Imputation of Medicare Payments During A&I Reconciliations

Issue:

During audits of the annual PPS rate reconciliations, Audits & Investigations (A&I) imputes Medicare revenue for dually eligible beneficiaries enrolled in managed Medi-Cal who had visits for which a wraparound (code 18) payment was made.

The specific adjustment reads: “Medicare and MAP Payments; To adjust Medicare payments received for Medi-Cal managed care patients.” The adjustment amount is calculated by multiplying the number of visits by 80% of the Medicare Upper Limit, and then subtracting the already reported amount.

Per the regulations referenced in the adjustment, 42 CFR 413.20 and 413.24, and CMS Publication 15-1 Section 2304, the provider is to maintain and furnish adequate documentation to substantiate payments received and costs incurred. Additionally, per W&I 14132.100(h), the FQHC shall be reimbursed “for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate..."

Position:

A&I should base the Medicare revenue figures on documentation of actual revenues received.

Annually, FQHCs generate Provider and Statistical Reimbursement (PS&R) System reports via the CMS enterprise portal for use in the yearly Medicare cost report. The annual Medicare cost report identifies the revenues received from Medicare. This documentation sufficiently identifies payments, so imputation is unnecessary.

Considerations:

Because Medi-Cal is the payer of last resort per federal and state statutes, providers must seek reimbursement from available third-party, other health coverage (OHC) (including Medicare) before billing Medi-Cal.

Before protesting an adjustment, review billing practices and ensure 1) eligibility was verified, 2) claim was submitted to known OHC, and 3) denials were appealed or documented[1].

[1] For example, if OHC denied claim for being out-of-network provider, Medi-Cal will assume liability for full payment if the claim notes, “Advisal given, recipient refused to utilize OHC.”