FQHC/RHC/PCC Medicaid Instructions for Completing the Interim Reconciliation for Supplemental Payment Form

Please note that a separate form should be completed for each Medicaid provider number under which you have received a supplemental payment.

Complete Provider Information located at the top of the form, including Name of Center, Medicaid Provider number, NPI number (National Provider Identifier) and Taxonomy (10 character code used to identify the unique specialty of your facility).

For the remainder of the form, please report data for each month during which the facility was appropriately licensed with Medicaid. Please note that facilities licensed as primary care centers with no FQHC designation are not eligible to receive supplemental payments beginning for dates of service 3/1/13 and thereafter.

Field Title	Field Description
The following instructions are for Tab 1 of the reconciliation form.	
PPS Rate	Insert the PPS rate effective during each month of the years 2011, 2012, and 2013.
Number of Visits or Claims	Insert the number of visits in the column of the appropriate MCO. If number of visits can not be determined, provide number of claims. Please indicate on the form whether visits or claims are reported. A visit/claim must meet all of the following criteria to be considered valid for payment:
	1. Dual eligible visits/claims are **excluded**. Dual eligibles are patients who have Medicaid as a secondary payor.
	2. Reported visits/claims can not be duplicated.
	3. Only visits/claims that have been adjudicated to a **paid status** by the MCO can be reported.
	4. Visits reported meet the definition of visit in accordance with 907 KAR 1:055.
	5. Visits/claims were incurred during a period when the facility was certified with Medicaid. For Primary Care Center providers with no FQHC designation, no visits/claims for dates of service beginning on 3/1/13 and thereafter are included.
	6. Visits/claims that were paid by any payor other than KY contracted Managed Care Organizations (and their contracted subcontractors) are excluded.
	7. Visits reported include a service performed by a physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, or other health care provider as defined in 907 KAR 1:055.
	Calculate the total number of visits/claims that meet the above criteria and insert this number for each month.

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CF **if** Claims	While reporting visits is preferred, if the number of visits can not be determined and the number of claims is provided instead, a conversion factor will be assessed in order to calculate an appropriate visit volume. If necessary, a conversion factor will be inserted during the reconciliation process. This column is for the Department for Medicaid Services' use -- providers will not complete this column.
Calculated PPS Payment	This number is calculated by multiplying the PPS rate by the number of visits or the adjusted number of claims (claims multiplied by the conversion factor). This value will be automatically calculated from the provider reported data. Please do not enter data into this column, as it will populate data through a formula.
Paid by MCO	Insert MCO payments into the appropriate column. All MCO payments, except incentive payments, should be reported. MCO payments include, but are not limited to: payments for ancillary services, administrative fee payments, capitation payments and sub-capitation payments, laboratory and radiology payments.
Total Estimated paid by MCO	This number is calculated by totaling all MCO payments for each month. This value will be automatically calculated from the provider reported data. Please do not enter data into this column, as it will populate data through a formula.
Auto System	The auto system column should not be completed by the provider. This column will be completed by the Department for Medicaid Services during the reconciliation process.
Field Title	**Field Description**
The following instructions are for Tab 2 of the reconciliation form.	
Changes of Ownership	In this table, please report any history of changes of ownership for your facility. This would include any prior or subsequent Medicaid provider numbers. Additionally, please report any prior or subsequent facility names and the effective dates of these changes.
Satellite Facilities	In this table, please disclose any satellite facilities owned by your facility. This list should include: • Former freestanding facilities purchased by your facility and made satellites. • Any satellite locations opened by your facility. Please report the prior provider name and number if applicable, as well as the effective date of licensure and location.
MCO Contracts	In this table, please list all contracts you have with Kentucky MCOs. Please also list the contract effective date for each MCO.