

# 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 Prospective Payment System (PPS) 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 rate<sup>1</sup> was established to comply with federal and state regulation<sup>2</sup> to reimburse a provider for the difference between their PPS rate (MOA Rate<sup>3</sup>) 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
2. W&I Code Section 14132.100(h)
3. MOA Rate applies to Indian Health Providers only

# PURPOSE OF CODE 2 (DIFFERENTIAL RATE)

## Code 2 Rate Calculation

PPS rate (MOA rate)	\$150
Less: 80% of the facilities Audited Medicare Rate *	<u>\$103</u>
Code 2 rate (differential rate)	\$ 47

\*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 rate<sup>1</sup> was established to comply with federal and state regulation<sup>2</sup> to reimburse a provider for the difference between their PPS rate (MOA Rate<sup>3</sup>) 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
2. W&I Code Section 14132.100(h)
3. MOA Rate applies to Indian Health Providers only

# 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.
- 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.

# EXAMPLE OF CALCULATION OF CODE 18 RATE (DIFFERENTIAL RATE)

PPS rate (MOA rate)	\$125
Less: weighted average MC plan pmts per visit*	<u>\$ 50</u>
Code 18 rate (differential rate)	\$ 75

\*Calculated using data submitted on DHCS form 3100

# ESTABLISHING A CODE 18 RATE (DIFFERENTIAL RATE)

- Important to develop code 18 rate that creates the smallest differences between the payments received and the PPS rate (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 prospective payment system (PPS) rate (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 (MAP)

- Certification Sheet
  - Clinic Name, NPI Number, Address, Signature certifying the information is true and correct etc.
- Page 1
  - Visit and payment information

# CALCULATION OF CODE 20 (MAP) RATE

PPS Rate	\$125
Less: Average MAP Capitated Payment*	<u>\$ 75</u>
Code 20 Rate	\$ 50

\*\$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)

# Reconciliation Request pages

## Makeup of the Reconciliation Request

- Cover page (Page 1)
- Statistical Data and Certification Worksheet (Page 2)
- Request to Update Differential Rates (Page 3)
- FQHC/RHC Reconciliation Worksheet Detail (Page 4)
  - ❖ Medi-Cal Managed Care Information (Monthly Breakdown) Medi-Cal Managed Care (Code 18)
  - ❖ Medi-Cal Non-Managed Care Medicare Crossover (Monthly Breakdown)
    - ✓ Code 2
    - ✓ Code 20
  - ❖ Healthy Family Information (Monthly Breakdown) Code 19 (This information will be removed from the reconciliation request)
  - ❖ **All Visit and Payments carry from this page to Page 5**

# RECONCILIATION REQUEST PAGES - CONTINUE

- Payment/Recovery Determination (Page 5)
  - Visits (broken out by period)
    - ❖ Line 1: Medi-Cal Managed Care - Code 18
    - ❖ Line 2: Medi-Cal Healthy Families – Code 19
    - ❖ Line 3: Medi-Cal MAP – Code 20
    - ❖ Line 4: Medi-Cal Crossover – Code 02

# RECONCILIATION REQUEST PAGES - CONTINUE

- Payments (broken out by period) (Page 5 Continue)
  - ❖ Medi-Cal Managed Care Plan – Code 18
  - ❖ Medicare & MAP for Code 18
  - ❖ Medi-Cal Code 18
  - ❖ Healthy Families Plan - Code 19
  - ❖ Healthy Families Patient Co-payments
  - ❖ Capitated Medicare Advantage Plans – Code 20
  - ❖ Medi-Cal Code 20
  - ❖ Medicare for Code 02
  - ❖ Medi-Cal for Code 02

# RECONCILIATION REQUEST PAGES - CONTINUE

- Settlement Summary (Broken-out by Period) (Page 5 continue)
  - ❖ PPS Rates (For the requested Fiscal Period)
  - ❖ Total Visits (Taken from visit section)
  - ❖ PPS Dollar Amount (PPS x Period Total Visits)
  - ❖ Less: Total Payments (Taken from payments section)
  - ❖ Amount Due the Clinic (State)
- Summary of Services (Page 6)
- Summary of Productive Time for Health Care Practitioners (Page 7)

# 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 [cdorders@xerox.com](mailto:cdorders@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 even if zero settlement or interim rate
  - If a health center has an interim rate, the health center should still file the Reconciliation Request form using the interim rate. DHCS will not finalize the filing until the final PPS rate is established.

# 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](mailto: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](http://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](mailto:reconciliation.clinics@dhcs.ca.gov) inbox

General FQHC questions send an email to [clinics@dhcs.ca.gov](mailto:clinics@dhcs.ca.gov) inbox

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

ANY QUESTIONS?