

Annual Reconciliation Request Training 101

Presented by Audits and Investigations, Financial Audits Branch,
Audit Review and Analysis Section

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OVERVIEW OF ANNUAL RECONCILIATION REQUEST AND ESTABLISHING DIFFERENTIAL RATES

- Purpose and process for establishing a code 2, 18 and 20 rate
- Reconciliation Request
 - Purpose
 - Requirements
 - Reconciliation Request Report
- Audit process
- Common Issues with Reconciliation Reports

TERMS

- DHCS – Department of Health Care Services
- HRSA - Health Resources and Services Administration
- MEI – Medicare Economic Index
- SPA – State Plan Amendment
- NPI - National Provider Identifier
- EPC - Erroneous Payment Correction
- PCSR – Paid Claims Summary Report

PURPOSE OF A RECONCILIATION REQUEST

To ensure a clinic receives the full Indian Health Service/Memorandum of Agreement 638 Clinic (IHS/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 (capitated plans only)

PURPOSE OF CODE 2 (DIFFERENTIAL RATE)

- The Medicare Crossover differential rate¹ was established to comply with federal and state regulation to reimburse a provider for the difference between their IHS/MOA rate and their Medicare reimbursement.
- Billing Code 2 reimburses providers on an interim basis the estimated amount payable for a Medi-Cal Crossover visits.

1. Differential rate is also referred to as wrap-around

PURPOSE OF CODE 2 (DIFFERENTIAL RATE)

Code 2 Rate Calculation

IHS/MOA rate*	\$330
Less: 80% of the facilities Audited Medicare Rate **	<u>\$103</u>
Code 2 rate (differential rate)	\$227

*2013 IHS/MOA Rate

**Medicare Cost Report and/or Medicare remittance advice may be requested to verify the Medicare rate.

PURPOSE OF CODE 18 (DIFFERENTIAL RATE)

- The managed care differential rate¹ was established to comply with federal and state regulation to reimburse a provider for the difference between their IHS/MOA rate and their Medi-Cal managed care reimbursement.
- Billing Code 18 reimburses providers on an interim basis the estimated amount payable for Medi-Cal managed care visits.

1. Differential rate is also referred to as wrap-around/code 18 rate

ESTABLISHING A CODE 18 RATE (DIFFERENTIAL RATE)

- Complete DHCS Form 3100 to establish or change the code 18 rate (differential rate).
- Forms and instructions are located on our webpage at:
<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

COMPLETING DHCS FORM 3100

Certification Sheet

- Clinic Name, NPI Number, Address, Signature certifying the information is true and correct etc.

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC STATISTICAL DATA AND CERTIFICATION STATEMENT MANAGED CARE DIFFERENTIAL RATE REQUEST		
Part A		
Contact Person:	Date Submitted:	
1. FQHC/RHC Name:	Telephone Number and e-mail address:	
2. FQHC/RHC Address:	Fiscal Year End:	
3. FQHC/RHC Number(s)	4. NPI Number(s)	
5. Type of Control (Check one)		
<input type="checkbox"/> Voluntary Nonprofit Corporation: <input type="checkbox"/> State <input type="checkbox"/> City <input type="checkbox"/> Government: Federal <input type="checkbox"/> County <input type="checkbox"/> Other		
6. FQHC/RHC Owned By		
7. Other FQHCs/RHCs, Hospitals, Skilled Nursing Facilities, Home Health Agencies, suppliers or other entities that are owned or related through common ownership or control to the individual or entity listed in item 6:		
Provider Name	Location	Clinic or Provider No.
Part B		
Certification Statement		
Intentional misrepresentation or falsification of any information contained in this request resulting in reimbursement by the Department may be punishable by fine and/or imprisonment under federal and state laws. (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments", 18 U.S.C 1347 "Health Care Fraud", California Welfare and Institutions Code 14123.25 "Civil Penalties for Fraudulent Claims", and Title 22 of the California Code of Regulations 51485.1 "Civil Money Penalties")		
Certification by Officer or Administrator of the Clinic		
I, _____, certify under penalty of perjury as follows:		
That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare		
Officer or Administrator of FQHC/RHC	Title:	Date:
Print Name: _____	_____	_____
Signature: _____	_____	_____
Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.		
Mail the original signed Managed Care Differential Rate Request form to:		
California Department of Health Care Services Audits and Investigations, Financial Audits Branch Audit Review and Analysis Section 1500 Capitol Avenue, MS 2109 P.O. Box 997413 Sacramento, CA 95899-7413		
For questions or assistance in completing these forms, you may submit questions to the following email address: Clinics@dhcs.ca.gov. You will receive an email response or if you do not have access to email, you may contact main number at (916) 650-6696.		

- Page 1
 - Visit and payment information
 - ✓ Important to include all payments (capitated/fee-for-service/Medicare)

Use of projected data

- If use projected data need to resubmit form 3100 after three months of actual claims are received.
- Code 18 rate will be set at \$25 until three months of actual data is received.

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC MEDI-CAL MANAGED CARE DIFFERENTIAL RATE REQUEST						
Clinic Name: _____	Fiscal Period: _____					
Medi-Cal No: _____	NPI No: _____					
1 Medi-Cal Managed Care	Plan A	Plan B	Plan C	Plan D	Plan E	Total
Plan Name	()	()	()	()	()	
2 Payment Information <input type="checkbox"/> Actual <input type="checkbox"/> Projected						
A. Managed Care Plan Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
B. Managed Care Medicare Crossover Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Managed Care Plan Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
3 Visit Information <input type="checkbox"/> Actual <input type="checkbox"/> Projected						
A. Managed Care Plan Visits	0	0	0	0	0	0
B. Managed Care Plan - Medicare Crossover	0	0	0	0	0	0
Total Managed Care Visits	0	0	0	0	0	0

EXAMPLE OF CALCULATION OF CODE 18 RATE (DIFFERENTIAL RATE)

IHS/MOA rate*	\$330
Less: weighted average MC plan pmts per visit**	<u>\$ 50</u>
Code 18 rate (differential rate)	\$280

*2013 IHS/MOA Rate

**Calculated using data submitted on DHCS form 3100

ESTABLISHING A CODE18 RATE (DIFFERENTIAL RATE)

- Important to develop code 18 rate that creates the smallest differences between the payments received and the IHS/MOA rate. We would like to see reconciliation settlement as minimal as possible.
- Use accurate data when filling out the DHCS form 3100.
- Use at least three months of payments/visits data when filling out DHCS form 3100.

PURPOSE OF CODE 20 (MAP)

The Medicare Advantage Plan (MAP) forms are designed to establish a MAP rate that reimburses a provider for the difference between their IHS/MOA rate and their Medicare Advantage Plan (capitated) average reimbursement per visit for Medicare/Medi-Cal (crossover) beneficiaries.

ESTABLISHING A CODE 20 RATE (MAP)

- Complete DHCS Form 3104 to establish a code 20 rate (MAP).
- Forms and instructions are located on our webpage at
<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

COMPLETING DHCS FORM 3104
FOR CODE 20
RATE REQUEST FOR CAPITATED
MEDICARE ADVANTAGE PLANS (MAP)

Rate Request for Capitated Medicare Advantage Plans (MAP) Form 3104

Certification Sheet

- Clinic Name, NPI
Number, Address,
Signature certifying
the information is
true and correct etc.

STATISTICAL DATA AND CERTIFICATION STATEMENT		
Part A		
1. Contract Start Date:	Date Submitted:	Fiscal Year End:
2. Contact Person:		Contact Telephone Number:
3. FQHC/RHC Name and Address		Contact Fax Number:
4. FQHC/RHC Number(s)		Contact Email Address:
5. Type of Control (Check one)		
<input type="checkbox"/> Voluntary Nonprofit Corporation: <input type="checkbox"/> State <input type="checkbox"/> City <input type="checkbox"/> Government: Federal <input type="checkbox"/> County <input type="checkbox"/> Other		
6. FQHC/RHC Owned By		
7. Other FQHCs/RHCs, Hospitals, Skilled Nursing Facilities, Home Health Agencies, suppliers or other entities that are owned or related through common ownership or control to the individual or entity listed in item 6:		
Provider Name	Location	Clinic or Provider No.
Part B		
Certification Statement		
Intentional misrepresentation or falsification of any information contained in this request resulting in reimbursement by the Department may be punishable by fine and/or imprisonment under federal and state laws. (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments", 18 U.S.C 1347 "Health Care Fraud", California Welfare and Institutions Code 14123.25 "Civil Penalties for Fraudulent Claims", and Title 22 of the California Code of Regulations 51485.1 "Civil Money Penalties")		
Certification by Officer or Administrator of the Clinic		
I, _____, certify under penalty of perjury as follows:		
That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and Institutions Code.		
Officer or Administrator of FQHC/RHC	Title:	Date:
Print Name: _____		
Signature: _____		
Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.		
Mail the original signed Managed Care Differential Rate Request form to:		
California Department of Health Care Services Audits and Investigations, Financial Audits Branch Audit Review and Analysis Section 1500 Capitol Avenue, MS 2109 P.O. Box 997413 Sacramento, CA 95899-7413		

Rate Request for Capitated Medicare Advantage Plans (MAP) Form 3104

- Page 1
 - Visit and payment information

FQHC/RHC MEDICARE ADVANTAGE PLAN(S) INFORMATION REQUEST

Clinic Name: _____ Fiscal Period: _____
 NPI No: _____

	Plan A	Plan B	Plan C	Plan D	Plan E	Total
Please Provide Plan Name						
<u>Payment Information</u>						
A. Payments Received from Medicare Advantage Plan(s)						\$0
<u>Visit Information</u>						
A. Medicare Advantage Plan Visits						.

CALCULATION OF CODE 20 (MAP) RATE

IHS/MOA Rate*	\$330
Less: Average MAP Capitated Payment**	<u>\$ 75</u>
Code 20 Rate	\$255

*2013 IHS/MOA rate

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

Adjusting differential 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.

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Makeup of the Reconciliation Request

**RECONCILIATION
REQUEST FORMS
(DHCS FORM 3097)**

Page 1- Cover Page

**MEDI-CAL FREESTANDING
FEDERALLY QUALIFIED HEALTH CENTER
OR
RURAL HEALTH CLINIC
PROSPECTIVE PAYMENT SYSTEM
RECONCILIATION REQUEST**

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 2- Certification Worksheet

FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC RECONCILIATION REQUEST IDENTIFICATION AND CERTIFICATION			
Part A - IDENTIFICATION			
1. FQHC/RHC Legal Name:		2. Doing Business as (DBA):	
3. FQHC/RHC Address (Street, City, State, Zip): Street:		4. National Provider Identifier(s): *	
City:		State:	
Zip:		6. Fiscal Year End:	
5. Type of Control (Check one): Nonprofit Corporation: ___ Government Controlled: Federal ___ State ___ County ___ City ___ For Profit Entity: ___		6. Fiscal Year End:	
7. Name of Contact Person:	8. Business Phone:	9. Fax No.:	10. E-mail Address:
11. FQHC/RHC Owned By:			
12. Other healthcare providers (Clinics, Hospitals, Long-term Care, Home Health Agencies, medical suppliers, etc.) that are related through common ownership or control to the individual or entity listed in item 11 (attach more pages if			
Provider Name	Address	NPI	
Part B - CERTIFICATION			
Intentional misrepresentation or falsification of any information contained in this request, resulting in reimbursement by the Department, may be punishable by fine and/or imprisonment under Federal law (42 CFR Section 1003.102; 18 USC Section 1347), and/or California law (Welfare and Institutions Code Section 14123.2; and 22 CCR Section 51485.1).			
<u>Certification by Officer or Administrator of the Clinic</u>			
I, (Name) _____ :			
Certify under penalty of perjury that I am a duly appointed official of the provider identified above, and am authorized to sign this certification statement. To the best of my knowledge, information, and belief I affirm each statement and amount in the accompanying Reconciliation Request Forms to be true, accurate, and in compliance with applicable Federal and California laws.			
Signature:		Title:	Date:
COMMENTS or ADDITIONAL INFORMATION:			
<i>*Only enter multiple NPI's if facilities were consolidated during rate setting process.</i>			
DHCS 3097 (10/13)		Page 2 of 7	

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 3- Request to Update Differential Rates

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC RECONCILIATION REQUEST REQUEST TO UPDATE INTERIM RATES

Clinic Name:				
NPI(s):				
FISCAL YEAR END:				

Please indicate whether or not your facility needs updates to these rates.

	Rate Request Form #	YES
1 <u>Medi-Cal Crossovers (Code 02)</u>	Not Required	_____
2 <u>Medi-Cal Managed Care Plan (Code 18)</u>	Form DHCS 3100 *	_____
3 <u>Healthy Families Plan (Code 19)</u>	Form DHCS 3105 *	_____
4 <u>Medicare Advantage Plan (Code 20)</u>	Form DHCS 3104 *	_____

Instructions:

Place an X under the YES if you would like to have your rates updated.
Please submit appropriate Rate Request Form to have Code 18, Code 19 or Code 20 rates updated.
This form will only apply to the NPI(s) listed.

* LINKS: Please click on the link below to retrieve the form and its instructions.

Code 18	Form DHCS 3100	Form 3100 Instructions
Code 19	Form DHCS 3105	Form 3105 Instructions
Code 20	Form DHCS 3104	Form 3104 Instructions

Please be sure to follow the instructions that go with each form above.

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 5 – Payment Recovery Determination

PROVIDER LEGAL NAME:				
NPI NUMBER(s):				
FISCAL YEAR END:				
PAYMENT / RECOVERY DETERMINATION				
VISITS				
		Period 1	Period 2	Total
1.	Medi-Cal Managed Care - Code 18			
2.	Healthy Families Plan - Code 19			
3.	Medi-Cal Crossovers w/Cap. MAP - Code 20			
4.	Medi-Cal Crossovers - Code 02			
5.	Total Visits			
PAYMENTS				
		Period 1	Period 2	Total
6.	Medi-Cal Managed Care Plans	\$ -	\$ -	\$ -
7.	Medicare & FFS MAP for Code 18	\$ -	\$ -	\$ -
8.	Medi-Cal for Code 18	\$ -	\$ -	\$ -
9.	Healthy Families Plans	\$ -	\$ -	\$ -
10.	Medi-Cal for Code 19	\$ -	\$ -	\$ -
11.	Patient Co-Payments	\$ -	\$ -	\$ -
12.	Capitated Medicare Advantage Plans	\$ -	\$ -	\$ -
13.	Medi-Cal for Code 20	\$ -	\$ -	\$ -
14.	Medicare for Code 02	\$ -	\$ -	\$ -
15.	Medi-Cal for Code 02	\$ -	\$ -	\$ -
16.	Total Payments	\$ -	\$ -	\$ -
SETTLEMENT SUMMARY				
		Period 1	Period 2	Total
17.	PPS Rates (Enter this data only)			N/A
18.	Total Visits (From Line 5)			
19.	PPS Dollar Amount (Line 17 x Line 18)			
20.	Less: Total Payments (From Line 16)	\$ -	\$ -	\$ -
21.	Amount Due Clinic (State) L19 - L20	\$ -	\$ -	\$ -
NOTE: Because PPS rates change on October 1st each year, it is necessary to compute a Period 1 and a Period 2 summary, and then combine them for proper settlement.				

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 6 – Summary of Services

SUMMARY OF SERVICES				
FQHC/RHC Name		NPI Number		
Reporting Period From:		Through:		
Please indicate what and where services are provided. If Off-Site, by	*	YES**		
		NO	ON-SITE	OFF-SITE Contractor
1. Medical				
2. Dental				
3. X-ray				
4. Laboratory				
5. Pharmacy				
6. Nutritional				
7. Psycho/Social				
8. Education				
9. CPSP				
10. Outreach				
11. Norplant Implants				
12. Optometry				
13. Chiropractic				
14. Podiatry				
15. Physical Therapy				
16. Occupational Therapy				
17. Treatment Room				
18. Surgery/Recovery				
19. Anesthesiology				
20. Radiology				
21. Nuclear Med/CT				
22. Clinical Lab				
23. Central Supplies				
24. Pathology				
25. Radiotope				
26. Electrocardiology				
27. Electroencephalography				
28. Other (specify):				
29.				
30.				
31.				
32.				
33.				

*NO = Service is NOT provided by the clinic.
 **YES ON-SITE = Service is provided within '4-walls' of clinic.
 **YES OFF-SITE = Service is provided outside clinic by contractual arrangement (include contractor's name).

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 7 – Summary of Productive Time for Health Care Practitioners

SUMMARY OF PRODUCTIVE TIME FOR HEALTH CARE PRACTITIONERS				
FQHC/RHC Name		NPI Number		
Reporting Period From:		Through:		
HEALTH CARE STAFF	1	2	3	4
	FTEs	# of VISITS	ON-SITE	OFF-SITE
1. Doctor of Medicine; MD **				
2. Doctor of Osteopathy; DO **				
3. Doctor of Podiatric Medicine; DPM **				
4. Doctor of Optometry; OD **				
5. Doctor of Chiropractics; DC **				
6. Doctor of Dental Surgery; DDS **				
7. Physician Assistant; PA				
8. Nurse Practitioner; NP				
9. MD, PA, NP Mental Health Specialists				
10. Certified Nurse Midwife; CNM				
11. Registered Dental Hygienist; RDH				
12. Visiting Nurse				
13. Clinical Psychologist				
14. Licensed Clinical Social Worker; LCSW				
15. Comprehensive Perinatal Health Worker				
16. Physician Services Under Agreement				
17. Acupuncturist *				
18. Physical Therapist *				
19. Marriage Family Therapist *				
20. Counselors *				
21. Nutritionist *				
23. Other (specify): *				
24.				
25.				
26.				
27.				
28.				
29.				
30. TOTALS	0.00	-		

Full Time Equivalent (FTE) assumes 2,080 hours worked in Patient Care activities (40 hrs/week for 52 weeks).
 ** Only include the Productive Time worked. Exclude all time spent in non-patient care activities.
 * Nonreimbursable Practitioners/Visits

VISITS/MEDI-CAL PAYMENTS TO BE REPORTED ON THE RECONCILIATION REQUEST

- Include Visits that meet the following criteria
 - ✓ The visit must meet the definition of a Medi-Cal visit (see provider billing manual).
 - ✓ The visit must be adjudicated by Medi-Cal through the fiscal intermediary (Xerox).
- Include ALL payments related to the adjudicated visits.
- Include visits/payments for Date of Service.

PAYMENT DATA (PCSR) INFORMATION

Providers can order payment data from Xerox by either calling 1-800-541-5555 or by emailing their request to cdrorders@xerox.com.

- It is a good idea to order payment data for the following reasons:
 - ✓ To ensure the visits and payments in your system matches what has been adjudicated by Xerox (fiscal intermediary).
 - ✓ If there are any variances found on the payment data you will have time to either bill or rebill for the visits that have been denied or appeal the denials through Xerox's appeal process.
 - ✓ Audits and Investigations does not have the ability to adjudicate patient claims.

RECONCILIATION REQUEST REQUIREMENTS

- Due within 150 days of facilities fiscal year end
 - File report even if the annual MOA rate increase has not been updated in the PMF system. Use your current MOA rate. Audits will correct the MOA rate during the audit process. You may include a note on the Reconciliation Request forms to ensure the auditor is aware the MOA rate needs to be adjusted accordingly.

RECONCILIATION REQUEST REQUIREMENTS - CONTINUED

- A partial year reconciliation also must be filed.
- If a clinic's reconciliation request is not received in a timely manner that clinic is put on payment withhold until forms are received.
- The reconciliation request forms are subject to audit.

RECONCILIATION REQUEST AUDIT

- A facilities Reconciliation may be either desk audited or field audited.
- 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).
- An Auditor may complete a billing review.
- All reported Medi-Cal Visits and Payments will be reconciled to the adjudicated visits compiled by the fiscal intermediary (Paid Claims Summary Report (PCSR)).

RECONCILIATION REQUEST AUDIT

- If the auditor makes adjustments to the reported reconciliation request, a 15 day letter will be sent.
 - 15 days to provide additional data
- After the final audit report is issued, you have 60 days to appeal any adjustments that you disagree with.

COMMON ISSUES

- Timely filing of the Reconciliation Request
- Signing of the Reconciliation Request
- Visit counts – including non-adjudicated visits and denied visits
- Properly reporting ALL actual managed care plan payments received during the period under review
 - Using an average rate per plan visit and then multiplying it by the reported visits. (Is not a valid methodology)
 - Not including all of the capitated plan payments received.
- Using the correct Medicare crossover visits rate per visit
- Billing Medi-Cal for visits that do not meet the definition of a visit

PAID CLAIMS SUMMARY REPORT (PCSR)

- A provider can order the payment data from Xerox by either calling 1-800-541-5555 or by emailing your request to cdorders@xerox.com.
- If a provider would like to look at submitted claims to see what the status is they can log into the Medi-Cal website at www.medi-cal.ca.gov, click on the Transactions Tab at the top, log on with their NPI # and PIN. Once this opens they can click on “Automated Provider Services” and then “Claim Status”.

Send questions related to the reconciliation process to:

reconciliation.clinics@dhcs.ca.gov inbox

General IHS/MOA questions send an email to clinics@dhcs.ca.gov inbox

For billing questions contact Xerox at **1-800-541-5555**

DHCS Primary, Rural, and Indian Health Division, Indian Health Program website:

<http://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx>

ANY QUESTIONS?