



INPATIENT PROVIDER MANUAL

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<http://www.rcdmh.org/Doing-Business/RUHSBH-Inpatient-Provider-Manual>

Table of Contents

CHAPTER 1 – INTRODUCTION AND CONTACT INFORMATION	5
Introduction	5
RUHS-BH Mission Statement.....	5
RUHS-BH Contact Information.....	5
CHAPTER 2 – HOSPITAL RESPONSIBILITIES.....	8
Hospitals with Medi-Cal Contracts.....	8
Hospitals with Indigent Contracts	8
IMD-Excluded Hospitalizations.....	9
Cultural Competency.....	9
TAR Errors	9
Census Information	9
Planned Admissions.....	10
CHAPTER 3 – INPATIENT MEDICAL NECESSITY CRITERIA.....	11
CHAPTER 4 – INTERDISCIPLINARY TREATMENT PLAN REQUIREMENTS	12
CHAPTER 5 – DOCUMENTATION OF ADMINISTRATIVE DAYS	13
CHAPTER 6 – INPATIENT CLAIMS PROCESS.....	14
Hospital Medi-Cal Claims	14
Psychiatrists/Psychologists Medi-Cal Claims	14
Indigent Inpatient Claims.....	14
IMD-Excluded Inpatient Claims	15
Medicare/Medi-Cal Claims	15
Other Health Coverage/Share of Cost.....	15
Submission of a TAR.....	16
Instructions for Completing a TAR.....	16
TAR Update Transmittal (TUT).....	17
Retroactive TAR.....	17
Timelines for TAR Submission	18
CHAPTER 7 – PROVIDER PROBLEM RESOLUTION PROCESS.....	19
Provider Informal Problem Resolution Process	19
Appeals.....	19
Hospital Appeals	19
IMD-Excluded Hospitalization Appeals.....	20

Professional Staff Provider Appeals	21
Timeline for Appeals.....	22
Timeline for Individual Provider Appeals.....	23
CHAPTER 8 – ADVERSE INCIDENTS, STANDARD PRACTICES AND PROCEDURES	24
Policy Statement	24
Definition	24
Confidentiality	24
Reportable Incidents	24
Adverse Incident/Unusual Occurrence Reporting Procedure.....	24
CHAPTER 9 – PATIENT NOTICES/GRIEVANCES/APPEALS	25
Introduction	25
Beneficiary Informational Materials.....	25
Patient Grievance Process	26
Confidentiality	26
CHAPTER 10 – MEDICATION DECLARATIONS	27
Medications for Dependents and Wards of Riverside Juvenile Court.....	27
Routine/Non-Emergency Situations.....	27
Emergency Situations	27
Submission of a Medication Declaration.....	28
CHAPTER 11 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)/ADVANCE DIRECTIVES	29
Privacy Rule.....	29
Notice of Privacy Practice (NPP)	29
Facsimile Transmittal of Protected Health Information (PHI).....	29
Transactions and Code Sets	30
Advance Directives	30
CHAPTER 12 – CONTRACTING WITH THE COUNTY AND LPS DESIGNATION.....	31
ATTACHMENTS.....	32
Attachment A: 24-Hour Inpatient Notification	
Attachment B: 24-Hour Notification Correction Request	
Attachment C: Indigent Screening Form: Adult	
Attachment D: Indigent Screening Form: Minor	

Attachment E: Inpatient TAR Processing Requirements

Attachment F: Specialty Mental Health Inpatient Services, ICD-10 Covered Diagnoses Table

Attachment G: Medical Necessity Documentation and Guidelines for Inpatient Providers (Acute Days)

Attachment H: Documentation of Administrative Days for Inpatient Providers

Attachment I: Notice of Adverse Benefit Determination (NOABD)

Attachment J: Inpatient Psychiatrist CPT Codes

Attachment K: Indigent Notification and TAR

Attachment L: California Guidelines for the Use of Psychotropic Medication with Child and Youth in Foster Care

Attachment M: Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents

Attachment N: Medication Declaration Fax Cover Sheet

Attachment O-1: JV-220

Attachment O-2: JV-220 S (Spanish)

Attachment P-1: JV-220A

Attachment P-2: JV-220A S (Spanish)

Attachment Q-1: JV-221

Attachment Q-2: JV-221 S (Spanish)

Attachment R-1: JV-223

Attachment R-2: JV-223 S (Spanish)

Attachment S-1: "Your Right to Make Decisions About Medical Treatment"

Attachment S-2: "Your Right to Make Decisions About Medical Treatment "(Spanish)

CHAPTER 1 – INTRODUCTION AND CONTACT INFORMATION

Introduction

Welcome to the Riverside University Health System-Behavioral Health (RUHS-BH) provider network. The RUHS-BH Quality Improvement Inpatient Program authorizes inpatient services for Riverside County Medi-Cal beneficiaries and residents of Riverside County who are indigent. This manual contains guidelines to meet RUHS-BH standards for the provision of high quality psychiatric inpatient services. If you have any questions, please call Quality Improvement Inpatient Program at 951-358-6031.

RUHS-BH Mission Statement

RUHS-BH aims 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 Information and Hours of Operation

Riverside University Health System-Behavioral Health (RUHS-BH) Quality Improvement Inpatient Program

9890 County Farm Road, Bldg. 1
Riverside, CA 92503

HOURS OF OPERATION:
Monday through Thursday, 8:00 A.M. - 5:30 P.M.
Friday, 8:00 A.M. - 4:30 P.M.

A. 24-HOUR NOTIFICATIONS OF HOSPITAL ADMISSIONS:

Fax the Notification form ([Attachment A](#)) within 24 hours for Medi-Cal and indigent patients to:

RUHS-BH Quality Improvement Inpatient Program
FAX: 951-358-4474

B. INITIAL HOSPITAL TAR/CHART REVIEW:

For hospitalizations of patients with Riverside County Medi-Cal (primary coverage) or for Riverside County indigent patients at hospitals with Indigent Contracts:

When submitting a claim, please submit a TAR and a complete and legible medical record for the entire hospitalization for review, authorization and reimbursement. For Riverside County indigent patients, include the *Riverside County Indigent Screening Form for Adults* ([Attachment C](#)) or *Minors* ([Attachment D](#)).

i. HOSPITAL TAR SUBMISSIONS

MAIL/SHIP TO:

RUHS-BH Quality Improvement Inpatient Program
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

ii. HOSPITAL TAR/CHART REVIEW STATUS INQUIRIES:

RUHS-BH Quality Improvement Inpatient Program
Phone: 951-358-6031
Fax: 951-358-4474

C. FIRST LEVEL OF APPEAL:

i. HOSPITAL TAR FIRST LEVEL OF APPEAL SUBMISSIONS:

(If you already submitted a complete copy of the medical record, it is not necessary to send another copy of it. Do send a new TAR and any additional records or letters that you want considered).

MAIL/SHIP TO:

RUHS-BH Quality Improvement Inpatient Program
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

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

The Appeal must include the following:

- Copy of the original HCFA form submitted (HCFA Form CMS 1500 with CPT Codes: 99222, 99232)
- New HCFA form requesting an appeal and a copy of the Denial/Pending letter
- Letter and supportive documentation substantiating the request for appeal
- Copy of the authorization denial letter from the reviewing Quality Improvement Inpatient Program psychiatrist

MAIL/SHIP TO:

RUHS-BH Quality Improvement Inpatient Program
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

iii. APPEAL STATUS INQUIRIES:

RUHS-BH Quality Improvement Inpatient Program
Phone: 951-358-6031
Fax: 951-358-4474

D. FOR CLAIMS/BILLINGS:

i. MANAGED CARE INPATIENT PROVIDERS CLAIMS: (Hospital Invoices, HCFA Claims)

RUHS-BH Invoice Processing
Unit 2085 Rustin Ave
Riverside, CA 92507

Phone: 951-358-7797
Fax: 951-358-6868

ii. ALL NON-PSYCHIATRIC INPATIENT CONSULTATION CLAIMS: (e.g. H & P, Neurologist, etc.)

Send claim directly to Conduent:
Conduent
PO Box 15200
Sacramento, CA 95851-1200

E. MANAGED CARE CONTRACT PROVIDER SUPPORT:

Provider Support Line: 951-358-7797

- Hours of Operation: Monday through Friday, 8:00 A.M. - 5:00 P.M.

F. PATIENT GRIEVANCES AND APPEALS:

RUHS-BH Quality Improvement Outpatient Program

Patient Grievances and Appeals

P.O. Box 7549

Riverside, CA 92513

Phone: 800-660-3570

G. PATIENTS' RIGHTS OFFICE:

RUHS-BH Patients' Rights Program

P. O. Box 7549

Riverside, CA 92513

Supervisor: Ann Venegas

Phone: 951-358-4600 or 800-350-0519

Fax: 951-358-4581

- Hours of Operation: Monday through Friday, 7:30 A.M. - 4:30 P.M.

H. DISCHARGE/AFTERCARE LINKAGE:

- Patients, parents and other family members:
CARES Line
Phone: 800-706-7500
 - Hours of Operation: Monday through Thursday, 8:00 A.M. to 5:00 P.M.; Friday, 8:00 A.M. - 4:30 P.M. (Available after-hours for emergencies)
- Inpatient providers:
Provider Support Line
Phone: 951-358-7797
 - Hours of Operation: Monday through Friday, 8:00 A.M. - 5:00 P.M.

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

(Does not apply to beneficiaries with dual Medicare/Medi-Cal or other health insurance)

Please reference Chapter 5 of the *Outpatient Provider Manual*, under *Inpatient Psychiatric Services*, located on the RUHS-BH website.

CHAPTER 2 – HOSPITAL RESPONSIBILITIES

Hospitals with Medi-Cal Contracts

Hospital patients must meet the following criteria in order for Medi-Cal reimbursement to be authorized by RUHS-BH Quality Improvement Inpatient Program (QI IP). RUHS-BH does not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility. The admitting hospital is responsible for verifying and performing the following:

1. Patient has current Riverside County Medi-Cal eligibility.
2. Patient meets Title 9 Medical Necessity criteria for hospitalization. (When an RUHS-BH beneficiary is admitted on an emergency basis RUHS-BH will approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing.)
3. The medical record must document Medical Necessity for admission and continued hospitalization.
4. The hospital must notify QI IP within 24 hours of intake by faxing to 951-358-4474 a correct, complete and legible *24-Hour Notification* form ([Attachment A](#)).
5. If any errors are found in the *24-Hour Notification* form, QI IP will fax a *24-Hour Notification Correction Request* ([Attachment B](#)) to the hospital. The hospital must fax back this form within 24 hours.
6. QI IP must receive a hospital Treatment Authorization Request (TAR) and a complete copy of the medical chart within fourteen (14) days from the patient's date of discharge or payment will be denied. For a description of the paperwork and documentation which must be submitted, please refer to *Inpatient TAR Processing Requirements*. ([Attachment E](#))
(In the event the hospital fails to fax the 24-Hour Notification form within 24 hours, the hospital must provide a hospital TAR and complete chart to QI IP within ten [10] days of discharge).
7. If a patient does not have Medi-Cal eligibility during the time of the hospitalization, but the patient later obtains Medi-Cal eligibility that covers the dates of the hospitalization, the hospital may submit a TAR retroactively. This TAR must be received by QI IP within sixty (60) days of the date that the hospital first learns of the retroactive eligibility.

Hospitals with Indigent Contracts

Only hospitals with a contract to treat Riverside County indigent patients will be reimbursed for the hospitalization of indigent patients. The admitting hospital is responsible for the following:

1. The hospital must verify and document that the patient has been a resident of Riverside County for at least thirty (30) days immediately preceding the hospitalization.
2. The hospital must verify and document that there are no other funding sources available to pay for the hospitalization.
3. The medical record must document Medical Necessity for admission and continued hospitalization.
4. The admitting hospital must notify QI IP within 24 hours of admission by faxing the following materials to 951-358-4474:
 - a. *24-Hour Notification* form ([Attachment A](#))
 - b. *Adult Indigent Screening* form ([Attachment C](#)) if the patient is an adult.
 - c. *Minor Indigent Screening* form ([Attachment D](#)) if the patient is a minor.
5. The hospital must submit a hospital indigent TAR ([Attachment K](#)) and a complete copy of the medical record to QI IP within fourteen (14) days of the patient's discharge date or payment will be denied.

IMD-Excluded Hospitalizations

It is the policy of RUHS-BH to reimburse hospitals for medically necessary IMD-Excluded hospitalizations. An IMD-Excluded hospitalization occurs when a Medi-Cal patient who is 21 through 64 years of age is admitted to a free-standing psychiatric hospital for acute care. RUHS-BH requires that every hospital seeking payment for IMD-Excluded hospitalizations **must** sign a contract with RUHS-BH.

The contract will state that any payment to the hospital will be at an all-inclusive rate to cover the hospital charges as well as any professional fees incurred. The contract will also state that administrative (admin) days will not be reimbursed. If a hospital does not complete a contract with RUHS-BH for IMD-Excluded hospitalizations within six (6) months following the discharge of the IMD-Excluded hospitalization, the entire hospitalization will be administratively denied.

When a hospital has a contract with RUHS-BH for IMD-Excluded hospitalizations, the admitting hospital is responsible for verifying and performing the following:

1. Patient has current Riverside County Medi-Cal eligibility.
2. Patient meets Title 9 Medical Necessity criteria for hospitalization.
3. The medical record must document Medical Necessity for admission and continued hospitalization.
4. The hospital must notify QI IP within 24 hours of admission by faxing to 951-358-4474 a correct, complete and legible *24-Hour Notification* form (Attachment A).
5. If any errors are found in the *24-Hour Notification* form, QI IP will fax a *24-Hour Notification Correction Request* (Attachment B) to the hospital. The hospital must fax back this form within 24 hours.
6. QI IP must receive a hospital TAR and a complete copy of the chart within fourteen (14) days from the patient's discharge date or payment will be denied. For a description of the paperwork and documentation which must be submitted, please refer to *Inpatient TAR Processing Requirements*. (Attachment E)
(In the event the hospital fails to fax the *24-Hour Notification* form within 24 hours, the hospital must provide a hospital TAR and complete chart to QI IP within ten [10] days of discharge.)

Cultural Competency

Hospital providers must provide culturally competent and culturally sensitive care for patients, including mental health interpretation services. Medical records must contain documentation showing the offer of these services and the patient's response. When a family member provides interpreter services, there must be documentation that other linguistic services were offered first, but the patient preferred to have a family member interpret for them. Provision of interpreter services is essential for physician and social work meetings and for process groups.

TAR Errors

If TARs are incomplete or incorrect they cannot be processed for reimbursement authorization. The hospital will be notified of the error(s) by fax. The provider must resubmit a new or corrected TAR within the 14-day time constraint; late resubmissions may result in denial. After receiving the corrected TAR, the medical record will be reviewed for medical necessity and possible approval of reimbursement.

Census Information

QI IP staff may call or send a fax requesting admission/discharge status information. Please comply with this request.

Planned Admissions

Pre-authorization of planned admissions (e.g. for electroconvulsive treatment [ECT] and other specialized treatments) is required. The request for authorization must document that the patient meets Medical Necessity criteria for admission. The request should be sent to the RUHS-BH Medical Director for his/her review and possible approval.

Send planned admission requests to:

RUHS-BH Health Administration
Attn: Matthew Chang, Director
4095 County Circle Dr.
Riverside, CA 92503
Phone: 951-358-4501

CHAPTER 3 – INPATIENT MEDICAL NECESSITY CRITERIA

In order for a patient to be eligible for coverage for hospitalization, a patient MUST meet one of the following criteria; the patient is:

- A current Riverside County Medi-Cal eligibility
- An indigent resident of Riverside County for at least thirty (30) days immediately preceding hospital admission
- A Medicare/Medi-Cal recipient --OR--
- A recipient of Medi-Cal and another healthcare coverage

Medi-Cal will pay for (reimburse) acute psychiatric hospitalizations when Medical Necessity is documented in the hospital records. Certain criteria must be met to establish that Medical Necessity is present; these criteria are described in California Code of Regulations, Title 9, Sections 1810 and 1820. In simplest terms, Medical Necessity is established when documentation in the hospital records shows that a particular patient could be reasonably, safely and effectively treated **only** in an acute psychiatric hospital setting and not at a lower level of care.

In order to establish Medical Necessity for admission and continued stay, the following must be documented:

- A. Diagnosis:** The patient has a mental health disorder which is the cause of his/her impairments. Only certain mental health diagnoses qualify for admission. For a current list of approved diagnoses please refer to *Specialty Mental Health Inpatient Services, ICD-10 Covered Diagnoses Table (Attachment F)*
- B. Impairment:** Documentation establishes the presence of symptoms or behaviors that:
- a. Indicate a current danger to self (DTS), danger to others (DTO) or of significant property destruction
 - b. Prevent a patient from providing for, or utilizing, food, clothing or shelter; i.e., grave disability (GD)
 - c. Present a severe risk to the patient's physical health
 - d. Represent a significant deterioration in ability to function
- OR--
- e. Require a psychiatric evaluation or treatment which can reasonably be provided only in a psychiatric hospital
- C. Level of Care:** The patient can only be safely treated in an acute hospital and not at a lower level of care.
- D. Efficacy:** The treatment planned for and provided to the patient must have a reasonable likelihood of reducing the impairments.

For a more in depth description of how to document to meet Medical Necessity, please refer to *Medical Necessity Documentation and Guidelines (Attachment G)*

CHAPTER 4 – INTERDISCIPLINARY TREATMENT PLAN REQUIREMENTS

If a patient is hospitalized for 72 hours or more (not counting weekends or holidays), an *Interdisciplinary Treatment Plan* (ITP) must be present in the records. This must be a stand-alone document and not just part of the psychiatrist Initial Evaluation document or a part of nursing assessment. The ITP must be signed by a treating psychiatrist prior to discharge. If this MD-signed ITP is not present, the entire hospitalization **must be denied** as an Administrative Denial. If a patient is hospitalized for less than 72 hours (not counting weekends or holidays), an ITP is not required.

For review purposes, the plan of care is considered to consist of the ITP plus the physician's admitting order sheet. The plan of care should include the following elements:

- a. Diagnoses, symptoms, complaints and complications indicating the need for admission
- b. A description of the functional level of the patient
- c. Specific observable and/or specific quantifiable goals/treatment objectives related to the patient's mental health needs and functional impairments resulting from the qualifying mental health diagnosis/diagnoses
- d. Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided (which are consistent with the qualifying diagnosis and includes the frequency and duration for each intervention)
- e. Any orders for:
 - 1) Medications
 - 2) Treatments
 - 3) Restorative and rehabilitative services
 - 4) Activities
 - 5) Therapies
 - 6) Social services
 - 7) Diet
 - 8) Special procedures recommended for the health and safety of the patient
- f. Plans for continuing care, including review and modification to the plan of care
- g. Plans for discharge
- h. Documentation of the patient's degree of participation in and agreement with the plan
- i. Documentation of the physician's establishment of the plan (i.e., signature)

CHAPTER 5 – DOCUMENTATION OF ADMINISTRATIVE DAYS

At some point during a hospitalization, a patient may no longer meet criteria for Medical Necessity but this patient may not have an appropriate placement to which to discharge. Under certain specific circumstances, the documentation for this patient may meet criteria for reimbursement for Administrative Days (Admin Days).

In order to receive reimbursement for Admin Days, the following criteria must be met:

- A. Presence of an Acute Day:** Sometime during the hospitalization, documentation must indicate that there was Medical Necessity for at least one acute hospital day.

- B. Appropriate Placement Calls Are Made To Appropriate Facilities:** Admin Days can be approved only when a patient is discharged to a specific type of placement facility and when placement calls follow a specific protocol.

For a more in depth description of how to document to qualify for Admin Days, please refer to *Documentation of Administrative Days for Inpatient Providers*. ([Attachment H](#))

CHAPTER 6 – INPATIENT CLAIMS PROCESS

Hospital Medi-Cal Claims

The hospital must submit a Treatment Authorization Request for Mental Health stay in Hospital (TAR – State Form 18-3) and a complete copy of the chart as outlined in *Inpatient TAR Processing Criteria* ([Attachment E](#)) to RUHS-BH QI IP. These must be received by QI IP within fourteen (14) days from the day the patient's discharge date or payment will be denied.

The copy sent **must** contain the entire chart, including all documents that are part of the treatment provided, inclusive of any medication administration records, and all legal documents within the chart as well as any legal documents related to the admission that may be stored separately. The absence of these documents or an incomplete or incorrectly completed TAR will result in a delay in authorization or denial of the claim.

QI IP will complete the chart review process within fourteen (14) days of receipt of the TAR and medical record. A clinician will review the TAR/chart and either approve 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 review is completed. The TAR is then faxed by QI IP to the State authorizing approved hospital bed days and a copy is faxed to the hospital for Medi-Cal payment submittal. QI IP will issue a Notice of Adverse Benefit Determination (NOABD) ([Attachment I](#)) to the patient in cases of any denied or modified bed days. The Notice of Adverse Benefit Determination (NOABD) informs the patient of the denial or modification and clearly states it is neither a bill nor a request for payment from the patient. The Notice Of Adverse Benefit Determination (NOABD) is required as a method of informing the patient that the services were retrospectively denied or changed the reimbursement to the provider.

Psychiatrists/Psychologists Medi-Cal Claims

The medical record submitted for hospital bed day authorization also supports the professional fee component of a Medi-Cal beneficiary's hospital stay. [Attachment J](#) lists the authorized CPT codes for inpatient psychiatric specialty mental health services.

Psychiatrist (or psychologist) claims for providing specialty mental health services will be matched to the submitted medical record and used to support Medi-Cal claims for professional fees. Professional fees are reimbursable according to the findings and determination of the chart review. Denial of professional fees occurs if documentation is missing or late or if the patient's documented condition does not meet Medical Necessity. Denial of the professional fee will also occur if the hospital fails to submit a TAR/chart within the fourteen day timeline. Do not submit professional fee claims to RUHS-BH Managed Care prior to patient discharge. RUHS-BH Managed Care must receive claims within thirty (30) calendar days of patient's discharge or the claims will be denied

Submit professional fee claims to:

RUHS-BH Managed Care
2085 Rustin Avenue
Riverside, CA 92507

Indigent Inpatient Claims

Only hospitals with a contract with RUHS-BH to treat indigent patients should submit claims to RUHS-BH for reimbursement. Within fourteen (14) days following discharge, QI IP must receive a copy of the *Notification of Admission for Indigent Funding* form ([Attachment K](#)), the *Indigent Screening Form* ([Attachment C - Adult](#) or [Attachment D - Minor](#)), and a copy of the complete medical record. Late submissions will be denied.

IMD-Excluded Inpatient Claims

IMD-Excluded hospitalizations will be eligible for reimbursement only after the hospital signs a contract with RUHS-BH for these hospitalizations. Within fourteen (14) days of discharge, QI IP must receive a TAR and a copy of the complete medical record. Per the contract, any professional fees are included in the hospital payment. Professionals should not file separate claims. Admin days are not eligible for reimbursement.

After the hospital is notified that the review for medical necessity is completed, the hospital is to submit an invoice and provide UB-04 CMS 1450 claim form for payment processing within thirty (30) days.

Submit invoices and UB-04 claims to:

RUHS Invoice Processing Unit
2085 Rustin Ave
Riverside, CA 92507
Phone: 951-358-7797
Fax: 951-358-6868

Denials of hospital bed days may be submitted for a Level 1 appeal to QI IP for a second review.

IMD-Excluded hospitalizations are not eligible for a Level 2 appeal performed by the state DHCS.

Medicare/Medi-Cal Claims

When a patient has both Medicare and Medi-Cal insurance, the Medicare insurance is always primary. Medi-Cal is eligible for possible reimbursement only after the Medicare benefits have been exhausted. The hospital must first bill Medicare. If Medicare denies all or part of the hospitalization because the benefits are exhausted, the hospital may then bill Medi-Cal through RUHS-BH. QI IP must receive a TAR, a copy of the medical record and a copy of the *Medicare Eligibility of Benefits* (EOB) form within the State timeline of sixty (60) days from the hospital's receipt of the EOB or per the mandated timeline detailed in the hospital's contract with RUHS-BH.

Other Health Coverage

When a patient has both Medi-Cal and private health insurance, the private health insurance is primary and must be billed first. If the private health insurance company denies all or part of the hospitalization, the hospital may then bill Medi-Cal through RUHS-BH. QI IP must receive a TAR, a copy of the medical record and a copy of the private insurance EOB within the State timeline of sixty (60) days from the hospital's receipt of the EOB or per the mandated timeline detailed in the hospital's contract with RUHS.

Share of Cost

Medi-Cal beneficiaries with a share of cost provision are not Medi-Cal eligible until their share of cost is paid.

Submission of a Medi-Cal TAR

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

Hospitals must also submit proof of the patient's Medi-Cal eligibility for the time of hospitalization by submitting a copy of the *Medi-Cal Eligibility Response* form, also known as POS or AVES. Write the County and Aid Codes on the TAR above box #11.

Instructions for Completing a Medi-Cal TAR

- When multiple TARs are submitted, number the TARs (e.g.: 1 of 3, 2 of 3, etc.) in the space 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-Write an "X" on all TARs.
- Box 10-Provider NPI number, Provider phone number, name, address, and 9-digit zipcode
- 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 counts, the day of discharge does not count, and 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 it is being submitted as a Retro TAR; otherwise, leave blank.
- Box 20-Date of Discharge: If there is also an Administrative Day TAR submitted, leave Box 20 Blank on the acute TAR and write below Box 20 "still in house." Write the date of discharge on the Administrative Day TAR.
- Box 21-Admitting diagnostic code must match the written diagnosis.
- Box 22-Discharge diagnostic code must match the written diagnosis.
- '*Patient's Authorized Representative*'-If known, enter the name and address of the patient's authorized legal representative, payee, 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. Leave this section blank on Appeal TARs.
- '*Signature of Provider & Date*'- Signed and dated by authorized hospital.
- '*Signature of Physician & Date*'- Signed and dated by the attending physician (or psychologists).
- '*For County Use Only*'-Leave blank.

TAR Update Transmittal (TUT)

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

- If Conduent identified an error, it will send a notification called *Unprocessable Mental Health TAR* directly to QI IP.
 - QI IP reserves the right to request written authorization from the hospital to make changes to the TAR if changes are required on the original TAR.
 - QI IP will fax the corrected TAR back to Conduent.
- If the hospital identified the error, the hospital shall fax a request to make changes to the original TAR to QI IP. QI IP will then resubmit the correction and a TUT form to Conduent.

Retroactive TAR

A retroactive TAR will be considered under the following circumstances:

- When a natural disaster or other catastrophic circumstances beyond the control of the provider has occurred and has been reported to an appropriate law enforcement or fire agency.
- When an Medi-Cal eligibility inquiry during the hospital stay showed that the patient had no eligibility but the patient later obtained Medi-Cal coverage for the time of the hospitalization. Print out the inquiries for submission with the TAR.
- When a denial of payment or a partial payment occurs from a third party payer such as Medicare or other health care insurers. The resulting EOB should be included with the TAR.

Retroactive TARs must be submitted to QI IP within the state timeline of sixty (60) days from the date of discovery of Medi-Cal eligibility or receipt of third party payor EOB or the Remittance Advice Statement (RA). 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 reflects the date of receipt and determines the start of the sixty (60) day timeline.

TARs are not considered retroactive if Medi-Cal eligibility is determined or third party benefits are expired or nonexistent during the hospitalization.

Timelines for TAR Submission

TIMELINES FOR INITIAL SUBMISSION OF A TAR

POINT OF AUTHORIZATION

Provider must submit TAR and chart documents for receipt by RUHS-BH QI IP within 14 days from patient discharge.



RUHS-BH has 14 calendar days after receipt of the TAR to send the reviewed and completed TAR to Conduent and the provider.

TIMELINES FOR A RETROACTIVE TAR

Submit a retroactive TAR within **60 calendar days** of:

- Discovery of Medi-Cal or RCHC eligibility or from a third party payer
- Notice of partial payment
- Exhaustion of Benefits

CHAPTER 7 - PROVIDER PROBLEM RESOLUTION PROCESS

Provider Informal Problem Resolution Process

For questions/concerns about clinical matters or medical necessity call:
Quality Improvement Inpatient Program
951-358-6031

For questions/concerns about payment authorizations, processes and referrals call:
Community Access, Referral, Evaluation & Support (CARES) and Managed Care Provider Support/Provider Relations
951-358-7797

For questions/concerns about billing/payments call:
Invoice Processing Unit (IPU)
951-358-7797, Option 6

For questions/concerns about claims made through Conduent call:
Conduent
800-541-5555

Appeals

Hospitals and professional staff providers have the right to access the Formal Provider Appeal Process if they are dissatisfied with a TAR/claim determination. Hospitals may send appeals involving a denied request for authorization or claim to QI IP.

Mail/Ship Appeals to:

RUHS-BH Quality Improvement Inpatient Program
Attention: Appeals
9890 County Farm Road, Bldg. 1
Riverside, CA 92503
Phone 951-358-6031

Hospital Appeals

QI IP must receive hospitals' written appeals within ninety (90) calendar days of the receipt of the denied or modified determination. (Appeals of a hospitalization of an indigent patient are an exception; these must be received within thirty [30] calendar days).

- The appeal request must include the following:
 1. A letter explaining what days are being appealed and summarizing the reasons the hospital believes RUHS-BH should have approved the claim
 2. A new (appeal) TAR
 3. A copy of the original hospital TAR
 4. A copy of the denial letter from the reviewing QI IP psychiatrist
 5. Any additional supporting documentation substantiating the request for appeal
- QI IP has sixty (60) calendar days from receipt of the appeal to inform the hospital of the appeal decision in writing.
- If the hospital is not satisfied with the outcome of the appeal, the hospital has thirty (30) calendar days from the date of QI IP's appeal decision to submit a second level of appeal in writing, along with supporting documentation, to the Department of Health Care Services (DHCS).

A hospital provider may not appeal to DHCS if RUHS-BH denied or modified payment authorization based on the hospital's failure to comply with the mandatory provisions of the contract between the hospital provider and RUHS-BH.

- The second level of appeal to DHCS should include, but is not be limited to:
 - The hospital contact person's name, address, and phone number
 - Clinical records supporting the presence of medical necessity
 - Any documentation supporting allegations of timeliness, including fax records, telephone records, or memorandums
 - A letter summarizing the reasons the hospital believes RUHS-BH should have approved the claim

Mail the above information to:

Department of Health Care Services
Mental Health Services Division
Attn: TAR Appeals
1500 Capitol Ave
Suite 72.442
MS 2703
Sacramento, CA 95814

Phone: 916-319-9641

- DHCS will notify RUHS-BH and the hospital of its receipt of a request for appeal within seven (7) calendar days. The notice to RUH-BH will include a request for specific documentation supporting denial of RUHS-BH payment authorization and documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal. RUHS-BH must submit the requested documentation to DHCS within twenty-one (21) calendar days of receipt of notice or DHCS will decide the appeal based solely on the documentation filed by the provider. DHCS may allow both a provider representative(s) and RUHS Behavioral Health representative(s) an opportunity to present oral arguments.
- DHCS should provide written notification of their decision to the provider and RUHS-BH within sixty (60) calendar days from the receipt of RUHS-BH's documentation. DHCS will include a statement addressing the issues raised, justification for their decision, and any actions required by RUHS Behavioral Health or the provider to implement the decision.

IMD Excluded Hospitals Appeals

QI IP must receive IMD Excluded hospitals' written appeals within thirty (30) calendar days of the receipt of the denial notification. Admin days are not reimbursable and therefore cannot be appealed.

The appeal request must include the following:

1. A letter explaining what days are being appealed and summarizing the reasons the hospital believes RUHS-BH should have approved the claim
2. A new (appeal) TAR
3. Copy of the original hospital TAR
4. Copy of the denial letter from the reviewing QI IP psychiatrist.

QI IP has sixty (60) calendar days from receipt of the appeal to inform the hospital of the appeal decision in writing.

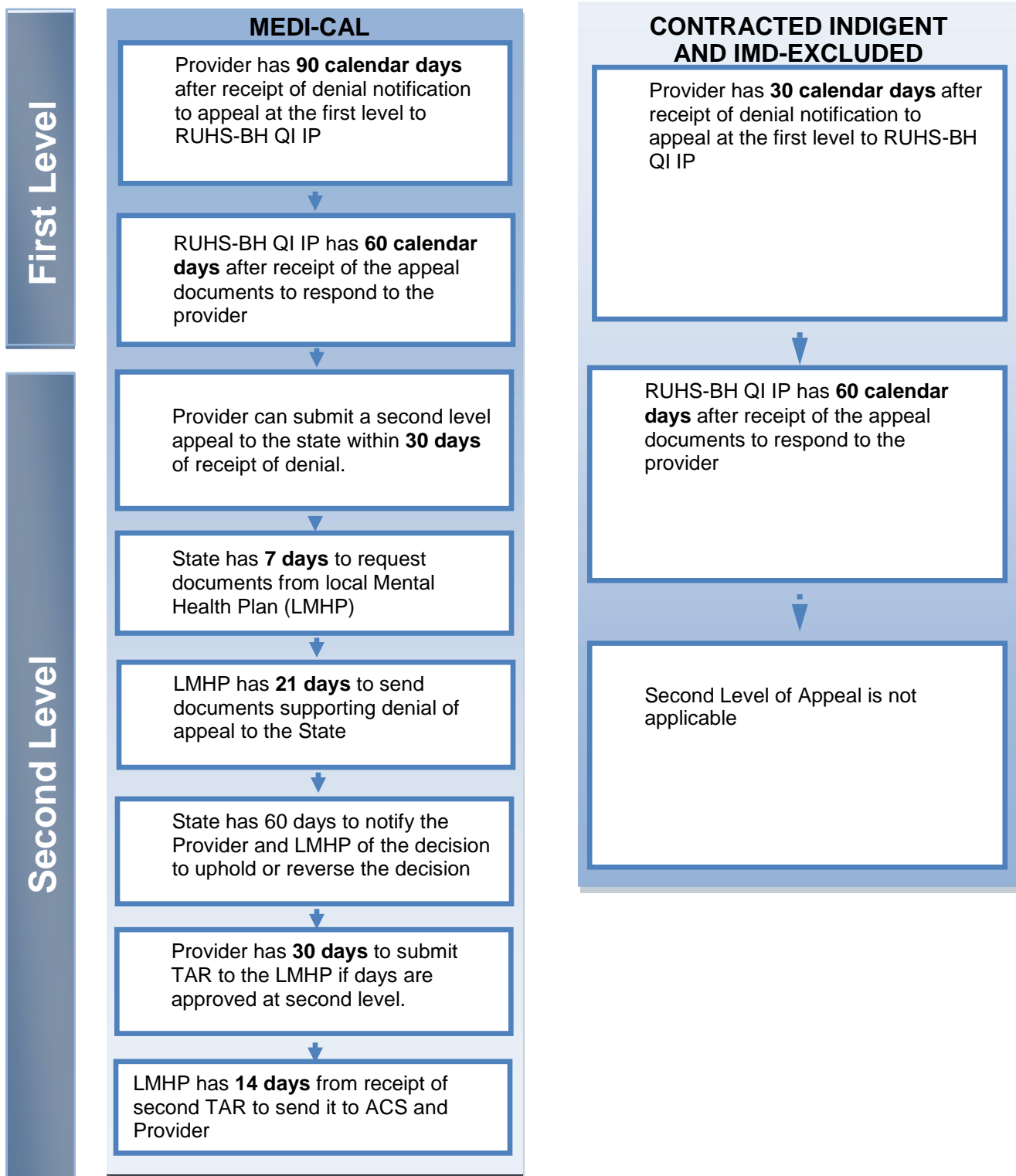
A second Level of Appeal (to DHCS) is not available.

Professional Staff Provider Appeals

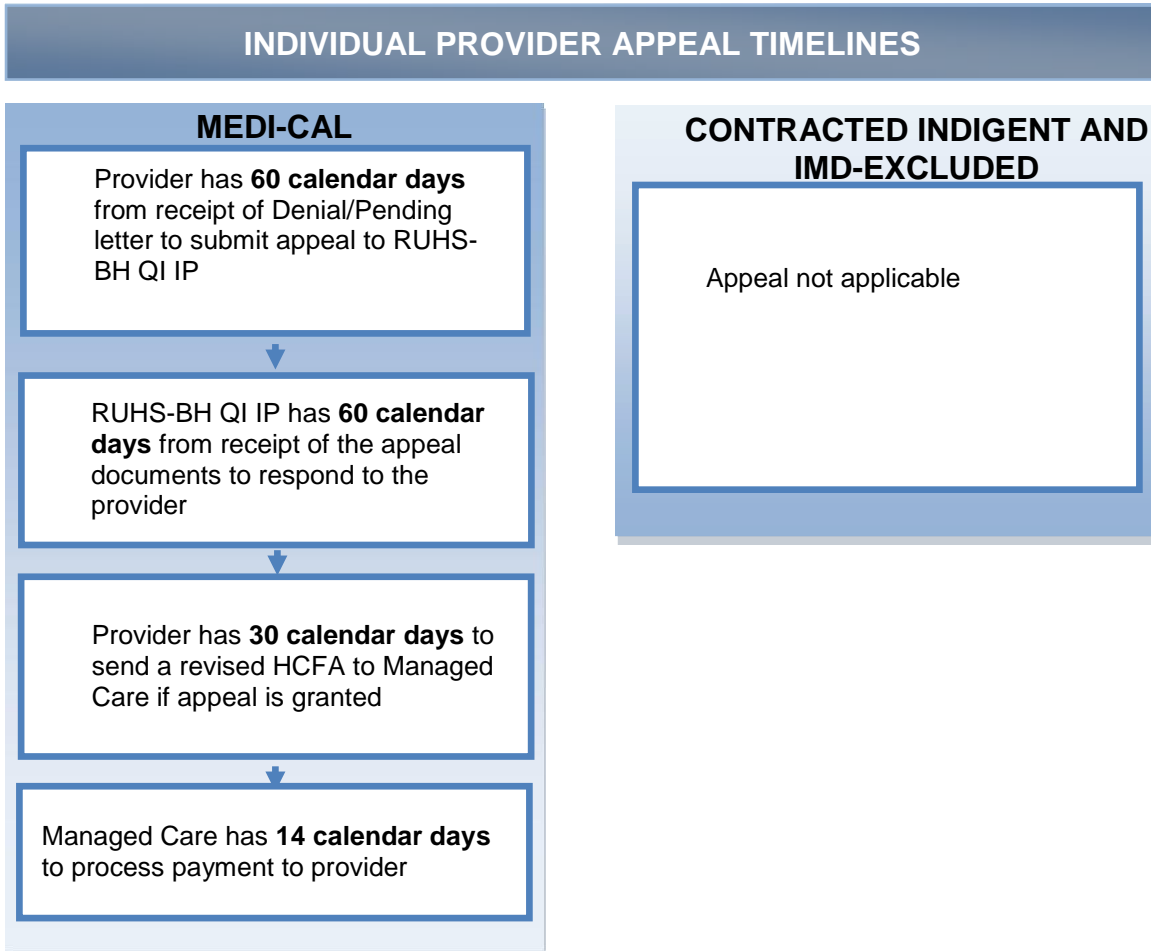
- QI IP must receive written appeals of denied visits/services by psychiatrists (or psychologists) within sixty (60) calendar days of the denial letter postmark date.
- The appeal must include the following:
 1. A letter of explanation for the appeal request
 2. Documentation substantiating the request for appeal
 3. A new HCFA (CMS-1500) form identifying the service dates under appeal
 4. A copy of the original HCFA (CMS-1500) form submitted to Managed Care
 5. A copy of the denial letter received from Managed Care
- QI IP has sixty (60) calendar days from receipt of the appeal to review the appeal and inform the professional staff provider in writing
- If the appeal review results in the approval of any services initially denied, the provider should submit a revised HCFA Form (CMS-1500) to Managed Care Department within thirty (30) calendar days from the receipt of the letter notifying the provider. The Managed Care Department must process the payment within fourteen (14) calendar days of receipt of the provider's revised CMS-1500.

Timeline for Appeals

HOSPITAL TAR APPEAL TIMELINES



Timeline for Individual Provider Appeals



CHAPTER 8 - ADVERSE INCIDENTS, STANDARD PRACTICES AND PROCEDURES

Policy Statement

- All adverse incidents involving RUHS-BH patients are systematically reported, reviewed and analyzed to identify opportunities for improvement in client care, treatment services and clinical operations.
- Serious adverse incidents should be reported to the RUHS-BH Medical Director and the Manager of QI IP.
- It is crucial to establish a method of conducting adverse incident reviews to identify systems and other issues/problem areas that may be adversely affecting the outcomes of care, as well as a process to develop corrective action plans that will improve treatment services, treatment outcomes and patient quality of life.

Definition

An adverse incident is any condition, event or situation that a reasonable person would view as being potentially harmful or as putting the safety of patients, employees, providers or visitors in jeopardy.

Confidentiality

Incident Reports are confidential communications, are considered privileged information and require identification as such.

Reportable Incidents

- All AWOL's
- All cases of patient deaths
- Incidents involving significant harm to oneself, including serious suicide attempts or self-injury
- Incidents involving significant harm to others, including serious assaults, homicide attempts and homicides
- Incidents involving significant injury that requires medical intervention for any patient or visitor at a site or during a treatment activity off-site

Adverse Incident/Unusual Occurrence Reporting Procedure:

Each facility/provider must develop and maintain site/provider specific policies and procedures for monitoring, reporting and investigating adverse incidents. The facility/provider must systematically monitor for adverse incidents, report them and implement any needed corrective actions in a timely manner. The provider is responsible for developing a system for reporting mandated investigations and corrective actions to the Department of Health Care Services and reporting staff or facility licensing violations to the appropriate professional licensing board(s) or agencies, including the National Practitioner Data Bank (NPDB).

QI IP will be available for consultation and will follow all RUHS-BH protocols as indicated. QI IP can be reached at 951-358-6031.

CHAPTER 9 - PATIENT NOTICES/GRIEVANCES/APPEALS

Introduction

All beneficiaries/patients of RUHS-BH services have the right to access complaint resolution/grievance process information and the right to file a grievance. The beneficiary/patient grievance process and Medi-Cal beneficiary appeal process provide mental health beneficiaries, their representatives and other patients of RUHS-BH with a method for resolving their concerns.

Beneficiaries/Patients shall be informed of their rights and the actions available to exercise those rights throughout the grievance and appeal processes (Title 9, Chapter 11, Sub-Chapter 5, Section 1850.205).

Each hospital facility will maintain and post a complaint resolution/grievance process to ensure the beneficiaries'/patients' right to a complaint, grievance and appeal process.

Beneficiary Informational Materials

Facilities will provide beneficiaries with a copy of the informational materials during initial services and upon request. Information on Patients' Rights (including appropriate telephone numbers) will be readily accessible and visibly posted in prominent locations. Information includes:

- Description of services available
- Process for obtaining services
- Beneficiary rights
- Right to request a change of provider
- Confidentiality rights
- Advance Directive information
- Description of the beneficiary problem resolution process
- Grievance and appeal process
- State Fair Hearing request process for Medi-Cal beneficiaries

Facility sites will post notices explaining complaint resolution and grievance process procedures in areas accessible to beneficiaries. Grievance information and self-addressed envelopes will be located next to the Grievance and Appeal Procedures and must be available to the beneficiary and/or beneficiary representative without the need for a verbal or written request.

All mental health facilities will display a notice to patients providing Patients' Rights and grievance and/or appeal information in a conspicuous location. The information shall include contact information for:

- RUHS-BH Patients' Rights: (800) 350-0519 or 951-358-4600
- RUHS-BH Quality Improvement **Outpatient** Program: (800) 660-3570

The beneficiary may authorize another person, such as the service provider, a friend, a family member, legal representative or Patients' Rights staff to act on his/her behalf during the complaint/grievance/appeal process.

Beneficiaries (or hospital staff members acting at the request of the beneficiary) will not be subject to discrimination or any other penalty for filing a grievance, appeal or State Fair Hearing. The facility protocol shall insure the confidentiality of a beneficiary's record.

Patient Grievance Process

A beneficiary, beneficiary's representative, or patient may file a grievance, orally or in writing, with his/her provider/hospital, a Patients' Rights Advocate, or QI Outpatient staff member. Examples of a grievance include concerns about the type of care provided, the quality of the care, the professional or facility providing care or interpersonal interactions with professionals or other staff.

Upon notification of a patient grievance, the RUHS-BH protocol will be followed. The Patients' Rights Program will work with the QI **Outpatient** Program to investigate the grievance. This usually includes speaking with the provider/hospital and the beneficiary and sometimes with others. After consideration of all of the available information, a conclusion is reached and any needed actions are taken. This may include initiating a plan of correction with the provider/hospital or granting a specific request of the beneficiary. Once a resolution is reached, a Patients' Rights staff member will notify both the provider/hospital and the beneficiary of the outcome.

The grievance recipient will make every effort to resolve the beneficiary/patient's grievance promptly. Parties may reach resolution through discussions between the beneficiary/patient/representative and the hospital representative or other persons involved. The contract provider (hospital) must notify Patients' Rights of the resolution of any reported beneficiary grievances.

Confidentiality

Grievance and Appeal procedures shall ensure the confidentiality of beneficiary/patient records. Beneficiaries/Patients must give informed consent prior to the release of any information or records to persons not legally authorized access.

CHAPTER 10 - MEDICATION DECLARATIONS

Medications for Dependents and Wards of Riverside Juvenile Court

Except for the exceptions noted below, it is necessary to obtain a signed Medication Declaration (JV 220) from juvenile court in order to prescribe psychiatric medication to minors who are wards or dependents of the court.

Dependents under family reunification and wards placed at home with their parents are exempted from Medical Declaration requirements and, under these circumstances, parents may consent to the use of psychiatric medications.

General Guidelines

Psychiatric evaluations are performed to assist in the development of an effective treatment plan. Each patient should participate in the development of his/her treatment plan, including the possible use of medications. When medications are recommended the provider should explain the anticipated benefits, risks, alternative treatments and possible immediate and long-term effects of specific medications to the minor using language that is compatible with the developmental stage of the minor. To the fullest extent practicable, the provider should try to obtain the signed consent of the minor. Reasons for any lack of patient participation should be clearly documented in the medical record.

Psychiatric evaluations and follow-up visits are authorized to determine the possible need for medication and evaluate the response to any prescribed medications including possible side-effects. When a minor consistently refuses needed medication, a Riese petition should be considered.

Routine/Non-Emergency Situations

The hospital physician can only prescribe psychiatric medications and dosages as specifically authorized by the court through the Medication Declaration process. A physician must submit a new Medication Declaration prior to changing medication(s) when there are indications that a patient requires a different psychiatric medication or dosage. The physician cannot prescribe any new medication until the court returns the Medication Declaration that authorizes the new medication.

Emergency Situations

A hospital physician may start any clinically appropriate psychiatric medication without an authorized Medication Declaration if he/she determines an emergency or life-threatening situation is present. The factors that support the determination must be clearly documented in the patient chart. The physician must immediately submit a new Medication Declaration for the ongoing use of any emergency or new medications, and describe the circumstances leading to the emergency determination on the new Medical Declaration (Question 3).

Physicians can continue prescribing the emergency medications in the hospital (or at a subsequent placement) until the court makes a determination. The physician, hospital, or placement must stop the medication(s) immediately if the court denies the request.

Submission of a Medication Declaration

The physician must fill out forms JV-220 and JV 220A, collectively known as a Medication Declaration (Med Dec). Associated workers can complete form JV-220, but the physician is responsible for completing and signing form JV-220A.

Fax the Med Dec to the RUHS-BH QI **Outpatient** office at (951) 955-7203.

The QI psychiatrist will review the Med Dec for completeness, clinical appropriateness and adherence to state recommended guidelines.

In 2016, Riverside County formally adopted the use of *California Guidelines for the Use of Psychotropic Medication with Child and Youth in Foster Care*. (See [Attachment L](#)) Since the state DHCS uses the LA County medication guidelines as a primary reference, the latest version of this document (*Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents*) is also attached. ([Attachment M](#))

The court will fax the signed Med Dec to QI **Outpatient** after the Judge/Commissioner authorizes or denies the use of submitted medications. QI **Outpatient** will fax a copy to the physician, hospital, and/or placement.

Authorized Med Decs are valid for six months (or less, if the court officer decides to specify a shorter time). The physician must submit a new Med Dec before the end of the six-month period to continue current medication, to start a new medication, or to adjust dosages.

Copies of the documents developed by the state for use in the Med Dec process are found in [Attachments N through R-2](#).

The forms are also available on the websites:

<http://www.courts.ca.gov/formnumber.htm>

<http://www.rcdmh.org/Doing-Business/RCDMH-Outpatient-Provider-Manual>

CHAPTER 11 - 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 is to protect health insurance coverage for workers and their families when they change or lose their job.

The law also includes a section titled Administrative Simplification, designed to reduce the administrative burden associated with the transfer of health information between organizations, and to increase the efficiency and cost-effectiveness of the health care system in the United States. The Privacy Rule and Transactions and Code Set are part of the Administrative Simplification section.

Privacy Rule

The Privacy Rule became effective April 14, 2003. It requires that healthcare workers 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 and to evaluate practices and enhance protections to prevent unnecessary, inappropriate access to PHI.

Privacy Rule Minimum Necessary Provisions Do Not Apply to:

- 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)

All Riverside County Medi-Cal beneficiaries must receive the *Notice of Privacy Practice* (NPP) explaining protected health information (PHI) and the beneficiary's rights and responsibilities. The beneficiary or his/her representative must sign an Acknowledgement Form confirming receipt of the NPP. If any patient refuses to sign the form, healthcare staff should note this on the form and file it in the beneficiary's medical record. Providers may elect to use their own HIPAA-compliant NPP or use the RUHS *Notice of Privacy Practice* as a template. The template may be found at: <http://www.ruhealth.org>. Providers are required to post a NPP poster containing all of the required information in the facility library.

Facsimile (FAX) Transmittal of Protected Health Information (PHI):

All providers are responsible for ensuring that all fax machines are located in a secure area. A fax coversheet with a pre-printed confidentiality statement is required for outgoing PHI facsimiles. The statement must include language instructing unintended recipients to contact the sender and destroy any documents received in error. Staff should verify new fax numbers with the recipient prior to sending documents.

The following are additional precautions to take to ensure the protection of health information:

- Position computer screens out of view of unauthorized persons
- Lock work stations when away from desk/office
- Secure the facility, i.e., locked file cabinets, secure entries, etc.
- Prevent unauthorized use of patient records by utilizing a check out system for patient files

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-10, CPT, and HCPC level 1 & 2.

Advance Directives

RUHS Policy 213-0 mandates that RUHS contracted providers supply adult patients with Advance Medical Directive information and the brochure “*Your Right to Make Decisions about Medical Treatment*” (See [Attachments S-1 \[English\]](#) and [S-2 \[Spanish\]](#)) at their initial meeting and upon request. The completed *Advance Medical Directives* document should be filed in the patient’s medical records. *Advance Medical Directive* information and brochures must comply with California state law and updated to reflect state law changes within ninety (90) days of implementation.

CHAPTER 12 – CONTRACTING WITH THE COUNTY AND LPS DESIGNATION

RUHS-BH encourages Medi-Cal FFS acute psychiatric inpatient facilities located within the Southern California Region to contract with RUHS-BH. Interested facilities can contact:

Program Support

Hours of operation: Monday through Friday, 8:00 A.M. - 5:00

P.M. Main Line: 951-358-4613

For detailed information about the LPS Designation process, please contact RUHS-BH Quality Improvement Inpatient Program at 951-358-6031.

ATTACHMENTS

- ❖ **Attachment A: 24-Hour Inpatient Notification**
- ❖ **Attachment B: 24-Hour Notification Correction Request**
- ❖ **Attachment C: Indigent Screening Form: Adult**
- ❖ **Attachment D: Indigent Screening Form: Minor**
- ❖ **Attachment E: Inpatient TAR Processing Requirements**
- ❖ **Attachment F: Specialty Mental Health Inpatient Services, ICD-10 Covered Diagnoses Table**
- ❖ **Attachment G: Medical Necessity Documentation and Guidelines for Inpatient Providers (Acute Days)**
- ❖ **Attachment H: Documentation of Administrative Days for Inpatient Providers**
- ❖ **Attachment I: Notice of Adverse Benefit Determination (NOABD)**
- ❖ **Attachment J: Inpatient Psychiatrist CPT Codes**
- ❖ **Attachment K: Indigent Notification and TAR**
- ❖ **Attachment L: California Guidelines for the Use of Psychotropic Medication with Child and Youth in Foster Care**
- ❖ **Attachment M: Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents**
- ❖ **Attachment N: Medication Declaration Fax Cover Sheet**
- ❖ **Attachment O-1: JV-220**
- ❖ **Attachment O-2: JV-220 S (Spanish)**
- ❖ **Attachment P-1: JV-220A**
- ❖ **Attachment P-2: JV-220A S (Spanish)**
- ❖ **Attachment Q-1: JV-221**
- ❖ **Attachment Q-2: JV-221 S (Spanish)**
- ❖ **Attachment R-1: JV-223**
- ❖ **Attachment R-2: JV-223 S (Spanish)**
- ❖ **Attachment S-1: “Your Right to Make Decisions About Medical Treatment”**
- ❖ **Attachment S-2: “Your Right to Make Decisions About Medical Treatment” (Spanish)**