INSTRUCTIONS FEDERALLY QUALIFIED HEALTH CENTER (FQHC) RURAL HEALTH CLINIC (RHC)/INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT (IHS/MOA) 638 CLINIC MEDICARE ADVANTAGE PLAN RATE REQUEST—REVENUE CODE 529 PROCEDURE CODES G0466—G0470 INSTRUCTIONS

Please read all instructions carefully before completing these forms.

The Medicare Advantage Plan (MAP) forms are designed to establish a MAP rate that reimburses a provider for the difference between their Prospective Payment Systems (PPS), or Indian Health Service Memorandum of Agreement (IHS/MOA) rate and their Medicare Advantage Plan average reimbursement per visit for **Medicare/non-managed care Medi-Cal (crossover) beneficiaries.**

The information provided on these forms is subject to the Medicare reasonable cost-based principles found in 42 CFR, Part 413, and in accordance with California's FQHC/RHC/IHS/MOA policies and procedures.

All Medi Cal providers must follow the e-file Medi Cal Worksheets Submission Protocol to submit FQHC/RHC Worksheets. Submit the e-file worksheets and the DocuSign Certification Statement located on the DHCS Forms & Publications webpage to Reconciliation.Clinics@dhcs.ca.gov, and you will receive an email response.

For assistance or questions, contact FQHC/RHC Section at (916) 322-1681 or clinics@dhcs.ca.gov.

We will return incomplete forms for correction. If the forms are returned, we will give instructions noting the deficiencies and corrective action needed.

MEDICARE ADVANTAGE PLAN RATE PROCESS

Medi-Cal bulletin #410 that issued in November 2008 informed providers that were establishing billing revenue code 529 procedures codes G0466 through G0470 (529 G0466-G0470) for the FQHC/RHC to bill for services provided to non-managed care plan Medicare/Medi-Cal beneficiaries enrolled in a capitated Medicare Advantage Plan Health Maintenance Organization (MAPHMO).

Effective September 1, 2009, FQHC/RHC/IHS/MOA providers who have not received an Explanation of Medicare Benefits (EOMB), Medicare Remittance Notice (MRN), or Remittance Advice (RA) from

their Medicare Advantage Health Maintenance Organization for their crossover patients must bill Medi-Cal using 529 G0466-G0470 instead of 520 G0466-G0470 and provide a justification for the absence of the EOMB, MRN, or RA. The justification consists of a statement in the remarks section of the claim form stating that no EOMB, MRN, or RA was received from the MAP.

Only FQHC/RHC/IHS/MOA providers receiving capitated payments from their Medicare Advantage Plan Health HMO for Medi-Cal non-managed care patients are to bill 529 G0466-G0470.

DOCUMENTATION

The reported data on these forms is subject to audit by the Department and must be supported by documentation such as Remittance Advice (RA), Explanation of Benefits (EOB), or other verifiable evidence. The Department will review the request forms and ask for this supporting documentation, thus minimizing the need for onsite reviews.

STATISTICAL DATA AND CERTIFICATION STATEMENT

PART A—GENERAL INFORMATION AND CERTIFICATION:

The purpose of this page is to collect licensee information, the licensee's mailing address, and the name of the person to contact for necessary information and to have the contents of the report certified. A licensee is defined as a legal entity, e.g., the organization to which the actual license is issued.

1. Enter Contact Person (Last, First)
2. Enter Contact Telephone Number (xxx) xxx-xxxx
3. Enter Date Submitted (mm/dd/yyyy)
4. Enter FQHC/RHC/HIS/MOA Name
5. Enter Contact Fax Number (xxx) xxx-xxxx
6. Enter Contact E-mail address
7. Enter FQHC/RHC Address
8. Enter Fiscal Period Start (mm/dd/yyyy)
9. Enter Fiscal Period End (mm/dd/yyyy)
10. Enter FQHC/RHC/HIS/MOA NPI Numbers(s)
11. Enter Contract Start Date (mm/dd/yyyy)
12. Enter Date Submitted (mm/dd/yyyy)
13. Enter Type of Control (Select from drop-down menu)
14. Enter Owner Number (xx)
15. Enter Location Number (xxx)
16. Enter FQHC/RHC/HIS/MOA Owned by:
17. Enter Additional Provider Name(s)

18. Enter Location
19. Enter NPI Number (if applicable)

PART B—Certification Statement:

Refer to the DocuSign Certification Statement located on the DHCS Forms & Publications webpage to complete this step. The Certification Statement must be signed and dated by the Administrator, Controller, Corporate Officer, or member of the Board of Directors. The official signing the report must have the legal capacity to make commitments for the organization.

MEDICARE ADVANTAGE PLAN RATE REQUEST FORM:

WORKSHEET 1 AND 2:

The Clinic's Legal Name, National Provider Identifier (NPI), and fiscal period will carry over from the Certification Sheet.

1. Enter the Medicare Advantage Plan under Plan A through J as necessary.

2. Payment Information—select the appropriate item from the drop-down menu identifying actual or projected payments.
   - Enter the capitation payments you received or expect to receive from each Medicare Advantage Plan(s).

3. Visit information—select the appropriate item from the drop-down menu identifying actual or projected visits.
   - Enter the Medicare Advantage Plan capitation visits for Medi-Medi beneficiaries.