

**LEA Medi-Cal Billing Option Program
October 7, 2011 Training Questions and Answers**

Note: These questions and answers are from the October 7, 2011 LEA Medi-Cal Billing Option Program training. LEAs should refer to the LEA Medi-Cal Billing Option Provider Manual (LEA Provider Manual) for all LEA Program and policy information. The LEA Provider Manual can be found at: <http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx>

LEA Program Training Materials

1. Will the October 7, 2011 training materials be available on the LEA Program website?

Yes, the training presentation is posted on the LEA website at <http://www.dhcs.ca.gov/provgovpart/Pages/2011-2012%20LEA%20Training.aspx>.

LEA Provider Eligibility

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

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.

LEA Provider Participation Agreement (PPA)/Annual Report

3. Will PPA/Annual Reports be submitted electronically and online like last year?

All LEA PPA/Annual Reports must be completed on the most recent forms and submitted to the address below:

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

4. Currently, we're using Provider Enrollment Forms from 2008. How long will DHCS continue to accept this version of forms for enrolling a new LEA provider?

Effective immediately, DHCS will only accept the current version of all of the forms included in the PPA/Annual Report.

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

You may send the PPA/Annual Report however you like, as long as it is postmarked by November 30th of each year.

6. Does the PPA/Annual Report have to be post marked by November 30th or arrive to the California Department of Education (CDE) by November 30th?

Ideally, DHCS would like to have all PPA/Annual Reports to CDE by November 30th each year. If they are not at CDE by November 30th, they must be post marked by the due date.

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7. When is the LEA collaborative agreement due?

The LEA collaborative agreement is part of the PPA/Annual Report and is due on November 30th each year. Please refer to provision 8 on page 3 of the PPA/Annual Report.

8. 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?

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 November 30th 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.

9. If an LEA does not renew one year and is suspended, can they reapply and possibly reenroll later?

Yes, LEAs are required to annually submit a PPA/Annual Report to reapply to bill in the LEA Medi-Cal Billing Option Program. If an LEA is suspended or does not submit a PPA/Annual Report and/or a CRCS form for a relevant fiscal year, they will not be allowed to claim for LEA services.

10. 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?

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 November 30th of each year otherwise they will not be allowed to claim for LEA services for that fiscal year.

11. 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?

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.

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

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>).

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

Once received, it will take Provider Enrollment approximately 30 days to process the PPA/Annual Report and send confirmation letters to the LEA.

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

Since the PPA/Annual Report is a contract, the individual designated/authorized by the district to sign contracts should sign the PPA/Annual Report.

15. Do LEAs have to complete the Amendment and Retroactive Certification of State Matching Funds for LEA Services in the PPA/Annual Report if it does not impact the LEA?

The LEA does not have to report any figure on the Certification of State Matching Funds for Retroactive Claiming (Attachment 1B) unless the LEA claimed for LEA services retroactively in the previous year. Similarly, the LEA does not have to report any figure on the Certification of State Matching Funds Amendment (Attachment 1A) unless the LEA is amending the matching funds for a respective fiscal year.

16. Why would we need to amend our state matching funds? Please provide an example.

Certification of Matching Funds: The certification of state matching funds designates the amount of non-federal funds the LEA has available to finance LEA Medi-Cal Billing Option Program activities for the fiscal year. An LEA may not be reimbursed more than the amount designated in the certification. If an LEA goes over the amount stated on the Certification of Matching Funds for the current or retroactive year, they may submit an amendment to increase the initial dollar amount. The amendment must be submitted prior to the CRCS of that fiscal year.

Example: For the current FY 2011/12 PPA/Annual Report the LEA indicates matching of \$xx amount. As the year progresses, the LEA realize that the reimbursements will exceed the initial amount. The LEA will complete the "amendment" page to increase the available match.

17. 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?

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.

18. If I report a certain amount on the PPA/Annual Report for the Certification of State Matching Funds for the current FY 2011-12 report, and as the year progresses, it is determined that the LEA reimbursement will exceed that original reported amount, then do I complete the Certification of State Matching Funds Amendment page to increase the available match?

Yes, your LEA will complete the Certification of State Matching Funds Amendment to adjust the available state match for the specific fiscal year.

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

Fill in the name of the LEA and 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.

20. How do LEAs determine the LEA matching funds?

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.

21. 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)?

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

22. How many times should the LEA collaborative meet?

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

23. 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?

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

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

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).

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25. 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?

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.

LEA Federal Medical Assistance Percentage (FMAP)

26. Is the FMAP 50 percent for dates of service beginning July 1, 2011? We have some services with dates of service after July 1, 2011 that are reimbursed at the 61.59 percent FMAP. Please clarify.

LEAs will be reimbursed at 50 percent FMAP effective for dates of service on or after July 1, 2011. Due to the timing of the claims processing system updates, the FY 2010/11 rebased maximum allowable rates and corresponding FMAP changes were not implemented until August 19, 2011. Therefore, claims paid after the system implementation date of August 19, 2011 should be reimbursed at 50 percent. Any claims reimbursed between July 1, 2011 and August 19, 2011 will be automatically reprocessed via a future Erroneous Payment Correction (EPC) to reflect the 50 percent FMAP and rebased maximum allowable rate.

27. Wasn't the increased FMAP rate of 61.59 percent available to California through June 2011?

The increased FMAP rate of 61.59 percent was available from 10/1/08-12/31/10, at which point it was "stepped-down", until it returned to the 50 percent FMAP, effective 7/1/11. The "stepped down" FMAP rates were 58.77 percent from 1/1/11 - 3/31/11 and 56.88 percent from 4/1/11-6/30/11.

LEA Rendering Practitioner Qualifications

28. 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?

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 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.

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29. Do our Speech-Language Pathologists require a license in order to bill the LEA Medi-Cal Billing Option Program, or will a credential suffice?

Currently, if a Speech-Language Pathologist is not licensed and only has a credential, s/he must receive supervision from a Licensed Speech-Language Pathologist to bill LEA for services under the LEA Medi-Cal Billing Option Program. Please refer to the loc ed rend and loc ed serv spe sections of the LEA Provider Manual.

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

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 loc ed rend section of the LEA Provider Manual for current qualified rendering practitioners.

LEA Prescription, Referral and Recommendation Requirements

31. 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?

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 loc ed bil section of the LEA Provider Manual.

LEA Assessment and Treatment Services

32. 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?

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.

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

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.

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34. 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?

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.

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

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.

36. 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?

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.

37. 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?

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.

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

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.

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

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.

LEA Targeted Case Management (TCM) Services

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

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

41. We completed our TCM Labor Survey over 10 years ago. Should we submit a revised version?

Although it is not required that your LEA submit a revised TCM Labor Survey, your LEA may do so if they believe current information will support a change in the TCM Category of Service.

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

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

43. 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?

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.

LEA Transportation Services

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

The LEA Provider Manual (section loc ed serv trans) 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.

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45. Do we need preauthorization for transportation?

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 local serv trans section of the LEA Provider Manual for details.

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

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 local serv trans section of the LEA Provider Manual.

47. 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?

The CCRs for LEA transportation are outlined in Title 22, Section 51231.1 and the local serv trans 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.

LEA Service Limitations

48. Please clarify the service limitations for IEP/IFSP assessments.

LEA IEP/IFSP assessment service limitations are by service type per beneficiary per LEA provider. For additional information, refer to the local indiv section of the LEA Provider Manual.

49. 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?

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.

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50. What are the daily and annual maximum limitations for IEP/IFSP psychosocial status assessments?

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 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.

51. 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.

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.

LEA Free Care and Other Health Coverage (OHC)

52. 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?

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.

Cost Reconciliation and Comparison Schedule (CRCS)

53. Is there any opportunity to get some hands on, one-on-one training for completing the CRCS report?

There is no one-on-one training available. However, LEA CRCS Documentation Trainings are posted on the website (<http://www.dhcs.ca.gov/individuals/Pages/LEA.aspx>) or e-mail the question to the LEA CRCS mailbox (lea.crcs.questions@dhcs.ca.gov).

54. How do I order the CRCS training DVD?

A taped CRCS training session from April 2006 is currently available from DHCS on DVD. Updates to the CRCS forms, as well as modifications to LEA versus State reporting responsibilities have been made since the April 2006 training session was conducted. Although the CRCS training occurred several years ago, explanation as to how to complete the CRCS forms and appropriate supporting documentation is still relevant to LEAs as they prepare the practitioner cost and hours. LEAs and billing vendors may request a copy of the CRCS training DVD by e-mailing lea@dhcs.ca.gov. There is no fee to obtain the DVD.

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55. 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?

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.

56. 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?

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.

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

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.

58. 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?

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

59. How long must the LEA keep service documentation and CRCS documentation? Is it three years from the date of service or date of payment?

An LEA should retain service documentation at least three years from the submission date of the CRCS. 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.

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

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

61. What will trigger a CRCS audit?

Every CRCS will be audited.

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October 7, 2011 Training Questions and Answers**

Note: These questions and answers are from the October 7, 2011 LEA Medi-Cal Billing Option Program training. LEAs should refer to the LEA Medi-Cal Billing Option Provider Manual (LEA Provider Manual) for all LEA Program and policy information. The LEA Provider Manual can be found at:<http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx>

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

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

63. 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?

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).

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

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.

65. 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?

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.

66. I found an issue with claiming encounters versus units on the CRCS. We have a very small district that has an hourly paid speech staff who worked a very small amount of time. Almost all of her time was spent providing services. Because some of these were initial treatments, they are being claimed as lasting 50 minutes on the CRCS, when in reality they were only 2 units in length. This is causing the CRCS percentage of time spent providing services to be 114 percent and inflating the time spent in some cases.

The FY 2006/07 through 2008/09 IRUS Reports incorrectly identified initial treatments as units instead of encounters. Reporting initial treatments as units on the CRCS can cause the percentage of time spent to exceed 100 percent. The FY 2009/10 IRUS Reports correctly identify initial treatments as encounters.