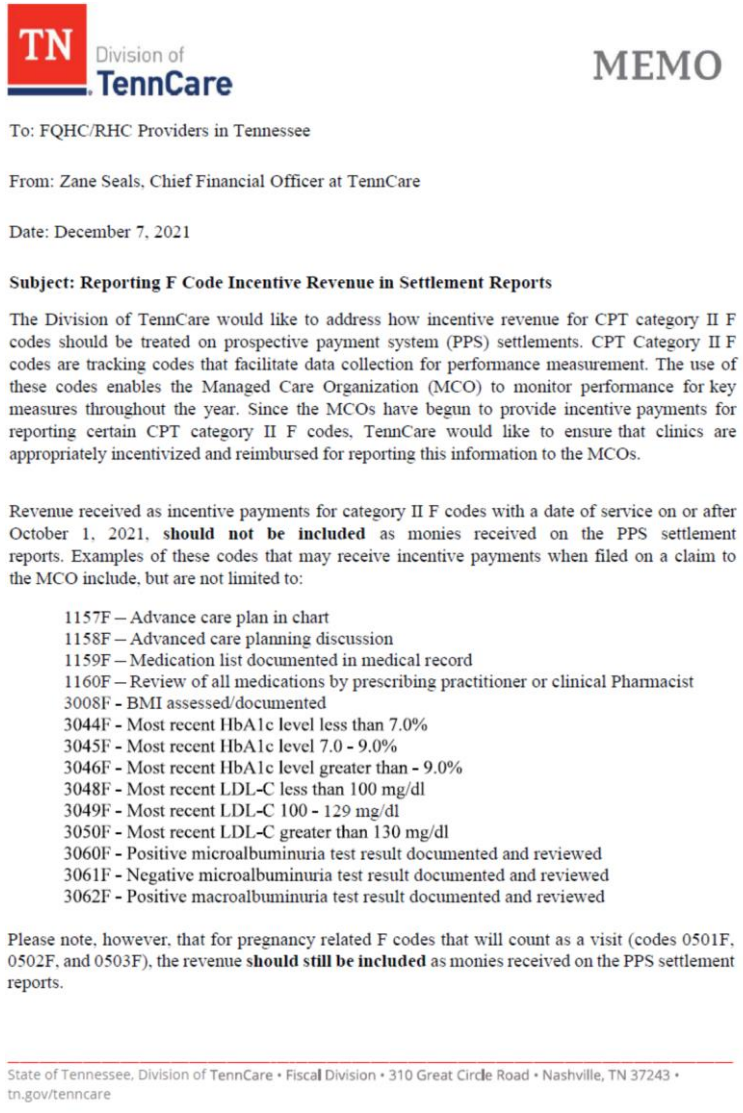
TennCare Quarterly Wrap Around Report Changes

- In December 2021, TennCare announced that revenue received for category II F codes with a DOS on or after October 1, 2021, should not be included in the PPS settlement reports.
  - Exception: Pregnancy related F codes that count as a visit (i.e., 0501F, 0502F, and 0503F), the revenue should still be included on the report.



TN Division of TennCare

MEMO

To: FQHC/RHC Providers in Tennessee

From: Zane Seals, Chief Financial Officer at TennCare

Date: December 7, 2021

Subject: Reporting F Code Incentive Revenue in Settlement Reports

The Division of TennCare would like to address how incentive revenue for CPT category II F codes should be treated on prospective payment system (PPS) settlements. CPT Category II F codes are tracking codes that facilitate data collection for performance measurement. The use of these codes enables the Managed Care Organization (MCO) to monitor performance for key measures throughout the year. Since the MCOs have begun to provide incentive payments for reporting certain CPT category II F codes, TennCare would like to ensure that clinics are appropriately incentivized and reimbursed for reporting this information to the MCOs.

Revenue received as incentive payments for category II F codes with a date of service on or after October 1, 2021, **should not be included** as monies received on the PPS settlement reports. Examples of these codes that may receive incentive payments when filed on a claim to the MCO include, but are not limited to:

1157F – Advance care plan in chart
1158F – Advanced care planning discussion
1159F – Medication list documented in medical record
1160F – Review of all medications by prescribing practitioner or clinical Pharmacist
3008F - BMI assessed/documented
3044F - Most recent HbA1c level less than 7.0%
3045F - Most recent HbA1c level 7.0 - 9.0%
3046F - Most recent HbA1c level greater than - 9.0%
3048F - Most recent LDL-C less than 100 mg/dl
3049F - Most recent LDL-C 100 - 129 mg/dl
3050F - Most recent LDL-C greater than 130 mg/dl
3060F - Positive microalbuminuria test result documented and reviewed
3061F - Negative microalbuminuria test result documented and reviewed
3062F - Positive macroalbuminuria test result documented and reviewed

Please note, however, that for pregnancy related F codes that will count as a visit (codes 0501F, 0502F, and 0503F), the revenue **should still be included** as monies received on the PPS settlement reports.

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TennCare Quarterly Wrap Around Report Changes

- In December 2021, TennCare also announced that visits which take place at a hospital with a DOS on or after January 1, 2022 should not be included in the PPS settlement reports.
  - This memo does not apply to those services that *must* occur at a hospital (i.e., maternity visits, global deliveries, sterilization, and/or other surgical OB-GYN services).

TN Division of TennCare

MEMO

To: FQHC/RHC Providers in Tennessee
From: Zane Seals, Chief Financial Officer at TennCare
Date: December 30, 2021
Subject: Reconciliation Payments for Hospital Visits

The purpose of this memorandum is to provide guidance regarding whether FQHC/RHC providers are entitled to reconciliation or "wraparound" payments for hospital visits. In doing so, TennCare would like to ensure that FQHC/RHC providers are informed on how hospital visits will be treated on the prospective payment system (PPS) settlement reports.

Pursuant to guidance from the Center for Medicare & Medicaid Services (CMS), FQHC and RHC visits cannot take place at an inpatient or outpatient hospital department, including a critical access hospital.[1] Therefore, **effective January 1, 2022**, visits which take place at a hospital will not qualify for the reconciliation or "wraparound" payment. As a result, the revenue from such hospital visits **should not be included** as monies received on the PPS settlement reports.

Please note, that this memo does not apply to maternity visits, global deliveries, sterilization, and/or other surgical OBGYN services which *must* occur at a hospital. Such visits are entitled to the reconciliation payment, and the monies received should be included on the PPS settlement reports.

For any questions, please contact Rebekah Stephens, Fiscal Performance Manager at Rebekah.stephens@tn.gov or (615) 687-4739.

Sincerely,

Zane Seals

Digitally signed by Zane Seals
Date: 2021.12.30 14:11:04 -06'00'

Zane Seals
Chief Financial Officer
Division of TennCare

[1] See CMS' April 2021 guidance found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf . See also CMS' Medicare Benefit Policy Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf .

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HBS Healthcare Business Specialists

Contact Information

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RHC Consultant
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Cleveland, Tennessee 37323
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dani.gilbert@outlook.com
www.ruralhealthclinic.com

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