

**LEA Medi-Cal Billing Option Program
Frequently Asked Questions (FAQs)**

****PLEASE REVIEW THE LEA MEDI-CAL BILLING OPTION PROVIDER MANUAL
FOR COMPLETE LEA PROGRAM AND POLICY INFORMATION****

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I. General Program Requirements

Q1. Is there a booklet that explains the LEA Medi-Cal Billing Option? Do you send periodic updates to LEA providers regarding program changes?

A. Yes, there is a specific portion of the Medi-Cal provider manual that explains the LEA Medi-Cal Billing Option Program. To obtain a copy, you can contact the Telephone Service Center (TSC) at 1-800-541-5555, or download an electronic copy on-line via the Medi-Cal website (www.medi-cal.ca.gov) or on the LEA Program website (<http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>). Updates to the Medi-Cal provider manual are automatically sent to all enrolled LEA providers; other parties may request to receive provider bulletins and manual replacement pages by calling TSC at 1-800-541-5555.

Q2. Can private schools participate in the LEA Medi-Cal Billing Option Program?

A. Private schools do not qualify as LEA providers. However, the Individuals with Disabilities Education Act (IDEA) 2004 does include provisions to ensure that students in private schools have access to special education services. For example, in certain cases a student may receive services at the public school district where the private school is located. According to California Education Code, Sections 56170 - 56177, a public agency must administer funds and property used to provide special education and related services.

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Q3. Are there any guidelines available on patient confidentiality?

- A. All medical records under this program are confidential and cannot be released without the written consent of the beneficiary or his/her personal representative. According to State Medi-Cal regulations, information can be shared or released between individuals or institutions providing care, fiscal intermediaries, and State or local official agencies. However, the Family Educational Rights and Privacy Act (FERPA) require that schools obtain written consent from the parent or guardian prior to releasing any medical information in personally identifiable form from the student's education record.

Confidentiality requirements are based on the following Federal and State codes and regulations:

1. 42 U.S. Code Section 1320c-9 and 20 U.S. Code Section 1232g (www.gpoaccess.gov/uscode/index.html);
2. 42 Code of Federal Regulations, Section 431.300 and 34 Code of Federal Regulations, Part 99 (www.gpoaccess.gov/cfr/index.html);
3. California Code of Regulations (CCR), Title 22, Section 51009 (www.ccr.oal.ca.gov);
4. Welfare and Institutions Code, Section 14100.2 (www.leginfo.ca.gov/calaw.html);
5. California Education Code, Section 49060 and 49073 through 49079 (www.leginfo.ca.gov/calaw.html).

Q4. Does the local match requirement have to be service specific (i.e., local funds paid for the specific service) or does it apply to the overall reimbursement (i.e., local funds/expenses are equal to/greater than the total federal reimbursement)?

- A. The local match is not service specific. LEA providers cannot use federal funds to match other federal funds. On an annual basis, LEA providers certify that they match the 50% local portion with non-federal funds.

Q5. Are there regulations stipulating that a billing vendor may not be paid on a percentage basis?

- A. In the March 2009 provider training sessions, Audits and Investigations personnel cited the following regulations:
California Code of Regulations § 51502.1. Requirements for Electronic Claims Submission.
(a) As used in this section, the following definitions shall apply:
(1) "Biller" includes any employee, officer, agent or director of the entity which will bill on behalf of a provider pursuant to a contractual relationship with the provider which does not include payment to billers on the basis of a percentage of amount billed or collected from Medi-Cal.

In addition, the Code of Federal Regulations, Title 42: Public Health, includes detail on payments made to business agents:

PART 447—PAYMENTS FOR SERVICES

Subpart A—Payments: General Provisions

§ 447.10 Prohibition against reassignment of provider claims

- (f) Business agents. Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if

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the agent's compensation for this service is—

- (1) Related to the cost of processing the billing;
- (2) Not related on a percentage or other basis to the amount that is billed or collected; and
- (3) Not dependent upon the collection of the payment.

Q6. Can school districts spend a portion of their Medicaid reimbursements for overhead/indirect cost?

- A. According to the LEA Medi-Cal Billing Option Provider Participation Agreement/Annual Report, federal funds received by an LEA provider for LEA services shall be reinvested to provide health and other support services for school children and their families. LEA providers may also spend a portion of the Medicaid reimbursements to cover.

II. LEA Provider Participation Agreement (PPA)/Annual Report

Q7. What is the due date for the Provider Participation Agreement (PPA)/Annual Report?

- A. The PPA/Annual Report must be submitted to the California Department of Health Care Services (DHCS) by October 10th of each year. Continued enrollment in the program is contingent upon submission of the PPA/Annual Report. If you have questions regarding the report, please contact DHCS, LEA Medi-Cal Billing Option Program at LEA@dhcs.ca.gov. To obtain a copy of a prior year PPA, please contact DHCS, Provider Enrollment Division at PEDcorr@dhcs.ca.gov. The PPA/Annual Report is available on the LEA Program website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEA%20Annual%20Report%20new.aspx>.

Q8. If we are already billing in the LEA Medi-Cal Billing Option Program, do we have to reapply or resubmit the PPA/Annual Report and the Provider Enrollment Information Sheet every fiscal year?

- A. Yes. The PPA/Annual Report is a contract for the LEA Medi-Cal Billing Option Program and each LEA is responsible for submitting a PPA/Annual Report by October 10th of each year. Since the LEA Medi-Cal Billing Option Program is affected by legislation, the terms and regulations that pertain to it may change annually.

Q9. Where will PPA/Annual Reports be submitted?

- A. All LEA PPA/Annual Reports must be completed on the most recent forms. LEAs may e-mail the PPA/AR to DHCS to LEA.AnnualReport@dhcs.ca.gov; however, all signature pages must be mailed to the address below:

California Department of Education
Coordinated School Health & Safety Office
Attn: Shalonn Woodard
1430 N Street, Suite 6408
Sacramento, CA 95814

Q10. Should we send the PPA/Annual Report via certified or registered mail?

- A. You may send the PPA/Annual Report however you like, as long as it is postmarked by October 10th of each year.

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Q11. In the PPA/Annual Report, do both the service and office address have to be reported? Or will DHCS/CDE accept one as long as the "mailing address" box is checked?

A. If the service and office address are different, both addresses need to be completed. Please refer to page 1 of the instructions for the PPA/Annual Report.

Q12. How do I update my LEA address or contact information?

A. LEA contact information will be updated annually with the submission of an LEA PPA/Annual Report. Please complete the LEA contact information form if there is a change of contact person. If you wish to submit a change of billing and/or mailing address, please submit a DHCS 6209, Medi-Cal Supplemental Changes Form to the Provider Enrollment Branch. Both of these forms can be obtained by visiting the LEA Medi-Cal Billing Option Program Website (<http://www.dhcs.ca.gov/provgovpart/Pages/LEAContactInformationForm.aspx>).

Q13. If an LEA district's contact information, such as address, changes, will the new PPA/Annual Report suffice as notice to CDE and DHCS?

A. If there is a change of information and it is noted on the Provider Enrollment Information Sheet that is submitted with the PPA/Annual Report, all parties will update their information. However, if there is a change in the middle of school year, the LEA should complete the LEA Contact Information Form on the LEA website (<http://www.dhcs.ca.gov/provgovpart/Pages/LEAContactInformationForm.aspx>).

Q14. If an LEA does not submit their PPA/Annual Report for the current year, do they have to wait for the next fiscal year to apply?

A. Yes, LEAs are required to annually submit a PPA/Annual Report to apply/reapply to bill in the LEA Medi-Cal Billing Option Program. LEAs must submit by October 10th of each year otherwise they will not be allowed to claim for LEA services for that fiscal year.

Q15. How long will approval take for the annually submitted PPA/Annual Report forms?

A. Once received, it will take Provider Enrollment approximately 90 days to process the PPA/Annual Report and send confirmation letters to the LEA.

Q16. Will completed PPA/Annual Reports be available on the LEA Program website in the event the LEA misplaces them? Will LEAs receive a confirmation that the report was received?

A. Once DHCS receives the PPA/Annual Report, the LEA will be notified. Completed PPA/Annual Reports will not be available on the website. If the LEA would like a copy of the agreement, they will need to send an e-mail to the LEA mailbox (lea@dhcs.ca.gov) to request it.

Q17. Please stipulate who is authorized to sign the PPA/Annual Report other than for a Superintendent or Assistant Superintendent?

A. Since the PPA/Annual Report is a legally binding contract, the individual designated/authorized by the district to sign contracts should sign the PPA/Annual Report. In most cases, this will be the Superintendent, Assistant Superintendent or Business Services/Fiscal Officer.

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Q18. On the PPA/Annual Report, how do we complete the Certification of State Matching Funds for LEA Services if our billing spans fiscal years and we do not have all of the relevant information?

- A. The PPA/Annual Report Certification of State Matching Funds for LEA Services is the amount your LEA has budgeted in the current fiscal year to fund the activities covered by the LEA Medi-Cal Billing Option Program.

Q19. How do LEAs determine the LEA matching funds?

- A. The matching funds are the funds that the LEA has reserved for the LEA program. In order to estimate the dollar amount that will be entered on the Attachment 1, add up the costs of employees who provide health services (wages, benefits, administrative costs), and any costs associated with health service contracts. Omit from the calculation any employees who are 100 percent federally funded, but include all other practitioners (e.g., nurses, counselors, psychologists, etc). Multiply the total health services costs by the percentage of students who are Medi-Cal eligible. You may obtain data on the percentage of Medi-Cal eligible students your LEA serves by: a) speaking with the County Social Services office; b) using a percentage based on the median of your Free and Reduced Lunch and Cal Works program recipients; or c) calculating a percentage based on previous eligibility data matches received from DHCS or the Department of Education.

Q20. What is the criteria for determining the dollar amount for Line 2 of Attachment 1, Certification of State Matching Funds for LEA Service?

- A. The certification of state matching funds is the estimated amount of non-federal matching funds that your LEA will be expending on health services to Medi-Cal enrolled students during the fiscal year. This form identifies the money that will be used by the LEA to supply health services to Medi-Cal enrolled students, and it is the maximum amount your LEA will be able to receive in matching federal Medicaid funds, reimbursed through the LEA Medi-Cal Billing Option, during the upcoming fiscal year.

Q21. Are there guidelines on allowable versus unallowable ways to spend LEA Medi-Cal Billing Option Program reimbursement received by our district?

- A. Any federal funds received by an LEA provider for LEA services shall be reinvested in services for school children and their families. These funds shall be used to supplement, not supplant, existing services. School-linked support services for children and families consist of services such as case-managed health, mental health, social, and academic support services benefiting children and their families. The services are intended to benefit children and their families and may include, examples originally outlined in SB 620, and now found in California Education Code, Section 8804(g).

Q22. The PPA/Annual Report Attachment 2a only has two pages for the LEA collaborative partners, which is not enough. Can we submit an additional page(s)?

- A. If additional pages are needed, you may attach additional sheets to the PPA/Annual Report.

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Q23. We have a separate form for the LEA collaborative meeting that each member has already signed. Do we have to schedule a new meeting to have them sign this new form, or can we just attach the form we already use?

A. LEAs will need to have the LEA collaborative members sign the PPA/Annual Report form.

Q24. How many times should the LEA collaborative meet?

A. It is up to the local collaborative to determine the planned frequency of meetings.

III. Eligibility

Q25. When my LEA verifies eligibility on the internet, do we need to have the student's Beneficiary Identification Card (BIC) number to check eligibility?

A. Yes; however, if you don't have the student's BIC number, you can use another eligibility determination method, such as the Memorandum of Understanding or the LEA Tape Match option. Refer to the LEA Medi-Cal Billing Option Provider Manual located for additional eligibility information.

Q26. How can I obtain a student's Medi-Cal Beneficiary Identification Card (BIC) number?

A. The student's BIC contains the 14-digit alphanumeric BIC number. However, if the card is not available, your LEA can obtain the BIC number using the LEA Tape Match system or a Memorandum of Understanding (MOU) with the county welfare department.

Q27. Many students do not have Medi-Cal coverage when we claim costs related to their services, what could be causing this?

A. The main reason why these students do not have coverage when LEAs bill for direct medical services is the delay between the date of service and date of claim for payment. The reason that this can be a problem is that Beneficiary Identification Card (BIC) numbers for students can change quickly. Students often get a Temporary Identification Number (TIN) to replace their BIC and when this is the case LEAs will not be able to bill claims. Our advice is as follows:

- Request BIC numbers based on date of service.
- Bill for services as close to the date of service as possible.
- If claims get rejected, LEAs should keep attempting to bill for the same student as they may become Medi-Cal eligible at a later date.

Q28. Does a Medi-Cal eligible student have continuing coverage or is there a limit on total funds for each recipient's health coverage?

A. Eligibility is determined on a monthly basis by the county. There is no limit on funds for each recipient's health coverage. The period of eligibility for Medi-Cal persons shall continue through each successive month during which the person is determined to be eligible. (Title 22, CCR, Section 50195)

Q29. Medi-Cal eligibility for students can only be determined quarterly through the DHCS Information Technology Services Division (ITSD) data layout. Is there a way to determine eligibility on a monthly basis?

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- A. Yes, there are several different ways to determine eligibility on a monthly basis. These methods include a Memorandum of Understanding (MOU) with the local county welfare department, Point of Service (POS) device, Automated Eligibility Verification System (AEVS), and the Medi-Cal website. These options are defined in the LEA Medi-Cal Billing Option Provider Manual located on pages 2 and 3.

Q30. What happens if my LEA loses its PIN number for the online eligibility verification option?

- A. A temporary Provider Identification Number (PIN) is issued by the POS/Internet Help Desk to providers who do not have a permanent PIN or have misplaced their permanent PIN. A temporary PIN is valid until midnight of the day it was issued. Providers can use a temporary PIN to verify eligibility and perform Share of Cost transactions. A temporary PIN can only be used on the Supplemental Automated Eligibility Verification System (SAEVS). A temporary PIN cannot be used with the POS Device, Automated Eligibility Verification System (AEVS), Provider Telecommunications Network (PTN) or on the Medi-Cal Web site.

To obtain a temporary PIN, please call the POS/Internet Help Desk at 1-800-427-1295. You can access SAEVS by calling 1-800-427-1295. Choose option 4 and then option 2.

Q31. Can a Medi-Cal eligible student who is enrolled in a school district or receives home schooling receive LEA services from another school district?

- A. Yes. A Medi-Cal eligible student may receive LEA services from another school district as long as the student is enrolled in a school district in California. Students receiving home schooling are enrolled in a school district. (Title 22, CCR, Section 51190.1)

IV. Assessment Policy and Billing

Q32. When an IEP/IFSP health assessment takes more than one day to complete, should we bill for a new assessment each day or for one assessment over the course of two days?

- A. For IEP/IFSP encounter-based assessments (physical therapy, occupational therapy, speech-language, audiological, health, and psychological), you will bill only one unit of service regardless of the amount of time it takes to complete the assessment. When billing for an assessment that takes multiple days to complete, use the “from-through” billing method to record the dates over which the assessment was conducted. If the assessment is completed on a single day, the “from-through” billing method is not required and LEAs may record the date of service on which the assessment was completed. The encounter-based rate has been developed to incorporate, among other tasks, preparation time, direct service time, and report writing time that occur over the course of the assessment, whether the assessment takes one day or several days to complete.

Q33. For our IFSP students (birth to age three), we do the initial, annual and a six-month/periodic review, as required by law. How do we bill for these services?

- A. The LEA Program allows for three types of IEP/IFSP assessments: initial/triennial, annual and amended.

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- Initial/triennial assessments may be billed once every third fiscal year;
- Annual assessments may be billed every year when an initial/triennial is not performed and billed; and
- Amended assessments may be billed when conducted to amend an initial, triennial or annual assessment that was performed in that fiscal year. Amended assessments may be billed once every 30 days.

In this example, the six-month assessment would be considered an amended assessment.

Q34. When conducting an annual assessment, certain information comes from the parent, and not necessarily from contact time with the student. Is this billable as an IEP/IFSP annual assessment?

- A. No, parent/guardian meeting time alone is not billable as an IEP/IFSP annual assessment. Required components of an annual assessment include:

- Review student records, such as cumulative files, health history, and/or medical records;
- Interview student and/or parent/guardian;
- Observe student in appropriate settings; and
- Write a report to summarize assessment results and recommendations for LEA services.

During an annual assessment, administration and scoring/interpreting of tests may or may not be included, depending on the needs of the student. However, direct student contact service time is required. In addition, documentation is required to support that you have met the requirements of the assessment.

Q35. Which assessments can utilize the rounding policy?

- A. You cannot round up time spent to conduct any assessment services. Assessments may only be billed for completed service time. The rounding policy applies to treatment services that are:
- Billed in 15-minute increments (nursing, trained health care aide and TCM services); or
 - Additional 15-minute increments provided beyond the initial 15-45 minute treatment session (physical therapy, occupational therapy, individual and group speech therapy, audiology, and individual and group psychology and counseling).

Q36. If a registered credentialed school nurse performs a hearing screening as part of a health assessment, can it be billed separately?

- A. All of the tests and procedures that are performed by a registered credentialed school nurse as part of a health assessment are reimbursable under one procedure code and maximum allowable rate.

Q37. If an IEP student receives an initial speech assessment in English and a second speech assessment in Spanish, can both assessments be billed as initial assessments under the LEA Program? What if two practitioners perform the initial assessment?

- A. No. Initial and triennial IEP/IFSP assessments are limited to one every third fiscal year per provider per assessment type. This means that if more than one initial/triennial speech assessment is billed under your LEA's National Provider Identifier (NPI) before the third fiscal

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year, the second claim will be denied.

Q38. If we bill for an assessment can we bill this again during MAA Program billing?

- A. LEAs may not bill under the LEA Medi-Cal Billing Option Program for report writing and other indirect service time. You may only bill for direct service time. Preparation of reports, travel time and other administrative activities that are related to the direct provision of health services are not claimable under the LEA Program, as this time was factored into the new LEA interim rate structure. Billing for indirect time would be “double-dipping”. In addition, report writing cannot be billed under MAA. For a single service, you may bill either MAA or LEA, but not both.

Q39. Can an IEP/IFSP assessment be billed to the LEA Medi-Cal Billing Option Program even if the student does not qualify for IDEA services?

- A. Yes, an IEP/IFSP initial assessment is provided to determine the student's eligibility, and if the student is determined ineligible for services under IDEA and no IEP/IFSP is developed, the IEP/IFSP initial assessment may still be billed to the LEA Medi-Cal Billing Option Program. If any additional assessments and treatment services are rendered after that determination, the services must be billed as non-IEP/IFSP services and meet the Free Care and Other Health Coverage requirements. These requirements are found in section loc ed bil of the LEA Provider Manual.

Q40. Can you clarify when non-IEP assessments are billable under the LEA Medi-Cal Billing Option Program?

- A. Non-IEP/IFSP assessments are allowable in the LEA Medi-Cal Billing Option Program on a very limited basis. In order for these services to be billed to Medi-Cal, stringent Free Care and Other Health Coverage requirements must be met. These requirements are found in section loc ed bil of the LEA Provider Manual.

Q41. Scoliosis Screenings are no longer a "mandate" and the law was legislatively suspended in FY 2010/11. Can these screenings now be billed?

- A. State mandated screenings during the statewide periodicity schedule (including vision, hearing and scoliosis testing) may never be billed to the LEA Medi-Cal Billing Option Program. Pursuant to the Budget Act, Chapter 712, Statutes of 2010, Item 6110-295-0001, Provision 1, the legislature has suspended the operation of a mandate and reimbursement for scoliosis screenings for FYs 2010/11 through 2012/13 through the State Controller's Office. Scoliosis screenings may only be reimbursed under the LEA Medi-Cal Billing Option Program if identified as medically necessary in the student's IEP/IFSP. The treatment must meet the supervision requirements and time increment noted in section loc ed serv nurs of the LEA Provider Manual.

V. Treatment Service Policy and Billing

Q42. For non-IEP/IFSP students, can we bill the LEA Program for services rendered under a Section 504 Plan?

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A. No. You may not bill Medi-Cal for services provided under a Section 504 Plan.

Q43. Can the assessment activity used for Section 504 Plan determination be billed to Medi-Cal as an initial assessment?

A. No. A Section 504 Plan determination is not equivalent to an IEP/IFSP determination under the LEA Medi-Cal Billing Option Program. LEAs may not bill Medi-Cal for services provided under a Section 504 Plan.

Q44. Can we bill for all mental health services that were previously covered under the County Mental Health Program?

A. Currently under the LEA Medi-Cal Billing Option Program, the only mental health services that are reimbursable include IEP/IFSP psychological assessments, psychosocial status assessments, psychology/counseling treatment and TCM services. No other mental health services are currently reimbursable.

Q45. What written section can we refer to where it states nursing services cannot bill for mental health services? What about psychological meds and other interventions or treatments performed by nursing?

A. Section loc ed serv nurs of the LEA Provider Manual outlines the allowable services that can be billed by a Registered Credentialed School Nurse, Licensed Registered Nurse, Certified Public Health Nurse or Certified Nurse Practitioner. Administration of medication and related observation are allowable nursing treatment services, but must meet the supervision requirements and minimum time increment to be billed to the LEA Medi-Cal Billing Option Program.

Q46. From a school psychologist perspective, where does behavior support plans fit into LEA billing? Would that be appropriate under amended as we often complete a behavior support plan in an addendum IEP?

A. Currently behavioral services are not reimbursable under the LEA Medi-Cal Billing Option Program. Allowable psychological services are outlined in loc ed serv psych of the LEA Provider Manual.

Q47. When a billable practitioner provides consultative service to a Medi-Cal eligible student's teacher who will be performing the treatment under the practitioner's supervision, is the practitioner's time spent consulting the teacher a billable treatment?

A. No, consultations with a Medi-Cal eligible student's teacher are not a covered service in the LEA Medi-Cal Billing Option Program. The reimbursement rates for treatment services already account for "preparation and completion activities." Accordingly, consultations are not separately billable in the LEA Medi-Cal Billing Option Program.

Q48. How do you bill medical counseling (previously billed as a health education/anticipatory guidance service) for IEP/IFSP students?

A. Although there is no specific billing code for health education/anticipatory guidance provided to an IEP/IFSP student, medical counseling may be provided by an appropriate practitioner as a treatment service within their scope of practice. For example, if a school nurse is providing

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counseling on nutrition to an IEP student that has an eating disorder (and the counseling is included in the student's IEP), this may be billed as part of the nursing treatment service.

Q49. What constitutes a non-IEP/IFSP health education/anticipatory guidance assessment? Is health education/anticipatory guidance reimbursable under the LEA Program if the service was provided by telephone?

- A. No. Health education/anticipatory guidance is preventative medical counseling and/or risk factor reduction provided to an individual/parent based on an evaluation of the individual's needs, and provided as a direct face-to-face service. When this service is provided to a non-IEP/IFSP student, the Free Care requirements must be met.

Nursing and Trained Health Care Treatment

Q50. Can nurses bill for immunizations, administration of medications, glucose monitoring or tube feeding?

- A. Nursing services include preventive and medically necessary procedures provided at the school site that are authorized in the IEP/IFSP. School nurses may provide immunizations, administer medications, monitor glucose or tube feed. However, the service must be provided to a specific Medi-Cal beneficiary and take, at a minimum, at least seven or more continuous treatment minutes in order to be reimbursed by Medi-Cal as a nursing service. When these treatment services are provided to a non-IEP/IFSP student, the Free Care requirements must be met.

Q51. Under nursing services, a student is often observed to determine whether they need a treatment service. After the treatment is provided, the student continues to be observed to assess whether the treatment was successful. For example, a nurse provides suctioning as authorized in the IEP/IFSP, and continues to monitor the student after the treatment. Can the observation time prior to and after the treatment be billed as part of the direct service time to meet the seven minute minimum time period?

- A. Yes. Medically necessary observation of a student as part of a direct medical service may be billed.

Q52. Are toileting, diapering and lifting reimbursable under the LEA Program if those services are documented as medically necessary in the student's IEP?

- A. Diapering, toileting and lifting are considered personal care services, which are not covered in California's Medicaid State Plan. Therefore, these services are not currently reimbursable under the LEA Program. Personal care services may not be billed as nursing treatment services under any circumstance, even if prescribed by a physician and included in an IEP.

Q53. Do nursing services have to be provided in continuous minutes?

- A. Nursing treatment services are billed in 15-minute increments. When seven or more continuous treatment minutes are rendered, a 15-minute increment can be billed. The minimum time (seven minutes) must be one continuous period and cannot be made up of shorter time periods provided throughout the day and added together.

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Q54. Does rounding for treatment services only apply to nursing and school health aide treatments?

- A. The rounding policy applies to two billing increment scenarios: (1) Treatments and TCM that are billed in 15-minute increments (nursing, school health aide, TCM services); and (2) Additional 15-minute treatment service increments beyond the initial 15-45 minutes (physical therapy, occupational therapy, group and individual speech therapy, audiology, and group and individual psychology and counseling). The rounding policy does not apply to any assessment services.

Q55. Under nursing services, do we need to have a frequency attached to the service in the IEP? Many times the nurses will provide services on an as-needed basis, which is reflected in the IEP. Is this acceptable?

- A. Nursing services may be authorized on an as-needed basis in the IEP/IFSP, as appropriate to the diagnosis. For certain medical conditions, physicians may authorize that services should be provided as required or needed. As long as the LEA maintains documentation that as-needed services are medically necessary, these services may be billed to Medi-Cal.

Q56. If we have an aide who is constantly accompanying an IEP/IFSP student and assessing or monitoring their medical condition, can we bill for the time when the aide is not providing direct medical care? For example, if an aide accompanies a student who must be constantly monitored for suctioning, can this monitoring time be billed?

- A. Yes, an LEA can bill for an IEP/IFSP student to receive constant monitoring as part of direct medical service if it is medically necessary and authorized in the IEP/IFSP.

Q57. School Nurses are seeing an increase in the number of students with mental health disorders that require observation by Trained Health Care Aides in order to prevent harm to self and/or others. What requirements are necessary to receive reimbursement for these services when the student has an IEP and the team agrees these nursing services are needed?

- A. Observation of a child by a Trained Health Care Aide is not billable under the LEA Medi-Cal Billing Option Program. Trained Health Care Aides may only provide medically necessary specialized physical health care services under the supervision of a licensed Physician or Surgeon, a Registered Credentialed School Nurse or a Public Health Nurse. "Observation" is not considered a specialized physical health care service.

Q58. Is "observation only" of an autistic student billable under the LEA Medi-Cal Program? The aide time is written into the student's IEP.

- A. No. Observation of an autistic student is considered a behavioral service and is not billable under the LEA Medi-Cal Billing Option Program. Trained health care aides may only provide medically necessary specialized physical health care services under the supervision of a licensed physician or surgeon, a registered credentialed school nurse or a public health nurse. "Observation" is not considered a specialized physical health care service.

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Group Therapy Treatment

- Q59. Group speech therapy and group psychology/counseling are currently billable services. Are there any other services billable in a group setting?**
- A. No, speech and psychology/counseling are the only services that may currently be provided in a group setting and reimbursable under the LEA Medi-Cal Billing Option Program.
- Q60. Are there a maximum number of students for “group” treatments?**
- A. To bill for group speech therapy or psychology and counseling services under the LEA Medi-Cal Billing Option Program, a group must be two or more students, but not more than eight students.
- Q61. If there are three students in the group therapy session that lasts for 45 minutes, do we bill 45 minutes for each Medi-Cal eligible student, or do we divide the total time of the session by the number of students and bill 15 minutes for each of the students?**
- A. Under this scenario, the LEA should bill 45 minutes for each Medi-Cal eligible student who participates in the group therapy session. LEAs will bill one unit of service for each completed 15-minute increment in the initial service session, up to a maximum of 45 minutes. In this case, the LEA will bill three units of group therapy (3 units x 15 minutes = 45 minutes) for each Medi-Cal eligible student in the group therapy session; all three units will be reimbursable under one initial service maximum allowable rate.

VI. LEA Service Limitations

- Q62. There is an annual service limitation of 24 services per fiscal year for non-IEP/IFSP services. If we transport a student to a therapy service, does that transportation count as one of 24 services in a fiscal year?**
- A. Yes. Each non-IEP/IFSP assessment, treatment and transportation service is included in the 24 services per fiscal year limitation. In addition, Free Care requirements must be met in order to bill for non-IEP/IFSP services.
- Q63. Please clarify the service limitations for IEP/IFSP assessments.**
- A. LEA IEP/IFSP assessment service limitations are by service type per beneficiary per LEA provider. For additional information, refer to the local individual section of the LEA Provider Manual.
- Q64. What are the daily and annual maximum limitations for IEP/IFSP psychosocial status assessments?**
- A. IEP/IFSP psychosocial status assessments are billed in 15-minute increments. These have no daily maximum unit limitation per assessment. However, there are yearly service limitations. Initial IFSP psychosocial status assessments are limited to one assessment per lifetime per beneficiary per LEA provider. Initial IEP and triennial IEP/IFSP psychosocial status assessments are limited to one assessment every third fiscal year per beneficiary per LEA provider. Annual IEP/IFSP psychosocial status assessments are limited to one assessment

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every fiscal year per beneficiary per LEA provider when an initial/triennial assessment is not billed during that fiscal year. Amended IEP/IFSP psychosocial status assessments are limited to one assessment every 30 days per beneficiary per LEA provider when an initial/triennial or annual assessment has been billed during that fiscal year.

Q65. What is the daily maximum limitation for non-IEP/IFSP treatment services? How does this differ from the yearly limitation of 24 services per fiscal year?

- A. LEA non-IEP/IFSP assessment and treatment services have daily maximum limitations (i.e., nursing treatment services are limited to 32 units = 8 hours of treatment per day). Non-IEP/IFSP services are limited to 24 services per fiscal year. Each non-IEP/IFSP assessment, treatment and transportation service reimbursed is included in the fiscal year limitation. Therefore, if the LEA bills 2 units (30 minutes) of non-IEP/IFSP nursing treatment, this is considered as one "service" of the 24 services per fiscal year. Note that Free Care requirements must be met in order to bill for non-IEP/IFSP services.

Q66. Will an amended assessment be paid if the student was not Medi-Cal eligible last year, but is now? The annual assessment would not have been billed and will not be in the student's paid claims history.

- A. Yes, your LEA may bill an amended IEP/IFSP assessment even though the annual assessment was not billed due to Medi-Cal ineligibility. The LEA must have the necessary service documentation in the student's files that document that the initial/triennial/annual IEP/IFSP assessment was originally performed prior to amending the assessment.

VII. Prescriptions, Referrals, Recommendations and Protocol

Q67. How long is a prescription/referral/recommendation for treatment services valid?

- A. Prescriptions, referrals and recommendations must be updated annually.

Q68. Is there a required format for prescriptions, referrals or recommendations for assessment services?

- A. Although there is no mandated format for this documentation, minimum requirements have been established including:
- Prescriptions: school name; student's name; reason for assessment; parent, teacher or practitioner observations and reason(s) for assessment; signature of prescribing practitioner, and type of practitioner.
 - Referral: school name; student's name; reason for assessment; parent, teacher or practitioner observations and reason(s) for assessment; signature of referring practitioner, and type of practitioner.
 - Recommendations must include a written statement in the student's record including: parent, teacher or practitioner observations and reason(s) for assessment; signature of recommending practitioner, and type of practitioner.

Although minimum requirements have been established, your LEA should develop standards that ensure adequate documentation of medical necessity for services exists in your files.

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Q69. Would an electronic version of a prescription, referral or recommendation be acceptable in place of a hard copy document?

- A. Electronic prescriptions, referrals or recommendations are acceptable only if there are processes in place to ensure that the prescription, referral or recommendation is provided by a valid, appropriate and qualified practitioner and includes an electronic signature. However, hard copies of these forms must be maintained for at least three years.

Q70. For IEP/IFSP students receiving treatment services, prescriptions, referrals and recommendations may be established in the IEP/IFSP. What does this mean?

- A. For treatment services, the appropriate health service practitioner(s) may record the prescription, referral and/or recommendation for treatment services directly in the child's IEP/IFSP or as a separate document that is attached to the IEP/IFSP.

Q71. Is it necessary to have a prescription, referral or recommendation from a health services practitioner to provide assessment services?

- A. The prescription, referral or recommendation for an assessment must be documented in one of two ways: (1) your LEA can obtain an individual written prescription, referral or recommendation from an appropriate health services practitioner; or (2) a referral by a parent, teacher or credentialed school nurse. Regardless of which option is used, the required documentation must be maintained in the student's files.

Q72. When the parent signs the parental consent portion of the Assessment Plan, is this form adequate to document a parental request for assessment services?

- A. No. A parent, teacher or school nurse request for assessment requires specific documentation of the observations and reason for the assessment. A parent signature on an Assessment Plan is not adequate documentation under the LEA Program requirements. LEAs may be able to modify documentation they currently use to incorporate the information required to bill Medi-Cal when a parent requests an assessment service.

Q73. Can a registered credentialed school nurse self-refer a student for a health assessment?

- A. Yes, a registered credentialed school nurse can self-refer, since they are one of the qualified practitioners listed to refer for assessment services. If a self-referral is made, the practitioner must still include the appropriate documentation in the student's file, including: observations and reason(s) for assessment, and the signature and practitioner title of the registered credential school nurse that is self-referring the student for the assessment.

Q74. When can a physician-based standards protocol be used to establish medical necessity?

- A. A physician-based standards protocol may be developed by your LEA and used to document the medical necessity of speech and audiology treatment services to meet California State requirements that a written referral be provided by a physician or dentist prior to rendering speech and audiology treatment services. However, according to federal law (42 CFR 440.110(c)), a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice is required to document medical necessity of speech and audiology treatment services. LEAs must meet both State and federal documentation requirements. Physician-based standards protocol does not meet federal requirements for documenting medical necessity of speech and audiology treatment services. In order to meet

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federal documentation requirements, a physician or other licensed practitioner of the healing arts (i.e., licensed speech-language pathologist or licensed audiologist) must refer the student for speech and audiology treatment services.

Q75. Will DHCS provide the physician-based standards protocol cover letter for the LEA providers?

- A. No, your LEA must develop and maintain its own physician-based standards protocol. The protocol may only be used to meet State requirements documenting medical necessity for speech and audiology treatment services. The protocol does not fulfill federal requirements as defined in 42 CFR 440.110(c), and noted in the answer above.

Q76. Are we to assume students enrolling in the district with a current IEP for speech therapy have already been referred by a doctor for services?

- A. No, there must be a written referral for speech therapy in the Medi-Cal eligible student's file for Medi-Cal to reimburse the LEA for speech therapy. In order to rely on another LEA's physician referral for speech therapy services, your LEA must maintain the referral documentation in the student's files, and have this information readily available for State and/or Federal review.

Q77. Can an occupational therapist prescribe treatment services based on his/her assessment?

- A. The occupational therapist conducting the assessment may determine the need for treatment services. However, State regulations require a written prescription by a physician or podiatrist, within the practitioner's scope of practice, to bill for occupational therapy treatment services in the LEA Program.

Q78. What are the prescription, referral and/or recommendation requirements for IEP/IFSP assessments? Does an assessment by an occupational therapist require a doctor's prescription?

- A. The prescription, referral or recommendation for an assessment must be documented in one of two ways: (1) your LEA can obtain an individual written prescription, referral or recommendation from an appropriate health services practitioner; OR (2) a referral by a parent, teacher or credentialed school nurse. Regardless of which option is used, the required documentation must be maintained in the student's files. Additional information can be found in the local ed bil section of the LEA Provider Manual.

VIII. Supervision Requirements

Q79. Can a certified public health nurse employed by an LEA supervise licensed vocational nurses (LVNs) and trained health care aides?

- A. No, LVNs and trained health care aides providing specialized health care services must be supervised by a licensed physician, registered credentialed school nurse or certified public health nurse employed by the State Department of Health Care Service. Although a certified public health nurse may be employed by an LEA to provide specialized physical health care services, that public health nurse is not qualified to supervise LVNs or trained health care aides who provide specialized health care services.

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Q80. If a district does not have a credentialed school nurse to provide supervision, can the LEA bill Medi-Cal for services provided by LVNs and health aides?

- A. In order for LEAs to bill Medi-Cal for LEA treatment services provided by LVNs and trained health care aides, these practitioners must be supervised by a licensed physician, registered credentialed school nurse, or certified public health nurse employed by the State Department of Health Care Service. In addition, the only type of nurse that is able to bill Medi-Cal for LEA nursing assessments is a credentialed school nurse. Therefore, a registered nurse (RN), certified public health nurse (CPHN) or certified nurse practitioner (CNP) who does not have a valid school nurse services credential may not bill Medi-Cal for LEA nursing assessments. For nursing treatment services, RNs, CPHNs and CNPs who are not also credentialed school nurses require supervision by a credentialed school nurse in order to bill Medi-Cal for services provided. Refer to LEA Medi-Cal Billing Option Provider Manual loc ed serv nurs and loc ed bil (pages 6-7) for additional information.

Q81. Has there been legislation that changes the supervision requirements for credentialed speech-language pathologists?

- A. Assembly Bill 2837, signed on September 28, 2006, became law immediately pending a provision for confirmation by the California Attorney General. On November 30, 2006, Attorney General Opinion #06-1011 affirmed AB 2837's provisions that a two-tier credential in Speech-Language Pathology (SLP) aligned to the American Speech Language Hearing Association's (ASHA) Certificate of Clinical Competence and satisfies federal Medicaid personnel standards for speech-language pathologists. CMS recently approved a State Plan Amendment (SPA) on December 16, 2011 that will allow DHCS to implement the law for Medi-Cal billing purposes. SLPs who hold a valid Commission on Teacher Credentialing (CTC) "Preliminary SLP Services Credential" or "Professional Clear SLP Services Credential" will be able to bill for services under the LEA Medi-Cal Billing Option Program without being supervised by a licensed SLP. In addition, SLPs with a "Professional Clear SLP Services Credential" are authorized to supervise credentialed SLPs. SLPs without a valid "Preliminary SLP Services Credential" or a "Professional Clear SLP Services Credential" will still require supervision by a licensed SLP or a credentialed SLP with a valid "Professional Clear SLP Services Credential". LEAs are still subject to the one year claims submission requirements and claims will be denied if received after the twelfth month following the month of service. LEA providers can find additional policy guidance in the Provider Policy Letter (PPL) Number 12-008 on the LEA Program website (<http://www.dhcs.ca.gov/formsandpubs/Pages/MAATCMPPLs.aspx>).

Q82. My LEA has several credentialed speech language pathologists (SLPs) being supervised by licensed SLPs. What exactly are the supervision requirements?

- A. The supervising practitioner must see each student at least once, have some input into the type of care provided, and review the student after treatment has begun. The supervising speech-language pathologist should periodically: observe assessments, evaluation and therapy; observe the preparation and planning activities; review student records; and monitor and evaluate assessment and treatment decisions of the credentialed speech-language pathologist. Supervision should be appropriate to the level of experience of the credentialed practitioner.

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These supervision requirements are also applicable to credentialed audiologists, who must be supervised by licensed audiologists.

Q83. My LEA has a credentialed speech-language pathologist with 20 years of experience and does not have a preliminary clear or professional clear services credential. Does the licensed speech-language pathologist still have to supervise this practitioner? What kind of supervision is required?

- A. Yes. Regardless of the years of experience a credentialed speech-language pathologist may have, a credentialed SLP without a preliminary clear SLP services credential or professional clear SLP services credential must be supervised by a licensed practitioner or a credentialed SLP with a professional clear services credential. Refer to the LEA Medi-Cal Billing Option Program Provider Manual local service for supervision requirements.

Q84. If a district only has credentialed speech-language pathologists (SLPs) without preliminary clear or professional clear services credentials, can they use the licensed SLPs from their SELPA as their supervisor?

- A. Yes. A credentialed SLP who does not have a preliminary clear or professional clear services credential requires supervision by a licensed speech-language pathologist or credentialed SLP with a professional clear services credential to provide speech therapy services. As long as the supervising speech-language pathologist meets the supervision requirements and duties, specified in the LEA Medi-Cal Billing Option Provider Manual local service page 4, there is no requirement that the licensed speech-language pathologist be employed by the LEA.

IX. Free Care and Other Health Coverage

Q85. What is the difference between the Free Care requirement and the Third Party Liability (TPL) requirement?

- A. The Free Care requirement and the TPL requirement are separate, yet interrelated requirements. The Free Care requirement is based on the basic premise that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free Care, or services provided without charge, are services for which there is no beneficiary liability and for which there is no Medicaid liability. In order for the services not to be considered “free”, the following conditions must be met:
- A fee schedule is established for the services provided (this can be a sliding scale to accommodate individuals with low income);
 - The LEA has determined whether every individual served has any third-party benefits (other health coverage), and
 - The LEA bills the beneficiary and/or any third parties for reimbursable services.

For purposes of the provision of school-based health services, there are two exceptions to the Free Care rule: (1) Medicaid-covered services provided as part of an IEP/IFSP, and (2) services provided by Title V of the Social Security Act (Title V of the Act is the Maternal and Child Health Services Block Grant).

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The TPL requirement is based on the basic premise that under Medicaid law and regulations, Medicaid is generally the payer of last resort. For this reason, even if services provided as part of an IEP/IFSP are exempt from the Free Care rule, they are not exempt from the TPL requirement. If any student (including those with an IEP/IFSP) has Other Health Coverage (OHC), those third party insurers must be billed prior to billing Medi-Cal for the service.

For more information on the Free Care rule or the TPL requirement, refer to the 1997 Medicaid and School Health: A Technical Assistance Guide, posted on the LEA Program website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>.

Q86. Does my LEA need to pursue Other Health Coverage (OHC) prior to billing Medi-Cal for both IEP and non-IEP students?

- A. Yes. For services authorized in a student's IEP/IFSP, Medi-Cal is still the "payer of last resort" to the student's private third party insurance coverage. If an IEP/IFSP student has third party insurance, your LEA must pursue OHC prior to billing Medi-Cal. For services not authorized in the student's IEP/IFSP, or for students without an IEP/IFSP, your LEA must additionally meet all Free Care requirements before billing Medi-Cal. This would include establishing a fee schedule, obtaining third party insurance information for the entire population receiving the service (Medi-Cal and non-Medi-Cal students), and billing OHC prior to billing Medi-Cal. Refer to the LEA Medi-Cal Billing Option Provider Manual local ed bil (page 2) for Free Care requirements.

Q87. How can my LEA find out whether a student has Other Health Coverage (OHC)?

- A. OHC information is available through the eligibility tape match.

Q88. To meet the Free Care and Other Health Coverage (OHC) requirements, can an LEA bill a claim to Medi-Cal after billing OHC, but before it has been processed by OHC?

- A. No, your LEA must receive a valid denial of non-coverage from OHC prior to billing Medi-Cal. The CMS' Medicaid and School Health: A Technical Assistance Guide (1997) provides additional guidance regarding OHC requirements. This document is available on the LEA Program website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>.

Q89. If the LEA submits a claim to another health insurance carrier, and there is no response after 90 days and the LEA submits the claim for reimbursement, how will DHCS know not to Pay and Chase the claim?

- A. Your LEA must receive a valid denial of non-coverage from OHC prior to billing to the LEA Medi-Cal Billing Option Program. A non-response is not a valid denial.

Q90. My LEA provides IDEA services to a student with OHC. Do I need individual parental consent to bill OHC, prior to billing Medi-Cal?

- A. Although there is language in the Medi-Cal Application that assigns third party recovery to the State, this agreement is between the beneficiary and the State of California. The LEA is not part of this agreement, and must obtain separate parental consent to bill OHC prior to billing Medi-Cal.

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Q91. Can my LEA bill for services rendered to non-IEP students if one parent refuses to provide Other Health Coverage (OHC) information?

- A. No, if one parent refuses to provide OHC information, the care is considered “free” and cannot be billed to Medi-Cal. Refer to the LEA Medi-Cal Billing Option Provider Manual loc ed bil (page 2) for Free Care requirements.

Q92. Can vision and hearing screenings mandated during the statewide periodicity schedule be billed to Medi-Cal?

- A. State mandated screenings (including vision, hearing and scoliosis testing) may never be billed to Medi-Cal.

Q93. If a non-IEP/IFSP child is referred for a vision assessment outside of the State mandated periodicity schedule, can Medi-Cal be billed?

- A. If the vision assessment is not provided on the State mandated periodicity schedule, it may qualify for Medi-Cal reimbursement if the Free Care requirements are met.

Q94. If an IEP/IFSP student receives an additional vision assessment outside of the State mandated vision assessment schedule, will that supplementary vision assessment be reimbursed through the LEA Program?

- A. LEAs may only bill additional vision assessments outside of the mandated schedule for an IEP/IFSP student as part of a health assessment. One initial/triennial IEP/IFSP health assessment is billable every third fiscal year per LEA. Annual health assessments may be conducted and billed every fiscal year when an initial/triennial IEP/IFSP health assessment is not billed. One amended assessment may be billed every 30 days following an initial, triennial or annual assessment. The supplementary vision assessment may be conducted as part of the initial/triennial, annual, or amended assessment, but is not separately billable.

X. Contracted Practitioners

Q95. My school district is part of an LEA consortium that bills under one National Provider Identifier and shares a school nurse. My school district is responsible for paying the salary and benefit expenses of the nurse. The remaining member school districts in the consortium contract for this nurse’s services. Given this situation, can all consortium members still bill for the nurse’s services under one provider number?

- A. Yes. Since LEAs participating in a billing consortium are all billing under a single Medi-Cal provider number, consortium members may bill for services provided by an employee of one of the consortium members, regardless of which school district in the consortium employs the practitioner.

Q96. Small districts may not be able to employ multiple providers (e.g., RN, speech therapists, psychologists, etc.) to provide health services. If the district employs only one type of practitioner (such as a credentialed school nurse), can it contract for other types of practitioners (such as speech therapists) and bill for services provided by these contracted practitioners?

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- A. The school district can contract with another enrolled LEA provider to provide services to Medi-Cal eligible students. Under this scenario, however, the enrolled LEA provider employing the practitioners will bill Medi-Cal for the services. The school district may also contract with additional health professionals to supplement health services that are being provided by its employed health staff. In order for the school district to bill Medi-Cal, the service provided by the contracted health professionals must be the same services that the school health employees provide.

XI. Rendering Practitioner Qualifications

Q97. If one of my special education teachers has the educational and credentialing requirements of a direct-care practitioner, can I bill Medi-Cal for direct health services provided by this person? For example, can my special education teacher who meets the requirements of a Program Specialist bill for Targeted Case Management (TCM) services?

- A. The job title does not need to match the LEA qualified rendering practitioner title, so long as the person providing a direct health service meets the educational and program credentialing requirements for billing under the LEA Medi-Cal Billing Option. In this example, your LEA may bill for TCM services rendered by a special education teacher who meets the qualifications of a Program Specialist.

Q98. Are services provided by occupational therapy assistants, speech therapy assistants or physical therapy assistants reimbursable under the LEA Program?

- A. No, therapy assistants are currently not qualified practitioners under the LEA Program.

Q99. Can a Physician Assistant be considered as a qualified practitioner?

- A. Currently, a Physician's Assistant is not on the list of approved providers that may bill under the LEA Medi-Cal Billing Option Program. Please refer to the local ed rend section of the LEA Provider Manual for current qualified rendering practitioners.

Q100. Can a school district bill for psychology/counseling services provided by a graduate student who is supervised by a licensed and/or credentialed psychologist, social worker or counselor?

- A. No. Psychology/counseling services provided by graduate students are not billable under the LEA Program. Qualified practitioners who may provide psychology/counseling services can be found in LEA Medi-Cal Billing Option Provider Manual local ed bil pages 6 and 7 and local ed serv psych page 2.

Q101. Can you explain the phrase ‘...or a valid credential issued prior to the operative date of Section 25 of Chapter 25 of Chapter 557 of the Statutes of 1990’ that appears in so many practitioner qualifications descriptions?

- A. The California Commission on Teacher Credentialing issues three types of credential service documents: Ryan, Standard, and General Credentials. The Ryan Credential is the only type that may be issued to first-time applicants. Standard and General Credentials were originally issued under previous provisions of law prior to 1970. These credentials are no longer issued

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on an initial basis, but renewals are issued to holders who qualify. The credentials listed in the LEA Provider Manual are the current Ryan Credentials issued to first-time applicants. If practitioners have the older Standard and General Credentials, they may still qualify to provide LEA services as long as they renew these credentials with the California Commission on Teacher Credentialing.

XII. Targeted Case Management (TCM) Policy and Billing

Q102. Does my LEA have to complete a TCM Labor Survey if we don't provide TCM?

- A. LEAs that do not provide and bill for TCM services do not need to submit a TCM Labor Survey.

Q103. How often does my LEA have to submit the TCM Labor Survey in order to bill for TCM services? Do TCM services need to be in the IEP?

- A. You are required to complete the Labor Survey only once, prior to billing for TCM services. Your LEA may resubmit a Labor Survey if they believe current information will support a change in the TCM Category of Service. The Labor Survey is available for download on the LEA Program Website at <http://www.dhcs.ca.gov/provgovpart/Pages/LEATCMLaborSurvey.aspx>. TCM is only billable for IEP/IFSP students, and must be authorized in the IEP/IFSP.

Q104. Can my LEA bill Medi-Cal Administrative Activities through the MAA Program and LEA TCM services?

- A. There is some overlap between Medi-Cal Administrative Activities through the MAA Program and LEA TCM services. Regardless of whether you bill Medi-Cal Administrative Activities through the MAA Program or TCM services through the LEA Program, you may not bill more than once for the same service. If your LEA is billing Medi-Cal Administrative Activities through the MAA Program, please refer to the California School-Based Medi-Cal Administrative Activities Manual, Section 5 (available at www.dhs.ca.gov/maa/webpages-section-units), for direction on how to account for time spent by case managers who are also participating in the LEA Medi-Cal Billing Option Program.

Q105. TCM services can be claimed in the MAA Program, but aren't TCM services an extension of a direct medical service and should be claimed in the LEA Medi-Cal Billing Option Program? For example, if I develop a plan for an IEP student, do I have a choice of billing through MAA or LEA Medi-Cal Billing Option Program?

- A. TCM services can be an extension of direct medical services. TCM claimed in the MAA Program is for administrative activities and TCM claimed in the LEA Medi-Cal Billing Option Program is for direct medical services.

Q106. Can a student have multiple case managers for TCM services and bill Medi-Cal? We are in a rural area and follow multiple problems for families. The nurse may go out one day and help the family find housing. The psychologist may go out and help the family find mental health services for a family member.

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- A. Medi-Cal recipients can be assigned more than one case manager. According to the LEA Medi-Cal Billing Option Provider Manual loc ed serv targ page 3, "The California Department of Health Care Services (DHCS) recommends that each Medi-Cal recipient be assigned to one case manager who has the ability to provide recipients with comprehensive TCM services." However, Medi-Cal practitioners in some schools have distinct areas of expertise, and in these cases, it may be necessary to have more than one case manager. When more than one case manager provides TCM services the LEA must avoid duplication of services when billing for the services. In order to do this the LEA provide must:
(1) clearly document the LEA and TCM services rendered by each TCM agency or provider, and (2) where necessary, enter into written agreements defining the case management services each agency and/or provider will be responsible for rendering. LEAs may only bill for TCM services when rendered by TCM providers identified in the LEA Medi-Cal Billing Option Provider Manual loc ed bil page 7.

Q107. Can Braille services for IEP students be listed under TCM by a Program Specialist?

- A. No, the LEA Medi-Cal Billing Option Program only reimburses LEAs for direct health care services provided to Medi-Cal eligible students.

XIII. Transportation Policy and Billing

Q108. Do we need preauthorization for transportation?

- A. The LEA Medi-Cal Billing Option Program does not require preauthorization for transportation services. Transportation may be provided to IEP/IFSP and non-IEP/IFSP students, but billing requirements are different. Please refer to page 2 of the loc ed serv trans section of the LEA Provider Manual for details.

Q109. What is the criteria to determine if transportation is medically necessary?

- A. Transportation is a medical necessity when a student's medical and/or physical condition requires it as medical intervention and treatment for certain medical conditions. Please refer to page 2 of the loc ed serv trans section of the LEA Provider Manual.

Q110. Can I only bill for mileage under the LEA Program?

- A. No, you cannot bill Medi-Cal for mileage without also billing for the corresponding "flat-rate" transportation. However, you may still bill for allowable non-emergency transportation under the "flat-rate" without billing mileage.

Q111. In order to bill Medi-Cal for non-emergency medical transportation services provided in a wheelchair van, must students be wheelchair-bound?

- A. Yes, under current regulations, in order to bill Medi-Cal for students being transported in a wheelchair van, the student must be transported in a wheelchair.

Q112. What is considered a "litter van"? Does a specially equipped bus that doesn't include a wheelchair lift but has been specially equipped according to needs documented in an IEP considered reimbursable?

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- A. The CCRs for LEA transportation are outlined in Title 22, Section 51231.1 and the local service section of the LEA Provider Manual. A "litter van" is a specifically defined vehicle that is used to transport in a prone or supine position because the beneficiary is unable to sit for the period of time needed for transport.

Q113. Can we bill for transportation to/from a covered service that we are not claiming? For example, the student is being transported to the County Office of Education (COE) for physical therapy service, which is authorized in the IEP. The COE is claiming for the physical therapy service.

- A. If the child is receiving a covered service on the same day he or she is transported, and both the service and the transportation are authorized in the student's IEP, your LEA may bill for the transportation even if another provider is responsible for billing the covered service. If an LEA bills only for transportation, they should maintain documentation that another covered service was provided on that day at a different venue.

Q114. Can an LEA provider be reimbursed for transportation to special education Medi-Cal eligible students who are given medication on a daily basis at school?

- A. For an LEA provider to be reimbursed for transportation, a Medi-Cal eligible student must receive a Medicaid covered service on the date of transport and both the transportation and Medicaid covered service must be included in the student's IEP. If dispensing medication to a student does not meet the seven continuous minutes of nursing treatment, it is not considered a Medicaid covered service under the LEA Medi-Cal Billing Option Program. (Title 22, CCR, Sections 51360 and 51535.5)

Q115. Where can I find LEA medical transportation regulations in the California Code of Regulations?

- A. The LEA Provider Manual (section local service transport) and the California Code of Regulations (CCR) Title 22, Section 51360(b) (8) and Section 51491(h) define LEA transportation services. LEAs must also meet the general Medicaid transportation requirements that are referenced in Sections 51360 and 51491. The LEA Medi-Cal Billing Option Program will only reimburse medical transportation and associated mileage, if all vehicles, drivers, attendants and requirements meet the standards specified in Sections 51323(a), 51231, 51231.1 and 51231.2. If the LEA does not meet all the requirements as defined in the regulations, the LEA may not be reimbursed for transportation under the LEA Medi-Cal Billing Option Program.

XIV. Documentation and Records Retention Requirements

Q116. How long are we required to retain documentation? Does this time period change if you are under investigation?

- A. You must maintain all documentation supporting services rendered for at least three years from the settlement date of CRCS submission. If your LEA is involved in an audit, review or investigation, all documentation for the audit/review/investigation period must be maintained until the issue is completely resolved. This may mean documentation is retained beyond the three year minimum.

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Q117. How long should my LEA retain documents related to the CRCS?

- A. Original hard-copy supporting documentation must be maintained until the auditing process for your LEA Medi-Cal Billing Option CRCS has been completed. In accordance with W&I Code Section 14170, please retain both your LEA's financial and medical records for three years from the date of submission of your CRCS forms.

Q118. Do we need to distinguish the documentation we maintain for educational purposes versus the documentation for Medi-Cal?

- A. Yes. All services rendered and billed to Medi-Cal must meet federal, State and program documentation requirements. Documentation for educational purposes may not fulfill these requirements.

Q119. Are we required to maintain documentation of services provided after the student leaves the LEA?

- A. If a student leaves your LEA, you must maintain documentation of services in accordance with the three year minimum retention timeline.

Q120. For an IEP/IFSP student, where should written prescriptions, referrals and recommendations be maintained?

- A. For IEP/IFSP students, written prescriptions, referrals, and recommendations can be documented in the student's IEP/IFSP or included as an addendum to the IEP/IFSP. A request for assessment by a parent, teacher, or school nurse must be maintained in the student's files. If your LEA currently uses a physician-based standards protocol to meet the State requirement for speech and audiology treatment referrals, a copy of the protocol cover letter must be kept in the student's files.

Q121. If the IEP assessment spans several days, what date should be documented for purposes of billing Medi-Cal?

- A. When billing Medi-Cal for an assessment that takes multiple days to complete, use the "from-through" billing method to record the dates over which the assessment was conducted.

Q122. Does each service encounter need to be documented with progress notes/documentation of services?

- A. Yes, CMS's Medicaid and School Health: A Technical Assistance Guide (August 1997) indicates that documentation should be maintained on a service-specific basis. In addition, documentation must be created at or near the time of service.

Q123. What is required for documenting treatment services?

- A. Practitioners should write case/progress notes each time the student is treated and save those notes in the student's file. Each service should be documented with the student's name, date of service, practitioner type, and signature. Notes made documenting the service should be consistent with the practitioner's professional standards.

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Q124. Can licensing and credentialing documentation for practitioners be kept in the LEAs central files?

- A. Documentation of licensing and credentialing of practitioners must be accessible for review by State and/or federal agencies. They may be maintained in your central files as long as they are accessible for audit or review.

Q125. For documentation purposes, is it acceptable for my LEA to present scanned documentation, or must all documentation be presented for State or federal review in its original hard-copy form?

- A. No, LEAs must maintain original hard-copy supporting documentation for services rendered for at least three years from the settlement date of the CRCS.

XV. Units of Service and Reimbursement Rates

Q126. Are report writing and other indirect service time accounted for in the new rates?

- A. Yes, the new rates account for indirect service costs associated with the direct provision of health services. Your LEA should only bill for direct service time.

Q127. Can we bill LEA, MAA, or both for the time it takes to prepare reports?

- A. LEAs may not bill under the LEA Program for report writing. You may only bill for direct service time. Preparation of reports, travel time and other administrative activities that are related to the direct provision of health services are not claimable under the LEA Program, as this time was factored into the new LEA interim rate structure. Billing for indirect time would be “double-dipping”. In addition, report writing cannot be billed under MAA. For a single service, you may bill either MAA or LEA, but not both.

Q128. For each LEA reimbursable service, Medi-Cal maximum allowable rates are listed in the LEA Medi-Cal Billing Option Provider Manual loc ed bil cd. Will we be reimbursed at the Medi-Cal maximum allowable rate?

- A. No. You will be reimbursed the Medi-Cal maximum allowable rate multiplied by the federal medical assistance percentage (FMAP), which is currently 50 percent. Note that the FMAP percentage can fluctuate slightly from year to year.

Q129. Are LEA claims subject to timeliness cutbacks if claims are submitted 6 months after the date of service?

- A. No. Assembly Bill 2950 eliminates timeliness cutbacks for LEA claims submitted for reimbursement between the seventh and twelfth month after the month of service. LEA claims were previously subject to reduced reimbursement of 75 and 50 percent of payable amount if submitted beyond six months. Effective for dates of service on or after January 1, 2007, LEA claims may be reimbursable within twelve months of the month of service. LEA claims submitted after the twelfth month of service without a legitimate delay reason code will continue to be denied.

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XVI. Claim Form Completion

Q130. When completing a claim, is there a specific order in which the modifiers should be recorded?

- A. The type of service, practitioner type and IEP/IFSP modifiers can be listed in any order; however the appropriate HCPCS/CPT procedure code must be listed first. When entering modifiers, do not include hyphens or spaces. More detailed information is available in the local ed bil ex and ub comp op sections of the LEA Medi-Cal Billing Option Provider Manual.

Q131. Can you bill more than one service on a single claim form per student?

- A. Yes, the procedure codes and modifiers will differentiate the services provided, as well as the rendering practitioner, if applicable.

Q132. For “from-through billing”, do the dates of service have to be consecutive?

- A. No, the dates do not need to be consecutive, but you can only bill one type of service per “from-through” claim line.

Q133. Where can LEA providers get the ICD-9 codes for the diagnosis code box on the claim form?

- A. LEA providers may obtain the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9) code book from:

Ingenix
P. O. Box 27116
Salt Lake City, UT 84127-0116
1-800-INGENIX (464-3649), 1-800-765-6588 (Customer Service), or

PMIC (Practice Management Information Corporation)
Order Processing Department
4727 Wilshire Blvd., Suite 300
Los Angeles, CA 90010-3894
1-800-MED-SHOP (633-7467) Monday-Friday 8:30 a.m. – 5:00 p.m. (CST)

Q134. Is there an LEA-specific ICD-9 code that should be used on all LEA claims?

- A. No. The ICD-9 diagnosis code should be appropriate to the medical diagnosis or covered service the student receives to support the service. Current Medi-Cal policy requires providers to bill using the highest level of ICD-9-CM diagnosis code available on a given date of service. Effective January 1, 2005, claims billed with an invalid diagnosis code will be returned. The code must provide the highest level of specificity available in order to be valid. For example, if a provider bills with a 3-digit diagnosis code when a 4-digit or 5-digit diagnosis code is available, the 3-digit code is considered invalid and the claim will be returned. This policy does not apply to medical transportation claims.

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XVII. Cost and Reimbursement Comparison Schedule (CRCS)

Cost and Reimbursement Comparison Schedule (CRCS) Purpose and Requirements

Q135. What is the purpose of the Cost and Reimbursement Comparison Schedule (CRCS)?

- A. The LEA Medi-Cal Billing Option Program (LEA Program) requires that LEAs annually certify that the public funds expended for LEA services provided are eligible for federal financial participation. The California Department of Health Care Services (DHCS) must also reconcile the interim Medi-Cal reimbursements to LEAs with the actual costs LEAs incur in the course of rendering eligible services. The CRCS will be used to compare each LEA's total actual costs for LEA services with interim Medi-Cal reimbursement for a specific fiscal year. This will determine if LEAs are owed additional funds to DHCS, or vice versa.

Q136. Is the CRCS mandatory?

- A. Yes, continued enrollment in the LEA Program is contingent upon timely submission of the CRCS each fiscal year. DHCS may implement a penalty for late or non-submission of CRCS forms and LEA payments may be reduced or withheld until the CRCS has been received and accepted for processing.

Q137. What time period should my LEA collect costs/hours information for when completing the CRCS?

- A. LEA information will be based on the costs incurred and hours worked within the CRCS reporting period. For example, for the FY 2009/10 CRCS, the LEA practitioner costs and hours will be for the July 1, 2009 to June 30, 2010 time period regardless of the fiscal year in which payment is received.

Q138. If you started billing in 2010-11 school year but billed back for services provided in the 2009-10 school year, do you need to fill out the FY 2009-10 CRCS report since we really didn't spend until the 2010-11 school year?

- A. LEAs must complete a CRCS form for the year that they provided LEA services. So if your LEA did not start billing until the FY 2010/11 school year, but also retroactively billed for services in FY 2009/10, your LEA must complete and submit a CRCS for FY 2009/10 and 2010/11.

Q139. If an LEA has not received LEA Medi-Cal Billing Option Program reimbursement before November 1st, will we still need to complete a CRCS report for the retro period?

- A. Your LEA must complete a CRCS for any year that they are enrolled in the LEA Medi-Cal Billing Option Program and eligible to receive Medi-Cal reimbursement. The CRCS is based on the date services are provided, not when the reimbursement is received. If your LEA did not receive any reimbursement for services provided during the fiscal year, a report must be submitted that includes zero reimbursement to meet program requirements.

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Contact Information

Q140. Where can I address questions regarding the CRCS?

- A. E-mail questions regarding the CRCS to LEA.CRCS.Questions@dhcs.ca.gov.

Q141. Where can I find LEA Program information?

- A. Visit the LEA Program website for current information at <http://www.dhcs.ca.gov/ProvGovPart/Pages/LEA.aspx>. Individuals may register to receive e-mail updates at <http://apps.dhcs.ca.gov/listssubscribe/default.aspx?list=DHCSLEA>.

Q142. How can I find out when new information for LEA providers is available?

- A. LEAs are encouraged to visit the LEA Program website regularly for the most up to date information at <http://www.dhcs.ca.gov/ProvGovPart/Pages/LEA.aspx>. By registering on the LEA Program website to receive e-mail updates you will be informed of updates as they are posted (register at <http://apps.dhcs.ca.gov/listssubscribe/default.aspx?list=DHCSLEA>).

Q143. Where can I address general LEA Program questions?

- A. E-mail general LEA Program questions to lea@dhcs.ca.gov.

State vs. LEA CRCS Responsibility

Q144. What information is my LEA responsible for completing on my CRCS forms?

- A. LEA providers must submit actual costs and annual hours worked for all practitioners during a specific fiscal year. Actual costs that LEAs will report in the CRCS include: salaries, benefits, and other costs related to the direct provision of health services, such as health-related materials and supplies. Hours that LEAs will report in the CRCS are based on the number of Full Time Equivalents (FTEs), and hours worked by these FTEs. LEAs will also be responsible for reporting costs incurred and hours paid for health services provided by independent contractors. In addition, LEAs will be responsible for inputting interim reimbursement, units of service and encounter information for the respective reporting period. DHCS will summarize reimbursement, units and encounter information for each LEA to assist LEAs with reporting the information on Worksheet A-4/B-4 for FYs 2006/07, 2007/08, 2009/10 and 2010/11. LEA providers must designate a signatory who will certify under penalty of perjury, to the accuracy of the data provided in the CRCS.

Q145. What portion of the CRCS forms is the State responsible for?

- A. The State will be responsible for intake and review of the CRCS forms for completeness, performing desk and/or field reviews, as necessary, and comparing the Medi-Cal paid claims reimbursement to audited LEA costs to calculate the overpayment or underpayment.

Q146. What is the responsibility of DHCS Audits and Investigations (A&I) Branch regarding the CRCS forms?

- A. DHCS A&I will audit the LEA's actual costs of providing LEA services to the interim Medi-Cal reimbursement paid for those services. A&I will conduct a desk and/or field review on each returned CRCS to complete the final settlement. The final settlement will determine

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whether the LEA was overpaid or underpaid for the LEA services provided based on their actual costs.

CRCS Reconciliation

Q147. How long does the State have to complete the reconciliation process?

- A. DHCS will complete the final settlement no later than three years from the date that the CRCS is submitted.

Q148. What will trigger a CRCS audit?

- A. Every CRCS will be audited.

Q149. How long does DHCS have to audit the CRCS? Is it three years from the CRCS submission or from the end of the fiscal reporting year?

- A. DHCS will complete the final settlement no later than three years from the date that the CRCS is submitted.

Q150. How will Audits and Investigations decide what type of audit review to perform?

- A. A&I will use a variety of screening tools in order to identify specific LEAs for a desk review or field audit. Your LEA should be prepared for the possibility of any of the audit levels and it is advised to keep thorough documentation of any calculations or assumptions you made in completing your CRCS forms (for example, compile a CRCS audit support binder with relevant practitioner costs, hours and units, encounter and reimbursement information).

Q151. Have all the audits been completed for FYs 2006/07 and 2007/08 CRCS reports?

- A. A&I is currently working on audits for FYs 2006/07, 2007/08 and 2008/09. Each LEA who participated in the LEA Medi-Cal Billing Option Program will receive a cost settlement statement once the audit is complete.

CRCS Documentation Requirements

Q152. How long will LEAs be required to retain documentation to support their submitted CRCS? Is it three years from the date of service or date of payment?

- A. According to State and federal regulations, LEAs must maintain documentation for three years, at a minimum, from the date the final CRCS is submitted. All supporting documentation will be subject to review and/or audit by State and/or federal authorities. If the LEA is involved in a review or audit, documentation must be maintained in full until all outstanding audit issues are resolved. This may mean that the LEA will have to maintain documentation beyond the three-year minimum requirement. LEAs should not destroy documentation until a final cost settlement is received. If an LEA decides to appeal the CRCS audit findings, they should retain all information until the appeal is settled.

Q153. Are LEAs required to submit all supporting documentation to DHCS with the CRCS?

- A. No, LEAs should not submit their supporting documentation to DHCS. However, as detailed in the CRCS, LEAs must maintain all of their documentation in accordance with State and federal requirements.

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Q154. Do we need to keep copies of Master Contracts that are currently negotiated and maintained by our local SELPA for the CRCS reports?

- A. Yes, contract agreements need to be maintained for CRCS documentation purpose.

Overpayment/Underpayment

Q155. What happens if my LEA owes the State money as a result of the CRCS settlement process?

- A. If your LEA's actual costs to provide Medi-Cal services are less than you received in interim reimbursements, you were overpaid during the respective fiscal year. If your LEA owes the State (overpayment) there will be a corresponding withhold from future Medi-Cal reimbursements; LEAs will not be expected to write the State a check.

Q156. What happens if the State owes my LEA money as a result of the CRCS settlement process?

- A. If your LEA's actual costs to provide Medi-Cal services are more than you received in interim reimbursements, you were underpaid during the respective fiscal year. If the State owes your LEA money (underpayment) the State will send your LEA a check for the difference between your actual reimbursement and your maximum eligible reimbursement.

CRCS Submission

Q157. Does DHCS want both electronic Excel and PDF versions of the CRCS forms so that you have the signature on file?

- A. LEAs are required to submit an electronic Excel version and scanned PDF version of the CRCS with the authorized representative signature on the CRCS Certification page in blue ink. LEAs must maintain the original hard copy CRCS with all worksheets and Certification page signed in blue ink on site for DHCS Audits and Investigations staff. LEAs are not required to submit a hard copy to DHCS; the PDF version will serve as the original hard copy submission. An Excel version of the completed (signed) CRCS form and scanned version of the original signed completed CRCS form (i.e. PDF, JPEG,etc) is required.

Q158. How do we know that DHCS has received all of CRCS forms and what is the timeline for confirmation of receipt?

- A. LEAs should receive an e-mail confirming the receipt of your CRCS forms if you submitted your electronic Excel and PDF versions of the CRCS form.

CRCS: Mechanics of CRCS Forms and Data Input

Certification Sheet

Q159. On the CRCS Certification page, how do I report the "NPI"?

- A. If your LEA has an assigned National Provider Identifier (NPI), you must include your LEA's 10-digit NPI and no text (e.g., "1234567890" and not "NPI 1234567890")

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Q160. What is the “Provider Number” field on the Certification Page?

- A. The Provider Number on the Certification form should include your LEA’s identification number that was used to bill claims prior to the National Provider Identifier (NPI). The Provider Number begins with an “SS” prefix and is followed by seven numeric digits. This is also the first seven digits of the County-District-School (CDS) number issued by CDE.

Q161. What if my LEA is a billing consortium and billing under one LEA provider number?

- A. When multiple school districts bill with one LEA provider number, it is advisable that one draft CRCS be completed for each of the school districts operating under that provider number. Each individual CRCS should then be aggregated into a final CRCS submitted by the billing consortium. This may help ensure that costs or practitioner hours aren’t excluded or double counted.

Q162. Is it acceptable to designate one individual as the CRCS contact person and another individual as the signatory who takes responsibility for the accuracy of the CRCS data submitted?

- A. Yes, it is acceptable to have one LEA contact person and another individual who is the signatory. It is important to make sure that the LEA contact person is fully knowledgeable about the LEA Program in your district or County Office of Education.

Q163. Is it acceptable to have a co-signatory on the CRCS?

- A. Yes, more than one individual may sign to the accuracy of the CRCS.

Q164. Can the LEA designate a third party as their point of contact?

- A. LEAs may choose a third party vendor as their point of contact to answer questions regarding the CRCS completion; however, LEAs are ultimately responsible and must sign and certify under penalty of perjury to the accuracy of the information reported on the CRCS. In addition, the point of contact will be directly receiving future LEA Program communications from DHCS.

Worksheets A, B and A.1/B.1

Q165. Is it necessary to break-out the function codes by each practitioner type?

- A. Yes, all salaries, benefits, and other costs must be split out by practitioner type for CRCS purposes. For FY 2006/07, 2007/08 and 2008/09 CRCS report, salaries and benefits are reported by practitioner type on Worksheets A and B.

Effective for the FY 2009/10 CRCS report and beyond, salaries and benefits are reported by practitioner type on Worksheet A.1/B.1.

Q166. Can federally funded employees be included in the CRCS FTE count?

- A. For FYs 2006/07, 2007/08 and 2008/09, if the practitioner is 100 percent federally funded and the practitioner’s time is dedicated to the federal program, then the practitioner should not be included in the FTE count. However, if the practitioner is partially federally funded and part of the practitioner’s time is devoted to the federal program, but the practitioner is also rendering LEA direct health services, exclude the portion of the FTE that is dedicated to the federal

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program. Only include the portion of the FTE that is not devoted to the federally funded program.

For the original FY 2009/10 submission, LEAs reported the total FTEs (federally funded and non-federally funded) by practitioner type for *all* qualified employed practitioners within your LEA, regardless of whether or not they provided LEA services to Medi-Cal beneficiaries. In May 2012, DHCS revised the FY 2009/10 CRCS instructions and updated the reporting requirements for federally funded employees. For the optional FY 2009/10 CRCS resubmission, LEAs report federally funded FTEs (or portion of FTEs) if their time is not dedicated to the federal program. Do not report federally funded FTEs (or portion of FTEs) if their time is dedicated to the federal program. Note that Resource Code 5640 (Medi-Cal Billing Option) is not considered to be restricted federal funds.

Q167. If my district receives federal funding, not directly identified to a practitioner group, but we choose to pay practitioners using these federal funds, do we claim these as federal revenues on the CRCS report? For example, I receive Title 1 funding that is unrestricted in how it is spent and we decide to pay psychologists with it. Is this considered federal funding for that practitioner group?

A. Yes, this is considered federal funding and the salary/expenditures are reported on Worksheet A.1/B.1 Column A and B. This federal portion is then identified on Column D with revenue account number on Column E in order to determine the Net Total Personnel Costs (Column F).

Q168. Regarding non-IEP/IFSP services on Worksheet B, do LEAs still need to have a 100 percent response rate from insurance carriers in order to bill for services provided by these practitioners?

A. LEAs cannot bill Medi-Cal for Free Care services unless the LEA does all of the following: (1) establishes a fee for each service provided, (2) collects a 100 percent response rate to obtain Other Health Coverage (OHC) information for all students served (Medi-Cal and non-Medi-Cal), and, (3) bills other responsible third party insurers. Please see the LEA Provider Manual section located bil, for more information:

<http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx>.

Q169. Our LEA employs several nurses, some of whom do not provide LEA services that are eligible for Medi-Cal reimbursement. Should these practitioner costs and hours be included on the CRCS?

A. For FYs 2006/07, 2007/08 and 2008/09, if your LEA can separate practitioners that do not bill for LEA services, you may exclude practitioner costs and associated hours from the CRCS. However, if your LEA cannot separate these practitioners out, you must ensure that both the practitioner costs and hours are included in the CRCS. The LEA's CRCS forms should not be impacted by practitioners that don't provide LEA services, since these practitioners won't have any corresponding LEA reimbursement. Essentially, the final overpayment/underpayment calculation will be based on LEA practitioners that bill for LEA services.

For the original FY 2009/10 submission, LEAs reported practitioner cost and associated hours for all qualified practitioners employed by the LEA, regardless of whether or not they provided LEA services to Medi-Cal beneficiaries. In May 2012, DHCS revised the FY 2009/10 CRCS

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instructions and updated the reporting requirements for “all qualified” practitioners. For the optional FY 2009/10 CRCS resubmission, LEAs report expenditures, FTEs and hours for all qualified district employed practitioners billing LEA reimbursable services in the LEA Medi-Cal Billing Option Program.

Q170. Our LEA employs a psychologist that will not authorize the services they provide to be billed to Medi-Cal. Should I include this practitioner on the CRCS?

- A. For FYs 2006/07, 2007/08 and 2008/09, if your LEA can identify this practitioner, you should exclude their costs and associated hours from the CRCS. However, if your LEA cannot identify this practitioner, you must ensure that both the practitioner costs and hours are included in the CRCS.

For the original FY 2009/10 submission, LEAs reported practitioner cost and associated hours for *all* qualified practitioners employed by the LEA, regardless of whether or not they provided LEA services to Medi-Cal beneficiaries. In this example, this includes the psychologist that does not authorize services to be billed to Medi-Cal. In May 2012, DHCS revised the FY 2009/10 CRCS instructions and updated the reporting requirements for “all qualified” practitioners. For the optional FY 2009/10 CRCS resubmission, LEAs report expenditures, FTEs and hours for all qualified district employed practitioners billing LEA reimbursable services in the LEA Medi-Cal Billing Option Program. Therefore, for the FY 2009/10 CRCS resubmission, the LEA should not include the psychologists cost and hours in the CRCS resubmission since this psychologist does not authorize services to be billed to Medi-Cal.

Q171. I am putting together the CRCS for a multi-district SELPA. Five out of fifteen districts participate in Medi-Cal LEA billing. When I checked the chart for the Indirect Cost Rate, it listed 0.00% for the SELPA. However, each of my five participating districts has an indirect cost rate. How do I know what Indirect Cost Rate to enter on Worksheet A?

- A. In instances where the SELPA has no indirect cost rate or where multiple school districts bill with one provider number (billing consortium), the appropriate way to determine the indirect cost rate that is entered on Worksheet A is to weight the individual district indirect cost rates by direct salary and benefit costs reported on the CRCS. The following is a simplified example:

A SELPA has three participating districts, A, B and C. District A accounts for salaries and benefits on the CRCS of \$10,000 and has an indirect cost rate of 5%; District B accounts for salaries and benefits on the CRCS of \$50,000 and has an indirect cost rate of 5%; District C accounts for salaries and benefits on the CRCS of \$100,000 and has an indirect cost rate of 3%. The SELPA should first determine each district's weighting of total salaries and benefits on the CRCS:

$$\text{District A} = \$10,000/\$160,000 = .0625$$

$$\text{District B} = \$50,000/\$160,000 = .3125 \quad \text{District C} = \$100,000/\$160,000 = .6250$$

The SELPA should then apply these weightings to the district's CDE-approved indirect cost rate:

$$\text{District A} = 5\% * .0625 = 0.3125$$

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District B = $5\% * .3125 = 1.5625$

District C = $3\% * .6250 = 1.875$

The indirect cost rate that the SELPA should report on Worksheet A of its CRCS is 3.75% ($.3125 + 1.5625 + 1.875$).

LEAs who use this methodology to calculate a weighted indirect cost rate should maintain adequate documentation for review/audit by State and/or federal authorities.

Q172. Our district uses the claim reimbursement posted in Resource Code 5640 to pay for psychologist and counselor positions. Should these positions' costs be excluded from the CRCS since they are federally funded?

- A. No, LEAs may use the LEA Medi-Cal Billing Option Program funds (Resource Code 5640) to hire and/or pay for practitioner total personnel costs. In March 2012, the Department issued Policy and Procedure Letter (PPL) # 12-006 that provided formal guidance on Resource Code 5640 funds. The PPL can be found on the LEA website at:
<http://www.dhcs.ca.gov/formsandpubs/Pages/2012PolicyandProcedureLetters.aspx>.

Worksheet A-1/B-1

Q173. How can I separate the supplies necessary for the direct provision of health services by practitioner type? For example, it will be difficult to precisely determine the extent that certain practitioners used non-capitalized equipment.

- A. An allocation methodology has been developed for the CRCS in the case that certain cost cannot be distinguished by practitioner in your LEA's SACS system. Costs in Worksheet A-1/B-1 (excluding contractor costs, Columns E and F) may be allocated based on salary proportions. The following is a simplified example illustrating how to allocate based on salary proportions:

LEA A, who employs LVNs and RNs, incurs \$2,629 for nursing materials/supplies. The LEA plans to allocate these costs between the nursing practitioners for CRCS reporting purposes using salary as the allocation basis. Total salaries for RNs and LVNs are \$130,633 and \$23,673, respectively, totaling \$154,306. Using these figures, LEA A determines that RN salaries account for 84.66% of the total nursing salaries, and that LVN salaries account for the remaining 15.34% ($\$130,633/\$154,306 = 84.6584\%$ and $\$23,673/\$154,306 = 15.3416\%$). In order to allocate the \$2,629 of nursing materials, LEA A will multiply the cost by the allocation percentages determined above. In doing so, LEA A determines that \$2,225.67 ($\$2,629 * 84.6584\%$, unrounded) of the \$2,629 will be reported on the RN line on Worksheet A-1/B-1 and the remaining \$403.33 ($\$2,629 * 15.3416\%$, unrounded) will be reported on the LVN line on Worksheet A-1/B-1.

Q174. Is the allocation methodology allowable for all CRCS reporting years?

- A. Yes, your LEA may use the cost allocation methodology beyond the first year of the CRCS to separate "other costs" based on practitioner salaries and wages on Worksheet A-1/B-1 (except for Contractor Costs in Columns E and F).

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Q175. Are photocopying costs, coded under object 5700 allowable costs that can be included in Worksheet A-1/B-1?

A. No, copying is not an allowable cost because it is not related to the direct provision of health services.

Q176. We have vehicle expenses related to direct health services which are paid out of object code 5600. Should we include these in object code 5200 as travel?

A. No, vehicle expenses coded to object code 5600 should not be included on the CRCS. Only object codes identified on Worksheet A-1/B-1 have been approved by the Centers for Medicare and Medicaid Services (CMS) and should be included on the CRCS.

Q177. There is not a column in the report for equipment, object code 6400. Where should we report equipment expenses?

A. No, equipment expenses coded to object code 6400 should not be included on the CRCS. Only object codes identified on Worksheet A-1/B-1 have been approved by the Centers for Medicare and Medicaid Services (CMS) and should be included on the CRCS.

Q178. We contract with a consultant to process our claims. Is that service to be billed under Object Code 5800 and 5100?

A. You may only report contractor costs related to practitioners contracted to perform direct health services. Costs for consultants who process claims are not allowed to be reported on the CRCS and must be excluded.

Q179. Where can LEAs get more information regarding Non-Capitalized Equipment expenditures?

A. LEAs can find more information on Non-Capitalized Equipment in the Standardized Account Code Structure (SACS) available at <http://www.cde.ca.gov/fg/ac/ac/>. LEAs can also refer to the California School Accounting Manual, Procedure 330 for more detail (<http://www.cde.ca.gov/fg/ac/sa/>).

Worksheet A-2/B-2

Q180. Our contracted audiologists charge a flat rate per child. Will an invoice for this provide enough detail for CRCS reporting and documentation purposes?

A. No, an invoice showing an encounter rate will not provide acceptable documentation. If your LEA includes these contractor expenses, you will need to document the hourly costs and expenses for each practitioner.

Q181. In Worksheet A-2/B-2, what hours can be included in Column B for contracted practitioners?

A. Report total hours paid to independent health service contractors by practitioner type. Total hours should only include direct health service time. If total hours are not available in your accounting system, they may be estimated by dividing the contractor costs by the average contract rate per hour.

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Q182. We are unsure how to account for Non-Public School (NPS)/Non-Public Agency costs. The contracts don't always break out the costs for the health related services, any suggestions for accounting for it accurately?

- A. Districts may contract with Non-Public Schools (NPS) to provide both instruction and health services for students; however, it is the LEA's responsibility to collect sufficient detail from their contractors to document for the provision of health services. In order to include contractor expenses and hours on the CRCS, the expenses and hours specific to Medi-Cal reimbursable health services must be identified and documented.

Worksheet A-3/B-3

Q183. If my LEA has one half-time FTE and one full-time FTE, how do you account for their time and expenses?

- A. Your LEA should record time and expenses for partial FTEs in the same manner as full-time FTEs. For example, if your LEA has one full-time nurse and one half-time nurse, record 1.5 FTEs in Worksheet A-3/B-3, Column A. If your full-time nurse has a salary of \$40,000 and your half time nurse has a salary of \$20,000, record \$60,000 in Worksheet A, Column A, Line 4 for FYs 2006/07, 2007/08 and 2008/09 CRCS reports. Effective the FY 2009/10 CRCS report, report salaries on Worksheet A.1/B.1, Column A.

Q184. Do LEAs need to record the number of times a practitioner has treated a child during the day or should they record the number of hours that the practitioner worked?

- A. For CRCS purposes, LEAs will be required to support the total number of hours required to work per fiscal year for each practitioner.

Q185. If a practitioner is under contract to work a "professional day," rather than a specific number of hours per day, how do I determine the annual hours required to work for that FTE on Worksheet A-3/B-3, Column B?

- A. In absence of a contract specific work day, the standard work day is 8 hours. To determine the number of annual hours required to work, the eight hour day should be multiplied by the number of days the practitioner is required to work per year.

Q186. How do you identify Extended School Year (ESY) activity in your claim? Usually ESY is for a period beyond the regular School Year contract hours.

- A. LEAs are to report all total personnel costs and annual hours practitioners are required to work per year. The Annual Hours Required to Work per FTE (Worksheet A-3/B-3, Column B) is based on annual productive hours per FTE. If your LEA has practitioners rendering services during summer school or is on an extended school year, that time should be included in Column B.

Q187. If my LEA only participated in the LEA Program for a portion of the year, should I pro-rate my expenses?

- A. If your LEA only participated in the LEA Medi-Cal Billing Option Program for a portion of the fiscal year, it is not necessary to pro-rate expenses on the CRCS report. The "pro-rating" of these expenses will take place on CRCS Worksheets A-3/B-3, where the Percent of Time Providing LEA Services is estimated for IEP/IFSP services and non-IEP/IFSP services. The

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percent of time estimates represent the number of units paid by Medi-Cal for each LEA service multiplied by the time (in minutes) worked by practitioners to provide one unit of service (numerator), divided by the total annual hours each practitioner type was required to work (denominator). The time worked by practitioners to provide one unit of service will be based on paid claims data (i.e., some services such as T1002, Nursing Services are billed and paid in 15-minute increments) or time increments from the LEA Program Rate Study.

Worksheets A-4/B-4

Q188. Are we supposed to report both encounters and units in Column B of Worksheets A-4 and B-4 on the CRCS report?

- A. Effective on your FY 2009/10 CRCS, LEAs are to report total units by procedure code and modifier combination in Column B for all LEA services except for initial treatment services. For initial treatment services (rows 1c, 1e, 2c, 2e, 3c, 3e, 7a, 7c, 8a, 10b, 11b, 12e, 12g), report total encounters by procedure code and modifier combination in Column B. CRCS Worksheets A-4 and B-3 instructions identify which lines within Column B to input units and which lines to input encounters.

Q189. If the initial service for speech therapy is reported on CRCS as one encounter, regardless of how many units/minutes were actually spent providing the service, why are we required to bill according to the number of units? Will this billing process be changed to allow the billing to be based on encounter?

- A. Due to HIPAA national coding requirements, LEAs must record the number of units (e.g., one, two or three units) for 15-45 minute initial treatment services when the time period is reimbursed at the same rate to accurately reflect the time it takes to complete the treatment service. For initial treatment services billed in 15-45 minute sessions, bill one unit for 15 completed minutes, two units for 30 completed minutes and three units for 45 completed minutes. There is no plan to change the billing for initial treatment services to encounter-based billing.

Q190. What is the Interim Reimbursement and Units of Service (IRUS) Report?

- A. The IRUS Report details paid LEA services for practitioner type for the dates of service in the specified fiscal year. The IRUS Report will assist LEAs to complete CRCS Worksheets A-4 and B-4 and populate interim reimbursement, units of service, and encounters for specific procedure code and modifier combinations. LEAs should verify reasonableness between your internal accounting system and the IRUS Report and report the accurate units, encounters and reimbursement information. Potential discrepancies between the IRUS Report and your internal system should be documented to support the numbers you input on Worksheets A-4 and/or B-4, and to provide an accounting trail for review and audit.

Q191. How long will DHCS provide the IRUS Report to assist LEAs in completing their CRCS?

- A. Beginning with the FY 2011/12 year, each LEA will be responsible for tracking their own costs, reimbursement, units and encounters for LEA paid services. The last Interim Reimbursement and Units of Service Report that DHCS will provide to LEAs will be for FY 2010/11.

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Q192. Licensed Marriage and Family Therapists, Counselors and Psychologists can do social work. How do we show this cost if we received payment in both areas of psychology and social work?

- A. Worksheets A-4 and B-4 collect the units and interim reimbursement that an LEA received by specific procedure code and modifier combinations that are aggregated by practitioner type. The practitioner type “Counselors” should include your costs and reimbursement for credentialed school counselors and licensed marriage and family therapists. The practitioner type “Psychologists” should include your costs and reimbursement for licensed psychologists, licensed educational psychologists, and credentialed school psychologists.

SACS Coding

Q193. The CRCS instructions include applicable function codes. If we have applicable expenses in other functions, can they be included as well?

- A. The Function and Object fields in Standardized Account Code Structure (SACS) are tools that can be useful for distinguishing costs and practitioner categories. However, LEAs must verify that costs they include on the CRCS are eligible. Only those costs related to the direct provision of health services can be included in the CRCS. “Restricted” SACS codes should be reviewed for appropriateness before completing the CRCS. For example, if your LEA ran a SACS report to identify all costs associated with Function Code 3120 (Psychology Services), the results may include Resource Code 7155. This Resource Code identifies Instructional Materials, Grades K-8. No instructional expenses can be included in the CRCS, as they are not direct health care services costs.

Q194. My LEA currently bills speech therapists in Function Code 1190. Should we switch this practitioner type to Function Code 3150?

- A. Function Code 1190 is an instructional code. The CRCS forms must exclude costs that are instructional in nature. According to the California School Accounting Manual (CSAM), Function Code 3150 is a more appropriate code for speech therapy services. Although Function Code 1190 is not necessarily an incorrect way to code certain speech services, it is an instructional code that may be a red flag to auditors.

Q195. If health aides can legitimately bill, does it matter if their salary is coded to an educational function?

- A. The CRCS captures costs related to the direct provision of health services only; instructional expenses must be excluded from the CRCS. Function Codes that are instructional in nature may be a red flag in a State and/or federal review. If your LEA is certain that the expenses are not instructional in nature and can provide supporting documentation to support the provision of health services (e.g., progress notes, treatment logs, credentialing information, etc.), your LEA may include these expenses on the CRCS. However, your LEA must maintain adequate documentation to support these expenditures in a State and/or federal review.

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Miscellaneous Questions

Q196. Why aren't transportation and Targeted Case Management Services (TCMS) included on the CRCS?

- A. LEAs should not report actual costs for transportation and TCMS provided in a school-based setting in the CRCS because these services were not part of the State Plan Amendment. Transportation and TCMS will continue to be paid as "final" (not interim) rates based on the prior rate structure. They will not be subject to the CRCS or final settlement. LEAs may continue to bill Medi-Cal for these services under existing program rules and regulations.

Q197. Are there limitations as to what costs an LEA can record on the CRCS?

- A. Yes. Only those costs related to the direct provision of health services may be recorded on the CRCS. Instructional costs cannot be included in the CRCS.

Q198. Will the CRCS affect the LEA's ability to reinvest federal funds received for LEA services?

- A. The CRCS will not affect the way the LEA may reinvest federal funds. As required in the LEA Provider Participation Agreement/Annual Report, any federal funds received by an LEA provider for LEA services should be reinvested in services for school children and their families to supplement existing services.

Q199. What if you discover through this process that you didn't claim something that is reimbursable, can you resubmit for that?

- A. LEAs have 12 months following the month in which services were rendered to submit claims for processing by the DHCS fiscal intermediary. After this time period, claims will be denied due to lack of timely submission.

Practitioners

Q200. Where can I get more information about the different categories of practitioners that should be included in the CRCS?

- A. The LEA Provider Manual provides detail on the required qualifications for each practitioner and the services they can render. The LEA Provider Manual is available on the LEA Program website (<http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx>). Additional information regarding practitioners can also be found in the CRCS training materials on the LEA Program website.

Q201. If aides (qualified providers under California Education Code, Section 49423.5 and are supervised by registered credentialed school nurse) are rendering and billing for services for a Medi-Cal eligible student using the appropriate procedure code and modifier, does it matter if their job classification is NOT Health Aide?

- A. No, the job title does not need to match the practitioner title of a "Trained Health Care Aide", as long as the person providing LEA school health aide services meets the qualifications specified in California Education Code, Section 49423.5.

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Q202. What is the penalty if a mistake is made on the CRCS by a third party service that is used to complete the CRCS report for us based on information we provided?

- A. LEAs are responsible for ensuring proper billing and maintaining adequate supporting documentation. A&I audits LEA providers, not billing vendors. The LEA must sign under penalty of perjury and certify to the accuracy of total overpayments/ (underpayments), including all the supporting information used in the calculation (e.g., practitioner costs and hours, indirect cost rate, interim reimbursement and units, etc.) on the CRCS.