

**CHECKLIST FOR PREPARING THE COUNTY-BASED MEDI-CAL
ADMINISTRATIVE ACTIVITIES (CMAA) DETAIL INVOICE**

LGA: _____ Claiming Unit: _____ Invoice #: _____

It is the responsibility of the authorized LGA Coordinator to review all invoices for completeness and accuracy prior to submitting to the Department of Health Care Services (DHCS). Invoices submitted using an incorrect format will be returned without being reviewed. Each CMAA Detail Invoice must be submitted with a completed checklist verifying the following items have been reviewed by the LGA Coordinator before it will be processed for payment:

- _____ Approved Comprehensive Claiming Unit Grid and Claiming Unit Function Grid(s) on file; time survey frequency must match and ensure the "95 percent confidence level" requirement is met
- _____ Current invoice forms located on DHCS website (Revised 5/03/2018 DHCS/SNFD) being used and in the proper format
- _____ Correct authorized LGA Coordinator name on the invoice
- _____ Correct contract number consistent throughout CMAA Detail Invoice
- _____ Correct period-of-service consistent throughout CMAA Detail Invoice
- _____ Claiming Unit Name matches the Claiming Unit Function Grid
- _____ Invoice number matches period-of-service. (If the invoice is a Correction, add C-1, C-2, etc. If the invoice is a Revision, add R-1, R-2, etc. If unsure, call your program analyst for instruction.)
- _____ Methodology used to determine the Medi-Cal discount percentage consistent with the Claiming Unit Function Grid
- _____ Total reimbursement amount greater than zero with no "Error" and no comments on the claim
- _____ Variance Form – If the total invoice amount's variance exceeds 20%, must check a variance narrative option and fill out a "Detailed Explanation." If the Medi-Cal percentage variance exceeds 10%, must check a variance narrative option and fill out a "Detailed Explanation"
- _____ Required supporting documentation attached for processing: **Cost Pools 1, 2, 4, 5, and 6** an organization chart with a detailed list of all staff names, their classifications, and their **salaries** and **benefits** claimed
- _____ Date and sign (in blue ink): Summary Invoice, Time Survey Results, Funding/Revenue Sources Worksheet, Cost Worksheet, Direct Charge Costs Worksheet, Claim Calculation Worksheets 1 and 2, and the Variance Worksheets 1 and 2
- _____ Mail entire original claim to DHCS at:

Regular Mail:

Department of Health Care Services
County-Based Claiming & Inmate Services Section
County-Based Medi-Cal Administrative Activities Unit
Attn: (Program Analyst)
P.O. Box 997436, MS 4603
Sacramento, CA 95899-7436

Overnight Mail:

Department of Health Care Services
County-Based Claiming & Inmate Services Section
County-Based Medi-Cal Administrative Activities Unit
Attn: (Program Analyst)
1501 Capitol Avenue, Suite 71.3024 MS 4603
Sacramento, CA 95814

SIGN AND DATE TO CONFIRM ALL ABOVE ITEMS HAVE BEEN REVIEWED PRIOR TO SUBMISSION.

Print Name of Authorized LGA Coordinator	Signature of Authorized LGA Coordinator	Date
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**CHECKLIST FOR PREPARING THE COUNTY-BASED MEDICAL ADMINISTRATIVE
ACTIVITIES (CMAA) SUMMARY INVOICE**

LGA: _____ Claiming Unit: _____ Invoice #: _____

It is the responsibility of the authorized LGA Coordinator to review all invoices for completeness and accuracy prior to submitting to the Department of Health Care Services (DHCS). Invoices submitted using an incorrect format will be returned without being reviewed. Each CMAA Detail Invoice must be submitted with a completed checklist verifying the following items have been reviewed by the LGA Coordinator before it will be processed for payment:

_____ Cover letter, identifying any irregularities or variations in the CMAA Detail Invoice, is attached to the CMAA Summary Invoice

_____ CMAA Summary Invoice, correctly formatted on agency letterhead for the agency under contract with the DHCS. (Use only the form located on the CMAA website)

_____ Ensure certifications and CALSTARS CODE information are correctly printed on the form

_____ Correct authorized LGA Coordinator name on the invoice

_____ Check Program/Department and Claiming Unit names are the same throughout CMAA Detail Invoice and name matches the Claiming Unit Function Grid

_____ Correct contract number consistent throughout CMAA Detail Invoice

_____ Correct period-of-service consistent throughout CMAA Detail Invoice

_____ Invoice number consistent throughout CMAA Detail Invoice

_____ 50% amount on Claim Calculation worksheet (page 2) is the same as reimbursement on Summary Invoice

_____ 75% amount on Claim Calculation worksheet (page 2) is the same as reimbursement on Summary Invoice

_____ Total on the Amount of Federal Government Reimbursement on Summary Invoice is the same as Total Invoice Amount on Claim Calculation worksheet (page 2)

_____ Date and sign (in blue ink): CMAA Summary Invoice

SIGN AND DATE TO CONFIRM ALL ABOVE ITEMS HAVE BEEN REVIEWED PRIOR TO SUBMISSION.

Print Name of Authorized LGA Coordinator

Signature of Authorized LGA Coordinator

Date