ANNUAL RECONCILIATION PROCESS FOR CODES 02, 18 AND 20

AUDIT REVIEW AND ANALYSIS SECTION

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OVERVIEW

- Purpose of establishing billing codes 02,18 and 20
- Process for establishing a code 02,18 and 20 rate
- Annual Reconciliation Request

PURPOSE OF MEDICARE CROSSOVER (CODE 02)

- Medicare Crossover (code 02) was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS rate (MOA rate) and Medicare reimbursement.

MEDICARE CROSSOVER (CODE 02)

- Billing Code 02 reimburses providers on an interim basis the estimated amount payable for Medicare / Medi-Cal Crossover visits
- Annual Reconciliation Request is required to reconcile the final payment to the clinic based on actual data (visits/payments)

EXAMPLE OF MEDICARE CROSSOVER (CODE 02) RATE CALCULATION

MOA Rate	$330
Less: Medicare Rate Per Visit*	($102)
Code 02 Rate	$228

*Medicare Upper Payment Limit (MUPL)

FQHC Urban Rate 2013 $128.00 (80% = $102.00)

FQHC Rural Rate 2013 $110.78 (80% = $88.62)

Maximum amount Medicare pays is the MUPL

PURPOSE OF CODE 20

- In the process of implementing for IHP
- Code 20 was established to reimburse a provider the difference between their PPS rate (MOA rate) and their Medicare reimbursement for Medicare Advantage Plans (capitated only)
- Provider does not receive EOMB from capitated MAP Plans. Code 20 was established to allow the crossover claims to be billed to Medi-Cal without a Medicare EOMB
- See billing manual for comments needed on claim form

CODE 20 (CONT.)

- Annual Reconciliation Request is required to reconcile the final payment to the clinic based on actual data (visits/payments)

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	$330
Average Managed Care Plan Payment	$ 50
Wrap Around Payment (Code 18)	$260
Annual Reconciliation Settlement	$ 20

ESTABLISHING A CODE 18 RATE

- To establish a code 18 rate it is necessary to complete Form 3100 and submit the completed form to the department.
- Forms and instructions are located on our webpage http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx

ESTABLISHING CODE 20 RATE

- To establish a code 20 rate it is necessary to complete DHCS Form 3104 and submit the completed form to the department.
- Forms and instructions are located on our webpage http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx

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 02,18 and 20 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 02) 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

IMPORTANT INFORMATION

- Important that the interim code 02, 18, 20 rates are set using accurate data
- Only adjudicated visits will be reconciled
- Can only bill codes 02, 18 and 20 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

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