Riverside County
Mental Health Plan

Inpatient
Provider Manual

http://www.rcdmh.org/Doing-Business/RCDMH-Inpatient-Provider-Manual

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CHAPTER 1 – INTRODUCTION

Introduction

We would like to welcome you to the Riverside County Mental Health Plan provider network. The Mental Health Plan authorizes inpatient services through the Quality Improvement Inpatient (QI Inpatient) Authorization and Appeals Department for Riverside County Medi-Cal beneficiaries and for resident indigent and Low Income Health Plan (LIHP) or Riverside County HealthCare (RCHC) minors and adults.

This manual was developed as a procedural reference for participating providers and contains guidelines that will assist you in meeting the standards set for the provision of psychiatric inpatient hospital services for the Riverside County Mental Health Plan. Please review the manual and maintain it as a reference for future use. We look forward to working with you to provide quality, cost-effective psychiatric inpatient hospital services to our consumers. If you have any questions, please call Quality Improvement Inpatient Authorization and Appeals Department at (951) 358-6031.

Riverside County Department of Mental Health Mission Statement

The Riverside County Department of Mental Health exists to provide effective, efficient, and culturally sensitive community-based services that enable severely mentally disabled adults, older adults, children at risk of mental disability, substance abusers, and individuals on conservatorship to achieve and maintain their optimal level of healthy personal and social functioning.

Mental Health Plan Contact Phone Number and Hours of Operation

Riverside County Department of Mental Health
Quality Improvement Inpatient Authorization and Appeals Department

http://rcdmh.org/opencms/english/mental_plan/

P.O. Box 7549
Riverside, CA 92513
HOURS OF OPERATION: Mon. through Thurs. 8 A.M. until 5:30 P.M.
Friday 8 A.M. until 4:30 P.M.

In order to assist you efficiently, please inquire or send the following to the departments and contacts below:

A. FOR 24-HOUR NOTIFICATIONS OF HOSPITAL ADMISSIONS:

Fax the Notification form (Attachment A) within 24 hours for both Medi-Cal and Indigents to:
Quality Improvement Inpatient
FAX: (951) 358-4474

B. FOR HOSPITAL TAR/CHART REVIEW:

All Hospital TARs with Riverside County Medi-Cal as the primary coverage or for Riverside County Indigents hospitalized at Hospitals with Indigent Contracts: Ensure that a complete and legible medical record for the entire hospitalization is submitted with the TAR for which a review, authorization and reimbursement are requested. Also, for Riverside County Indigents, ensure that the Riverside County Indigent Screening form for either Adults (Attachment C) or Minors (Attachment D) is included in the chart packet

a. Hospital TAR submissions via FedEx and UPS delivery:

RCDMH Quality Improvement Inpatient
Authorization and Appeals
4095 County Circle Drive
Riverside, CA. 92503

b. Hospital TAR related mail correspondence and phone inquiries:

RCDMH Quality Improvement Inpatient
Authorization and Appeals
P.O. Box 7549
Riverside, CA 92513

Main Line: (951) 358-6031

C. FOR HOSPITAL TAR/CHART REVIEW STATUS INQUIRIES:

Quality Improvement Inpatient Authorization and Appeals
Main Line: (951) 358-6031
Fax: (951) 358-4474

D. FOR FIRST LEVEL OF APPEAL:

ALL HOSPITAL TAR AND RIVERSIDE COUNTY INDIGENT FIRST LEVEL OF APPEALS:

Quality Improvement Inpatient Authorization and Appeals
Authorization and Appeals
P.O. Box 7549
Riverside, CA 92513
Main Line: (951) 358-6031
Fax: (951) 358-5038

ALL INPATIENT ATTENDING PSYCHIATRIST PROFESSIONAL FEES/FIRST LEVEL OF APPEALS: (for Medi-Cal beneficiaries only)

(HCFA Form CMS 1500 with CPT Codes: 99222, 99232)
The Appeal must have the following:

- A copy of the original HCFA form first submitted
- A brand new HCFA form to request for an appeal and a copy of the Denial/Pend letter
- A letter giving the reasons that the appeal is being requested and any supporting documentation, which would help determine the outcome of the appeal

- A copy of the authorization denial letter from the reviewing physician at Quality Improvement Inpatient

Quality Improvement Inpatient
Authorization and Appeals
P.O. Box 7549
Riverside, CA 92513
Main Line: (951) 358-6031
Fax: (951) 358-5038

E. FOR CLAIMS/BILLINGS:

ALL MANAGED CARE INPATIENT PROVIDERS CLAIMS
(Hospital Invoices, HCFA Claims)

MANAGED CARE DEPARTMENT, RCDMH
4060 A County Circle Drive
Riverside, CA 92503
Office Phone: (951) 358-7797
Fax: (951) 358-6868

ALL NON-PSYCHIATRIC IN-HOSPITAL CONSULTATION CLAIMS (i.e. H & P, Neurologist, etc.)
(HCFA Form CMSW 1500)

Send claim directly to ACS

F. FOR MANAGED CARE CONTRACT PROVIDER SUPPORT:

Contact the Provider Support Line
Hours of Operation: 8:00 A.M. to 5:00 P.M. Monday through Friday
Phone: (951) 358-7797

G. FOR CONSUMER GRIEVANCES AND APPEALS

Quality Improvement RCDMH
Consumer Grievances and Appeals
P.O. Box 7549
Riverside, CA 92513
Office Phone: 1-800- 660-3570

H. FOR PATIENTS' RIGHTS OFFICE

Patients' Rights Office, RCDMH
P. O. Box 7549
Riverside, CA 92513
ATTN: Eunice Wright
Office Phone: (951) 358-4600 or 1-800-350-0519
Fax: (951) 358-4581
Hours of Operation: Monday through Friday 7:30 A.M. to 4:30 P.M.
Supervisor: Mary Stetkevich

I. FOR DISCHARGE/AFTERCARE LINKAGE:

Consumers, parents, and family members: 1-800-706-7500 (CARES Line)
Inpatient providers: (951) 358-7797 (Managed Care)

Hours of Operation: 8:00 A.M. to 5:00 P.M. Monday through Friday
(for both CARES and Managed Care)

J. PSYCHIATRIC CONSULTATIONS FOR MEDI-CAL BENEFICIARIES ON A MEDICAL/SURGICAL FLOOR OF A HOSPITAL

(Does not apply to beneficiaries with Medicare/Medi-Cal or Other Health Insurance/Medi-Cal)

Please reference the Outpatient Provider Manual, Chapter 5, Inpatient Psychiatric Services (found on the RCDMH website)

K. LOW INCOME HEALTH PLAN (LIHP) or RIVERSIDE COUNTY HEALTHCARE (RCHC)

1. All 24-hour notification of admissions are faxed to (951) 358-4474
2. RCHC Treatment Authorization Requests (Attachment I) and charts are sent to RCDMH at P.O. Box 7549, Riverside, CA 92513, Mail Stop #3826 for regular postal service or 4095 County Circle Drive, Riverside, CA. 92503 for Fed Ex or UPS delivery.
3. For RCHC-related questions: leave a message on a confidential voicemail at (951) 358-6427 during office hours of Monday through Thursday from 8 a.m. until 5:30 p.m and Friday from 8 a.m. to 4:30 p.m. Calls will be responded to within one hour during business hours. If more urgent assistance is needed after hours when the office is closed, call (951) 452-3223.
4. MD Professional Fees are inclusive. Do not send a separate claim or bill.

CHAPTER 2 – HOSPITAL RESPONSIBILITIES

Hospitals with Medi-Cal Contracts

Riverside County Department of Mental Health (RCDMH) will authorize payment for hospitalized consumers only when the following criteria are met. No pre-authorization is required for emergency psychiatric admissions. The admitting hospital is responsible for verifying the following:

1. Consumer has current Riverside County Medi-Cal eligibility.
2. Consumer meets Title 9 Medical Necessity criteria for hospitalization.
3. Chart documentation sufficiently justifies Medical Necessity for hospitalization.
4. The hospital notifies RCDMH within 24 hours of intake by faxing a correct, complete and legible 24-Hour Notification form (Attachment A) to (951) 358-4474.
5. If any corrections are needed on the received 24-Hour Notification form, a 24-Hour Notification Correction Request (Attachment B) will be faxed to the hospital. The hospital will then fax a corrected 24-Hour Notification form to (951) 358-4474 within 24 hours.
6. A hospital Treatment Authorization Request (TAR), accompanied with a complete copy of the chart, must be received at Riverside County Department of Mental Health Quality Improvement Inpatient within fourteen (14) days from the day the patient is discharged. Receipt of TAR and chart after the fourteenth (14^{th}) day will be denied for payment.
7. There is a sixty (60)-day timeline (from date of discovery of Medi-Cal eligibility) for submission of a **retroactive** TAR.

Hospitals with Indigent Contracts

Riverside County Department of Mental Health will reimburse hospitals with Indigent Contracts for uninsured consumers only when the following criteria are met. The admitting hospital is responsible for verifying the following:

1. Consumer has been a resident of Riverside County for at least thirty (30) days immediately preceding hospitalization.
2. The hospital documents that all other possible funding sources have been ruled out.
3. Consumer meets Medical Necessity criteria for hospitalization.
4. Chart documentation sufficiently justifies Medical Necessity for hospitalization.
5. The admitting hospital must notify RCDMH within 24 hours of intake by faxing the following materials to (951) 358-4474:
    a. The 24-Hour Notification form (Attachment A) (correct, complete and legible)
    b. An accurate and complete Adult Indigent Screening form (Attachment C) if the patient is an adult.
    c. An accurate and complete Minor Indigent Screening form (Attachment D) if the patient is a minor.
6. A hospital Indigent TAR, accompanied with a complete copy of the chart, must be received at Riverside County Department of Mental Health Quality Improvement Inpatient within fourteen (14) days from the day the patient is discharged. Receipt of TAR and chart after the fourteenth (14^{th}) day will be denied for payment.

Other Hospitals

Riverside County Department of Mental Health will authorize payment for hospitalized consumers **only** when the following criteria are met. The admitting hospital is responsible for verifying the following:

1. Consumer has Riverside County Medi-Cal eligibility.
2. Consumer meets Title 9 Medical Necessity criteria for hospitalization.

3. Chart documentation sufficiently justifies Medical Necessity for hospitalization.
4. The hospital notifies Riverside County Department of Mental Health
   a. Within 24 hours of intake by faxing a correct, complete and legible 24-Hour Notification form to (951) 358-4474
   b. Or, in the event that the hospital fails to fax a 24-Hour Notification form within 24 hours, the hospital must provide a completed hospital TAR and complete chart to QI Inpatient within ten (10) days of admission.
5. A hospital TAR, accompanied with a complete copy of the chart, must be received at Riverside County Department of Mental Health Quality Improvement Inpatient within fourteen (14) days from the day the patient is discharged. Receipt of TAR and chart after the fourteenth (14^{th}) day will be denied for payment.

Low Income Health Plan (LIHP) or Riverside County HealthCare (RCHC)

On January 2012, Riverside County implemented a new Low-Income Health Plan for adults only. The plan is named Riverside County HealthCare (RCHC). This plan will provide health care coverage for many county residents who currently do not have any health insurance coverage. To be eligible for the plan, adults will need to meet the basic income requirement with income up to 133% of the Federal Poverty Level (FPL).

A RCHC plan member may require inpatient (hospital) psychiatric care and treatment at any time. Any RCHC member may be hospitalized at a RCDMH contract hospital in accordance with the standards and policies already set by RCDMH. Enrolled RCHC members requiring psychiatric hospitalization may be admitted to any hospital or PHF for acute psychiatric care when Medi-Cal Medical Necessity Criteria are met. Members who have been placed on a 5150 emergency mental health detention order must be sent to the nearest 5150 designated facility for the required psychiatric evaluation to be completed. If the RCHC member requires psychiatric hospitalization under the 5150, the RCHC member may be sent to any Riverside County 5150 designated facility that is on the current RCDMH-approved list.

All acute psychiatric hospital facilities that accept a RCHC member for admission and treatment will be required to follow the RCHC plan medication formulary in prescribing medications for the RCHC member. The RCHC formulary medications are generically-available medications only, including the psychotropic medications. The current approved formulary for the RCHC plan is available Riverside County HealthCare Plan website or by calling the Riverside County Regional Medical Center Pharmacy.

Psychiatrists at a RCDMH contact hospital will need to be sure what insurance coverage the person has. Before prescribing medications for a RCDMH patient, the psychiatrist will need to check the RCHC formulary to identify the list of medications that may be prescribed for the RCHC members. Psychiatrists should prescribe psychotropic medications only within the RCHC plan formulary.

If the psychiatrist prescribes a non-formulary medication for a RCHC plan member, the psychiatrist must understand that when the patient/member is discharged, any non-formulary medications that have been prescribed will not be covered by the RCHC plan. The patient will need to pay the full cost of these medications out of their own pocket and therefore may not be able to continue them.

For the initiation of the RCHC plan, all prescriptions for RCHC members who are being discharged from RCDMH contract hospitals will be processed only through the three (3) RCRMC pharmacies. RCHC plan members will have no payments or copayments for their psychotropic medications as long as they use

only the RCRMC pharmacies to obtain their medications. Information regarding these 3 RCRMC pharmacies is listed below.

RCHC plan members can take their written prescriptions to any other pharmacy they choose. However, they must pay the full cost of their prescription medications if prescriptions are taken to any other pharmacy than one of the 3 RCRMC pharmacy locations. All prescriptions for controlled substances for patients being discharged from RCDMH contract hospitals must be taken directly to one of the 3 RCRMC outpatient pharmacy locations to have these prescriptions filled in person.

COVERED PHARMACIES

1. RCRMC Moreno Valley Campus Pharmacy
   25620 Cactus Ave.
   Moreno Valley, CA 92555
   (951) 486-4515 (outpatient pharmacy)
   (951) 486-4522 (mail order)

2. RCRMC Arlington Campus Pharmacy
   9990 County Farm Rd.
   Riverside, CA 92503
   (951) 358-6107

3. The Neighborhood Pharmacy (Use this pharmacy only as a last resort)
   7140 Indiana Ave.
   Riverside, CA 92504
   (951) 358-6107

All other procedures for processing RCHC members through an inpatient psychiatric hospitalization are the same as for any other RCDMH client. Notification of any admission of a RCHC member must be provided to the RCDMH QI Inpatient office within 24 hours of the admission. The hospital is expected to process claims for reimbursement of services provided by following the usual Treatment Authorization Request (TAR) process.

All RCHC-related questions can be left on a confidential voicemail box at (951) 358-6427. Office hours are Monday through Thursday from 8 a.m. until 5:30p.m and Friday from 8 a.m. until 4:30p.m. Calls about a RCHC member who needs to be hospitalized and requests for guidance on what to do to transfer the patient to a Riverside County facility can be left on the (951) 358-6427 voicemail. Calls will be responded to within one hour during business hours. If more urgent assistance is needed after hours, when the office is closed, call (951) 452-3223. (See Chapter 1, Section K for procedural information)

Cultural Competency

Hospital Providers must provide culturally competent care for consumers. There must be documented evidence in all charts that mental health interpreter services were offered and documentation of the consumer's response to offers of interpreter services. When families provide interpreter services, there must be documentation that other linguistic services were offered first, but the client preferred to have a family member interpret for him/her. It is especially essential that interpreter services be provided for physician and social work meetings and for process groups.

TAR Errors

Incomplete or incorrect TARs cannot be processed for reimbursement authorization. The provider will be notified via letter (which may be mailed or faxed dependent upon what is needed to complete or correct the TAR). The provider must then immediately resubmit a new or corrected TAR, remembering the 14-day timeline constraint and late resubmissions may result in denial. After all corrections have been completed, the TAR and chart will be processed for payment authorization review.

Census Information

A Quality Improvement Inpatient staff may call or fax requesting admission/discharge status information. If a call is received, please provide discharge and/or continued hospital stay information as requested. A Daily Census form may also be designed by the facility and be faxed to Quality Inpatient at (951) 358-4474.

Planned Admissions

Planned admissions (i.e. electroconvulsive treatment (ECT), and other specialized treatment will be approved when written documentation indicates that the beneficiary meets medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services and must be approved by Riverside County Mental Health Medical Director previous to treatment.

Send planned admission requests to:

Quality Improvement Inpatient
Attention: Jerry Dennis, MD Medical Director
P.O. Box 7549
Riverside, CA 92513
Main Line: (951) 358-6031

Acute Day Services

Those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis and treatment of a mental disorder meeting the medical necessity criteria (See Chapter 3).

Administrative Day Services

Defined as psychiatric inpatient hospital services provided to a consumer who has been admitted for acute psychiatric inpatient services, and the consumer's stay must be continued beyond the consumer's need for acute services due to a temporary lack of appropriate residential placement options. The following are Administrative Day requirements:

- The chart note is labeled to identify that it is a note documenting discharge planning and/or placement activity, such as "Discharge Planning, Case Management, or Social Services."
- During the stay, the consumer previously has met medical necessity criteria for acute psychiatric inpatient hospital services for at least one day.
  CCR, Title 9, Chapter 11, Sections 1820.220(j) (5) and 1820.225(d) (2)

- There is no immediately available appropriate non-acute placement treatment facility in a reasonable geographic area, and the hospital documents contacts with a minimum of five (5) appropriate, non-acute treatment facilities per week subject to the following:
    1. Quality Improvement Inpatient may waive the five contact requirements if there are fewer than five appropriate non-acute treatment facilities available. In no case shall there be less than one contact per week.
    2. The lack of placement options at appropriate, non-acute treatment facilities and the contacts made are documented.
    3. Documentation of all contacts made, including documentation of lack of placement options, must include:
        a. The status of the placement option(s)
        b. The dates of the contact
        c. The name of the facility and name and telephone number of the contact person with whom the discharge planner speaks (Busy signals, no answer, or messages left on an answer service do not count.)
        d. The signature of the person making each contact

        CCR, Title 9, Chapter 11, Sections 1820.220(j) (5) and 1820.225(d) (2)
    4. There must be at least one placement call made on the first day of requested Administrative Days.
    5. If the discharge plan is for a board and care placement, more contacts with various facilities are needed since these facilities are numerous. It is NOT acceptable for a patient to be kept in the hospital waiting for an opening at a specific board and care when placement can be found elsewhere. If there is a bed pending, the hospital is responsible to continue to make calls searching for other placement during that waiting period.
    6. When a patient is to be discharged to an Institution for Mental Diseases (IMD), once the placement is identified, there **must be at least one documented placement search contact on the same day after Administrative Day designation has been ordered. Within the same first week, subsequent searches need to be conducted and documented.** Follow up documentations need to be noted for each facility to determine acceptance, pending or denied status.

If a patient is on conservatorship, the hospital will work with RCMH's Long Term Care Unit at phone number: (951) 358-6919. Long Term Care will keep a placement log, and the hospital is responsible for obtaining a copy of this log to be submitted with the TAR.

CHAPTER 3 – INPATIENT MEDICAL NECESSITY CRITERIA

Admission Criteria and Diagnosis

Consumers **MUST** meet one of the following:

- Current Riverside County Medi-Cal eligibility
- An indigent resident of Riverside County for at least thirty (30) days immediately preceding hospital admission
- Medicare/Medi-Cal recipient
- Other Healthcare/Medi-Cal recipient

Also, the following criteria must be met:

- Consumer meets Title 9 Medical Necessity criteria for hospitalization
- Chart documentation sufficiently justifies Medical Necessity for hospitalization

The following criteria for Medical Necessity in sections A, B and C must be met.

A. **Diagnosis:** The following diagnoses are reimbursable by Medi-Cal. If consumer does not meet criteria for these diagnoses, the TAR/claim will be denied. Although Riverside County recognizes the DSM-IV codes for treatment, providing the ICD9-CM codes is expected for claim submittal.

Included Diagnoses:
(From the Diagnostic and Statistical Manual, Fourth Edition (1994), published by the American Psychiatric Association)
CCR Title 9, Chapter 11, Section 1820.205(a) (1) (A-R)

- Pervasive Developmental Disorders, **includes Autistic Disorders**
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Cognitive Disorders (only Dementias with Delusions or Depressed Mood)
- Substance induced Disorders, only with a Psychotic, Mood, or Anxiety Disorder
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Intermittent Explosive Disorder
- Pyromania
- Adjustment Disorders
- Personality Disorders, **includes Antisocial Personality Disorders**
- An Included Diagnosis when an Excluded Diagnosis is also present – but only if the included diagnosis and the related impairment is the focus of treatment.

B. **Cannot be Safely Treated at a Lower level of Care,** except that a person who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met the criterion.

Requires Psychiatric Inpatient Hospital Services because of a Mental Disorder Due to the Indications in either 1 or 2 below:
CCR Title 9, Chapter 11, Sections 1820.205(a) (2) (B) 1 a-d, 1820.205(a)(2)(B) 2a-c, and 1820.205(b)(1-4)

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
    - Represent a current danger to self or others, or significant property destruction
    - Prevent the consumer from providing for, or utilizing, food, clothing, or shelter
    - Present a severe risk to the consumer's physical health
    - Represent a recent, significant deterioration in ability to function

2. Requires admission for one of the following:
    - Further psychiatric evaluation
    - Medication treatment (psychotropic medications)
    - Other treatments that can only reasonably be provided if the consumer is hospitalized

C. **Continued Stay Criteria**

- Continued presence of indications which meet medical necessity criteria as specified in B-1 above
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
- Presence of new indications which meet medical necessity criteria specified in B-1 above
- Need for continued medical evaluation or treatment that can only be provided if the consumer remains in psychiatric inpatient hospital.

CHAPTER 4 – INPATIENT CLAIM PROCESS

Hospital Medi-Cal Claims

After consumer's discharge, the hospital must submit a Treatment Authorization Request for Mental Health stay in Hospital (TAR –State Form 18-3) along with a complete copy of the chart as outlined in Attachment E: Inpatient TAR Processing Criteria. The Hospital TAR, accompanied with a complete copy of the chart, must be received by Riverside County Department of Mental Health within fourteen (14) days from the day the patient is discharged. Receipt of the TAR and chart after the fourteenth (14th) day will be denied for payment.

The chart **must** include every document that was a part of the chart as well as any medication administration record and legal paperwork that may be kept separate from the actual chart. The absence of these documents or an incomplete or incorrectly completed TAR may prevent the chart review from being completed and reimbursement of the claim will be delayed if not denied.

Upon receipt of the TAR/chart, Quality Improvement Inpatient will complete the chart review process within fourteen (14) days. A Nurse will review the TAR and chart and will either approve the TAR or refer the TAR/chart to a staff psychiatrist. The psychiatrist will review and make a final determination regarding any denied days before the TAR is finalized. Once finalized, the form 18-3 is faxed to the state authorizing Hospital bed days. A copy of the completed form 18-3 is also faxed to the hospital for Medi-Cal payment submittal. In the case of a denied or modified TAR, QI Inpatient will also issue an NOA-C (Attachment F) to the consumer. The NOA-C clearly states that this is not a bill so that the beneficiary knows that he/she is not responsible for the cost of the service rendered, but that the service was retrospectively denied or changed the payment request to the provider.

Psychiatrists/Psychologists Medi-Cal Claims

The medical record submitted for payment authorization will also be used to support the professional component of a Medi-Cal beneficiary's hospital stay as well. The authorized CPT codes for inpatient psychiatric specialty mental health services are shown on Attachment G.

Psychiatrist's/psychologist's professional fees for specialty mental health services will be matched to the hospital chart documentation and used to support Medi-Cal claims payments. Professional fees are reimbursable according to the chart review determination. If there is documentation missing, late, or medical necessity is not met, the doctor's services will be denied. If the hospital fails to submit a TAR/chart within the fourteen (14) day timeline, the professional fee will be denied. Professional fee claims should not be submitted to RCDMH prior to patient discharge.

Claims must be received by the **RCDMH Managed Care Unit, 4060 A County Circle Drive, Riverside, CA 92503** within **thirty (30) calendar days** of consumer's discharge. Claims will be denied if received after the thirtieth (30th) day.

Indigent Inpatient Claims

The hospital should develop a claim form similar to Attachment H. A copy of the Indigent TAR form along with the Indigent Screening Forms (Attachment D-Minor and Attachment C- Adult) and a copy of the chart must be received by Riverside County Department of Mental Health Quality Improvement Inpatient within 14 days from the day the patient is discharged. Notification of Admission for Indigent Funding

(Attachment H), Indigent Screening Forms (Attachment D-Minor and Attachment C-Adult) and chart copy received later than the fourteenth (14th) day after the consumer's discharge will be denied for payment.

Low Income Health Plan (LIHP) or Riverside County HealthCare (RCHC)

In the Fall of 2011, Riverside County implemented a new Low-Income Health Plan for adults only. The Plan is named Riverside County Health Care (RCHC). This plan provides health care coverage for many county residents who currently do not have any health insurance coverage. To be eligible for the plan, adults need to meet the basic income requirement with income up to 133% of the Federal Poverty Level (FPL).

A RCHC plan member may require inpatient (hospital) psychiatric care and treatment at any time. Any RCHC member may be hospitalized in accordance with the standards and policies already set by Riverside County Department of Mental Health. Enrolled RCHC members requiring psychiatric hospitalization may be admitted to any hospital or PHF for acute psychiatric care when Medi-Cal Medical Necessity Criteria are met (see Chapter Three for Medical Necessity Criteria). Members who have been placed on a 5150 emergency mental health detention order must be sent to the nearest 5150 designated facility for the required psychiatric evaluation to be completed. If the RCHC member requires psychiatric hospitalization under the 5150, the RCHC member may be sent to any Riverside County 5150 designated facility that is on the current RCDMH-approved list.

All acute psychiatric hospital facilities that accept a RCHC member for admission and treatment will be required to follow the RCHC plan medication formulary in prescribing medications for the RCHC member. The RCHC formulary consists of medications which are generically-available medications only, including the psychotropic medications. The current approved formulary for the RCHC plan is available on the Riverside County Health Care Plan website.

All other procedures for processing RCHC members through an inpatient psychiatric hospitalization are the same as for any other RCDMH client. Notification of any admission of a RCHC member must be provided to the RCDMH QI Inpatient office within 24 hours of the admission (Fax number: (951) 358-4474.

All RCHC-related questions can be left on a confidential voicemail box at (951) 358-6427. Office hours are Monday through Thursday from 7a.m. until 5:30p.m. Calls about a RCHC member who needs to be hospitalized and requests for guidance on what to do to transfer the patient to a Riverside County facility can be left on the (951) 358-6427 voicemail. Calls will be responded to within one hour during business hours. If more urgent assistance is needed after hours, when the office is closed, call (951) 452-3223. When submitting a claim for hospitalization, complete a Treatment Authorization Request (TAR), attach a complete copy of the medical record and send it to Riverside County Department of Mental Health Quality Improvement Inpatient. For regular postal service, the mailing address is P.O. Box 7549, Riverside, CA. 92513, Mail Stop #3826. For Fed Ex or UPS delivery, send to 4095 County Circle Drive, Riverside, CA 92503. Hospitals should develop a TAR claim form that is similar to Attachment I. A copy of the RCHC TAR form and complete copy of the medical record must be received by Riverside County Department of Mental Health Quality Improvement Inpatient within fourteen (14) days from the day that the patient is discharged. Notification of Admission for RCHC Funding and chart copy received later than the fourteenth (14th) day after the consumer's discharge will be denied for payment.

For requests for pre-authorization for outpatient services, call the CARES Line at 1-800-706-7500.

Medicare/Medi-Cal Claims

These claims are not reimbursable by the Riverside County Mental Health Plan until the beneficiary's Medicare benefits have been exhausted. If the stay was only partially reimbursed or fully denied by

Medicare, Quality Improvement Inpatient must be sent a TAR/chart with an Eligibility of Benefits form (EOB) from Medicare. The TAR, EOB form, and complete chart must be received by Quality Improvement Inpatient within the State time line of sixty (60) days from the hospital's receipt of the EOB or per the mandated timeline detailed in the hospital's contract with RCDMH.

Other Health Coverage/Share of Cost

Medi-Cal beneficiaries can also have insurance through a private insurance carrier. In these instances, Medi-Cal is the secondary insurer, and a TAR, copy of EOB, and complete chart must be received by Quality Improvement Inpatient within a sixty (60) day State time line from the hospital's receipt of the EOB from the private insurance carrier or per the mandated timeline detailed in the hospital's contract with RCDMH. Medi-Cal beneficiaries with a share of cost are not Medi-Cal eligible until they have paid their share of cost.

Submission of a TAR

An original DHCS form 18-3 (TAR) must be submitted. Hospitals may order these forms by calling the State's Fiscal intermediary-ACS at (800) 541-5555 or (916) 636-1200.

Hospitals will submit proof of the consumer's Medi-Cal eligibility during time of hospitalization along with the TAR. Eligibility can be determined by POS, AVES or Medi-Cal Eligibility Response. The County and Aid Codes are to be written on the TAR above box #11.

Instructions For Completing a TAR

- When multiple TARs are submitted, number the TARs (ex: 1 of 3, 2 or 3…) in the space that is to the right of the heading Confidential Patient Information.
- Box 6-Leave blank
- Box 7-Date of admission
- Box 8-Leave blank on acute day TAR. On Administrative Day TAR, place the last day of the acute stay in this box.
- Box 9-Place an "X" on all TARs.
- Box 10-Provider NPI number, Provider Phone Number, Name & Address and 9-digit zip code
- Box 11-Patient's Medi-Cal ID number
- Place the Medi-Cal County Code and Aid Code numbers above Box 11.
- Box 12-Blank
- Box 13-M or F
- Box 14-Date of Birth MM/DD/YYYY and Age (check accuracy with DOB)
- Box 15-Medicare Status: 0=No Medicare, 1=Medicare, Part A only, 2=Medicare Part B only, 3=Medicare, Part A & B
- Box 16-Other Coverage. "X" if patient has other insurance. "0" if no other insurance
- Box 17-Number of days requested on this TAR. Remember: The day of admission is counted, but not the day of discharge. Also, the maximum number of days is limited to 99 days per TAR.
- Box 18-Type of days: "0" for acute days and "2" for administrative days
- Box 19-Enter an "X" if the TAR is being submitted as a Retro TAR; otherwise, leave blank
- Box 20-Date of Discharge. If there is also an Administrative Day TAR being submitted, leave Box 20 Blank on the acute TAR and write below Box 20 "still in house." The date of discharge is placed on the Administrative Day TAR.
- Box 21-Admitting diagnostic code, which must match the written diagnosis
- Box 22-Discharge diagnostic code, which must match the written diagnosis.

- '*Patient's Authorized Representative'*-If known, enter the name and address of the patient's authorized legal representative, payee, or conservator, or the parent's name if the patient is a minor.
- '*Describe Current Condition Requiring Hospitalization'*-Complete as instructed on the TAR. Also, use this space to indicate specific dates requested when submitting multiple TARs
- '*Planned Procedures'*-Complete as instructed. On Appeal TARs, leave this section blank.
- '*Signature of Provider & Date*'-To be signed & dated by the hospital representative
- '*Signature of Physician & Date*'-To be signed & dated by the attending physician or psychologist
- '*For County Use Only*'-Leave blank.

TAR Update Transmittal (TUT)

TUTs are used to correct errors on TARs that are already on the ACS Master File.

- If ACS identifies an error, they will send a notification called "Unprocessable Mental Health TAR" directly to RCDMH QI Inpatient Authorization and Appeal Unit.
  - If changes are required on the original TAR, RCDMH QI Inpatient reserves the right to request written authorization from the hospital to make changes to the TAR.
  - The corrected TAR is then faxed back up to ACS.
- If the hospital identifies the error, the hospital shall fax to RCDMH QI Inpatient Authorization and Appeal Unit a request to make changes to the original TAR.
  - RCDMH will resubmit to ACS the correction and a TUT form.

Retroactive TAR

A Retroactive TAR is submitted for the following:

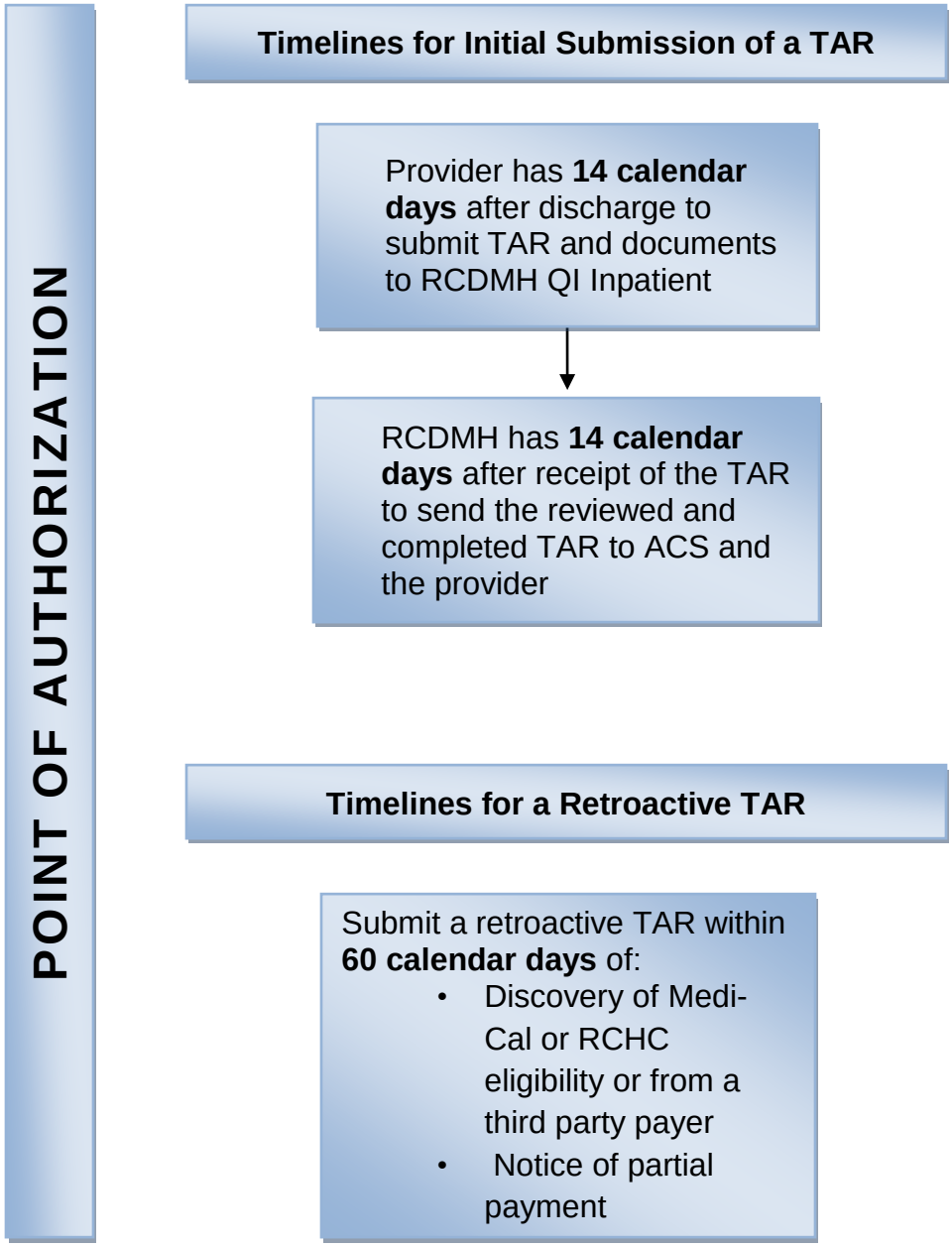
- In case of a natural disaster or circumstances beyond the control of the provider, which has been reported to an appropriate law enforcement or fire agency Title 9, Chapter 11, 1820.215.
- Medi-Cal eligibility inquiry during the hospital stay showed that the patient had no eligibility. Print out the inquiry for submission with the TAR.
- Denial of payment (exhaustion of benefits) or a partial payment from a third party payer (Medicare or other health care insurance)

Retroactive TARs must be submitted within a sixty (60) day State time line from the date of discovery of Medi-Cal eligibility or of the date of the Remittance Advice Statement (RA) or Notice of Exhaustion of Benefits (EOB) that was received from the third party payor.

Submit the retroactive TAR with proof of Medi-Cal eligibility and either the RA or EOB. The run date on the proof of eligibility or the date stamp on the RA or EOB, which reflects the date of receipt, will determine the start of the sixty (60) day timeline for submission of a retroactive TAR.

Note that TARs will not be considered retroactive if, at any time during the hospitalization, it is determined that there is Medi-Cal eligibility or that the third party benefits have expired or did not exist.

Timelines for TAR Submission



CHAPTER 5 - PROVIDER PROBLEM RESOLUTION PROCESS

Provider Informal Problem Resolution Process

Most complaints are solved quickly and easily on an informal level by discussing the issues with the people directly involved in the problem. If there are payment authorization concerns or questions that are fiscally related, contact the Managed Care Department, Claims and Billing Division. If there are clinically related concerns or questions, contact Quality Improvement Inpatient at (951) 358-6031. If a provider is not satisfied with their determination, the provider can send an appeal to Quality Improvement Inpatient involving a denied request for authorization or denied claims. On claims paid through ACS, a provider should contact ACS directly.

Providers have the right to access the Formal Provider Appeal Process at any time they are dissatisfied with a TAR/claim determination.

Appeals

Appeals should be mailed to:

Riverside County Department of Mental Health (RCDMH)
Quality Improvement Inpatient
Attention: Appeals
P.O. Box 7549
Riverside, CA 92513
Telephone (951) 358-6031
Fax (951) 358-5038

Appeals sent via UPS/FedEx should be sent to:

Riverside County Department of Mental Health (RCDMH)
Quality Improvement Inpatient
Attention: Appeals
4095 County Circle Drive
Riverside, CA 92503
Telephone (951) 358-6031
Fax (951) 358-5038

Appeal Procedures for Hospital Providers:

A hospital provider may appeal a denied or modified request for the MHP authorization. Additionally, a psychiatrist/psychologist provider may all appeal the processing or payment of that provider's claim to the MHP.

Hospital TAR Appeal

- A written appeal by a FFS hospital must be received by Quality Improvement Inpatient within **ninety (90) calendar days** of the receipt of the denied or modified request from the MHP and **thirty (30) calendar days** for Indigent Appeals.

- The appeal **must** include the following:

1. A cover letter of explanation for the appeal request
2. A new appeal TAR
3. Denial letter from the reviewing QI Inpatient M.D.
4. A copy of the original hospital TAR
5. All supporting documentation which would help to determine the outcome of the appeal

- Quality Improvement Inpatient has **sixty (60) calendar days** from receipt of the appeal to inform the hospital provider in writing of the appeal decision.

- Quality Improvement Inpatient's determination can result in the denial of the appeal, in full or in part, based on the following:
  1. The provider did not comply with the required timelines for notification or submission of the MHP request.
  2. There is missing documentation.
  3. Medical necessity criteria was not met.
  4. Requirements for approval of administrative days were not met.

- The hospital provider has **thirty (30) calendar days** from the date of Quality Improvement Inpatient's written decision of denial, to submit in writing, along with supporting documentation, a second level of appeal to the Department of Health Care Services (DHCS).

- If, however, Quality Improvement Inpatient does not respond within sixty (60) calendar days to the hospital provider appeal, the appeal should be considered denied. The hospital provider may then appeal to the DHCS within thirty (30) calendar days after sixty (60) calendar days from submission to Quality Improvement Inpatient.

- A hospital provider may not appeal the denial or modification of RCDMH payment authorization to DHCS when the denial or modification is based on RCDMH's determination that the hospital provider has failed to comply with the mandatory provisions of the contract between the hospital provider and RCDMH.

- Otherwise, the second level of appeal to DHCS should include, but not be limited to:
  1. Any documentation supporting allegations of timeliness, including fax records, telephone records or memo, if at issue
  2. Clinical records supporting the existence of medical necessity, if at issue.
  3. A summary of reasons why RCDMH should have approved the payment authorization
  4. A contact person(s) name, address, and phone number

  This information should be mailed to:

  Department of Health Care Services
  Mental Health Services Division
  Attn: TAR Appeals
  1500 Capitol Ave
  Suite 72.420
  MS 2300
  Sacramento, CA 95814
  Main Phone: (916) 319-9641

- The DHCS will notify RCDMH and the hospital provider of its receipt of a request for appeal within **seven (7) calendar days.** The notice to RCDMH will include a request for specific documentation supporting denial of RCDMH payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal. RCDMH will submit the requested documentation to DHCS within **twenty-one (21) calendar days** of the day the notice was received by RCDMH or the DHCS will

decide the appeal based solely on the documentation filed by the provider. The DHCS may allow both a provider representative(s) and RCDMH representative(s) an opportunity to present oral argument to the DHCS.

- DHCS will have **sixty (60) calendar days** from the receipt of RCDMH's documentation or from the twenty-first (21st) calendar day after the request for documentation was received by RCDMH, whichever is earlier, to notify the provider and RCDMH, in writing, of its decision. DHCS will include a statement of the reasons for the decision that addresses each issue raised by the provider and RCDMH, and any actions required by RCDMH or the provider to implement the decision. If the DHCS fails to act within the sixty (60) calendar days, the appeal may be considered to have been denied by DHCS.

Inpatient Psychiatrist/Psychologist Provider Appeal

- A written appeal by an inpatient psychiatrist/psychologist provider must be received at Quality Improvement Inpatient within **sixty (60) calendar days** from the date of the postmark on the Denial/Pend letter received from Managed Care.

- The appeal **must** include the following:
  1. A letter of explanation for the appeal request
  2. Documentation which would help determine the outcome of the appeal
  3. A new HCFA (CMS-1500) form that identifies the dates of services being appealed
  4. A copy of the original HCFA (CMS-1500) form first submitted to Managed Care
  5. A copy of the Denial/Pend letter received from Managed Care
  6. If denial is based on RCDMH not receiving the hospital TAR/chart, then the individual provider has the responsibility to (1) obtain proof of TAR/chart receipt via FedEx/UPS/Postal Service tracking confirmation directly from the hospital, and (1) ensure that the tracking confirmation shows receipt of that TAR/chart by RCDMH no later than the fourteenth (14th) day from the beneficiary's discharge. QI Inpatient will draft a letter to providers that states the claim has been denied due to the hospital not submitting a TAR within the allotted time frame. This letter will direct providers back to the hospital the service was provided at. The letter will also state that this can be appealed; however proof of notification within the timeline will need to be provided. This letter will be sent out by QI Inpatient within thirty (30) days of receipt date on the claim in no TAR has been received.

- Quality Improvement Inpatient has **sixty (60) calendar days** from receipt of the appeal to:
  1. Review the HCFA (CMS-1500) appeal
  2. Inform the hospital provider in writing of the appeal decision

- If an appeal is granted, the provider may submit a **revised** Health Insurance Claim Form (CMS-1500) to Managed Care Department for payment authorization within **thirty (30) calendar days** from receipt of Quality Improvement Inpatient's appeal decision. Managed Care Department will have **fourteen (14) calendar days** from the date of receipt of the provider's revised CMS-1500 for payment to take corrective action and process the payment.

Timeline for Appeals

HOSPITAL TAR APPEAL TIMELINES

First Level

Second Level

MEDI-CAL*

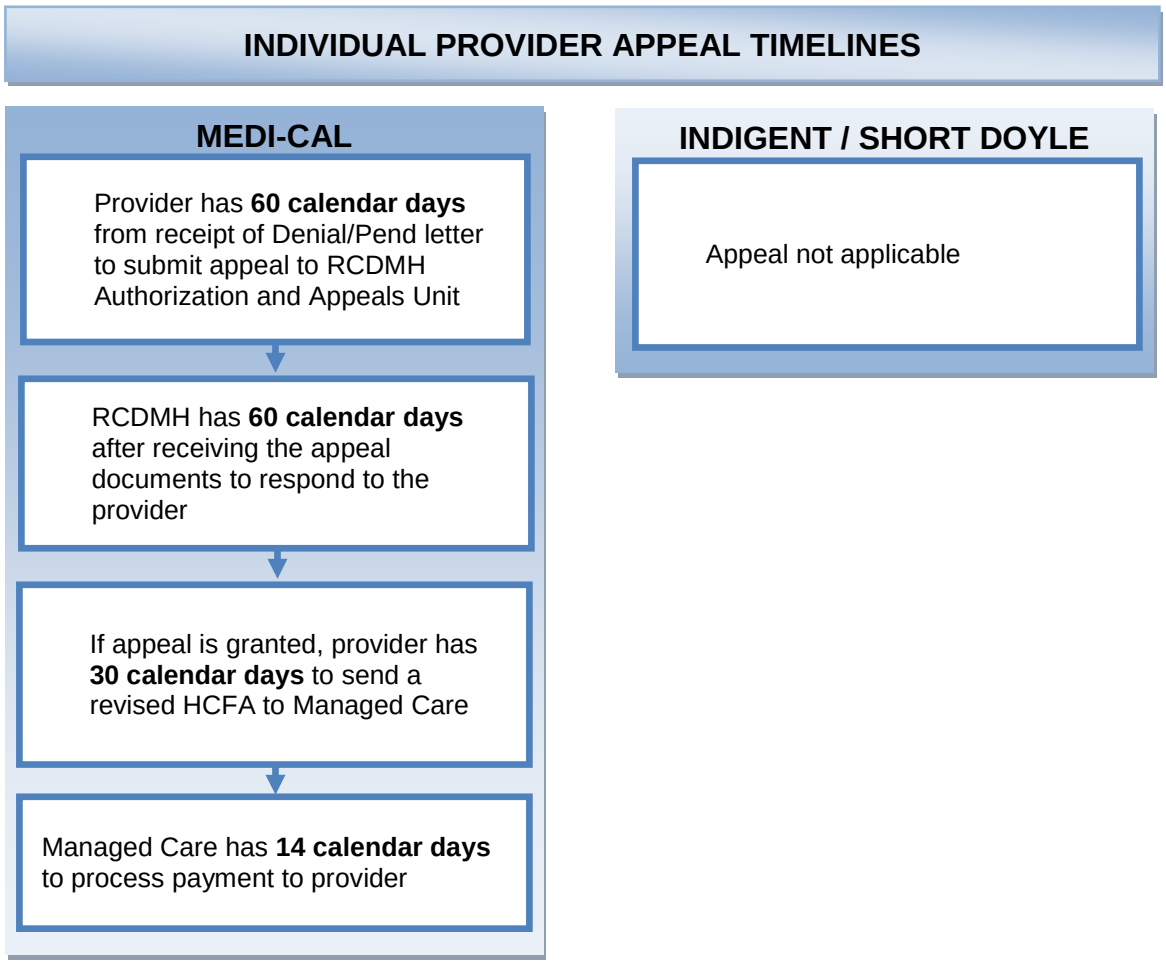
- Provider has **90 calendar days** after notification of denied days to appeal at the 1st level to RCDMH Authorization and Appeals Unit
- RCDMH has **60 calendar days** after receiving the appeal documents to respond to the provider
- If the 1st level appeal is not fully approved, provider has **30 days**, after notification, to send a 2nd Level appeal to the State
- State has **7 days** to request documents from local Mental Health Plan (LMHP)
- LMHP has **21 days** to send documents supporting denial of appeal to the State
- State has 60 days to notify the Provider and LMHP of the decision to uphold or reverse the decision
- If days are approved at 2nd Level, provider has **30 days** to submit TAR to the LMHP
- After receiving 2nd TAR, the LMHP has **14 days** to send the TAR to ACS and Provider

INDIGENT / SHORT DOYLE**

- Provider has **30 calendar days** after notification of denied days to appeal at the 1st level to RCDMH Authorization and Appeals Unit
- RCDMH has **60 calendar days** after receiving the appeal documents to respond to the provider
- 2nd Level of Appeal is not applicable

*Applicable to all hospitals
**Applicable to contracted hospitals only

Timeline for Individual Provider Appeals



CHAPTER 6 - ADVERSE INCIDENTS, STANDARD PRACTICES AND PROCEDURES

Policy Statement, Definition, General Principle and Reportable Incidents

Policy Statement

- All adverse incidents involving RCDMH clients are reported, reviewed and analyzed in a systematic way to identify opportunities for improvement in client care and treatment services, as well as clinical operations.
- A method for conducting reviews of adverse incidents to identify systems and other issues/problem areas that may be adversely affecting the outcomes of care shall be established.
- Through a systematic review of adverse incidents, identifying issues of concern, and developing corrective action plans responding to issues that may need to be addressed and corrected, improvements in outcomes, quality of care and treatment services and quality of life for consumers can be achieved.

Definition
An adverse incident is defined as any condition, event or situation which, in the mind of a reasonable person, jeopardizes or is reasonably considered to be seriously harmful to consumers, employees, providers or visitors.

General Principle
Incident Reports are confidential communications and are, as a result, privileged information and need to be identified as such.

Reportable Incidents

- All client deaths for all causes
- Incidents involving significant dangerousness to self, including serious suicide attempts or self-injury
- Incidents involving significant dangerousness to others, including serious assaults, homicide attempts and homicides
- Incidents involving significant injury that requires medical intervention for any client or visitor at a site or during a treatment activity off-site

Adverse Incident/Unusual Occurrence Reporting Procedure:

Each facility/provider is expected to develop and maintain policies/procedures which are site/provider specific for monitoring, reporting and investigating adverse incidents. The facility/provider must ensure that Adverse Incidents are monitored systematically and that corrective action is implemented in a timely manner. A system for reporting mandated investigations and corrective actions to the Department of Health Care Services must be put into place, and the provider will be responsible for reporting licensing violations regarding licensed professional staff to the appropriate professional licensing board(s), and to the National Practitioner Data Bank (NPDB); and licensing violations regarding licensed facilities to the appropriate agency.

Quality Improvement Inpatient will be available for any requested consultation and will follow all RCMH protocols as needed. QI Inpatient main number: (951) 358-6031.

CHAPTER 7 - CONSUMER NOTICES/GRIEVANCES/APPEALS

Introduction

All beneficiaries/consumers of RCDMH services have the right to have access to adequate information regarding complaint resolution/grievance process and shall have the right to file a grievance.
A beneficiary/consumer grievance process and a Medi-Cal beneficiary appeal process provide mental health beneficiaries or their representatives and other consumers of mental health services with a method for resolving their concerns. Throughout the grievance and appeal processes, beneficiaries/consumers will be informed of their rights and of the steps available to them to exercise those rights. Title 9, Chapter 11, Sub-Chapter 5, Section 1850.205

Each hospital facility will maintain a complaint resolution/grievance process, ensuring the beneficiaries'/consumers' right to a complaint, grievance and an appeal process.

Beneficiary Informing Materials

Facilities will provide beneficiaries with a copy of the informing materials when the beneficiary initially accesses services and upon request. Information on Patients' Rights (including appropriate telephone number) will be readily accessible and visibly posted in prominent locations.

- a description of services available
- the process for obtaining the services
- beneficiary rights
- the right to request a change of providers
- confidentiality rights
- advance directive information
- a description of the beneficiary problem resolution process

The information provided will include both the grievance and appeals processes and will state that a Medi-Cal beneficiary may request a State Fair Hearing after they have completed the problem resolution process.

Notices explaining complaint resolution and grievance process procedures will be posted in facility sites that are accessible to the beneficiaries. Grievance information, along with self-addressed envelopes for mailing grievances and/or appeals will be located next to the descriptions of the Grievance Procedure and the Appeal Procedure. The grievance, appeals, and self-addressed envelopes must be available to the beneficiary and/or beneficiary representative without the beneficiary and/or beneficiary representative having to make a verbal or written request to anyone.

A notice will be conspicuously displayed in all mental health facilities providing information for the consumer to call Patients' Rights and information to register a grievance and/or appeal. The telephone number for Patients' Rights is (800) 350-0519. The Quality Improvement Outpatient Program is responsible for overseeing any grievances that are made to RCDMH; the telephone number is (800) 660-3570. Grievance and/or appeal information will also be available through Quality Improvement Inpatient at (951) 358-6031.

The beneficiary may authorize another person to act on his/her behalf. For example, the beneficiary may ask the service provider, a friend, a family member, legal representative, or Consumer's Rights staff. At the beneficiary's request, that person may act on the beneficiary's behalf in the use of the complaint/grievance/appeal process.

Beneficiaries will not be subject to discrimination or any other penalty for a filing a grievance, appeal, or State Fair Hearing. The procedure for the process shall insure the confidentiality of a beneficiary's record. Informed consent shall be obtained from beneficiaries when any information or records are released to anyone not specifically authorized by law to have access.

Consumer Grievance Process

A beneficiary or beneficiary's representative or consumer may file a grievance, orally or in writing with his/her provider/hospital, with a Patients Rights Advocate, or with Quality Improvement Inpatient. An example of a grievance might be as follows: the quality of care of services provided, aspects of interpersonal relationships such as rudeness of an employee, etc.

At any time that QI Inpatient is notified of a consumer grievance, the program will follow RCDMH protocol and will confer with QI Outpatient on grievance outcome determination as needed as per the RCDMH Outpatient Provider Manual.

Every effort to provide for resolution of the beneficiary's/consumer's grievance as quickly and simply as possible will be made by the recipient of the grievance. Resolution may be reached through discussions between the beneficiary/consumer, or the beneficiary's representative and the hospital representative or other persons involved in the matter at hand. If the contract provider (hospital) reaches resolution of any beneficiary's grievance that had been forward to RCMH, the contract provider (hospital) will notify QI Inpatient of the resolution. QI Inpatient will review and approve the resolution.

Confidentiality

Grievance and Appeal procedures shall ensure the confidentiality of beneficiary/consumer records. Informed consent shall be obtained from beneficiaries/consumers when any information or records are released to anyone not specifically authorized by law to have access.

CHAPTER 8 - MEDICATION DECLARATIONS

General Information

Each consumer should participate in the development of his/her treatment plan, which may include the use of medications. Consumers should be informed to the fullest extent practicable of the anticipated benefits, risks, alternative treatments, and possible immediate and long-term effects of specific medications and consumer signed consent obtained.

Psychiatric Evaluations are authorized to determine the need for medication. After the initial psychiatric evaluation, ongoing psychiatric monitoring is authorized only when psychiatric medications are being prescribed. For children, when there are no medications being prescribed, the MD may be authorized collateral sessions in order to determine if medications might become needed in the immediate future. Whenever a patient is consistently refusing psychiatric medication for more than 3-4 days, a Riese Hearing must be considered.

Medications for Dependents and Wards of Riverside Juvenile Court

Aside from the exceptions noted below, minors who are wards or dependents of the court should not be prescribed psychiatric medication without authorization from the juvenile court in the form of a signed Med Dec (Medication Declaration/JV 220).

An exception is made for dependents placed at home with their parents under family reunification and wards who are place at home with their parents. Under these circumstances, parents may consent to the use of psychiatric medications.

However, in the hospital, the only exception for starting psychiatric medications for wards and dependents without signed authorization is when the treating physician determines that an emergency situation is present. In addition to circumstances when life and limb are threatened, an emergency may include the need to use medications to prevent undue suffering.

Routine/non-emergency situations

The hospital physician may only prescribe psychiatric medications and doses which have previously been specifically authorized by the court. If the physician believes that different psychiatric medications are indicated or needed at higher doses than previously authorized, he must complete and submit a new Med Dec. The new medication may not be prescribed until the new Med Dec is returned to the physician, hospital and/or placement.

Emergency situations

If the hospital physician determines that an emergency is present, he/she may start any clinically-appropriate psychiatric medication without waiting for an authorized Med Dec. However, if these medications or any other new medications are to be used on an ongoing basis, the physician must submit a new Med Dec at the time of starting the emergency medications. On this new Med Dec form, the physician must complete Question #3 describing what circumstances led to the determination that an emergency was present.

These emergency medications can continue to be prescribed in the hospital (or at a subsequent placement) until a decision has been made by the court. If the court decides to deny the request for these medications, they must be stopped as soon as the physician, hospital, or placement is notified.

Submission of a Medication Declaration

The physician must fill out forms JV-220 (Attachment J-2 & J-2(S) and JV 220A (Attachment J-3 & J-3 (S), which are collectively known as a Med Dec. It is allowable for an associated worker to fill out and sign the one page JV-220; the physician is responsible for filling out and signing the three page JV-220A.

The Med Dec is then faxed to the RCMDH QI Outpatient office at (951) 955-7203.

The QI Psychiatrist then reviews the submitted Med Dec for completeness and clinical appropriateness. It is then forwarded to Juvenile Court.

After the Judge/Commissioner makes his decision to either authorize or deny the use of the submitted medications, the signed Med Dec is faxed back to the QI office. The QI office then faxes a copy to the physician, hospital and/or placement.

Authorized Med Decs are valid for six months (or possibly less if the court officer decides to specify a shorter time). Even if there are no changes in a minor's medication, a new Med Dec must be re-submitted before the end of the six month period. A plan to start a new medication or to use a dose of medication higher than currently authorized requires a new submission at that time.

Additional information about the use of psychiatric medications wards and dependents may be found in RCDMH Policy 280: Consent for Medication of Court Wards and Dependents Not Under Conservatorship. A Copy of this policy may be found in the RCDMH publication Psychotropic Medication Guidelines, revised December 2008. This publication also describes other policies and guidelines relevant to use of medications in minors and adults and should be reviewed by the treating physician.

Addition forms, such as JV-223, in both English and Spanish, are also available as attachments (Attachment J-5 & J-5S).

The forms are also available on the websites:
http://www.courts.ca.gov/formnumber.htm
http://rcdmh.org/opencms/english/mental_plan/outpatient_attachments/ (Attachment 4)

CHAPTER 9 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)/ADVANCE DIRECTIVES

The Health Insurance Portability and Accounting Act (HIPAA) was signed into federal law in 1996. The purpose of this law was to protect health insurance coverage for workers and their families when they change or lose their job.

However, the law also includes a section called Administrative Simplification. This section is specifically designed to reduce the administrative burden associated with the transfer of health information between organizations, and more generally, to increase the efficiency and cost-effectiveness of the United States health care system. Part of this Administrative Simplification was the Privacy Rule and Transactions and Code Set. The Privacy and Transactions and Code Set standards are finalized and became effective in the year of 2003.

Privacy Rule

The Privacy Rule was effective April 14, 2003. The Privacy Rule requires that we take reasonable steps to limit our workforce use/disclosure/request for protected health information (PHI) to the **minimum necessary** to accomplish the intended workforce purpose; to evaluate practices and enhance protections to prevent unnecessary, inappropriate access to PHI by person, or by class of person.

Privacy Rule Minimum Necessary Provisions Do Not Apply:

- Disclosures to or requests by a health care provider for treatment purposes
- Disclosures to the individual who is the subject of the information
- Uses or disclosures made pursuant to an authorization requested by the individual
- Uses or disclosures required for compliance with the standardized Health Insurance Portability and Accountability Act transactions
- Uses or disclosures that are required by other law

Notice of Privacy Practice (NPP)

A Notice of Privacy Practice (NPP) must be distributed and explained to all Riverside County Medi-Cal beneficiaries' protected health information (PHI). The notice should also describe the rights and responsibilities of the beneficiaries. The beneficiary or his/her representative should sign an Acknowledgement Form that he/she has received a copy of the NPP. The Acknowledgement Form is placed in the beneficiary's chart. If a beneficiary or his/her representative refuses to sign the Acknowledgment Form, this should be noted on the Form. The Form is placed in the beneficiary's chart. Providers may elect to use their own HIPAA-compliant NPP or, for their convenience, may use the Riverside County Notice of Privacy Practice as a template. A copy of this notice can be obtained from the Department's website: http://mentalhealth.co.riverside.ca.us.

Notice of Privacy Practice (NPP) Poster: A notice of NPP poster containing all of the information of the NPP must be posted in the lobby of the provider.

Facsimile Transmittal of Protected Health Information (PHI):

All providers must insure that fax machines are in a secure area. When faxing PHI, a fax coversheet must be used that includes a pre-printed confidentiality statement. The statement must include instructions for destruction of the document in the event that the fax is received in error and that the recipient should contact the sender immediately to inform them that the fax was received in error. Fax numbers not previously used should be verified to help ensure that the information reaches the appropriate destination by calling and checking with the person/facility to which the information is being faxed.

The following are additional precaution steps that should be taken to ensure the protection of health information:

- Position computers so the screen is not easily read by unauthorized people
- Lock work stations when away from desk/office
- Facilities should be secured, i.e., locked cabinets for files, secure entries, etc.
- Consumer files should have a check out method to prevent unauthorized use of patient records

Transactions and Code Sets

Transactions and Code Sets became effective on October 16, 2003. The Department of Health and Human Services (HHS) was required to adopt "national standards" for electronic health care transactions and code sets. These national standard codes include: ICD-9, CPT and HCPC level 1 & 2. Local **CPT Codes** and **DSM IV** will no longer be accepted for use as a service and diagnostic treatment categories.

Advance Directives

It is the policy of the RCDMH that all RCDMH contracted providers provide all adult consumers with an information brochure concerning their rights under California state law regarding Advance Medical Directives at the first face to face contact for services and thereafter upon request by the consumer. In the event a consumer presents a specific, completed, appropriately witnessed and signed executed Advance Medical Directive to a staff member, the document shall be placed in the consumer's mental health file and the presence of the Advance Medical Directive shall be documented in his/her chart.

RCDMH contracted providers shall provide the "Your Right to Make Decisions about Medical Treatment" brochure (See Attachment I) regarding Advance Medical Directives when they have their first face-to-face service contact with the consumer and thereafter upon request from a consumer. The brochure regarding Advance Medical Directives shall be maintained in compliance with existing California state law and will be updated to reflect changes in state law within ninety (90) days of the implementation of a change.

CHAPTER 10 – CONTRACTING WITH THE COUNTY AND PROVIDER SITE REVEIW

Contracting with the County

State of California certified Medi-Cal FFS acute psychiatric inpatient facilities located within the Southern California Region are encouraged to contract with RCDMH and may contact the Provider Support Line from 8:00 A.M. until 5:00 P.M. Monday through Friday at (951) 358-7797

The Local Mental Health Plan requires that each Contract Provider maintains:

- Compliance with the contract between the provider and RCDMH
- A safe facility and the storage and dispensing of medications in compliance with state and federal laws and regulations
- Compliance with documentation standards, maintenance of records, and facility standards as required by RCDMH

The facility and services of providers will be reviewed on a regular basis to determine compliance with regulatory and contract standards.

All Contract Providers must immediately inform RCDMH Provider Support of all of the following:

- Any/all changes that affect the provider's ability to provide contracted services
- Changes in ownership
- Mergers
- Financial viability
- Insurance
- Permits
- Licenses
- Staffing Pattern
- Other dated material and changes that are required from the contract package

Change of Ownership or Location (the following applies to both):

- RCDMH must be notified at least sixty (60) days prior to a change of address for any contracted Hospital Provider to:

  MANAGED CARE DEPARTMENT, RCDMH
  4060 A County Circle Drive
  Riverside, CA. 92503
  Office Phone: (951) 358-7797 Fax: (951) 358-6868

- Sixty (60) days prior to the change of ownership or location, the local mental health director or designee must inform the DHCS, Program Compliance, (916) 651-3838, of the following:
  - The current provider name and date of termination, if applicable
  - The new address of provider, if applicable
  - The name of the new provider, if applicable
  - The date of ownership or location of change
  - Any major staff or program changes
- Involuntary changes of location due to disaster should be reported as soon as possible and are not subject to the sixty (60) days prior notification requirement.

ATTACHMENTS

24-Hour Inpatient Notification: Attachment A
24-Hour Notification Correction Request: Attachment B
Indigent Screening Form Adult: Attachment C
Indigent Screening Form Minor: Attachment D
Inpatient TAR Processing Criteria: Attachment E
NOA-C: Attachment F
Inpatient Psychiatrist CPT Codes: Attachment G
Indigent Notification and TAR: Attachment H
LIHP/RCHC Notification and TAR: Attachment I
RCMH Policy 280-Consent for Medication of Court Wards and Dependents not Under Conservatorship: Attachment J
Medication Declaration Fax Cover Sheet: Attachment J-1
JV-220: Attachment J-2
JV-220 S Spanish: Attachment J-2 (S)
JV-220A: Attachment J-3
JV-220A S Spanish: Attachment J-3 (S)
JV-221: Attachment J-4
JV-221 S Spanish: Attachment J-4 (S)
JV-223: Attachment J-5
JV-223 S Spanish: Attachment J-5 (S)
Your Right to Make Decisions About Medical Treatment English: Attachment K-a
Your Right to Make Decisions About Medical Treatment Spanish: Attachment K-b