

**2014 LEA MEDICAL
BILLING OPTION
PROGRAM
DOCUMENTATION
TRAINING**

INTRODUCTIONS

- **California Department of Health Care Services (DHCS)**
 - Safety Net Financing Division (SNFD)
 - Administers the LEA Medi-Cal Billing Option Program
 - Provides policy guidance and oversight
 - Administers the Provider Participation Agreement
 - Develops rates for services
 - Provides reimbursement for eligible services
 - Audits and Investigations (A&I)
 - Financial Audits Branch (FAB)
 - Conducts financial audits/reviews of LEA Medi-Cal Billing Option Program providers Cost and Reimbursement Comparison Schedule (CRCS)
 - Medical Review Branch (MRB)
 - Performs federally mandated post-service, post-payment utilization reviews (random audits)

LEARNING OBJECTIVES

- Legal and Regulatory LEA Medi-Cal Billing Option Program documentation requirements
- Documentation requirements to support LEA Medi-Cal Billing claims
- Documentation DHCS auditors commonly review
- Documentation that should be included in student records
- Proper and improper billing documentation

QUESTIONS

- Submit questions via message box throughout the training
- Webinar Q&A session at the end of training session

SECTION 1: OVERVIEW OF STATE AND FEDERAL AUDITS

Legal and Regulatory LEA
Medi-Cal Billing Option
Program Documentation
Requirements



2009 MEDI-CAL PAYMENT ERROR STUDY

DOCUMENTATION ERRORS

- There was no documentation of the time spent providing services.
- There was no documentation of the type and extent of services provided to this beneficiary.
- There was no documentation provided to support the claimed service was provided.
- The assessment that was provided had not been signed by anyone. Therefore, it is not possible to determine if it was in fact the nursing assessment.
- No transportation trip log provided that indicated the number of miles the child was transported.
- Limited documentation does not support a minimum of seven minutes, as required.
- No signature or other identification of the person providing the service so their qualifications to provide the service cannot be verified.

SPEAKER NOTES:

The 2009 Medi-Cal Payment Error Study, conducted by the Medi-Cal Review Branch, discovered numerous problems with LEA billing and documentation, within the LEA Medi-Cal Billing Option program.

LEA MEDI-CAL BILLING OPTION PROGRAM SERVICES

- Services in an Individualized Education Plan (**IEP**) or Individualized Family Services Plan (**IFSP**)
- Services are **medically necessary** health services
- Included in Medi-Cal **State Plan**
- Extent, duration and scope are defined

SPEAKER NOTES:

- LEA Medi-Cal Billing Option Program covers medical services outlined in the LEA Medi-Cal Billing Option Program's Provider Manual for students with an IEP/IFSP.
- Services must be medically necessary as identified by a practitioner within the scope of treatment.
- Extent, duration and scope of treatment must be identified in the students IEP/IFSP.
- Not all services listed in an IEP/IFSP are included in the Medi-Cal State Plan and the LEA Medi-Cal Billing Option Program Provider Manual, so it is not automatic that a service is reimbursable just because it's listed in the IEP/IFSP.

LEA EDUCATIONAL RESPONSIBILITIES

- All LEAs must meet Federal and State Special Education requirements
- LEAs who choose to become Medi-Cal providers must meet Medi-Cal requirements, in addition to Special Education requirements
- Under the Individuals with Disabilities Education Act (IDEA), the LEA must provide eligible students with an IDEA-compliant IEP
 - Note: The LEA Medi-Cal Billing Option Program only provides specific services related to IDEA, which are located in the LEA Provider Manual

SPEAKER NOTES:

- The LEA Medi-Cal Billing Option program provides specific services, which can be found in the LEA Provider Manual, and it's important to note that not all IDEA-compliant services are included as services offered by the LEA Medi-Cal Billing Option Program.

BILLING RESTRICTIONS

- **Free Care:** Med-Cal will not reimburse LEA providers for services provided to Medi-Cal recipients if the same services are offered for free to non-Medi-Cal recipients.
 - Exceptions to the Free Care principle:
 - Medi-Cal covered services provided under an IEP/IFSP
 - The LEA provider still must pursue any Other Health Coverage (OHC) for reimbursement before billing Medi-Cal

LEA DOCUMENTATION RESPONSIBILITIES

- LEAs are responsible for ensuring proper billing and maintaining adequate documentation
- A&I conducts audits of providers, not billing agents/vendors. LEAs need to keep records of instructions to billing agents/vendors
 - **Note:** It is against regulation for billing agents/vendors to bill on a percentage basis for the processing of Medi-Cal claims. [Code of Federal Regulations § 447.10](#) & [California Code of Regulations § 51502.1](#)

SPEAKER NOTES:

- It is the LEA, and not the billing agent or vendor, who is ultimately responsible for ensuring that there is proper billing and adequate documentation.
- It is the LEA that is audited and not the billing agent or vendor, so LEAs should maintain the required records.
- It is against regulation for billing agents or vendors to be paid on a percentage basis to the amount that is billed or collected, or to be paid dependent upon the collection of the payment.

CENTERS FOR MEDICARE & MEDICAID SERVICES TECHNICAL ASSISTANCE GUIDE

"A school, as a [Medi-Cal] provider, must keep organized and confidential records that details client specific information regarding all specific services provided for each individual recipient of services and retain those records for review."

CALIFORNIA CODE OF REGULATIONS § 51476

- For a minimum of three years, from the Cost and Reimbursement Comparison Schedule (CRCS) submission date, the LEA provider must keep, maintain and have available records that fully disclose the type and extent of LEA services provided to Medi-Cal recipients. The required records must be made at or near the time the service was rendered. Such records shall include, but not be limited to the following:
 - Billings
 - Treatment authorization requests
 - All medical records, service reports, and orders prescribing treatment plans

SPEAKER NOTES:

- Medi-Cal Providers must maintain all records and supporting documents of billed services for a minimum of three years (more if under review or audit).

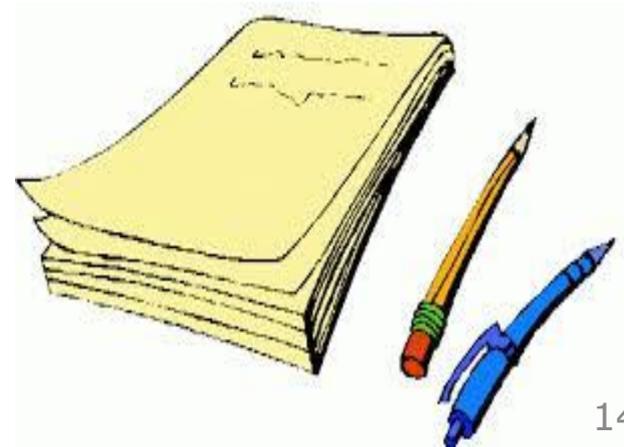
[LEA Provider Manual Reference: \(loc ed a prov\)](#)

CALIFORNIA CODE OF REGULATIONS § 51270

- LEA Providers shall maintain records as necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary.
- LEA Providers shall maintain records showing that all LEA Practitioners, which it employs or with which it contracts, meet and shall continue to meet all appropriate licensing and certification requirements.

SECTION 2: GENERAL DOCUMENTATION REQUIREMENTS

What Documents are the
DHCS Auditors
Reviewing?

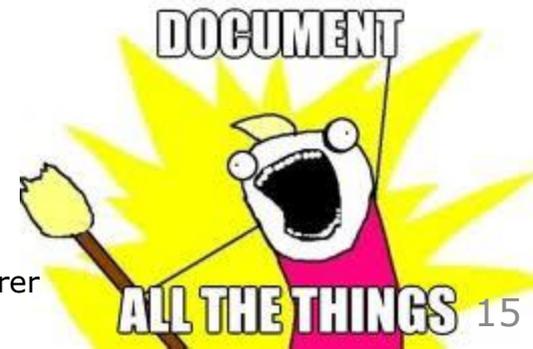


WHY IS DOCUMENTATION SO IMPORTANT?

- As the old saying goes: if you do not document it, it did not happen.
- Similarly, if documentation is poor, it may not adequately reflect the true nature of what happened.

SPEAKER NOTES:

- Documentation is all an auditor has to determine if an action actually happened. The clearer and more obvious the documentation is, the better.



DOCUMENTS REQUIRED TO BILL

- To bill for services outlined in the LEA Medi-Cal Billing Option Program, the student must have:
 - An assessment ([CCR § 51476](#)),
 - An IEP/IFSP identifying medically necessary treatment ([CCR § 51535.5](#)),
 - A referral/prescription authorizing treatment ([CCR § 51476](#)),
 - Progress/case notes that support the service billed ([CCR § 51476](#)),
 - A LEA Medi-Cal Billing Option Program service performed by a qualified practitioner ([CCR § 51491](#)); and must,
 - Be Medi-Cal Eligible ([CCR § 51535.5](#))

AUTHORIZATION FOR LEA MEDI-CAL BILLING OPTION PROGRAM ASSESSMENT SERVICES

- LEAs must document all assessments with either:
 1. A written prescription
 - A formal prescription for services within the practitioner's scope of service
 2. A written referral
 - Issued by a physician or dentist, within the practitioner's scope of practice
 3. A written recommendation
 - Less formal than a prescription or referral and issued by the appropriate health service practitioner
 - A request from a parent, teacher, registered credentialed school nurse, or by the appropriate health services practitioner

- The prescription, referral, or recommendation, must be documented in the student's file

SPEAKER NOTES:

LEAs must use one of these methods to refer a student for an assessment for services provided under the LEA Medi-Cal Billing Option Program. Document an assessment in the student's file with a written prescription, referral or recommendation.

- A parent, teacher or registered credentialed school nurse may request an assessment for a student in substitution of a prescription, referral or recommendation by an appropriate health services practitioner.

[LEA Provider Manual Reference: \(loc ed bil\)](#)

DOCUMENTING PRESCRIPTIONS, REFERRALS & RECOMMENDATIONS FOR ASSESSMENTS

Assessment Type	Written Prescription	Written Referral	Written Recommendation
Psychological and Psychological Status			By a physician, registered credentialed school nurse, licensed clinical social worker, licensed psychologist, licensed educational psychologist, or licensed marriage and family therapist, within the practitioner's scope of practice. *
Health and Health/Nutrition			By a physician or registered credentialed school nurse. *
Audiology and Speech Therapy		By a physician or dentist, within the practitioner's scope of practice.	*
Physical Therapy and Occupational Therapy	By a physician or podiatrist, within the practitioner's scope of practice.		*

*A parent, teacher or registered credentialed school nurse may request an assessment for a student in writing in substitution of a written prescription, referral or recommendation by an appropriate health services practitioner.

SPEAKER NOTES:

- This chart outlines the MINIMUM requirements for prescriptions, referrals, and recommendations for assessments billed under the LEA Medi-Cal Billing Option Program.
- This chart shows that psychological and health/nutrition assessments may be requested with a minimum of a recommendation, so a prescription, referral or recommendation would all be acceptable.
- Audiology and AT assessments must have a referral at a minimum so a referral or prescription would also apply.
- PT and OT assessments require a prescription.
- Exception is that a parent, teacher or registered credentialed school nurse may request an assessment for a student in writing for any of these assessment types.

ASSESSMENT DOCUMENTATION

Written prescriptions, referrals, and recommendations for assessments must be maintained in the students file and include:

	Prescriptions/ Referrals	Recommendation
School/District Name	✓	
Student's Name	✓	✓
Type of Assessment Needed	✓	
Parent, teacher, or practitioner observations and reason(s) for assessment	✓	✓
Name, Title, and Signature of prescribing/referring practitioner	✓	✓
Date	✓	✓

SPEAKER NOTES:

- This chart outlines the MINIMUM requirements for assessment documentation content.
- Prescriptions and referrals require documentation including the date, school and district name, the student's name, the type of assessment needed along with the observations and reasons for the assessment, and the name and signature of the prescribing practitioner.
- A recommendation does not need to include the school and district name, or the type of assessment needed, since it may be coming from a parent or someone who wouldn't necessarily have that information.

[LEA Provider Manual Reference: \(loc ed a prov\)](#)

QUESTION:

True or False

The LEA is only required to maintain prescriptions for assessments in the students file.

Answer:

False: Prescriptions, referrals, and recommendations must be documented and maintained in the student's file.

LEA MEDI-CAL BILLING OPTION PROGRAM

IEP/IFSP TREATMENT SERVICES

- Treatment services must be billed according to the services identified in the student's IEP/IFSP and include:
 - Service type(s)
 - Number and frequency of LEA treatment service
 - Length of treatment, as appropriate

SPEAKER NOTES:

- IEPs and IFSPs identify the required health-related services for each student and dictate the Medi-Cal services that are provided and reimbursable under the LEA Medi-Cal Billing Option Program.
- The information should include the service type, with the recommended number and frequency of the treatment service, as well as the length of service.

[LEA Provider Manual Reference: \(loc ed a prov\)](#)

ALIGNMENT WITH IEP/IFSP

- Service documentation must align with each student's IEP/IFSP as reflected in the:
 - Present Level of Performance (PLP) Summary
 - Goals
- Service provided must be on the IEP/IFSP.
- Service documentation must be relevant to IEP/IFSP goals or diagnosis

SPEAKER NOTES:

- The service provided must be included in the IEP/IFSP. The documentation must support the goals or diagnosis. Not all services listed in an IEP/IFSP are included in the LEA Medi-Cal Billing Option Program provider manual, so a service may not be reimbursable under this program specifically because it's listed in the IEP/IFSP.

DOCUMENTING PRESCRIPTIONS, REFERRALS & RECOMMENDATIONS FOR TREATMENT

	Prescription	Referral	Recommendation
Physical Therapy and Occupational Therapy Treatment Services	(By Physician or Podiatrist)		
Speech Therapy and Audiology Treatment Services		(See Note 1)	
Psychology and Counseling Treatment Services			(By Physician, Credentialed School Nurse, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Psychologist, or Licensed Educational Psychologist)
<p>Note: (1) A physician-based standards protocol may be developed and used to document medical necessity of speech and audiology treatment services to meet California State requirements that a written referral be provided by a physician or dentist. The protocol does not fulfill federal requirements, as defined in 42 CFR 440.110(c), which requires a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice (i.e., licensed speech-language pathologist or licensed audiologist) to refer the student for speech and audiology treatment services. LEAs must meet both State and federal documentation requirements.</p>			

SPEAKER NOTES:

- Unlike assessments, prior authorization requirements for treatments MUST be authorized by a health service practitioner and referral by a parent or teacher does NOT constitute authorization for services.
- PT and OT treatment services must be ordered with a prescription from a physician or podiatrist while psychology and counseling treatments can be ordered via recommendation, referral or prescription by an authorized health services practitioner.
- Speech therapy and audiology treatments can be authorized through a Physician-Based Standards Protocol, rather than a referral by a physician or dentist.
 - If a SLP or audiologist provides a referral for ST or audiology, the LEA must also have a Physician-Based Protocol implemented.
 - Physician-Based Standards must establish minimum standards of medical need for referrals to speech therapy and audiology treatment services. If the LEA relies on the Physician-Based Standards protocol, documentation must be available for state/federal review. Services rendered under the protocol must be consistent with the standards established in the protocol.

TREATMENT DOCUMENTATION

Written prescriptions, referrals, and recommendations for treatment must be maintained in the students file and include:

	Prescriptions/ Referrals	Recommendation
Student's Name	✓	✓
Practitioner observations and reason(s) for treatment	✓	✓
Specific Treatment Needed (especially for medications/feedings)	✓	✓
Written statement in the students file from the recommending practitioner		✓
Signature of prescribing/referring, recommending practitioner	✓	✓
Name and title of the practitioner	✓	
Date	✓	✓

SPEAKER NOTES:

- For treatment documentation, prescriptions, referrals and recommendations all must include the date, student's name, practitioner observations and recommended treatment and signature of practitioner.
- A recommendation must also include a written statement from the recommending practitioner.

QUESTION:

Who may authorize a student's treatment services?

- A. A practitioner
- B. A parent
- C. A teacher
- D. All of the above

Answer:

A. A Practitioner

LEA MEDI-CAL BILLING OPTION PROGRAM TREATMENT SERVICES AND QUALIFIED PRACTITIONERS

Treatments	Qualified Practitioners **Prior authorization and supervision requirements may apply**
Physical Therapy	Licensed Physical Therapist
Occupational Therapy	Registered Occupational Therapist
Speech-Language	Licensed Speech-Language Pathologist or Speech-Language Pathologist
Audiology	Licensed Audiologist or Audiologist
Psychology and Counseling	Licensed Physician/Psychiatrist Licensed Clinical Social Worker, Licensed Psychologist, Licensed Educational Psychologist, Credentialed School Psychologist, Licensed Marriage and Family Therapist
Nursing	Registered Credentialed School Nurse, Certified Public Health Nurse, Licensed RN, Certified Nurse Practitioner, Licensed Vocational Nurse
Trained Health Care Aide	Trained Health Care Aide

Note: Only the services provided by a qualified practitioner, outlined in the LEA Provider Manual, may be billed under the LEA Medi-Cal Billing Option Program.

SPEAKER NOTES:

- Listed on this chart are the 7 treatment services that are reimbursable under the LEA Medi-Cal Billing Option Program, along with the Qualified Practitioners for each.
- Speech therapy, and psychology and counseling treatment services may be provided and billed for individual **or** group sessions.
- Prior authorization may be required and there may be supervision requirements.
- Refer to the individual services sections of the LEA provider manual for specific policy guidance.

[LEA Provider Manual Reference: \(loc ed bil\)](#)

GENERAL DOCUMENTATION REQUIREMENTS

- Medi-Cal review of documentation for claims billed under the LEA Medi-Cal Billing Option Program may seek to verify:
 - The student received the billed service
 - The service was a Medi-Cal benefit
 - The service was performed by qualified personnel
 - Medical necessity and appropriate authorization for the service is documented in the student's IEP/IFSP

SPEAKER NOTES:

- During a DHCS or Medi-Cal audit, the LEA will most likely need to provide documentation to show that the student received the billed service, it was a Medi-Cal benefit performed by qualified personnel, and there was medical necessity and appropriate authorization for the service documented in the student's IEP/IFSP.
- Regardless of the service type, these are the general documentation requirements. There may be additional requirements for specific service types.

AUDITORS LIKE TO SEE

- Documents that could stand alone
 - Each service encounter with a Medi-Cal eligible student must be documented according to the Business and Professions Code of the specific practitioner type, and include, but not be limited to:
 - Date of service
 - Full name of student and birth date
 - Student's Medi-Cal identification number
 - Name of agency rendering the service
 - Name and title of practitioner rendering the service
 - Place of service
 - Signature of rendering practitioner

SPEAKER NOTES:

- Auditors want to see documentation that could stand alone, so independently of any other documentation it would show specifically who it was for, the date and place of service, and exactly who rendered the service.
- Service encounters should be documented according the Business and Professions Code of the specific practitioner type.

QUESTION:

A significant element was missing from the last slide. What is it?

Answer:

Nature, extent, and units of service.

REQUIRED SUPPORTING DOCUMENTATION

- Supporting documentation describes the nature or extent of services and includes, but is not limited to the following:
 - Progress and case notes
 - Contact logs
 - Nursing and health aide logs
 - Transportation trip logs
 - Assessment reports

SPEAKER NOTES:

- Documentation of the Nature and Extent of a service should include the progress and case notes – which could reference the student’s IEP/IFSP.
- Documentation could also include various logs such as contact logs, nursing and health aide logs and transportation trip logs, and assessment reports.

DESCRIPTION OF SERVICE

- Documentation must fully disclose the type and extent of services and answers questions such as:
 - **What** was done and **why**?
 - May reference IEP/IFSP goals or protocols
 - **How much**?
 - Time, miles, feeding, medication
 - What was **response**?
 - Context may be important
 - Was any **additional action** taken or planned?
 - Next steps

SPEAKER NOTES:

- Referencing the IEP/IFSP goals or protocols may support what was done and why.
- Always log the quantitative elements such as the time spent providing a service, number of miles transporting a student, and the timing and frequency of feedings and medications.
- It's important to also include the student's response and any additional actions taken or planned.

WHAT ARE AUDITORS REVIEWING IN THE STUDENT'S FILE?

- Assessment documentation
- IEP/IFSP
- Detail of progress/case notes
- Does the service meet the minimum standards of quality

Note: For LEA services that are authorized in a student's IEP/IFSP, a copy of the IEP/IFSP that identifies the child's need for health services and the associated IEP/IFSP assessment reports must be maintained in the provider's files. LEA services must be billed according to the provisions of the student's IEP/IFSP, including service type(s), number and frequency of LEA services, and length of treatments, as applicable.

SPEAKER NOTES:

- Auditors may request documentation showing:
 - That the required prescription, referral, or recommendation for assessment and treatment services is in the student's file.
 - They will also want to see if the service performed is documented in the student's IEP/IFSP.
 - And the progress/case notes should document the nature and extent of the service, support that the service is documented at the level claimed and substantiate the encounters or units of service billed.
- Important that the LEA have the student's IEP/IFSP and the assessment reports maintained in the student's file, since LEA services must be billed according to the provisions of the student's IEP/IFSP.

QUESTIONS TO ASK YOURSELF

- Does the service documentation:
 - Align with IEP, diagnosis, and physician's order?
 - Meet professional standards for the services provided?

- Is the service documentation accurate and complete?
 - Does it contain:
 - Description of activity?
 - Outcome statement?
 - Objective measure of student's response to procedure?

REMEMBER

- Auditors may request information to back up what is in the student's file, such as copies of prescriptions, referrals, progress/case notes, protocols, training and supervision logs, physician based standards etc.

QUESTION:

What does documentation seek to verify?

Answer:

1. The service was performed by qualified personnel
2. The student has an IEP/IFSP documenting medical necessity
3. The student is a Medi-Cal beneficiary
4. The student received the billed service

QUESTION:

True or False

Supporting documentation is not required when the treatment is documented in the IEP/IFSP?

ANSWER:

False: Supporting documentation describing the nature or extent of service is required for all LEA Medi-Cal Billing Option Program treatment services.

SECTION 3: LEA MEDI-CAL BILLING OPTION PROGRAM SERVICE DOCUMENTATION

By Practitioner/Service
Type



STANDARD OF PRACTICE

- Providers in each discipline are educated to know how to describe accurately and completely the nature and type of service they deliver to individual students
- The description of the service reflects the standard of practice for each discipline

SPEAKER NOTES:

- In addition to program rules adopted by the Medi-Cal program through regulation and policy, licensed providers are responsible for assuring that documentation reflects that services provided are done in accordance with their own licensing standards and scope of practice, including those under the licensed individual's supervision.
- LEA services are medical services, recorded in medical records in addition to being school services and school records. Medical record standards apply.

ACCURACY AND COMPLETENESS

- All service documentation should include the following:
 - A brief description of the activity
 - An outcome statement (what happened)
 - An objective measure (or professional reflection) of the individual student's response to the activity and progress toward the IEP/IFSP goal

SPEAKER NOTES:

- This describes a service that is reimbursable under the LEA program.
- Without these elements for IEP/IFSP services, it is possible that the service may not qualify for reimbursement.

DOCUMENTATION
REQUIREMENTS AND SAMPLES
FOR NURSING AND TRAINED
HEALTH CARE AIDE (THCA)
TREATMENT SERVICES

THCA BILLING- SUPERVISION REQUIREMENTS

- THCAs may only provide services and bill under the supervision of a credentialed school nurse, public health nurse, or licensed physician

SPEAKER NOTES:

- School health aid services are specialized physical healthcare services (includes catheterization, suctioning, g tube feeding or other services requiring medically related training).
- Such services are delineated in California Education code 49423.5.
- The THCA must be trained in the performance of the task and documentation.
- Schools may have protocols, but actual performance of the task must be documented.

CONTINUOUS BILLING FOR NURSING/THCA SERVICES

- Billed in 15 minute units
 - Must be 7 or more continuous minutes of physical health care services
 - Cannot add smaller time increments to make a unit
 - Continuous minutes = 1:1 care
 - Continuous means you cannot stop and do something else for a while unless someone else takes over
 - Documentation must occur for each time unit billed
- Includes specialized physical health care
 - Does not include behavioral supervision
 - Does not include 1 : 1 tutoring
 - Does not include service of less than 7 minutes

SPEAKER NOTES:

- Personal care is also not considered specialized physical health care and the time spent undressing/dressing, toileting, performing personal hygiene should not be counted toward THCA billable minutes.

[LEA Provider Manual Reference: \(loc ed serv nurs\)](#)

DOCUMENTATION REQUIREMENTS FOR NURSING AND THCA TREATMENT SERVICES

- All nursing/THCA treatment service documents must include the information identified in the general documentation requirements section of this training
- &**
- Nursing logs
 - Supporting documentation describing the nature and extent of Nursing and THCA service

SPEAKER NOTES:

- In addition, documentation of training, if requested, should be available and up to date.

[LEA Provider Manual Reference: \(loc ed serv nurs\)](#)

ACCEPTABLE DOCUMENTATION FOR NURSING/THCA SERVICES

IEP Documentation

- Student requires a District assigned qualified provider to perform G-tube feedings...

Service Documentation

- **Diagnosis**: Gastrostomy Status
- **MD Order**: Pediasure, 1 can (8oz) via G-tube at 9am and 1pm. May be fed orally soft or pureed foods (Ex. Yogurt, applesauce, pudding and assist with drinking liquids)
- **Activity**: Gastrostomy Button Feeding: Syringe Method
- **Event Results**: (taken from 9am session note) Student was fed 8oz of Pediasure followed by a flush of 35cc of water via G tube. Student tolerated the procedure well and resumed his class work.

SPEAKER NOTES:

Here is an example of documentation that may be considered adequate for nursing/THCS services.

- Assuming previously mentioned requirements fulfilled: student and provider identification, date of service, signature etc.
- The IEP and MD order establish the necessity. The activity describes what is to be done, what is done. A time is included. The results tell what happened and relay observations.
- There is enough information here to tell what actually happened and why.
- Other information might include flow, how long feeding takes, what was observed that resulted in the statement "tolerated well" (what had THCA been instructed to look for). And, in case of any out of ordinary events/complications what steps were taken, additional time spent.

ACCEPTABLE CONTINUOUS BILLING NURSING TREATMENT LOG

Student Name: _____			File Number: _____			Date: ___/___/___									
THCA Name: _____			THCA Supervisor: _____												
TIME	ACTIVITY	RESP. RATE	RESPIRATION QUALITY (CIRCLE ONE)		SKIN COLOR (CIRCLE ONE)		SKIN QUALITY (CIRCLE ONE)		DEMEANOR (CIRCLE ONE)		TUBING CHECK (CIRCLE ONE)	TANK LEVEL	ACTION TAKEN (SEE PROGRESS NOTES)	INITIALS	
9:00 - 9:15			Irregular _____	Gasping _____	Blue _____	Red _____	Pink _____	Warm _____	Dry _____	Moist _____	Alert _____	Agitated _____	Kinked/ Leaks/ _____	No Kinks/ No Leaks _____	
9:15 - 9:30			Wheezing _____	Labored _____	Other _____	Gray _____	Pallid _____	Cold _____	Cool _____	Hot _____	Responsive _____	Somnolent _____	Other _____		
9:30 - 9:45			Irregular _____	Gasping _____	Blue _____	Red _____	Pink _____	Warm _____	Dry _____	Moist _____	Alert _____	Agitated _____	Kinked/ Leaks/ _____	No Kinks/ No Leaks _____	
9:45 - 10:00			Wheezing _____	Labored _____	Other _____	Gray _____	Pallid _____	Cold _____	Cool _____	Hot _____	Responsive _____	Somnolent _____	Other _____		
10:00 - 10:15			Irregular _____	Gasping _____	Blue _____	Red _____	Pink _____	Warm _____	Dry _____	Moist _____	Alert _____	Agitated _____	Kinked/ Leaks/ _____	No Kinks/ No Leaks _____	
10:15 - 10:30			Wheezing _____	Labored _____	Other _____	Gray _____	Pallid _____	Cold _____	Cool _____	Hot _____	Responsive _____	Somnolent _____	Other _____		
10:30 - 10:45			Irregular _____	Gasping _____	Blue _____	Red _____	Pink _____	Warm _____	Dry _____	Moist _____	Alert _____	Agitated _____	Kinked/ Leaks/ _____	No Kinks/ No Leaks _____	
THCA Signature: _____			Date: ___/___/___												
Supervisor Signature: _____			Title: _____			Date: ___/___/___									

SPEAKER NOTES:

- Nursing treatment log may be included with the supporting documentation required to bill for continuous monitoring of a medically necessary specialized physical healthcare service.

 - There must be a written recommendation by a physician stating the reason continuous monitoring is necessary, and
 - The plan for continuous monitoring including measurable goals must be documented in the student’s IEP.
 - The LEAs may bill one 15-minute unit of THCA services when seven or more continuous treatment minutes are rendered.
 - The minimum time of seven minutes cannot be made up of shorter time periods provided throughout the day and added together.
- Documentation must occur for each time a unit is billed, detailing the nature and extent of the service. However, if multiple units are billed as a result of a medical event that occurs during the continuous monitoring period, the LEA has the option to document the nature and extent of the medical event in lieu of documentation for each unit billed.

SUPPORTING DOCUMENTATION

- Progress notes are required in addition to the nursing treatment log
- Progress notes describe:
 - Unlisted or other findings and
 - Performance of tasks such as suctioning, replacing tubing,
 - Notifies supervising professional, or
 - Summons emergency services

SPEAKER NOTES:

- The form of a progress note is not determined by DHCS. LEAs may have designated formats.
- In the preceding treatment log, notes can be incorporated in to the log. They can also be made separately. If nursing was notified for any reason would expect nursing notes.

UNACCEPTABLE DOCUMENTATION FOR NURSING/THCA SERVICES

IEP Documentation

- **PLP Summary:** Student needs District assigned qualified provider to perform gastrostomy feedings as ordered by his physician and to be trained by the school nurse in G-tube replacement.

Service Documentation

- **Diagnosis:** Epilepsy
- **Physicians Order:** "None transcribed"
- **Activity:** Gastrostomy Tube Feeding: Syringe Method
- **Event Results:** 300cc's of water via g-tube, tolerated well

SPEAKER NOTES:

- The IEP is an adequate start, but the diagnosis does not support the treatment service, and there is no physician's order.

UNACCEPTABLE NURSING TREATMENT LOG

DHCS School District
Specialized Procedure
Daily Log of Care

Your Information

Name: _____

Title: _____

Attention

Providers should maintain service records that fully disclose the type and extent of services provided.

Health Aides should only document time spent performing specialized procedures for which they have been trained and are supervised by a Licensed Physician, Registered Credentialed School Nurse, or Certified Public Health Nurse

Your Information	
Student Name: <u>Suzie Jane Example</u>	Date of Birth: <u>2/28/2000</u>
ICD-9 Code (diagnosis) : <u>V44.1</u>	Service Description : <u>G-Tube feeding. Feeding via G-Tube 2 times on that day</u>
Authorized in IEP/IFSP: <u>IEP</u>	

Log of Care

Service Dates: 7/1/11 thru 7/30/11

Enter the dates for each day. Enter the total minutes of the treatment session for each day.

Provider Code	Comments	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
		1	2	3	4	7	8	9	10	11	14	15	16	17	18	21	22	23	24	25	28	29	30	31		
29-Jan-00	Monitored student for 8 hours each day and 2 G-tube feedings per day		8		8	8	8	8	8	8	8	8	8	8	8	8	8		8	8		8				

Additional Provider Information

Printed Name	Practitioner Title	Practitioner Signature

Attention

Be sure to fill in the Additional Provider Information section if different providers have logged services.

Use the Comments field to note additional treatment services as needed. Note: The Vendor will process claims based on the primary diagnosis.

SPEAKER NOTES:

- This log does not show:
- Feeding times
 - Activities that were done between the feeding times to justify continuous monitoring, broken out in 15 minute increments
 - Diagnoses outlined in the IEP/IFSP matching the continuous billable service?

ITEMS MISSING FROM UNACCEPTABLE NURSING/THCA DOCUMENTATION

- The unacceptable continuous billing log and progress/case notes did not indicate:
 - What was observed
 - What was done
 - Was any action taken
 - Time(s) service was performed
 - The specific medical need for continuous monitoring

SPEAKER NOTES:

- The log does not even document the occurrence of the g tube feedings.

DOCUMENTATION FOR NURSING/THCA SERVICES MUST:

- Be objective:
 - What was done, seen, heard or felt
- Be factual, accurate and specific
 - Based on
 - IEP goals
 - Physicians orders
 - Nursing protocols
- Identify the presence as well as absence of characteristics
 - Every undesirable observation has at least one possible corresponding favorable observation

SPEAKER NOTES:

The presence as well as absence....what does one see that allows the conclusion that all is well, tolerated procedure well.

- Depending on the reason for observation - alert, responsive to verbal prompt, smiling, skin warm/pink, abdomen soft, breathing unlabored

QUESTION:

True or False?

Only THCAs are required to include progress/case notes and supporting documentation with a nursing log.

Answer:

False: Both nurses and THCAs must include progress/case notes and supporting documentation with a nursing treatment log.

PRESCRIPTION REQUIREMENTS FOR OCCUPATIONAL AND PHYSICAL THERAPY TREATMENT SERVICES

PRESCRIPTION REQUIREMENTS

- Occupational Therapy and Physical Therapy treatment services require a written prescription by a physician or podiatrist, within the practitioner's scope of practice (CCR, Title 22, Section 51309[a])
- The written prescription must be maintained in the student's files and documented in the student's IEP/IFSP

SPEAKER NOTES:

- The prescription is required for treatment services.
- Prescription must be current and annual update required.

[LEA Provider Manual References: \(loc ed serv occu\) and \(loc ed serv phy\)](#)

DOCUMENTATION REQUIREMENTS AND SAMPLES FOR OCCUPATIONAL THERAPY TREATMENT SERVICES

DOCUMENTATION REQUIREMENTS FOR OCCUPATIONAL THERAPY TREATMENT SERVICES

- All Occupational Therapy treatment service documents must include the information identified in the general documentation requirements section of this training
- &**
- A written prescription by a physician or podiatrist, authorizing treatment
 - Supporting documentation describing the nature and extent of Occupational Therapy treatment service

ACCEPTABLE DOCUMENTATION FOR OCCUPATIONAL THERAPY SERVICES

IEP Documentation

- **Goal:** Demonstrating improved visual motor skills, Student will print words with 80% accuracy 4 out of 5 trials with 2-3 verbal visual prompts.

Service Documentation

- **Session Activity:** Student worked on sensory motor, fine motor, visual motor, visual perceptual, and bilateral coordination skills with rolling over therapy ball, weight bearing on hands, picking up and placing shape card onto matching picture, clipping paper clips to edge of card and matching clip to color on card, and writing.
- **Session Results:** Student was able to weight bear on hands while over ball and maintain position on hands, collapsing to elbows one time, however, able to push back up to hands when prompted. He named shape with prompts for rectangle and matched card to appropriate picture. He demonstrated adequate bilateral coordination skills to hold card with one hand and hold clip with other hand. He required demonstration and minimal assist initially to clip paper clip to edge of card. By last few attempts, he was able to clip paper clip to card without assist. He held a pencil with a functional grasp and copied accurately with minimal prompts. He wrote with minimal to moderate prompts for letter size, space, and alignment. He required moderate prompts to stay focused on task as he was easily distracted.

SPEAKER NOTES:

- Assuming the documentation fulfills previously mentioned criteria, this example may be considered adequate.
- The activity, what is planned and actually done, relates to the goal.
- The student's response to the therapeutic activity is described and elements such as copied accurately, description of prompting relate to goal and what actions were taken to achieve.

UNACCEPTABLE DOCUMENTATION FOR OCCUPATIONAL THERAPY SERVICES

IEP Documentation

- **Goal**: To address visual motor and motor planning skills, Student will copy a 6 word sentence from a model with 90% accuracy 4/5 opportunities and no more than 2 verbal prompts.

Service Documentation

- **Session Activity**: Chart update for end of year
- **Session Results**: Chart update for end of year

SPEAKER NOTES:

- Activity and results do not describe the provision of the service listed in the goal.

DOCUMENTATION
REQUIREMENTS AND SAMPLES
FOR PHYSICAL THERAPY
TREATMENT SERVICES

DOCUMENTATION REQUIREMENTS FOR PHYSICAL THERAPY TREATMENT SERVICES

- All Physical Therapy treatment service documents must include the information identified in the general documentation requirements section of this training

&

- A written prescription by a physician or podiatrist, authorizing treatment
- Supporting documentation describing the nature and extent of Physical Therapy treatment service

ACCEPTABLE DOCUMENTATION FOR PHYSICAL THERAPY SERVICES

IEP Documentation

- **Goal:** To demonstrate improved single limb balance on each leg, student will ascend at least 8 steps with a reciprocal pattern without holding on to external support and with contact-guard assistance of adult for safety, in 3/5 trials

Service Documentation

- Session Activity - Student was seen for play-based strengthening of the trunk and LE muscles, gross motor skills training, stair training to improve functional mobility
- Session Results - Student participated fairly well. He focused mostly on climbing ladders on the playground apparatus and playing ball which included throwing, catching, and kicking. He incorporates jumping and single limb balance doing those activities. In stairs, he required one HHA going down with alternating feet without a handrail. Ascending stairs with alternating feet for about 5-6 steps. Continue with plan of care

SPEAKER NOTES:

Assuming all previous criteria are met, this is an example of what may be considered adequate documentation.

- The goal is clear.
- Activity as planned relates to the goal, and the results further describe what was done in the session.
- The note is specific to the particular day's session, and relates to measurable outcomes in goals by listing # of steps, amount of assistance/external support needed.

UNACCEPTABLE DOCUMENTATION FOR PHYSICAL THERAPY SERVICES

IEP Documentation

- **Goal**: To demonstrate improved balance and coordination student will walk ten feet heel to toe along a 4 inch wide line or beam without assistance 4/5 trials 80% of the time.

Service Documentation

- **Session Activity**: Gross motor
- **Session Results**: Student performed as in the previous session.

SPEAKER NOTES:

- This documentation of the activity gross motor is not specific.
- Taken together with the results, the nature and extent of service is not documented. The results may be the same as previous session, but this note doesn't stand alone. It doesn't give measurable observation, describe the current performance level, or include any information about the therapists actions or level of assistance.

PHYSICIAN-BASED STANDARDS FOR SPEECH AND AUDIOLOGY TREATMENT SERVICES

PHYSICIAN-BASED STANDARDS PROTOCOL

- LEAs may use an overall Physician-Based Standards Protocol for Speech Pathology and Audiology treatment services
 - Protocol **must be reviewed and approved** by a Physician **no less than once every two years**
 - Specific contents of a protocol may vary with each LEA

SPEAKER NOTES:

- Physician scope of practice should be appropriate for LEA.
- Specific contents vary...each variation must be separately approved.

COMPONENTS OF PHYSICIAN-BASED STANDARDS PROTOCOL

Basic components of a protocol typically include:

- **Eligibility and exit criteria**
- Indication of **medical necessity** and speech and language disorders are not due to unfamiliarity with the English language
- Developmental **norms** for speech and language development
- A statement that **assessment** and **treatment services** must be **documented** in writing
- **Acknowledgement that parents are provided information** through the IEP process to share with their primary care physician
- **A statement indicating that a physician** designated by the LEA is **available to audit records** for services billed to Medi-Cal where medical necessity is a requirement for reimbursement

SPEAKER NOTES:

Basic components of a protocol typically include:

- **Eligibility and exit criteria** set by the LEA for Speech and Language services for disorders of articulation, language, fluency (stuttering), and voice as referenced in the LEA's documents and publications
- Indication that **medical necessity** for these disorders is established through criteria that is reflective of the American Speech-Language Hearing Association (ASHA) publication *Preferred Practices for the Profession of Speech Language Pathology (1997)* and the CA Education Code, Section 56333
- Indication that speech and language disorders are not due to unfamiliarity with the English language
- **Developmental norms** for speech and language development
- A **statement** that assessment and treatment services **must be documented** in writing
- **Acknowledgement that parents are provided information** through the IEP process to share with their primary care physician
- A **statement indicating that a physician** designated by the LEA **is available to audit records** for services billed to Medi-Cal where medical necessity is a requirement for reimbursement

PHYSICIAN-BASED STANDARDS DOCUMENTATION REQUIREMENTS

- In each student's file:
 - A copy of the cover letter with the physician's contact information and signature that states the physician reviewed and approved the protocol standards
 - Proof that the services rendered are consistent with the protocol standards
- In the LEA's file:
 - A printed copy of the protocol standards
 - Contact information for individuals responsible for developing the protocol standards
 - Contact information for the practitioners who have reviewed and rely upon the protocol standards to document medical necessity

SPEAKER NOTES:

- Proof that services are consistent may include relevant excerpts from protocol, students evaluation matching eligibility criteria.
- It follows that goals and activities planned through IEP should be aligned with the eligibility and the exit criteria.

[LEA Provider Manual Reference \(loc ed serv hear\) and \(loc ed serv spe\)](#)

DOCUMENTATION REQUIREMENTS AND SAMPLES FOR SPEECH TREATMENT SERVICES

DOCUMENTATION REQUIREMENTS FOR SPEECH TREATMENT SERVICES

- All speech treatment service documents must include the information identified in the general documentation requirements section of this training

&

- Documentation authorizing treatment, including:
 - A written referral by a physician, dentist, or licensed speech-language pathologist

OR

- A referral by a licensed speech-language pathologist must include a physician-based standards protocol
- Supporting documentation describing the nature and extent of treatment

SPEAKER NOTES:

- This is similar to previous requirements with the addition of requirement for the written referral. This is a must.
- Provider manual states: The written referral must be maintained in the student's files. For students covered by an IEP or IFSP, the physician, dentist or licensed speech-language pathologist referral may be established and documented in the student's IEP or IFSP. If IEP is considered the referral it must be signed by the referring person.

ACCEPTABLE DOCUMENTATION FOR SPEECH SERVICES

IEP Documentation

- **Goal:** Student will reduce sound and syllable substitutions and omissions and maintain 80% accuracy in 4 word utterances during structured language activities in 4 of 5 opportunities.

Service Documentation

- **Session Activity:** Naming activity to facilitate progress toward articulation goals.
- **Session Results:** Final k sound- 60% accurate, mod-max cues.

SPEAKER NOTES:

- This documentation describes what was done, relates it to the goal and the results are recorded specifically and objectively. The note is quite brief, however, and it may serve well to document time spent.

UNACCEPTABLE DOCUMENTATION FOR SPEECH SERVICES

IEP Documentation

- **Goal**: Student will correctly answer simple wh- questions using 5-6 word utterances with 70% accuracy in 3/4 trials.

Service Documentation

- **Session Activity**: Review of IEP, PLPs, goals, assessments.
- **Session Results**: Review of IEP, PLPs, goals, assessments.

SPEAKER NOTES:

- This documentation lacks description of an activity that corresponds to the IEP goal, or a description of the student's performance and any actions on part of therapist.
- This does not describe speech therapy treatment service that is billable as an LEA Medi-Cal service.

DOCUMENTATION REQUIREMENTS AND SAMPLES FOR AUDIOLOGY SERVICES

DOCUMENTATION REQUIREMENTS FOR AUDIOLOGY TREATMENT SERVICES

- All audiology treatment service documents should include the information identified in the general documentation requirements section of this training
- &**
- Documentation authorizing treatment, which may include:
 - A written referral by a physician, dentist, or licensed speech-language pathologist
 - A referral by a licensed speech-language pathologist must include a physician-based standards
 - Supporting documentation describing the nature and extent of treatment

SPEAKER NOTES:

- As in speech therapy, the requirements include a written referral.

ACCEPTABLE DOCUMENTATION FOR AUDIOLOGY SERVICES

IEP Documentation

- **Goal:** Student will demonstrate proper use and care with the use of her hearing devices for both ears, with 80 % accuracy.

Service Documentation

- **Session Activity:** Equipment check/listening check demonstrate use of properly functioning amplification.
- **Session Results:** Using ci's on 2/2 trials, working fine per listening check, able to detect lings on 4/6 trials and needed visual cues for some ling discrim, able to discrim 3/6 lings without visuals. continue w/ goal.

SPEAKER NOTES:

- This is an example of what may be considered acceptable documentation, assuming all other criteria are satisfied.
 - Goal demonstrates the purpose of the activity.
 - Activity and session results together disclose the nature and extent of the service and the student's performance, practitioners intervention with cues. It relates back to the goal.
- Other information that might be relevant...listening situation. Is it quiet room, background noise? Ling sound check forms72

UNACCEPTABLE DOCUMENTATION FOR AUDIOLOGY SERVICES

IEP Documentation

- **Goal:** Continues to make correct and consistent use of well maintained and properly functioning hearing technology in 5 of 6 observations.

Service Documentation

- **Session Activity:** 5/9/12 Audiologist completed IEPs. Services provided on 5/16/12 discussed amplification the benefits and limitations.
- **Session Results:** Limited discussion amplification very inconsistent.

SPEAKER NOTES:

- Goal makes it look as if the goal has already been achieved.
- Date of service is confusing from session activity since two dates are listed.
- Service provided is unclear.
- If unable provide appropriate amplification, is equipment checked for malfunction? What steps are taken by provider?
- Extent and nature of service is inconsistent and lacking.

DOCUMENTATION
REQUIREMENTS AND SAMPLES
FOR
PSYCHOLOGY/COUNSELING
TREATMENT SERVICES

DOCUMENTATION REQUIREMENTS FOR PSYCHOLOGY/COUNSELING TREATMENT SERVICES

- All psychology/counseling treatment service documents should include the information identified in the general documentation requirements section of this training

&

- Supporting documentation describing the nature and extent of treatment

ACCEPTABLE DOCUMENTATION FOR PSYCHOLOGY/COUNSELING SERVICES

IEP Documentation

- **Goal:** The student will discuss thoughts, feelings, behaviors and external factors that contribute to elevated levels of anxiety and implement positive strategies to improve self-esteem and academic success with 80% accuracy, 5 out of 5 situations.

Service Documentation

- **Session Activity:** Working on identifying though patterns that increase anxiety such as focusing on seemingly negative aspects of life that cannot presently be changed.
- **Session Results:** With 80% accuracy, the student wrote down 6 pros and cons of living in a foster home to help him replace some persistent negative thoughts related to his living situation.

SPEAKER NOTES:

- This example may be considered adequate.
- The IEP goal contains quantitative measures, identifies the issue (elev level of anxiety) and relates to academic performance.
- Activity and results disclose the nature and extent of the service, specifically how the IEP goal was addressed with quantitative measures.

UNACCEPTABLE DOCUMENTATION FOR PSYCHOLOGY/COUNSELING SERVICES

IEP Documentation

- **Goal:** Instead of shutting down and screaming, the student will learn to request help and talk out loud his problem(s) when the tasks are too difficult for him with 70% consistency in 3 out of 5 trials.

Service Documentation

- **Session Activity:** Student was observed in his classroom.
- **Session Results:** The student did not scream in class.

SPEAKER NOTES:

- Taken together the activity and observation do not describe the outcome in terms of what was observed. (but what was not observed)
- The note doesn't say whether the goal was addressed because it doesn't describe tasks observed and whether they may be perceived as difficult by the student, so lack of screaming may not apply.
- There may not have been an activity related to the goal at all according to this documentation.

DOCUMENTATION REQUIREMENTS FOR TRANSPORTATION SERVICES

TRANSPORTATION

- In order to bill for medical transportation services through the LEA Medi-Cal Billing Option Program, the LEA **must**:
 - Provide transportation in a medical vehicle that contains lifts, ramps, and restraints
 - Document the need for health and transportation services in the students' IEP/IFSP
 - Provide a transportation trip log that includes the trip, mileage, origination point and destination point for each student, student's full name, and date transportation was provided
 - Review school attendance records to verify that the child was in school
 - Verify the student received an approved LEA school-based Medi-Cal service, other than transportation, on the date the transportation was provided

DOCUMENTATION REQUIREMENTS FOR TARGETED CASE MANAGEMENT SERVICES

TARGETED CASE MANAGEMENT (TCM)

- The LEA must create a care plan to document LEA TCM Services
- The care plan must reference the IEP/IFSP
- The IEP/IFSP must specifically identify the TCM services that are being provided to the student
 - Example: Instead of TCM services will be provided; use, practitioner/case manager will assist student and family with resources for tutoring services

SECTION 4: UPCOMING AREAS OF INTEREST

What is the LEA
Medi-Cal Billing
Option Program
working on?



UPCOMING AREAS OF INTEREST

- LEA Onboarding Handbook
 - Provide basic orientation, information, and resource for program requirements to new LEAs
- LEA Program Technical Assistance Visits
 - Assist LEAs in the proper administration of the LEA Medi-Cal Billing Option Program
- Specialized Transportation
 - Remove barriers and facilitate medical transportation claiming
- Speech Therapy delivered via Telehealth
 - Provide speech therapy services via electronic modality to remote sites
- RMTS within the LEA Med-Cal Billing Option Program
 - Determine time spent providing direct services
- Elimination of CPT Code 92506
 - Replace code 92506 with 4 new codes (92521, 92522, 92523, 92524)

SECTION 5: LEA MEDI-CAL BILLING OPTION PROGRAM RESOURCES

There are several resources available to obtain LEA Medi-Cal Billing Option Program information.



LEA MEDI-CAL BILLING OPTION PROGRAM RESOURCES

- LEA Medi-Cal Billing Option Program Website
 - <http://www.dhcs.ca.gov/provgovpart/pages/lea.aspx>
- LEA Medi-Cal Billing Option Program Website Subscription Notice
 - <http://apps.dhcs.ca.gov/listssubscribe/default.aspx?list=DHCSLEA>
- LEA Medi-Cal Billing Option Program Policy or General Questions
 - E-mail: LEA@dhcs.ca.gov

DOCUMENTATION QUICK CHECK

(Use the checklist below to ensure your files meet the documentation requirements)

Assessment: (Prescription, Referral, Recommendation)	<input type="checkbox"/>	Progress/Case Notes must include:	
Logs: (Contact logs, Nursing and health aide logs)	<input type="checkbox"/>	• Date of service	<input type="checkbox"/>
Verify:		• Student's Full Name	<input type="checkbox"/>
• The student has an IEP/IFSP that identifies medical services	<input type="checkbox"/>	• Student's Birth Date	<input type="checkbox"/>
• Authorization for treatment a by health service practitioner (Physician based protocol)	<input type="checkbox"/>	• Medi-Cal identification number	<input type="checkbox"/>
• The student received the billed service	<input type="checkbox"/>	• Place of Service	<input type="checkbox"/>
• The service was performed by qualified practitioner identified in the LEA Provider Manual	<input type="checkbox"/>	• Name and title and signature of practitioner rendering the service	<input type="checkbox"/>
• The service was a Medi-Cal benefit	<input type="checkbox"/>	• Name of agency rendering the service	<input type="checkbox"/>
Progress/Case notes reference and explain:		• Date of service	<input type="checkbox"/>
• IEP/IFSP goals or protocols	<input type="checkbox"/>		
• What was done and why?	<input type="checkbox"/>		
• How much? (Time, miles, feeding, medication)	<input type="checkbox"/>		
• What was response?	<input type="checkbox"/>		
• Was any additional action taken or planned?	<input type="checkbox"/>		

SPEAKER NOTES:

- We recommend using the Documentation Quick Check checklist to ensure your files meet the minimum documentation requirements.

Q & A



Thank you for your patience.

We will return shortly with answers to some of your documentation questions.