ANNUAL RECONCILIATION PROCESS FOR CODE 18 AND CODE 19

AUDIT REVIEW AND ANALYSIS SECTION
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PRESENTER:

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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
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**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPS Rate/MOA Rate</td>
<td>$100</td>
</tr>
<tr>
<td>Managed Care Plan Payment</td>
<td>$ 25</td>
</tr>
<tr>
<td>Wrap Around Payment (Code 18)</td>
<td>$ 25</td>
</tr>
<tr>
<td>Annual Reconciliation Settlement</td>
<td>$ 50</td>
</tr>
</tbody>
</table>
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) $25
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
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 a 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 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

- 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
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