

ANNUAL RECONCILIATION PROCESS

AUDITS AND INVESTIGATIONS - AUDIT REVIEW AND
ANALYSIS SECTION
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OVERVIEW

- Annual Reconciliation Request
 - Requirements
 - Tips for filling out the reconciliation request forms
- Process for establishing a code 18 and 20 rate

RECONCILIATION REQUEST
REVIEW (FORM 3097)

PURPOSE OF A RECONCILIATION REQUEST

- To insure a clinic receives the full PPS rate / MOA rate for all qualifying Differential visits
 - ❖ Types of Differential Visits
 - Code 02 – Medicare Crossover
 - Code 18 – Medi-Cal Managed Care
 - Code 20 – Medicare Advantage Plan

ANNUAL RECONCILIATION REQUEST

- Due Annually within 150 days after your fiscal year end. Must file even if you have a zero settlement.
- If not received timely clinic is put on withhold until forms received.
- The information provided on these forms is subject to the Medicare Reasonable Cost Principles in 42 CFR, Part 413 in accordance with the State's Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC) State Plan Amendment.
- Subject to audit

ANNUAL RECONCILIATION REQUEST

- DHCS has three years from the date that DHCS received the Reconciliation Request to audit the report.
- A provider must maintain all documentation to support all reported visits/payments (i.e. remittance advices, explanation of benefits, documentation from the managed care plans supporting payments).
- All reported Medi-Cal Visits and Payments will be reconciled to the adjudicated visits compiled by the fiscal intermediaries and the Paid Claims Summary Report (PCSR Report).

TIPS FOR FILLING OUT RECONCILIATION FORMS

- Managed Care Plan Payments – include all capitated and/or fee-for-service payments received for patient services.
- Medicare Payments – payments can be determined by summing all your Medicare payments received for all adjudicated Medi-Cal code 02 visits.
- Include Medicare payments that are related to beneficiaries enrolled in Medicare/Medi-Cal managed care under the Managed Care portion of the Recon (Column 3). They should be billed as a code 18.
- Only include visits that were adjudicated by the Medi-Cal fiscal intermediary (Xerox)

TIPS FOR FILLING OUT RECONCILIATION FORMS

- A provider can order a copy of the Medi-Cal payment data (Paid Claims Summary Report) from the fiscal intermediary (Xerox).
- The payment data can be ordered through Xerox by either calling 1-800-541-5555 or by emailing their request to **cdrorders@xerox.com**.
- Insure your facility maintains all the documentation used to fill out the reconciliation request form.
- E-mail **clinics@dhcs.ca.gov** with questions related to filling out the forms

ANNUAL RECONCILIATION REQUEST

- Forms and instructions are located at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

ESTABLISHING A CODE 18
AND 20 RATE

ESTABLISHING A CODE 18 RATE

- Complete Form DHCS 3100
- Forms and instructions are located on our webpage <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

COMPLETING FORM DHCS 3100

- Certification Sheet (see attachment)
 - Clinic Name, NPI Number, Address, Signature certifying the information is true and correct etc.
- Page 1
 - Visit and payment information
 - Important to include all payments (capitated/fee-for-service/Medicare)
 - Actual or projected data
 - If you use projected data you need to resubmit form 3100 after you receive three months of actual claims
 - If you don't have projected data the code 18 rate will be set at \$25 until three months of actual data is received

CALCULATION OF CODE 18 RATE

PPS rate (MOA rate)	\$300
Less: weighted average MC plan pmts per visit*	<u>\$100</u>
Code 18 rate (differential rate)	\$200

*Calculated using data submitted on DHCS form 3100

ESTABLISHING A CODE 20 RATE

- Complete Form DHCS 3104
- Forms and instructions are located on our webpage <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

COMPLETING FORM DHCS 3104

- Certification Sheet (see attachment)
 - Clinic Name, NPI Number, Address, Signature certifying the information is true and correct etc.
- Page 1
 - Visit and payment information
 - Include capitated Medicare Advantage Plan visits and payments
 - Actual or projected data
 - If use projected data need to resubmit form 3104 after you receive three months of actual claims
 - If you don't have projected data the code 20 rate will be set at \$25 until three months of actual data is received

CALCULATION OF CODE 20 RATE

MOA Rate	\$300
Less: Average MAP Capitated Payments*	<u>\$ 75</u>
Code 20 Rate	\$225

*\$15,000 (Total Capitated MAP Payments) / 200 (total visits for beneficiaries in a capitated MAP) = \$75 average MAP capitated payments

ADJUSTING CODE 18 AND 20 RATES

- 'Request to Update Rates' (page 3) is included in the annual reconciliation request forms.
- You can request a rate adjustment at any time.

PROCESS FOR ADJUSTING RATES

- A&I submits a rate sheet to Provider Enrollment Division (PED).
- It typically takes PED Four to Six weeks to update the rates in the Provider Master File (PMF).
- Code 2, 18 and 20 rates are adjusted going forward so that an Erroneous Payment Correction (EPC) is not created. The claims are adjusted through the reconciliation process.

ADDITIONAL INFORMATION

- For questions related to the reconciliation process an e-mail can be sent to Clinics@DHCS.ca.gov