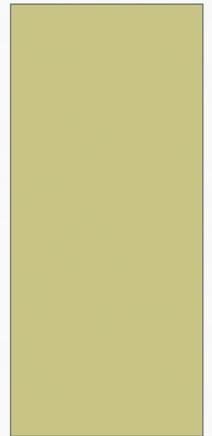


ANNUAL RECONCILIATION PROCESS FOR CODE 18 AND CODE 19

AUDIT REVIEW AND ANALYSIS SECTION
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Department of Health Care Services
Audit Review and Analysis Section

OVERVIEW

- Purpose of establishing a code 18 and code 19 billing code
- Billing to the fiscal intermediary
- Process for establishing a code 18 and 19 rate
- Annual Reconciliation Request
 - Requirements
 - Reconciliation Request Report
 - What to expect during an audit

PURPOSE OF CODE 18 (WRAP AROUND)

- The managed care wrap-around rate was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS rate (MOA rate) and their Medi-Cal managed care reimbursement (W&I Code Section 14132.100 (h))

CODE 18 (WRAP AROUND)

- Billing Code 18 reimburses providers on an interim basis the estimated amount payable for Medi-Cal managed care visits
- Annual Reconciliation Request is required to reconcile the final payment to the clinic based on actual data (visits/payments)

EXAMPLE OF MANAGED CARE WRAP AROUND FOR ONE VISIT

PPS Rate/MOA Rate	\$100
Managed Care Plan Payment	\$ 25
Wrap Around Payment (Code 18)	<u>\$ 25</u>
Annual Reconciliation Settlement	\$ 50

PURPOSE OF CODE 19

- The Healthy Families Code 19 Rate was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS/MOA rate and their Healthy Families Program Payments

CODE 19

- Billing Code 19 reimburses providers on an interim basis the estimated amount payable for Healthy Families Program visits
- Currently an Annual Reconciliation Request is required to reconcile the final payment to the clinic based on actual data until Medi-Cal transition takes place in 2013

EXAMPLE OF HEALTHY FAMILIES PROGRAM WRAP AROUND

PPS Rate/MOA Rate	\$100
Healthy Families Program Plan Pmt	\$ 25
Patient Co-Payments	\$ 10
Wrap Around Payment (Code 19)	<u>\$ 25</u>
Annual Reconciliation Settlement	\$ 40

ESTABLISHING A CODE 18 RATE

- Necessary to complete Form 3100 to establish code 18 rate
- Forms and instructions are located on our webpage <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

COMPLETING FORM 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 use projected data need to resubmit form 3100 after receive three months of actual claims
 - If don't have projected data code 18 rate will be set at \$25 until three months of actual data is received

ESTABLISHING A CODE 19 RATE

- Necessary to complete Form 3105 to establish code 19 rate
- Forms and instructions are located on our webpage <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>

COMPLETING FORM 3105

- 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 payment information (capitated/fee-for-service/co-payments)
 - Actual or projected data
 - If use projected data need to resubmit form 3105 after receive three months of actual claims

ESTABLISHING A CODE 18/19 RATE

- Important to develop code 18 and code 19 rates that create the smallest differences between the payments received and the PPS rate/MOA rate. We would like to see reconciliation amount due the Clinic/State as small as possible

BILLING CODE 18 TO FISCAL INTERMEDIARY

- Once the wrap-around rate is established you should bill simultaneously to Fiscal Intermediary (Xerox) using code 18 for each Medi-Cal managed care service that meets the definition of a Medi-Cal visit, and bill the Medi-Cal managed care plan for the patient's visit
- Must bill Medicare for dual eligible
- Only adjudicated claims will be reconciled
- Billing code 18 is not required unless you wish to include managed care visits on your annual reconciliation

BILLING CODE 18 TO FISCAL INTERMEDIARY (CONT)

- Code 18 Claim (two types of patients)
 - Most frequent application – Medi-Cal managed care plan patients (the plan reimburses the health center on a fee-for-service or on a capitation basis)
 - Medicare/Medi-Cal crossover patients where Medicare (either traditional or managed care) is the primary payer and a Medi-Cal managed care plan is the secondary payer

BILLING CODE 18 TO FISCAL INTERMEDIARY (CONT)

- Out of Area Network
 - FQHC Provider
 - Cannot turn away patients
 - Must bill managed care plan
 - Must inform the patient that they need to be seen at clinic assigned to by the managed care plan
 - Keep records of paid claim / denial from managed care plan
 - MOA Provider
 - Managed Care Plans are required to reimburse MOA providers for services provided to American Indians even if out of network (SSA Title 22, Section 55150)

BILLING CODE 18 TO FISCAL INTERMEDIARY (CONT.)

Billing Codes

- Codes 11 to 13 – Mental Health Services
 - Code 14 – Marriage Family Child Counselor (MOA Providers Only)
 - Codes 15 to 17 – Acupuncture/Chiropractor/Heroin Detox
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- Only bill these codes when the service is carved out of the Managed Care Contract
 - Paid at Full PPS Rate/MOA Rate

Can find detail on billing codes in your program billing manual

RECONCILIATION REQUEST
REVIEW (FORM 3097)

ANNUAL RECONCILIATION REQUEST

- Forms and instructions are located at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>
- Due annually within 150 days after your fiscal year end
- If not received timely clinic is put on payment 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
- The reconciliation request forms are subject to audit

IDENTIFICATION AND CERTIFICATION WORKSHEET (SEE ATTACHMENT)

- This worksheet Part A must contain the following information:
 - Legal Name of the Facility
 - Doing Business as (DBA)
 - Facility Address
 - NPI Number
 - Type of Control
 - Reporting Period
 - Contact Person Name (Phone #, e-mail Address)
 - If applicable Name of Home Office
 - Signed by an Officer or Administrator
- Part B must contain
 - Officer or Administrator Name and signature
 - Certifying the information is true and correct

REQUEST TO UPDATE INTERIM RATES

- Can request to update your code 18 and 19 rates annually when you file the reconciliation request
- If have any changes to your plans
- If the settlement amount is a material amount due the state/clinic will want to request a decrease/increase to your interim rate
- Will want to look at each code (code 18/code 19) individually and determine if it should be adjusted

FQHC/RHC RECONCILIATION WORKSHEET DETAIL

- This worksheet contains the following information
 - ❖ Medi-Cal Managed Care Information (Monthly Breakdown)
 - Medi-Cal Managed Care (Code 18)
 - Visits, managed care payments (fee-for-service and capitated), Medicare and MAP payments and code 18 payments
 - ❖ Healthy Families Program Information (Monthly Breakdown)
 - Healthy Families Program (Code 19)
 - Visits, Healthy Families plan payments (fee-for-service and capitated), managed care payments, patient co-payments and code 19 payments
 - ❖ Medi-Cal Non-Managed Care Crossover (Monthly Breakdown)
 - Capitated MAP Plans (Code 20)
 - Visits, MAP payments and code 20 payments
 - Medi-Cal Crossovers (Code 02)
 - Visits, Medicare payments and code 18 payments

FQHC/RHC RECONCILIATION WORKSHEET SUMMARY

- Payment/Recovery Determination
 - Summarizes Visits by Period 1 and 2
 - Summarizes Payments by Period 1 and 2
 - Settlement Summary
- Period 1 and Period 2
 - Necessary to break out by period due to annual rate change on October 1st to account for MEI increase
 - Example: If Fiscal Year End is December 31
 - Period 1 is January 1 through September 30
 - Period 2 is October 1 through December 31

ADDITIONAL WORKSHEETS

- Summary of Services Provided by Clinic
- Summary of Healthcare Practitioners
- These worksheets are used for FQHC/RHC providers for information purposes

HEALTHY FAMILIES PROGRAM RETROACTIVE RECONCILIATION (FORM 3091)

- Forms and instructions are located at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>
- Complete for retroactive periods from October 1, 2009 through May 31, 2012 if applicable

IMPORTANT INFORMATION

- Important that the interim code 18/19 rates are set using accurate data
- Only adjudicated visits will be reconciled
- Can only bill code 18 and code 19 for a visit as defined in statute and State Plan Amendment (SPA)
- All capitated and fee-for-service plan payments must be included (Medi-Cal is the payer of last resort)
- Submit reconciliation requests timely

ACCEPTANCE OF RECONCILIATION

- Auditor reviews reconciliation when received to ensure forms are complete
- A 60% tentative settlement is paid to the provider if the amount is due to the clinic

AUDIT OF RECONCILIATION REQUESTS

- May be a desk audit or a field audit
- Department has three years from the date the Department receives the forms to audit them
- Must maintain all documentation to support reported visits/payments such as remittance advices, explanation of benefits, documentation from the managed care plans supporting payments
- Auditor may complete a billing review to ensure provider billed for a valid visit as defined in statute
- Reconcile to the fiscal intermediaries Paid Claims Summary Report (PCSR Report)

QUESTIONS?

CONTACT INFORMATION

For questions related to the
reconciliation process

reconciliation.clinics@dhcs.ca.gov

General FQHC questions
clinics@dhcs.ca.gov

Billing questions
Xerox 1-800-541-5555