



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Federally Qualified Health Centers and Rural Health Clinics

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		<ul style="list-style-type: none">Added the Requesting and Retrieving Wrap Reports on the IHCP Portal subsection	

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Federally Qualified Health Centers and Rural Health Clinics

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member’s managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Bulletins](#) at in.gov/medicaid/providers.

Introduction

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are facilities designated to provide healthcare services to medically underserved urban and rural communities. FQHCs receive government grants, which help them provide primary care services to all patients, regardless of their ability to pay. FQHCs and RHCs have increased the use of nonphysician practitioners, such as physician assistants and nurse practitioners, in rural areas.

The Indiana Health Coverage Programs (IHCP) provides reimbursement for medical care provided to its members in FQHCs and RHCs.

Provider Enrollment Considerations

IHCP requirements for FQHC and RHC enrollment are described in the following sections. See the [Provider Enrollment](#) module for more information about enrolling as an IHCP provider and updating provider information on file.

Federally Qualified Health Centers

FQHCs receive funds through the *Public Health Service (PHS) Act* and receive FQHC status from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. For IHCP reimbursement purposes, FQHCs and FQHC look-alikes are treated the same. For information regarding this process, contact the Indiana Primary Health Care Association at 317-630-0845 or info@indianapca.org.

To enroll as an FQHC with the IHCP, providers must submit a copy of the Centers for Medicare & Medicaid Services (CMS) approval letter verifying FQHC status, along with their completed application, to the IHCP Provider Enrollment Unit.

The provider must also submit the proper financial documents to Myers and Stauffer LC, the IHCP rate-setting contractor, to have a reimbursement rate determined for the FQHC. Myers and Stauffer forwards the rate document to the Provider Enrollment Unit so the encounter rate can be loaded into the Core Medicaid Management Information System (*CoreMMIS*).

Rural Health Clinics

RHC services are defined in *Code of Federal Regulations 42 CFR 405.2411* and *42 CFR 440.20*. RHCs receive Medicare designation through the CMS. Clinics must contact the Indiana Department of Health (IDOH) to request RHC status for the IHCP.

The IHCP requires all RHCs to submit finalized (reviewed or audited) cost reports and copies of their Medicare rate letters to Myers and Stauffer. For more information about becoming an RHC under the IHCP, contact the IDOH at 317-233-1325 or 800-382-9480, the Indiana Primary Health Care Association at 317-630-0845, or other practice consultants.

Rendering Providers

The IHCP reimburses FQHCs and RHCs for valid encounters with the following qualifying practitioners:

- Physician
- Physician assistant
- Advanced practice registered nurse (APRN)
- Licensed clinical psychologist
- Licensed clinical social worker (LCSW)
- Licensed clinical addiction counselor (LCAC)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Dentist
- Dental hygienist
- Podiatrist
- Optometrist
- Chiropractor

All FQHC and RHC qualifying practitioner specialties that are eligible for IHCP enrollment must be enrolled in the IHCP as rendering providers, and their Provider IDs and National Provider Identifiers (NPIs) must be linked to the FQHC or RHC group enrollment.

*Note: When billing for services performed by a qualifying FQHC or RHC practitioner with a specialty that is **not eligible for IHCP enrollment**, the NPI of an IHCP-enrolled supervising practitioner must be entered as the rendering provider on the claim.*

When a rendering provider is no longer associated with the FQHC or RHC, the clinic must notify the IHCP Provider Enrollment Unit in writing or via the *Provider Maintenance* page of the IHCP Provider Healthcare Portal (IHCP Portal) so that the information on file for the clinic provider is current.

Change in Scope of Services

The IHCP understands that changes may occur in the scope of FQHC and RHC services. The IHCP considers changes in scope of services on a case-by-case basis, when providers meet filing requirements with Myers and Stauffer prior to the occurrence of a planned change in scope of services. The FQHC or RHC must, on their own behalf, correspond with Myers and Stauffer to complete the change in scope of services. For more information, see the *Indiana FQHC/RHC Change in the Scope of Service Guidelines*,

accessible from the [Myers and Stauffer website](#) at myersandstauffer.com (under Health Clinics > FQHC-RHC Change in Scope of Service).

Each time an FQHC or RHC facility expands or decreases its scope of service and receives an adjustment to its encounter rate, Myers and Stauffer must forward the new rate letter to the IHCP Provider Enrollment Unit to ensure that reimbursement remains accurate.

Termination of FQHC or RHC Status

When a clinic's FQHC or RHC status is terminated, notifications are typically made as follows:

- Termination of FQHC status:
 - The CMS notifies the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP).
 - The FSSA OMPP then notifies the IHCP Provider Enrollment Unit.
- Termination of RHC status:
 - The CMS notifies the clinic.
 - The provider must send a copy of the termination to the IDOH.
 - The IDOH then forwards the termination notice to the IHCP Provider Enrollment Unit.

Until FQHC or RHC status is reinstated, the provider must enroll in the IHCP as a medical clinic. Failure to do so will result in disenrollment as a provider and loss of any managed care members assigned to primary medical providers (PMPs) linked to that location.

Covered FQHC and RHC Services

The IHCP reimburses FQHCs and RHCs for services – and supplies incidental to such services – that the IHCP would otherwise cover if furnished by a physician or incidental to a physician's services. The IHCP considers any ambulatory service included in the Indiana Medicaid State Plan to be a covered FQHC or RHC service, if the FQHC or RHC offers such a service. FQHCs and RHCs are subject to the same prior authorization requirements as other IHCP providers.

The IHCP reimburses FQHCs and RHCs for services to homebound individuals only in the case of FQHCs and RHCs located in areas with shortages of home health agencies, as determined by the FSSA.

FQHCs and RHCs can provide preventive services and encounters, care coordination, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/HealthWatch services (see the [EPSDT Services](#) module).

For information on telehealth services provided by FQHCs and RHCs, see the [Telehealth Encounters](#) section.

FQHC and RHC Billing and Reimbursement

In accordance with Section 702 of the *Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000* (BIPA), the IHCP implemented a prospective payment system (PPS) for reimbursing FQHCs and RHCs for IHCP-covered services. FQHCs and RHCs receive a facility-specific PPS rate determined by Myers and Stauffer. Myers and Stauffer forwards the specific PPS rate information to the IHCP fiscal agent, and the Provider Enrollment Unit loads the applicable PPS rate for reimbursement of the Healthcare Common Procedure Coding System (HCPCS) dental or medical encounter procedure code to the specific provider enrollment file for reimbursement of fee-for-service (FFS) FQHC and RHC claims.

Note: IHCP-enrolled FQHCs must submit an Indiana Medicaid Cost Report annually, which is used in establishing their PPS rate, as well as when reviewing any requests for a change in scope of service. Instructions for completing the FQHC cost report and filing it with the state of Indiana are available in the FQHC Cost Report Instructions and Manual on the [Myers and Stauffer website](http://myersandstauffer.com) at myersandstauffer.com (under Health Clinics > FQHC-RHC Indiana Medicaid Cost Report).

The following subsections provide **FFS** billing and reimbursement information for FQHC and RHC providers. For *general* FFS billing instructions, see the [Claim Submission and Processing](#) module. For FQHC and RHC claims submitted under the **managed care** delivery system, see the [Managed Care Considerations – Wraparound Payment for Medical and Dental Encounters](#) section.

FQHC and RHC Encounters

A valid FQHC or RHC encounter is defined as a face-to-face visit (either in person or via telehealth) between an IHCP member and a qualifying practitioner (see the [Rendering Providers](#) section) at an FQHC, RHC or other qualifying, nonhospital setting.

*Note: For guidance on billing services rendered by an FQHC or RHC provider within a **hospital setting**, see the [Hospital Services](#) section. For guidance on billing designated services that are **carved out of the PPS** and individually reimbursable separate from the encounter claim, see the [Services Carved Out of the PPS Rate](#) section.*

FQHC and RHC facilities are required to submit fee-for-service claims for valid encounters as follows:

- Report valid **medical** encounters on the professional claim (CMS-1500 claim form, IHCP Portal professional claim or 837P transaction) using HCPCS encounter code **T1015** – *Clinic, visit/ encounter, all-inclusive*.
- Report valid **dental** encounters on the dental claim (American Dental Association 2012 Dental Claim Form [ADA 2012], IHCP Portal dental claim or 837D transaction) using HCPCS encounter code **D9999** – *Unspecified adjunctive procedure, by report*.

Exception: Effective for dates of service on and after July 1, 2021, FQHCs and RHCs are not required to include the T1015 encounter code on crossover claims. See the [Crossover Claims for Dually Eligible Members](#) section for details.

Additionally, all claims for valid FQHC and RHC encounters must include one of the following place-of-service (POS) codes:

- 02 – *Telehealth provided other than in patient’s home**
- 03 – *School*
- 04 – *Homeless Shelter*
- 10 – *Telehealth provided in patient’s home**
- 11 – *Office*
- 12 – *Home*
- 31 – *Skilled nursing facility*
- 32 – *Nursing facility*
- 50 – *Federally qualified health center*
- 72 – *Rural health clinic*

**Note: POS code 10 became allowable for FQHC and RHC encounter claims effective July 21, 2022, and the definition for POS code 02 was changed to specify “other than in a patient’s home.”*

FQHC and RHC claims (other than crossover claims) that are submitted with a POS code from the preceding list (02, 03, 04, 10, 11, 12, 31, 32, 50 or 72) and that do **not** include the T1015 or D9999 encounter code are denied for EOB code 4121 – *D9999 & T1015 must be billed with a valid CPT/HCPCS code*. Providers can resubmit these claims with the appropriate encounter code properly included on the claim.

In addition to the T1015 or D9999 encounter code, FQHC and RHC providers must also include all Current Procedural Terminology (CPT^{®1}), Current Dental Terminology (CDT^{®2}) codes, and other HCPCS procedure codes appropriate to the services provided during the visit. For claims containing the T1015 or D9999 encounter code, the claim logic compares the other procedure codes used against a list of valid procedure codes approved by the Family and Social Services Administration (FSSA) as meeting criteria for the encounter code, and adjudicates the claim as follows:

- If the claim contains one or more of the procedure codes approved as meeting encounter criteria, and it is billed with a valid POS code for FQHC/RHC encounters, then **the encounter rate (T1015 or D9999) is reimbursed according to the usual and customary charge (UCC)** established by Myers and Stauffer from the provider-specific rate on the provider file. All *other* procedure codes on the claim (any codes other than the T1015 or D9999 encounter code) are denied with explanation of benefits (EOB) code 4173 – *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology*. The provider should **not** resubmit procedure codes separately that were denied for EOB code 4173; reimbursement for those services is included in the PPS rate.
- If the claim contains a procedure code approved as meeting encounter criteria, but that code is billed without a valid POS code for FQHC/RHC encounters, then the entire claim is denied with EOB code 3373 – *Deny FQHC/RHC claim with T1015 or D9999 procedure code when all other details are submitted with invalid place of service for FQHC/RHC*. Providers can resubmit claims denied for EOB code 3373 for payment with a corrected POS code, if appropriate.
- If the claim does not contain any of the procedure codes approved as meeting encounter criteria, the entire claim is denied with EOB code 4124 – *The CPT/HCPCS code billed is not a valid encounter*. Providers should **not** resubmit claims denied for EOB code 4124 for payment.

For a complete list of medical and dental procedure codes that meet the criteria for a valid FQHC or RHC encounter, see the [Myers and Stauffer website](http://myersandstauffer.com) at myersandstauffer.com (under Health Clinics > FQHC-RHC Annual Encounter Code Listings). The list is reviewed annually to account for new or end-dated procedure codes.

Encounters on Consecutive Dates of Service

Providers can bill only one unit of T1015 or D9999 on a single detail line of the claim. Providers should break down consecutive service dates so that they bill each day on a separate line.

Multiple Encounters on the Same Date of Service

The IHCP allows reimbursement for only one medical encounter code (T1015) per IHCP member, per billing provider, per day – unless the primary diagnosis code differs for each additional encounter. Multiple T1015 encounter claims from an FQHC or RHC for a member on the same date of service that do not include a different primary diagnosis code are denied for EOB code 5000 or 5001 – *This is a duplicate of another claim*.

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² CDT copyright 2023 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association.

If a member visits an office twice on the same day with two different diagnoses, a second claim can be submitted for the second visit, using a separate professional claim form or electronic claim submission. However, this policy does not allow a provider to bill multiple claims for a *single* visit with multiple diagnoses by separating the diagnoses on different claims.

When two valid practitioners, such as a physician and a psychologist, see the same patient in the same day, the principal diagnoses should not be the same.

Note: FQHCs and RHCs must strictly follow proper billing guidelines when submitting multiple diagnosis codes on a single claim. Diagnosis codes must be listed according to their importance, with the first code being the primary diagnosis – that is, the one that most strongly supports the medical necessity of the service:

- *The diagnosis code submitted in field 21A on the CMS-1500 claim form is considered the primary diagnosis for determining duplicate claims.*
- *In the IHCP Portal, the first code entered in the Diagnosis Codes field is the primary diagnosis.*
- *For 837P electronic transactions, the first diagnosis code entered in the Loop 2300 HI segment (H101) is the primary diagnosis.*

The IHCP allows reimbursement for only one dental encounter code (D9999) per IHCP member, per billing provider, per day. If a claim is submitted with more than one unit, the claim detail will be cut back to one unit and post EOB code 9916 – *Pricing Adjustment – Usual and customary charge (UCC) rate pricing applied.*

Telehealth Encounters

FQHC and RHC providers may bill for telehealth services if the service rendered is considered a valid FQHC or RHC encounter (as defined in this module) **and** a covered telehealth service (as defined in *Telehealth and Virtual Services Codes*, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers)). When billing valid telehealth encounters, the encounter code (T1015 or D9999) should be billed as usual, and each service provided during the encounter must include an appropriate telehealth POS code (02 or 10) and telehealth modifier (93 or 95), as described in the *FQHC and RHC Telehealth Services* section of the [Telehealth and Virtual Services](#) module.

Note: Dental services do not require a modifier indicating the method of telehealth delivery. Dental services cannot be provided via audio-only telehealth. The only dental service that FQHCs and RHCs can bill as telehealth is D0140 – Limited oral evaluation - problem focused.

When an FQHC or RHC bills as an *originating site* (where the patient receiving telehealth is located), the claim must also include procedure code Q3014 – *Telehealth originating site facility fee*, billed with POS code 02 and modifier 95. To be eligible for reimbursement, it must be medically necessary for a medical professional to be present with the member, and the service provided must include all components of a valid encounter.

See the [Telehealth and Virtual Services](#) module for more information.

Services Provided Outside a Valid Encounter

Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling and dispensing prescriptions, giving injections, or providing optician services do not, *in and of themselves*, constitute encounters. Providers can include these services in the encounter reimbursement when they are performed *in conjunction with* an office visit with a qualifying practitioner. The IHCP does not reimburse for these services through claim submission if performed *without* a face-to-face visit with a qualifying practitioner.

For services provided by FQHCs or RHCs that are not valid encounters with a qualifying practitioner (such as injections performed by a nurse without a corresponding visit to satisfy the valid encounter definition), reimbursement is included in the PPS rate because the cost of the service is included in the facility's cost report. FQHCs and RHCs should contact Myers and Stauffer for information about cost reports.

Exceptions to this rule are described in the following section, *Services Carved Out of the PPS Rate*.

Services Carved Out of the PPS Rate

The IHCP has designated certain services as carved out of the PPS rate and separately reimbursable to FQHCs and RHCs when billed on a claim without the T1015 or D9999 encounter code and with POS code 71 – *Public health clinic*, instead of one of the POS codes used for FQHC/RHC encounter claims.

COVID-19 Vaccine Administration

The IHCP separately reimburses FQHCs and RHCs for the administration of the coronavirus disease 2019 (COVID-19) vaccine to IHCP members.

Claims for this service should be submitted on a professional or dental claim (*CMS-1500* or *ADA 2012 claim form* or electronic equivalent) using the applicable COVID-19 vaccine administration procedure code along with POS code 71. The T1015 or D9999 encounter code must **not** be included on the claim, or the claim will deny with EOB code 4173.

The procedure code for the applicable COVID-19 vaccine product should be included (along with POS code 71) on the same claim as the vaccine administration. However, the PPS carve-out applies **only** to the administration fee, **not** to the vaccine product. FQHC and RHC claim details for COVID-19 vaccine products will be reimbursed at \$0 because reimbursement for the vaccine is included in the PPS rate. FQHCs and RHCs should include the cost of the vaccine in the facility's cost report.

COVID-19 vaccination services are carved out of managed care; therefore, the claim must be submitted as FFS for all IHCP members, including those enrolled under a managed care program.

If the FQHC or RHC provided other services on the same date as the COVID-19 vaccination, those services should be billed on a separate claim following the usual FQHC/RHC billing guidance.

*Note: For all **other** vaccinations, FQHC and RHC rates include payment for the vaccine and its administration, and these services cannot be billed separately. These services can be included in the encounter reimbursement when performed in conjunction with an office visit to a valid provider, but they are not reimbursable through claim submission if performed without a face-to-face visit with a qualifying practitioner.*

LARC Product Billing

Effective for dates of service on or after Nov. 1, 2022, designated long-acting reversible contraceptive (LARC) products will be carved out of the PPS rate and separately reimbursable to FQHC and RHC providers. For a list of applicable procedure codes, see *Obstetrical and Gynecological Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

FQHCs and RHCs should bill for these LARC products on a separate claim, with POS code 71, and without encounter code T1015.

Providers can bill for a LARC product supplied on the same day as a valid T1015 encounter – but it must be billed on a separate claim.

Hospital Services

FQHCs and RHCs use the professional claim (*CMS-1500* claim form or electronic equivalent) to bill the IHCP for medical services provided in **all** settings, including hospitals and other facilities that do not qualify as FQHC or RHC encounter settings. The claim must include the appropriate POS code for the setting in which the service was delivered.

It is not necessary for FQHCs or RHCs to include the T1015 encounter code on claims with POS codes 19 through 26 (urgent care facilities, on- and off-campus outpatient hospitals, inpatient hospitals, emergency rooms, ambulatory surgical centers, birthing centers, and military treatment facilities). The IHCP reimburses FQHCs and RHCs for claims with POS codes 19 through 26 at the current reimbursement rate for each specific CPT or HCPCS code. The IHCP considers these services to be non-FQHC or -RHC services provided by a valid practitioner, but in a setting other than an FQHC- or RHC-qualifying place of service.

Medicaid Rehabilitation Option Services

IHCP reimbursement for Medicaid Rehabilitation Option (MRO) services is available only when the services are billed by an IHCP-enrolled community mental health center (CMHC). MRO services are not reimbursed when billed under the FQHC or RHC provider specialties.

Because a number of FQHC facilities are operated by CMHCs, the IHCP allows such facilities to enroll separately as both a FQHC and a CMHC for the purposes of MRO billing. Any MRO services provided at the facility must be billed under the CMHC Provider ID, and following the normal MRO billing procedures, as described in the [Medicaid Rehabilitation Option Services](#) module.

The *Non Reimbursable Costs* section of the FQHC cost report (page 3: *Expenses, Reclassifications, and Adjustments*) has been updated to include a line for MRO services. FQHC providers must include nonreimbursable costs associated with MRO services provided at their facility in all cost reports. This information is used for calculating prospective payment reimbursement rates.

Note: In a clinic where both FQHC and CMHC providers render services, the FQHC provider must include their separate POS code when billing.

Crossover Claims for Dually Eligible Members

Crossover claims are claims made to Medicaid for Medicare-covered services provided to members who are dually eligible for both Medicare and Medicaid, and for which Medicare or a Medicare Advantage Plan has made a payment (including payments of zero, due to coinsurance, copayment or deductible).

The IHCP excludes all FQHC and RHC crossover claims from the PPS logic, as well as the crossover reimbursement methodology, and continues to pay coinsurance or copayment and deductible amounts for dually eligible members.

For dates of service on and after July 1, 2021, FQHCs and RHCs are not required to include the T1015 encounter code on crossover claims – including claims that cross over automatically from Medicare, as well as those that the FQHC or RHC submits directly to the IHCP after payment was made by Medicare or a Medicare Advantage Plan.

When submitting claims to Medicare, FQHCs and independent RHCs use the institutional claim (*UB-04* claim form or electronic equivalent). The IHCP accepts the institutional claim type for FQHC and RHC claims that cross over **automatically** from the Medicare payer to the IHCP. However, FQHCs and RHCs **must** use the professional claim (*CMS-1500* claim form or electronic equivalent) to submit Medicare-processed claims that did **not** automatically cross over to the IHCP, including claims allowed by Medicare that failed to cross over as well as Medicare-denied claims.

Note: All professional crossover claims submitted to the IHCP by a provider (as opposed to those that cross over automatically) must show Medicare or Medicare Advantage Plan as the previous payer and must include the Medicare-paid amount (actual dollars received from Medicare or the Medicare Advantage Plan) as well as Medicare deductible and coinsurance or copayment information at both the header (claim) and detail (service) level. If submitting the claim on a paper form, billers must include a completed IHCP TPL/Medicare Special Attachment Form, available on the [Forms](#) page at in.gov/medicaid/providers. If Medicare or a Medicare Advantage Plan denied the claim, providers must attach the Explanation of Medicare Benefits (EOMB) or Advantage Plan EOB. For additional information about Medicare crossover billing, see the [Claim Submission and Processing](#) module.

Third-Party Liability

All third-party liability (TPL), patient or waiver liability, and copayments apply, as appropriate, to FQHC and RHC services. Designated preventive pediatric care services provided during an encounter and appropriately billed bypass TPL. See *Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance* on the [Code Sets](#) page at in.gov/medicaid/providers.

The IHCP applies previous TPL payments at the detail level. See the [Third-Party Liability](#) module for general information about TPL.

Managed Care Considerations – Wraparound Payment for Medical and Dental Encounters

FQHCs and RHCs can participate with an IHCP managed care entity (MCE). The MCE provider contract must specify the contractual arrangements to ensure that the FQHC or RHC is reimbursed for services. FQHC and RHC claims for IHCP members enrolled in a managed care plan such as Hoosier Care Connect, Hoosier Healthwise or the Healthy Indiana Plan (HIP) must be submitted to the applicable MCE for processing, unless the service is explicitly carved out of the managed care delivery system.

For all FQHC and RHC encounters, including for managed care members, the IHCP requires encounter code D9999 on dental claims and T1015 on professional (medical) claims with the exception of crossover claims and claims for services that are carved out of the PPS. FQHC and RHC wraparound (supplemental) payments for medical and dental encounters with IHCP managed care members are systematically processed in CoreMMIS on a claim-by-claim basis.

Wraparound payment amounts are displayed on the provider’s weekly remittance advice (RA), and providers can also use the IHCP Portal to request reports with wraparound payment information for specific date ranges.

Note: To improve the identification of health-risk factors of expectant mothers, the IHCP provides an additional \$60 for Notification of Pregnancy (NOP) when submitted for managed care members as described in the [Obstetrics and Gynecological Services](#) module and billed to the MCE as G9997 TH. The NOP service itself does not constitute a valid encounter. Wraparound FQHC/RHC payments will not be made if the NOP (G9997 TH) is the only service reported with encounter code T1015.

Wraparound Payment Information on the Remittance Advice

The IHCP RA for FQHCs and RHCs includes the following fields:

- Sum of All Payors – This field displays the total amount paid by the MCE and other insurance carriers, on a claim-by-claim basis. Claims with a Sum of All Payors amount of zero will be returned with EOB code 3370 – *Sum of All Payors amount is zero for the COB field for the encounter claim. Please verify and resubmit.*
- Wrap Amount – This field displays the difference between the provider-specific FQHC/RHC rate and the sum of all payors’ amount for each claim. Claims where the difference between the provider-specific rate and the sum of all payor’s amount is zero will post with EOB code 3372 – *Calculated Wrap Around payment amount is zero.*

Wraparound payments and adjustments are grouped separately on the RA, and listed for each claim with a wraparound payment or adjustment processed for the week. Claims are sorted by type (medical or dental). See the [Financial Transactions and Remittance Advice](#) module for more information.

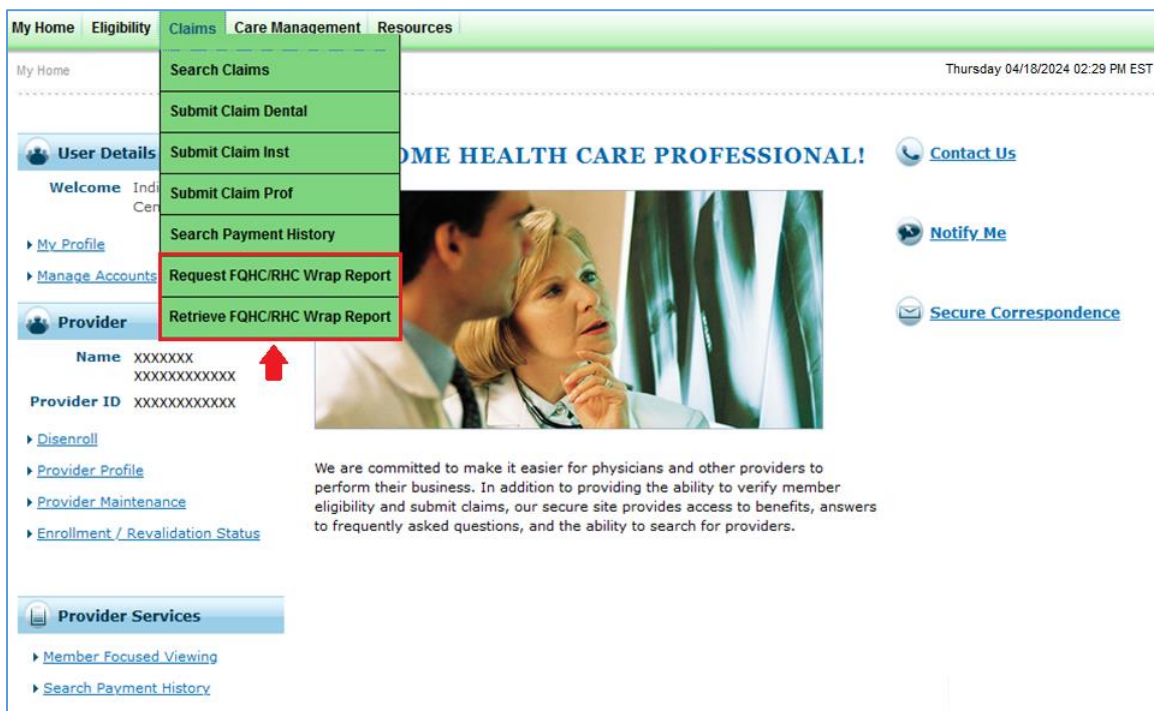
Requesting and Retrieving Wrap Reports on the IHCP Portal

The IHCP Portal can generate reports with wraparound payment information for a given date range. The report lists all managed care claims processed for the requesting provider within the indicated date range. For each claim, the spreadsheet shows the place of service code, MCE ID, patient number, Member Medicaid ID, claim number, date of service, billed amount, claim status, detail status, payment date, sum-of-all-payers amount and wrap payment amount.

FQHC and RHC providers can request and download wrap reports as follows:

1. Sign in to the [IHCP Provider Healthcare Portal](#).
2. Select the **Claims** tab in the top menu to display the drop-down list, and then click **Request FQHC/RHC Wrap Report**.

Figure 1 – FQHC/RHC Wrap Report Options on the IHCP Portal



3. Enter date parameters you want in the From and To fields of the *Request FQHC/RHC Wrap Report* panel, and then click **Submit**.

Note: The date range for the request must be within the same calendar month. Date ranges that span across months must be submitted as separate requests. Providers can request as many reports as they want, for various date ranges going back to the automation effective date of July 1, 2021.

Figure 2 – Request FQHC/RHC Wrap Report

Request FQHC/RHC Wrap Report

Provider Information

Provider ID 000000000 ID Type NPI Name xxxxxx xxxxxxxx xxxxxxxx

* Indicates a required field.
The From and To date range must be in the same calendar month.

Date Range *From *To

Submit **Cancel**

Pending Report Requests

#	From Date	To Date
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4. Each submitted request is added to the Pending Report Requests list until the report has been generated and is ready for retrieval.

Note: Reports can be retrieved the next business day.

5. The following business day, log back into the IHCP Portal and, from the **Claims** drop-down list, select **Retrieve FQHC/RHC Wrap Report**.
6. Enter the date parameters you want on the *Retrieve FQHC/RHC Wrap Report* panel and then click **Search**.
7. In the list of available reports, find the report you want and click **Download**. The report will be downloaded in .csv format to open in Excel.

Figure 3 – Retrieve FQHC/RHC Wrap Report

Retrieve FQHC/RHC Wrap Report

Provider Information

Provider ID xxxxxxxxxxxx ID Type NPI Name xxxxxxxxxxxx xxxxxxxxxxxx xxxxxxxx

* Indicates a required field.
The From and To date range must be in the same calendar month.

Date Range *From *To

Search **Reset**

Reports Available for Download

#	From Date	To Date	Action
1	2023-01-01	2023-01-31	Download