THIRD PARTY BILLING: A MANUAL FOR CALIFORNIA'S SCHOOL HEALTH CENTERS

Developed by the California School Health Centers Association and L.A. Care Health Plan

March 2009

March 2009

Dear School Health Center Friends and Colleagues:

School health centers provide invaluable services to underserved populations. However, as we all know, financial sustainability continues to be a challenge. For this reason, the California School Health Centers Association has partnered with L.A. Care Health Plan to create this billing manual for California's school health centers. We hope this manual will help increase billing revenue and thereby strengthen your sustainability. We also hope the manual will help school districts and providers that are considering starting a school health center to understand potential sources of revenue for a new center.

This guide is designed to give you tips and best practices on how to develop/improve your billing practices, successfully submit billing claims, and maximize the amount of reimbursement that is available to you. The manual is organized around three general categories of billing: primary care services, reproductive health services, and services provided by school districts.

Given the differences in size, staffing, and scope of services offered at school health centers, we understand there is variation in the capacity of clinics to integrate into the health care delivery and billing systems. However we believe this integration is important to better position school health centers to receive increased reimbursement from health plans for essential services provided to their members. This is especially important in California's complex managed care system. L.A. Care has provided a detailed chapter on working with managed care organizations, including tips and best practices on contracting, billing procedures, and verifying patient insurance status. You will find some of the information in the managed care chapter is specific to working with L.A. Care however we believe this material can be applicable to working with other health plans as well.

Please share these materials with others you think may benefit from this type of resource. Feel free to contact the California School Health Centers Association at www.schoolhealthcenters.org, (510) 268-1260 or L.A. Care Health Plan at www.lacare.org, (213) 694-1250 extension 4379 with any questions.

Sincerely,

Serena Clayton, PhD
Executive Director
California School Health Centers Association

Elaine Batchlor, MD, MPH
Chief Medical Officer
L.A. Care Health Plan

Acknowledgements

The California School Health Centers Association would like to thank L.A. Care Health Plan for generously printing this manual.

The California School Health Centers Association and L.A. Care Health Plan would like to thank the following individuals who provided their valuable time and expertise to review this manual:

Carol Brown, P.H.N.
Deputy Director
City of Berkeley, CHDP Program

Linda Calmes, RN, BSN, PHN, MS-HAS
Nurse Consultant III
Maternal Child & Adolescent Health/OFP Branch
CA Department of Health Services

Elena Chavez
Policy Analyst, West Coast Office
Consumers Union

Patricia De Voe
Pediatric Nurse Practitioner
Los Angeles Unified School District – CHDP Program

Sandra N. Jones, Ph.D.
Director, Student Health Services - Jordan High School
Watts Healthcare Corporation

Leslie Louie, Ph.D.
Program Administrator, RAMP
Public Health Institute

Tracy Macdonald, MPP, MPH
Director of Adolescent Health Services
La Clinica de la Raza

Jan Marquard
Director of School Health Services
Northeast Valley Health Corporation

Rene Mollow, MSN, RN
Associate Director
CA Department of Health Services

Deanna Niebuhr, MPP
Director of Health Programs
Bay Area Partnership for Children and Youth

Maggie Petersen
CHDP Project Coordinator
CA Department of Health Services

Vergia Slade, MHA
Senior Public Health Programs Administrator
Health Net

Mari Taylan, MPH
Health Program Specialist
Maternal Child & Adolescent Health/OFP Branch
CA Department of Health Services

Elizabeth Touey
Chief
Administrative Claiming, Local and Schools Services Branch
CA Department of Health Services

Table of Contents

Introduction

Chapter 1	Third-Party Billing for Medical Services: Why is it Important?	7
Chapter 2	Assessing your Billing Potential: Should Billing be a Priority for your Health Center?	8
Chapter 3	Billing-at-a-Glance: What are the Options for School Health Centers?	9

Primary Care Services Billing

Chapter 4	Child Health and Disability Prevention (CHDP)	12
Chapter 5	Medi-Cal (Full Scope)	17
Chapter 6	Healthy Families	21
Chapter 7	Billing within the Managed Care System	25

Reproductive Health Services Billing

Chapter 8	Family PACT	37
Chapter 9	Medi-Cal Minor Consent	41

School District/ Local Educational Agency (LEA) Billing

Chapter 10	LEA Medi-Cal Billing Option Program	45
Chapter 11	Medi-Cal Administrative Activities Program (MAA)	49

Other Sources of Third Party Revenue

Chapter 12	Other Sources of Third Party Revenue	53

Appendices

Appendix 1	Sample Consent Forms	55
Appendix 2	Sample PM 160 INF Form	58
Appendix 3	Sample CMS 1500 Form	60
Appendix 4	L.A. Care Patient Service Delivery Flowchart	61
Appendix 5	Sample PM 161 Form	62
Appendix 6	A Guide to Acronyms	64

Chapter 1 - Third-Party Billing for Medical Services: Why Is It Important?

School health centers have grown across California, from a handful in the late-1980s to approximately 154 today. Despite this growth, sustainable funding remains a challenge. School health centers currently expend considerable effort to obtain a patchwork of funding from local, state and federal sources, in-kind support from schools and other sponsors, private donations and insurance payments. Until recently, school health centers relied heavily on local, state and federal grants and private funding from foundations and hospitals. However, uncertainty of these sources combined with a move toward market-driven health care financing has increasingly led school health centers to rely on reimbursements from third-party payers. Although there are a handful of California school health centers that are able to fund themselves almost entirely through third-party billing, there is a wide range in the amount of revenue centers generate from billing. For example, 2004 data collected by the California School Health Centers Association (CSHC) found that among six school health centers run by Federally Qualified Health Centers, the percentage of services reimbursed by third-party sources varied from 25% to 80%. Reasons for these disparities include:

- Type and volume of services provided
- Number of patients served
- Characteristics of the patients served (e.g., age, insurance status)
- Geographic location and availability of other providers
- Type of Medi-Cal managed care system in the county
- Type of organization running the health center
- Capacity and infrastructure for billing
- Billing policies and procedures

Although there are limitations to the amount of revenue some school health centers can generate through billing, most centers have the potential to increase their third-party billing revenue. This manual provides information about third-party billing options currently available to school health centers including detailed program information on client eligibility, application procedures, reimbursable services, program administration, and billing tips.

Chapter 2 - Assessing Your Billing Potential: Should Billing Be A Priority For Your Health Center?

Third-party billing can be a major revenue source for many school health centers. However, in order to be efficient and effective, several important conditions must exist. Before investing time and resources in developing billing systems, there are several factors to consider:

Patient population

- What is the age range of the patient population?
- What is the income level of the students served?
- What percentage of the service population is undocumented and therefore not eligible for some sources of third-party billing?
- What percentage of the patient population are members of managed care plans with which you do not have contracts so you cannot bill?

Services provided

- What types of services does your school health center provide?
- How well do these services match up with the services covered by the various billing options? (see Billing-At-A-Glance)

Fiscal sponsor

- Who is the fiscal sponsor and what is their billing capability (e.g., are they a FQHC that can bill at a higher reimbursement rate?)
- How is the working relationship between the school health center and the fiscal sponsor?

Clinic infrastructure

- What is the relationship with the service providers? Are key staff members committed to billing?
- Does the school health center have the staff capacity and expertise necessary to bill effectively?
- Does the school health center have the management information systems in place that are necessary to bill effectively?
- Can billing staff attend appropriate billing training?

Other sources of funding

- What other sources of funding support the school health center?
- What percentage of the clinic's budget is supported by these revenue sources?
- How sustainable are these revenue sources?

Chapter 3 – Billing At-A-Glance: What Are The Options For School Health Centers?
Third-Party Revenue Sources for School Health Centers

Funding Source	What services are covered?	Who can provide the service?	Who can the service be provided to?	What is the billing mechanism?	How well does this work for school health centers?
CHDP	Preventive care including: • health/ developmental history • physical health assessments, • immunizations, nutritional assessments oral health assessments behavioral assessments vision/ hearing screening lab tests for anemia, TB, glucose, lead, urine, STIs, etc. • health ed and anticipatory guidance	Any Medi-Cal provider who has also been enrolled as a CHDP provider	Children up to age 19 or 21 (depending on income) including the uninsured	Billing submitted to state. Single billing form.	The billing process is simple, particularly with the introduction of the Gateway system.
Full-Scope Medi-Cal	Comprehensive	Any Medi-Cal provider or a Medi-Cal Managed Health Plan if enrolled	People enrolled in the Medi-Cal program; U.S. citizenship or legal residency required (which includes asylum)	Billing submitted to State (for fee-for-service) or to a health plan	In counties with Medi-Cal managed care, school health centers must negotiate contracts with each health plan. Unless the school health center is a federally qualified health center (FQHC), reimbursement rates do not cover the true costs of providing care.

Funding Source	What services are covered?	Who can provide the service?	Who can the service be provided to?	What is the billing mechanism?	How well does this work for school health centers?
Healthy Families	Comprehensive	Any Medi-Cal provider	Uninsured children up to age 19 of low and moderate income families; U.S. citizenship or legal residency required.	Billing submitted to health plan.	Same as above
Family PACT	Reproductive health services: education, counseling, contraception, treatment of STIs, screening mammograms for women 40-55 years old.	Any Medi-Cal provider in good standing enrolled in the Family PACT program.	Any income-eligible female under 55 or male under 60 (almost all youth are eligible as they are considered a family of one); California residency (*No documentation required*).	Billing submitted to State (via EDS).	Billing is easy to do and onsite enrollment makes it easy for school health centers to participate in the Family PACT program. However, reimbursement is typically well below the actual cost of providing the service.
Medi-Cal Minor Consent	The program includes services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.	Any Medi-Cal provider	Youth up to age 21 who are living with their parents or guardians. No income or proof of residency requirements.	Billing submitted to State	This is an excellent source of revenue for FQHCs that have the capacity to bill because they receive cost-based reimbursement rates. However, setting up billing systems and renewing eligibility every month can be barriers to billing.

Funding Source	What services are covered?	Who can provide the service?	Who can the service be provided to?	What is the billing mechanism?	How well does this work for school health centers?
School-Based Medicaid Administrative Activities (MAA)	Outreach for Medi-Cal enrollment; referrals to Medi-Cal services; translation; arranging transportation; and MAA program planning	Person funded by state or local government funds through relationship with county or Local Educational Agency (LEA).	Public school system students who may be eligible for Medi-Cal.	One-week time study completed each quarter; a contract/operational plan with a Local Educational Consortium (LEC) or Local Governmental Agency (LGA); and quarterly invoices with detailed cost and funding data.	Expenditures must be made by an LEA or local government agency (LGA—county or city government) using non-federal funds or State funds that have not already been matched with federal funds at the State level (i.e., block grants). Some school health centers could probably do more MAA claiming but there is little incentive unless they have an agreement that the unrestricted funds will come back to the health center.
Local Educational Agency (LEA) Medi-Cal	Medical assessments and evaluation and selected medical services, including vision, hearing, psycho-social, nutrition and anticipatory guidance (education).	Person who is certified or licensed to provide the specific service and is paid by the school district either as an employee or under contract.	Students enrolled in Medi-Cal whose Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) require the specific service; or, to any Medi-Cal enrolled student as long as the service provided has not been provided for free to other students. (See the LEA Provider Manual, pages "loc ed bil 2 and 3." http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/locedbil_o09.doc	Billing submitted by LEA biller (or the school district) to the state.	An important revenue source when school health center staff are school district employees or are paid by district funds under contract. However, in many cases, school health center staff and funding comes from outside the school, so this program cannot be used (unless they subcontract with the LEA). As of 2005, excludes state mandated assessments (same screening can be billed if requested by teacher on an individual IEP or IFSP child, but cannot be billed if part of mandatory screening of all kids)

#

Chapter 4 - Child Health and Disability Prevention (CHDP)

What is CHDP?

The Child Health and Disability Prevention (CHDP) program is a health promotion and disease prevention program through which eligible children and youth receive preventive health assessments and can be referred for diagnosis and treatment. The program aims to serve children and youth in California who have unmet health needs that could be prevented or corrected by early detection and prompt medical diagnosis and treatment. Specifically, the CHDP program provides:

- Regular preventive health assessments for infants, children, and adolescents
- Coordination of follow-up care and referral of children with suspected health problems for necessary diagnosis and treatment
- Assistance to children in order to find medical and dental homes for their health care
- Linkages to needed resources and specialty care providers

The CHDP program is responsible for meeting the federally mandated Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements and developing California's standards and guidelines for the provision of quality preventive health services to eligible children. To ensure that eligible children receive quality health services, CHDP program staff, including physicians, public health nurses, dentists, nutritionists and health educators, partner with mental health programs, schools and social service agencies.

Who is eligible for the program?

1) Children from birth to age of 21 who are enrolled in Medi-Cal are eligible for CHDP services. CHDP well-child exams can be provided to Medi-Cal recipients following the federally-mandated EPSDT Program schedule (http://www.dhcs.ca.gov/services/chdp/Pages/Qualify.aspx)

2) CHDP covers periodic preventive health services and health assessments to non-Medi-Cal eligible children and youth from birth to age 19 whose family's self-reported income is equal to or less than 200 percent of the federal income guidelines regardless of immigration status.

Who administers the program?

The CHDP program is administered by the State Children's Medical Services Branch (CMS), located within the California Department of Health Care Services, and local CHDP programs, found in every local health department. The local programs are responsible for the day-to-day administration of the program, which includes provider recruitment and oversight, outreach to families with eligible children, community education, care coordination, and implementation of state and federal regulations.[1]

[1] http://www.dhcs.ca.gov/services/chdp/Pages/ProgramOverview.aspx

What is the cost to the client?

CHDP health services and assessments are free.

What services are reimbursable?

CHDP covers a full range of health assessment services including:

- Health and developmental history
- Complete physical examinations
- Immunizations
- Oral health assessments
- Nutritional assessments
- Behavioral assessments
- Vision and hearing testing
- Laboratory tests for anemia, blood lead, tuberculosis, urine abnormalities, sexually transmitted diseases, and other health problems
- Health education and anticipatory guidance

CHDP also provides health exams for medically necessary interperiodic assessments including:

- Children starting kindergarten or first grade who need a health exam to enroll in school
- Children who need sports physicals
- Foster children
- Children with a history of perinatal problems
- Children with significant developmental disabilities

CHDP is not funded to provide treatment for the conditions identified in the assessment but it can provide coordination of care to assist families with appointment scheduling, transportation, and access to diagnostic and treatment services. CHDP providers may contact the local CHDP office to request these services for their CHDP clients. Referrals will depend on the type of health coverage the student has.

What are the reimbursement rates?

Reimbursement rates are determined by the type of CHDP clinic providing services. Some clinics are comprehensive care providers (with 24 hour coverage) while others are considered health assessment only providers. Physical exams reimbursement rates range from $33 to $62 (2006) depending on the age of the child and whether the visit is new/extended or routine.

How is the program funded?

CHDP is a combination of state and federal funds.

How do clients apply for the program?

A simple pre-enrollment application is completed by a parent if the child is not already a Medi-Cal fee-for-service beneficiary. The one-page pre-enrollment application can be found on the DHCS website at:
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4073.pdf

The CHDP Program is a "Gateway" for uninsured children to pre-enroll into the Medi-Cal or Healthy Families program. The CHDP provider can use either the Internet (Medi-Cal website) or a Point of Service (POS) device to determine eligibility for CHDP health assessments and pre-enroll children into temporary Medi-Cal, if the child is not already enrolled in Medi-Cal or Healthy Families. Once the CHDP provider enters the child's information into the computer and verifies eligibility, the child is immediately eligible for temporary full-scope, comprehensive health care coverage and may *immediately* receive health services and any needed follow-up using an eligibility document produced at the time of enrollment. The temporary coverage for qualifying children is available for the calendar month in which the CHDP application was filed and the following month, pending a completed application to Medi-Cal or Healthy Families if families want ongoing coverage for their children.

For more information about CHDP Gateway, visit or call your local CHDP program office. A list of local program offices can be found on the DHCS website at:
http://www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx

What are the provider requirements?

Health assessments can be provided by private physicians, nurse practitioners, county local health departments, community clinics, managed care plan providers, and some local school districts with school health centers. CHDP has approximately 4,700 provider sites statewide. School health centers that meet the following qualifications are eligible to participate as a CHDP provider:

- Possess an active Medi-Cal provider number
- Enrolled in the local CHDP program
- Meet the licensure requirements
- Employ clinicians that meet the conditions of participation for CHDP providers.

Requirements for participation as a CHDP provider are found in the CHDP Provider Manual.
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/chdp/manual/provenroll_c00.doc

How do providers apply to participate in the program?

Providers must apply to their local CHDP program. A list of local program offices can be found on the DHCS website at: http://www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx

If a provider is already a Medi-Cal provider, the application process takes approximately five weeks. If the provider is not an authorized Medi-Cal provider, the CHDP application process can take up to six months.

The following application forms and/or procedures must be completed by those organizations that wish to participate as a CHDP Health Assessment provider:

- Application (DHS 4490)
- Facility review by the local CHDP (DHS 4493)
- Medical review (DHS 4492)

The two-page provider **application** form, *CHDP Health Assessment Provider Application* (DHS 4490), and instructions can be downloaded from the DHCS website at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4490.pdf

A **medical record review** (DHS 4492) is performed to ensure that the following conditions are met:

- *Format*: Organized medical record keeping system that permits effective and confidential client care and quality review;
- *Documentation*: Well-documented medical records facilitate communication, coordination, and promote the efficiency and effectiveness of treatment; and
- *Coordination and Continuity of Care:* Medical record includes the client's medical history, health status, medical treatment, reports from specialty providers and future health care needs and treatment plans.

DHCS Form 4492 includes the medical record review tool and instructions and can be downloaded from the DHCS website at:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CHDPForms.aspx

The **facility review** (DHS 4493) is conducted to ensure the following site access and safety conditions are met:

- Appropriate emergency medical equipment and supplies;
- Personnel qualifications;
- Licensure and/or certification;
- Site management;
- Clinical Laboratory Improvement Amendment (CLIA) compliance;
- Appropriate examination equipment; and
- Immunizations (and proper immunization storage)

DHS Form 4493 which includes the facility review tool and instructions can be found at:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CHDPForms.aspx

Other information

Other CHDP brochures and flyers can be downloaded from the DHCS website at: http://www.dhcs.ca.gov/formsandpubs/publications/Pages/default.aspx

How well does CHDP work for school health centers?

The simple enrollment process allows for easy billing for preventive health services that follow the periodicity schedule. For school health centers with the capacity to bill Medi-Cal and Healthy Families, the Gateway enrollment process makes it easy to enroll and bill for comprehensive services for qualified children who are not already Medi-Cal fee-for-service beneficiaries, as well as children and adolescents who are already Medi-Cal beneficiaries.

However it is important to note that CHDP is a preventive health program; therefore care for illness is not reimbursable and must be billed through the Medi-Cal program.

School health centers have found the following practices useful for maximizing revenue through CHDP:

- If pre-enrollment in Medi-Cal at the time of a CHDP health assessment takes place at the *beginning* of the month then the child has two full months of eligibility.
- Pre-enrollment in Medi-Cal using the Gateway process requires a parent/guardian signature, which can sometimes be hard to obtain from teenage students. Including a CHDP pre-enrollment application with a student registration packet for school enrollment and partnering with coaches to send home CHDP pre-enrollment forms for sports physicals are two strategies that can be useful. Please note that health centers must still be certain that parents/guardians understand the nature of the papers they are signing and that they are certifying their income. The signature is only good for the date of the CHDP health assessment, which should be clearly marked prior to obtaining the signatures.

Additional Information

http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx

Chapter 5 - Medi-Cal (Full Scope)

What is Full Scope Medi-Cal?

Medi-Cal is the main source of health insurance for low-income and disabled people in California and provides coverage to more than 6 million Californians, including one of every four California children. Full-scope Medi-Cal provides comprehensive health, dental and vision services to children, pregnant women, parents, elderly and blind individuals and people with disabilities who receive public assistance or meet income and other eligibility criteria.

Who is eligible for the program?

Age	Family Income
Birth to 1 year (and pregnant women)	At or below 200% of Federal Poverty Level
1 to 6 years	At or below 133% of Federal Poverty Level
6 to 19 years	At or below 100% of Federal Poverty Level
19 to 21 years	At or below the State Maintenance Need Level, which is currently 69% of Federal Poverty Level

For current federal poverty level (FPL) guidelines, go to: http://aspe.hhs.gov/poverty/09poverty.shtml. Families must also meet other eligibility requirements (e.g., value of other assets if family income is over the FPL guidelines for the age of the child, California residency, and qualified immigration status). In 2005, President Bush signed into law the Deficit Reduction Act, which made certain changes to Medicaid (called Medi-Cal in California). One of those changes was the requirement for individuals declaring to be U.S. citizens to show documentary evidence of this fact as well as proof of identity. For information about the state and federal law regarding this requirement and the implementation of this requirement in California, go to: http://www.dhcs.ca.gov/services/medi-cal/Pages/DRA.aspx

What is the cost to the client?

There are no monthly premiums or co-payments for children under the age of 18 who qualify for full-scope Medi-Cal. There may, however, be a share of cost if the family's income is above the FPL allowance for the given age of the child.

What services are reimbursable?

Medi-Cal covers a full range of services including:

- Preventive medical services
- Immunizations
- Inpatient and outpatient services
- Hospitalization
- Laboratory and x-ray services
- Well-child exams
- Prescription drugs
- Maternity services
- Dental benefits
- Vision benefits
- Mental health services

What are the reimbursement rates?

Rates vary depending on whether the health center billing is a Federally Qualified Health Center (FQHC) and the types of service provided.

How is the program funded?

Approximately 55% of the Medi-Cal budget is funded by the Federal Government, 38% by the State General Fund, and the remaining 7% comes from other state and local funding sources. The state receives 50% federal financial participation (FFP) for most Medi-Cal programs. There are some programs, such as family planning services, Breast and Cervical Cancer Treatment Program and the enhanced children's FPL programs, that receive greater FFP.

Who administers the program?

The California Department of Health Care Services (DHCS) administers the Medi-Cal program, and determines program eligibility, benefits, provider payment and beneficiary cost-sharing levels. However, DHCS must work closely with the federal government (Centers for Medicare and Medicaid Services or CMS), which provides regulatory oversight including reviewing, amending and approving waivers to program rules and monitoring service delivery, quality, funding, and eligibility. Each of California's 58 counties also plays a key role in implementing the Medi-Cal program. Counties are responsible for interpreting state guidance on policies and procedures; conducting eligibility determination, enrollment and recertification; and developing and administering their own trainings, policies and procedure manuals. All counties must apply the same eligibility rules to individuals applying for Medi-Cal. Counties may have different procedures in place to administer their program. Health plans contract with DHCS to provide services to Medi-Cal beneficiaries. Some counties operate a single health system for their Medi-Cal population. For a list of the Medi-Cal managed care organizations in your area, go to: http://www.dhcs.ca.gov/individuals/Pages/MMCDConsumerGuide.aspx

---

[2] http://www.chcf.org/documents/policy/MediCalFactsAndFigures2006.pdf (page 5)

[3] http://www.chcf.org/documents/policy/MediCalFactsAndFigures2006.pdf (page 4)

How do clients apply for the program?

There are several ways to apply for Medi-Cal:

1. For the joint Medi-Cal and Healthy Families Program application, apply over the phone by calling 1-800-880-5305. A customer service representative can assist in filling out the form over the phone and then mail the finished application form to the client for a final signature. Interpretation services are available.

2. Get assistance in person from the local county social services office or at hospitals and clinics where county eligibility workers are located.

3. Get assistance from a Certified Application Assistant (CAA) who is often available at community organizations such as community health clinics. CAAs can now submit applications on Health-e-App, an internet-based application system that simplifies and reduces the application processing time.

A parent signature is required and families are generally notified within 45 days of the receipt of the application.

What are the provider requirements?

Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Application criteria include having an established place of business and proof of liability insurance coverage and professional liability insurance coverage. For more information, visit http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp. Note that the minimum criteria to be a *primary care provider* are more extensive, and most school health centers do not meet these requirements, though the "parent" health center likely does, as in the case of a community health center or private provider's office.

How do providers apply to participate in the program?

Interested providers must complete an application packet specific to their provider type. Provider application packages are available from the Provider Enrollment page of the Medi-Cal website: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp.

How well does Full Scope Medi-Cal work for school health centers?

In counties with fee-for-service Medi-Cal, school health centers bill the state directly. However, many counties have some form of Medi-Cal managed care. This means that school health centers cannot bill the state directly, but rather must negotiate a contract with one or more health plans in order to bill for the services they provide. Health plans serving the Medi-Cal population vary in every county, and some have been interested in working with school health centers. Note that federally qualified health centers (FQHCs) enjoy a higher reimbursement rate that

---

[4] http://www.chcf.org/documents/policy/MediCalFactsAndFigures2006.pdf (page 17)

more closely matches the cost of providing care. Please see Chapter 7 for more information on working effectively with health plans and billing within the managed care system.

The Medi-Cal website lists several billing tips: http://files.medi-cal.ca.gov/pubsdoco/billing_tips.asp

Additional Information

www.medi-cal.ca.gov

Chapter 6 - Healthy Families

What is Healthy Families?

Healthy Families is California's State Children's Health Insurance Program (SCHIP) and provides health insurance coverage for uninsured children and teens in low- and moderate income families who are not eligible for no-cost Medi-Cal. The program provides comprehensive health, dental and vision services.

Who is eligible for the program?

- Age - Infants, children and teens up to age 19
- Income - Family incomes must be between 100% and 250% of the Federal Poverty Level
- Lack of Insurance Coverage - Must be uninsured, not eligible for no-cost Medi-Cal and not covered by employer sponsored health insurance within the past 3 months (with some exceptions).
- Residency - Must be California residents and U.S. citizens, U.S. nationals or qualified immigrants.

Age	Family Income
Birth to 1 year	200% - 250% of Federal Poverty Level
1 to 6 years	133% - 250% of Federal Poverty Level
6 to 19 years	100% - 250% of Federal Poverty Level

For the latest federal poverty level guidelines, go to http://aspe.hhs.gov/poverty/09poverty.shtml

What is the cost to the client?

The cost to the client varies depending on the number of children enrolled and the income of the family. In 2007, families pay premiums of $4 - $15 per child per month to participate (maximum of $45 per family). Monthly premiums are determined by family income, family size, and insurance plan combination (health, dental, vision), however a family will never pay more than $45 per month regardless of how many children they enroll in the program.

What services are reimbursable?

Healthy Families covers a full range of services including:

- Preventive medical services
- Immunizations
- Inpatient and outpatient services

- Hospitalization
- Laboratory and x-ray services
- Well-child exams
- Prescription drugs
- Maternity services
- Dental benefits
- Vision benefits
- Mental health services

What are the reimbursement rates?

Reimbursement rates differ from county to county depending on the contracts signed by individual managed care plans.

How is the program funded?

Healthy Families is jointly funded by the federal and state governments through the federal State Children's Health Insurance Program (SCHIP). Approximately two-thirds of the program costs are federal dollars and one third are state.

Who administers the program?

The Managed Risk Medical Insurance Board (MRMIB) administers the Healthy Families program.

How do clients apply for the program?

There are several ways to apply for Healthy Families:

1. Fill out an application online at http://www.healthyfamilies.ca.gov/English/appldownload.html

2. Apply over the phone by calling 1-800-880-5305. A customer service representative can assist in filling out the form over the phone and then mail the finished application form to the client for a final signature. Interpretation services are available. Information about which documents are needed for reference can be found online at http://www.healthyfamilies.ca.gov/English/joining.html

3. Get assistance in person from the local county social services office or from a Certified Application Assistant who is often available at community organizations such as community health clinics. CAAs can now submit applications on Health-e-App, an internet-based application system that simplifies and reduces the application processing time.

A parent signature is required for the application and eligibility is determined within 10 days. Coverage begins 10 days from the date Healthy Families determined that a child qualifies for the program.

What are the provider requirements?

Providers must first determine what health plans are under contract to provide Healthy Families services in their county (http://www.healthyfamilies.ca.gov/English/choosing.html).

Specific application information and provider requirements can be obtained from the health plan's provider relations unit.

The Healthy Families program is run entirely through managed care. Each county contracts with health plans to provide Healthy Families services. This means that school health centers cannot bill the state directly, but rather must for negotiate a contract with one or more health plans in order to bill for the services they provide. Health plans serving the Healthy Families population vary in every county, and some have been more interested than others in working with school health centers. Please see Chapter 7 for more information on working effectively with health plans and billing within the managed care system.

How well does Healthy Families work for school health centers?

Since the Healthy Families program is run through managed care, school health centers must negotiate contracts with each health plan to be able to bill for Healthy Families. If the school health center already has contract/s with local managed care health plans, then it would be minimally burdensome to also bill those plans for students with Healthy Families. Additionally, there are not many students enrolled in Healthy Families. Note that federally qualified health centers (FQHCs) enjoy a higher reimbursement rate that more closely matches the cost of providing care.

Additional Information

http://www.healthyfamilies.ca.gov/hfhome.asp

CHAPTER 7:
Billing Within the Managed Care System

Information in this chapter has been provided by L.A. Care Health Plan

L.A. Care Health Plan
555 W. Fifth Street
Los Angeles, CA 90013-3036
Toll Free: 1-888-4LA-CARE

www.lacare.org

Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

For a Healthy Life

Chapter 7 - Billing Within the Managed Care System

In this chapter, we discuss ways to help school health centers work more effectively with managed care organizations. The chapter is designed to provide information on how to submit claims and maximize the amount of reimbursement that is available to school health centers for seeing patients with health insurance. Some of the tips and best practices are a result of a reimbursement pilot project L.A. Care Health Plan conducted in 2005 to gain information on how school health centers can better work with managed care organizations. L.A. Care is the Local Initiative Medi-Cal managed care organization for Los Angeles County and serves residents through a variety of programs including Medi-Cal, Healthy Families, Healthy Kids, and Medicare.

We recognize that every health plan has its own criteria on covered services and how to submit claims and every school health center differs in its scope of services, size, and staffing. Given these differences, the information contained in this chapter should be used if it adds value to your processes and customized as you see fit.

Below is a link to help you identify Medi-Cal managed care organizations in California (by county): http://www.dhcs.ca.gov/individuals/Pages/MMCDConsumerGuide.aspx

Contracting with Managed Care Organizations

In order for school health centers to work with managed care organizations, a partnership must be developed and defined, usually in the form of a signed memorandum of understanding (MOU) or a contract/agreement. The purpose of the agreement is to frame the clinical, administrative, and financial relationship between the managed care organization, the student's primary care physician (PCP), the school health center, and its sponsoring agency (i.e., school district, community clinic, hospital).

The state of California requires that Medi-Cal managed care organizations execute MOUs or agreements with school health centers to support the provision of school-based CHDP services. This includes direct reimbursement or indirect support to assure access to CHDP services for members at school health centers. These MOUs or agreements should include guidelines specifying coordination of services, reporting requirements, and quality standards. School health centers will only be reimbursed for services delivered to managed care members defined in the agreement.

We recommend that school health centers utilize the templates for MOUs or agreements the managed care organization has developed. It has most likely been approved in the past and is a good starting point. The managed care organization should be able to accommodate the need for flexibility at the school health center and will consider incorporating alternative or

L.A. Care Best Practice
Legal Resources

Take advantage of the existing legal resources and contract templates that managed care organizations have. They have experience in successfully executing these types of agreements with providers.

[5] www.healthinschools.org

additional language into the agreement. Each managed care organization will want to include specific language that is required for their business practices and to meet regulatory requirements however, much of the language in the template should be basic and included in every school health center/managed care organization agreement.

Contract negotiation can be costly and time consuming so once a MOU or agreement with a managed care organization has been approved, school health centers should continue to use the template and only propose to amend the scope of services when necessary. Contract standardization will eventually become a component of maintaining quality of health care services delivered to managed care members seen at school health centers.

Sections in the agreement school health centers should pay attention to include:

- Covered services
- Services that require prior authorization
- Reimbursement structure (billing and payment mechanism)
- Maintenance of confidentiality for services for which adolescents can give their own consent
- Coordination of care with the student's primary care provider
- Communication, data exchange, and medical record policies

L.A. Care Contracting Tips

Talk to your Liaison - When contracting with L.A. Care, you will be assigned to a liaison in our Provider Network Operations Department. This liaison will be your single point of accountability for monitoring the contracting process and will be able to answer any questions you have. The liaison will also be able to put your clinic or your clinic's legal representative in contact with L.A. Care's Legal Department as needed.

Members Can't be Billed - Your contract contains a provision that states that even if L.A. Care fails to pay you for some reason, school health centers cannot bill L.A. Care members for services provided or sue members to collect money owed to you by L.A. Care. This is the law for both Medi-Cal managed care members and members of other L.A. Care health coverage programs such as Healthy Families or Healthy Kids.

Keep Those Records - Your contract contains provisions that require school health centers to maintain not only member records, but also accounting and administrative records of the school health centers and make those records available for review by L.A. Care as may be required by law, and by state and federal agencies. Note, the contract also requires L.A. Care to maintain the confidentiality of information given to L.A. Care by the school health centers. L.A. Care will only disseminate the information as required by law. Holding on to those records can also assist the clinic in the case of appealing denied claims.

Follow the Provider Manual - The Provider Manual is part of the contract and is included as an exhibit to the contract. School health centers are required to provide services in accordance with the Provider Manual.

[5] http://www.uchsc.edu/schoolhealth/res_pages/managed_care.htm

Why Does the Contract Include a Business Associate Agreement and What is it? - When L.A. Care contracts with a provider who has access to the personal health information of L.A. Care members, federal HIPAA law requires that L.A. Care include in the contract certain protections for members' personal health information. The Business Associate Agreement sets forth those protections and discusses the uses and disclosure of a member's personal health information.

Know Those Timeframes - The contract and provider manual contain timeframes and deadlines for various responsibilities. For example, the contract requires that school health centers provide L.A. Care with member medical records within 5 business days of a request by L.A. Care in connection with a member complaint.

Basic Billing Capacity

An effective billing system requires dedicated staff and resources to verify eligibility and monitor billing activities. School health centers with a history of billing, existing infrastructure, and a commitment to reinvesting reimbursement back into the clinic report the greatest level of success. Areas that school health centers should think about prior to starting to work with managed care organizations include:

- Scope of primary care services offered at your health center
- Ability to bill for services rendered
- Knowledge of third party reimbursement
- Ability to identify insurance status of patients
- Percent of patients covered by public health insurance programs (i.e., Medi-Cal, Healthy Families, Healthy Kids)
- Ability of school health center to meet the minimum criteria to be a primary care provider site according to managed organization regulations
    - Physician on site a minimum number of hours per week
    - Pass State facility site review (physician site audit and medical record review)
    - Credentialing of all physicians
    - Clinical location available in a general location (open to non-students)

Establishing and maintaining billing capacity requires dedicated staff and computer resources to verify student insurance status and complete and submit billing forms. Considered most

[7] http://www.nasbhc.org/atf/cf/{CD9949F2-2761-42FB-BC7A-CEE165C701D9}/Funding_IB_MedicaidReimbursement.pdf

[8] http://www.advocatesforyouth.org/publications/sbhc6.pdf

essential is a basic billing infrastructure that has the capacity to correctly complete forms, submit them to the appropriate parties, and monitor the reimbursement that comes in (accounts receivable). Recommended internal resources include:

- A supply of PM 160 Information Only forms and CMS 1500 forms (different managed care organizations may require different forms)
- Dedicated staff to enter data, verify eligibility and insurance status, and track claims, denials, and payments
- Staff that are knowledgeable coders

Appropriate information systems and staff are critical to third party billing. Participants of the reimbursement pilot sponsored by L.A. Care indicated that staff dedicated to verifying student insurance status and eligibility and completing claim forms is essential to maintaining day to day operations. It is recommended that clinics dedicate part of a full time employee to these tasks. The staff member should ideally be an experienced coder and be familiar with billing managed care.

In addition to a part time biller, school health centers should also assess the value of dedicating a position to enrolling students into applicable health insurance programs. The position can often pay for itself if there is a significant Medi-Cal eligible population at the school and especially if the school health center is run by a federally-qualified health center. Also, developing a relationship with the staff who process your clinic's enrollment applications at the county level (e.g., eligibility workers, supervisors, etc.) can facilitate a smoother application process and allow for troubleshooting when problems arise.

The State of California Department of Health Care Services' Fiscal Intermediary Contract (currently Electronic Data Systems) offers classes on the Medi-Cal billing process, how to complete claim forms field-by-field, determine eligibility, and identify common billing errors. Call 1-800-541-5555 or check the Medi-Cal Website (www.medi-cal.ca.gov) to get information on classes in your area. You can also register online for training seminars using the Medi-Cal Website.

The Medi-Cal website also offers online tutorials on how to better understand various Medi-Cal processes including how to verify eligibility using the Point of Service (POS) network. Go to http://files.medi-cal.ca.gov/pubsdoco/eo/webbasedtutorials.asp for more information.

Verifying Patient Insurance Status

Obtaining accurate and current information from students may be difficult, though there are mechanisms that school health centers can put in place to streamline this process. Before a student is seen by a health professional at the school health center, a number of activities should be undertaken in preparation of an organized and timely visit. Health centers should verify

[9] http://www.nasbhc.org/atf/cf/{CD9949F2-2761-42FB-BC7A-CEE165C701D9}/Funding_IB_MedicaidReimbursement.pdf

the student's insurance status or eligibility for public programs such as Medi-Cal or Healthy Families. Below are some suggestions from school health centers in Los Angeles County on their pre-appointment procedures to verify insurance status.

- When students submit consent forms for care, do not accept the form unless their insurance information is completed.
- When calling parents to verify the signature on the consent form, request any missing insurance information. Sample consent forms can be found in Appendix 1.

Several automated systems are available to providers of care to verify patient eligibility for public health insurance programs including:

1. Medi-Cal website
2. Point of Service (POS) device
3. Automated Eligibility Verification System (AEVS)

In order to use these systems, you will need basic information from the student including:

- Birth date
- Benefits Identification Card (BIC) number

If the student's BIC information is unavailable or unknown, their Social Security number (SSN) and the current date can be entered into these systems and the BIC number will be returned. Medi-Cal recognizes the importance of protecting the identity and health information of recipients and strongly encourages all providers to avoid using a recipient's SSN whenever possible.

1. Medi-Cal Website (https://www.medi-cal.ca.gov/Eligibility/Login.asp)

The most commonly used method of verifying eligibility for Medi-Cal (according to participants of the L.A. Care reimbursement pilot) is the Medi-Cal website (https://www.medi-cal.ca.gov/Eligibility/Login.asp). Users must be Medi-Cal providers to be issued a login and password by the State of California Department of Health Care Services' Medi-Cal Fiscal Intermediary (currently, Electronic Data Systems, also known as EDS). You will need information from the student's Benefits Identification Card (specifically the BIC number to obtain information on the student's current eligibility status).

For more information on how to become a Medi-Cal provider, go to http://www.dhcs.ca.gov/provgovpart/Pages/HowtoEnrollasaProvider.aspx

2. Point of Service (POS) Device

The point of service (POS) device is another way to verify Medi-Cal recipient eligibility. The POS device is a machine that contains an internal printer and keyboard that allows you to enter alphanumeric characters. You will need the student's BIC number to access information. You

can use the printer to print responses received from the system. Clinics will need to dedicate a separate telephone line for the POS device. Users must be a Medi-Cal provider to access this system. POS device user guides can be located online here:
http://files.medi-cal.ca.gov/pubsdoco/pos_home.asp

The California Department of Health Care Services' Fiscal Intermediary, EDS, also offers an online tutorial on how to verify recipient eligibility using the POS device. It can be located online here:
http://pro.medi-cal.ca.gov/wct/EO/recipelig05/recipelig05default.asp

3. Automated Eligibility Verification System (AEVS) 1-800-866-2387

Another option of verifying Medi-Cal eligibility is the Automated Eligibility Verification System (AEVS), an interactive voice response system that allows you to access recipient eligibility. You can access AEVS by calling 1-800-866-2387. There is no enrollment requirement to use AEVS, however, you must have a valid personal identification number (PIN). PINs are issued to providers upon their enrollment into Medi-Cal, but if you are not enrolled in Medi-Cal you can obtain a temporary PIN by following these steps:

1. Call the EDS Telephone Service Center (TSC) at (916) 636-1200 or the Provider Support Center at (800) 541-5555.
2. Select the option for Point of Service (POS)-related questions, then the option for POS devices and downloads, then the option for all other inquiries. You will be connected to a EDS
3. operator, who will provide you with a temporary PIN that can be used for AEVS.

For instructions on how to use AEVS, refer to the Medi-Cal website at: http://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp

L.A. Care Tip

L.A. Care Interactive Voice Response System (IVR) 1-866-LACARE6 (1-866-522-2736)

L.A. Care has an automated, toll free provider information telephone line where providers can access L.A. Care member eligibility information 24 hours a day, 7 days a week. This will assist clinics in identifying which agreement L.A. Care members can be billed under.

During business hours, providers may check eligibility for ten members through one phone call and 25 members during non-business hours. The IVR gives providers up to date member eligibility information. You will need the member's L.A. Care member identification number as well as their birth date.

Step 1 When you hear the welcome message, you will be given these choices:

1. To check eligibility, press 1
2. For claims information, press 2,
3. For all other questions, press 3
4. To repeat the choices, press *

Step 2 Press 1 for eligibility

Step 3 Enter the numeric portion of the Member Identification Number followed by the pound (#) sign

Step 4 Enter the member's eight digit date of birth. For example, May 5, 2003 should be entered as 05052003.

Step 5 You will hear member verification information:

- The last four digits of the identification number are XXXX
- The first two characters of the member's last name are XX
- Press # to confirm this selection
- Press 8 to return to the previous menu

Step 6 If the correct member is identified, press # to confirm the selection

Step 7 Enter the eight digit date of service. For example, May 5, 2003 should be entered as 05052003. Please note this application can only check the current month and 12 months prior.

Step 8 You will hear the member's eligibility information as follows:

- The member's Plan's name is XXXX
- The participating medical group is XXXX
- The provider's name is XXXX
- The effective date is MM DD YYYY (this is the effective date of the member with the medical group and primary care physician)
- To spell the physician's name, press 1
- Your confirmation number is CN XXXXXX
- To repeat this information, press *

Step 9 To check another member's eligibility:

- You may check up to ten member identification numbers for eligibility during L.A. Care's normal business hours (M-F 8am – 5pm) and up to 25 during non-business hours
- To check another member's eligibility, press 1
- To end the call, hang up or press 9

Primary care providers in L.A. Care's network can also check eligibility online via our provider portal. Go to http://www.lacare.org/providers/patienteligibility for more information.

Billing Procedures

School health centers that succeed in billing are characterized by two attributes: a strong business orientation and a philosophy to seek reimbursement for every service rendered. Most managed care organizations require that school health centers complete and submit a PM 160 Information Only form and CMS 1500 (previously known as the HCFA 1500) for reimbursement. Samples of these forms can be found in Appendices 2 and 3.

The Medi-Cal website also offers Medi-Cal billing tips for providers: http://files.medi-cal.ca.gov/pubsdoco/billing_tips.asp

Once a school health center has verified a member's insurance status, complete a PM 160 Information Only form and CMS 1500 form and submit to the appropriate managed care organization.

> ***L.A. Care Tip***
> For L.A. Care members, submit both completed forms to:
>
> L.A. Care Health Plan
> Attn: Claims Dept.
> P.O. Box 712129
> Los Angeles, CA 90071

PM 160 Information Only Form

Payment of claims is dependent on how accurately the PM 160 Information Only (INF) form is completed. A sample PM 160 INF form can be located in Appendix 2. Below are some helpful tips billing using a PM 160 INF form:

- The PM 160 INF form should be signed by the provider or designated representative. Do not use a signature stamp.
- The PM 160 INF form should be completely filled out for the type of assessment rendered (complete, partial, or recheck).
- All required check marks, code numbers, and fees should be entered.
- The provider number should be accurate. Reimbursement is directed to the provider according to the provider number entered on the PM 160 INF.
- The benefits identification card (BIC) number entered on the PM 160 INF belongs to the individual for whom services were rendered, and that the recipient whose BIC is listed is enrolled in Medi-Cal during the month the services were rendered.
- Both the county name and corresponding county code for the patient's residence are entered. Or if the child or youth lives in Berkeley, Long Beach, or Pasadena, enter the two-digit city code.
- All comments, concerns, or problems are entered in the Comments/Problems area.
- "Tobacco Prevention/ Cessation Questions" are answered.
- The appropriate diagnosis code is entered in the correct box.
- The recipient date of birth matches the date of birth on the Medi-Cal file (even if it is incorrect on the file).
- The service location (city, state, and nine-digit zip code where service was provided) matches the service address on the CHDP provider master file.
- The appropriate two-digit place of service code is entered.
- Remove any side perforations before submitting the claim.

[10] http://www.nasbhc.org/atf/cf/{CD9949F2-2761-42FB-BC7A-CEE165C701D9}/Funding_IB_MedicaidReimbursement.pdf

Many managed care organizations utilize optical character recognition (OCR) equipment to scan submitted hardcopy forms into electronic files. Below are some PM 160 INF preparation tips that will help managed care organizations expedite processing of the claim:

- Type information onto the PM 160 INF, use black ink, or utilize an electronic PM 160 INF form. Do not use pencil or red ink. Press hard so all four copies are legible. Do not use liquid correction ink ("white out").
- Do not use a highlighter.
- Do not place staples through the bar patch (upper left corner) on the PM 160 INF form
- Legibly enter the provider's name and return address on the outside of the envelope.

Additional instructions on how to complete a PM 160 INF form can be found here: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/chdp/manual/confclmcomp_c00.doc

CMS 1500 Form

Each CMS 1500 is a complete billing form. A sample CMS 1500 form can be found in Appendix 3. If there is not enough space available on the CMS 1500 to bill all procedures provided on the same date of service, complete a new billing form for the rest of the procedures. Below are some tips on how to successfully complete a CMS 1500 form.

- Be sure you are using the new CMS 1500 (08-05) form (downloadable here: http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf)
- Pay special attention to correct billing codes and dollar amounts. Be sure you have the most current information for the date of service billed.
- Avoid tiny print, print that overlaps onto a line, no more than 6 lines per claim, and poorly hand written claims forms.
- When using carbon forms, send only the original or top copy
- Do not carry over totals from one CMS 1500 to the other.
- Do not attach Post-it notes to the claim form
- Trim forms carefully only at the perforations. Narrower margins cannot be scanned. The form should be 8.5 inches x 11 inches.
- Do no submit claims with zero charges

The Medi-Cal website offers an online tutorial on how to complete a CMS 1500 form. It can be located here:
http://pro.medi-cal.ca.gov/wct/eo/cms1500_07/cms1500_07default.asp

Electronic Billing Options

School health centers are encouraged to explore the benefits of electronic claims submission. Electronic transactions expedite processing, minimize errors, and streamline business office operation.

When claims are denied by the managed care organization, examine why to prevent the same mistake from happening in the future. An incorrect code may mean the difference between payment and denial. If claims are consistently being denied, ask the Claims Department of the managed care organization to help troubleshoot why. Also, maintain impeccable records just in case your claim is denied. Providing the appropriate back up may help in substantiating your claim.

L.A. Care Tip – Common Coding Errors

The L.A. Care Claims Department identified the most common coding errors they see on claims. Please see below for the top six offenders.

COVERED SERVICE	DO NOT USE…	INSTEAD, USE…
Hearing Audiometrics	**92552 or 99823**	**92551**
Snellen Eye Test (ages 3-6 years and 7-20 years)	**92015 or 92012**	**92081** depending on the age category
Hemoglobin, Hematocrit	**99830**	**83020, 85014 or 85014** depending on the chart
Urine - Dipstick	**99831**	**81001 – 81002**
Lead Blood-Lead Level Type	**99834**	**83655** depending on the chart
Administration of a vaccine (vaccines themselves are not reimbursable)	**N/A**	**90471** for one vaccine **90472** for two or more vaccines

Care Coordination with the Patient's Primary Care Physician (PCP)

The American Academy of Pediatrics recommends that children receive care from a medical home, defined as care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective, and delivered or directed by physicians who provide primary care and help to manage and facilitate all aspects of pediatric care. While some school health centers can serve this role (health centers that serve as primary care provider sites in a managed care network), most others cannot. For this reason, a school health center should share medical information with the patient's primary care physician (PCP) in order to maintain continuity of care and coordinate timely follow up care or referrals to specialty care if needed.

All the health center participants in L.A. Care's reimbursement pilot indicated that it is important to share information with the patient's PCP however, approximately 40% of the participants regularly communicated and made referrals to PCPs while another 40% did not have formal procedures to refer their patients to their PCPs (the other 20% served as PCP sites in L.A. Care's network). Most school health centers cite barriers in their ability to identify

L.A. Care Best Practice – LINK

Clinics that utilize the Los Angeles-Orange Immunization Network (LINK) registry should input all immunizations given to the student so that PCPs and other providers of care may access the student's record. LINK is a free web-based software that securely captures immunization information. The more clinics that adopt and use LINK, the more patient records will be accessible by providers. Clinics can get more information about LINK by calling (213) 351-7800.

the assigned PCP of their patients enrolled in with a managed care organization. This coupled with the resources it takes to call or fax documentation to the patient's PCP makes it a labor intensive task.

Since students may access health care services at their school more frequently than at their PCP's office, school health centers play an important role in maintaining and supporting the student's medical home. School health centers can educate students and families on the role of their PCP and the specialty care referral process. Ideally, services rendered by school health centers and PCPs should be complementary, not duplicative. The L.A. Care reimbursement pilot found that although there was some duplication of services, school health centers are an important site for well care visits for students.

How to Share Information

Most clinics in the L.A. Care reimbursement pilot indicated that faxing a copy of the PM 160 INF, PM 161, or a notification of services form to the student's PCP is the preferred method of sharing information (see Appendices 2 and 5). Second is a direct telephone call from the clinic's nurse to the student's PCP. The type of information that should be shared with the PCP includes notation of the visit, services rendered, immunizations, referrals, and required follow up.

The PM 161 form can be downloaded here: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/pm161.pdf

Minor Consent

Confidentiality is an important issue to students and reporting responsibilities are different depending on the service rendered. A helpful toolkit on understanding minor consent laws in California including which minors can consent for what services and providers' confidentiality obligations can be downloaded for free here: http://www.californiateenhealth.org/download/teen_confidentiality_doc.pdf

Chapter 8 - Family Pact (Planning, Access, Care and Treatment)

What is Family PACT?

Family PACT is a unique California government program providing family planning reproductive health services. The goal of the program is to help ensure that low-income men, women and children have access to the health education, counseling and family planning services needed to improve their reproductive health and decrease the likelihood of unintended pregnancy.

Family PACT serves women and men who reside in California, who are at risk of pregnancy or causing pregnancy, and who have no other source of healthcare. If a client is pregnant or sterile due to vasectomy, tubal ligation, hysterectomy, or menopausal they are not eligible for Family PACT services. The program is specifically designed to ensure confidentiality of services and can be used to pay for reproductive services provided to the teenage population. For more information on California's Minor Consent Law, go to:
http://www.teenhealthrights.org/fileadmin/teenhealth/teenhealthrights/ca/07_CA_MinorConsentChapter.pdf
.
Who is eligible for the program?

There are four conditions that must be met in order to bill the Family PACT program.

1. *Age:* Women must be 55 or younger, and men must be 60 or younger.
2. *Income:* Gross Family Income must be below 200% of the Federal Poverty Level. (Almost all youth are eligible because their income is calculated based on a family of one.)
3. *Lack of insurance coverage:* The client must have no other source of health care coverage for family planning and/or a desire/need to keep the services confidential. (Note: Insured teens are eligible if they need to keep their care confidential).
4. *Residency:* Client must be a California resident, however no papers are required, and clients are not denied services if they do not have a social security number.

What is the cost to the client?

Services are provided at no cost to the client.

What services are reimbursable?

The following services are reimbursable under the Family PACT program:

- Baseline and periodic reproductive physical health exams (testicular/penile exam due to STIs or symptoms based on family planning method used.)
- Family planning and birth control along with education/counseling, including emergency contraception

[11] Brindis, Claire and Philip Darney. "California's Family PACT Program: Program and Evaluation Summary." January 2000. Center for Reproductive Health Research and Policy Department of Obstetrics, Gynecology and Reproductive Sciences and Institute for Health Policy Studies, University of California – San Francisco.

- Sterilization for men and women (vasectomy and tubal ligation)
- Pregnancy tests, counseling and referrals
- Sexually transmitted disease testing and treatment
- Cancer screenings (screening mammograms and pap tests)
- Hepatitis B immunizations
- Referrals for services not covered by the program are encouraged at low-cost or free to clients

For benefits package codes, procedures, medications and contraceptive supplies, please refer to the Provisional Clinical Services Benefits Grid on the Family PACT website under program letters: http://www.familypact.org/en/Providers.aspx

For Family PACT providers who were also granted a different category of service under a demonstration project called TeenSMART, Family PACT will also reimburse for outreach and training activities such as public education and marketing targeting adolescents in counties with high pregnancy rates.

What services are NOT reimbursable?

- Prenatal and perinatal care
- Abortion
- HIV or hepatitis treatment

What are the reimbursement rates?

Reimbursements, unless otherwise stated in the Family PACT Policy, Procedures and Billing Instructions Manual, defers to Medi-Cal policies, codes, rates and claims submission procedures. All providers bill fee for service. Providers are reimbursed according to Medi-Cal policy unless otherwise stated and claims are subject to Medi-Cal time guidelines. All Family PACT claims are sent to and processed by EDS (Electronic Data Systems).

How is the program funded?

The program was initially funded in 1997 by the State of California, but a federal Medicaid waiver approved in 1999 enabled the program to receive 90% federal reimbursement (this waiver expired March 31, 2006 and California is currently renegotiating it with the Federal government).

Who administers the program?

The program is run by the Office of Family Planning (OFP) at the California Department of Public Health.

How do clients apply for the program?

Immediate on-site enrollment is one key advantage of the Family PACT program. The enrollee must fill out a Client Eligibility Certification form, which includes his/her name, date of birth, self-declared income, demographic info, and phone number. The enrollee then receives a

[12] Family PACT is not accepting new providers for the TeenSMART program.

green plastic HAP (Health Access Program) card from the provider, which is good for one year. Enrollment forms are available on the web at: http://www.familypact.org/en/Providers/ClientEligibilityEnrollment.aspx and questions can be directed to the OFP Information/Referral Service: (800) 942-1054.

What are the provider requirements?

- Must be a Medi-Cal provider in good standing
- Must attend a provider orientation and update session (see below)
- Must follow program policies, standards and administrative procedures
- Must provide a scope of Comprehensive Family Planning services consistent with Family PACT standards (directly or by referral)

How do providers apply to participate in the program?

1. ***Provider Application:*** Application to participate in the Family PACT Program (DHS 4468) is available on the Family PACT website at http://www.familypact.org/_Resources/Documents/CDPH_4468%287-07%29pdf.pdf

2. ***Provider Agreement Form:*** Providers must also complete the Family PACT Program Provider Agreement (DHS 4469) also available on the Family PACT website at http://www.familypact.org/_Resources/Documents/CDPH_4469%287-07%29pdf.pdf

3. ***Orientation Update Sessions:*** Medi-Cal providers (medical directors or clinicians responsible for medical services) must attend a Provider Orientation and Update Session. Upon completion of the session, a *Certificate of Attendance* will be mailed to the provider. Office staff members, such as clinic managers and receptionists, are also encouraged to attend. Clinicians and staff who have already attended an Orientation Session are encouraged to attend subsequent sessions in order to keep current with program policies and services. Training sessions, orientation location/dates, tutorials and web-casts for providers are found on the Family PACT website: http://www.familypact.org/en/Providers/provider-training/orientation-sessions.aspx or by calling the Provider Resource Line at 1-877-FAMPACT for provider information.

Program forms and additional information may be obtained by calling the Health Access Programs (HAP) Hotline at 1-800-541-5555 or http://www.cdph.ca.gov/programs/familypact/Pages/default.aspx

How well does Family PACT work for school health centers?

The Family PACT program is easily accessible, fairly uncomplicated to bill, and allows for one year of eligibility. In fact, Family PACT reimbursements constitute a significant percentage of California school health centers' overall third-party revenue. Moreover, Family PACT reimbursements represent one of the few third-party billing options available to fund the family planning education and case management that school health centers provide.

On the other hand, Family PACT reimbursement rates are low and do not cover the true costs of providing care. Family Pact does not reimburse for abortion or care for pregnant minors.

Some practices that school health centers have found helpful include:

- Setting up an efficient billing system that is easy to update since new codes are introduced every year.
- Utilizing billing documentation forms that are clear and easy for providers to fill out. Family PACT has downloadable forms (Superbills, Clinical Practice Alerts and Fact Sheets) for providers at http://www.familypact.org.

Chapter 9: Medi-Cal Minor Consent

What is Medi-Cal Minor Consent?

California Family Code states that minors may receive the following services *without parental consent*: pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, services related to sexual assault, drug and alcohol abuse, and outpatient mental health treatment and counseling. The Medi-Cal Minor Consent program exists to ensure minors can receive these confidential "sensitive services." While Medi-Cal Minor Consent Law covers a range of services, this manual will focus only on the minor consent services for which there is a direct billing mechanism for school health centers.

Who is eligible for the program?

- ***Age:*** Up to 21 years old (see reimbursable services section below)
- ***Income:*** No income requirement. If the minor is employed, income documentation needs to be presented.
- ***Lack of insurance coverage:*** Teens must still be living with their parents or receiving parental financial support. Financially independent teens must apply for regular Medi-Cal and minors who already have full Medi-Cal cannot be issued Minor Consent Medi-Cal, but may obtain an "immediate need" paper card if they need confidential services. Minors who are covered by a private insurance plan (e.g., Kaiser) can apply for Minor Consent Medi-Cal (or Family PACT) if their ability to receive confidential services is infringed by using their parent's plan.
- ***Residency:*** Must be a California resident. Client must provide a name, phone number and address, however a social security number is *not* required.

What is the cost to the client?

Services are provided at no cost to the client since share of the cost is based on the minor's income only.

What services are reimbursable?

Limited services include: family planning, sexual health, treatment for sexually transmitted diseases, pregnancy and pregnancy-related issues, services vary according to age:

[13] http://www.co.solano.ca.us/resources/PublicHealth/MCHbureau/AFLP/MinorConsentrev5802.pdf

[13] M. Simmons, J. Shalwitz, S Pollock (2002). *Understanding Confidentiality and Minor Consent in California: an Adolescent Provider Toolkit.* San Francisco, CA: Adolescent Health Working Group, San Francisco Health Plan.

Children under age 12 (no minimum age requirement)	Youth Age 12 years and older
Pregnancy and pregnancy-related care	Pregnancy and pregnancy-related care
Family planning services	Family planning services
	Sexually transmitted disease treatment and counseling

What are the reimbursement rates?

Rates vary depending on the types of service provided and whether the Health Center billing is a Federally Qualified Health Center (FQHC). Billing is submitted to the State.

How is the program funded?

Minor consent services (for adolescents who are not full scope Medi-Cal beneficiaries) are supported solely through the State General Fund. No federal funds are claimed unless the adolescent is pregnant or postpartum.

Who administers the program?

The Medi-Cal Minor Consent program is a part of the Medi-Cal program, which is administered by the California Department of Health Care Services.

How do clients apply for the program?

Application processes vary from county to county, but in many cases in order to enroll, the applicant must meet face to face with an eligibility worker and must contact their eligibility worker on the first day of every month in order to continue their benefits. In order to maintain confidentiality, very little information is necessary to apply. The application includes name, date of birth, address (which is not entered into the computer), and phone number, however no form of identification or verification is required. The client receives a paper Medi-Cal card the same day the services are requested. The card is good for one year, but must be reactivated each month (except in Alameda County which has a waiver allowing eligibility to last one year).

What are the provider requirements?

In order to provide Medi-Cal Minor Consent services, providers must be Medi-Cal providers.

How do providers apply to participate in the program?

Information about how to apply to become a Medi-Cal provider can be found at: http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/PED_FAQS.pdf or by calling (800) 541-5555.

How do Family PACT and Medi-Cal Minor Consent Differ?

1) **Services Covered:**

Service	Family PACT	Medi-Cal Minor Consent
Family planning and birth control, including emergency contraception	✓	✓
Pregnancy tests, counseling and referrals	✓	✓
Pregnancy and related care		✓
Abortion		✓
Sexually transmitted disease testing and treatment*	✓	✓
HIV testing and counseling	✓	
Cancer screenings	✓	
Baseline and periodic physical exams	✓	
Referrals for services not covered by the program	✓	

* These Minor Consent Services are only covered for youth ages 12 and older.

2) Eligibility:

Client Characteristic	Family PACT	Medi-Cal Minor Consent
Age	Up to 55	Up to 21
Income	<200% poverty level (teens income assessed based on family of one) If in need of confidential services, no income requirement.	Covered under Minor Consent
Citizenship	California resident (no identification required)	California resident (Social security number not required)
Period of Eligibility	One year	One month

How well does Medi-Cal Minor Consent work for school health centers?

[15] Alameda County has a waiver which extends eligibility to one year.

Enrollment for Medi-Cal Minor Consent requires completion of a simple, one-page form and usually involves a meeting with an eligibility worker. The Minor Consent application process may be worthwhile for some providers due to the reimbursement rate differences. For example, in 2007 a family planning visit reimbursement under Medi-Cal Minor Consent for one Federally Qualified Health Center was $355.41, while the same visit reimbursement from Family PACT would be $40.00.

Billing Tips

- HIV testing and treatment is not covered by the Minor Consent program.
- Most California counties require clients to renew eligibility every 30 days so the higher reimbursement may not justify the extra paperwork burden except for certain counties with yearly eligibility.
- It's helpful to maintain a good relationship with the Eligibility Worker assigned to work with your school health center. This will allow for speedier processing and troubleshooting when needed.
- Since students have to complete an application form, some may consider this an inconvenience, so incentives such as healthy snacks could be offered.

Chapter 10 – The Local Education Agency (LEA) Medi-Cal Program

The Local Educational Agency (LEA) Medi-Cal Billing program reimburses LEAs for specific health services. LEAs are usually school districts or county departments of education. Originally, LEAs could be reimbursed for services provided to all students enrolled in Medi-Cal. However recent changes have meant that most reimbursement is for health services for children in special education. These are children with an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

Established in 1993 in conjunction with the California Department of Education, the LEA Medi-Cal Billing Option Program aims to:

1. Provide comprehensive health services to eligible Medi-Cal students and, when applicable, to their families
2. Allow Local Educational Agencies to become Medi-Cal providers and bill the Medi-Cal program for the health services provided by the medical professionals they employ
3. Facilitate reinvestment in health and social services for students and their families

For additional information, see the LEA Medi-Cal Billing Option Provider Manual at: http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx

Who is eligible for the program?

LEAs will only receive reimbursement for services provided to students who qualify for full-scope Medi-Cal during the service dates, though all students with IEPs or IFSPs will receive the required services outlined in their IEP/IFSP regardless of whether the services rendered qualify for LEA Medi-Cal reimbursement. Most school districts/LEAs will submit all services provided to potentially eligible students to their LEA Medi-Cal billing company. Some large LEAs perform their own LEA Medi-Cal billing, and screen students who received billable services for Medi-Cal eligibility themselves before billing. The company/LEA billing office will verify which students are eligible for full-scope Medi-Cal during the service dates, and will receive reimbursement for eligible students' billable services accordingly.

What is the cost to the client?

Some Medi-Cal recipients must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called 'share of cost.' A Medi-Cal recipient's 'share of cost' is similar to a private insurance plan's out-of-pocket deductible.

What services are reimbursable?

[16] For more information, refer to the LEA Provider manual available online at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/locedelig_o09.doc

The following assessment and treatments are reimbursable to LEAs. These services are provided primarily to Special Education students, though some health assessment services provided to students who qualify for full-scope Medi-Cal and without an IEP or IFSP may be reimbursable, so long as they are not provided as part of state-mandated health screenings (e.g., grade level-wide vision, hearing, or scoliosis screening).

IEP/IFSP Assessments

- Psychological
- Psychosocial Status
- Health/Nutrition
- Audiological
- Speech-Language
- Physical Therapy
- Occupational Therapy

Non-State Mandated, Non-IEP/IFSP Assessments

- Psychosocial
- Health Status/Nutrition
- Health Education/Anticipatory Guidance
- Hearing
- Vision
- Developmental

Treatment Services for Students with IEP/IFSP

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Audiology (including Hearing Check)
- Psychology and Counseling
- Nursing Services
- School Health Aide Services
- Targeted Case Management
- Transportation and Mileage (must be in a litter van or wheelchair van)

What are the reimbursement rates?

Reimbursement for LEA services is based on time spent or on a flat-fee structure following the terms specified by the California Department of Health Care Services. The provider participation agreement requires LEAs to reinvest the reimbursement in health and social services.

LEAs can bill for the Medi-Cal maximum allowable listed in the LEA provider manual. The Medi-Cal reimbursement will be at the Federal Medical Assistance Percentage (currently 50 percent) of the Medi-Cal Maximum allowable. The current Federal Medical Assistance

[17] Targeted case management services assist eligible children to access needed medical, social, educational and other services when TCM is covered by the student's IEP. TCM services include a needs assessment, development of a service plan, linkage and consultation, assistance with accessing services outside the school system and progress review. Note that the LEA may bill TCM or MAA for a service, but not both. Additional information: http://www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx .

Percentage (FMAP) participation rate may be obtained from the LEA Medi-Cal Billing Option Provider Manual: http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx
Once they have set up a system, many LEAs generate a large volume of claims. However, the rate of reimbursement is lower than the Medi-Cal rate. In July of 2006, California's Department of Health Care Services implemented a new cost-based rate methodology. As a part of this new rate, a reconciliation report must be completed. If the report shows that LEAs were underpaid the cost of providing the services, they will receive a supplemental payment.

How is the program funded?

This program is funded by federal dollars that are provided as a match to non-federal funds spent by LEAs on qualifying health services.

Who administers the program?

The LEA program is part of Medi-Cal and is administered by the California Department of Health Care Services. School districts bill for specific health services provided to students and then receive federal reimbursement from the California Department of Health Care Services.

How do clients apply for the program?

Students and/or families do not apply for LEA Medi-Cal. Instead, participating school districts sign a "provider participation agreement" which ensures that districts comply with relevant laws and regulations and use qualified practitioners. The agreement also outlines requirements for reinvestment of Medi-Cal reimbursements.

What are the provider requirements?

To be eligible in California for reimbursement of these costs, the LEA must be enrolled as a Medi-Cal provider, and the services must be covered under Medi-Cal, be medically necessary, and performed by a qualified professional. An LEA provider employs or contracts with qualified medical care practitioners to render services to Medi-Cal eligible students and their families. Also, as stated above, participating LEAs must sign a "provider participation agreement" which ensures that districts comply with relevant laws and regulations and use qualified practitioners.

How do providers apply to participate in the program?

LEAs may apply to participate in this program. An LEA must complete enrollment forms to apply to be an LEA provider. The forms can be accessed online at
http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderEnrollment.aspx

How well does LEA Medi-Cal work for school health centers?

A few school health centers in California received significant funding from their district's LEA program. For this to occur, the LEA must 1) participate in the LEA program, and 2) reinvest the funds generated in the school health center. Although LEAs must reinvest the revenue in health services, there are always many competing demands for these funds. Due to a variety

of administrative, communication, and knowledge barriers, more than half of California's school districts do not participate in LEA (as of Sept 2006, EDS reports 527 LEA providers out of approximately 1,000 school districts). Additionally, the restriction of LEA billing only for services provided to students with IEPs or IFSPs has resulted in a significant decrease in reimbursement for school districts. Two additional requirements may impede reimbursement: third party liability and the free care requirement.

Third party liability is the legal obligation of Medi-Cal providers to seek payment from private health insurance to pay the eligible medical claims of Medi-Cal beneficiaries before the Medi-Cal provider submits its claim to DHCS. Although a school district, as a Medi-Cal provider, may be required to bill a private health insurer before billing Medi-Cal, Part B of the Individuals with Disabilities Education Improvement Act (IDEA) provides that schools may not cause students with disabilities to incur additional health care costs, or to suffer reduced health care coverage through third party billing at the time of the service or in the future. If a private insurer is billed, it may reduce or exhaust a beneficiary's lifetime benefits. This is the IDEA principle of free and appropriate access to public education. (For additional information see www.fape.org.) An example of this scenario may be a child enrolled in Medi-Cal who also has partial insurance under a parent's private insurance policy. If the student has an IEP or IFSP, the school might not need to bill the private insurer. If the student is not served under IDEA, then the school would be required to bill the private insurer before billing Medi-Cal. The Third Party Liability requirement can create a significant administrative burden for school billing programs. For more information, refer to the Consumers Union publication, "No Dollar Left Behind: Leveraging Funding for Healthy Children and Healthy Schools", available online at: http://www.consumersunion.org/pdf/NoDollarLeftBehind.pdf

The *Free Care Requirement,* as interpreted by the Centers for Medicare and Medicaid Services (CMS), precludes Medi-Cal from paying for the costs of health services and activities which are provided free to all students by a school district. If a school district offers routine vision and hearing screening to all students free of charge, for example, then it cannot bill Medi-Cal for the screenings provided to students enrolled in Medi-Cal. School districts can only bill for these services after establishing a fee for the service, collecting third party insurance information and then billing third party insurers. This requirement places a large burden on school billing programs.

Services provided under the Individuals with Disabilities Education Act (IDEA) are *exempt* from the free care requirement. However, these same services are still subject to the third party liability requirements. As a result, most school districts only bill for services provided to students with special education needs, as specified in their Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs), and do not have other health insurance. The Free Care Requirement is not a federal regulation or statute and has recently been challenged by the state of Oklahoma. The future may entail an attempt by CMS to codify the requirement and an increased interest by states to address this barrier through legal action or negotiation.

Additional Information

For more information on the LEA Medi-Cal Billing Option program, go to http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx

Chapter 11 - School-Based Medi-Cal Administrative Activities Program (MAA)

The school-based Medi-Cal Administrative Activities (MAA) program reimburses schools for carrying out Medi-Cal-related administrative activities, such as outreach, enrollment assistance, or the administration of Medi-Cal services. The program was established in order to provide school districts with the means to obtain federal reimbursements for 50% of the costs they incur conducting Medi-Cal administrative activities.

Unlike other Medi-Cal programs, MAA does not reimburse for services based on bills submitted for each individual served. Rather, reimbursement is determined by the estimated amount of time school staff spend performing MAA activities. These estimates are based on time surveys. Schools use the results of these time surveys to determine the percentage of school costs they can claim under MAA. Individual students' insurance information is not needed in order to claim under MAA.

Who is eligible for the program?

The MAA program differs from previously discussed billing programs in that individual students are not eligible. Instead, any local educational agency (LEA), such as a school district, may be eligible if the students it serves are potentially eligible for Medi-Cal.

What is the cost to the client?

There is no cost to students.

What services are reimbursable?

MAA reimburses county offices of education, school districts and community colleges for the administrative activities that directly support efforts to identify and enroll potential eligible students into the Medi-Cal program and assist with access to Medi-Cal covered services. Reimbursable activities include outreach, facilitating applications, translation, arranging transportation, Medi-Cal program planning, policy development, and interagency coordination.

What services are NOT reimbursable?

Administrative activities not associated with a covered Medi-Cal service or with campaigns designed to identify and enroll Medi-Cal eligible students into the Medi-Cal program are not reimbursable.

What are the reimbursement rates?

The MAA program reimburses school districts and county offices of education for a portion of the costs incurred in administering Medi-Cal funded programs. Time spent by school staff on MAA is identified using a quarterly time survey. The results of the time survey are then used in a series of calculations to determine the percentage of school costs that can be claimed. The

billing formula is: % billable time * salary * % Medi-Cal population. For more information, see the School-Based MAA Manual at http://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx

Participating school districts often pay an administrative fee in proportion to the amount of their reimbursements to consortia and vendors for assistance in administering the program, thereby reducing the amount of funds available to the school districts.

How is the program funded?

MAA utilizes federal funds to reimburse local educational agencies for a portion of the costs incurred in performing administrative and outreach activities to Medi-Cal eligible children. In order to be eligible for MAA reimbursement, the LEA must spend *non-federal* funds on these activities.

Who administers the program?

The federal Centers for Medicaid and Medicare Services (CMS) contracts with the California Department of Health Care Services (DHCS). DHCS administers the program for the state and contracts with intermediaries (regional administrators) to help DHCS administer the school-based MAA program. Currently, these intermediaries are 11 LECs (local educational consortium) and 61 LGAs (local governmental agencies). The 11 LECs are certain County Offices of Education. The LGAs are County Public Health Departments and approximately 20 LGAs contract with DHCS to contract with school districts for the MAA program. A list of these LECs may be found at http://www.dhcs.ca.gov/provgovpart/Pages/MapoftheLECService.aspx .

How do clients apply for the program?

Not applicable. Students and families receive services from the school, if available, without an application.

What are the provider requirements?

Any LEA is eligible to participate in the MAA program if they are conducting reimbursable activities (outreach, facilitating applications, translation, arranging transportation, Medi-Cal program planning, policy development, and interagency coordination). However if these activities are conducted by individuals whose salaries are 100% covered by federal funds (e.g., a federal grant), the LEA cannot apply for MAA reimbursement because it has not spent any non-federal funds. Approximately 52% of school districts in California participate in MAA.

How do providers participate in the program?

The LEA must contract with either a LEC or a LGA and pay an administrative fee. The LEC or LGA (see "Who administers the program?") in turn contracts with DHCS. School districts may also need to contract with a vendor because the process is so complex. They pay an additional fee for vendor services.

---

[18] California State Auditor, Department of Health Services: Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts are Still Losing Millions Each Year in Federal Reimbursement, August 2005 p. 41

After the LEA establishes a contract with an LEC or an LGA, it must identify staff funded with state or local dollars who are conducting eligible activities. The following are potential MAA participants and activities:

- School Health Services Personnel: Health service staff and providers, such as school nurses, health clerks, and school psychologists, who directly administer health care for students and refer them to Medi-Cal covered services.
- Healthy Start: Healthy Start staff members often make referrals to Medi-Cal covered services and assist families with enrollment in Medi-Cal and Healthy Families.
- Community Parent Liaisons: These staff often talk to parents about a child's health issues and advise about available Medi-Cal resources. Liaisons often serve as translators for families and district staff, which may also be billable.
- Child Development Programs: These programs identify and address health problems at an early age.
- Special Education: Staff may help special education students coordinate services, or arrange for non-emergency transportation to Medi-Cal covered services.
- Preschool Program: Staff refer children to Medi-Cal services and assist them with enrollment in Medi-Cal and Healthy Families.
- Drug and Alcohol Programs: Staff perform administrative activities associated with drug and alcohol counseling, treatment, and referrals to Medi-Cal.
- Principals, Administrators, Clerical staff: Billable services are also often performed by school administrators, directors of student support services, coordinators of attendance and welfare, coordinators of safe and drug-free programs, health services coordinators, directors of special education, directors of early education extended learning programs, and clerical staff.

All staff who are conducting eligible activities must complete a time survey at least three times a year. Additional documents needed include a contract/operational plan that details which staff will perform which MAA and a quarterly invoice that details the costs of having performed MAA. Participation in the MAA program requires annual training and maintenance of an audit file. For additional information, see the School-Based MAA Manual at http://www.dhcs.ca.gov/provgovpart/Pages/SMAAManual2007.aspx

How well does MAA work for school health centers?

MAA provides unrestricted funds to school districts. Therefore, school health centers benefit only if school districts designate some of the funds to the school health center for health services. The school health center can be a separate claiming unit, thereby assuring that most of the reimbursement comes back to the school health center, but school health center staff can only directly participate in MAA claiming if they are employed by the school district, and agencies that are federally funded (e.g., FQHCs) cannot bill for nor receive MAA reimbursement.

School districts have incurred high administrative overhead costs in completing MAA billing. A 2005 state audit of the MAA program revealed that school districts paid as much as 20 percent of

---

[19] A federal school based audit in LaPorte Texas has disallowed Principals and Administrators. California is reviewing prior CMS guidance to substantiate billing for Principals and Administrators. However, based on their MAA billable time, it may hurt, not help, the invoice to include Principals and Administrators.

their MAA reimbursements to private vendors and consortia for assistance in administering the program, thereby reducing the amount of funds available to the school districts. Additionally, LEAs may experience delays in receiving reimbursement, as the federal CMS has been auditing California MAA programs since 2003 and continues to defer several million dollars in payments to the State pending completion of these audits.

Although school districts received $91 million from MAA for fiscal year 2002–03, it is estimated they could have received an additional $57 million had all school districts participated and certain districts fully used MAA. The two consistent reasons offered by school districts that have underused the program were 1) the lack of an experienced MAA coordinator with sufficient time to focus on the program and 2) a general resistance to and a lack of support for recording time spent on reimbursable activities. However, the audit strongly recommended additional support to school districts, stating "As the administering state agency for MAA, Health Services has a responsibility to California to help school districts receive all the federal funds to which they are entitled."

The Consumers Union, through its Healthy Kids Healthy Schools project, offers tips for successfully implementing MAA at http://www.consumersunion.org/pdf/healthyfuture.pdf

Additional Information

Contact your local educational consortium or your local governmental agency. You can also visit the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx

An online *School Based MAA Manual* Updated July 2007 is also available at http://www.dhcs.ca.gov/provgovpart/Pages/SMAAManual2007.aspx

---

[20] State Audit p. 41
[21] State Audit p. 5
[22] State Audit p. 6
[23] State Audit p. 6

Chapter 12 - Other Sources of Third Party Revenue

Children's Health Initiatives - "Healthy Kids Insurance"

A growing number of local coalitions have developed health insurance programs to provide comprehensive medical, dental and vision insurance to uninsured children who do not qualify for Medi-Cal or Healthy Families because their family income is too high or because of their immigration status. Many California counties have adopted innovative solutions to expand health insurance coverage to uninsured children and families through the Children's Health Initiative (CHI). To some degree the structure, financing, and political dynamics have varied in each county with a CHI, but the vision, target population, and expansion products have been fairly similar in scope. The programs seek to reach all children living in families with incomes up to 300% of the federal poverty level (with the exceptions of San Mateo and Riverside Counties), who do not qualify for existing public coverage. While their circumstances and approaches differ, and some have recently reduced funding, most CHIs share a bold vision of **health coverage for all children** and three key supporting strategies. These strategies include:

(1) Cultivating Public-Private Partnerships to provide affordable health coverage to all children;
(2) Creating a Single "One Open Door" Outreach and Enrollment Pathway; and
(3) Creating a New and Comprehensive *Healthy Kids Insurance Program*.

To research a program in your area and for enrollment applications, visit the website of the Institute for Healthy Policy Solutions, which tracks the progress of these local Healthy Kids Insurance programs at http://ihps-ca.org/localcovsol/index.html.

Expanded Access to Primary Care (EAPC)

Expanded Access to Primary Care is a state-funded program that pays Federally Qualified Health Clinics (FQHCs) and FQHC look-alikes to offer expanded outpatient services to qualified children. These services include preventative care, health education, health assessments, and treatment and referral services. For additional information: http://www.dhcs.ca.gov/services/rural/Pages/EAPCPage.aspx

CaliforniaKids

This is a program of the CaliforniaKids Healthcare Foundation designed to provide subsidized health coverage for preventive and primary care outpatient services to low income children who do not qualify for public health insurance programs due to their immigration status. For additional information: http://www.californiakids.org.

---

[24] For more information on FQHC look-alikes, see http://bphc.hrsa.gov/policy/pin0321.htm .

[25] FQHCs serve communities designated by the Federal government as "medically underserved" and receive a higher reimbursement rate for all services they provide.

Appendix 1 - Sample Consent Form (adapted from Northeast Valley Health Corporation)

School Health Center
General Consent for Treatment, Payment or Health Care Operations

Name of Student: ______________________ **Grade:** __________
Address: ______________________ **City:** __________
Home Phone Number: ______________________ **Birth Date:** __________
School: ______________________ **Student's SS#:** __________
Parent/Legal Guardian Emergency/ Work Phone No: ______________________

I have read and understand the services offered at this school health center ("health center"). I hereby authorize the health center to provide my son or daughter with simple, common, and routine health care services such as those listed below, to the extent my consent is required by law. I understand that under federal and state laws there are certain services that my child may receive that do not need my consent.

- Diagnosis and treatment of minor and acute illnesses
- Diagnosis and treatment of mental health issues
- First aid for minor injuries
- Physical examinations
- Assistance with chronic ongoing illnesses such as asthma, diabetes, and epilepsy
- Treatment of acne and other skin problems
- Immunizations
- Vision and hearing screening
- Laboratory Services
- Limited x-ray services
- Prescriptive and over-the-counter items
- Diet and weight control programs
- Referral for health care services that cannot be provided at the health center
- Emergency treatment

---

1. I understand that this consent only applies to services provided at the health center and does not allow any other private or public facility to provide services to my son or daughter.
2. I hereby authorize the health center to give my insurance carrier(s) medical or dental record information needed to complete my son or daughter's insurance claims.
3. I understand that my son or daughter's medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my son or daughter's care and treatment.
4. I understand that this consent may be revoked, restricted or revised at any time in writing by me however, will not affect services and/or treatment previously provided by health center and other prior reliance by health center on this consent.

Signature of Parent/Guardian/Conservator: ______________________ **Date:** ________

Print Name: ____

Insurance and Financial Information

I request and authorize direct payment to the health center of any insurance benefits (HMO, private insurance, Medi-Cal, etc.) otherwise payable to or on behalf of my son or daughter for services rendered by the health center at a rate not to exceed the actual charges for those services.

For health center services – I understand that neither my son or daughter nor my family will be charged directly for services provided by the health center. I understand that the health center will seek payment from all third party payment sources and/or grant funds. If my son or daughter is covered by any type of health insurance, I will provide insurance information to the clinic.

Signature of Parent/Guardian/Conservator: ____________________________ **Date:** ________

Print Name: ____

No charge will be made directly to you for any health services provided on school premises. The health center is permitted to recover payment for such services from insurance companies or other third party payors (HMOs, private insurance, Medi-Cal, etc.). We ask that you supply the insurance information requested below.

Medi-Cal/Medicaid # (if applicable): ____

Other Health Insurance Name: ____

Other Health Insurance Phone No: ____

Name of Insured: ____

Social Security No. of Insured: ____

Insurance Effective Date: ____

For Office Use Only

Date Received: ____

Signature Verified by: ____

School Health Center

Minor Consent Form

I am here for one or more of the following services:

- Family planning (any birth control method)
- Pregnancy testing and related care
- Diagnosis and treatment of sexually transmitted disease (STD)
- Diagnosis and treatment of contagious reportable disease or condition
- HIV testing, counseling and treatment
- Alcohol or drug abuse intervention
- Outpatient mental health treatment
- Care for rate and/or sexual assault

I am 12 years of age or older. My birthday is ___________________________________.

I have read and understand the services offered at the school health center ("health center"). The health center can provide me with services that are simple, common, and routine such as those described above.

I understand that my medical records will be kept confidential but that this information may be shared among health care providers associated with the health center. No other disclosures of my health information will be made without my written permission, except as permitted or required by law. I hereby authorize the health center to furnish my insurance carrier(s) with the necessary medical record data required to complete insurance claims.

I have reviewed and received a copy of my rights as a patient of the health center.

Signature: ____________________________________ **Date**: ______________________

Print Name: ____

Witness Signature: _____________________________ **Date**: ______________________

Appendix 2 – Sample PM 160 Form

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | LA Code | 94102104848 J

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

CHDP ASSESSMENT
Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column NEW C	KNOWN D	DATE OF SERVICE Mo. Day Year / FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12
CODE / OTHER TESTS — PLEASE REFER TO THE CHDP LIST OF TEST CODES					CODE / OTHER TESTS

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE /
HEMOGLOBIN | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS

ROUTINE REFERRAL(S) (√): ☐ BLOOD LEAD ☐ DENTAL
PATIENT IS A FOSTER CHILD (√) ☐

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

DIAGNOSIS CODES 1 2

THE QUESTIONS BELOW MUST BE ANSWERED
1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/Cessation. Yes ☐ No ☐

PATIENT VISIT (√): 1 New Patient or Extended Visit; 2 Routine Visit
TYPE OF SCREEN (√): 1 Initial; 2 Periodic
TOTAL FEES

1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

PROVIDER OF SERVICE: Name, Address, Telephone Number (Please include Area Code) | PROVIDER NUMBER | PLACE OF SERVICE

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY | AID | IDENTIFICATION NUMBER

1 √ If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter BIC number.
2 √ Patient eligible for CHDP benefits only.

SITE OF SERVICE IF OTHER THAN ABOVE:

This is to certify that the screening information is true and complete, and the results explained to the child or his parent or guardian. I understand that payment and satisfaction of this claim may be from Federal or State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

SIGNATURE OF PROVIDER DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

COPY 1 - MAIL TO MEDICAL CHDP → Medi-Cal/CHDP, P.O. Box 15300, Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (1/07)

Listed below are Place of Service (POS) Codes and Corresponding Descriptions to be used when Billing CHDP services

POS Code	Description
11	Office (any location other than Place of Service code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services
Department of Health Care Services
MS 8100
1515 K Street, Suite 400
Sacramento, CA 95814

(916) 327-1400

PM 160
06/07

Appendix 3 – Sample CMS 1500 Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

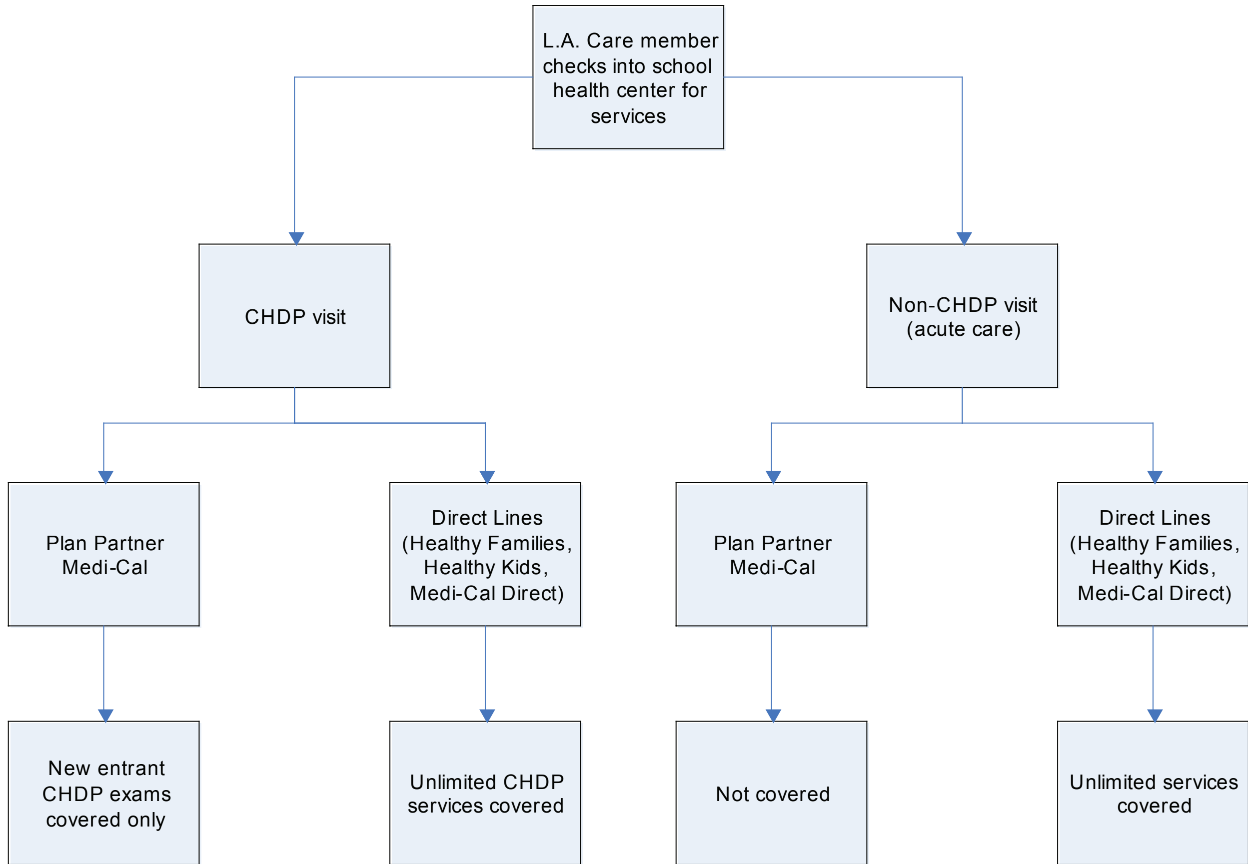
a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Appendix 4 - L.A. Care Patient Service Delivery Flowchart



Appendix 5 – Sample PM 161 Form

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention Program

CHDP CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT

CHDP Health Assessment Provider:

- Retain original form in patient's medical record.
- Send photocopy to diagnosis/treatment provider.

Diagnosis/Treatment Provider:

- Complete and sign form. Retain the signed form in patient's medical record.
- If patient consent is given, send photocopy of completed and signed form to the CHDP Health Assessment Provider.
- If patient consent is given, send photocopy of completed and signed form to the local CHDP program. To find the mailing address for the local CHDP Program, go to www.dhs.ca.gov/chdp.

CHDP HEALTH ASSESSMENT PROVIDER COMPLETES THIS SECTION:

Patient name (Last) (First) (Initial) | BIC number

Date of birth: Month | Day | Year — Sex: ☐ Female ☐ Male — Patient's county of residence — Code — Telephone number

Responsible person (Name) (Street) (City) (ZIP code)

Dear ______________________:
(Diagnosis/Treatment Provider)

The above named patient received a CHDP health assessment on ______________ (Date). The following suspected condition(s) was identified as needing further evaluation:

1. ______________________

2. ______________________

3. ______________________

After you have seen and examined the patient, please note your findings below. If appropriate consent has been obtained below, please send a photocopy to me and/or the local CHDP program. Thank you,

Printed name of CHDP Health Assessment Provider — Signature — Date

Mailing Address (street, number) — City — ZIP code — ( ) Telephone number

PARENT COMPLETES THIS SECTION:

CONSENT: I have read the release of information disclosure on page 2 and I hereby authorize release of information to:

☐ Local CHDP Program ☐ CHDP Health Assessment Provider

Signature of Responsible Person — Date

DIAGNOSIS/TREATMENT PROVIDER COMPLETES THIS SECTION:

A. What was your diagnosis (ICD terminology) of **suspected condition 1**?	What was your diagnosis (ICD terminology) of **suspected condition 2**?	What was your diagnosis (ICD terminology) of **suspected condition 3**?
ICD Code *(optional)*	ICD Code *(optional)*	ICD Code *(optional)*
B. **Result of diagnosis:** *(Check appropriate line.)* ☐ Abnormality not confirmed ☐ Abnormality confirmed: ☐ No treatment indicated ☐ Treatment indicated—given ☐ Treatment indicated—referred ☐ Treatment indicated—not given nor referred **Reason:**	**Result of diagnosis:** *(Check appropriate line.)* ☐ Abnormality not confirmed ☐ Abnormality confirmed: ☐ No treatment indicated ☐ Treatment indicated—given ☐ Treatment indicated—referred ☐ Treatment indicated—not given nor referred **Reason:**	**Result of diagnosis:** *(Check appropriate line.)* ☐ Abnormality not confirmed ☐ Abnormality confirmed: ☐ No treatment indicated ☐ Treatment indicated—given ☐ Treatment indicated—referred ☐ Treatment indicated—not given nor referred **Reason:**

Diagnosis/Treatment Provider signature ➤ — Date examined: Month | Day | Year — Diagnosis/Treatment Provider's telephone number ( )

PM 161 (09/07) Page 1 of 2

RELEASE OF INFORMATION DISCLOSURE

To the responsible person:

When your child or you are referred for diagnosis and/or treatment as a result of a CHDP health assessment, this form will be used to assist in the referral. Certain information regarding the reason for referral will be written on this form.

The original will be kept in your child's or your confidential patient file by the CHDP health assessment provider, and a copy will be sent to the health care provider or agency providing diagnostic and/or treatment services.

The results of the diagnostic and/or treatment services will be recorded on the copy. It will be kept by the diagnostic and/or treatment provider in your child's or your confidential patient file. With your permission, copies will be distributed as follows:

- A copy will be sent to your local CHDP program to let them know that your child or you received the recommended services. The director or the deputy director of the local CHDP program at your local health department has the responsibility to maintain this copy as a confidential record.

- A copy will be sent to the CHDP health assessment provider to let this provider know that your child or you received the recommended services. This copy will be kept by the health assessment provider in your child's or your confidential patient file.

Appendix 6 - Acronyms Guide

CAA- Certified Application Assistant
DHCS - California Department of Health Care Services
CHDP- Child Health and Disability Prevention
CMS- Children's Medical Services
CMS^{2}- Centers for Medicare and Medicaid Services
CSHC- California School Health Centers Association
EDS- Electronic Data Systems
EPSDT- Early, Periodic Screening, Diagnosis, and Treatment
Family PACT- Family Planning, Access, Care, and Treatment
FQHC- Federally Qualified Health Center
HAP- Health Access Program
IDEA- Individuals with Disabilities Education Act
IEP- Individualized Education Program
IFSP- Individualized Family Service Plan
LEA- Local Educational Agency
LEC- Local Education Consortium
LGA- Local Governmental Agency
MAA- Medi-Cal Administrative Activities
MRMIB- Managed Risk Medical Insurance Board
OFP- Office of Family Planning
POS- Point of service
SCHIP- State Child Health Insurance Program