Riverside County Behavioral Health Plan

Inpatient Provider Manual

Riverside University HEALTH SYSTEM Behavioral Health

April, 2018

Table of Contents

CHAPTER 1 – INTRODUCTION

Introduction

Welcome to the Riverside University Health System (RUHS) - Behavioral Health provider network. The Behavioral Health Plan authorizes **inpatient services through the Riverside County Quality Improvement Inpatient Authorization and Appeals Department for Riverside County Medi-Cal beneficiaries and for resident indigent minors and adults.** The Inpatient Provider Manual for participating providers contains guidelines for meeting the standards for provision of psychiatric inpatient hospital services. Please call Quality Improvement Inpatient Authorization and Appeals Department with any questions at (951) 358-6031.

RUHS - Behavioral Health Mission Statement

The Riverside University Health System- Behavioral 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 Information and Hours of Operation

Riverside University Health System – Behavioral Health
Quality Improvement Inpatient Authorization and Appeals Department

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:

Quality Improvement Inpatient
FAX: (951) 358-4474

B. HOSPITAL TAR/CHART REVIEW:

Hospital TARs with Riverside County Medi-Cal (primary coverage), or for Riverside County Indigent patients at hospitals with Indigent Contracts: Submit a complete and legible medical record for the entire hospitalization with the TAR when requesting a 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

VIA FEDEX AND UPS DELIVERY

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

VIA U.S. POSTAL MAIL

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
P.O. Box 7249
Riverside, CA 92503

ii. HOSPITAL TAR RELATED INQUIRIES:

VIA FEDEX AND UPS DELIVERY

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

VIA U.S. POSTAL MAIL

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
P.O. Box 7249
Riverside, CA 92503

Main Line: (951) 358-6031

iii. HOSPITAL TAR/CHART REVIEW STATUS INQUIRIES:

RUHS Behavioral Health- Quality Improvement Inpatient
Main Line: (951) 358-6031
Fax: (951) 358-4474

C. FIRST LEVEL OF APPEAL:

i. HOSPITAL TAR AND RIVERSIDE COUNTY INDIGENT FIRST LEVEL OF APPEALS:

VIA FEDEX AND UPS DELIVERY

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

VIA U.S. POSTAL MAIL

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
P.O. Box 7249
Riverside, CA 92503

Main Line: (951) 358-6031
Fax: (951) 358-5038

ii. 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:

- Copy of the original HCFA form submitted
- 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 physician

RUHS Behavioral Health- Quality Improvement Inpatient
Authorization and Appeals
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

Main Line: (951) 358-6031
Fax: (951) 358-5038

D. FOR CLAIMS/BILLINGS:

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

RUHS Invoice Processing Unit
2085 Rustin Ave
Riverside, CA 92507
Mail Stop 3805

Office Phone: (951) 358-7797
Fax: (951) 358-6868

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

(HCFA Form CMSW 1500)

Send claim directly to **Conduent.**

E. MANAGED CARE CONTRACT PROVIDER SUPPORT:

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

F. PATIENT GRIEVANCES AND APPEALS:

RUHS Quality Improvement
Patient Grievances and Appeals
P.O. Box 7549
Riverside, CA 92513

Office Phone: 1-800- 660-3570

G. PATIENTS' RIGHTS OFFICE:

RUHS Patients' Rights Office
P. O. Box 7549
Riverside, CA 92513

Hours of Operation: Monday through Friday, 7:30 A.M - 4:30 P.M.
Supervisor: Ann Venegas
Office Phone: (951) 358-4600 or 1-800-350-0519
Fax: (951) 358-4581

H. DISCHARGE/AFTERCARE LINKAGE:

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

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 Medicare/Medi-Cal or Other Health Insurance)

Please reference Chapter 5 of the Outpatient Provider Manual, under Inpatient Psychiatric Services, located on the RUHS 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 Behavioral Health. Patient Pre-authorization is not required for emergency psychiatric admissions. The admitting hospital is responsible for verifying the following:

1. Patient has current Riverside County Medi-Cal eligibility.
2. Patient meets Title 9 Medical Necessity criteria for hospitalization.
3. Chart documentation sufficiently justifies Medical Necessity for hospitalization.
4. The hospital notifies RUHS Behavioral Health within 24 hours of intake by faxing a correct, complete, and legible 24-Hour Notification form (Attachment A) to (951) 358-4474.
5. RUHS Behavioral Health will fax a 24-Hour Notification Correction Request (Attachment B to the hospital if any corrections are needed; the hospital must fax a corrected 24-Hour Notification form to (951) 358-4474 within 24 hours.
6. RUHS Behavioral Health Quality Improvement Inpatient must receive a hospital Treatment Authorization Request (TAR) and a complete copy of the chart within fourteen (14) days from the patient's discharge date, or payment will be denied.
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

Indigent hospital patients must meet the following criteria in order for reimbursement by RUHS Behavioral Health to hospitals with Indigent Contracts. The admitting hospital is responsible for verifying the following:

1. Patient has been a resident of Riverside County for at least thirty (30) days immediately preceding hospitalization.
2. The hospital provides documentation of ruling out all possible funding sources.
3. Patient meets Medical Necessity criteria for hospitalization.
4. Chart documentation sufficiently justifies Medical Necessity for hospitalization.
5. The admitting hospital must notify RUHS Behavioral Health within 24 hours of intake 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.
6. RUHS Behavioral Health Quality Improvement Inpatient must receive a hospital Indigent TAR and a complete copy of the chart within fourteen (14) days from the patient's discharge date, or payment will be denied.

IMD Excluded Hospitals

IMD Excluded hospital patients must meet the following criteria in order for reimbursement to be authorized by RUHS Behavioral Health.

The admitting hospital is responsible for verifying the following:

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

3. Chart documentation sufficiently justifies Medical Necessity for hospitalization.
4. The hospital notifies RUHS Behavioral Health within 24 hours of intake by faxing a 24-Hour Notification form to (951) 358-4474. In the event the hospital fails to fax the form within 24 hours, the hospital must provide a hospital TAR and complete chart to QI Inpatient within ten (10) days of admission.
5. RUHS Behavioral Health Quality Improvement Inpatient 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.

Other Hospitals

Patient must meet the following criteria in order for the Medi-Cal reimbursement to be authorized by RUHS Behavioral Health. The admitting hospital is responsible for verifying the following:

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

Cultural Competency

Hospital Providers must provide culturally competent care for patients, including mental health interpretation services. Charts must contain documentation showing the offer of these services, the patient's response, or if a family member provides interpretation services. **When families provide 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 provider will be notified of such via mailed or faxed letter. The provider must resubmit a new or corrected TAR within the 14-day time constraint; late resubmissions may result in denial. The TAR and chart will be processed for payment authorization review after completion of corrections.

Census Information

Quality Improvement Inpatient staff may call or fax requesting admission/discharge status information. Please provide discharge and/or continued hospital stay information as requested. The facility may also create a Daily Census Form to fax to Quality Inpatient at (951) 358-4474.

Planned Admissions

Pre-authorization of planned admissions (e.g. electroconvulsive treatment [ECT] and other specialized treatments) is required. Documentation indicating that the beneficiary meets Medical Necessity criteria for acute psychiatric inpatient hospital services must be provided and the admission approved by RUHS Behavioral Health Medical Director prior to admission in order for the admitting hospital to request reimbursement.

Send planned admission requests to:

RUHS Behavioral Health Quality Improvement Inpatient
Attn: Matthew Chang, Medical Director
4095 County Circle Dr.
Riverside, CA 92503

Main Line: (951) 358-4504

Acute Day Services

Acute day services are hospital provided services and equipment that meet medical necessity criteria, and are required for diagnosis and treatment of a beneficiary's mental disorder (See Chapter 3).

Administrative Day Services

Administrative day services are hospital services provided to a patient whose stay continues beyond the patient's need for acute services due to a temporary lack of appropriate residential treatment placement options. The following are Administrative Day requirements:

- The chart note label identifies it as a note documenting discharge planning and/or placement activity, such as "Discharge Planning, Case Management, or Social Services."
- The patient previously met medical necessity criteria for acute psychiatric inpatient hospital services for at least one day during the stay.
  CCR, Title 9, Chapter 11, Sections 1820.220(j) (5) and 1820.225(d) (2)
- Immediate placement in an appropriate, non-acute residential treatment facility within a reasonable geographic area is unavailable, and the hospital documents contact with a minimum of five (5) appropriate, non-acute residential 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. If fewer than five (5) facilities are documented as unavailable, at least one contact per week is required.
  2. Documentation on all contact calls to appropriate, non-acute treatment facilities must include:
     a. Contact dates
     b. Facility name, and the name and telephone number of the person the discharge planner contacts (busy signals, no answer, messages left with an answering service or on a machine are not considered contacts).
     c. Placement option(s) status
     d. Signature of the person making each contact (CCR, Title 9, Chapter 11, Sections 1820.220(j) (5) and 1820.225(d) (2))
  3. There must be at least one appropriate placement call made on the first day of requested Administrative Days.
  4. **A board and care placement search must be for an augmented board and care per State requirement. The hospital can only search for other board and care placements after denial from available augmented board and care facilities. It is also necessary to contact more than the required minimum of 5 facilities when the discharge plan is for board and care placement due to the large number of available board and care facilities. It is unacceptable keeping a hospitalized** patient waiting for a specific board and care if placement is available at another location. The hospital is responsible for continuing the search for other placement options during the waiting period between pending bed discovery and placement.
  5. A minimum of one documented placement search contact must occur on the day the facility/hospital orders Administrative Day designation for patients discharged to an Institution for Mental Diseases (IMD), It is required that subsequent searches be conducted and documented within the same first week.
  6. It is necessary to note follow-up at every contacted facility to determine status: noting acceptance or denial of the patient for that day's contact.

The hospital will work with RUHS Behavioral Health's Crisis Inpatient/Long Term Care Program for patients on LPS conservatorship. Contact Crisis Inpatient/ Long Term Care at: (951) 358-6919. Long Term Care will develop and maintain a placement log; the hospital is responsible for obtaining a copy of this log for submission with the TAR.

CHAPTER 3 – INPATIENT MEDICAL NECESSITY CRITERIA

Admission Criteria and Diagnosis

Patients **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

Patients **MUST** meet the following criteria:

- Patient meets Title 9 Medical Necessity criteria for hospitalization
- Chart documentation sufficiently justifies Medical Necessity for hospitalization admission and continued stay

Criteria for Medical Necessity include the following:

A. **Diagnosis:** The following diagnoses are reimbursable by Medi-Cal. The TAR/claim will be denied if the **p**atient does not meet criteria for these diagnoses or if the patient has an excluded diagnosis. Please note: 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. Unable to receive treatment safely at a lower level of care, except for persons who can receive treatment safely with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode meets 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 patient from providing or utilizing food, clothing, or shelter
   - Present a severe risk to the patient'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 patient is hospitalized

C. Continued Stay Criteria

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

CHAPTER 4 – INPATIENT CLAIM 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 Attachment E: Inpatient TAR Processing Criteria to RUHS Behavioral Health. These must be received by RUHS Behavioral Health 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 record, 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.

Quality Improvement (QI) Inpatient will complete the chart review process within fourteen (14) days of receipt of the TAR/Chart. 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 is finalized. Form 18-3 is faxed by QI Inpatient to the State authorizing hospital bed days and a copy is faxed to the hospital for Medi-Cal payment submittal. QI Inpatient will issue a NOA-C (Attachment F) to the patient in cases of TAR denial or modification. The NOA-C informs the patient of the denial or modification and clearly states it is neither a bill nor a request for payment from the individual. The NOA-C is required as a method of informing the patient that the services were retrospectively denied or changed the reimbursement to the provider. It also notifies the patient that he/she is not responsible for the cost of services rendered.

Psychiatrists/Psychologists Medi-Cal Claims

The medical record submitted for payment authorization also supports the professional component of a Medi-Cal beneficiary's hospital stay. Attachment G lists the authorized CPT codes for inpatient psychiatric specialty mental health services.

Psychiatrist/psychologist 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. Denial of doctor's services occurs if documentation is missing, 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 (14) day timeline. Do not submit professional fee claims to RUHS Behavioral Health prior to patient discharge.

Submit professional fee claims to: **RUHS Managed Care, 2085 Rustin Avenue, Riverside, CA 92507. RUHS Managed Care must receive claims** within **thirty (30) calendar days** of patient's discharge. Claims received after the thirtieth (30^{th}) day will be denied.

Indigent Inpatient Claims

The hospital should develop a claim form similar to Attachment H. RUHS Behavioral Health Quality Improvement Inpatient must receive a copy of the Notification of Admission for Indigent Funding (Attachment H), the Indigent Screening Forms (Attachment D-Minor and Attachment C- Adult), and a copy of the chart for receipt by RUHS Behavioral Health within 14 days of patient's discharge date or payment will be denied.

IMD Excluded Inpatient Claims

IMD Excluded hospital bed day with inclusive pro fee are reimbursable according to the chart review determination.

Once hospital receives review determination from QI Inpatient, hospital is to submit an invoice and provide UB-04 CMS 1450 claim form for payment processing within thirty (**30**) days.

For Appeals, hospital will attach appeal letter with determination from QI Inpatient for overturned denied service dates with invoice.

Submit invoices and UB-04 claims to:

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

Medicare/Medi-Cal Claims

These claims are not reimbursable by the RUHS Behavioral Health until the beneficiary exhausts his or her Medicare benefits. For partially reimbursed or denied stays, Quality Improvement Inpatient must receive a TAR, chart, and 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.

Other Health Coverage/Share of Cost

Medi-Cal beneficiaries may have a private insurance carrier. In these instances, Medi-Cal is the secondary insurer. Quality Improvement Inpatient must receive a TAR, chart, 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. Medi-Cal beneficiaries with a share of cost 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 the State's Fiscal intermediary-**Conduent** at (800) 541-5555 or (916) 636-1200.

Hospitals will submit proof of the patient's Medi-Cal eligibility during time of hospitalization. POS, AVES, or Medi-Cal Eligibility Response can determine eligibility. 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 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 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 psychologist.
- '*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 RUHS QI Inpatient Authorization and Appeal Unit.
    - RUHS QI Inpatient reserves the right to request written authorization from the hospital to make changes to the TAR if changes are required on the original TAR.
    - RUHS 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 RUHS QI Inpatient Authorization and Appeal Unit. .
    - RUHS/QI Inpatient will resubmit the correction and a TUT form to Conduent.

Retroactive TAR

Submit a Retroactive TAR for the following:

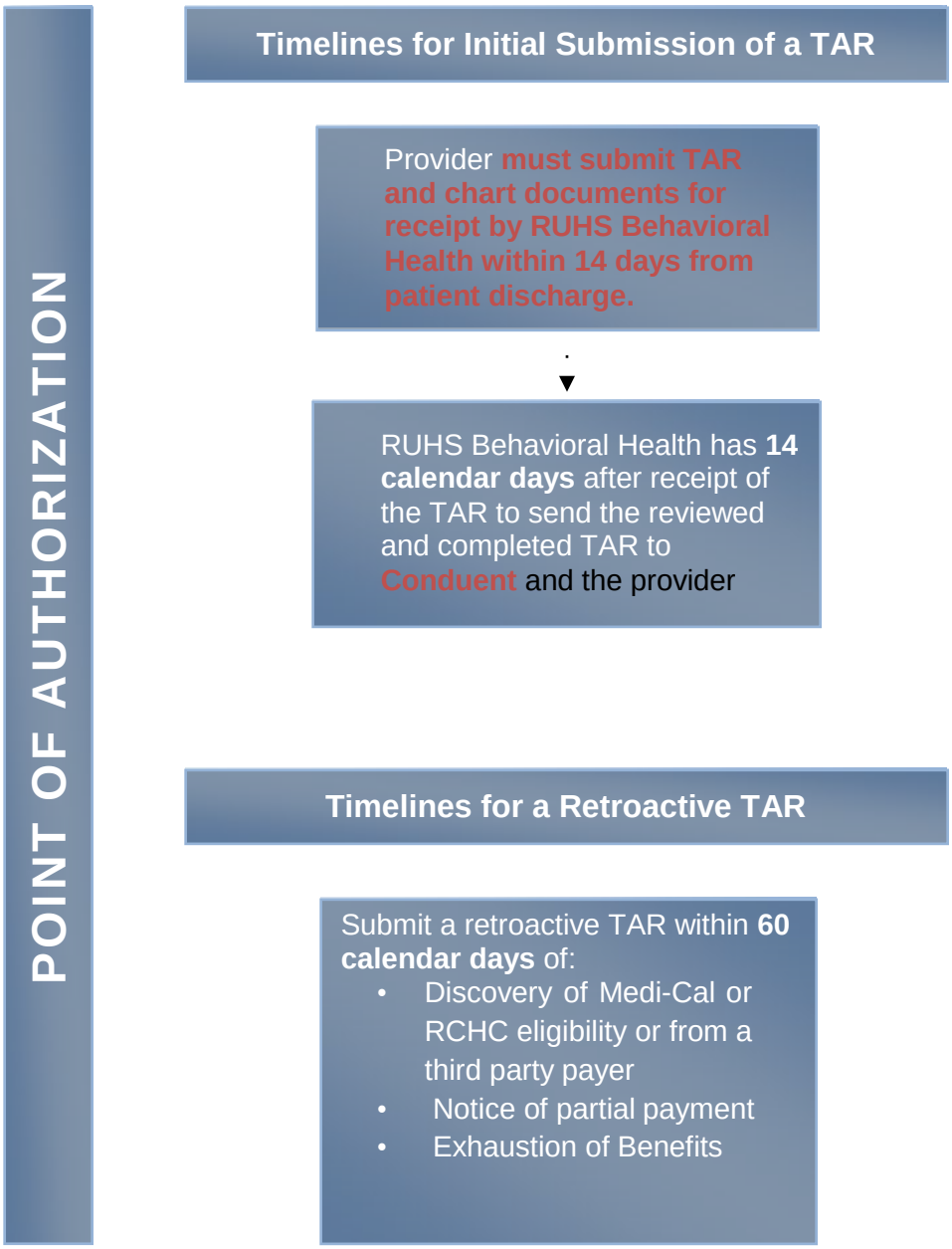
- Due to a natural disaster or circumstances beyond the control of the provider that has been reported to an appropriate law enforcement or fire agency Title 9, Chapter 11, 1820.215.
- Medi-Cal eligibility inquiry during the hospital stay showed that the patient had no eligibility. Print out the inquiry 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)

Submit retroactive TARs within the State timeline of sixty (60) days from the date: of discovery of Medi-Cal eligibility, of the Remittance Advice Statement (RA), or receipt of third party payor Notice of Exhaustion of Benefits (EOB).

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 non-existent during the hospitalization.

Timelines for TAR Submission



CHAPTER 5 - PROVIDER PROBLEM RESOLUTION PROCESS

Provider Informal Problem Resolution Process

Most complaints are resolved quickly, easily, and informally by discussing the issues with the parties directly involved in the problem. Contact the Managed Care Department, Claims, and Billing Division with payment authorization and fiscal questions or concerns. Contact Quality Improvement Inpatient at (951) 358-6031 with clinically related questions and concerns. Providers may send appeals involving a denied request for authorization or claim to Quality Improvement Inpatient. Providers should contact Conduent directly for any claims paid through Conduent.

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

Appeals

Mail Appeals to:

RUHS Behavioral Health
Quality Improvement Inpatient
Attention: Appeals
P.O. Box 7249
Riverside, CA 92503
Telephone (951) 358-6031

Appeals sent via UPS/FedEx:

RUHS Behavioral Health
Quality Improvement Inpatient
Attention: Appeals
9890 County Farm Road, Bldg. 1
Riverside, CA 92503

Telephone (951) 358-6031

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 appeal the processing or payment of that provider's claim to the MHP.

Hospital TAR Appeal

- Quality Improvement Inpatient must receive FFS hospitals' written appeals within **ninety (90) calendar days** of the receipt of the denied or modified MHP request, and **thirty (30) calendar days** for Indigent Appeals.

- The appeal **must** include the following:
  1. Cover letter of explanation for the appeal request
  2. New appeal TAR
  3. Denial letter from the reviewing QI Inpatient M.D.

4. Copy of the original hospital TAR
5. All supporting documentation substantiating the request for appeal

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

- Quality Improvement Inpatient's determination can result in full or partial appeal denial based on the following:
  1. The provider did not comply with the required timelines for notification or submission of the MHP request.
  2. Missing documentation or missing required signatures.
  3. Medical Necessity was not present/documented
  4. Administrative Day requirements were not met/documented.

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

The hospital provider should consider the appeal denied if Quality Improvement Inpatient does not respond within sixty (60) calendar days. In the absence of response, the hospital provider may appeal to DHCS within 30 calendar days after the 60 calendar days from submission to QI Inpatient (90 days total).

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

- 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 memorandums
  2. Clinical records supporting the existence of medical necessity
  3. Summary of reasons why RUHS Behavioral Health should have approved the payment authorization
  4. Hospital contact person(s) name, address, and phone number

  Mail information 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 RUHS Behavioral Health and the hospital provider of its receipt of a request for appeal within **seven (7) calendar days.** The notice to RUHS Behavioral Health will include a request for specific documentation supporting denial of RUHS payment authorization and documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal. RUHS Behavioral Health must submit the requested documentation to DHCS within **twenty-one (21) calendar days** of receipt of notice 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 RUHS Behavioral Health representative(s) an opportunity to present oral argument.

- DHCS must provide written notification of their decision to the provider and RUHS Behavioral Health within **sixty (60) calendar days** from the receipt of RUHS Behavioral Health's documentation, or from the twenty-first (21st) calendar day after RUHS Behavioral Health received the request for 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. Parties may consider the appeal denied if the DHCS fails to act within the **sixty (60) calendar days.**

IMD Excluded Hospitals Appeals

Quality Improvement Inpatient must receive IMD Excluded hospitals' written appeals within **thirty (30) calendar days** of the receipt of the denied.

The appeal **must** include the following:

1. Cover letter of explanation for the appeal request
2. New appeal TAR
3. Denial letter from the reviewing QI Inpatient M.D.
4. Copy of the original hospital TAR
5. All supporting documentation substantiating the request for appeal

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

Second Level of Appeal is not applicable.

Inpatient Psychiatrist/Psychologist Provider Appeal

- Quality Improvement Inpatient must receive inpatient psychiatrist/psychologist provider written appeals within **sixty (60) calendar days** from the Denial/Pending letter postmark date.

- The appeal **must** include the following:
  1. Letter of explanation for the appeal request
  2. Documentation substantiating the request for appeal
  3. New HCFA (CMS-1500) form identifying the service dates under appeal
  4. Copy of the original HCFA (CMS-1500) form submitted to Managed Care
  5. Copy of the Denial/Pending letter received from Managed Care
  6. Denials based on RUHS Behavioral Health not receiving the hospital TAR/chart:
     QI Inpatient has thirty (30) days from receipt of claim to notify providers of claim denial due to non-receipt of the hospital TAR/chart within the allotted period; the notice will direct providers back to the hospital that provided services and will inform providers of their right to appeal. The individual provider is responsible for obtaining the FedEx/UPS/Postal Service tracking information confirming the hospital sent the TAR/Chart and verifying that RUHS Behavioral Health received it by the fourteenth (14th) day from the date of beneficiary's discharge.

- 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 of the appeal decision in writing

- The provider may submit a **revised** Health Insurance Claim Form (CMS-1500) to Managed Care Department within **thirty (30) calendar days** from receipt of Quality Improvement Inpatient's decision granting appeal. 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

First Level

Second Level

MEDI-CAL*

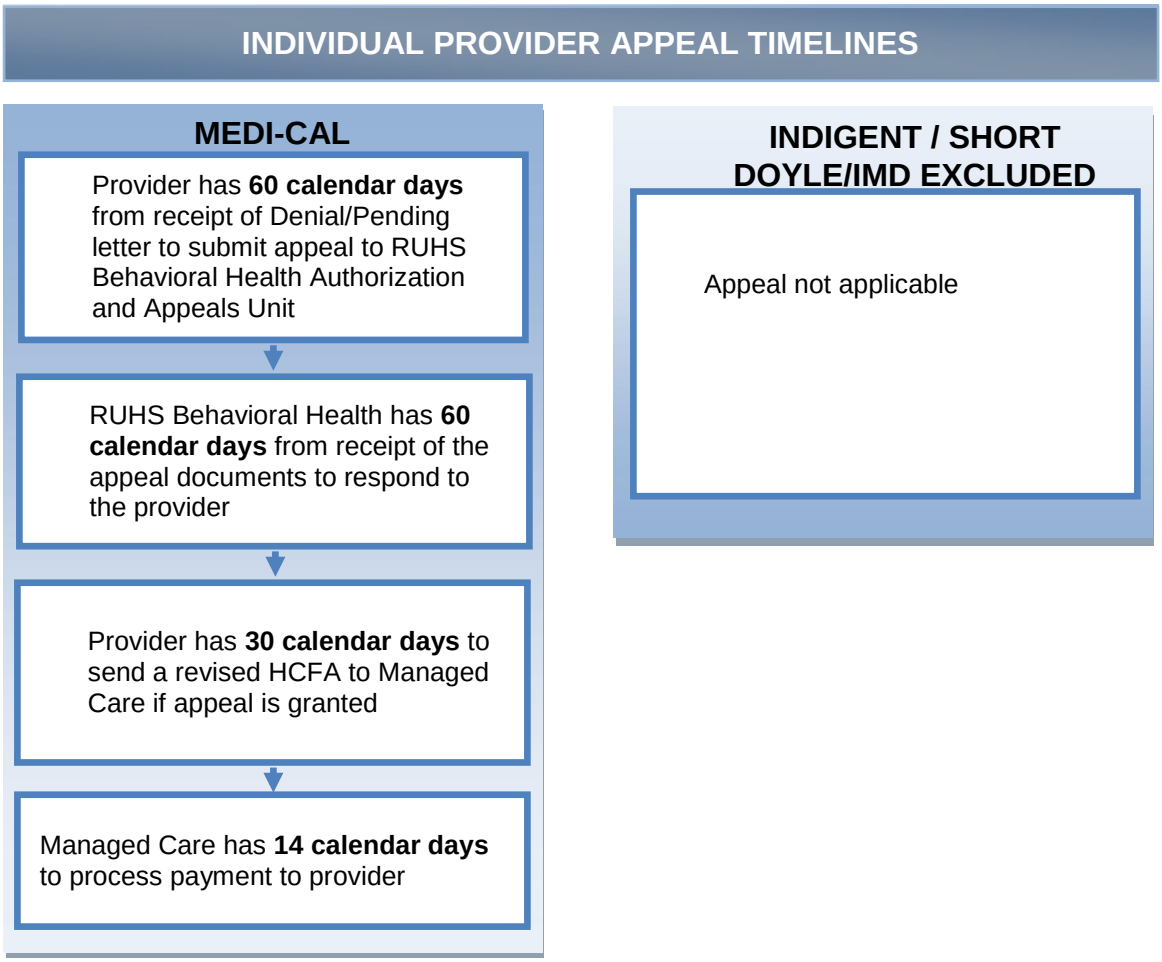
- Provider has **90 calendar days** after receipt of denial notification to appeal at the first level to RUHS Behavioral Health Authorization and Appeals Unit
- RUHS Behavioral Health has **60 calendar days** after receipt of the appeal documents to respond to the provider
- Provider can submit a second level appeal to the state within **30 days** of receipt of denial.
- 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
- Provider has **30 days** to submit TAR to the LMHP if days are approved at second level.
- LMHP has **14 days** from receipt of second TAR to send it to ACS and Provider

INDIGENT / SHORT DOYLE**/IMD EXCLUDED

- Provider has **30 calendar days** after receipt of denial notification to appeal at the first level to RUHS Behavioral Health Authorization and Appeals Unit
- RUHS Behavioral Health has **60 calendar days** after receipt of the appeal documents to respond to the provider
- Second 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 RUHS clients are systematically reported, reviewed, and analyzed to identify opportunities for improvement in client care, treatment services, and clinical operations.
- 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.

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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.

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

Reportable Incidents

- All cases of client deaths
- Incidents involving significant danger to oneself, including serious suicide attempts or self-injury
- Incidents involving significant danger 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 must develop and maintain site/provider specific policies and procedures for monitoring, reporting, and investigating adverse incidents. The facility/provider must systematically monitor adverse incidents and implement corrective action 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, and the National Practitioner Data Bank (NPDB).

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

CHAPTER 7 - PATIENT NOTICES/GRIEVANCES/APPEALS

Introduction

All beneficiaries/patients of RUHS Behavioral Health 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 mental health 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 a complaint resolution/grievance process to ensure the beneficiaries'/patients' right to a complaint, grievance, and an appeal process.

Beneficiary Informing Materials

Facilities will provide beneficiaries with a copy of the informing 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:

- Patients' Rights - (800) 350-0519.
- Quality Improvement Outpatient Program (for any grievances made to RUHS Behavioral Health is (800) 660-3570.
- Grievance and/or appeal information available through Quality Improvement Inpatient - (951) 358-6031.

The beneficiary may authorize another person, such as, the service provider, a friend, a family member, legal representative, or Patient's Rights staff, to act on his/her behalf during 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, and facility protocol shall insure the confidentiality of a beneficiary's record and comply with provider's confidentiality protocol.

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 or QI 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.

Upon notification of a patient grievance, RUHS Behavioral Health protocol will be followed; and Patients' Rights and/or QI Inpatient will confer with QI Outpatient on grievance outcome determination as needed per the RUHS Behavioral Health Outpatient Provider Manual.

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 8 - MEDICATION DECLARATIONS

General Information

Each patient should participate in the development of his/her treatment plan, including the use of medications. Providers should extensively explain the anticipated benefits, risks, alternative treatments, and possible immediate and long-term effects of specific medications to Patients, and obtain their signed consent to the fullest extent practicable. Reasons for lack of patient participation should be clearly documented in the patient chart. 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, it is necessary to obtain a signed Medication Declaration (V 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.

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) if there are indications that a patient requires a different psychiatric medication or dosage; the physician, hospital, and/or placement 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 (Attachment J-2 & J-2(S) and JV 220A (Attachment J-3 & J-3 (S), 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 Behavioral Health QI Outpatient office at **(951) 955-7203**.

The QI Psychiatrist reviews the submitted Med Dec for completeness and clinical appropriateness, and forwards it to Juvenile Court.

The court faxes the signed Med Dec to QI Inpatient after the Judge/Commissioner authorizes or denies the use of submitted medications. QI Inpatient 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, hospital, and/or placement 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.

Additional information about the use of psychiatric medications, wards, and dependents is found in RUHS Behavioral Health Policy 280: Consent for Medication of Court Wards and Dependents Not Under Conservatorship (Attachment H). A Copy of this policy is located in the RUHS Behavioral Health publication *Psychotropic Medication Guidelines*, revised December 2008. Treating physicians should review this publication for additional policies and guidelines relevant to use of medications in minors and adults.

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

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(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 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 United States health care system. 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 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 and to evaluate practices and enhance protections to prevent unnecessary, inappropriate access to PHI.

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)

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; staff to make note of any patient refusals to sign directly on the form and file in the beneficiary's chart. Providers may elect to use their own HIPAA-compliant NPP or use the Riverside County Notice of Privacy Practice as a template from the Department's website: http://www.ruhealth.org .

Notice of Privacy Practice (NPP) Poster: Providers are required to post a NPP poster containing all of the NPP information in the facility lobby.

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. 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-9, CPT, and HCPC level 1 & 2. You may not use local **CPT Codes** or **DSM IV** as service and diagnostic treatment categories.

Advance Directives

RUHS Policy 213-0 mandates that RUHS contracted providers supply adult patients with Advance Medical Directive legal rights information and the "Your Right to Make Decisions about Medical Treatment" brochure (See Attachment I) at their initial meeting and upon request. Document the receipt of any complete and fully executed Advance Medical Directives from patients and file within the patient's mental health file/chart. Advance Medical Directive information/brochures must comply with California state law and updated to reflect state law changes within ninety (90) days of implementation.

CHAPTER 10 – CONTRACTING WITH THE COUNTY AND PROVIDER SITE REVEIW

Contracting with the County

RUHS encourages State of California certified Medi-Cal FFS acute psychiatric inpatient facilities located within the Southern California Region to contract with RUHS. 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.

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

- Contract compliance between the provider and RUHS
- A safe facility
- Medication storage and dispensing practices compliant with state and federal laws and regulations
- Compliance with documentation standards, records maintenance, and facility standards as required by RUHS

RUHS will review the facility and provider services on a regular basis to determine compliance with regulatory and contract standards.

All Contract Providers must immediately inform RUHS Provider Relations at (951) 358-5111 of all of the following:

- Any 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 required from the contract package

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

- Contracted Hospital provider must notify RUHS at least sixty (60) days prior to a change of address to:

  RUHS Program Support
  P.O. Box 7549
  Riverside, CA 92513

  Office Phone: (951) 358-4613
  Fax: (951) 358-4792

- The local mental health director or designee must inform the DHCS, Program Compliance (916) 651-3838 of the following, within sixty (60) days prior to the change of ownership or location:
  - 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 change
  - Any major staff or program changes
- Report involuntary changes of location due to disaster immediately; they are not subject to the sixty (60) day notification requirement.

ATTACHMENTS

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