Please read all instructions carefully before completing these forms.

Annual reconciliations are mandatory for all providers’ Prospective Payment System (PPS) or Indian Health Services (IHS) / Memorandum of Agreement (MOA) final settlements. Adjudicated visits must be reimbursed at the PPS rate(s) or IHS/MOA rate after subtracting all prior payments for visits that occur in the review period. Only claims that have been adjudicated by the Medi-Cal fiscal intermediary will be reconciled.

The information provided on these forms is subject to the Medicare reasonable cost based principles found in 42 CFR, Part 413 and in accordance with California’s FQHC/RHC/ IHS/MOA policies and procedures.

The Reconciliation Request forms consist of a Statistical Data and Certification page followed by pages 1 through 5. Page 1 is for which billing codes (02, 18, or 20) need to be updated. Pages 2 & 3 are worksheets to reconcile visits and payments applicable to Medi-Cal Managed Care Plans and for crossover services of dual eligible beneficiaries. Lastly, page 4 & 5 are to report services available and applicable practitioners.

A Reconciliation Request form must be completed for each NPI number and submitted within 150 days after the end of the facility’s first complete fiscal year. We no longer accept consolidated reconciliation forms.

All Medi-Cal providers follow the e-File Medi-Cal Worksheets Submission Protocol for submission of FQHC/RHC Worksheets. Submit the e-file forms to Reconciliation.Clinics@dhcs.ca.gov and you will receive an email response.

For assistance or questions, contact FQHC/RHC Section at (916) 322-1681 or Clinic@dhcs.ca.gov.

Incomplete forms will be returned for correction. If they are returned, instructions will be given noting the deficiencies and corrective action needed.

**RECONCILIATION PROCESS**

California’s State Plan requires the Department of Health Care Services (Department) make supplemental payments to FQHC/RHC/ IHS/MOA providers for beneficiaries enrolled in Medi-Cal Managed Care Plans and Medicare crossover visits.

These ‘interim’ payments along with all other payments the provider received that are associated with any adjudicated visits occurring within the review period must be included in total payments, including payments for “incident to” services.

The Department has 3 years from the date these forms are received and accepted for processing to determine if the total payments were greater than or less than the provider’s allowable PPS or IHS/MOA reimbursement. The information gathered here is used to determine the final settlement amount. Effective 5/1/03, the Department can only reconcile Managed Care Plan visits and payments adjudicated (billed and paid) by the Medi-Cal fiscal intermediary.

**Note**: Child Health and Disability Prevention (CHDP) services have been removed from the FQHC/RHC/ IHS/MOA Reconciliation Request. CHDP services performed for Non-Managed Care beneficiaries that constitute a valid FQHC/RHC/ IHS/MOA visit, as defined above should be billed to the Medi-Cal fiscal intermediary using Code 01 in accordance with the FQHC/RHC/ IHS/MOA Provider Billing Manual found on the DHCS web site at (http://files.medi-cal.ca.gov/pubsdoco/manuals\_menu.asp).

CHDP services performed for Medi-Cal Managed Care beneficiaries that qualify as a valid FQHC/RHC/ IHS/MOA visit as defined above should be billed as a Medi-Cal Managed Care visit using Code 18. Thus these visits and their associated payments will be reconciled as set forth in these instructions.

**DOCUMENTATION**

The reported data on these forms is subject to audit by the Department and must be supported by documentation such as remittance advices (RA), explanation of benefits (EOB), or other verifiable evidence. The Department will review the Request forms and may ask for this supporting documentation, thus minimizing the need for onsite reviews.

**STATISTICAL DATA AND CERTIFICATION STATEMENT**

Complete Part A, lines 1 through 12 with the requested information. If you need additional space to identify entities that you owned, attach a page with the provider name, location, and clinic provider number. Complete Part B, Certification Statement with the requested information. The individual signing this statement must be an officer or other authorized responsible person.

**PAGE 1 – REQUEST TO UPDATE INTERIM RATES (Billing Codes 02, 18, & 20)**

This page is only used to request updates to the interim rates. Please answer YES for any interim rate you wish to have changed and complete the applicable forms.

Enter the Clinic Name, NPI and Fiscal Period and the remaining pages will populate automatically.

**PAGE 2 - RECONCILIATION FORM – DETAIL**

Complete this page as follows: ***FIRST*** enter the appropriate Month and Year in the left most column, beginning with the first month of the entities’ fiscal year, ***SECOND*** enter the monthly visit counts, and prior payment amounts, as described below. Enter all data associated with the type of encounters applicable to the clinic site. Be sure to use ‘Date of Service’ as the basis for reporting this information.

**BILLING CODES DEFINED**

The reconciliation process is necessary for those visits/services billed and paid using revenue codes that pay less than the full PPS rate, i.e. Codes 02, 18, and 20. These are also known as ‘interim’ rates.

Non-crossover Medi-Cal beneficiaries that are not enrolled in a Managed Care plan are billed using Codes 01, 03, and 04 for Medical services, Dental services, and Optometry services respectively. There is no need to reconcile these billing codes as they have already been paid the full PPS rate.

*However, these services may be reviewed and can be adjusted during the reconciliation process if the auditor finds that inappropriate payments were made for non-billable or ‘incident to’ services such as injections, screenings/tests, or duplicate billings.*

If a Medi-Cal beneficiary has Medicare coverage use the following table to determine which billing code to use. For regular Medi-Cal / Medicare crossovers bill a Code 02. Code 18 applies if the beneficiary is enrolled in a Medi-Cal Managed Care Plan. If the Primary Payer is a Medicare Advantage Plan (MAP) then follow the chart below:

|  |  |  |
| --- | --- | --- |
| **Type of MAP Arrangement** | **Type of Medi-Cal Arrangement** | **Use Billing Code** |
| PRIMARY PAYER | SECONDARY PAYER |  |
| Medicare Advantage Plan* Capitated Arrangement
 | Medi-Cal* Non-Managed Care
 | Code 20 |
| Medicare Advantage Plan* Fee for Service Arrangement
 | Medi-Cal* Non-Managed Care
 | Code 02 |
| Medicare Advantage Plan* Capitated Arrangement
 | Medi-Cal* Managed Care
 | Code 18 |
| Medicare Advantage Plan* Fee for Service Arrangement
 | Medi-Cal* Managed Care
 | Code 18 |

# VISITS DEFINED:

A “visit” for FQHC or RHC services is defined in regulations and the SPA as any of the following:

(a) A face to face encounter between an FQHC/RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or visiting nurse, hereafter referred to as a “health professional,” to the extent the services are reimbursable under the Medi-Cal program. A “physician” means:

(i) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.

(ii) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.

(iii) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.

(iv) A doctor of chiropractic authorized to practice chiropractic by the State and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.

1. Comprehensive perinatal services (CPSP) when provided by a comprehensive perinatal services practitioner as defined in the California Code of Regulations, Title 22, Section 51179.7.

Encounters with more than one health professional and/or multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day if:

1. When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment.
2. OR when the clinic patient is seen by a health professional or comprehensive perinatal services practitioner, and is also seen by a dentist or Registered Dental Hygienist on the same date.

A “visit” for an IHS/MOA provider is a face-to-face encounter provided in the tribal facility between a tribal patient and the health professional (see billable providers below).

Billable providers: Physician, Physician Assistant, Nurse Practitioner, Nurse Midwife, Clinical Psychologist, Licensed Clinical Social Worker and Marriage and Family Therapists and their registered interns, Visiting Nurse if services are provided in the Tribal facilities, CPSP providers.

**COLUMN HEADINGS DEFINED:**

# MEDI-CAL MANAGED CARE – Code 18 (Columns 1 through 4): If the clinic has more than one managed care plan, combine all data for entry into this section.

**Column 1 – Code 18 (Managed Care) Visits** – Report all adjudicated visits for the review period for Medi-Cal beneficiaries that are enrolled in a Managed Care Plan regardless of Medicare eligibility.

**Column 2 – Medi-Cal Managed Care Plan Payments** – Report **all** Medi-Cal Managed Care Plan payments (both fee-for-service {FFS} and capitated) in this column. The plan payments should include payments related to “incident to” services. Do not include risk-pool payments.

**Column 3 - Medicare and MAP Payments** –Report the Medicare (or its fiscal intermediary) and Medicare Advantage Plan payments for Medi-Cal Managed Care crossover patient visits.

**Column 4 - Code 18 Payments** –Report the payments received from Medi-Cal fiscal intermediary for Code 18.

##### MEDI-CAL NON-MANAGED CARE CROSSOVERS (Columns 5 through 10):

**Medicare Advantage Plans (MAP) Code 20** - Billing systems must differentiate between MAP services for **Capitated (Code 20)** versus **Fee-for-Service (Code 02)** patients. Crossovers can only be billed with an attached Medicare Explanation of Benefits (EOB). Since EOB’s are not available in the capitation environment a special billing code was developed - Code 20.

**Column 5 – Code 20 (MAP) Visits** – Report all the adjudicated visits during the reporting period for Non-Managed Care Medi-Cal crossover beneficiaries enrolled in a **CAPITATED** MAP.

**Column 6 – Capitation Payments from MAP(s)** – Report the **CAPITATED** payments received from Medicare Advantage Plans.

**Column 7 - Code 20 (Medi-Cal) Payments** – Report the payments received from Medi-Cal fiscal intermediary for Code 20.

**Medi-Cal Crossovers**

**Column 8 – Code 02 (Crossover) Visits** – Report all the adjudicated visits during the reporting period for Medicare/Medi-Cal crossovers if the beneficiary is **not** enrolled in any Managed Care Plan **and** is not a participant in a capitated MAP.

**Column 9 - Medicare Crossover Payments** – Report the payments received from Medicare or its fiscal intermediary for Medicare/Medi-Cal dual eligible patients who are **not** enrolled in a Medi-Cal Managed Care Plan **and are not** enrolled in a capitated MAP.

**Column 10 - Code 02 (Medi-Cal) Payments** – Report the payments received from Medi-Cal fiscal intermediary for Code 02.

**ENTER TOTALS for PERIODS 1 AND 2**

For FQHC/RHC providers **Period 1** refers to the period of time within the clinic’s fiscal year that is prior to October 1st. This is the time interval before the Medicare Economic Index (MEI) adjustment factor is implemented.

For FQHC/RHC providers **Period 2** refers to the period of time within the clinic’s fiscal year beginning October 1st. For example, a clinic with a June 30th fiscal year end would have the 3 months of July, August, and September in Period 1. The remaining 9 months of the clinic’s fiscal year would be in Period 2. Only the period totals are carried forward to Page 2.

For IHS/MOA providers that have a fiscal year end of December 31st, all information can be input in Period 1. If your fiscal year end is a date other than December 31st¸ then Period 1 refers to the period of time prior to January 1st when the MOA rate is adjusted. For example, a clinic with a June 30th fiscal year end would have the months of July through December in period 1. The remaining six months of the clinic’s fiscal year would be in Period 2 after the MOA rate is adjusted.

# PAGE 3 - RECONCILIATION REQUEST FORM - SUMMARY: (Enter the PPS or IHS/MOA Rates ONLY)

If completing the forms electronically you only need to enter the correct PPS or IHS/MOA rates for Periods 1 and 2. This summary page automatically populates the areas for visits and payments (from the detail reported on page 2) and determines the amount due the State or clinic.

**PAGE 4 and 5 – SUMMARY OF SERVICES / SUMMARY OF HEALTHCARE PRACTITIONERS**

Complete pages 4 and 5 and include with your submission of reconciliation data.

These pages do not apply to IHS/MOA providers.