STATE OF CALIFORNIA – Health and Human Services Agency

Drug Medi-Cal Organized Delivery System (DMC ODS)

SHORT DOYLE/MEDI-CAL MONTHLY CLAIM FOR REIMBURSEMENT OF QUALITY ASSURANCE - UTILAZATION REVIEW (QA/UR) COSTS Form MC XXXX (Revised xx/xx)	*(See instruction on reverse side*	Fiscal Year Claim For (Month)
Date:	County Code	County

Name:		Position #:	
Classification:		Form #	
*SPMP – Skilled Professional Medical Personnel		A SPMP*	B OTHER
1	Salary		
2	Benefits		
3	Training		
4	Travel		
5	General Expense	■	
6	Communication	■	
7	Facility Operation	■	
8	TOTAL (1 thru 7)		
9	Percent of Time Spent on QA/UR		
10	Percent of Time Spent on QA/UR for Medi-Cal		
11	Claimable Amount (8) x (9) x (10)		
12	FFP – 75% Amount (11A) x (0.75)		■
13	FFP – 50% Amount (11B) x (0.50)	■	
14	County Match to FFP (11A minus 12A) and (11B minus 13B)		
15	TOTAL AMOUNT CLAIMABLE (12A + 13B)		

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Medi-Cal services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Sections 1090-1099 of the Government Code; that the amount for which reimbursement is claimed herin is in accordance with Welfare and Institutions Code Section 14124.24; that the claim is based on actual, total-fund expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County further certifies under penalty of perjury that: all claims for services provided to county clients have been provided to the clients by the County or County-contracted provider; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete. The County understands that payment of these claims from federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursuant to the Code of Federal Regulations (CFR) Title 42, Section 433.32, the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS cost report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing services, on request, within the State of California to DHCS, the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, gender, or physical or mental disability.

Date: ____ Signature: ____________________________________
County Alcohol and Other Drug Programs Administrator

Executed at____, California

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts; that I am authorized to sign this certification on behalf of the County, and that the information is to be used for filing a claim with the federal government for federal funds pursuant to CFR Title 42, Section 430.30. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on actual, total-funds expenditures made by the County of public funds that meet the requirements for claiming federal financial participation (FFP) pursuant to all applicable requirements of state and federal law, including, but not limited to CFR Title 42, Section 430.30 and 433.51, and the Federal Office of Management and Budget Circular A-87, and that the expenditures claimed have not previously been, nor will they be claimed at any other time as claims to receive FFP funds under Medicaid or any other program. I understand that DHCS must deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all records of funds expended are subject to review and audit by DHCS and/or the federal government and that, pursuant to CFR Title 42 Section 433.32, all records necessary to fully disclose the extent of services furnished to clients must be kept for a minimum of three years after the final determination of costs is made through the DHCS cost report settlement process and retained beyond the three year period if audit findings have not been resolved.

Date: ____________________________________ Signature: ____________________________________

Title: ____________________________________ Executed at ____________________________________, California
County Auditor-Controller, City Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer

* Skilled Professional Medical Personnel

Instructions for Completing the Drug Medi-Cal Organized Delivery System (DMC ODS), Quality Assurance/Utilization Review (QA/UR) Claim Form (MC XXX)

When completing the form use the tab key to move to the next cell.

Enter the Fiscal Year, Claim-for-Quarter-Ended date (for example, September 30, December 31, March 31 and June 30), current date, and county name.

If you are using this form to bill for services performed by individual staff in place of allocating salaries and wages to programs based on a time study, complete the employee name, job classification, and position number boxes.

Under the federal Office of Management and Budgets Circular A-87, Attachment B, item 8(h), a payroll system tracking all work time is normally required when seeking federal reimbursement. However, a time survey provides a substitute system for allocating salaries and wages to programs in place of daily activity reports. f a county is using a time-survey process to allocate salaries and wages to programs, then the employee identification information is not required on the claim form. In the latter case, Department of Health Care Services' auditors may examine the county time-survey data and allocation process and procedures during DMC audits.

Lines 1-2, Columns A & B: In column A, enter the total quarterly salary and benefits received by the skilled professional medical personnel (SPMP) and their direct support staff who performed QA/UR activities. For example, if the employee's annual salary is $50,000, then the quarterly salary to be entered on line 1 would be $12,500 (equal to $50,000 divided by 4 quarters). In column B, enter the total quarterly salary and benefits received by staff other than SPMP who performed QA/UR activities.

Line 9: Enter the percentage of time staff that the county employee spent on all QA/UR activities (in decimal form) for all programs. For example, if the percentage is 50 percent, enter 0.5.

Line 10: Considering the percentage of time entered on line 9, enter the percentage of that time that the county employee spent only on DMC QA/UR activities (in decimal form). For example, if line 9 indicated that the employee spent 50 percent of his/her work time on all QA/UR activities, and of that 50 percent, the employee spent 25 percent on DMC QA/UR activities, then enter 0.25 on line 10. If the county performs QA/UR activities for DMC only, then enter 1.0 on line 10, meaning 100 percent.

Lines 8, 11, 12, 13, 14 and 15 are automatically calculated. The computed total FFP reimbursement amount is shown on line 15A.

Print the form and obtain the required signatures. Scan the completed form and send to the contact identified in the Information Notice.