



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# NEWSLETTER

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Volume 24, No. 09

July 2014

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**TO:** Federally Qualified Health Centers (FQHCs) – **For Action**  
Health Maintenance Organizations (HMO) – **For Information Only**

**SUBJECT:** **FQHC Wraparound Reimbursement: Confirming Policies for Determining Valid Medicaid-Eligible Encounters & FQHC Appeals Process**

**EFFECTIVE:** Immediately

**PURPOSE:** The Division of Medical Assistance and Health Services (DMAHS) is confirming procedures for wraparound reimbursement to FQHCs for all valid Medicaid-eligible claims in conformance with the July 9, 2013 decision of the United States Court of Appeals for the Third Circuit in NJPCA v. New Jersey Department of Human Services et al. and the related May 31, 2014 Order by the United States District Court.

The Third Circuit's Opinion affirms the federal requirement that States participating in the Medicaid program provide for procedures of pre-payment and post-payment claims review in order to ensure the proper and efficient payment of claims and management of the program. In order to strengthen that claims review, DMAHS relies on HMOs to determine whether a claim is Medicaid-eligible, a practice which the Court found to be consistent with federal Medicaid law. The appeal process described below allows FQHCs the opportunity to meaningfully challenge an adverse claim payment determination that is made by an HMO that the FQHC believes is incorrect. FQHCs must strictly adhere to the procedures and timeframes described below so that a timely and correct determination on requests for wraparound payment and any associated appeals can be made.

**BACKGROUND:** The Third Circuit's decision and the District Court's Order confirmed that DMAHS has the authority to require detailed claim level data from FQHCs for reported encounters, as well as the HMO payment amount and HMO payment date. Additionally, under the decision, DMAHS is within its statutory and regulatory authority to require claim level data in order to ensure the proper and efficient payment of claims and management of the program. The Third Circuit found that the State is obligated to make payment only for Medicaid-eligible encounters.

Therefore, consistent with the law, DMAHS continues to require all detailed claim level data to be provided by the FQHCs for reported encounters, including HMO payment information and the supporting claim data spreadsheets provided by the State to the NJPCA and FQHCs in 2013, for pre-payment and post-payment review. In order to conform to the Third Circuit's Opinion regarding the adequacy of the appeal process in

the event of an adverse claim payment determination by an HMO, DMAHS has provided a formal appeal process to FQHCs in order to ensure that valid FQHC claims are paid by the HMOs and that valid wraparound payments are able to be determined and provided in a timely manner.

**ACTION:** Confirmation of the procedure for determining Medicaid-eligible encounters. The goal is to verify a claim's eligibility for reimbursement within the timeframe of the reimbursement period.

### **Determining valid Medicaid-eligible encounters**

DMAHS, in determining whether a claim is Medicaid-eligible, may rely on many sources, including data supplied by FQHCs, HMOs, or its own administrative process, and may refuse to pay invalid claims. DMAHS is confirming that, consistent with federal law and the Third Circuit's opinion, it relies on HMOs to determine whether a claim is Medicaid-eligible. Accordingly, the following policies apply:

- All encounters reported to DMAHS for quarterly wraparound reimbursement must first have their claims submitted to the member's assigned HMO plan for claims processing and HMO payment. The claim must pass through the HMO's claim processing system, resulting in a payment determination, prior to the encounter's submission to DMAHS.
  1. Pended claims, therefore, are disallowed in the wraparound process until determinative action has been completed by the HMO. (Do not submit these claims with wraparound reports.)
  2. HMO-denied claims that were validly denied because they were not eligible for Medicaid reimbursement should not be reported on the FQHC's quarterly report submissions.
  3. Duplicate encounters are disallowed in the wraparound process because they are not eligible for reimbursement. (Do not submit these claims with wraparound reports.) If a center believes that an encounter identified by DMAHS as a duplicate encounter is not a duplicate, the appeal process described below may be initiated.
  4. Claims denied by the HMO due to incorrect, missing, or duplicate claim details are disallowed in the wraparound process because they are not eligible for reimbursement if the claim information is incorrect or incomplete. (Do not submit these claims with wraparound reports.) The center must resubmit the claim for HMO processing with all data corrected and completed, and such claims do not qualify for DMAHS review under the appeal process below until the HMO has reprocessed the claim. Should the HMO again deny the claim once correct claim information has been submitted by the FQHC to the HMO, the appeal process below may be initiated.
  5. Claims containing errors in the supporting claim data submitted to DMAHS, including incorrect, missing, or duplicate Medicaid ID numbers, are disallowed in the wraparound process. An FQHC may use the appeal process below to correct any errors in the data that it has previously submitted to DMAHS.

6. DMAHS provides a file containing all encounters that have been paid by DMAHS for the quarter (“encounter file”). If the center believes that DMAHS has omitted an encounter from the wraparound payment that has been adjudicated by the HMO, that encounter should be reported through the appeal process below for initial determination.
- DMAHS performs claim review prior to issuing wraparound payments. Therefore, FQHCs must submit all supporting claim data in the required format simultaneously with their quarterly wraparound reports. DMAHS reviews supporting claim data in detail to determine whether the claims are eligible for reimbursement under program rules and processes wraparound payments accordingly. Any request for wraparound payment that is not supported by claim data is ineligible for reimbursement.

**ACTION:** Appeal process. The goal is to achieve a determination within the timeframe of the reimbursement period.

### **The Appeal Process**

- Upon review of the quarterly wraparound reports, DMAHS provides an encounter file to all FQHCs to indicate which encounter requests have been determined to be valid and eligible for wraparound reimbursement and which have not been approved. Any FQHC that wishes to challenge an HMO’s determination of an *invalid Medicaid claim ineligible for reimbursement* has 15 days from the receipt of the encounter file to initiate an appeal process with DMAHS indicating which HMO-denied encounters are being challenged as improperly denied.
- Along with its appeal request, the FQHC shall submit supporting claim data for any encounter that is being challenged as improperly denied. The format for the supporting claim data is the same as the format to be used for quarterly wraparound submissions of supporting claim data. Example spreadsheets and explanatory instructions were sent by DMAHS to the New Jersey Primary Care Association (NJPCA) by letter dated January 11, 2013 and to the FQHCs by letter dated February 27, 2013. These documents are also attached hereto for ease of reference. *DMAHS only accepts appeals of denials for which the FQHC provides complete supporting claim data.*
  1. In all submissions, including regular quarterly wraparound submissions, Column “M” of the supporting claim data spreadsheet should be used to identify any special circumstances pertaining to the encounter, particularly regarding HMO payment. Any information that helps explain or support the validity of the alleged Medicaid-eligible encounters in dispute should be provided. Capitated or bundled claims should be identified by a note entered in this column.
  2. In cases of appeal, Column “M” should indicate the word “appeal” and contain a brief summary as explained above. A separate abstract should accompany the encounter data outlining any measures taken by the FQHC with the HMO to resolve the alleged improper denial.

DMAHS notifies a center regarding the result of an appeal within 45 days from the date the appeal is received in the DMAHS' Office of FQHC Policy and Reimbursement. The notice includes:

- a. total accepted valid Medicaid-eligible determinations
- b. total invalid Medicaid-eligible determinations

After final review, valid Medicaid-eligible encounters are processed for wraparound reimbursement.

Any FQHC that disagrees with DMAHS' determination may request a Fair Hearing before the Office of Administrative Law, in accordance with N.J.A.C. 10:49-10.3. Any request for a Fair Hearing shall be mailed to: Fair Hearing Unit PO Box 712 Mail Code 3, Trenton, NJ 08625-0712.

If you have any questions concerning this Newsletter, please contact the **Office of FQHC Policy and Reimbursement** at **609-588-2669**.