Annual Reconciliation Request Training 101

Presented by Audits and Investigations, Financial Audits Branch, FQHC/RHC Section

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Health Program Auditor

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 Indian Health Service/Memorandum of Agreement 638 Clinic (IHS/MOA) 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[1] was established to comply with federal and state regulation to reimburse a provider for the difference between their IHS/MOA rate 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

Purpose of Code 2 (Differential Rate)

Code 2 Rate Calculation

IHS/MOA rate*	$391
Less: 80% of the facilities Audited Medicare Rate **	$150
Code 2 rate (differential rate)	$241

*2017 IHS/MOA Rate

**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[1] was established to comply with federal and state regulation to reimburse a provider for the difference between their IHS/MOA rate 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

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.

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
STATISTICAL DATA AND CERTIFICATION STATEMENT
MANAGED CARE DIFFERENTIAL RATE REQUEST

Part A

Contact Person:	Date Submitted:
1. FQHC/RHC Name:	Telephone Number and e-mail address:
2. FQHC/RHC Address:	Fiscal Year End:
3. FQHC/RHC Number(s)	4. NPI Number(s)

5. Type of Control (Check one)
[ ] Voluntary Nonprofit Corporation: [ ] State [ ] City
[ ] Government: Federal [ ] County [ ] Other

6. FQHC/RHC Owned By

7. Other FQHCs/RHCs, Hospitals, Skilled Nursing Facilities, Home Health Agencies, suppliers or other entities that are owned or related through common ownership or control to the individual or entity listed in item 6:

Provider Name	Location	Clinic or Provider No.

Part B

Certification Statement

Intentional misrepresentation or falsification of any information contained in this request resulting in reimbursement by the Department may be punishable by fine and/or imprisonment under federal and state laws. (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments", 18 U.S.C 1347 "Health Care Fraud", California Welfare and Institutions Code 14123.25 "Civil Penalties for Fraudulent Claims", and Title 22 of the California Code of Regulations 51485.1 "Civil Money Penalties")

Certification by Officer or Administrator of the Clinic

I, , certify under penalty of perjury as follows:

That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare

Officer or Administrator of FQHC/RHC Print Name: _____ Signature: _____	Title:	Date:

Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.

Mail the original signed Managed Care Differential Rate Request form to:

California Department of Health Care Services
Audits and Investigations, Financial Audits Branch
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
P.O. Box 997413
Sacramento, CA 95899-7413

For questions or assistance in completing these forms, you may submit questions to the following email address: Clinics@dhcs.ca.gov. You will receive an email response or if you do not have access to email, you may contact main number at (916) 650-6696.

Completing DHCS Form 3100 (Continued)

Page 1

- **Visit and payment information**
  - ✓ **Important to include all payments (capitated/fee-for-service/Medicare/any other third party payments)**
- **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.**

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
MEDI-CAL MANAGED CARE DIFFERENTIAL RATE REQUEST

Clinic Name: _____ Fiscal Period: _____

Medi-Cal No: _____ NPI No: _____

1 Medi-Cal Managed Care Plan Name	Plan A ( )	Plan B ( )	Plan C ( )	Plan D ( )	Plan E ( )	Total
2 Payment Information [ ] Actual [ ] Projected						
A. Managed Care Plan Payments	$ -	$ -	$ -	$ -	$ -	$ -
B. Managed Care Medicare Crossover Payments	$ -	$ -	$ -	$ -	$ -	$ -
Total Managed Care Plan Payments	$ -	$ -	$ -	$ -	$ -	$ -
3 Visit Information [ ] Actual [ ] Projected						
A. Managed Care Plan Visits	0	0	0	0	0	0
B. Managed Care Plan - Medicare Crossover	0	0	0	0	0	0
Total Managed Care Visits	0	0	0	0	0	0

Example of Calculation of Code 18 Rate (Differential Rate)

- IHS/MOA rate* $391
- Less: weighted average MC plan pmts per visit** $100
- Code 18 rate (differential rate) $291

*2017 IHS/MOA Rate

**Calculated using data submitted on DHCS form 3100

Establishing a Code18 Rate (Differential Rate)

- Important to develop code 18 rate that creates the smallest differences between the payments received and the IHS/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 IHS/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 Rate Request for Capitated Medicare Advantage Plans (MAP)

- Rate Request for Capitated Medicare Advantage Plans (MAP) Form 3104
- Certification Sheet Clinic Name, NPI Number, Address, Signature certifying the information is true and correct etc.

STATISTICAL DATA AND CERTIFICATION STATEMENT

Part A

1. Contract Start Date:	Date Submitted:	Fiscal Year End:
2. Contact Person:		Contact Telephone Number:
3. FQHC/RHC Name and Address		Contact Fax Number:
4. FQHC/RHC Number(s)		Contact Email Address:

5. Type of Control (Check one)
   [ ] Voluntary Nonprofit Corporation: [ ] State [ ] City
   [ ] Government: Federal [ ] County [ ] Other

6. FQHC/RHC Owned By

7. Other FQHCs/RHCs, Hospitals, Skilled Nursing Facilities, Home Health Agencies, suppliers or other entities that are owned or related through common ownership or control to the individual or entity listed in item 6:

Provider Name	Location	Clinic or Provider No.

Part B

Certification Statement

Intentional misrepresentation or falsification of any information contained in this request resulting in reimbursement by the Department may be punishable by fine and/or imprisonment under federal and state laws. (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments", 18 U.S.C 1347 "Health Care Fraud", California Welfare and Institutions Code 14123.25 "Civil Penalties for Fraudulent Claims", and Title 22 of the California Code of Regulations 51485.1 "Civil Money Penalties")

Certification by Officer or Administrator of the Clinic

I, , certify under penalty of perjury as follows:

That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and Institutions Code.

Officer or Administrator of FQHC Print Name: _____ Signature: _____	Title:	Date:

Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.

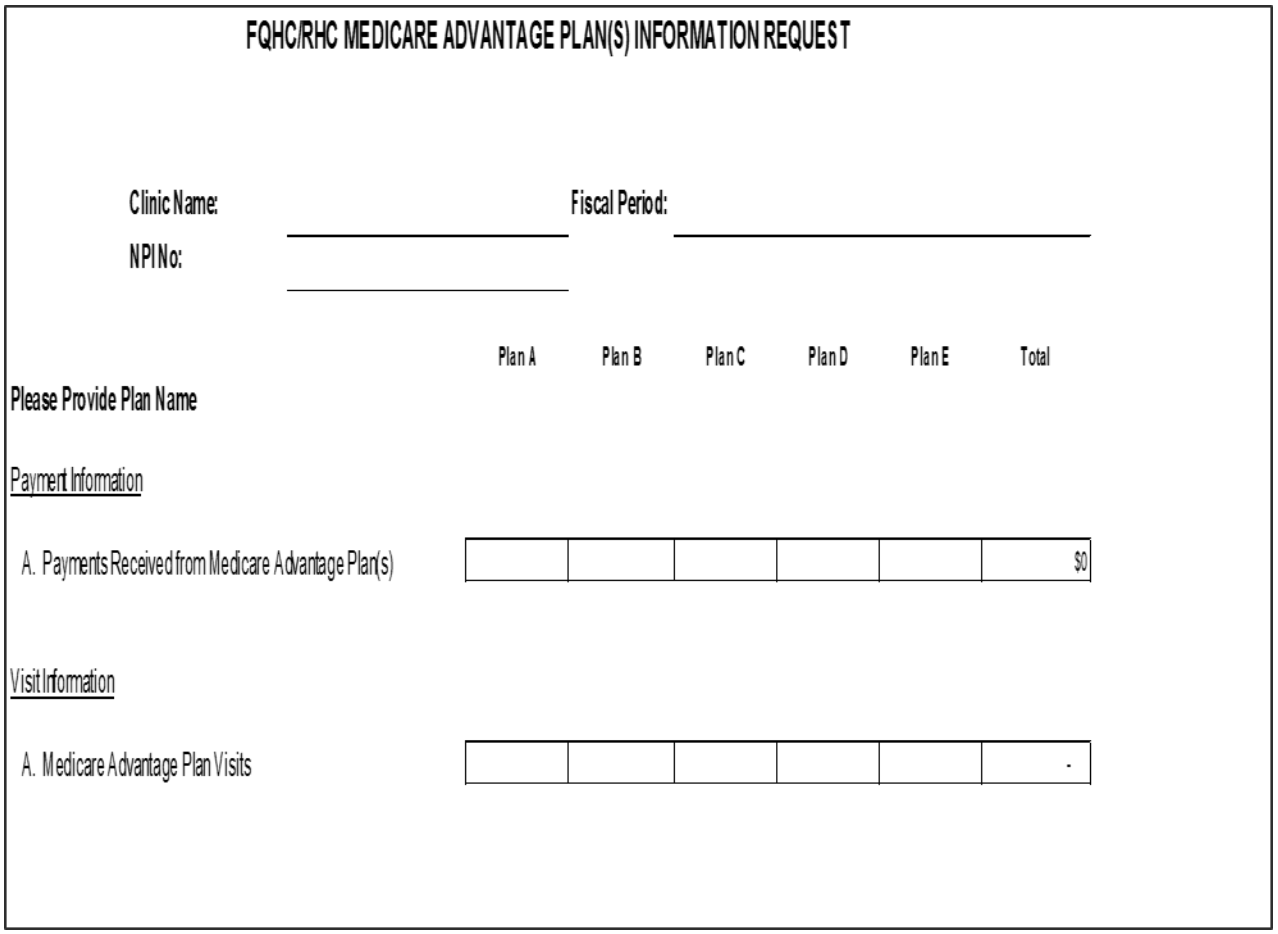
Mail the original signed Managed Care Differential Rate Request form to:

California Department of Health Care Services
Audits and Investigations, Financial Audits Branch
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
P.O. Box 997413
Sacramento, CA 95899-7413

- Rate Request for Capitated Medicare Advantage Plans (MAP) Form 3104

Page 1

- Visit and payment information



FQHC/RHC MEDICARE ADVANTAGE PLAN(S) INFORMATION REQUEST

Clinic Name: _____ Fiscal Period: _____

NPI No: _____

Please Provide Plan Name	Plan A	Plan B	Plan C	Plan D	Plan E	Total
Payment Information						
A. Payments Received from Medicare Advantage Plan(s)						$0
Visit Information						
A. Medicare Advantage Plan Visits						-

Calculation of Code 20 (MAP) Rate

IHS/MOA Rate*	$391
Less: Average MAP Capitated Payment**	$ 75
Code 20 Rate	$316

*2017 IHS/MOA rate

**$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 1) 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 FORMS (DHCS FORM 3097)

Cover Page

MEDI-CAL FREESTANDING

PROSPECTIVE PAYMENT SYSTEM

RECONCILIATION REQUEST

FOR

FEDERALLY QUALIFIED HEALTH CENTER

RURAL HEALTH CLINIC

OR

INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA)

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Identification and Certification Worksheet

FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC/
INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT (IHS/MOA) 638 CLINIC
RECONCILIATION REQUEST

STATISTICAL DATA AND CERTIFICATION STATEMENT

Part A - General Information

1. FQHC / RHC / IHS/MOA Legal Name:		2. Doing Business as (DBA):	
3. FQHC / RHC / IHS/MOA Address (Street, City, State, Zip):			4. National Provider Identifier (NPI):
City:	State:	Zip:	
5. Type of Control (Check one) Nonprofit Corporation: ___ Government Controlled: Federal ___ State ___ County ___ City ___ For Profit Entity: ___			6. Fiscal Year End:
7. Name of Contact Person:	8. Business Phone:	9. Fax No.:	10. E-mail Address:
11. FQHC / RHC / IHS/MOA Owned By:			

12. Other healthcare providers (Clinics, Hospitals, Long-term Care, Home Health Agencies, medical suppliers, etc.) that are related through common ownership or control to the individual or entity listed in item 11 (attach more pages if

Provider Name	Address	NPI

Part B - Certification Statement

Intentional misrepresentation or falsification of any information contained herein may be punishable by fine and/or imprisonment under federal and State laws: (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments"; 18 U.S.C. 1347 "Health Care Fraud"; California Welfare and Institutions Code 14123.25 "Civil Money Penalties for Fraudulent Claims"; and Title 22 of the California Code of Regulations 51485.1 Civil Money Penalties)

Please be advised that continued submission of claims or worksheets/cost reports for items or services which were not provided as claimed are not reimbursable under the Medi-Cal program. If claims are made in violation of an agreement with the State, you or your organization may be subject to civil money penalty assessments in accordance with the Welfare and Institution Code, Section 14123.2.

Certification by Officer or Administrator:

I, _____, certify under penalty of perjury as follows:
Print Name

That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and Institutions Code.

Officer or Administrator of FQHC / RHC / IHS/MOA	Title:	Date:
Print Name: _____		
Signature: _____		

Follow the e-file Medi-Cal Worksheet Submission Protcol for submission of FQHC/RHC Worksheets to the inbox below. You will receive an email response.

o Reconciliation.Clinics@dhcs.ca.gov

For assistance/questions please contact ARA at (916) 650-6696 or Clinics@dhcs.ca.gov

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 1- Request to Update Interim Rates

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA)
RECONCILIATION REQUEST

REQUEST TO UPDATE INTERIM RATES

Clinic Name:				**Page 1 of 5**
NPI:				
Fiscal Period:	**From:**		**To:**	

Please indicate whether or not your facility needs updates to these rates.

Place an X under the YES if you would like to have your rates updated.

Please submit appropriate Rate Request Form(s) 3100 or 3104 to have Code 18 or Code 20 rates updated.

These worksheets will only apply to the NPI listed.

			YES
1	**Medi-Cal Crossovers (Code 02)**	Not Required	
2	**Medi-Cal Managed Care Plan (Code 18)**	Form DHCS 3100 *	
3	**Medicare Advantage Plan (Code 20)**	Form DHCS 3104 *	

*** LINKS:** Please click on the link below to retrieve the forms and instructions.

Code 18	Form DHCS 3100	Form 3100i Instructions
Code 20	Form DHCS 3104	Form 3104i Instructions

Please be sure to follow the instructions that go with each form above.

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 2 - IHS/MOA Reconciliation Worksheet Detail

- 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
- All Visit and Payments carry from this page to Page 3

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA)
RECONCILIATION REQUEST WORKSHEET - DETAIL

Clinic Name:	0	Page 2 of 5
NPI:	0	
Fiscal Period:	From: 1/0/1900	To: 1/0/1900

	1	2	3	4	5	6	7	8	9	10
	ALL MEDI-CAL MANAGED CARE				MEDI-CAL NON-MANAGED CARE CROSSOVERS					
						CAPITATED MAP PLANS		MEDI-CAL CROSSOVERS		
Month/Year	Code 18 Visits	Managed Care Plan Payments	Medicare & MAP Payments	Code 18 Payments	Code 20 Visits	Capitated MAP Payments	Code 20 Payments	Code 02 Visits	Medicare Payments	Code 02 Payments
Annual Total	-	$ -	$ -	$ -	-	$ -	$ -		$ -	$ -
Period 1 Total										
Period 2 Total										
Grand Total *	-	$ -	$ -	$ -	-	$ -	$ -		$ -	$ -

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 3 – Payment Recovery Determination

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA)
RECONCILIATION REQUEST WORKSHEET - SUMMARY

Clinic Name:	0			Page 3 of 5
NPI:	0			
Fiscal Period:	From:	1/0/1900	To:	1/0/1900

PAYMENT / RECOVERY DETERMINATION

	VISITS	Period 1	Period 2	Total
1.	Medi-Cal Managed Care - Code 18			
3.	Medi-Cal Crossovers w/ Capitated MAP - Code 20			
4.	Medi-Cal Crossovers - Code 02			
5.	**Total Visits**			

	PAYMENTS	Period 1	Period 2	Total
6.	Medi-Cal Managed Care Plans	$ -	$ -	$ -
7.	Medicare & MAP for Code 18	$ -	$ -	$ -
8.	Medi-Cal for Code 18	$ -	$ -	$ -
9.	Capitated Medicare Advantage Plans	$ -	$ -	$ -
10.	Medi-Cal for Code 20	$ -	$ -	$ -
11.	Medicare for Code 02	$ -	$ -	$ -
12.	Medi-Cal for Code 02	$ -	$ -	$ -
13.	**Total Payments**	$ -	$ -	$ -

	SETTLEMENT SUMMARY	Period 1	Period 2	Total
14.	PPS or IHS/MOA Rates (Enter this data only)			N/A
15.	Total Visits (From Line 5)			
16.	PPS or IHS/MOA Dollar Amount (Line 14 x Line 15)			
17.	Total Payments (From Line 13)	$ -	$ -	$ -
18.	**Amount Due Clinic (State) L16 - L17**	$ -	$ -	$ -

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 4 – Summary of Services

N/A for IHS/MOA Providers

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA)
SUMMARY OF SERVICES

Clinic Name:	0				Page 4 of 5
NPI:	0				
Fiscal Period:	From:	1/0/1900	To:	1/0/1900	

	Please indicate what and where services are provided.	* NO	YES** ON-SITE	YES** OFF-SITE	YES** Contractor
1.	Medical				
2.	Dental				
3.	Dental Hygienist				
4.	X-ray				
5.	Laboratory				
6.	Pharmacy				
7.	Nutritional				
8.	Psychology				
9.	Psychiatry				
10.	Social / Behavioral Health Services				
11.	Marriage Family Therapy				
12.	Drug Counseling				
13.	Education				
14.	CPSP				
15.	Outreach				
16.	Optometry				
17.	Chiropractic				
18.	Podiatry				
19.	Physical Therapy				
20.	Occupational Therapy				
21.	Treatment Room				
22.	Surgery/Recovery				
23.	Anesthesiology				
24.	Radiology				
25.	Nuclear Med/CT				
26.	Central Supplies				
27.	Pathology				
28.	Radiosotope				
29.	Electrocardiology				
30.	Electroencephalography				
31.	Women, Infants and Children (WIC)				
32.	Other (specify):				
33.					
34.					
35.					
36.					
37.					

*NO = Service is NOT provided by the clinic.
**YES ON-SITE = Service is provided within '4-walls' of clinic.
**YES OFF-SITE = Service is provided outside clinic by contractual arrangement (include contractor's name).

NOTE=Worksheet Not Applicable to IHS/MOA providers

RECONCILIATION REQUEST FORMS (DHCS FORM 3097)

Page 5 – Summary of Productive Time for Health Care Practitioners

N/A for IHS/MOA Providers

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA)
SUMMARY OF PRODUCTIVE TIME FOR HEALTH CARE PRACTITIONERS

Clinic Name:	0				Page 5 of 5
NPI:	0				
Fiscal Period:	From:	1/0/1900	To:	1/0/1900	

	HEALTH CARE STAFF	1 FTEs	2 # of VISITS	3 ON-SITE	4 OFF-SITE
1.	Doctor of Medicine (MD)				
2.	Doctor of Osteopathy (DO)				
3.	Doctor of Podiatric Medicine (DPM0				
4.	Doctor of Optometry (OD)				
5.	Doctor of Chiropractics (DC)				
6.	Doctor of Dental Surgery (DDS)				
7.	Physician Assistant (PA)				
8.	Nurse Practitioner (NP)				
9.	Mental Health Specialists (MD, PA, NP)				
10.	Certified Nurse Midwife (CNM)				
11.	Registered Dental Hygienist; RDH				
12.	Visiting Nurse				
13.	Clinical Psychologist				
14.	Licensed Clinical Social Worker (LCSW)				
15.	Comprehensive Perinatal Health Worker				
16.	Physician Services Under Agreement				
17.	Physical Therapist *				
18.	Marriage Family Therapist *				
19.	Drug Counselors *				
20.	Nutritionist *				
21.	Acupuncturist*				
22.	**Other (specify): ***				
23.	WIC				
24.	Health Education				
25.	Community Outreach				
26.					
27.					
28.					
29.	**TOTALS**	0.00	-		

Full Time Equivalent (FTE) assumes 2,080 hours worked in Patient Care activities (40 hrs/week for 52 weeks).

* Nonreimbursable Practitioners/Visits

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 (Conduent).

- 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 Conduent by either calling
  1-800-541-5555 or by emailing their request to cdrorders@conduent.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 Conduent (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 Conduent'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 report even if the annual MOA rate increase has not been updated in the PMF system. Use your current MOA rate. Audits will correct the MOA rate during the audit process. You may include a note on the Reconciliation Request forms to ensure the auditor is aware the MOA rate needs to be adjusted accordingly.

Reconciliation Request Requirements (Continued)

- A partial year reconciliation also must be filed.
- Forms must be received on time. Providers are 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 is sent to the provider for review.
  - 15 days to provide additional data or to ask questions related to the reconciliation before the audit is finalized.
- 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, regardless of whether or not the patient has a related visit.
- 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 Conduent by either calling 1-800-541-5555 or by emailing your request to cdrorders@conduent.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, 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 inbox

- General IHS/MOA questions send an email to
- clinics@dhcs.ca.gov inbox

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

- DHCS Primary, Rural, and Indian Health Division, Indian Health Program website:
- http://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx

ANY QUESTIONS?