



Provider Manual

2010 - 2011



Provider Manual

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Introduction

The Health Plan of San Mateo (HPSM) provides health services to more than 58,000 residents of San Mateo County. All HPSM programs are designed to emphasize easy access to quality care for our members.

This Provider Manual contains policies and procedures relevant to providers that are contracted with HPSM. Please be aware that different policies and procedures may apply depending on the program(s) with which you are contracted.

The purpose of this manual is to familiarize participating providers and their staff with HPSM operations. It is designed as a reference tool to assist you with the administrative tasks related to accessing and providing comprehensive, effective, and quality medical services to HPSM members. HPSM reserves the right to revise these policies and procedures at our sole discretion and at any time.

If you have any questions regarding the information contained within, please call your Provider Services Representative (see listing at the end of this section labeled "Who to Call Reference List").

HPSM: Keeping Members Healthy

At HPSM, our primary concern is keeping our members healthy. Once a member chooses his or her Primary Care Physician (PCP) from our network, this highly skilled medical professional will provide the highest quality medical care, maintain medical records, and, when necessary, refer members to specialists.

HPSM: Quality

HPSM is committed to excellence. HPSM's Quality Improvement team carries out the Plan's mission to constantly improve our healthcare delivery system and to measure our member's healthcare outcomes. Using the PDSA (Plan, Do, Study, Act) rapid cycle model for quality improvement, HPSM has implemented many innovative quality improvement projects, supporting our providers in delivering the highest quality care in the most cost-efficient, culturally sensitive and expedient manner.

Our Website: www.hpsm.org

Providers may access a variety of plan information when visiting our web site. The site offers information on HPSM programs, up-to-date participating provider information, (including a provider directory, Member Handbook/Evidence of Coverage for each line of business, eligibility verification, clinical guidelines, preventive health guidelines, disease management programs, results of satisfaction surveys, authorization and referral forms, the latest HPSM news as well as an electronic version of this provider manual), health tips, plan history, and organizational philosophy. HPSM maximizes the use of technology to assist our providers to better serve our members.

Provider Manual Updates

This manual will be updated regularly as policies, programs and procedures change. Updates and supplements will be distributed as they occur and will be available as downloadable documents from our website for your convenience.

Please be sure to replace the existing pages in the manual upon receipt of any updates. This will assure that the manual you have available is the most current.

Comments and Suggestions

We welcome your feedback regarding this manual and hope that you will offer any suggestions on how we can improve either subject matter or layout. HPSM's goal is to make this manual as helpful and easy to use as possible. Please call the Provider Services Department at (650) 616-2106 if you have suggestions or comments.

Please note that existing provider contracts may supersede some policies stated in this material.

The following section briefly describes HPSM's six lines of business. These include: Medi-Cal, Healthy Kids, Healthy Families, HealthWorx, ACE and CareAdvantage.

Medi-Cal

HPSM was originally created and began operations in 1987 to serve San Mateo County Medi-Cal beneficiaries in a managed care environment. California legislation and waivers to Federal Medicaid laws allow HPSM to be the exclusive insurer of health care services for nearly all Medi-Cal beneficiaries in San Mateo County. This includes seniors and persons with disabilities.

Medi-Cal members must present their HPSM member identification card to access all covered services. Medi-Cal members may be subject to minor co-payments of \$1 - \$5 and are not subject to balance billing, per Title 22. The 11-digit member HPSM ID number is printed on the front of the HPSM identification card. The member number is the Client Index Number or CIN number plus 00. The State of California also issues Medi-Cal beneficiaries an ID card (BIC Card). It is always best to ask to see the member's HPSM ID card since the identification numbers may differ.

Please remember that it is the **provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to member's eligibility on the date of service. Please see Section 2 for information on how to verify member eligibility.

Healthy Kids (HK)

The Healthy Kids program was developed by a coalition of community based organizations (CBO), local and State politicians, businesses, healthcare organizations and philanthropic leaders in San Mateo County, who all shared a common vision of universal access to health insurance coverage for all of San Mateo County's children. In August 2002, the San Mateo County Board of Supervisors established the Children's Health Initiative (CHI) Coalition as the decision-making body for a project to provide universal healthcare to children in San Mateo County. The County Health System was designated as the lead agency of the coalition that includes representatives from the San Mateo Hospital Consortium, First 5 San Mateo, San Mateo Labor Council, the Peninsula Community Foundation, the San Mateo County Health System, San Mateo County Human Services Agency, and HPSM.

Healthy Kids provides medical and dental services to San Mateo resident children from birth through age eighteen. Children enrolled in Healthy Kids are not eligible for full-scope Medi-Cal or Healthy Families and their families' household income is up to 400% of the Federal Poverty Level (FPL). Since February 2003, when the program was implemented, Healthy Kids membership has grown to over 6,000 members.

Healthy Kids members must present their HPSM member identification card to access all covered services. Healthy Kids member co-payments are listed on the member identification card. The 11-digit member ID number is printed on the front of the identification card.

Please remember that it is the **provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to member's eligibility on the date of service. Please see Section 2 for information on how to verify member eligibility.

Healthy Families (HF)

In 1998, HPSM began to serve Healthy Families beneficiaries. Health Families, California's S-CHIP program, like Medi-Cal, is funded through a combination of state and federal funds. The program provides health services to citizen and resident children from birth through age eighteen whose families do not meet Medi-Cal's income guidelines for full-scope coverage but whose income, per state regulations, is up to 250% of the Federal Poverty Level (FPL).

Healthy Families members must present their HPSM member identification card to access all covered services. Healthy Families member co-payments are listed on the front of the member identification card. The 11-digit member ID number is printed on the front of the identification card.

Please remember that it is the **provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to member's eligibility on the date of service. Please see Section 2 for information on how to verify member eligibility.

CareAdvantage

In January 2006, HPSM began a Medicare Advantage (MA)/Prescription Drug Plan (PD). Members are dual eligible members (Medicare and Medi-Cal) who have enrolled in HPSM's Medicare Advantage health plan, CareAdvantage. Members must have both Medicare Part A (hospital insurance) and Part B (medical insurance) and full-scope Medi-Cal through HPSM. CareAdvantage members must live in San Mateo County.

Some dual eligible members may elect to remain in Original fee for service Medicare and enroll in a Prescription Drug Plan (PDP); others may join another Medicare Advantage Plan. In both cases, the member will retain their Medi-Cal eligibility with HPSM but will not be members of CareAdvantage.

CareAdvantage members must present their CareAdvantage identification card to access all covered services. CareAdvantage members are only responsible for a prescription drug co-payment per prescription which conforms to Medicare guidelines. The 11-digit member CareAdvantage ID number is printed on the front of the CareAdvantage identification card. The member identification number uses the following format: CAx + last 6 characters of the member's social security number + 00.

Please remember that it is the **provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to

member's eligibility on the date of service. Please see Section 2 for information on how to verify member eligibility.

HealthWorx (HW)

HealthWorx provides low cost health benefits for San Mateo County Public Authority In-Home Supportive Services (IHSS) Workers, San Mateo County Extra Help employees and City of San Mateo part-time employees. Eligibility for HealthWorx is determined by the governing entity.

The In-Home Supportive Services program provides domestic and personal care assistance to eligible aged or disabled persons who are at risk for institutionalization.

HealthWorx is also offered to San Mateo County Extra Help Employees. Eligibility for this program is determined by the San Mateo County Employee Benefits Division. HealthWorx for City of San Mateo part-time employees is determined by the City of San Mateo.

HealthWorx members must present their HPSM member identification card to access all covered services. Member co-payment amounts are listed on the front of the member identification card. The 11-digit member number is printed on the front of the identification card.

Please remember that it is the ***provider's responsibility to verify the member's eligibility at the time of service*** as reimbursement for rendered services is subject to member's eligibility on the date of service. Please see Section 2 for information on how to verify member eligibility.

HealthWorx members may be eligible for HPSM's Individual Conversion Plan (ICP) after they have exhausted the COBRA and Cal-COBRA continuation coverage available to them through their employer. Please contact an HPSM Member Services Representative at 1-800-750-4776 or 650-616-2133 if you have questions about the Individual Conversion Plan option.

San Mateo County ACE

San Mateo County ACE is a program available to uninsured residents of San Mateo County who are not eligible for coverage through Medicare, Medi-Cal, private insurance or other third-party coverage. **ACE is a coverage program and is not considered health insurance.** Enrollment in the ACE program is processed through the San Mateo County Coverage Unit. Strict income and asset levels apply. Services are primarily available through the San Mateo Medical Center and Ravenswood Family Health Center. Referral to other providers is only through an authorized referral process. The 11-digit member number is printed on the front of the identification card and begins with W.

Service Area

HPSM's service area covers the entire County of San Mateo, including the following communities:

- Daly City
- Brisbane
- Colma
- South San Francisco
- San Bruno
- Pacifica
- Millbrae
- Burlingame
- Montara
- El Granada
- Half Moon Bay
- Hillsborough
- San Mateo
- Foster City
- Belmont
- San Carlos
- Redwood City
- East Palo Alto
- Menlo Park
- Atherton
- Woodside
- Portola Valley
- Unincorporated Areas of San Mateo County



Who to Call Reference List

Eligibility – Providers are encouraged to use these resources to verify member eligibility

For all HPSM Programs

WebClaims Access (Eligibility, Authorization status, Claims) **(650) 616-2024**
www.hpsm.org
 24-Hour Automated Telephone Eligibility Verification (ATEV) **(800) 696-4776**

For Medi-Cal Program

24-Hour State Automated Eligibility Verification System **(800) 456-2387**
 Medi-Cal website **www.medi-cal.ca.gov**

Member Services – Medi-Cal, Healthy Families, Healthy Kids, HealthWorx and ACE

Benefits/Co-pay Information **(650) 616-2133**
 Explanation of Benefits **(800) 750-4776**
 (HPSM)
 PCP Selection/Change
 Health Insurance Premium Payment (HIPP) Program
 Member Eligibility
 Healthy Kids Enrollment/Disenrollment
 Member Complaints **(650) 616-2164 or (650) 616-2191**

Provider Services

(650) 616-2106

Capitation Questions
 Fee Schedule
 Contracts and Contract Terms
 Credentialing and Re-credentialing
 Participation Request
 Participation Status
 Access and Availability
 Provider Survey

Claims

(650) 616-2056

Claim Submission
 Claim Status
 Claim Payment Inquiries
 Provider Disputes

(650) 616-2836

Quality Department

(650) 616-2166

Provider Site and Medical Record Review
 Peer Review
 Quality Improvement Projects/Data Collection (HEDIS)
 Member Satisfaction Survey (CAHPS)

Health Services**(650) 616-2070 Hunt Group**

Treatment Authorizations (TAR) for Medical Services

Inpatient Authorizations

Out-of-Area Authorizations

Outpatient Services

Durable Medical Equipment

Utilization Management

Pharmacy Review

Referral Authorizations (RAF) for Specialist Referrals

Care Coordination Program

Chronic Disease Management Program

Clinical Practice Guidelines

Preventive Care Management Program

Prior Authorizations (PA) and Pharmacy Services

(650) 616-2088

Pharmacy Benefit Manager: InformedRx (IRX) Customer Service Hours: 24 hours per day/7 days per week:

(866) 441-2422

IRX Help Desk Hours: M-F, 6 a.m.-6 p.m.; Sat-Sun, 6 a.m.-2:30 p.m.

Health Education/Cultural & Linguistic Services**(650) 616-2165**

Interpreter Services

Health Education Brochures

Health Education Classes

Well Woman Program (Breast and Cervical Cancer screening)

Prenatal Program

CareAdvantage Unit – for CareAdvantage Members Only**(650) 616-2174**

Benefits/Co-pay Information

(866) 880-0606

Explanation of Benefits

PCP Selection/Change

Member Eligibility

Enrollment/Disenrollment

Member Complaints

(650) 616-2164 or (650) 616-2191

Section 2

Member Services

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Introduction

The Health Plan of San Mateo provides customer service to its members through the following departments:

- The HPSM Member Services Department assists members who have Medi-Cal, Healthy Families, Healthy Kids, HealthWorx and San Mateo County ACE. Member Services Representatives can help members with questions about their HPSM coverage and provide assistance in resolving problems related to healthcare services. The Member Services Department can be reached at 1-800-750-4776 or (650) 616-2133. Call Center hours are Monday through Thursday from 8 a.m. to 6 p.m. and Friday from 9:30 a.m. to 6 p.m. Hearing impaired members can use the California Relay Service (CRS) at (800) 735-2929 (TTY) or dial 711. Office hours are Monday through Friday, 8 a.m. to 5 p.m. Member Services Representatives speak Spanish and Tagalog and can access telephone interpreters to assist members with other language needs.
- The HPSM CareAdvantage Unit assists members who have CareAdvantage coverage. CareAdvantage is HPSM's Medicare Advantage/Prescription Drug Plan. CareAdvantage Navigators can help members with questions about their CareAdvantage coverage and provide assistance in resolving problems related to healthcare services. The CareAdvantage Navigators can be reached at (866) 880-0606 Monday through Sunday from 8 a.m. to 8 p.m. Hearing impaired members can use the California Relay Service (CRS) at (800) 735-2929 (TTY) or dial 711. Office hours are Monday through Friday, 8 a.m. to 5 p.m. CareAdvantage Navigators speak Spanish, Tagalog, Mandarin, Cantonese and Russian and can access telephone interpreters to assist members with other language needs.

HPSM mails each new member a welcome packet which includes their Member Handbook and Evidence of Coverage (EOC). These publications tell members:

- How to choose a PCP or change his/her PCP
- How to receive care
- What the member's benefits are
- What to do if a member has a question or a problem

The most recent EOC for each of the programs can be downloaded from the HPSM website at www.hpsm.org. There are links to the EOCs under the "Members" section of HPSM's website. The EOCs are also available in hard copy format from the Provider Services staff.

Member Rights and Responsibilities

Each program's EOC includes a section on Members Rights and Responsibilities. These Member Rights and Responsibilities are established and enforced by California State Law, HPSM Policies and Procedures, and in provider contracts between you and HPSM. Some of the key Member Rights and Responsibilities are:

HPSM members have the right to:

- Get dignified, courteous, and considerate treatment regardless of race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, medical condition, or stage of illness.
- Get up-to-date information about HPSM, HPSM's services and how to use them.
- Get care from the Primary Care Provider (PCP) the member chooses from HPSM's network or change the member's PCP to another HPSM network doctor.
- Access family planning services, Federally Qualified Health Centers, certified nurse practitioner services, Indian Health Service Facilities, sexually transmitted disease services and Emergency services outside HPSM's network. Minors also have the right to access minor consent services.
- Know and understand their medical problem. Receive information on available treatment. Obtain a second opinion from a different doctor at no cost to the member.
- Participate in decisions about their medical care. The member has the right to refuse or discontinue treatment and prepare advance directives.
- Have their confidential health information protected. Members also have the right to access their health information for reasons allowed by law and receive copies of, or add a statement to their records.
- Get information and services in a way which respects their language and culture. Receive information in the member's language or alternative formats and large size print upon request.
- Not use family or friends as interpreters, including as sign language interpreters.
- Use HPSM's free interpreter service, including during discussion of complex medical conditions and treatment options and after hours services, and file a Grievance if the member's language needs are not met.
- File a Grievance about HPSM or the care the member receives, either orally or in writing.

- Freely exercise these rights without adversely affecting how the member is treated by HPSM and/or providers.

HPSM members have the responsibility to:

- Carefully read all HPSM member materials to understand how to use HPSM benefits and what procedures to follow when they need care.
- Do their best to keep appointments and call the provider or clinic as soon as possible if there is a need to cancel or reschedule an appointment.
- Show their HPSM ID card or remember to tell the provider that they are an HPSM member before receiving care.
- Follow the treatment plan they and their provider have agreed upon.
- Provide accurate and complete information about their health care needs when they see a provider. Let their provider know if they have a medical condition.
- Ask their doctor questions if they do not understand something or are unsure about the advice they are given.
- See the specialists to whom their Primary Care Provider (PCP) refers them.
- Actively participate in health care programs that will keep them well.
- Work with their provider to build and maintain a good working relationship.
- Use the emergency room only in cases of an emergency or as directed by their provider.
- Follow up with their PCP after getting care at an emergency facility.
- Report lost or stolen ID cards to HPSM and do not let anyone else use their ID card.
- Contact HPSM if they do not understand how to use their benefits or have any problems with the services provided.
- Help HPSM maintain accurate and current records by providing timely information regarding changes in address, family status and other health care coverage.
- Promptly follow the HPSM Grievance procedure if the member believes he/she needs to submit a Grievance.

- Treat all HPSM personnel and health care providers respectfully and courteously.

Missed Appointments by Members

The *Member Handbook and Evidence of Coverage (EOC)* reminds members that if they cannot keep their appointment or want to cancel an appointment, they need to call their provider to cancel or reschedule as soon as possible. A provider's office can send HPSM a Missed Appointment Report. The HPSM Member Services Department or CareAdvantage Unit will send a letter to the member documenting the missed appointment and reminding him/her to follow his/her doctor's advice and the importance of calling to cancel appointments in advance. HPSM will also remind members that missed appointments may be a basis for a provider requesting reassignment of a member to a different provider for care. You will receive a copy of this letter for the member's medical record.

Advance Directives

HPSM provides written information in the HPSM Member Handbook about members' rights under California State Law to make healthcare decisions, including the right to accept or refuse treatment and the right to execute Advance Directives. San Mateo County residents may arrange to have "Do Not Resuscitate" (DNR) orders.

Providers are required to document in the patient's medical record whether he/she has executed an Advance Directive. Information on Advance Directives is available at the California Medical Association website at <http://www.cmanet.org/publicdoc.cfm/7>. A simplified Advance Directive form is available and can be downloaded from our website. The document is available in English and Spanish and the link can be found through the "Provider" section of our website under "Provider Resources."

Member's Right to Select a Provider

Primary Care Physician (PCP)

HPSM Members' care is managed by the PCP that they have selected. A PCP may be a pediatrician, a general practitioner, a family practitioner, an internist, a Federally Qualified Health Care Clinic (FQHC), a Native American health service provider, a nurse practitioner, or in some cases, an OB/GYN provider.

The name and telephone number of each member's PCP is printed on their individual HPSM Member Identification (ID) Card.

Women's Services – OB/GYN Services

Female HPSM members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by their PCP or members may self-refer to any contracted OB/GYN or PCP within the HPSM network for OB/GYN services.

Pregnancy Care

The Health Plan of San Mateo encourages pregnant women to get early prenatal care. Members may select an Obstetrician or Certified Nurse Midwife for care during

pregnancy. Members have the right to select Certified Nurse Midwife services from an out-of-plan Medi-Cal Provider if they are not available through HPSM.

Indian Health Services

American Indians or Alaskan Natives who are HPSM members may choose any available Indian Health Service Provider available, as provided under Federal Law. The provider does not have to be an HPSM network provider and HPSM will make arrangements to coordinate appropriate services for these members.

Programs and Enrollment Information

The following programs are offered by the Health Plan of San Mateo. You may receive inquiries from existing or new patients asking how they can join the various programs offered by the Health Plan of San Mateo.

Medi-Cal

Medi-Cal is a government program administered through the State of California Department of Health Services. Eligibility is determined by the San Mateo County Human Services Agency; or through Supplemental Security Income (SSI). Eligibility guidelines and enrollment information is available at the Human Services Agency website at <http://www.smchsa.org> or prospective members can call the San Mateo Health Insurance TeleCenter at (800) 223-8383 to find out if they are eligible to receive Medi-Cal health benefits.

Healthy Kids

Uninsured children from birth through age 18 who are not eligible for coverage through Medi-Cal or Healthy Families and fall within certain income guidelines may be eligible to enroll in the Healthy Kids program. Enrollment information can be found on the Children's Health Initiative website at <http://www.smcchi.org> or prospective members may call the San Mateo County Coverage Unit at (650) 616-2002 for more information.

Healthy Families

Uninsured children from birth through age 18 who are residents of California and fall within certain income guidelines may be eligible to enroll in the Healthy Families program. More information about the Healthy Families program is available at www.healthyfamilies.ca.gov. Enrollment information can also be found on the Children's Health Initiative website at <http://www.smcchi.org> or prospective members can call (650) 616-2002 for more information.

CareAdvantage

CareAdvantage is HPSM's Medicare Advantage/Prescription Drug Plan and was designed for people who have both Medicare and Medi-Cal. Members must have Medicare Part A (hospital insurance) and Part B (medical insurance) and full-scope Medi-Cal through HPSM. CareAdvantage members must live in San Mateo County. Prospective members may call a CareAdvantage Representative at 1-888-252-3153 or (650) 616-1500 for more information about enrollment. A link to the Medicare Online Enrollment Center (OEC) is also available on the HPSM website at www.hpsm.org. People with questions about Medicare can also call the local Health Insurance Counseling and Advocacy Program (HICAP) at (800) 434-0222.

HealthWorx/ICP

San Mateo County Public Authority In-Home Support Services (IHSS) workers and certain San Mateo County Extra Help Employees and City of San Mateo Per Diem employees are eligible for HealthWorx.

- IHSS Workers need to call the SEIU Local 715 at 1-877-734-8521 or (650) 779-9910
- San Mateo County Extra Help Employees must contact the San Mateo County Employee Benefits Division at (650) 363-1919

Please note, City of San Mateo part-time employees should call SEIU at 1-877-734-8521 or (650) 779-9910.

HealthWorx members are also eligible for COBRA, CalCOBRA, and an Individual Conversion Plan (ICP). These programs are available to former HealthWorx members whose employment has been discontinued. Members should call Member Services at (650) 616-2133 for more information.

San Mateo County ACE

The San Mateo ACE Program is a county-sponsored program that provides health care coverage to low-income adult residents of San Mateo County who meet eligibility requirements. HPSM administers the San Mateo ACE Program under a contract with San Mateo County. **San Mateo ACE is not insurance.** The San Mateo ACE Program covers a wide range of health care and pharmacy benefits under a coordinated system of care, but it is not an insurance product subject to state insurance requirements. It is a payer of last resort, which means it pays only for certain services that are not covered by other existing coverage programs. Services are primarily provided through the San Mateo Medical Center and the Ravenswood Family Health Center. ACE participants may be referred for specialty services to non-County providers but prior authorization is required. Prospective enrollees can call (650) 616-2002 for more information.

Identifying HPSM Members

Health Plan of San Mateo (HPSM) members may be enrolled in one of HPSM programs. These programs are Medi-Cal, Healthy Families, Healthy Kids, HealthWorx, San Mateo County ACE and CareAdvantage. The majority of HPSM members are in the Medi-Cal program. All HPSM members are issued HPSM Identification (ID) cards showing the program they are enrolled in, and the PCP on record for them. Examples of ID cards can be found later in this chapter.

PCP Case Management List

Case Management lists are distributed monthly to Primary Care Physicians. The list includes all members assigned to the PCP and information such as assigned member name, member ID number, date assigned to the PCP, and prior PCP if applicable. Please see the last section of the Provider Manual for a sample of the monthly Primary Care Physician Case Management List.

Medi-Cal Members

HPSM Medi-Cal Members are Medi-Cal beneficiaries who are determined to be eligible for Medi-Cal by the San Mateo County Human Services Agency, or are eligible for Supplemental Security Income (SSI), which provides Medi-Cal as an automatic benefit.

Medi-Cal eligible beneficiaries with qualifying aid codes are automatically enrolled in HPSM.

Each member is issued an HPSM identification card in addition to the Benefits Identification Card (BIC) issued by the State. Sample cards are included later in this section.

Types of Medi-Cal Members

Full Scope Capitated Members

These are members who are entitled to the full scope of HPSM Covered Benefits and Services and are assigned to a Primary Care Provider for case management.

Full Scope Special Members

Full scope special members are those whose health care services are delivered in a fee-for-service manner for a limited period of time. Special members are not assigned a PCP and do not require referrals to see contracted, in-network specialists.

Members with chronic or complex medical conditions may be granted special member status to allow for direct access to specialists. Special members may self-refer to any HPSM specialist provider and have "HPSM" assigned as their Primary Care Provider. Members of this group may include the following:

- Specific eligibility status (e.g. retroactively eligibles, share-of-cost, other specific aid code designations).
- Out-of-County institutional and residential placement.
- Court jurisdiction for foster care and adoption.
- Individuals currently diagnosed with AIDS or End-Stage Renal Disease (ESRD) who require dialysis.
- Individuals given a temporary "one month only" special member status in order to choose another Primary Care Provider (PCP).
- Individuals assigned to the Special Member status by the HPSM Medical Director.

The HPSM Medical Director or designee is responsible for evaluating members and provider requests for Special Member Status. The Medical Director will review the requests of those members who have been designated Special Members. The purpose of the review is to:

- Reaffirm the decision, or
- Return the member to a case management status due to an improvement in the member's situation or medical need.

Special Members may be placed into a capitated case-management group and be required to select a Primary Care Provider (PCP) at the earliest possible date when their aid code changes, or if their health condition and/or other factors change.

Share-of-Cost Members

Some Medi-Cal subscribers (recipients) must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share-of-Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible.

Until a member has met his/her SOC amount for the month, they are not eligible for Medi-Cal coverage. After a member meets the SOC for the month, HPSM will pay for the member's covered medical expenses for the rest of the month. More information about the Medi-Cal SOC can be found at the Medi-Cal website at

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

Healthy Families Members

Healthy Families is a low cost insurance for children up to their 19th birthday. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal. Healthy Families is California's Children Health Initiative Program, and the program is administered by the Managed Risk Medical Insurance Board (MRMIB). MRMIB determines eligibility for the program and program cost sharing requirements.

Healthy Kids Members

Healthy Kids is a San Mateo County based low cost insurance for children up to their 19th birthday. It provides health, dental and vision coverage to children who do not have insurance and do not qualify for Medi-Cal or Healthy Families. The San Mateo County Coverage Unit processes applications and determines final eligibility.

CareAdvantage Members

Health Plan of San Mateo (HPSM) CareAdvantage Members are dual eligible members (Medicare **and** full-scope Medi-Cal) who have enrolled in HPSM's Medicare Advantage/ Prescription Drug Plan, CareAdvantage. CareAdvantage members must live in San Mateo County. Members must have both Medicare Part A (hospital insurance) **and** Part B (medical insurance) and full-scope Medi-Cal through HPSM.

Enrollment in CareAdvantage is optional. Some dual eligible members may elect to remain in original fee for service Medicare and enroll in a Prescription Drug Plan (PDP) or join another Medicare Advantage Plan. In both of these cases, the member will retain his/her Medi-Cal eligibility but **will not** be a member of CareAdvantage.

HealthWorx Members

Health Plan of San Mateo (HPSM) HealthWorx Members are In-Home Support Services (IHSS) workers in San Mateo County who have met eligibility requirements by working a specified number of hours in a calendar quarter. Eligibility is determined by the local union, SEIU Local 715.

HealthWorx members may also be San Mateo County Extra Help Employees who have met eligibility requirements by working a specified number of hours in the prior fiscal year. Eligibility is determined by the San Mateo County Employee Benefits Division.

HealthWorx members may also be City of San Mateo Per Diem employees who have met eligibility requirements established by the City of San Mateo.

San Mateo County ACE

San Mateo ACE is offered to San Mateo County residents who are not eligible for coverage through Medicare, full-scope or share-of-cost Medi-Cal, private insurance or other third-party payers. Enrollees in the ACE program must meet established income levels. Asset levels are also considered in determining eligibility for the ACE program. The San Mateo County Coverage Unit processes applications and determines final eligibility for the ACE Program. Services for ACE participants are primarily offered at the San Mateo Medical Center and Ravenswood Family Health Center. Services to other providers is by authorized referral only.

Member Eligibility

It is important that the member eligibility is checked at the time of each visit. A member's eligibility can change at any time for any number of reasons, including change in aid code, non-payment of premiums, and home address change.

Ways to Check Eligibility

Check Monthly Primary Care Physician (PCP) Case Management List

PCPs should check for the member's name on the list sent at the beginning of each month. It is available via HPSM's web portal "eReports." This listing will also let you know if any patients have been added or deleted from your practice, along with an effective date or termination date.

Please see the end of this manual for a sample of the PCP Case Management List.

Check HPSM's Website, www.hpsm.org

The website allows for both electronic billing and member eligibility information (including PCP Assignment) for dates of service within the prior six (6) months. To obtain a provider login and password, please contact the HPSM Provider Services Department at (650) 616-2106.

Check HPSM's ATEV/IVR

Eligibility information is also available by telephone, using the HPSM's 24-hour Automated Telephone Eligibility Verification/Interactive Voice Recognition (ATEV/IVR) system. To verify eligibility and PCP assignment for dates of service within the prior six (6) months, please call (800) 696-4776. Please have the member's ID number available. When a member is not assigned a PCP, the eligibility recording will state "Special Member." Since member status can change from month to month, it is important to verify a member's status for the month that the service was rendered.

Check Medi-Cal's 24-Hour State Automated Eligibility Verification System (for Medi-Cal members only)

Please call (800) 456-2387.

Check Medi-Cal's Website (for Medi-Cal and Medicare/Medi-Cal members only)

Eligibility information is available on the State of California's Medi-Cal website, www.medi-cal.ca.gov. For assistance in obtaining a login and password for the State of California Medi-Cal website, please call the POS Help Desk at (800) 427-1295 for more information.

Check the Point of Service (POS) device (for Medi-Cal members only)

Swiping the patient's Beneficiary Identification Card (BIC) in a POS device will also enable you to determine eligibility. The POS device provides eligibility as well as Share-of-Cost liability information for dates of service within the prior twelve (12) months. To learn more about using POS devices, please call the State POS Help Desk at (800) 427-1295.

Please remember that verification of active enrollment is subject to retroactive adjustment in accordance with the terms and conditions of coverage described in the member's benefit plan.

Specialist providers, hospitals, and other service providers should verify eligibility on the date that the service is rendered. A referral or authorization is not sufficient to guarantee that the member is eligible on the date of service.

Identification Cards and Co-Payments

Each HPSM member is issued an identification card which gives specific information about the member. This information includes:

Program name

Member's name

Member's date of birth

Member's ID number (Effective date of the most current member information)

Member's Primary Care Physician (PCP)

PCP's office phone number

Pharmacy Benefit Manager

ID CARDS BY LINE OF BUSINESS

Medi-Cal ID Card:



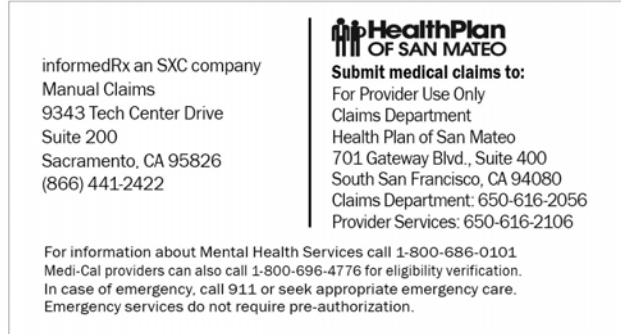
HealthPlan OF SAN MATEO

Medi-Cal

ID: _____ EFF DATE: _____
 _____ DOB: _____

PCP: _____

HPSM MEMBER SERVICES: 1-800-750-4776 **MEDICARE:**
 PBM: informedRx - 1-866-441-2422
 PCN# IRX GROUP# 090002 BIN#610011



HealthPlan OF SAN MATEO

informedRx an SXC company
 Manual Claims
 9343 Tech Center Drive
 Suite 200
 Sacramento, CA 95826
 (866) 441-2422

Submit medical claims to:
 For Provider Use Only
 Claims Department
 Health Plan of San Mateo
 701 Gateway Blvd., Suite 400
 South San Francisco, CA 94080
 Claims Department: 650-616-2056
 Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101
 Medi-Cal providers can also call 1-800-696-4776 for eligibility verification.
 In case of emergency, call 911 or seek appropriate emergency care.
 Emergency services do not require pre-authorization.

HealthWorx ID Card:



HealthPlan OF SAN MATEO

HealthWorx

ID HWK- _____ EFF DATE: _____
 _____ DOB: _____

PCP: _____

HPSM MEMBER SERVICES: 1-800-750-4776
 PBM: informedRx - 1-866-441-2422
 PCN# IRX GROUP# 090002 BIN#610011



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Submit medical claims to:
 For Provider Use Only
 Claims Department
 Health Plan of San Mateo
 701 Gateway Blvd., Suite 400
 South San Francisco, CA 94080
 Claims Department: 650-616-2056
 Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101
 Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM
 PIN 24 hours a day.
 In case of emergency, call 911 or seek appropriate emergency care.

Healthy Families ID Card:



HealthPlan OF SAN MATEO

Healthy Families

ID HF- _____ EFF DATE: _____
 _____ DOB: _____

PCP: _____

HPSM MEMBER SERVICES: 1-800-750-4776
 PBM: informedRx - 1-866-441-2422
 PCN# IRX GROUP# 090002 BIN#610011



HealthPlan OF SAN MATEO

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 Claims Department
 Health Plan of San Mateo
 701 Gateway Blvd., Suite 400
 South San Francisco, CA 94080
 Claims Department: 650-616-2056
 Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101
 Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM
 PIN 24 hours a day.
 In case of emergency, call 911 or seek appropriate emergency care.

Healthy Kids ID Card:

		<h3>Healthy Kids</h3>	
ID HK- DELTA DENTAL ID		EFF DATE:	
PCP:		DOB:	
<p>HPSM MEMBER SERVICES: 1-800-750-4776 PBM: informedRx - 1-866-441-2422 PCN# IRX GROUP# 090002 BIN#610011 DELTA DENTAL: 1-866-527-9564 GROUP NO. SM60</p>			

informedRx an SXC company Manual Claims 9343 Tech Center Drive Suite 200 Sacramento, CA 95826 (866) 441-2422	 <p>Submit medical claims to: For Provider Use Only Claims Department Health Plan of San Mateo 701 Gateway Blvd., Suite 400 South San Francisco, CA 94080 Claims Department: 650-616-2056 Provider Services: 650-616-2106</p>
<p>For information about Mental Health Services call 1-800-686-0101 Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM PIN 24 hours a day. In case of emergency, call 911 or seek appropriate emergency care.</p>	

CareAdvantage ID Card:

		<h3>CareAdvantage (HMO)</h3> <p>An HPSM Medicare Plan</p>	
EFF. DATE: ID:		HPSM CareAdvantage Unit: 1-866-880-0606	
DOB:		RxBin: 610011	
PCP:		RxPCN: IRX	
		RxGrp: 090002	
		Issuer: 80840	
<p style="text-align: center;">MedicareRx Prescription Drug Coverage  CMS-H5428 001-0</p>			

informedRx an SXC company Manual Claims 9343 Tech Center Drive Suite 200 Sacramento, CA 95826 (866) 441-2422	 <p>Submit medical claims to: For Provider Use Only Claims Department Health Plan of San Mateo 701 Gateway Blvd., Suite 400 South San Francisco, CA 94080 Claims Department: 650-616-2056 Provider Services: 650-616-2106</p>
<p>HPSM CareAdvantage Unit: 1-866-880-0606; 1-800-735-2929 (TTY) In case of emergency, call 911 or seek appropriate emergency care</p>	

Individual Conversion Plan ID Card:

		<h3>Individual Conversion Plan</h3>	
ID-		EFF DATE:	
PCP:		DOB:	
<p>HPSM MEMBER SERVICES: 1-800-750-4776 PBM: informedRx - 1-866-441-2422 PCN# IRX GROUP# 090002 BIN#610011</p>			

informedRx an SXC company Manual Claims 9343 Tech Center Drive Suite 200 Sacramento, CA 95826 (866) 441-2422	 <p>Submit medical claims to: For Provider Use Only Claims Department Health Plan of San Mateo 701 Gateway Blvd., Suite 400 South San Francisco, CA 94080 Claims Department: 650-616-2056 Provider Services: 650-616-2106</p>
<p>For information about Mental Health Services call 1-800-686-0101 Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM PIN 24 hours a day. In case of emergency, call 911 or seek appropriate emergency care.</p>	

Co-Payment Requirements and Co-payment Table by Program

Service	Healthy Kids-HK*	Healthy Kids-K1*	Healthy Families-9H**	Healthy Families-H1**	HealthWorx	ICP
Physician Visit (PCP)	\$5	\$10	\$5	\$10	\$5	\$25
Physician Visit (Specialist)	\$5	\$10	\$5	\$10	\$5	\$25
Prescription	\$5	\$10	\$5	\$10	\$5	\$10/\$35 or 50% of charges
ER	\$5 - (waived if admitted)	\$15 (waived if admitted)	\$5 (waived if admitted)	\$15 (waived if admitted)	\$25	\$100
Hospital	\$0	\$0	\$0	\$0	\$0	\$200 per day
Vision	\$5	\$10	Not covered by HPSM***	Not covered by HPSM	Not covered by HPSM***	\$25
Dental	Covered through Delta Dental	Covered through Delta Dental	Not covered by HPSM	Not covered by HPSM	Not covered by HPSM	Not covered by HPSM

There are ***no co-pays for preventive health care services*** except for the Individual Conversion Plan (ICP).

* Healthy Kids co-payments are based on the current Federal Poverty Income Guidelines. Category A members have \$5.00 co-payments. Category B and C members have \$10.00 and \$15.00 co-payments. \$250 annual co-pay maximum per family for Healthy Kids. Members will be notified when the maximum has been reached. Please note that Healthy Kids co-payments are tied to the Healthy Families co-payments and are subject to change. Refer to the aid code column of the monthly Case Management report to determine the members aid code (HK or K1).

** Healthy Families co-payments are based on the current Federal Poverty Income Guidelines. Category A members have \$5.00 co-payments. Category B and C members have \$10.00 and \$15.00 co-payments. \$250 annual co-pay maximum per family. Members will be notified when the maximum has been reached. Please note that Healthy Families co-payments are determined by the State and are subject to change. Refer to the aid code column of the monthly Case Management report to determine the members aid code (9H or H1).

*** Except for cataract spectacles and lenses that replace the natural lens of the eye after surgery – no co-pay.

CareAdvantage members pay a co-payment when they fill each covered prescription. The amount the member pays will depend on his/her income and is determined by Medicare. Medicare changes the co-payment amount annually. Members who live in a long-term care facility do not have any co-payments.

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. This catastrophic coverage begins when the total cost of the drugs that the member receives under the Medicare Part D benefit reaches the specified amount (in 2010 the amount was \$6,440). This includes costs that are paid by the member, as well as costs that CareAdvantage and certain others pay. Once the total drug costs reaches the catastrophic amount in a calendar year, the member will no longer have to pay any prescription co-payments for the rest of the calendar year.

PCP Selection Process

HPSM members are encouraged to select his or her own PCP as soon as they become eligible for or are enrolled in an HPSM program. Member Services Representatives/CareAdvantage Navigators are available to assist members with the PCP selection process.

When Medi-Cal members become eligible, “New Member Packets” are mailed to the member, requesting that they select a PCP. New HPSM Medi-Cal members are placed in the special member category for one month to allow them time to select a PCP. Members who do not select a PCP are automatically assigned to a PCP (see below for more information) according to the guidelines prescribed by the California Department of Health Care Services.

New HPSM members in other programs (Healthy Kids, Healthy Families, HealthWorx, ACE and CareAdvantage) are required to select a PCP as part of their initial enrollment process.

Members may elect to continue an established relationship with an HPSM participating provider, or choose a new Primary Care Provider from the HPSM Provider List.

Established Patients Only (EPO) PCPs

If a member selects a PCP who is in an “Established Patients Only (EPO)” status, the selection will be denied unless the provider confirms the member is an established patient.

There are two ways an EPO PCP can approve selection by a member. If a member contacts HPSM about a selection request, Member Services staff will fax a “Provider Selection Form for HPSM Physicians Accepting Established Patients Only” form to the provider’s office. If the provider or an authorized employee of the office signs and returns the form, then the member will be assigned to the EPO PCP. Alternatively, the standard “Primary Care Physician Selection/Change of Address Form (PCP/COA)” can be completed by the member, and the provider or an authorized employee of the office

can indicate on the form the approval to accept the member. The standard PCP/COA form is available in many PCP offices, can be requested from HPSM, or can be downloaded from HPSM's website, www.hpsm.org

Automatic Assignment of a PCP (for Medi-Cal members only)

The PCP auto-assignment program is designed to match members and PCPs by geographic location, member age, PCP capacity and specialty.

If a member is auto-assigned to a PCP, the member is notified by mail of the automatic selection and information is included in the packet informing the member of the option to change if he or she wants to do so.

Changing Primary Care Providers

Members may request a change in PCP selection at any time. Member Services Representatives or CareAdvantage Navigators will discuss the reason for the change with the member so that HPSM can provide help as necessary and monitor for quality of care.

Changes in the PCP selection can be effective only at the beginning of a specific month, so requests for PCP changes must be received by the 22nd of the month to be effective the 1st of the following month. After HPSM staff complete the change, the member will receive a confirmation letter, and a new HPSM ID card with the new PCP selection.

When a PCP change request is approved due to the deterioration of the doctor/patient relationship, the HPSM Medical Director, at his/her discretion, may arrange for care of the member by another physician until the change becomes effective.

Member Reassignment

Providers may request that a member be reassigned to another provider based on the following criteria:

- Lack of member cooperation
- Consistent failure to keep appointments
- Non-compliance with the provider's instructions
- Poor understanding and/or communication between doctor and patient
- Inability to establish a relationship, continue a relationship or the deterioration of an existing relationship
- Abusive behavior toward the provider and/or the provider's staff
- Member exhibits drug seeking behavior
- Member has a past history of bad debt and no payment arrangements with PCP prior to coverage under a HPSM program
- A determination that care can be more appropriately provided by another provider due to geographic, cultural, and other social situations or considerations.

Physician requests for member reassignment must be in writing, documenting the reasons for the request, and sent to the HPSM Provider Services Department to initiate the process. Requests for member reassignment can be mailed to the Provider Services Department, or submitted by fax to (650) 616-8046.

A request for change of a PCP during “active treatment” will require a special review by the Medical Director and the Grievance Coordinator. Active treatment is defined as care for a medical condition which is ordinarily not short term in nature (i.e. sore throat, cold, etc.) and which is most appropriately continued by the current treating PCP. Examples of active treatment conditions include: late stage perinatal care, pre-operative preparation for a scheduled surgery, post operative follow-up, or any medical condition/treatment which, in the opinion of the Medical Director, should be completed by the current treating PCP. This process allows HPSM to assist the member as necessary and monitor for quality of care during the transition to a new PCP provider.

Action on such requests is at the discretion of the Medical Director or designee who will determine if the change would have a detrimental effect on the health of the member during the course of active treatment.

The Medical Director may, upon consultation with the current treating PCP and the new proposed PCP, determine that the change is acceptable during the course of the active treatment period.

All such requests for member reassignment during active treatment, whether they are initiated by the provider or the member, will require documentation from the current treating PCP. This documentation must include the member’s diagnosis(es), member’s current physical condition, treatment plan as well as the reasons for the request for member reassignment.

A written notice of the decision will be sent to the requesting member or provider, with information about the rights of the individual to file a grievance and the necessary procedures to take such an action. Please see Section 4 of this Manual for information about the HPSM Complaint and Grievance procedures.

Continuity of Care for New Members

As required by California law, under some circumstances, HPSM will provide continuity of care for new Members who are receiving medical services from a non-participating provider, such as a doctor or hospital, when HPSM determines that continuing treatment with a non-participating provider is medically appropriate. In such cases the HPSM contracted provider may be required to coordinate a member’s care with a non-contracted provider.

A new member may request permission to continue receiving medical services from a non-participating provider if he/she was receiving this care before enrolling in HPSM and if the member has one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with HPSM.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the member enrolls with HPSM.
- Performance of a surgery or other procedure that the member's previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the time the member enrolled with HPSM.

Members should contact either the Member Services Department or CareAdvantage Unit to request continuing care or to obtain a copy of HPSM's Continuity of Care policy. Normally, eligibility to receive continuity of care is based on the member's medical condition. However, eligibility is not based strictly upon the condition and will be determined by the HPSM Medical Director. If the request is approved, the member will be financially responsible only for applicable co-payments.

HPSM will request that the non-participating provider agree to the same contractual terms and conditions that are imposed upon participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, HPSM is not required to continue that provider's services. HPSM is not required to provide continuity of care as described in this section to a newly covered member who was covered under an individual subscriber agreement. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement.

HPSM staff will notify a member of HPSM's decision. If HPSM determines that the member does not meet the criteria for continuity of care, the member can file a grievance with HPSM. Members can also contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-

888-466-2219; or at the TDD number for the hearing impaired, (877) 688-9891; or online at www.hmohelp.ca.gov

Continuity of Care for Termination of Provider

HPSM will provide continuity of care for covered services rendered to a member by a provider whose participation has terminated, if the member was receiving this care from this provider prior to termination and if the member has one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time the provider stops contracting with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- Performance of a surgery or other procedure that HPSM had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to a member in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with HPSM prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, HPSM is not required to continue the provider's services beyond the contract termination date.

Members should contact either the Member Services Department or CareAdvantage Unit to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on the member's medical

condition and will be determined by the HPSM Medical Director. However, eligibility is not based strictly upon the condition. If the request is approved, the member will be financially responsible only for applicable co-payments.

HPSM staff will notify a member of HPSM's decision. If HPSM determines that the member does not meet the criteria for continuity of care, the member can file a grievance with HPSM. Members can also contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, (888) 466-2219; or at the TDD number for the hearing impaired, (877) 688-9891; or online at www.hmohelp.ca.gov

Section 3

Member Complaints

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ii.	Member Grievances	3
iii.	Appeals of Organization Determinations	5

Introduction

This Section describes the procedures that Members and their authorized representatives may use to submit complaints to HPSM. The information is included in this Manual since Providers may file Complaints on behalf of Members, or offer assistance to Members in filing Complaints. The Section begins with definitions and then details the Grievance and Appeals processes. Providers need to be aware that Members have different Appeal rights depending upon the line of business in which the Member is enrolled. These differences are described in the sections that follow. Also, please keep in mind that HPSM Members may be dually eligible for both Medicare and Medi-Cal, but not be enrolled in HPSM's Medicare line of business, CareAdvantage. If dually eligible members are covered under Medicare fee-for-service, the CareAdvantage procedures described in this Section will not apply. HPSM does not discriminate against or disenroll members for filing Complaints. HPSM has interpreter services available to assist members with language barriers.

Member Complaints

Members have the right to submit Complaints to HPSM. A Complaint is any oral or written expression of dissatisfaction with any HPSM service – clinical or non-clinical – a Member receives or regarding reimbursement for a bill that a Member has paid. A Complaint can be a Grievance or an Appeal or both.

A **Grievance** is a Complaint expressing dissatisfaction with any aspect of HPSM's or a Provider's operations, activities, or behaviors – including quality of care concerns – regardless of whether any remedial action is requested or can be taken. A Grievance may be filed by a Member with HPSM either directly, or by referral from the Legal Aid Society of San Mateo County or another advocacy group, and may be filed either verbally by telephone or in person, in writing via mail, or electronically via HPSM's website. Grievances may also be communicated directly to Providers and be resolved by a Medical Group or facility.

An **Organization Determination** is any decision made by or on behalf of HPSM regarding the payment or provision of a service a Member believes he or she is entitled to receive. An Organization Determination is made in response to a Treatment Authorization Request or a request for Prior Authorization submitted by a Provider and may include approval, denial, deferral, or modification of the request.

An **Appeal** is a Complaint that deals with the review of an adverse Organization Determination of a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care service, or on any amounts the Member must pay for a service.

Member Grievances

Members may submit a Grievance to HPSM if they are dissatisfied with any aspect of HPSM's or a Provider's operations, activities, or behaviors. Please note that the Grievance procedures for Members receiving Medicare benefits under HPSM CareAdvantage differ slightly from procedures for Members receiving benefits under HPSM's other lines of business. These differences are clearly indicated throughout this section.

Filing a Grievance

Member Grievances can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Heath Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

For HPSM CareAdvantage: Grievances must be filed within **60** calendar days of the incident or action with which the member is dissatisfied.

For All Other Lines of Business: Grievances must be filed within **180** calendar days of the incident or action with which the member is dissatisfied.

Member Grievances may be received by HPSM's Member Services Department, the CareAdvantage Unit, or by one of HPSM's Grievance and Appeals Coordinators. Except in the case of an Expedited Grievance (see below), if a Complaint is received by Member Services or CareAdvantage that staff will make every effort to resolve the Complaint within 24 hours. If the complaint cannot be resolved in 24 hours, the complaint will be forwarded to a Grievance and Appeals Coordinator for further processing.

Processing and Resolving Standard Grievances

Once a Grievance is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter to the Member within 5 calendar days. He or she will investigate the Grievance, which may include notifying the Member's Provider of the Grievance, if applicable.

Making a Determination

The Grievance and Appeals Coordinator will issue a resolution letter within 30 days of receipt of the Grievance. Appropriate administrative review and follow-up will continue until all actions stated in the resolution have been completed.

Submitting Grievances to the Department of Managed Health Care

This applies to Members in Healthy Families, Healthy Kids, HealthWorx, and Medi-Cal. Members enrolled in CareAdvantage do not have this option.

Members may submit Grievances to the Department of Managed Health Care (DMHC) under the following conditions:

- They disagree with the decision made by HPSM
- HPSM has not resolved their Grievances within the 30-day time frame

To submit a Grievance to the DMHC, a member must complete a Consumer Complaint Form, which can be accessed at www.dmhc.ca.gov/gethelp and submit it via fax or mail to:

Department of Managed Health Care
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(916) 229-0465 Fax

HPSM will abide by the decision made by the DMHC and will work to complete the actions recommended by the DMHC as quickly as possible.

Mediation

Prior to filing a Grievance with the Department of Managed Health Care, a Member may request voluntary mediation with HPSM. A Member does not have to participate in voluntary mediation for longer than thirty (30) days before being able to submit a Grievance to the Department of Managed Health Care. Expenses for mediation are paid for equally by HPSM and the Member.

Expedited Grievances (for CareAdvantage Members ONLY)

HPSM CareAdvantage members have the option of requesting an Expedited Grievance under certain circumstances. These circumstances are:

- HPSM refused to expedite an Organization Determination.
- HPSM extended the time frame to process an Organization Determination.
- HPSM refused to expedite an Appeal (also called a reconsideration).
- HPSM extended the time frame to process an Appeal (or reconsideration).

In these cases, CareAdvantage members may ask to speak to the Grievance and Appeals Coordinator immediately. The Grievance and Appeals Coordinator who will consult with appropriate HPSM staff and respond to the Grievance within 24 hours of HPSM's receipt of the original Grievance.

Appeals of Organization Determinations

Any member who is dissatisfied with an Organization Determination made by HPSM regarding the status of a service or benefit may request an Appeal of this determination. This is true for Organization Determinations regarding both pre-service and retrospective authorizations and usually is the result of a denial.

As an HPSM contracted Provider, you may file an Appeal on behalf of HPSM members, but you cannot charge members for performing this service. An authorized representative of the member may also request an Appeal.

Appeals procedures for members receiving Medicare benefits provided under HPSM's CareAdvantage program differ from the Appeals procedures for members receiving benefits through HPSM's other lines of business. Discussion of the procedures is clearly separated to avoid confusion. HPSM also distinguishes between standard Appeals and Appeals that require expedited review in cases where standard time frames would jeopardize a member's life, health, or ability to regain maximum function. Please be sure to refer to the appropriate Appeals procedures if you would like to submit an Appeal. They are discussed as indicated below:

Medi-Cal, Healthy Kids (HK), Healthy Families (HF), and HealthWorx (HW)

- Standard Appeals under Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx.
- Expedited Appeals under Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx
- Independent Medical Review for Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx

Medi-Cal Only

- State Hearing
- Expedited State Hearing

HPSM CareAdvantage

- Standard Appeals under HPSM CareAdvantage
- Fast-Track Appeals to a Quality Improvement Organization under HPSM CareAdvantage
- Expedited Appeals under HPSM CareAdvantage
- External Appeals under HPSM CareAdvantage

CareAdvantage Appeals can be for medical services and supplies or for drugs covered under the Medicare Part D prescription drug benefit. The timeframes and processes for Part D Appeals differ from Appeals for medical services and supplies. These differences are noted in the following sections.

Note: Members or their authorized representatives may cancel their request for an Appeal at any time by forwarding the request in writing to HPSM's Grievance and

Appeals Coordinator. Verbal requests can be accepted for all product lines except HPSM CareAdvantage.

Standard Appeals (for Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx)

The first step in the Appeals process is called a reconsideration. You may request a reconsideration of an HPSM adverse Organization Determination for a member participating under the programs listed above if you or your member disagrees with HPSM's decision. You may also be called upon to assist a member or authorized representative if he/she requests an Appeal, or to forward relevant medical records to help us make a determination on an Appeal.

How to File an Appeal

Appeals can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

- Electronically via HPSM's website: www.hpsm.org.

Appeals may be received by HPSM's Member Services Department or by a Grievance and Appeals Coordinator.

An Appeal must be filed within **90** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 90-day requirement for good cause.

Processing the Appeal

Once the Appeal is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter within 5 calendar days and work with appropriate HPSM staff to begin investigation of the case. Additional information may be required from Providers involved in the member's treatment.

After all relevant documentation is collected, the case is forwarded to either HPSM's Medical Director or Associate Medical Director. The physician who made the initial determination will not be involved in the appeal process.

Making a Determination

Using all available information, HPSM will make a reconsideration determination and notify the Provider and/or the member within 30 calendar days. This timeframe applies to both pre-service and retrospective authorizations. For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered or the payment has been made.

For determinations that uphold initial adverse determinations, HPSM provides written notification that includes the reason for denial and information about additional levels of Appeal that may be available.

Expedited Appeals (for Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx)

You may request an expedited reconsideration of an HPSM adverse Organization Determination for a member participating in the programs listed above if you or your member believes that applying the standard 30-day timeframe for processing a reconsideration would jeopardize the member's life, health, or ability to regain maximum function. HPSM will also expedite a reconsideration for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

In addition to HPSM's expedited Appeals process, Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx members can also contact the California Department of Managed Health Care (DMHC) and request an urgent review. Members do not need to go through HPSM's expedited reconsideration process before contacting the DMHC.

How to File an Expedited Appeal

Expedited Appeals can be submitted to HPSM through the following routes:

- Verbally, by visiting HPSM in person or calling: (650) 616-0050
- In writing via mail or facsimile to:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

Requests for expedited Appeals will automatically be forwarded to an HPSM Grievance and Appeals Coordinator.

For telephone and facsimile requests for expedited reconsideration that are submitted during non-business hours, HPSM's answering service will receive the request and immediately page HPSM's Medical Director to provide expedited review.

An Expedited Appeal must be filed within **90** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 90-day requirement for good cause.

Requests for urgent review by the Department of Managed Health Care can be submitted by calling (888) HMO-2219.

Processing the Appeal

Upon receiving the request for an expedited reconsideration, a Grievance and Appeals Coordinator will confer with licensed clinical staff to determine if the request meets the criteria for an expedited review. This decision will be made within the first 24 hours from the receipt of the request.

If the reconsideration does not qualify for an expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of this decision and any Grievance and Appeal rights, including the right to contact the DMHC. The case will then be forwarded through the standard reconsideration process.

If the reconsideration qualifies for expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of the decision and of the member's right to contact the DMHC. He/she will work with appropriate HPSM staff to collect all relevant information about the member's condition and forward the case file to an independent local physician for review within the first 48 hours after receiving the request if necessary.

Making a Determination

Using all available information, HPSM will make a reconsideration determination and will notify you and/or the member as expeditiously as the member's health requires, but no later than 72 hours of HPSM's receipt of the request.

For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered.

For determinations that uphold initial adverse determinations, HPSM provides written notification that includes the reason for denial and information about additional levels of Appeal that may be available.

Independent Medical Review (IMR) (for Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx)

If you or your member disagrees with a decision HPSM has made on a reconsideration based on medical necessity, or if HPSM does not make a decision within the standard

30-day time frame, the member can request an Independent Medical Review (IMR) by the Department of Managed Health Care (DMHC). ***An IMR may also be requested if HPSM denies a treatment because it is experimental or investigational; in this case, the member does not need to complete HPSM's reconsideration process before requesting an IMR.*** Information on requesting an IMR can be obtained by calling (888) HMO-2219, or by visiting the DMHC website at www.hmohelp.ca.gov

Note: A Medi-Cal member who has already participated in a State Hearing (see below) is not eligible to receive an IMR from the DMHC.

The IMR will review the case to determine whether or not the care requested is medically necessary. A decision on an IMR must be returned within 30 days of the DMHC's receipt of the IMR application for standard Appeals, or within 3 business days for expedited Appeals.

If the IMR determines that the service is medically necessary, HPSM will approve the requested service or make a payment within 5 business days.

State Hearing (for Medi-Cal ONLY)

Medi-Cal members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with HPSM's decision regarding approval of a requested service. A State Hearing is an Appeal with an Administrative Law Judge from the Department of Social Services. Expedited State Hearings may also be requested.

Requests for State Hearings can be submitted by telephone at (800) 952-5253 or in writing to:

State Department of Social Services
State Hearing Division
Post Office Box 944243
Mail Station 19-37
Sacramento, CA 94244-2430
Fax: (916) 229-4110

Requests for Expedited State Hearings should be submitted to:

Expedited Hearing Unit
State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
Fax: (916) 229-4267

A Medi-Cal member may request a State Hearing at any time, without completing HPSM's reconsideration process. Requests for State Hearings must be submitted within **90** days of an action with which the member is dissatisfied. For standard State

Hearings, a decision must be made within 90 days of the request. For expedited State Hearings, a decision must be made within 72 hours.

Standard Appeals for CareAdvantage Members ONLY

Please refer to the section on Part D Appeals for additional information.

As with HPSM's other product lines, the first step in the Appeals process for HPSM CareAdvantage is a reconsideration. You may request a reconsideration of an HPSM adverse Organization Determination for a CareAdvantage member if you or your member disagrees with this decision. You may, as a physician providing treatment to a member, upon providing notice to the member, request a standard reconsideration on the member's behalf. If you appeal the decision on behalf of a member, **the member will not have to submit documentation designating you as the member's authorized representative.** You may also be called upon to assist a member or authorized representative if he/she requests an Appeal, or to forward relevant medical records information to help us make a determination on an Appeal.

How to File an Appeal

Appeals can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

Note: Appeals under HPSM CareAdvantage cannot be submitted via HPSM's website.

An Appeal must be filed within **60** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 60 day requirement for good cause.

Appeals may be received by HPSM's CareAdvantage Unit or by a Grievance and Appeals Coordinator.

Processing the Appeal

Once the Appeal is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter within 5 calendar days and work with appropriate HPSM staff to begin investigation of the case. Additional information may be required from Providers involved in the member's treatment.

After all relevant documentation is collected, the case is forwarded to either HPSM's Medical Director or Associate Medical Director.

Making a Determination

Using all available information, HPSM will make a reconsideration determination, and will notify you and/or the member within 30 calendar days or within 60 calendar days for reconsiderations on retrospective authorizations. For all reconsiderations HPSM may extend these timeframes for up to 14 calendar days if requested, or if such extension is in the best interest of the member. A member may request an expedited Grievance if he/she disagrees with HPSM's decision to extend the timeframe.

For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered or the payment has been made.

For determinations that uphold initial adverse determinations, HPSM provides written notification that includes the reason for denial. The case will automatically be forwarded to the Independent Review Entity (IRE). The IRE is contracted by the Medicare program to conduct additional levels of review for Medicare Appeals. See External Appeals for HPSM CareAdvantage for more information.

Fast-Track Appeals to a Quality Improvement Organization (for CareAdvantage Members ONLY)

If a member disagrees with HPSM's decision to terminate or change the level of care for services received in an inpatient stay, skilled nursing facility (SNF), home health agency (HHA), or a comprehensive outpatient rehabilitation facility (CORF), he/she may Appeal the decision to the Quality Improvement Organization (QIO) with which the Medicare program has contracted. In California, the QIO is Health Services Advisory Group (HSAG).

Members are notified of their right to submit this Appeal to the QIO when they receive their Notice of Discharge and Medicare Appeal Rights for inpatient stays, their Notice of Medicare Non-Coverage for SNF, CORF, or HHA terminations, or other notice of non-coverage.

Members must request an Appeal by noon of the first business day following receipt of the notice in order to avoid financial liability during the contested time. The QIO will make a determination within 24 hours. If the member misses the deadline for a QIO fast-track Appeal, he/she may still request an expedited reconsideration from HPSM as described below.

Expedited Appeals (for CareAdvantage Members ONLY)

You may request an expedited reconsideration of an HPSM adverse Organization Determination for a CareAdvantage member if you or your member believes that applying the standard timeframe for processing a reconsideration would jeopardize a member's life, health, or ability to regain maximum function. HPSM will also expedite a reconsideration for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities if a member does not request an Appeal to a QIO within the required timeframes.

How to File an Expedited Appeal

Expedited Appeals can be submitted to HPSM through the following routes:

- Verbally, by visiting HPSM in person or calling: (650) 616-2850
- In writing via mail or facsimile to:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2002 Fax

An Appeal must be filed within **60** calendar days from receipt of HPSM's notice of an adverse Organization Determination. HPSM may allow an exception to this 60-day requirement for good cause.

Appeals submitted by an authorized representative must be accompanied by documentation indicating the member's authorization.

Requests for expedited Appeals will automatically be forwarded to HPSM's Grievance and Appeals Coordinator.

For telephone and facsimile requests for expedited reconsideration that are submitted during non-business hours, HPSM's answering service will receive the request and immediately page HPSM's Medical Director to provide expedited review.

Processing the Appeal

Upon receiving the request for expedited reconsideration, the Grievance and Appeals Coordinator will confer with licensed clinical staff to determine if the request meets the criteria for expedited review. This decision will be made within the first 24 hours from the receipt of the request.

Note: All requests for expedited review that have the support of a physician will automatically be approved.

If the reconsideration does not qualify for expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of this decision and any Grievance and Appeal rights. The case will then be forwarded through the standard reconsideration process. A member may request an expedited Grievance if he/she disagrees with HPSM's decision to process the request according to the standard timeframe.

If the reconsideration qualifies for expedited review, a Grievance and Appeals Coordinator will immediately notify the member and Provider of the decision and work with appropriate HPSM staff to request all relevant information about the member's condition within the first 24 hours.

Making a Determination

Using all available information, HPSM will make a reconsideration determination, and HPSM will notify you and/or the member as expeditiously as the member's health requires, but no later than 72 hours after HPSM's receipt of the request. HPSM may extend this timeframe for up to 14 calendar days if requested, or if such extension is in the best interest of the member. A member may request an expedited Grievance if he/she disagrees with HPSM's decision to extend the timeframe.

For determinations that reverse the initial adverse determinations, HPSM will provide both oral and written notification, and will follow-up to ensure that the service has been rendered.

For determinations that uphold initial adverse determinations, HPSM will provide both oral and written notification that includes the reason for denial. The case will automatically be forwarded to the IRE. See External Appeals for HPSM CareAdvantage for more information.

Appeals regarding Part D (Prescription Drug) Benefits (for CareAdvantage Members ONLY)

Although the appeal process is similar, the timelines for Part D prescription drug benefit appeals differ as do the rules regarding who can file an appeal. For a Part D Standard Appeal (known as a redetermination), only the member or a member's authorized representative can appeal an HPSM decision. A physician can be a member's authorized representative. However, you and the member will have to complete and submit the member authorization form or information requested. Using all available information, HPSM will make a determination, and will notify the member or authorized representative within 7 calendar days. A member, physician, or authorized representative can request an Expedited Appeal. In that case HPSM will notify you and/or the member within 72 hours of our determination. If HPSM's upholds its decision, a member or authorized representative must request external review by the IRE. A physician, unless also an authorized representative, cannot request this external review.

External Appeals (for CareAdvantage ONLY)

HPSM CareAdvantage members have access to successive levels of Appeal to contest adverse Organization Determinations, reconsideration determinations, and redeterminations (for Part D). These include:

- Review by an Independent Review Entity (IRE)
- Administrative Law Judge (ALJ) hearing
- Medicare Appeals Council (MAC) hearing
- Judicial review

Independent Review Entity

As noted above, all adverse reconsideration determinations except those regarding Part D benefits are automatically forwarded to and reviewed by the Medicare-contracted Independent Review Entity (IRE) for external review. For a Part D reconsideration to be reviewed by the IRE, the member must submit a written request to the IRE within 60 days of the date of the reconsideration decision. In this case, the IRE is required to solicit the prescribing physician's views on the case.

The IRE will make a determination on the case within the same time frames as HPSM:

- 7 days for a Part D Appeal;
- 30 days for a standard pre-service authorization Appeal;
- 60 days for a standard retrospective authorization Appeal; and
- 72 hours for an expedited Part D or pre-service authorization Appeal.

If the IRE overturns HPSM's decision, HPSM will authorize and/or provide service or payment within the following timeframes:

- 72 hours for a standard Part D appeal
- 14 calendar days for a standard pre-service authorization
- 30 calendar days for a standard retrospective authorization
- 72 hours for an expedited pre-service authorization
- 24 hours for an expedited Part D appeal

Administrative Law Judge Hearing

In cases where the service being contested has met minimal dollar amount standards (set annually) the member, Provider, or authorized representative can request a hearing before an Administrative Law Judge (ALJ). This request must be made within 60 calendar days of receiving notice by the IRE and should be submitted to the Social Security Administration or the IRE. Upon request, HPSM can also forward members' requests for an ALJ hearing to the IRE.

If the ALJ overturns HPSM's decision, the following timeframes will apply:

- 72 hours to authorize and/or provide service for pre-service Part D appeals
- 72 hours to authorize payment for Part D appeals and 30 days to issue payment
- 60 calendar days to authorize and/or provide service or payment for non-Part D appeals

HPSM may request a review by the Medicare Appeals Council (MAC; see below), in which case HPSM may wait for the MAC's decision before authorizing service or payment.

Medicare Appeals Council

Any party to an Appeal, including a member, Provider, authorized representative, or HPSM, can request a hearing before the Medicare Appeals Council (MAC). This request must be made within 60 calendar days of receiving notice by the ALJ and should be submitted in writing to the MAC. Upon request, HPSM can also forward members' requests for a MAC review.

If the MAC overturns HPSM's decision, the same timeframes for acting upon the decision as are required for ALJ decisions will apply.

Judicial Review

Any party to an Appeal, including a member, Provider, authorized representative, or HPSM, can request judicial review of a MAC decision if: (1) the MAC denied the request for a review, and (2) the amount of the service in question meets the minimal dollar amount set annually. To request judicial review, the party must file a civil action in a U.S. District Court.

If judicial review overturns HPSM's decision, the same timeframes for acting upon the decision as are required for ALJ and MAC decisions will apply.

Section 4

Claims

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Filing a Paper Claim

Before filing any claim, be sure to confirm the member's eligibility. It is very important you include the member's correct identification number. Do not bill with a Social Security number. (Please see Section 2 - Member Eligibility).

Non-Hospital

To be eligible for payment, all paper claims must be filed on fully and accurately completed CMS 1500 forms with the current ICD-9 diagnosis codes (at the highest level of specificity) and CPT-4 procedure codes (including applicable modifiers). Claims may be pended or denied when data items on claim forms are incomplete or incorrect. Table 3 - 1 contains descriptions of field numbers and HPSM requirements corresponding to the standard CMS 1500 Claim Form.

Hospital

To be eligible for payment, inpatient and outpatient hospital paper claims must be submitted to HPSM using a fully and accurately completed UB-04 claim form. Claims may be pended or denied when data items on claim forms are incomplete or incorrect. Table 3 - 2 contains description of field numbers and HPSM requirements corresponding to the standard UB-04 Claim Form

Long Term Care Paper Claims

To be eligible for payment, long term care paper claims must be submitted to HPSM using a fully and accurately completed 25-1 claim form. Claims may be pended or denied when data items on claim forms are incomplete or incorrect

CHDP Paper Claims

To be eligible for payment, all CHDP claims must be submitted to HPSM using a fully and accurately completed PM 160 Informational form.

It is very important to include your appropriate NPI Number when submitting claims.

Paper claims should be submitted to the following address:

Health Plan of San Mateo
Attention: Claims Department
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Paper claims are acknowledged on the remittance advice (RA) within 15 working days of receipt.

The status of all submitted claims may be checked via HPSM's website (www.hpsm.org) once a User ID and Password have been established. Please contact the HPSM Provider Services Department at (650) 616-2106 for assistance.

Table 3-1 – CMS-1500 Field Descriptions and Requirements

Field #	Description	Requirement
1	Medicaid/Medicare/Other ID	Enter an "X" in the Medicaid Box (for all programs except CareAdvantage)
1A	Insured's ID	Enter Member's HPSM ID number
2	Member's Name	Entered as it appears on the HPSM ID Card
3	Member's DOB/Sex	Enter Member's DOB in 6-digit format (MMDDYYYY)
4	Insured's Name	Use if billing for a newborn using Mom's ID
5	Member's Address/Telephone	Enter Member's Complete Address and Telephone Number
6	Patient Relationship to Insured	This field may be used when billing for an infant using the mother's ID by checking the "Child" box
7	Insured's Address	Not Required by HPSM
8	Patient Status	Not Required by HPSM
9	Other Insured's Name	"X" if applicable
9A	Other Insured's Policy/Group Number	"X" if applicable
9B	Other Insured's Policy/Group Number	"X" if applicable
9C	Employer's Name/School Name	"X" if applicable
9D	Insurance Plan Name/Program Name	"X" if applicable
10	Is Patient's Condition Related To:	Not Required by HPSM
10A	Employment	"X" if applicable
10B	Auto Accident/Place	"X" if applicable
10C	Other Accident	"X" if applicable
10D	Reserved for Local Use	Enter the amount of patient's Share-of-Cost for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$) (e.g. if billing for \$100, enter 10000 not 100).

Table 3-1 – CMS-1500 Field Descriptions and Requirements

Field #	Description	Requirement
11	Insured's Policy Group or FECA Number	"X" if applicable
11A	Insured's Date of Birth/Sex	"X" if applicable
11B	Employer's Name or School Name	"X" if applicable
11C	Insurance Plan Name of Program Name	"X" if applicable
11D	Is There Another Health Benefit Plan?	Enter an "X" in the box if the recipient has other coverage.
12	Patient's or Authorized Person's Signature	Not Required by HPSM, use "Signature on File"
13	Insured's or Authorized Person's Signature	Not Required by HPSM, use "Signature on File"
14	Date of Current Illness/Injury/Pregnancy	"X" if applicable
15	Similar Illness	"X" if applicable
16	Date Unable to Work	Not Required by HPSM
17	Referring Provider	Physician name or other source (for PAPER CLAIMS ONLY)
17A	ID Number of Referring Physician	Enter the referring or prescribing or ordering practitioner's NPI.
18	Hospitalization Dates	Enter dates of admission and discharge.
19	Reserved for Local Use	Use this area for providing additional information which may be necessary for HPSM to process your claim appropriately; such as "Baby using Mom's ID", anesthesia start/stop times, or proof of eligibility.
20	Outside Lab	"X" if applicable .Name of outside lab must be listed in box 32.

Table 3-1 – CMS-1500 Field Descriptions and Requirements

Field #	Description	Requirement
21.1	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers of the ICD-9-CM at its highest specificity. Do not use decimal point.
21.2	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code at its highest specificity, if present.
21.3	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code at its highest specificity, if present.
21.4	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code at its highest specificity, if present.
22	Medicaid Re-submission Code	Not Required by HPSM
23	Prior Authorization Number	For physician and pediatric services requiring a Treatment Authorization Request (TAR). It is not necessary to attach a copy of the TAR to the claim. Recipient information and NPI on the claim must match the TAR. Only one TAR Control Number can cover the services billed on any one claim.
24A	Date(s) of Service	Enter the date or date span the service was rendered in the "From" and "To" boxes in the 6-digit, MMDDYY, format. Do not bill "future" dates – services cannot be billed until after the "from" date on the claim.
24B	Place of Service	Enter one code indicating where the service was rendered.
24C	Type of Service	Not Required by HPSM
24D	Procedures, Services, or Supplies Modifier	Enter the applicable procedure code (HCPCS or CPT-4) and modifier, if required.
24E	Diagnosis Code Pointer	Reference diagnosis code(s) from box 21 applicable to each service line.
24F	Charges	In full dollar amount, enter the usual and customary fee for service(s). Do not use the dollar sign (\$). If an item is a taxable medical supply, include the applicable state and county sales tax.

Table 3-1 – CMS-1500 Field Descriptions and Requirements

Field #	Description	Requirement
24G	Days or Units	Enter the number of medical "visits", surgical lesions, hours of detention time, units of anesthesia time, etc.
24H	EPSDT Family Plan	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are CHDP-screening related. Leave blank if not applicable.
24I	ID Qualifier	Not required by HPSM
24J	Rendering Provider ID Number	Enter NPI if applicable
24.1 -.6	Claim lines	Follow instructions for each claim line.
25	Federal Tax ID Number	Enter the 9-digit provider Tax ID number.
26	Patient's Account No.	This is an optional field that will help you to easily identify a recipient on RAs.
28	Total Charge	In full dollar amount, enter the total for all services. Do not enter a decimal point (.) or dollar sign (\$).
29	Amount Paid	Enter the amount of payment received from the other coverage (Box 10D). Do not enter Medicare payments in this box. Medicare payment amount will be calculated from the Medicare EOMB/RA when submitted with the claim.
30	Balance Due	Enter the difference between Total Charges and Amount Paid.
31	Provider Signature/Date	Not required for CareAdvantage claims
32	Service Facility Location Information	Can include Outside Lab. List location where service was rendered.
32a	NPI of Facility	NPI of location listed in Box 32.
32b		Not Required
33	Billing Provider Info and Phone Number	Required
33a	NPI of Billing Provider	Required
33b		Not Required.

TABLE 3-2 – UB-04 Field Descriptions and Requirements

Field #	Description	Requirement
1	Hospital Name, Address and Zip Code	Enter the hospital name, address and 5-digit zip code.
2	Alternate Address of Facility	Not Required by HPSM
3	Patient Control Number	This is an optional field that will help you easily identify a recipient on RTDs and RAs.
3b	Medical Record Number	This is an optional field that will help you easily identify a recipient on RTDs and RAs.
4	Type of Bill	Enter the appropriate Type of Bill code as specified in the UB-04 Manual Billing Procedures.
5	Federal Tax ID Number	Enter the 9-digit Federal Tax ID number.
6	Statement Covers Period (From-Through)	In 6-digit format MMDDYY, (Month, Day, Year) enter the dates of service included in this billing.
7	Blank	Not Required by HPSM
8	Patient Name	Required
8a	Blank	Not Required
8b	Patient Name	Last name, first name, middle initial
9	Patient Address	
9a	Patient's Street Address	Required
9b	City	Required
9c	State	Required
9d	Zip	Required
9e	Zip + 4	Not Required
10	Birth date	8-Digit, MMDDYYYY
11	Sex	Enter M or F
12	Admission Information - Date	Enter admit date as 6 digits, MMDDYY
13	Admission Hour	Enter as 2 digit - Eliminate the minutes, convert the hour of admission/discharge to 24-hour (00-23) format (for example, 3 p.m. = 15)

TABLE 3-2 – UB-04 Field Descriptions and Requirements

Field #	Description	Requirement
50A-C	Payer	Enter name of Coverage of Health Plan
51A-C	Member Health Plan ID	Required
52A-C	Release of Information Certification	Y or N
53A-C	Assignment of Benefits Certification Indicator	Y or N
54A-B	Prior Payment	Enter the full dollar amount of payment received from Other Coverage or Share of Cost if applicable.
55A-C	Estimated Amount Due	Enter the difference between "Total Charges" and any deduction.
56	NPI	Required
57	Unlabeled	Sometimes used for TIN
58A-C	Insured's Name	Required
59A-C	Patient's Relationship to Insured	If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's Relationship to the Medi-Cal recipient (e.g. 03 Child).
60A-C	Insured's Unique ID	Enter the Member's ID number.
61A-C	Insured Group Name	Not Required by HPSM
62A-C	Insurance Group Number	Not Required by HPSM
63A-C	Treatment Authorization Codes	For services requiring a Treatment Authorization Request (TAR) enter the TAR Control Number.
64A-C	Document Control Number	Not Required by HPSM
65A-C	Employer Name	Not Required by HPSM
66A-H	Diagnosis Codes	No entry can be made
67 A-Q	Diagnosis Codes	Enter all letters and/or numbers of the ICD-9-CM codes at their highest level of specificity, if present.
Field #	Description	Requirement
68	Blank	
69	Admit DX	Not Required by HPSM

TABLE 3-2 – UB-04 Field Descriptions and Requirements

70 a-c	Patient Reason DX	Not Required
71	PPS Code	Not Required
72 a-c	ECI	Not Required
73	Blank	
74	Principal Procedure Code and Date	Enter the appropriate HPCPS or CPT-4 code identifying the primary medical or surgical procedure.
75	Blank	
76	Attending Physician ID	Include physician name, NPI and qualifier
77	Operating Physician ID	Include physician name, NPI and qualifier
78-79	Other	If applicable
80	Remarks	Use this area for procedures that require additional information, e.g. enter Mother's name when the baby is using Mother's ID and the baby's birth date.
81 a-d	CC	Not Required

For **HOSPITAL OUTPATIENT SERVICES** billed on a UB-04 form, the following fields are “NOT REQUIRED BY HPSM:”

16–22, 43, 46

In addition, Field #44 requirement should read: Enter CPT-4 procedure code and appropriate modifiers, if needed.

TABLE 3-3- LTC 25-1 Field Description and Requirements

Field #	Description	Requirement
1	Claim Control Number	HPSM use only. DO NOT mark in this area. A unique 13-digit number, assigned by HPSM to track each claim, will be entered here when the claim is received by HPSM
1A	Provider Name, Address	Enter your name and address if this information is not pre-imprinted. Please confirm that this information is correct before submitting claims.
	Zip Code (Box 128).	Enter the five-digit ZIP code
		Enter the five-digit ZIP code of the facility if this information is not already pre-imprinted.
2	Provider Number	Enter your Medi-Cal provider number if it is not preprinted. Include all nine characters of the number. Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with other than the 9-character Medi-Cal provider number will be denied.
3	Delete	If an error has been made for a particular patient, enter an "X" in this space to delete both the upper and lower line. Enter the correct billing information on another line. When the <i>Delete</i> box is marked "X", the information on both lines will be "ignored" by the system and will not be entered as a claim line.
4	Patient Name	Enter the patient's last name, first name and if known, middle initial. Avoid nicknames or aliases.
5	Medi-Cal Identification Number	Enter the 10-character recipient ID number as it appears on the Benefits Identification Card (BIC).
6	Year Of Birth	Enter the patient's year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years of age or older, enter the recipient's age and the full four-digit year of birth (CCYY) in the <i>Explanations</i> area (Box 126a).
7	Sex	Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the BIC.
8	ARF Reference Number	For services requiring an ARF, enter the nine-digit ARF Reference Number. It is not necessary to attach a copy of the ARF to the claim. Recipient information on the ARF must match the claim. Be sure the

TABLE 3-3- LTC 25-1 Field Description and Requirements

		billed dates fall within the ARF authorized dates.
9	Medical Record Number	This is an optional field that will help you to easily identify a recipient. Enter the patient's medical record number or account number in this field (maximum of five characters – either numbers or letters may be used). Whatever you enter here will appear on the RA.
10	Attending M.D. Medi-Cal ID No.	Enter the physician's nine-character Medi-Cal Provider Number. If the physician does not have a provider number, enter his/her State license number (not always nine characters). Be sure the attending physician's ID number is entered on a(n): <ul style="list-style-type: none"> • Admit claim • Initial Medi-Cal claim for a Medi-Care/Medi-Cal crossover patient • Claim when there is a change in the attending physician's provider number.
11	Billing Limit Exception	If there is an exception to the six-month billing limitations from the month of service, enter the appropriate reason code number and include the required documentation. The appropriate documentation must be supplied to justify the exception to the billing limitation.
12 / 13	Date Of Service	Enter the period billed using a six-digit MMDDYY [Month, Day, Year] format for the FROM and THRU dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the ARF cover the period billed. For example, September 1, 2003 is written 090103. Note: When a patient is discharged, the through date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.
14	Patient Status	Enter the appropriate patient status code from the list below. The patient status code must agree with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days). Code Patient Status 00 Still under care 01 Admitted 02 Expired 03 Discharged to acute hospital 04 Discharged to home

TABLE 3-3- LTC 25-1 Field Description and Requirements

		<p>05 Discharged to another LTC facility 06 Leave of absence to acute hospital (bed hold) 07 Leave of absence to home 08 Leave of absence to acute hospital /discharged 09 Leave of absence to home/discharged 10 Admitted/expired 11 Admitted/discharged to acute hospital 12 Admitted/discharged to home 13 Admitted/discharged to another LTC facility 32 Transferred to TC status in same facility</p>
15	Accommodation Code	<p>Enter the appropriate accommodation code for the type of care billed, as listed in <i>the Long Term Care Accommodation Codes</i> Note: HPSM does not require that a copy of Form LTC 231 (<i>Certification for Special Program Services</i>) be attached to the <i>Payment Request for Long Term Care</i> (25-1).</p>
16	Primary DX (Diagnosis) Code	<p>Enter the Primary ICD-9-CM diagnosis Code (International Classification of Diseases 9th Revision, Clinical Modification) for the following:</p> <p>Admit claim Initial Medi-Cal claim for a Medi-Care/Medi-Cal crossover patient Change in diagnosis</p> <p>Note: ICD-9-CM coding must be three, four or five digits with the fourth and fifth digits included if present. The vertical line serves as the decimal point. Do not enter decimal point when entering this code.</p> <p>Current copies of the ICD-9-CM codes may be ordered from: PMIC 4727 Wilshire Blvd., Suite 300 Los Angeles, CA 90010 1-800-633-7467</p>
17	Gross Amount	<p>When billing for full Medi-Cal coverage, compute the gross amount by multiplying the number of days times the appropriate Medi-Cal daily</p>

TABLE 3-3- LTC 25-1 Field Description and Requirements

		rate for the accommodation code listed. When entering the gross amount, do not use symbols (\$) or (.). The pre-printed vertical line serves as the decimal point. Use this method in entering all dollar amounts on the <i>Payment Request</i> form
18	Patient Liability / Medicare Deductible	<p>Enter the recipient's net Share of Cost (SOC) liability. The recipient's net liability is determined by subtracting from the recipient's original SOC shown on the Medi-Cal card, the amount expended by the recipient that qualifies under Medi-Cal rules as expenditures which may be used to reduce the patient's SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items "not covered" by Medi- Cal.</p> <p>The recipient's net SOC liability is the amount billed to the recipient. This SOC is deducted from the amount billed to HPSM.</p> <p>The PATIENT LIABILITY entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the <i>DHS 6114</i> form, <i>Item 15</i>.</p> <p>When billing the recipient for less than the SOC amount indicated by the Host, enter an explanation in the <i>Explanations</i> area on the claim form</p>
19	Other Coverage	<p>Enter the amount paid by other insurance carrier(s) for the period billed, if applicable. Other Coverage includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. Note: If the Host indicates a coverage code "L" for the recipient, providers must bill Other insurance carriers prior to billing Medi-Cal.</p>
20	Net Amount Billed	<p>Enter the amount requested for this billing. To compute the net amount, subtract patient liability and Other Coverage (if any) from the gross amount billed. If the net amount billed computes to \$00.00, enter the amount as "0000". Do not leave blank.</p>
21	M.D. Certification	Not required.

TABLE 3-3- LTC 25-1 Field Description and Requirements

22	Additional Claim Lines	
116		The <i>Payment Request</i> form may be used to bill services for as many as six patients. Bill only one month's services on each line.
117	Attachments	Enter an "X" if attachments are included with the claim. Leave blank if not applicable. Note: If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied.
118	Provider Reference No.	Enter any number up to seven digits to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. This number will be referenced by HPSM on any forms sent to you that pertain to the billing data on the form. It will not be included on the <i>Remittance Advice</i> .
119	Date Billed	In six-digit format, enter the date the claim is submitted for HPSM payment.
120	FI USE ONLY	Leave blank.
126		Not applicable
126A	Explanations	Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area.
127	Signature of Provider Or Person Authorized by Provider (Representative)	The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ball-point pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file at HPSM.
127A	Affix Label Here	BIC cards do not have labels. Leave these boxes blank.

Timelines for Claims Submission

Medi-Cal, Healthy Kids, HealthWorx, Healthy Families

Claims Submission from Date of Service	Reimbursement Policy
0-6 months	100% of approved payment
7-9 months	75% of approved payment
10-12 months	50% of approved payment
> 1 year	0% of approved payment (without written justification)

YOUR CLAIMS MUST BE SUBMITTED WITHIN 180 DAYS FROM THE DATE OF SERVICE IN ORDER TO QUALIFY FOR THE FULL APPROVED PAYMENT AMOUNT. Claims received beyond 180 days from the date of service will be pro-rated according to the guidelines listed in the table above and the member may not be balance billed.

Timely Submission for CareAdvantage Claims

YOUR CLAIMS MUST BE SUBMITTED WITHIN 1 CALENDAR YEAR FROM THE DATE OF SERVICE.

Additional Documentation Needed

The following are common circumstances that will require additional documentation to be submitted with the claim:

Non-specific injection codes (i.e., 90782)

Indicate the name, NDC number and dose of medication administered.

Multiple procedures that are performed at the same session

Indicate the number of procedures performed in the narrative and in the Units section of the form.

Unlisted codes or codes that are "Not otherwise classified" usually ending in "99"

Submit procedure, office or operative notes describing the procedure performed.

Multiple surgical procedures

Submit an operative report with the claim.

Special supplies

Submit description (e.g., 99070). All special supplies should be coded utilizing their HCPC Level II codes. Special supplies coded 99070 will require adequate documentation to ensure that usual and customary supplies over and above the general

and accepted practice were used. These claims may be pending for reimbursement consideration.

High level (99285) Emergency Room claims.

Billing Tips for Claims Submission

HPSM uses optical character recognition (OCR) technology to facilitate expedited turnaround time of your paper claims submission.

1. Verify member eligibility prior to submission of a claim. Use only the member's HPSM ID number, not Social Security or other numbers.
2. Be sure to indicate the National Practitioner Identifier (NPI) on your claim form under PIN # in Box 33 (CMS-1500).
3. Service dates cannot be in the future even when part of a date span
4. If you are billing claims for a physician in a group practice, use the group NPI in the PIN # section in Box 33 (CMS-1500) and not the rendering physician's individual NPI number.
5. Remember to include RAF and TAR numbers when needed. The NPI on the claim form should match the one used on the TAR
6. For CMS-1500 paper claims, remember to sign and date each claim legibly – no signature stamps. Please use blue or black ink only. Signatures are not required on UB-04 claims, all lines of business. **Signatures are not required for CareAdvantage claims.**
7. For paper claims, place any attachments that are smaller than 8½ x 11 on a piece of 8½ x 11 blank paper.
8. Remember procedure codes 1000-8000 require modifiers.
9. Vision claims require Modifiers. (Qualifying Codes not used after 07/06)
10. When billing more than one of the same procedures for Lab or X-Rays, enter on one line with the appropriate count and documentation.
11. "On-Call Providers" need to contact Provider Services so that their services/claims will be paid.
12. Submit claims electronically.
13. Do not submit paper claims with:
 - changes made with dry line or correction fluid .
 - data touching the box edges or data running outside of the numbered boxes.
 - Handwritten descriptions.
 - Super-bills.

Important Billing Guidelines

It is very important that your billing staff check their error reports to guarantee timely claims submission. **A rejected claim will not be considered to have been submitted to HPSM.**

Claims for services provided to members who are later determined to be retroactively eligible with HPSM must be submitted **within 60 days of determination of eligibility.**

Note: In order to avoid a denied claim for late submission, please note in the remarks section the date that Proof of Eligibility (POE) was received by the Provider.

Claims for services provided to members who have other insurance as primary coverage and HPSM as secondary coverage must be submitted to HPSM within one year of the month of service to meet timeliness requirements.

What are the Advantages to Submitting Claims Electronically?

Reduces your administrative costs

- Handling of paper claims is eliminated.

Accurate Claims Data

- Your claims are formatted and submitted directly into our host system. This prevents the original claim data from having to be re-keyed.

Faster Claims Submission

- Claims enter our system faster and, in turn, claims are processed quicker.

What are the Requirements to Submit Claims Electronically?

- All existing claims data is still required
- All information that is currently submitted on your paper claims must also be included on all electronic claims (see Filing a Paper Claim).

Filing an Electronic Claim

Who Do We Contact at HPSM to Get Started?

To get started today, please contact HPSM MIS Department at (650) 616-2017.

HPSM supports the following batch claim file formats:

- CMC (Inpatient, Outpatient, Professional)
- UB-04 Version 4 of 6 Flat file (Inpatient, Outpatient)
- NSF 3.01
- ANSI X.12 EDI (3921) 837
- HIPAA 837 4010 (Professional and Institutional)

HPSM also has the ability to receive claims information over the web.

Delivery Method	Directions
FTP (File Transfer Protocol)	FTP to www.hpsm.org . Dial-in number is (650) 616-8062. Plain text only, migrating to 128-bit SSL encryption. Please contact the HPSM MIS Department at (650) 616-2026 to set up your User ID and Password and receive more detailed instructions.
E-mail	E-mail to ec@hpsm.org PGP encryption preferred.
WebClaims	CMS-1500 professional claims can be completed and submitted via HPSM's website at www.hpsm.org . Please contact the HPSM Provider Services Department at (650) 616-2106 to set up your User ID and Password and receive more detailed instructions.
Clearinghouses	Emdeon (WebMd): HPSM Payer ID code is: SX174. Call Emdeon Business Services Support at (877) 469-3263. Office Ally: Call Office Ally at (949) 464-9129 to obtain an ID and password or visit www.officeally.com .

The status of all submitted claims, regardless of submission method, can be checked via HPSM's website (www.hpsm.org) once a User ID and Password have been established. Please contact the HPSM Provider Services Department at (650) 616-2106 for assistance.

Important Reminders

Be sure that you have a valid NPI number.

This is very critical in the electronic process. It is imperative that your NPI number be included on all electronic claims. Please check with HPSM's Provider Services Department before initiating submission to verify your Medi-Cal or Medicare Provider ID.

How Do I Know My Claims Have Made It Into HPSM's Claim System?

Electronic claims are acknowledged via e-mail within 2 working days.

Additionally, HPSM will **reject** claims with the following common errors:

- Invalid HPSM Member ID Number
- Invalid Medi-Cal Provider ID Number
- Member ineligible on date of service
- No NPI number

It is very important that your billing staff check their error reports to guarantee timely claims submission. **A rejected claim will not be considered to have been submitted to HPSM.**

If you are not currently filing claims electronically and wish to do so, please call the HPSM EC Coordinator at (650) 616-2017 or send an email to: ec@hpsm.org.

All electronic claims must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The deadline for HIPAA compliance for electronic transactions and code sets for all covered entities was October 16, 2003.

For questions regarding electronic claim submission and testing, please call the HPSM EC Coordinator at (650) 616-2017.

Methods of Reimbursement

Fee-for-Service

Providers contracted under the fee-for-service reimbursement arrangement are paid for approved services based on the applicable HPSM fee schedule. All payments generated to fee-for-service providers are a direct result of claims submitted to HPSM. All claims must be submitted to HPSM within one hundred eighty (180) days of the date of service in order to qualify for the full approved payment. A pro-rated amount will be paid if the claim is submitted more than one hundred eighty (180) days from the date of service, as per contract provisions.

Capitation

Providers contracted under a capitation payment arrangement are paid a monthly per member per month (PMPM) for each HPSM Medi-Cal member, including CareAdvantage members, on the monthly PCP Case Management List. This payment covers the cost of all capitated procedures performed. (See Primary Care Capitation Code List in the end of this section.)

The monthly payment is received whether or not the patient is seen by the provider in any given month. Capitated providers are reimbursed on a fee-for-service basis for approved covered services not included in the capitation arrangement. Claims for all services must be submitted to HPSM within one hundred eighty (180) days of the date of service in order to qualify for the full approved payment, regardless of whether these services are included in the capitation arrangement or not. A pro-rated amount will be paid if the claim is submitted more than one hundred eighty (180) days from the date of service, as per contract provisions. This claims data is then used to determine among other things, encounter rates and utilization of preventive services and is the basis of our reporting of the Health Plan Employer Data Information Set (HEDIS) to the California Department of Health Services and other state and Federal regulatory agencies. (For more information on HEDIS see Section 8). Proper submission of claims data will significantly reduce the need for on-site Medical Record review or requests for chart copies to be mailed to HPSM.

PLEASE NOTE: All practitioners should ensure that claim forms are submitted with appropriate CPT-4 procedure codes and/or Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes for each service rendered at the time of the visit regardless of payment methodology (i.e. monthly capitation payment or fee-for-service).

HPSM Fee Schedule

For most services, HPSM reimburses providers the lesser of the billed amount or the maximum allowable fee based on the California Department of Health Care Services (DHCS) Medi-Cal rates. Reimbursement rates may change during the year. Any code listed may have a service limitation associated with it or need prior authorization.

To review current Medi-Cal rates, please see the Medi-Cal website at www.medi-cal.ca.gov. The HPSM Fee Schedule for PCPs, Specialists a.k.a. Referral Providers (non-OB), OB Specialists, Other Service Providers, Hospitals, and Pharmacies are described below.

For Healthy Kids, Healthy Families, and HealthWorx, HPSM uses the Medi-Cal Fee Schedule as the base. The main differences are that PCPs are paid Fee-For Service under these programs, not at a capitated rate, and these programs have higher co-pays as well. Co-pay amounts are subtracted from the total Fee schedule amounts due before payment is released by HPSM.

For CareAdvantage, HPSM uses the Medicare Participating Fee schedule. To review current rates, please see the Palmetto website at www.palmettogba.com

Contracted PCPs

Primary Care Physicians are paid a capitation amount each month for each Medi-Cal member (including CareAdvantage) on their Case Management list. For HPSM, PCPs are Family Practice, General Practice, Internal Medicine, and Pediatric providers. OB/GYN providers are eligible to serve as PCPs should they enter into a contract with HPSM to serve as such.

Supplemental Notes for Payment to Primary Care Providers

1. Capitation rates are based on a defined Scope of Services that includes office visits, inpatient services, preventative services, minor surgical procedures, and some laboratory services. The Scope of Services can be found later in this Section.
2. Capitation rates may be adjusted for age/sex cost differences where deemed appropriate.
3. PCPs may receive an “Extended Hours” capitation rate which is 10% higher than the base capitation rate, if the PCP maintains eight (8) additional office hours per week, in any combination of weekday evenings after 6:00 p.m. and weekends.
4. PCPs may receive a 20% supplemental capitation payment quarterly if they are open to new members and accept new members who are automatically assigned to them.

5. If the PCP has joined the IZ Registry, they can receive extra payment for each member under 18.
6. For services provided to Medi-Cal members outside of the Capitation Scope of Services, PCPs are paid 123% State Medi-Cal rates for covered services.

PCP Fee Schedule for Other Programs

For other programs (Healthy Kids, Healthy Families, and HealthWorx), PCPs are paid at 133% State Medi-Cal rates for covered services.

Contracted Specialists (non-OB) a.k.a. “Referral Providers”

Contracted Specialists (a.k.a. “Referral Providers”) are reimbursed at 123% of State Medi-Cal rates for covered services for Medi-Cal and 133% for Healthy Kids, Healthy Families, and HealthWorx. CareAdvantage contracted specialists are paid at 90% of the Medicare Participating Fee Schedule.

Contracted Specialists (OB)

Contracted Obstetricians are paid a global fee for prenatal care, currently \$1,600. Global Services include antepartum care, delivery, and post partum care, including:

- Hospitalized admission
- Patient history
- Vaginal or Caesarean section delivery
- Physical examination after previous Caesarean section delivery
- Labor management
- Hospital discharge
- All applicable postoperative care

The postpartum office visit is reimbursed at \$50.00

Global Billing Requires 4 OB Visits

In order to bill for global obstetrical care, providers must render services for at least four (4) OB visits. Otherwise, services are paid for on a fee-for-service basis. Document services for global obstetrical care in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form, or on an attachment, for reimbursement.

If you are billing electronically, provide at least 4 visit dates in the Remarks field. The initial pregnancy-related office visit may be counted as one of the 4 visits.

If fewer than 4 visits are rendered, providers must bill services on a per-visit basis. In the event you do not indicate the 4 visit dates, your claim will be denied (code 4x, “Denied-Does not meet criteria for OB Global Billing).

In the event a provider plans to bill a global fee but then does not perform the delivery, each antepartum visit (HCPCS code Z1034) must be billed separately.

Contracted Other Service Providers

Contracted Other Service Providers are reimbursed at 100% of State Medi-Cal rates for covered services for Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx. CareAdvantage contracted Other Service Providers are reimbursed at 90% of the Medicare Participating Fee Schedule.

Contracted Hospitals

Contracted Hospitals are reimbursed on a per-diem basis for Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx. Contracted Hospitals are paid the current DRG rate for CareAdvantage members.

Contracted Pharmacies

HPSM contracts with a pharmacy benefit manager, InformedRx, for pharmacy services. Contracted pharmacies bill InformedRx for drugs and HPSM for medical supplies.

HPSM Payment Policies, Rules, and Non-Standard Coding Methodologies

HPSM follows the payment policies and rules outlined in the Medi-Cal Provider Manuals for Medi-Cal, Healthy Families, Healthy Kids and HealthWorx. HPSM follows Medi-Cal modifier requirements for these lines of business. HPSM follows the current Medicare guidelines for the CareAdvantage line of business.

The Center for Medicare and Medicaid Services (CMS) oversees Medicare and Medicaid plans on a national level. CMS requires health plan compliance programs to identify health care fraud, abuse, and waste. The goal of HPSM's compliance program is to focus on areas of government concern, such as unbundling, up-coding, medically unnecessary services, duplicate billing, and billing for services not rendered.

HPSM has implemented *Virtual Examiner*® as a technologically advanced tool for reviewing billing practices. Using nationally recognized payment and coding guidelines, *Virtual Examiner*® allows HPSM's claims system to pend, edit, or deny claim entries based on CMS and AMA guidelines.

Your HPSM RAs outline the nature of the coding and edits that have been identified by HPSM's Claims Department. Please use this information as an instrument to review and improve your billing practices.

HPSM's policy regarding consolidation of multiple services or charges, and payment adjustments due to coding changes:

In cases where a provider submits a claim to HPSM for an "unbundled" services, HPSM reimburse according to the bundled payment schedule.

HPSM's policy regarding multiple procedures:

HPSM will reimburse the allowable amount for multiple procedures with appropriate documentation.

HPSM's policy regarding reimbursement for assistant surgeons:

HPSM reimburses 20% of the Medi-Cal allowable amount for the procedure code. See the Medi-Cal rates schedule under procedure type "O".

HPSM's policy regarding reimbursement for the administration of immunizations and injectable medications:For Medi-Cal

You must be a VFC provider to be reimbursed through VFC. The VFC program, operated by the State Department of Health Services, furnishes federally purchased pediatric vaccines to health care providers at no cost to serve children birth-18 years whose parents cannot pay out of pocket for vaccines. Vaccines are used for children covered by Medi-Cal or CHDP, children without health insurance or whose insurance does not cover vaccine, and American Indian or Alaskan native children. For more information, contact the State toll free at 877-2 GET VFC (877-243-8832).

Use SL modifiers to get reimbursed for the administrative fee from HPSM. For high-risk adults, use the SK modifier.

For Healthy Kids, Healthy Families, HealthWorx and CareAdvantage:

Vaccines for Healthy Families, Healthy Kids children, HealthWorx and CareAdvantage should be billed directly to HPSM.

HPSM'S Long Term Care Billing and Procedure Codes:

Claims shall be submitted according to established protocols as set forth in the EDS Medi-Cal Manual, in reference materials from PLAN, and/or as set forth in the Provider Manual. If the Member has other health insurance the other insurance must be billed prior to billing PLAN in accordance with §§ 4.5 and 4.8 of the Agreement.

Nursing Facility Provider shall bill using its National Provider Identifier (NPI) on and after May 23, 2007 and should include the ICD-9-CM diagnosis code(s) of the Member's condition on any Claim. An approved modifier must be included, wherever applicable.

Nursing Facility Provider who has rendered Covered Services to eligible Members shall submit Claim forms within one hundred eighty (180) Days of the date of service, in accordance with the provisions of § 4.4(a) of the Agreement, however Claims submitted after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable.

Reimbursement Guidelines

Claims are required to have accurate and specific ICD-9 diagnosis codes and CPT-4 procedure codes and/or HCPCS codes. Claims are reviewed for the following items and reimbursement for covered services will be based on the most appropriate coding:

CHDP

The PM 160 Information Only form is to be used by providers when claiming payment for pediatric preventive services (PPS) rendered to HPSM members. Include covered services historically reimbursed by the California Child Health and Disability Prevention (CHDP) program.

All claims for PPS services are to be submitted using the PM 160 Information Only form and to the Health Plan of San Mateo Claims Department at:

**Health Plan of San Mateo
Attn: Claims Department
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080**

Health Plan of San Mateo will reimburse the providers at the current CHDP rates.

Evaluation and Management Services

Office visit codes for initial or new patients will be allowed for separate reimbursement, according to the CPT guideline, when billed in conjunction with a reimbursable procedure (see CPT-4 starred procedures).

Reimbursement will not be made when the services are considered part of the pre-operative and/or post-operative care provided as part of evaluation and management services of a major surgical procedure (global billing). Claims will be reviewed for claim history to determine appropriate Evaluation and Management visit codes in relation to initial versus established patient. In addition, reimbursement will not be made when the services provided are covered under a capitation arrangement.

Medical Services After Hours

After hours' codes are not reimbursable when billed in conjunction with an Evaluation and Management Service.

Hospital Discharge Day

Visit is not separately reimbursable when billed in conjunction with a reimbursable procedure and/or an Evaluation and Management Service performed on that same discharge date.

Incidental Procedures

Incidental procedures will not be separately reimbursed when billed separately on a claim for the same date of service as a primary procedure.

Unbundling

When submitting surgical or laboratory claims, use the single most comprehensive CPT -4 Procedure Code that accurately describes the entire service. When two or more procedure codes are used where a single code (or primary code) includes those codes billed, all codes will automatically be rebundled and payment will be made for the primary code only.

Mutually Exclusive Procedures

When two or more codes appear on a claim for procedures that are usually not performed at the same operative session on the same patient on the same date of service, or when two or more codes describing the same type of procedure are submitted on the same claim, they are considered mutually exclusive and only one code will be reimbursed.

Unlisted Procedures

Unlisted procedures should not be billed unless a more specific and current CPT-4 procedure code is unavailable in the current CPT-4 reference for the year the procedure was performed. When billing with an unlisted code, a written description of the procedure must be submitted for consideration. Unlisted procedures may not be eligible for coverage under the Plan contract, and reimbursement will be based on the terms, limitations, and policies of the Plan. **Lack of documentation will result in denial for any unlisted procedure.**

Cosmetic Procedures

Cosmetic surgery can be described as any procedure performed to improve the general physical appearance, where a physical functional deficit is not documented and medical necessity is not substantiated. Cosmetic surgery is not a covered benefit. In following CMS guidelines and CPT-4 coding rationale, clinical indication for possible cosmetic surgery must be substantiated with a detailed history and physical findings, previous unsuccessful medical treatment, functional impairment or limitations following disease, infection, trauma or previous surgery. Psychological stress does not constitute medical necessity.

Special Supplies

All special supplies should be coded utilizing the HCPCS Level II codes. Special supplies coded 99070 will require adequate documentation to ensure that usual and customary supplies over and above the general and accepted practice were used. These claims may be pended for reimbursement consideration.

Modifiers

Listed services may be modified under certain circumstances. When applicable, the modifying circumstance against general guidelines should be identified by the addition of the appropriate modifier code. Note that the utilization of modifiers will be reviewed, and supporting documentation may be requested. Inappropriate use of a modifier or using a modifier when it is not necessary will result in denial or a delay in claim payment. Some CPT-4 codes, by nature of their description, are for the professional or technical component only. In these cases, a modifier will make the claim suspend unnecessarily.

Additional Items

Claims will also be screened for the following: duplicate procedures, obsolete procedures, experimental procedures, age and sex discrepancies, and questionable necessity of an assistant surgeon.

Coverage Groups

It is required by HPSM that all contracted practitioners, both Primary Care Physicians (PCPs) and specialists, have seven days a week, 365 days a year call coverage for his/her practice.

All practitioners must provide HPSM with a list of the covering physicians as part of their credentialing or re-credentialing application. All practitioners must also notify HPSM if the list of covering physicians changes. Only one visit will be approved for the covering physician services, unless the office is closed for an extended period of time. Patients should be instructed to follow up with their PCP.

NOTE: If a practice is closed for more than 24 hours, the practice must notify the Provider Services Department (see Section 1 - Who to Call).

If there are members of your coverage group that do not participate with HPSM, your practice must inform them of the HPSM policies and procedures (i.e., billing procedures, address, prior approval) and the non-participating provider must agree in advance to accept the applicable HPSM reimbursement, as payment in full, for any covered services rendered. In addition, when billing for services, the non-participating practice-practitioner must clearly identify the name of the HPSM practice/practitioner for whom they are covering in Box 19 of the CMS 1500 claim form.

Surgical Reimbursements

The surgical fee for all therapeutic surgical procedures covers:

- The pre-operative evaluation and care beginning with the decision to perform surgery;
- The surgical procedure and intra-operative care;
- Anesthesia, if used, whether it is local infiltration, digital or regional block and/or topical;

- Normal uncomplicated follow-up care, including the routine post-operative hospital care and routine office visits within the post-operative period. Supplies that are considered usual and customary to the surgical procedure are not separately reimbursable.

Assistant Surgeons

When an assistant surgeon is used for a procedure, it should be noted on the claim by adding an assistant surgeon modifier (80) to the procedure code. All claims are subject to review pursuant to any applicable state or federal laws or regulation or any requirements of California Department of Health Services, Department of Managed Health Care or CMS. The claim will then be reviewed to determine if there was a medical necessity for an assistant surgeon, consistent with Milliman Care Guidelines. A procedure which always requires the use of an assistant surgeon according to the Milliman Care Guidelines will automatically be approved for payment at a reduced rate. This is currently set at 20% of the fee payable to the primary surgeon.

Assistant surgeon fee may be payable for procedures which are not on the list of assistant surgeon allowed procedures. For these exceptions, a TAR will be required and documentation supporting the medical justification for an assistant surgeon must be submitted for pre-authorization. The list of procedures for which an assistant surgeon is allowed is downloadable from the HPSM website or you may contact your Provider Services Representative for a hard copy.

HOSPITAL DISCHARGE DAY

If the day of discharge or death occurs with an emergency or regular admission, it is not reimbursable except when the discharge/death occurs on the day of admission – even though the day may be covered by the accommodation quantity authorized on the Treatment Authorization Request (TAR).

LTC REIMBURSEMENT

Payment to Nursing Facility for Skilled Nursing Facility Services provided in accordance with 22 CCR § 51123 shall be as set forth below:

(a) Provider shall furnish all equipment, drugs, supplies, and services necessary to provide nursing facility services except as provided in subsection (c) below. Such equipment supplies and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and State licensing regulations.

(b) Services included but not limited to the following are those which are not included in the payment rate and which are to be billed separately by the Nursing Facility thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies:

- (i) Allied health services ordered by the Attending Physician; (ii) Physician services; (iii) legend drugs and Insulin; (iv) laboratory

services; (v) alternating pressure mattresses/pads with motor and therapeutic air/fluid support systems/beds; (vi) atmospheric oxygen concentrators and enrichers and accessories, oxygen (except emergency), liquid oxygen system, and portable gas oxygen system and accessories; (vii) blood, plasma and substitutes; (viii) dental services; (ix) durable medical equipment as specified in 22 CCR § 51321(g) and medical supplies as specified in 22 CCR § 59998 and parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Member; (x) prescribed prosthetic and orthotic devices for exclusive use by Member; and (xi) X-rays.

(c) Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental. The Member shall be responsible for reimbursement for any such personal items.

(d) Payment to nursing facilities for inpatient services shall be the State's prevailing allowable rate for the Nursing Facility as may be set forth in 22 CCR § 51511.

If Provider also renders intermediate care services, Provider shall be reimbursed as set forth in Attachment A.

Full Payment. The rates agreed to in this Exhibit 1, are to be the only payments made by PLAN to Nursing Facility for inpatient services provided to Members except where otherwise may be provided hereunder in the Agreement on in this Exhibit 1.

(e) Notwithstanding (e) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require PLAN to implement benefit changes that would result in reimbursement to Nursing Facility at a rate different than the rates set forth in (e) (ii) of this Exhibit 1 or, PLAN reserves the right, but does not have the obligation, to make said adjustments. In the event PLAN does elect to make such an adjustment, PLAN shall be obliged only to do so back to the beginning of the current fiscal year.

(f) Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved inpatient Days by the applicable rates, set out above, to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

ACCOMMODATION CODES AND REIMBURSEMENT

Facility should submit UB 04 Claim forms and include accommodation codes as follows:

21 Nursing Facilities Level A Regular Services

22 Nursing Facilities Level A Leave Days (non developmentally disabled patient)

The parties to this Agreement agree that Nursing Facility shall be reimbursed by PLAN when it receives Clean Claims for intermediate care services billed with accommodation codes 21 or 22 at the per diem rate of the ICF's daily State Medi-Cal rate.

Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Intermediate Care Services for the Developmentally Disabled and for Nursing Level A Intermediate Care Facilities.

(a) Intermediate Care Facilities providing intermediate care services for the developmentally disabled shall furnish all equipment, drugs, services and supplies necessary to provide intermediate care services for the developmentally disabled except as provided in subsection (b) below. Such equipment, drugs, supplies, and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and State licensing regulations.

(b) Not included in the payment rate and to be billed separately by the ICF thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are as follows:

- (i) Allied health services ordered by the attending physician; (ii) physician services; (iii) legend drugs and Insulin; (iv) laboratory services; (v) alternating pressure mattresses/pads with motor and therapeutic air/fluid support systems/beds; (vi) atmospheric oxygen concentrators and enrichers and accessories, oxygen (except emergency), liquid oxygen system, and portable gas oxygen system and accessories; (vii) blood, plasma and substitutes; (viii) dental services; (ix) durable medical equipment as specified in 22 CCR § 51321(g) and medical supplies as specified in 22 CCR § 59998 and parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Member; (x) prescribed prosthetic and orthotic devices for exclusive use of patient; and (xi) X-rays.

(c) Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental. The Member shall be responsible for reimbursement for any such personal items.

(d) Payment to ICF facilities for inpatient services for Developmentally Disabled shall be: (i) the State's allowable rate for the ICF; or (ii) the rate charged to the general public, whichever is lowest. ICF must complete the information set forth in Attachment A, attached hereto, and submit it to the PLAN at the time the Agreement is signed.

<u>Description</u>	<u>Accommodation Code</u>
ICF Developmental Disability Program	41
ICF/DD-H 4-6 beds	61

ICF/DD-H 7-15 beds	65
ICF/DD-N 4-6 beds	62
ICF/DD-N 7-15 beds	66

Payment for inpatient services for Nursing Facility Level A is as follows:

<u>Description</u>	<u>Accommodation Code</u>
Nursing Facilities Level A- Regular Services	21
Nursing Facilities Level A - Leave Days- (non developmentally disabled patient)	22

Nursing Facility shall be reimbursed by PLAN when it receives Clean Claims for intermediate care services billed with accommodation codes 21 or 22 at the ICF's daily State Medi-Cal rate.

Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Full Payment. The rates as set forth above for both Developmental Disabled and Nursing Facility Level A services are to be the only payments made by PLAN to ICF for inpatient services provided to Members except where otherwise may be provided hereunder in this Exhibit 1 or any attachment thereto.

(e) Notwithstanding (d) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require PLAN to implement benefit changes that would result in reimbursement to ICF at a rate different than the rates set forth in (d) of this Exhibit 1, PLAN reserves the right, but does not have the obligation, to make said adjustments. In the event PLAN does elect to make such an adjustment, PLAN shall be obliged only to do so back to the beginning of the current fiscal year.

(f) Based on valid Claims submitted by ICF, if PLAN reimburses ICF at the Per Diem Rate, PLAN shall multiply the number of approved inpatient Days by the applicable rates, set out above, to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Coordination of Benefits Billing Instructions

How to Submit Claims When HPSM is the Secondary Plan

All claims must be submitted within ninety (90) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB should be attached to the claim.

Medicare Part A and B member claims must be submitted with the Explanation of Medicare Benefits (EOMB) form attached to the claim.

If the primary plan denies services asking for additional information, that information must be submitted to that carrier prior to submitting to HPSM.

How to Define the Primary and Secondary Plans

Once it has been determined that coordination of benefits applies, the following rules are used to define the primary and secondary plans.

- Subscriber or dependent
- Active or retired
- Effective date
- Dependent children of non-divorced parents (gender rule and birthday rule)
- Children of divorced parents (parents who have remarried and parents who have not)
- Medicare (Primary and Secondary payer)

Subscriber or Dependent

The plan that covers the member as a subscriber pays before the plan that covers the member as a dependent.

Active or Retired

If one of the family members is retired and continues to hold group coverage through his or her previous employer, the subscriber vs. dependent rule holds true. The active plan is primary for all family members.

Medicare

Medicare is Primary payer when:

- Patient is 65 or older, retired, and/or disabled with no group health coverage from former employer or employer of family;
- Patient is 65 or older, retired, and has health plan from former employer;
- Patient is 65 or older, retired, and spouse is employed but doesn't have an employer group health plan;
- Patient is eligible for Medicare solely because of end stage renal disease (ESRD) and health plan of the current or former employer of patient or family has been billed for the first 30 months of Medicare eligibility. This applies regardless of whether the patient is under or over 65;

- Patient works for the military and is covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS will pay as secondary plan; or
- Patient is a veteran who rejects VA benefits.

Medicare is Secondary payer when:

- Patient is 65 or older, is actively employed and has coverage under an employer group health plan;
- Patient is 65 or older and is covered under an actively employed spouse;
- Patient is disabled, under the age of 65 and is covered with 100 or more employees;
- Patient is under 65 and eligible for Medicare solely because of end stage renal disease and the health plan of the current or former employer of the patient or family member has not yet been billed for the first 30 months of Medicare eligibility;
- Patient is "Working Aged". Retired patient who is Medicare eligible returns to work, even temporarily, and receives employee health benefits;
- Patient who is eligible for Medicare and has a retired spouse returns to work, even temporarily, and gets employee benefits that covers the patient services; or
- Patient who is eligible for Medicare has VA benefits that cover the services.

Effective Date

The effective date rule applies when one member has two active group coverages. This often occurs when a member has more than one job and has elected coverage through both employers or was offered two coverages from the same employer and elected to have both. When this happens, the plan with the earliest effective date is primary.

Dependent Children of Non-Divorced Parents

This rule states that the plan of the parent with the earlier birthday is primary and the plan of the parent with the later birthday is secondary. This applies only to the month and day of birth, not the year. The birthday rule is the most common rule that is used by health insurance plans today.

Children of Divorced Parents

When children of divorced parents are covered under both parents' plan, and there is a custody/divorce decree that states one parent has primary responsibility for medical expenses, the plan of the parent with the primary responsibility is primary.

If there is no court decree assigning medical expenses responsibility, or parents hold joint medical expense responsibility, the plan of the parent with custody of the children is primary and the plan of the parent without custody is secondary.

If the children are covered under the plans of their natural parents and stepparents, the order of benefits is as follows:

- Plan of the parent with custody pays first.
- Plan of stepparent with custody pays secondary.

- Plan of parent without custody pays third.
- Plan of stepparent without custody pays last.

Medi-Cal is not liable for the cost of HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. To establish Medi-Cal's liability, the provider must obtain an acceptable denial letter from the HMO. For additional information, refer to "HMO Denial Letters" in the Other Health Coverage (OHC).

Please remember, Medi-Cal is the payer of last resort in all cases.

Balance Billing

As a contracted provider with HPSM, there are circumstances in which you must not bill a HPSM member. You are generally prohibited by the terms of your contract and by California State Law from billing HPSM members for any costs related to services you provide, other than any applicable deductible, co-pay or co-insurance amount.

You Must Not Balance Bill A Member:

- For the difference between the charge amount and the HPSM fee schedule.
- When a claim has been denied for late submission, unauthorized service, or as not medically necessary.
- When claims are pending review by HPSM.

Please remember to obtain the member co-pays indicated on the HPSM member ID card or co-insurance at the time of service.

Should you have any questions regarding billing HPSM members, please contact HPSM Member Services at (650) 616-2133.

Primary Care Medi-Cal Capitation Code List

Office Visits

99201- 99205	Office/outpatient visit, new, 10-40 minutes
99211- 99215	Office/outpatient visit, established, 10-40 minutes

Immunization Administration

90465	IZ administration under 8 years of age (including subcutaneous and intramuscular routes) when physician counsels the patient/family; first injection, per day
90466	Each additional administration
90467	IZ administration under 8 years of age (including intranasal and oral routes) when physician counsels the patient/family; first administration, per day
90468	Each additional administration
90471	IZ administration, (including subcutaneous and intramuscular routes) one vaccine, single or combo
90472	Each additional administration
90473	IZ administration, (including intranasal and oral routes) one vaccine, single or combo
90474	Each additional vaccine, single or combo

Minor Surgical and Other Miscellaneous Procedures

10060	Drainage of boil
10080	Drainage of pilonidal cyst
10120	Removal, foreign body
10140	Drainage of hematoma
10160	Puncture drainage of lesion
11055	Trim skin lesion, two to four lesions
11056	Trim skin lesion, more than four lesions
11057	Puncture drainage of lesion
11100	Biopsy of lesion
11101	Biopsy, each additional lesion
11200	Removal of skin tags
11400 -11441	Removal of skin lesions: 0.05 cm to 1.0 cm
11719	Trimming of non-dystrophic nails
11720	Debridement of nails, one to five
11721	Debridement of nails, six or more
11731	Avulsion of nail plate, single
11732	Avulsion of nail plate, each additional

11740	Drain blood from under nail
11900	Injection into skin lesion
16000	Initial treatment of burns
20612	Aspiration and/or injection of ganglion cysts
26720	Treatment of finger fracture: each
28490	Treatment of big toe fracture
30300	Removal of foreign body, intranasal (office procedure)
45300	Proctosigmoidoscopy
46600	Diagnostic anoscopy
46606	Anoscopy and biopsy
46608	Anoscopy with removal of foreign body
46900	Destruction of of lesion(s), anus (e.g. condyloma, molluscum, etc.) simple, chemical
51000	Aspiration of bladder by needle
51701	Insertion of non-indwelling bladder catheter
51702	Insertion of temporary indwelling bladder catheter
51705	Change of cystotomy tube, simple
54050	Destruction of lesion(s), penis (e.g. condyloma, molluscum, etc.) simple, chemical
56501	Destruction of lesion(s), vulva, simple
57170	Diaphragm or cervical cap fitting with instructions
65205	Removal of foreign body, eye
69200	Clear outer ear canal
69210	Remove impacted ear wax
69400	Eustacian tube inflation, transnasal
Laboratory Services	
81000	Urinalysis, with microscopy
81001	Urinalysis, automated with microscopy
81002	Urinalysis: without microscopy
81003	Urinalysis: automated without microscopy
81005	Urinalysis: chemical, qualitative
81007	Urinalysis: bacteria screen, except culture or dipstick
81015	Urinalysis: microscopic only
81020	Urinalysis: two or three glass test
82270	Blood: Occult, feces: consecutive collected specimens
82272	Blood: Occult, feces, single specimen (e.g. from rectal exam)
82948	Stick Assay Blood Glucose
85004	Blood count, automated differential WBC count
85013	Blood count, spun microhematocrit

85014	Hematocrit
85018	Hemoglobin, Colorimetric
85025	Blood count, complete, automated or automated differential
WBC count	
85027	Blood count, complete automated
85041	Blood count, RBC count, automated
85048	Blood count, leukocyte (WBC), automated
85049	Blood count, platelet, automated
85650	RBC sedimentation rate: Wintrobe
86580	TB intradermal test
87081	Bacterial culture, screening only for single organism
87084	Culture with colony estimation from destiny chart
87086	Urine culture, colony count
87168	Macroscopic examination, arthropod
87172	Pinworm exam (e.g. cellophane tape prep)
87205	Smear, stain and interpretation: Routine stain
87210	Smear, stain and interpretation: Wet mount
87220	Tissue examination for fungi (KOH Slide)

ECG, Hearing Tests and Supplies

92551	Pure Tone Hearing Test: Air Only
92552	Pure Tone Audiometry: Air Only
92553	Audiometry, Air and Bone
92555	Speech Threshold Audiometry
92556	Speech Audiometry, Complete
92557	Comprehensive Audiometry
93000	Electrocardiogram, Complete
93005	Electrocardiogram, Tracing
93010	Electrocardiogram Report
93040	Rhythm ECG with Report
93041	Rhythm ECG, tracing only
93042	Rhythm ECG, report only
99070	Special Supplies covered for any of the above CPT codes covered by capitation

Mental Health Services

90801	Psychiatric diagnostic interview
90802	Interactive psychiatric diagnostic interview
90804	Individual psychotherapy 20-30 minutes
90806	Individual psychotherapy 45-50 minutes

90810	Interactive individual psychotherapy 20-30 minutes
90812	Interactive individual psychotherapy 45-50 minutes
90805	Individual psychotherapy with E/M 20-30 minutes
90807	Individual psychotherapy with E/M 45-50 minutes
90808	Individual psychotherapy 75-80 minutes
90809	Individual psychotherapy with E/M 75-80 minutes
90811	Individual psychotherapy with E/M 75-80 minutes
90814	Interactive psychotherapy 75-80 minutes
90815	Interactive psychotherapy with E/M 75-80 minutes
90813	Interactive individual psychotherapy
90846	Family psychotherapy without patient present
90847	Family psychotherapy without patient present
90849	Multiple family group psychotherapy
90853	Group psychotherapy
90857	Interactive group psychotherapy
90862	Pharmacologic management and review
90875	Psychotherapy with biofeedback 20-30 minutes
90876	Psychotherapy with biofeedback 45-50 minutes
90880	Hypnotherapy
90885	Evaluation of records
90887	Consultation with family
90889	Preparation of psychiatric report
90901	Biofeedback training, any modality
90911	Biofeedback training perineal muscles, anal or urethral sphincter
96101	Psychological testing by PhD or MD, per hour
96102	Psychological testing by technician, per hour
96103	Psychological testing by computer, with qualified healthcare professional interpretation
96105	Assessment of aphasia, with interpretation and report, by hour
96116	Neuropsychological status exam
96118	Neuropsychological testing by PhD or MD per hour
96119	Neuropsychological testing by technician, per hour
96118	Neuropsychological testing by computer, with qualified healthcare professional interpretation

Contacting the Claims Department

Providers should check HPSM's website for member eligibility and claims status. Providers are encouraged to direct questions to the Claims Department via e-mail at claimsinquries@hpsm.org. The Claims Department is available by phone (650) 616-2056 Monday, Tuesday, Thursday and Friday from 8am to 5pm, closed from 12-1:30 and Wednesdays from 8am to 12pm.

Claims Disputes

Please refer to Section 5 - Provider Disputes Resolution for information.

Claims Status Inquiries via HPSM's Web Claims System

Providers who are registered with HPSM's Web Claims System may review the status of their claims by logging on with their user ID and password.

Providers who are interested in using the Web Claims System should contact the HPSM Provider Services Department at (650) 616-2106 for assistance.



Section 5

Provider Disputes and Grievances

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Provider Disputes

Introduction

If you have a dispute regarding a claim you submitted to HPSM, you may participate in HPSM's Provider Dispute Resolution (PDR). This process applies to all lines of business for contracted as well as non-contracted providers with one exception. This exception is for non-contracted providers who have a dispute regarding a claim for services provided an HPSM CareAdvantage member. In this case, the dispute must be resolved following federal guidelines that apply to Medicare managed care plans which are described at the end of this Section.

If a provider is dissatisfied with aspects of HPSM's operations or with another provider's or member's activities or behaviors, the provider may submit a Provider Grievance which is also described in this Section. To understand how to appeal a denial of a service authorization, please refer to the Member Grievance and Appeals Section of this Manual.

Provider Dispute Resolution

HPSM offers the Provider Dispute Resolution (PDR) for Providers to resolve claims issues. (The PDR replaces the Claims Inquiry Form or CIF process.) You can address any of the following concerns through HPSM's Provider Dispute Resolution Process:

- Claims believed to be inappropriately denied, adjusted, or contested.
- Resolution of a billing determination or other contract dispute.
- Disagreement with a request for reimbursement of an overpayment of a claim.

Examples of problems that can be resolved through the PDR:

- If a claim has been underpaid.
- A claim was overpaid due to a payment or billing error.
- A procedure was denied as inclusive to another procedure in error.
- Corrected claim where a previous payment was made.
- Utilization management decisions once a service has been provided

Providers should submit their dispute through submission of a Provider Dispute Resolution Request form. The form requests the following information:

- Provider name
- NPI
- Provider contact information
- Identification of the disputed item, including
 - the original HPSM claim number
 - date of service

- a clear description of the basis upon which the Provider believes the payment amount, request for additional information, request for the overpayment of a claim, denial, adjustment or other actions is incorrect.

A sample of the Provider Dispute Resolution form is included in the Forms Section of this chapter. In addition, the form is available on HPSM's website at www.hpsm.org. Provider disputes can be completed online and submitted through HPSM's web site. If you would like to submit PDRs via HPSM's website, please contact the Provider Dispute Resolution Assistant at 650-616-2817 for assistance. Forms submitted through the website go directly to the Provider Disputes Unit. If you want to print the form and send it via the mail or fax, please send your PDR to the address or fax number noted below. To expedite resolution be sure to mark your envelope to the attention of Provider Disputes. :

Health Plan of San Mateo
Attn: Provider Disputes
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Fax (650) 829-2051

Time Period for Submission

Provider disputes should be sent within 365 days of the last determination for timely consideration. HPSM will return any provider dispute that is lacking the information required (as previously noted) if it is not readily accessible to HPSM. In this case, HPSM will clearly identify in writing the missing information necessary to resolve the dispute. A provider may submit an amended provider dispute within 30 working days of the date of receipt of a returned provider dispute requesting additional information.

Time Frames for Resolution

HPSM will send an acknowledgement letter to the Provider within 15 working days of receipt of the dispute. If a Provider completes and submits the PDR form online, HPSM will send an acknowledgement letter within 2 working days of receipt.

HPSM will resolve a provider dispute or amended provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. If an investigation shows that a claim was originally denied or paid incorrectly due to HPSM error, any interest and penalty due for late payment will be included in the claim payment. Payment will be made within 5 working days from the issuance of HPSM's determination. If the dispute involves an issue of medical necessity or utilization management, the Provider may appeal this through HPSM's Appeal Process within 60 working days after issuance of the final determination. To understand

how to appeal, please refer to the Member Grievance and Appeals Section of this Manual.

Please refer to the flow chart at the end of this Section. The flow chart provides an overview of the PDR described.

Non-Contracted Provider Dispute Resolution—CareAdvantage Only

Non-Contracted providers who want to submit a CareAdvantage Dispute have 60 calendar days from the date they receive notification of HPSM's action (EOP) to submit their dispute. However, unlike other lines of business, providers must sign a waiver of liability statement attesting that they waive any right to collect payment from the member in order for HPSM to process the dispute. If the waiver is received timely, HPSM will process the dispute within 60 calendar days from the date the waiver was received. If a waiver is not submitted, HPSM must send the dispute to the Medicare-contracted Independent Review Entity (IRE), which will issue the final dispute decision..

To facilitate this process, HPSM's Dispute Resolution Form includes the necessary waiver on the second page.

Provider Grievances

If a provider is dissatisfied with other aspects of HPSM's operations or with another provider's or member's activities or behaviors, the provider may submit a Provider Grievance:

A **Provider Grievance** is a formal oral or written expression of dissatisfaction by a provider with any aspect of HPSM's operations, or another provider's or member's activities or behaviors – with the exception of HPSM's decisions regarding claims or service authorizations – regardless of whether any remedial action is requested or can be taken.

Filing a Provider Grievance

Provider Grievances can be submitted through the following routes:

- Verbally, by visiting HPSM in person or calling (650) 616-2850
- In writing via mail or facsimile at:

Health Plan of San Mateo
Attn: Grievance and Appeals
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Fax (650) 616-8235

Provider Grievances may be received by HPSM's Provider Services Department or by the Grievance and Appeals Coordinator.

A Provider Grievance must be filed within 365 calendar days from the date of an incident or action that is dissatisfactory.

Processing the Grievance

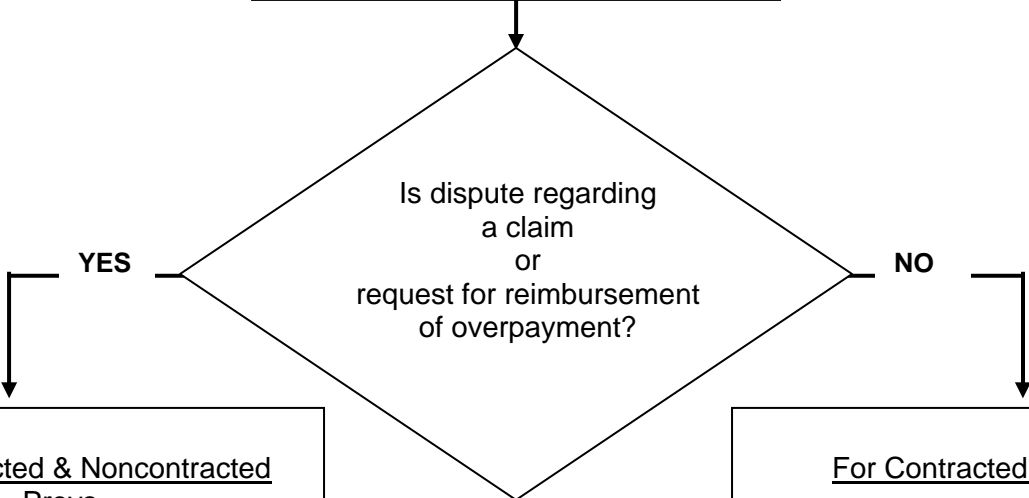
Once a Grievance is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter within 5 calendar days. He or she may follow up with you to clarify the problem and identify your preferred course of action.

Making a Determination

A Grievance and Appeals Coordinator will issue a resolution letter within 30 calendar days of receipt of the Provider Grievance. Appropriate administrative review and follow-up will continue until all actions stated in the resolution have been completed. We will notify you of the decision in writing.

Written Provider Dispute Rec'd

- provider name
- provider ID#
- provider contact info

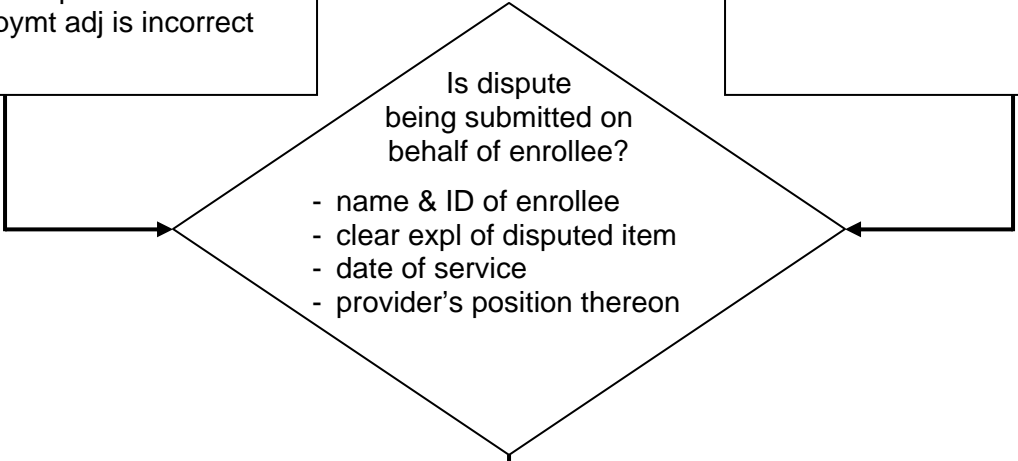


For Contracted & Noncontracted Provs

- clear ID of the disputed item
- date of service
- clear expl. of basis for provider's feeling pymt request denial contest or pymt adj is incorrect

For Contracted Providers

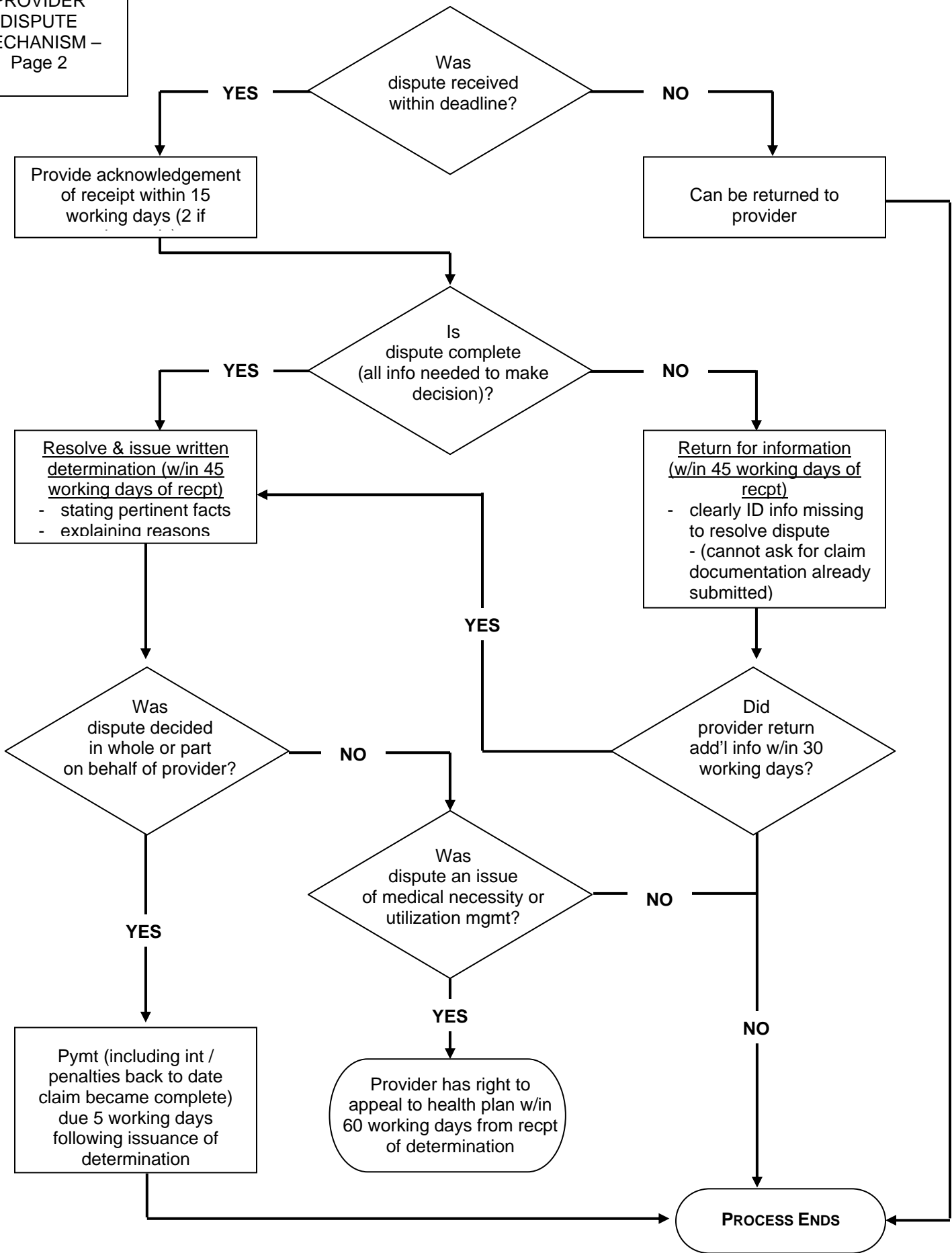
- clear explanation of issue and provider's position thereon



Refer Dispute to HPSM's Grievance Process

- HPSM may verify the member's authorization to proceed with the grievance

Date Stamp the dispute when received and process as a Provider Dispute (**SEE PAGE 2**).





PROVIDER DISPUTE RESOLUTION REQUEST

By submitting this form, I agree not to bill the member(s) named on it.

Initial here and sign at bottom of form: _____

INSTRUCTIONS

- **For routine follow-up**, please contact Health Plan of San Mateo's Claims Department at (650) 616-2056.
- **To request dispute resolution**, please complete the form below. **Fields with an asterisk (*) are required.**
- Be specific when completing the *Description of Dispute* and *Expected Outcome*.
- Provide additional information to support the description of the dispute. You do not need to include a copy of a claim that was previously processed.
- **Fax** the front and the back of the completed form to **(650) 829-2051** or **mail** it to:
Attn: Provider Disputes
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

*Provider Name:		*NPI #:	
Provider Address:			
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other (please specify):			
Line of Business: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> CareAdvantage <input type="checkbox"/> Healthy Families <input type="checkbox"/> HealthWorx <input type="checkbox"/> ACE		<input type="checkbox"/> Contracted <input type="checkbox"/> Non-Contracted (<i>see back of form, for CareAdvantage only</i>)	

*Claim Information Single Multiple "like" claims (complete a Supplemental Form) Total number of claims: _____

*Member Name		Date of Birth:	
*Member ID Number:		Original Claim ID Number (if multiple claims, use attached spreadsheet):	
Service "From/To" Dates <i>*Required for Claim, Billing, and Reimbursement of Overpayment Disputes</i>		Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type	<input type="checkbox"/> Denied Claim	<input type="checkbox"/> Underpayment of a Claim	<input type="checkbox"/> Request for Reimbursement of Overpayment
	<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision		<input type="checkbox"/> Contract Dispute
	<input type="checkbox"/> Other (please specify):		

* Description of Dispute (continue on back if needed):
Expected Outcome:

_____	_____	()
Contact Name (please print)	Title	Phone Number
_____	_____	()
Signature	Date	Fax Number

Check here if additional information is attached. (Please do not staple additional information.)

For Health Plan Use Only: Tracking #:	Provider ID #:
----------------------------------------------	----------------

HEALTH PLAN OF SAN MATEO PROVIDER DISPUTE RESOLUTION REQUEST (SIDE 2)

I am NOT a CareAdvantage Contracted Provider. *(Please complete and sign the waiver below.)*

I am a Contracted Provider. *(Please disregard the waiver.)*

**HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT**

Member Name

Member ID / Member HIC Number

Provider Name

Dates of Service

Health Plan of San Mateo

Health Plan

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date

H5428_CA_3070_08 (approved 02/08/2008)

Description of Dispute (continued)

For Health Plan Use Only: Tracking #:

Provider ID #:



**PROVIDER DISPUTE RESOLUTION REQUEST
Supplemental Form for Use with Multiple “Like” Claims**

By submitting this form, I agree not to bill the member(s) named on it.
Initials of signatory on main form: _____ For CareAdvantage only, also see back of form.

This form provides additional information for the following dispute resolution request:

Provider Name	Date
To cross-reference this supplemental form with the main form, please give member's name from main form:	

#	Member Last Name ----- Member First Name	DOB	Health Plan ID #	Original Claim ID #	Service “From/To” Dates	Original Claim Amount Billed ----- Original Claim Amount Paid	Expected Outcome
1	-----					-----	
2	-----					-----	
3	-----					-----	
4	-----					-----	

For Health Plan Use Only
Tracking #:
Provider ID #:

Check here if additional information is attached. (Please do not staple additional information.)
This is Supplemental Form # _____ of _____ supplemental forms for this request.

HEALTH PLAN OF SAN MATEO
 PROVIDER DISPUTE RESOLUTION REQUEST
 SUPPLEMENTAL FORM (SIDE 2)

- I am NOT a CareAdvantage Contracted Provider. (Please complete and sign the waiver below.)
- I am a Contracted Provider. (Please disregard the waiver.)

HEALTH PLAN OF SAN MATEO WAIVER OF LIABILITY STATEMENT	
Member Name #1 from reverse side	Member ID / Member HIC Number
Member Name #2 from reverse side	Member ID / Member HIC Number
Member Name #3 from reverse side	Member ID / Member HIC Number
Member Name #4 from reverse side	Member ID / Member HIC Number
Member Name #5 from reverse side	Member ID / Member HIC Number
Provider Name <i>Health Plan of San Mateo</i> Health Plan	Dates of Service
As a provider of the mentioned member(s), I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.	
Signature <i>H5428_CA_3070_08 (approved 02/08/2008)</i>	Date

For Health Plan Use Only: Tracking #: _____ Provider ID #: _____

Section 6

Ancillary Services

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SPECIAL NOTE TO PROVIDERS REGARDING CareAdvantage

- Items in this section are not inclusive of benefit coverage under CareAdvantage.
- CareAdvantage members are eligible for both Medicare and Medi-Cal. Medi-Cal benefits will apply to those CareAdvantage members who are full scope Medi-Cal beneficiaries.
- For CareAdvantage members coverage requirements and rules for a dual eligible under Title XVII and XIX should be transparent.
- There are no TAR requirements for the CareAdvantage product line except for DME, home health, non-emergency medical transportation, inpatient transplants and skilled nursing facility stays through December 31, 2009..

If you have questions or need to verify benefit coverage for CareAdvantage members, contact the CareAdvantage Unit at (650) 616-2174.

Laboratory Testing

HPSM has relationships with recognized vendors of laboratory services, including free standing and hospital based laboratories, to ensure member access and the highest quality and consistency of care.

HPSM has relationships with the following vendors:

- Quest Laboratories (located in Burlingame and Palo Alto)
- Chinatown Medical Laboratory (located in San Francisco)
- Satellite Laboratory Services (located in Redwood City, dialysis related)

In addition, all of our contracted hospital facilities have outpatient laboratory services available for our members.

We do recognize that some testing is best completed while the patient is in the office, when a provider can most efficiently assess and develop a plan to address the patient's care needs. HPSM also appreciates that as health care systems and groups of providers have progressively integrated, the completion and communication of these diagnostic services are tightly woven into that integration. As a result, HPSM will also support office-based diagnostic testing that adheres to office CLIA certification at provider and member convenience.

Providers of CLIA-certified office-based testing are expected to maintain the necessary certification to ensure quality control and consistency of results. Services will only be covered for members who are otherwise under the care of a provider in that practice. Most of these services are covered under the PCP capitation agreement. Please refer to Section 3 – Primary Care Capitation Code List for details. Services not on the list will be reimbursed based on the Medicare or Medi-Cal fee schedule depending on the member's coverage.

Whether you choose to utilize the services of our preferred vendors or perform these services in your own office, our primary goal is to ensure our members receive the diagnostics they require in a manner that facilitates delivering high quality care.

Prescription Drugs

The HPSM Pharmacy staff is available to consult with providers about plan benefits and exclusions, drug formularies, prior authorization process, and other clinical pharmacy issues related to HPSM members. HPSM contracts with InformedRx, Inc. as our Pharmacy Benefits Manager to administer the pharmacy benefit through its network of retail, home infusion and long-term care pharmacies. InformedRx is primarily responsible for processing pharmacy claims, and assist with day-to-day pharmacy billing problems and issues. All Prior Authorization (PA) requests are reviewed and processed by HPSM Pharmacy staff.

InformedRx telephone customer service (help desk) phone number is (866) 441-2422. You may contact InformedRx directly 24 hours per day, 7 days per week.

HPSM Pharmacy staff is available to answer your questions regarding pharmacy services, formularies, and prior authorization process. They can be reached at (650) 616-2088, from 8:00 AM to 5:00 PM, Monday through Friday. (Please note: On Wednesdays, the Health Services department is closed from 8 a.m. to 12 noon.)

HPSM Drug Formularies

HPSM maintains three separate drug formularies. There is one formulary for HPSM-Medi-Cal, Healthy Kids, Healthy Families and HealthWorx; one for the Medicare Prescription Drug Plan Part D benefit of CareAdvantage, and another formulary for the Access and Care for Everyone (ACE) program. The HPSM-Medi-Cal and CareAdvantage formularies are reviewed by the HPSM Pharmacy Review Committee. The committee is comprised of community pharmacists and physicians representing various medical/surgical and psychiatric specialties. It meets bi-monthly and systematically reviews the formulary on a periodic basis. HPSM's approach to formulary management is to consider drugs to be included on the formulary if they are documented to be cost-effective, based on pharmacoeconomic analysis. As such, the HPSM drug formularies are mandatory generic enforced. The CareAdvantage formulary also includes preferred and non-preferred branded drugs that may be available through prior authorization or step therapy. Provider requests for consideration of new drugs to be added to the HPSM formularies must be submitted in writing using the HPSM Request for Formulary Modification form, available online at www.hpsm.org. A copy of this form is included in the Forms section. Completed forms may be sent to:

Health Plan of San Mateo
Attn: Pharmacy Review Committee.
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

(650) 829-2079 Fax

The HPSM formularies are available on the HPSM website, and the HPSM-Medi-Cal Formulary is also posted on www.epocrates.com. Hard copies of the HPSM formularies are also available from your Provider Services Representative upon request. The HPSM formularies list all drugs by either the chemical name, brand name (if one exists), and/or the name of the generic equivalent. If you have any questions regarding the HPSM drug formularies, please contact the HPSM Pharmacy staff at (650) 616-2088.

Non-Formulary Drugs

HPSM participating providers and pharmacies are responsible for using the HPSM formularies first. If a prescribed drug is not on the formulary, the pharmacist will call the prescribing provider to request a change to a formulary alternative. If an alternative is not available or inappropriate for member's condition, the pharmacist must submit a Medication Request Form (MRF) to HPSM at (650) 829-2045. (See Pharmacy Prior Authorization (PA) Process for information on submitting a Medication Request Form).

Changes in Drug Formularies

If a member is on a drug, and HPSM removes the drug from its formulary, the prescriber will be asked to consider the formulary alternatives. If the formulary alternatives cannot be utilized, a Medication Request Form (MRF) must be submitted to HPSM with the reasons the member cannot switch.

Psychotherapeutic (Mental Health) Drugs and Lab Tests For HPSM Medi-Cal and Health Families Members

For HPSM/Medi-Cal and Healthy Families (HF) members, mental health drugs prescribed by psychiatrists for these members *had been the responsibility of the San Mateo Behavioral Health and Recovery Services (BHRS)* for many years. The mental health drugs carve-out arrangement to the BHRS program had ended June 30, 2010. Thus, MedImpact – the PBM for BHRS – has stopped adjudicating pharmacy claims after June 30, 2010.

Since **July 1, 2010**, HPSM had taken over the administration of the Medi-Cal covered Mental Health Pharmacy Benefits for HPSM-Medi-Cal and HF members. **InformedRx (IRX)** is the PBM that accepts online pharmacy claims for the Medi-Cal covered Mental Health drugs prescribed by psychiatrists for HPSM Medi-Cal and HF members.

The BHRS mental health drug formulary (drug list prescribed by psychiatrists) has been integrated into the main HPSM-Medi-Cal Drug Formulary. However, the rules and restrictions of the BHRS formulary remain unchanged, and they will be applied the same way as in the past when a psychiatrist prescribes a mental health medication. For details of the BHRS Formulary, refer to page 123 of the 2010 HPSM-Medi-Cal Formulary Handbook.

As a reminder, claim submission to **IRX** for HPSM Medi-Cal members requires the members' CIN numbers. Do NOT use the BHRS assigned Client ID numbers starting July 1, 2010 for HPSM-Medi-Cal members. The CIN numbers are required for billing all pharmacy claims (non-mental health and mental health) for HPSM-Medi-Cal members. If you encounter claim submission related problems, please do not hesitate to contact IRX Pharmacy Help Desk at **866-441-2422**.

Psychiatrists, submitting prior authorization requests for any HPSM membership, should fax or mail the requests on a MRF to HPSM Pharmacy Services for review.

Laboratory Blood Tests ordered by psychiatrists will be reimbursed by BHRS. Bio-Cypher is the lab vendor at the County Regional Centers. Members requiring outpatient laboratory tests as part of their mental health treatment should be referred to a County Health Center where Bio-Cypher is available.

If you have additional questions or require further information on labs, please contact the BHRS at (650) 599-1061.

Mental Health drugs prescribed by non-psychiatrist HPSM providers are covered by HPSM. The following psychotherapeutic drugs require prior approval of HPSM with the submission of a PA.

- Clozapine (Clozaril®)
- Risperidone (Risperdal®)
- Olanzapine (Zyprexa®)
- Quetiapine (Seroquel®, and Seroquel XR)
- Naltrexone (Revia®)
- Ziprasidone (Geodon®)
- Aripiprazole (Abilify®)
- Paliperidone (Invega®)

Laboratory Blood Tests ordered by non-psychiatrist HPSM providers are covered by HPSM.

Pharmacy Prior Authorization (PA) Process

Prior authorization of selected pharmacy services allows HPSM to balance patient care, quality, safety, and cost objectives in a manner which facilitates the most efficient use of resources and results in favorable health status outcomes.

Prior authorization provides access to non-formulary drugs and supplies when the HPSM Formulary cannot meet the member's needs.

A Prior Authorization (PA) request must also be used when Plan or formulary restrictions and limits (e.g. code 1 and frequency of billing) are not met or exceeded. The details must be well explained and documented on the request form. HPSM uses

Medication Request Forms (MRFs). There is one MRF for CareAdvantage requests, and a separate MRF for all other lines of business. Copies of these forms are available in the Forms section. They are also available online on the HPSM website www.hpsm.org

The MRF approval process for pharmacy services is as follows:

The provider completes a Medication Request Form (MRF) and submits it via fax to HPSM at (650) 829-2045. Providers may also call (650) 616-2088 with this information.

NOTE: For pharmacies submitting MRFs for CareAdvantage members, a CMS Appointment of Representative (AOR) Form must also be submitted with each MRF. This form is available in the Forms section. It is also available online on the HPSM website.

HPSM Pharmacy staff will review the clinical information in the MRF, utilizing criteria developed and approved by HPSM's Pharmacy Review Committee. MRFs that are approvable based on meeting criteria established by HPSM Pharmacy Committee will usually be processed within 24 hours of submission for Medi-Cal requests, and CareAdvantage expedited requests. If a MRF is not approvable based on the information that is included on the MRF, HPSM Pharmacy staff will make attempts to request additional information from the provider. For all lines of business, if the additional information submitted is not sufficient to meet criteria or if no response is received from the provider within 1 day, the HPSM pharmacy technicians will issue a deferral notice of action to the provider and the member, informing them in writing what additional information is needed to approve the MRF. If after 21 days (for Medi-Cal), the information on hand is still not sufficient to meet criteria, the MRF will be forwarded to HPSM Medical Director and/or licensed pharmacists for final determination. For CareAdvantage standard PA requests, if the additional information is not sufficient to meet criteria or if no response is provided within 48 hours, HPSM Pharmacy staff will defer ("toll") the request to the requestor, and asks for additional information. If no additional information is received after the tolling period (deferral period) of 14 days (for a standard request) and 5 days (for an expedited request), HPSM staff will make a final determination based on the original submitted information.

Note: For CareAdvantage members, HPSM adheres to a 72-hour standard determination and a 24-hour expedited determination time frame, as mandated by CMS. For Medi-Cal plan members HPSM adheres to a 24 hour determination time frame. For San Mateo ACE Program, HPSM adheres to a 72 hour standard request timeframe only.

The MRF deferral process for pharmacy services is as follows:

For all lines of business, a decision on a MRF will be deferred if it is submitted with insufficient medical justification or incomplete information.

Prior to sending a deferral notice to a provider for an incomplete MRF, the HPSM Pharmacy staff will make attempts to contact the provider to obtain the additional medical information needed to approve the MRF.

If HPSM Pharmacy staff is unable to obtain the necessary documentation, the MRF is returned to the provider with a Deferred Notice. The notice describes the specific information required in order to make a determination regarding the medical necessity of the requested service/item. The Provider will be given additional business days to provide the requested information.

Members are notified in writing of deferrals within 24 hours of the receipt of the request for Medi-Cal.

The MRF denial process for pharmacy services is as follows:

The Medical Director (or its designee) may make a denial of service determination based on medical necessity. The Medical Director consults with appropriate specialists as needed, before denying a MRF. The Medical Director may discuss the determination with the prescribing physician, if necessary, to ensure that appropriate patient care is not delayed.

If a request for a drug is denied, a Denial Letter is sent to the requesting provider and Denial Notice of Action Letter to the member. The Denial Letter and Notice of Action Letter explain the reason for the denial and provide information on how the member may file an appeal with HPSM regarding the Plan's decision.

Members are notified in writing within 24 hours of the receipt of the request for Medi-Cal members.

Plan Initiated MRFs

There may be some rare instances where HPSM is required to initiate a MRF for a provider (i.e., out-of-state services or treatment). Documentation of medical necessity is requested from the provider and the review process is the same as it is for a MRF initiated by a participating pharmacy provider.

Authorization Processing Time for PAs

Prior Authorization and Continuing Service PAs

For CareAdvantage, approval decisions for prior authorization and continuing pharmacy requests are made within 72 hours of the request for standard decisions. For all other lines of business, approval decisions for prior authorization and continuing pharmacy requests are made within 1 business day of the receipt of the information reasonably necessary to make a decision.

Processing Time for Retroactive Service PAs

Approval decisions for retroactive pharmacy requests are made within 1 day of receipt of the information reasonably necessary to make a decision. For CareAdvantage, retro requests are reviewed as a standard (72 hour) request only.

Processing Time for Medically Urgent and Faxed Pharmacy PAs

Approval decisions for medically urgent pharmacy PAs, as identified on the PA by the words "Medically Urgent", are made within 24 hours of the receipt of the request.

Evening and Weekend Prior Authorization Requests

For CareAdvantage, evening, weekend/holidays prior authorization requests are reviewed by HPSM's on-call pharmacist. If the on-call pharmacist is unable to approve an urgent Prior Authorization request, the request will be forwarded to HPSM's on-call physician for final determination within 24 hours of the original request. For standard requests, a determination will be made within 72 hours of the request.

For all other lines of business, the PA review process occurs on business days only. If a request is submitted on a weekend or holidays, eligible members may be given up to a one-time fill of three (3) day supply of medication. The PA request will be promptly reviewed on the next business day. Contact InformedRx's Customer Service at (866) 441-2422 for this one-time override procedure. HPSM will reimburse the pharmacy for up to a one-time fill of three (3) day supply of urgent medication, dispensed to an eligible member.

Emergency services are exempt from prior authorization but must be justified according to the following criteria:

- Any service classified as an emergency, which would have been subject to prior authorization had it not been an emergency, must be supported by a physician's, podiatrist's, dentist's, or pharmacist's statement which describes the nature of the emergency.
- The provider's statement must include comprehensive clinical information about the member's condition, and state why emergency services rendered were considered to be immediately necessary. A statement that an emergency existed is not sufficient.
- The statement must be signed by a physician, podiatrist, dentist, or pharmacist who had direct knowledge of the emergency described in the statement.

Completing a Medication Request Form

It is important to fill out the MRF completely. The following data items are frequently not completed by providers and result in pending or denied PAs.

- Prescribing Provider's Name, Phone Number and Fax Number
- ICD-9-CM Diagnosis Code
- Medical Justification (including formulary alternatives tried)
- Specific Services Requested
- Specific Directions for Use

Important Reminder on Charging Cash to HPSM Members

Never bill member in place of submitting a PA. You will be required to reimburse any money collected from an eligible HPSM member.

Members should never be told that a drug is not covered by Medi-Cal or HPSM unless a specific denied Prior Authorization Request has been obtained. All drugs are potentially covered through the PA process, unless it is a specific exclusion of the program.

Appeals Process

Members and Providers may request that HPSM reconsider an initial adverse determination. The request must be made in writing within sixty (60) days of the date of the original adverse determination notice for CareAdvantage appeals and within 180 days for all other lines of business. See Section 3 Member Complaints for more information on requesting an appeal.

Quality Review

The Medical Director, the Pharmacy Manager and the Health and Provider Services Director will monitor utilization patterns for quality of care by reviewing the following:

- All claims paid for members that require prior authorization with a PA. Included in the review are checks for drug interactions and therapy duplication;
- Quarterly, standard and/or special MIS utilization/quality reports;
- PAs, on a daily basis, for initiation and completion of treatment/services;
- Potential problems noted by the Pharmacist Reviewer, or at on-site-reviews.

The Pharmacy Manager, Health Services Director, or Medical Director will present follow-up reports from the Health Services staff on this monitoring to the Pharmacy Review, Peer Review and the Quality Management and Oversight Committee.

Pharmacy Management Programs

HPSM has worked cooperatively with InformedRx to develop high quality, cost-effective pharmacy programs, which maximize the safe and appropriate use of pharmacy services while controlling costs that do not compromise the safety or effectiveness of pharmacy care for our members. The pharmacy management program includes:

- Pharmacy Network
- Pharmacy Benefits Plan which outlines coverage formulary co-payments and other requirements
- Generic Drug Substitution (Mandatory)
- Prior Authorization
- Step Therapy
- Quantity/Co-pay/Days limits
- Drug Utilization Review (DUR)
- Educational Programs

Pharmacy Network

An extensive network, which includes over 55,000 pharmacies throughout the United States, is available to members through the InformedRX network. Covered drugs filled at a participating pharmacy are subject to the patient's applicable co-pay(s) as defined by their pharmacy coverage.

Pharmacy Benefits

Each program has a detailed description of the pharmacy benefits coverage and exclusions in the member's EOC. For full scope Medi-Cal there are no member co-pays for pharmacy benefits. For all other members, pharmacy co-pays will vary. The co-pay will also vary depending on whether the prescription is for a generic or brand name drug and whether it is a preferred drug in the HPSM formulary. For some members, there may be annual drug cap amount. For questions on eligibility, pharmacy benefits, or co-pays call InformedRx's Customer Service at (866) 441-2422. They are available 24 hours per day, 7 days per week.

Provider-administered medications in a physician's office or a clinic (those medications that cannot be self-administered, generally IM and IV) are covered subject to the member's medical benefits and are not subject to the pharmacy co-pay. These should be administered by the provider and billed directly to HPSM. A Treatment Authorization Request (TAR) may be required.

Diabetic medications and supplies, in accordance with California State Law are administered under the patient's pharmacy benefits. These supplies and medications may be subject to a co-pay depending on which program the member is eligible for. Diabetic medication and supplies are not subject to any pharmacy benefit cap limitations.

HPSM will cover for medically necessary enteral formulas and for modified solid food products through pharmacy prior authorization, in accordance with California State Law,

for the treatment of certain inherited diseases. This benefit is subject to any pharmacy benefit cap limitations depending on the program.

Co-payments and Cost Sharing

HPSM pharmacy benefits for some programs may require member co-payments/cost-sharing for prescriptions. The co-pay may also vary depending on whether the prescription is for a generic or brand name drug and whether it is a preferred drug on the HPSM formulary. Programs may have annual drug cap amounts as well.

Prior Authorization and Medical Exceptions

See previous section for details on “Pharmacy Prior Authorization (PA) Process.”

A physician may request a re-consideration in writing. A member or physician may provide additional information to be considered for the review. Providers and members have the right to appeal the determination. An appeal regarding a denied prior authorization/exception is initiated by writing or by calling the HPSM Grievance and Appeals Coordinator.

Exception Process

A formulary exception process is maintained by HPSM and administered through HPSM for cases in which members cannot tolerate a formulary drug. The exception process will allow the member to receive non-formulary medications. All formulary exceptions are subject to medical necessity review similar to the PA process.

A benefit exception/override process is also maintained by HPSM. Examples of a benefit exception might include lost/stolen/or destroyed medications. HPSM Pharmacy staff reviews these requests, and maintains the authority to grant administrative overrides following review of the member’s situation as appropriate.

Drug Utilization Review (DUR)

Drug Utilization Review is an InformedRX system based drug review process, which alerts the pharmacist and physicians to important therapeutic issues regarding the use of medication. InformedRx’s (IRX) DUR program safeguards members by verifying the safety of dispensing a medicine against the member's pharmaceutical history and providing education when the prescription is filled. The goals are to protect members against harmful drug events, avoid severe drug interactions, and reduce costs for our members, and prevent overuse of medications. The prescription being filled is evaluated and information may be provided before or after the prescription is filled to warn the pharmacist, member, or physician of a potential misadventure or a less expensive alternative.

Concurrent Drug Utilization Review (CDUR)

CDUR performs online analysis at the point of prescription dispensing, where each prescription is screened for a broad range of safety and economic considerations.

CDUR helps to ensure safe and effective prescription drug therapy. InformedRx maintains a personal medication profile for each patient that keeps track of his/her drug history. This history includes prescriptions from multiple physicians, information on drug allergies and medical conditions. The profile helps to prevent drug interactions, identify both high quality and cost-effective alternatives to treatments, and assures that the individual patient is using the drug safely. To ensure safe prescription drug therapy, the Drug-to-Drug Interaction Program identifies potentially harmful or fatal drug interactions at the pharmacy. The pharmacist will receive a system edit when filling a prescription that has a potential severe drug-to-drug interaction.

Drug Quantity Management - Quantity/Days per Co-pay

This program focuses on selected drugs or drug categories that are high-cost, prone to overuse/misuse, and/or potentially unsafe in high quantities. The program establishes appropriate threshold levels of utilization for these drugs based on clinically recommended dosing and/or duration recommendations and keeps drugs from being dispensed above appropriate thresholds. HPSM has identified a number of medications that have the potential for significant overuse, misuse, waste, or abuse.

HPSM has implemented a quantity per co-pay program which includes medications recommended to us by the HPSM Pharmacy Review Committee to ensure that patients receive the recommended, safe quantities for these drugs. Quantity or Days limits are based on the recommended dosage and duration approved by the Food and Drug Administration, the manufacturer, and supported by clinical literature.

Safety and Alert Programs

HPSM will mail affected physicians and members the appropriate information when a drug is withdrawn from the market due to safety concerns. The names of the physicians' patients may be included in the communication or can be provided upon request.

Mental Health and Substance Abuse

San Mateo County Behavioral Health and Recovery Services (BHRS)

For Medi-Cal members, all mental health services are covered by the BHRS. For all other programs (CareAdvantage, Healthy Kids, Healthy Families, and HealthWorx), HPSM has subcontracted the mental health services to the BHRS. Emergency psychiatric services and mental health services provided by a member's PCP, within the scope of his or her licensure, are covered by HPSM. With these exceptions, all other mental health services for HPSM members are provided through the BHRS.

As an HPSM provider, you are a critical link to behavioral health care services for your patients. By working collaboratively, you, HPSM and the BHRS, can ensure that HPSM members are receiving specialized attention for their behavioral health care needs. The BHRS has a team of professional staff and a network of providers and facilities. The BHRS provides a full range of managed mental health care services from outpatient treatment to intensive inpatient treatment, customized to meet the individual needs of the member.

The BHRS has outpatient service centers in Daly City, San Mateo, the Coastsides, Redwood City and East Palo Alto, in school-based locations, and through a network of community agencies and independent providers. Priority populations include seriously mentally ill adults and children, older adults at risk of institutionalization, children in special education or at risk of out-of-home placement, and people of any age in major crisis. These county and community resources provide outpatient services, residential treatment, rehabilitation and other services for adults and children.

The BHRS operates the Cordilleras Mental Health Center, a 120-bed skilled nursing facility in Redwood City, through a contract with Telecare Corporation.

BHRS services are aimed at helping members with mental illness maintain their independence and helping children with serious emotional problems become educated and stay with their families.

The BHRS ACCESS Team & DUAL Team work collaboratively with the Substance Abuse Services and Providers in San Mateo County and evaluate the impact alcohol and other drugs may have on mental health, as part of the Mental Health clinical assessment.

When mental health services are not the most suitable resource for an individual seeking services, the BHRS ACCESS and DUAL teams attempt to provide information and referral to available resources in the larger San Mateo County community of agencies and organizations, along with information on how to best make use of such resources to meet members' individual needs.

How the BHRS Can Help

The BHRS Access Team can assist you with referrals for patients who have mental health needs, as well as for those patients whose physical illness is a result of a mental health problem. The BHRS staff are available to consult with you and share ideas on clinical treatment approaches, managing difficult cases (e.g. eating disorder), and using new treatment resources.

You can also expect close communication from the BHRS about your patient's care, subject to the patient's consent. If you initiated the call to the BHRS, you will be contacted when the patient has entered the outpatient treatment. Regardless of whether or not you initiated the call to the BHRS you will be contacted when medical evaluations or tests are required during inpatient treatment.

How to Refer a Patient to BHRS

To refer a patient to BHRS, follow these steps:

- Call the BHRS Access Team at (800) 686-0101.
- Inform the care coordinator that you are calling on behalf of your patient.
- Let the care coordinator know why you are referring your patient to BHRS so he or she can further assist you.
- Your call will be directed to a clinician who will discuss the situation with you and jointly determine the most appropriate treatment setting.
- If the situation is life-threatening, the patient will be referred immediately to the nearest emergency room. When necessary, BHRS will coordinate transportation for the patient.
- For emergencies that are not life-threatening, an appointment is scheduled for the member to meet with a BHRS network provider within 48 hours.
- If the situation is not an emergency, you can call BHRS while the patient is in your office and BHRS will work with you to identify an appropriate network provider. You can also provide the patient with SMCMHP's toll-free number, and he or she can contact BHRS directly.

Your role in the referral process is very important. Your support and encouragement may help your patients approach their treatment with a better outlook, thereby increasing the likelihood of their successful recovery. For more information on how BHRS can help you in referring your patients to their Mental Health/Substance Abuse services, call BHRS toll free at (800) 686-0101. Staff is available during normal business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m.) to assist you.

Diagnostic Radiology and Advanced Imaging

HPSM members have many contracted facilities from which to choose for their diagnostic radiology and advanced imaging needs. All contracted hospital facilities provide outpatient radiology services. In addition, HPSM has contracted with a number of free-standing radiology facilities. Please refer to the Provider List to find the most convenient location for your patient.

In an effort to determine the most appropriate and cost-effective diagnostic imaging option, HPSM requires prior authorizations (TAR) for certain diagnostic radiology and advanced imaging studies. Refer to Section 7 – Utilization Management - Prior Authorization for general criteria for authorizations.

Treatment Authorization Requests (TAR) will be required for HPSM members (Medi-Cal, Healthy Kids, Healthy Families, and HealthWorx) for the following procedures when performed on an outpatient basis in Outpatient Hospital Facilities, Free Standing Radiology Facilities, and Non-Radiology Office-Based Settings:

- MRI
- MRA
- Nuclear Medicine
- PET Scans
- Obstetrical Ultrasounds in excess of three (3) during a pregnancy.

To ensure that the TAR process fully considers patients' symptoms and clinical findings, HPSM requires that the radiology facility obtain the TAR from HPSM Health Services prior to scheduling the patient for the requested services. Claims submitted by a participating provider or facility for diagnostic radiology and advanced imaging tests that have not been authorized through HPSM may be denied. The member is held harmless and balance billing is not permitted.

Exceptions: Radiology services provided to an HPSM member during an inpatient hospitalization or in the emergency department do not require a TAR for technical services.

General Guidelines for Submitting TARs for MRI Studies

PLEASE NOTE: These are general guidelines. Cases are reviewed on an individual basis – the more information that is provided on the TAR, the faster the authorization can be processed. Please remember, a TAR can only be deferred once.

If you have any questions or need assistance, please call Health Services at (650) 616-2079 and ask to speak to an Utilization Review nurse.

MRI cervical spine

- a) History consistent with cervical radicular disease process
- b) Physical exam with description of neurologic exam consistent with cervical radicular disease
- c) Plain radiographs AP/Lateral/oblique have been obtained in last 6 months with reading
- d) Any supporting laboratory tests (i.e. EMG)
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI thoracic spine

- a) History consistent with thoracic disease process
- b) Physical exam with description of thoracic spine findings
- c) Plain radiographs AP/Lateral have been obtained in last 6 months with reading
- d) Any supporting laboratory tests
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI lumbar spine

- a) History consistent with lumbar radicular disease process
- b) Physical exam with description of neurologic exam consistent with lumbar radicular disease
- c) Plain radiographs AP/Lateral/oblique have been obtained in last 6 months with reading
- d) Any supporting laboratory tests
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan
- g) MRI lumbar spine for chronic back pain will be authorized following North American Spine Society Guidelines.

MRI brain

- a) History consistent with central neurologic disease process
- b) Physical exam with description of neurologic exam consistent with central neurologic disease
- c) CT scan of head – if not done, explanation why CT head is not suitable
- d) Any supporting laboratory tests
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI chest

- a) History consistent with thoracic disease process
- b) Physical exam with description of findings related to thoracic disease process
- c) CT of chest – if not done, explanation why CT chest is not suitable
- d) Any supporting laboratory tests
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI abdomen

- a) History consistent with abdominal disease process
- b) Physical exam with description of findings related to abdominal disease process
- c) Ultrasound, CT or contrast study of abdomen – if not done, explanation why these other tests are not suitable
- d) Any supporting laboratory tests
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI pelvis

- a) History consistent with pelvic disease process
- b) Physical exam with description of findings related to pelvic/lower abdominal disease process
- c) CT of pelvis – if not done, explanation why CT pelvis is not suitable
- d) Any supporting laboratory tests
- e) Tentative diagnosis or differential
- f) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI shoulder

- a) History consistent with shoulder injury
- b) Physical exam with description of findings related to shoulder injury, excluding cervical radicular symptoms
- c) Plain radiographs of shoulder AP/lateral/axillary and cervical spine AP/lateral/oblique have been obtained within the last 6 months
- d) Tried and failed conservative therapy, including steroid injection(s), NSAIDs, and/or physical therapy – if not done, why conservative therapy not tried
- e) Any supporting laboratory tests
- f) Tentative diagnosis or differential
- g) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI knee

- a) History consistent with knee injury
- b) Physical exam with description of findings related to knee injury, excluding lumbar radicular symptoms
- c) Plain radiographs of knee AP/lateral/notch view and lumbar spine AP/lateral/oblique have been obtained within the last 6 months
- d) Tried and failed conservative therapy, including steroid injection(s), NSAIDs, and/or physical therapy – if not done, why conservative therapy not tried
- e) Any supporting laboratory tests
- f) Tentative diagnosis or differential
- g) Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

Radiology Authorization Summary Information Sheet

TARs are required for the following diagnostic radiology and advanced imaging studies:

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET Scans)
- Nuclear Medicine
- OB Ultrasounds (in excess of three (3) during a pregnancy)

One TAR number is required for each procedure.

A TAR is valid for the timeframe indicated on the TAR.

Settings Requiring a TAR:

- Outpatient Hospital Facilities (In-Patient and Emergency Department are exempt)
- Free Standing Radiology Facilities
- Non-Radiology Office Based Settings

Information Required:

- Member's name, date of birth, Member ID number, the exam(s) requested and CPT procedure code, including all pertinent modifiers.
- Working diagnosis or rule out diagnosis (non-specific diagnoses will be returned).
- The signs and symptoms that call for the exam including how long they have been present.
- Any previous imaging studies that have been performed and the results, and any pertinent lab results.
- Any history of prior treatment, whether drugs, surgery, or other therapies, and for how long.
- Any other information that indicates the need for the exam.

Please note that HPSM will make a determination of medical necessity only. Always verify eligibility, benefits and co-payments for a member directly with HPSM Member Services.

Please remember the applicable modifier(s) when submitting TARs for these services.

Chiropractic Care and Acupuncture

HPSM contracts with local chiropractic providers for the provision of chiropractic services for HPSM members. **Benefits are subject to program coverage and limitations.** Acupuncture services are available for Medi-Cal, Healthy Kids, Healthy Families and HealthWorx members. **Benefits are subject to program limitations.** In general, visits are limited to 2 per month. These services are provided through contracted providers listed in the Provider Directory.

Both chiropractic and acupuncture services are self-referred and do not require authorization, subject to the limits of the program.

As of July, 1, 2009 Acupuncture and Chiropractic services will no longer be covered for Medi-Cal members pursuant to the California Department of Health Services Optional Benefits Exclusion. Please contact HPSM's Provider Services or Health Services Department for specific exceptions where these services may be covered. Or you may go to www.hpsm.org to review HPSM's notification. Providers will be given 30 day notification of any future changes to benefit coverage.

Physical, Occupational, & Speech Therapy

Physical and Occupational Therapy

All HPSM members are provided physical and occupational therapy services through our outpatient, hospital-based physical and occupational therapy units within the contracted hospital network. Initial evaluations do not require a TAR; however, all other physical and occupational therapy services do require a prospectively submitted TAR. The initial therapy TAR must include a copy of the initial evaluation, as well as a copy of the physician's prescription for therapy.

TARs for continuing therapy services should be submitted at least two weeks before the end of the current authorization in order to prevent a lapse in therapy services. Continuing therapy TARs must include a copy of the latest therapy evaluation and a copy of the physician's prescription for additional therapy. Requests for additional therapy without a specific diagnosis may be deferred for specialist evaluation.

If there is a long waiting time prior to the anticipated start of a therapy program, please indicate this on the initial therapy TAR. The additional waiting time will be added to the approved TAR to avoid the need to submit a time extension for an already approved TAR.

If therapy services are planned following a scheduled surgical procedure, please submit these requests along with the surgical TAR, in order to prevent any delays in obtaining authorization for post-operative outpatient rehabilitation services.

Speech Therapy

All HPSM members have access to outpatient speech therapy services. Initial evaluations do not require a TAR; however, all other speech therapy services do require a prospectively submitted TAR. The initial therapy TAR must include a copy of the initial evaluation, as well as a copy of the physician's prescription for therapy. In addition, the results of a recent hearing test should be included with the TAR.

For patients who may be eligible for a school-based speech therapy program (3 years of age and older), an evaluation by the school district will be required for additional therapy sessions. The school district evaluation requirement may be waived if there are extenuating circumstances which prevent the evaluation from taking place on a timely basis. Participation in a school-based speech therapy program, if the member is eligible, is required while school is in session (September through June).

As of July, 1, 2009, speech therapy provided outside hospital outpatient settings or outside the home health benefit services will no longer be covered for Medi-Cal members pursuant to the California Department of Health Services Optional Benefits Exclusion. Please contact HPSM's Provider Services or Health Services Department for specific exceptions where these services may be covered. Or you may go to www.hpsm.org to review HPSM's notification. Providers will be given 30 day notification of any future changes to benefit coverage.

Podiatry (CareAdvantage and Medi-Cal only)

CareAdvantage

Podiatry services are a covered benefit for the treatment of injuries and disease of the feet (such as hammer toe or heel spurs). Routine foot care is covered for members with certain medical conditions affecting the lower limbs (diabetes).

Medi-Cal

Podiatry benefits are provided for HPSM Medi-Cal members. Healthy Kids, Healthy Families and HealthWorx do not have access to podiatry services unless the service requested is related to diabetes. For these cases, podiatry services may be authorized with a TAR.

Podiatry services are provided through our contracted providers located throughout San Mateo County. Services are limited to two office visits a month. All Medi-Cal podiatry procedures/surgeries require a TAR except for the following procedure codes:

11730	Avulsion of nail plate, partial or complete, simple; single
11732	Each additional nail plate (use in conjunction with 11730)
99321	New patient evaluation – domiciliary, rest home, custodial care – level 1
99331	Established patient evaluation – domiciliary, rest home, custodial care - level 1

Please refer to the Podiatry Supplement for information on frequency of service limits and qualifying diagnosis codes.

Vision Care

Vision care services are covered through a variety of different methods, depending on the specific program that the member is enrolled in. The section below describes each of the various programs and their associated vision care benefits.

CareAdvantage

Outpatient physician services for eye care is a covered benefit for people who are at high risk of glaucoma, such as people with a history of glaucoma, people with diabetes, and African-American who are age 50 and older are covered for glaucoma screening once per year.

Members are eligible for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

Medi-Cal

Members who need an examination for eye glasses may go directly to an optometrist for a visit once every two years (without the need for a referral from the PCP*). For other eye problems, members should see their PCP for a referral to an ophthalmologist.

Members are eligible for new eyeglass (frames and lenses) every two years. Lost, stolen, or broken glasses may be replaced under extenuating circumstances. If members repeatedly lose or break their eyeglasses, they may be responsible for replacement eyeglasses.

*Only Willow Clinic optometrists require a referral (RAF), since they do not have their own provider number.

As of July, 1, 2009 vision services will no longer be covered for Medi-Cal members pursuant to the California Department of Health Services Optional Benefits Exclusion. Please contact HPSM's Provider Services or Health Services Department for specific exceptions where these services may be covered. Or you may go to www.hpsm.org to review HPSM's notification. Providers will be given 30 day notification of any future changes to benefit coverage.

Healthy Families

Eyeglasses or contacts necessary after cataract surgery are a covered benefit directly through HPSM.

All other vision care services are provided through the member's Vision Service Plan. They can be reached at (800) 877-7239, Monday through Friday, 6:00 a.m. to 6:00 p.m.

Healthy Kids

Vision benefits are provided through HPSM's network of professional vision care providers. Members ***must*** select a provider for vision care from those listed in HPSM's Provider List. This list can be viewed and downloaded from the HPSM website (www.hpsm.org). It can also be obtained in hard copy format by writing or calling a Member Service Representative at (800) 750-4776.

If a Member obtains vision care services from an out-of-network provider, the Member is responsible for payment in full to the provider.

Cost to Member: \$5 co-payment per examination

- Frames and Lenses - A frame allowance of \$75. If Member chooses a frame that exceeds the plan allowance, the Member will pay the difference.
- Elective Contact Lenses - An allowance of \$110 towards the cost of exam, contact lens evaluation, fitting costs, and materials. The Member is responsible for any costs exceeding this allowance.
- Necessary Contact Lenses- No co-payment
- Low vision benefits - Supplemental testing: no co-payment
- Supplemental care: \$5 co-payment

Examinations: Each Member is entitled to a comprehensive vision examination; including a complete analysis of the eyes and related structures as appropriate, to determine the presence of vision problems or other abnormalities as follows:

- Case History: Review of Member's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
- Evaluation of the health status of the visual system including:
 - 1) external and internal examination, including that of direct and/or indirect ophthalmoscopy
 - 2) assessment of neurological integrity, including that of papillary reflexes and extraocular muscles
 - 3) biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes
 - 4) screening of gross visual fields
 - 5) pressure testing through tonometry
- Evaluation of refractive status including:
 - 1) evaluation of visual acuity
 - 2) evaluation of subjective, refractive, and accommodative function
 - 3) objective testing of a Member's prescription through retinoscopy
- Binocular function test
- Diagnosis and treatment plan, if needed
- Examinations are limited to once each twelve (12) month period, which begins with the date of the last exam.

Lenses: The Member's provider will order the proper lenses necessary for the Member's visual welfare. Lenses are limited to once each twelve (12) month period, which begins with the date of the last exam.

Frames: Frames are limited to once every twelve (12) month period, which begins with the date of the last exam.

Medically Necessary Contact Lenses: Medically necessary contact lenses may be prescribed for certain conditions with prior authorization from HPSM, such as:

- 1) following cataract surgery,
- 2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- 3) certain conditions of Anisometropia; and
- 4) keratoconus.

With approval, contact lenses are in lieu of eligible benefits for that eligibility period. Contact lenses are limited to once each twelve (12) month period, which begins with the date of the last exam.

Elective Contact Lenses (instead of corrective lenses and a frame): Limited to once each twelve (12) month period, this begins with the date of the last exam.

Low Vision: A low vision benefit is provided to Members with severe visual problems that are not correctable with regular lenses. This benefit requires prior authorization from HPSM. With authorization, supplemental testing and supplemental care, including low vision therapy as visually necessary or appropriate, will be provided.

Any cost associated with the selection of the items listed below will be the financial responsibility of the Member.

Exclusions:

- Benefits that are neither necessary nor appropriate
- Benefits that are not obtained in compliance with the rules and policies of HPSM's Vision Plan for Healthy Kids
- Vision training
- Aniseikonic lenses
- Plano lenses
- Two pairs of glasses in lieu of bifocals, unless medically necessary and with prior authorization
- Replacement or repair of lost or broken lenses or frames prior to being eligible for services
- Medical or surgical treatment of the eyes
- Services or materials for which the Member is covered under a Worker's Compensation policy
- Eye examinations or any corrective eyewear required as a condition of employment
- Services or materials provided by any other group benefit providing vision care

There is no benefit for professional services or materials connected with:

- Blended lenses (bifocals which do not have a visible dividing line)
- Contact lenses, except as specified above

- Oversized lenses (larger than standard lens blank to accommodate prescriptions)
- Progressive multifocus lenses
- Coated or laminated lenses
- UV protected lenses
- Other optional cosmetic processes
- Photocromic or tinted lenses

There are no out-of-network benefits.

HealthWorx

Vision Services are covered through the Services Employees International Union (SEIU), Local 715 for those IHSS workers who meet eligibility requirements. For more information about Vision Benefits, Members need to call the SEIU, at (408) 954-8715 ext. 186.

Durable Medical Equipment

Durable medical equipment (DME), when prescribed by a licensed practitioner, is covered when medically necessary to preserve bodily function essential to activities of daily living or to prevent significant physical disability. There are program specific limitations which are outlined below. DME may be obtained from any licensed DME provider who has a Medi-Cal provider number. HPSM contracted DME providers are listed in the HPSM provider directory. There are no co-payments required from members for these services.

CareAdvantage

**Note: TAR requirement remain in effect for DME request effective 1/1/2006.*

- Crutches
- Hospital Beds
- IV Infusion pump
- Oxygen and oxygen equipment
- Nebulizers
- Walker
- Colostomy bags and supplies directly related to colostomy care
- Pacemakers
- Blood glucose monitor, test strips, lancets, lancets devices, and glucose control solution

Exclusions:

- Orthopedic shoe or supportive devices for the feet (certain exceptions apply)

Medi-Cal

Covered items include, but are not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors (must be obtained from a pharmacy)

- Apnea monitors
- Pulmoaides and related supplies
- Asthma related equipment – nebulizers, tubing and related supplies, spacer devices for metered dose inhalers
- Ostomy bags, urinary catheters and related supplies
- Insulin pumps and related supplies
- Other diabetic self-management supplies, as medically necessary (must be obtained from a pharmacy)

Excluded items include, but are not limited to:

- Comfort and convenience items
- Experimental or research equipment
- Devices not medical in nature, including modifications to the home or automobile
- More than one piece of equipment that serves the same function, unless medically necessary

Healthy Families and Healthy Kids

Covered items include (but not limited to) medical equipment appropriate for use in the home which:

- primarily serves a medical purpose;
- is intended for repeated use; and
- is generally not useful to a person in the absence of illness or injury

The Health Plan of San Mateo may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss.

Covered items include:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes (must be obtained from a pharmacy)
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
- Ostomy bags, urinary catheters, and related supplies
- Insulin pumps and all related supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Podiatric devices to prevent or treat diabetes complications

Excluded items include:

- Comfort and convenience items
- Disposable supplies, except ostomy bags, urinary catheters and supplies consistent with Medicare coverage guidelines

- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same purpose, unless medically necessary

HealthWorx

Covered items include, but are not limited to medical equipment appropriate for use in the home which:

- primarily serves a medical purpose;
- is intended for repeated use; and
- is generally not useful to a person in the absence of illness or injury

The Health Plan of San Mateo may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss.

Covered items include:

- Oxygen and oxygen equipment
- Blood glucose monitors (must be obtained from a pharmacy)
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
- Ostomy bags, urinary catheters, and related supplies
- Insulin pumps and all related supplies

Excluded items include:

- Comfort and convenience items
- Disposable supplies, except ostomy bags, urinary catheters and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same purpose, unless medically necessary

Wheelchairs

Manual and powered wheelchairs are covered (must meet clinical criteria per product line) under all HPSM programs. The requirements for obtaining a wheelchair are:

- (1) The wheelchair is prescribed by a licensed medical provider;
- (2) HPSM has made a determination that the proposed wheelchair is medically necessary;
- (3) The wheelchair provider has received an authorization via an authorized treatment authorization request (TAR) form from the HPSM Health Services Department

Wheelchairs may be obtained from any licensed DME provider who has a Medi-Cal provider number. HPSM contracted wheelchair providers are listed in the HPSM provider directory.

A Treatment Authorization Request must be submitted to the Health Services Department in order to begin the process for obtaining a wheelchair. HPSM generally requires an independent member evaluation when a request for a wheelchair is submitted to Health Services. The HPSM contracted evaluator is a specialist who performs an onsite evaluation of the member. If the HPSM contractor is unable to perform the onsite member evaluation, the request for the wheelchair will be denied for administrative reasons.

HPSM reserves the right to determine whether to rent or purchase the proposed equipment.

Audiology/Hearing Aids

Audiology services, including hearing tests and hearing aids are covered under most of HPSM programs, subject to specific program limitations described below. All hearing aids require submission of a treatment authorization form (TAR) to the HPSM Health Services Department for approval. Audiology services may be obtained from any licensed provider who has a Medi-Cal provider number. Contracted HPSM audiology specialists and hearing aid dispensers are listed in the HPSM provider directory. There are no co-payments required from members for these services.

CareAdvantage

Diagnostic hearing and balance exams are a covered benefit.

Exclusion:

- Hearing aids and hearing exam for the purpose of fitting a hearing aid

Medi-Cal

HPSM covers screening and examinations. Hearing aids are covered when provided by an HPSM contracted specialist. A referral is required from the PCP if more visits are needed after the initial screening hearing evaluation.

Exclusions:

- Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.
- Charges for a hearing aid which is more than the prescribed correction for the hearing loss

Replacement parts for hearing aids and repair of hearing aids after the covered one year warranty period

As of July, 1, 2009, audiology services provided outside the hospital outpatient settings will no longer be covered for Medi-Cal members pursuant to the California Department of Health Services Optional Benefits Exclusion. Please contact HPSM's Provider Services or Health Services Department for specific exceptions where these services may be covered. Or you may go to www.hpsm.org to review HPSM's notification. Please note: hearing aids are not eliminated from the Medi-Cal benefit program. Providers will be given 30 day notification of any future changes to benefit coverage.

Healthy Families, Healthy Kids, and HealthWorx

Covered services include:

- Audiological evaluation to measure the extent of hearing loss
- Hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Monoaural or binaural hearing aids, including ear mold(s), hearing aid instrument, initial battery, cords, and other medically necessary ancillary equipment
- Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid

Exclusions:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids and repair of hearing aids after the covered one year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices

Prosthetics/Orthotics

Prosthetic and orthotic devices are covered under all HPSM programs when such appliances are medically necessary for the restoration of function or replacement of body parts. Coverage is subject to specific program limitations as outlined below.

Covered items must be prescribed by a licensed physician or podiatrist, authorized by HPSM Health Services Department through a submitted treatment authorization request (TAR) form and dispensed by an HPSM contracted provider.

A list of HPSM contracted prosthetists and orthotists can be found in the HPSM provider manual. HPSM reserves the right to determine whether to replace or repair a requested prosthetic or orthotic device. There are no co-payments required from members for these services.

CareAdvantage

- Prosthetic devices and related supplies (other than dental)
- Braces, Prosthetic shoes, artificial limbs
- Therapeutic shoes (includes shoe fitting or inserts) only with diagnosis of severe diabetic foot disease.
- Breast prosthesis (including surgical brassiere after mastectomy)
- Repair and replacement of prosthetic devices

Exclusion:

- Orthopedic shoe or supportive devices for the feet (certain exceptions apply)

Medi-Cal

All requested items must be determined by HPSM to be medically necessary.

Healthy Families, Healthy Kids, and HealthWorx

Prosthetics and orthotics are covered as follows:

- Medically necessary replacement prosthetic/orthotic devices as prescribed by a licensed practitioner acting within the scope of his/her licensure
- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetic conditions
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

Excluded items:

- Over-the-counter items
- Corrective shoes, shoe inserts and arch supports, except for therapeutic footwear for diabetics
- Non-rigid devices, such as elastic knee supports, corsets, elastic stocking, and garter belts
- Dental appliances

- Electronic voice producing machines
- More than one device for the same part of the body, unless medically necessary

California Children's Services (CCS)

California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. San Mateo County operates its own CCS program with offices located in San Mateo. The program is funded with state, county and federal tax monies, along with some fees paid by parents.

The California Children's Services (CCS) program is responsible for determining eligibility and providing case management and authorization of services related to the CCS-eligible condition. HPSM remains responsible for delivering primary and preventive health care services that are unrelated to the CCS-eligible condition.

The Health Services Utilization Management team works closely with the CCS staff to coordinate care for these special needs children. It is important to note that while CCS may authorize certain services (e.g., inpatient days), however it is HPSM's responsibility to determine level of care.

Questions concerning which diagnoses and what services are covered under the CCS program, should be directed to the CCS office in San Mateo, located at:

CCS
2000 Alameda de las Pulgas, Suite 230
San Mateo, CA 94403
(650) 573-2755
(650) 573-2751 Fax

Hours of operation are Monday through Friday 8:00 a.m. to 5:00 p.m.

The San Mateo County website for CCS is:

http://www.co.sanmateo.ca.us/smc/departament/home/0,,1954_191102_194496,00.html

Golden Gate Regional Center (GGRC)

Golden Gate Regional Center serves individuals with developmental disabilities and their families who reside in Marin, San Francisco and San Mateo counties. In addition, GGRC provides early intervention services to infants between birth and three years of age who are developmentally delayed or believed to be at high risk of having a developmental disability, and genetic counseling and testing for individuals at high risk of having a child with a disability.

Regional centers are the hub of a comprehensive network which links people to services, acts as a community focus for individuals with developmental disabilities, their families and service providers. GGRC provides lifelong support for their clients and their families.

Any HPSM member may be referred for GGRC services via telephone or letter. The request goes to the San Mateo County Intake Supervising Social Worker who conducts a basic screening to determine if further assessment and diagnostic services are appropriate. Persons with developmental disabilities may apply for services directly or be referred by others.

Please send referrals to:

Golden Gate Regional Center of San Mateo County
3130 La Selva Drive, Suite 202
San Mateo, CA 94403
(650) 574-9232
(650) 345-2361 Fax

The Supervising Social Worker will assign an Assessment Social Worker who will schedule an initial appointment with the member to be held within 15 working days following the initial contact (or request for services). This appointment takes place in the member's home or at the regional center, at which time the member and his/her family are given an overview of the regional center and its services.

If necessary, the Assessment Social Worker will arrange for assessments to determine eligibility. For infants and toddlers between birth and three years of age, assessments regarding eligibility are performed within 45 days following the initial intake. For persons three years of age and older, assessments are performed within 60 days following initial intake. Assessments may include - but are not limited to - psychological, medical or developmental evaluations.

Eligibility determinations are made by a group of regional center professionals of differing disciplines, such as psychologist, physician and social worker. Eligibility for ongoing regional center services is established upon determination that the person has

a developmental disability with a substantial handicap, or for infants from birth to three years of age, is at risk of having a developmental disability.

Referred HPSM members are notified of their eligibility by letter within 10 days after the determination is made. Any applicant who is not eligible for ongoing regional center services will be informed of his/her appeal rights and the fair hearing process, and will also be referred to other appropriate resources.

Additional information about Golden Gate Regional Center can be obtained from its website: <http://www.ggrc.org>

Section 7

Utilization Management

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Utilization Management Overview

PROGRAM SCOPE

The Health Plan of San Mateo (HPSM) Utilization Management Program (“the UM Program”) encompass management and evaluation of care across the continuum of care. This includes pre-service review and authorization, concurrent and retrospective review of inpatient care including acute care, rehabilitation and skilled nursing, (for Care Advantage members only), pharmaceuticals, DME, and ambulatory services.

The UM Program is designed to promote the provision of medically appropriate care; to monitor, evaluate, and manage resource allocation; and to monitor cost effectiveness and quality of the healthcare delivered to our members through a multidisciplinary, comprehensive approach and process. The Utilization Management Program supports the HPSM mission.

- The mission of HPSM is to provide members with access to quality healthcare services delivered in a cost effective and compassionate manner.

Utilization and Resource Management functions are performed by HPSM's Health Services Department. The Health Service Department's vision is that services are designed around the member's journey in the healthcare system with the goal to improve the member's experience and health outcome.

ORGANIZATION

Background

The Health Plan of San Mateo (HPSM) was created in the mid 1980s by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a County Organized Health System (COHS) authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Because it is based within the community it serves, HPSM is especially sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. In 2006, HPSM began a Special Needs Medicare Advantage Plan (MA SNP) which allows HPSM to offer the Medicare and Medi-Cal benefits under one umbrella to all dually eligible individuals. HPSM's mission is to provide members with access to high quality services delivered in a cost-effective and compassionate manner.

Since opening its doors in October of 1987, HPSM has greatly improved access to healthcare for San Mateo County beneficiaries. At its inception, the organization's primary focus was to serve the health care needs of San Mateo County Medi-Cal beneficiaries including nearly all Medi-Cal eligible individuals in the county, with membership including the TANF population as well as aged and disabled recipients.

Over the years, HPSM has added three additional product lines in response to community needs. These include Healthy Families, Healthy Kids and HealthWorx. The first two lines of business serve low income children while the latter serves In-Home Supportive Services (IHSS) workers and eligible San Mateo county temporary employees. In January 2009, HPSM became a third party administrator for San Mateo County's Access and Care for Everyone (ACE) program. The San Mateo ACE Program is a coverage program provided by the County of San Mateo, which is committed to providing health care coverage to uninsured residents of the county. Additional information on the ACE will be forthcoming. By taking on these additional groups and a state licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.

HPSM's Delivery System

HPSM is able to fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly contracted provider network. HPSM's network includes over 800 primary care physicians and over 1200 specialists. In addition, HPSM's network includes 8 hospitals and medical centers located in San Mateo County and in neighboring San Francisco as well. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager, InformedRX.

The following chart summarizes the membership in HPSM's current lines of business:

(Membership statistics are as of September 2010)

September 2010	Medi-Cal ¹	Healthy Families	HeathWorx	Healthy Kids	CareAdvantage ¹	Total Membership
Membership	54,525	6020	1030	5360	7860	74,795

SCOPE OF SERVICES

HPSM provides a comprehensive scope of acute and preventive care services for San Mateo County's Medi-Cal, Healthy Families, Healthy Kids, HealthWorx and dually eligible population. Certain services are not covered by HPSM or may be provided by a different agency. These are:

- Mental Health services are administered by the San Mateo County Health Services Agency (HSA) for Medi-Cal. HPSM contracts with San Mateo County's Behavioral Health and Recovery Services division for services for its other lines of business.

¹ 8,000 of HPSM's Medi-Cal members are dual eligible members under CareAdvantage

- Dental services are provided through California's Denti-Cal program for Medi-Cal members. Delta Dental contracts with HPSM to provide services for Healthy Kids and Care Advantage members.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for the specific medical services and equipment provided by CCS-approved specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.
- Childhood Health and Development Program (CHDP) is managed at the County level.
- HPSM works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOU) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

- A. The San Mateo Health Commission (SMHC) and the San Mateo Community Health Authority (SMHA) have ultimate accountability and responsibility for the quality of care and services provided to HPSM members. The Commission holds the Executive Director, Medical Director and Director of Health and Provider Services accountable and responsible for the quality of care and services provided to members. The Executive Director, Medical Director and Director of Health and Provider Services ensure separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced.
- B. The Executive Director allocates financial and employee resources to fulfill the program objectives. The Executive Director delegates authority, when appropriate, to the Medical Director, the Chief Financial Officer (CFO), the Director of Health and Provider Services and the Director of Member Services and Outreach. The Executive Director shall ensure that the QMP satisfies all remaining requirements of the Quality Improvement (QI) Plan, as specified in the State Contract.
- C. The Medical Director in collaboration with the Director of Health and Provider Services is responsible for the Utilization Management Program. The Medical Director is also responsible for the Quality Management Program. At least quarterly, the Health and Provider Services Director presents reports on Health Services activities to the Quality Management Oversight Committees. The Medical Director chairs the Quality Management Oversight Committee that

- D. The Director of Health and Provider Services is responsible for management of the Health Services Department. The Director of Health and Provider Services report monthly on Health Services activities to the Senior Management team at monthly medical management meetings. The Medical Director and the Director of Health and Provider Services are the Executive Director's designees in the day-to-day implementation of Utilization Management and are responsible for ensuring that the program is properly developed, implemented and coordinated.
- E. The Health Services Clinical Manager is responsible for day to day management and oversight of the utilization review process for all product lines for all members. The Health Services Clinical Manager works closely with the Health Services Care Coordination Manager to assure members receive high quality, medically necessary care in a way that balances individual need and cost effectiveness in the short and long term.
- F. The Care Coordination Manager is accountable to plan, organize, develop and manage the care coordination system in Health Services. The Care Coordination Manager's primary focus is on high risk members as identified through emergency and inpatient recidivism and also those members requiring complex medical care coordination. The Health Services Care Coordination manager interacts regularly with the provider community and outside agencies including but not limited to the Regional Centers, California Children's Services, County Mental Health, the County public hospital and Aging and Adult Services.
- G. The Pharmacy Services Manager has management responsibility for overseeing pharmacy benefits operations activities, including Medi-Cal and Medicare Part D programs, formulary management, cost containment and reimbursement strategies, program administrative leadership, supervision of pharmacy staff, program development and policy enhancement.
- H. The Provider Services Manager is responsible for provider network development, contracting, and provider relations management for contracted and non-contracted providers. The Provider Services Department is responsible for assuring that providers are able to efficiently deliver services to members and receive prompt reimbursement for services performed. The Provider Services Representatives perform provider education and assist providers in problem resolution.
- I. The Director of Planning and Evaluation Services is responsible for the overall coordination of planning and evaluation services, including contract requirements and coordination of external quality review requirements. As part of this function, the Director ensures that HPSM meets the requirements set forth by the Department of Health Care Services (DHCS), Department of Health Services Managed Medi-Cal Division (DHS/MMCD), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid (CMS), and the Managed Risk Medical Insurance Commission (MRMIB). The compliance staff works in collaboration with the HPSM Quality Assessment and Improvement Department

PURPOSE OF THE UTILIZATION MANAGEMENT PROGRAM

The purpose of the Utilization Management Program is to define and describe HPSM's multidisciplinary, comprehensive approach to managing resource allocation through systematic monitoring of medical necessity and quality while maximizing the cost effectiveness of the care and service provided to members.

The Utilization Management Program will ensure that:

- HPSM Health Services Utilization Management (UM) review staff utilize nationally recognized standard criteria and informational resources to determine the medical necessity of healthcare services to be provided (e.g., Medi-Cal Manual of Criteria issued by the State of California, Milliman Care Guidelines).
- HPSM Health Services UM review staff, that includes physicians, licensed nurses, and unlicensed trained employees, carries out the responsibilities designated for their level of expertise within their respective scope of practice, and as defined in their Job Position Descriptions.
- HPSM Utilization Management Program collaborates with the HPSM Quality Assessment and Improvement program to ensure ongoing monitoring and evaluation of quality of care and service, and continuous quality improvement.
- At least annually, the Utilization Management Program description, policies, and procedures are reviewed at one of the monthly medical management meetings, attending by senior management and it is also reviewed at the Quality Management Oversight Committee meeting. The UM Program is revised if necessary.

Care Coordination Activities include the following:

- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under and over utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service.
- Ensuring that members have access to the appropriate care and service within their health plan benefits and consistent with accepted standards of medical practice.

- Retaining the ultimate responsibility for the determination of medical necessity for HPSM members and ensuring that authorization requests are handled efficiently according to HPSM UM timeliness standards.
- Evaluating the results of the Utilization Management Program utilizing data includes:
 - Membership statistics
 - Quality and utilization management reports, such as bed day utilization, ambulatory care and ancillary utilization patterns.
 - Conducting regular monitoring visits with follow-up for quality improvement activities or corrective actions to ensure continued compliance with HPSM standards.
- Monitoring of services to evaluate utilization patterns.
- Monitoring performance to ensure qualified healthcare professionals perform all components of utilization review. Maintaining a process for a licensed physician to conduct reviews on all cases that do not meet medical necessity criteria, or service requests that are not addressed by criteria.
- Maintaining a process to ensure that all Health Services UM reviewers have access to appropriate board certified specialists to assist in determining medical necessity as needed.
- Ensuring inter- and intra-rater reliability through a defined internal process.
- Ensuring the confidentiality of member and provider information.

UM PROGRAM GOALS

The Utilization Management Program shall endeavor to promote the delivery of high quality care in the most cost-effective manner for HPSM's members, and thus contribute to the achievement of the HPSM mission. The Utilization Program goals and objectives are:

- Improve the quality of care delivered to members by ensuring they receive the appropriate level and mix of medical services in the most appropriate setting- The right service at the right time at the right place for the right reason.
- Facilitate communication and develop positive relationships between members and contracted providers by providing timely appropriate utilization review processing.
- Identify members with special needs and ensure that appropriate care is delivered to them through collaboration with county partners. This will reduce overall healthcare expenditures by developing and implementing effective preventive care and health promotion programs.
- Identify actual and/or potential quality issues during utilization review activities and refer to the Medical Director.
- Ensure compliance with regulatory agencies.

PROGRAM STRUCTURE

The Utilization Management Staff work collaboratively with contracted healthcare providers in the community, in an effort to assure the delivery of appropriate, cost effective, quality evidence-based healthcare. The Utilization Management Program necessitates the cooperative participation of all HPSM contracted healthcare providers, including physicians, allied healthcare professionals, hospitals, outpatient facilities as well as members to ensure timely and effective delivery of healthcare services. Several collaborative projects between the plan and our county partners have been implemented. These collaborative projects identify members with special needs and ensure that appropriate care is delivered to them. Collaborative projects include but are not limited to, the Care Transition program. The Care Transition project focuses on providing well coordinated community-based senior services, including limiting gaps in care between inpatient and outpatient and community-based senior services. The Care Transition project's model is to improve transitional care between the hospital and home or skilled nursing facilities.

The Health Services Department is responsible for all UM processing for members in all programs. Leadership is provided by the Director of Health and Provider Services, who directly supervises the Health Services Clinical Manager, the Health Services Care Coordination Manager and Pharmacy Services Manager. The Health Services Clinical Manager directly supervises the UM Nursing review staff and Authorization Assistants. The Pharmacy Services Manager supervises the pharmacy staff and day to day operations of pharmacy benefit management. The Care Coordination Manager supervises the Nurse Case Managers, Care Coordination Technician and the day to day management of the Care Coordination unit.

The Health Services Department collaboratively contributes to the development and implementation of the HPSM Utilization Program, as well as supporting policies and procedures. This Utilization Management Program is developed in compliance with the California Department of Health Services, the Center for Medicare and Medicaid Services (CMS) regulations for Medi-Cal and Knox-Keene regulations 1300.70, and SB 59.

The Utilization Program is reviewed and evaluated for effectiveness at least annually by the Medical Director and the Director of Health and Provider Services. Recommendations for revisions and improvement are made as appropriate and the subsequent annual Utilization Program is based on the findings of the annual program evaluation.

COMMITTEE ORGANIZATION AND REPORTING STRUCTURE

The structure of the Utilization Management Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of the HPSM healthcare delivery. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization.

The Organization Chart and the Program Committees Reporting Structure outlines HPSM's governing body, HPSM senior management, as well as committee reporting structure and lines of authority. Position job descriptions and Committee policies/procedures define associated responsibilities and accountability.

HPSM Utilization Management Workgroup

The Utilization Management Workgroup promotes the optimal utilization of healthcare services while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The Workgroup monitors the utilization of healthcare services by HPSM members in all programs to identify areas of under or over utilization that may adversely impact member care. The Workgroup meets bi-weekly.

Role and Responsibility

- Provides coordination UM functions.
- Provides oversight for appropriateness and clinical criteria used to monitor care and services provided to HPSM members.
- Monitors data and reports and identifies opportunities for improvement of internal processes and systems.
- Measures and documents effectiveness of actions taken.
- Review and evaluation of data to identify under or over utilization patterns.
- Review care management issues related to continuity and coordination of care for members.

Care Coordination Meetings

Role and Responsibility

HPSM meets at least quarterly with other community partners to address issues regarding the coordination of healthcare delivery services involving the San Mateo County Mental Health Plan, California Children's Services (CCS), and Aging and Adult Services (AAS). HPSM does not provide Mental Health services for Medi-Cal members; the Department of Health Services utilizes other contracts to provide this care. HPSM also does not provide CHDP services, but works closely with this agency to coordinate services. HPSM does reimburse for CCS services through its

contracted providers. Memoranda of Understanding (MOU) exist between each of these community partners, which require quarterly meetings to clarify systems issues and coordinate the care of complex cases. The MOU clarifies responsibilities and establish protocols and procedures for the exchange of information and maintaining confidentiality. These quarterly coordination meetings are attended by representatives of each of the respective organizations.

- System-wide issues and specific cases are addressed to promote continuity and coordination of care between the medical and behavioral healthcare providers.

Peer Review Committee/Physician Advisory Group (PRC/PAG)

The PRC/PAG provides guidance and peer input into the HPSM practitioner and provider selection process and determines corrective actions as necessary to ensure that all practitioners and providers that serve HPSM members meet generally accepted standards for their profession or industry. The PRC/PAG shall review, investigate, and evaluate the credentials of all internal HPSM medical staff for membership and maintain a continuing review of the qualifications and performance of all internal medical staff. The PRC/PAG includes practicing physicians from the contracted healthcare provider network.

The PAG meets on a bimonthly basis while appropriate peer review committees meet on an ad-hoc basis as needed. The Chairperson of this committee is a physician member of the commission.

Role and Responsibility

- Provides linkage with practicing physicians in the community for input to HPSM Quality and Utilization Programs.
- Reviews of quality of care issues.
- Peer Review.
- Reviews provider trends as related to UM and Quality issues.
- Takes corrective actions, when necessary, to improve provider performance and optimize systems and processes.

PCP Specialty Referral Process

What Services Require a RAF?

For all product lines (CareAdvantage, Medi-Cal, Healthy Families, Healthy Kids and HealthWorx) there is a “RAF free holiday” for in network referrals. The “RAF free holiday” does not apply to out of network referrals. For CareAdvantage, the RAF free holiday is effective January 1, 2006. For all other lines of business, the RAF free holiday is effective February 1, 2006.

RAF requirements will resume upon notification by the HPSM.

RAFs are only needed for members to see non-participating plan specialist providers for evaluation and treatment. The covered service CPT codes are: All CPT codes ranging from 90000-99499 (except: EEG and other testing codes such as 93000, 93015, and 93236).

RAFs are not needed for members to see doctors for sensitive services, like OB/GYN services, family planning services, sexually transmitted disease/HIV testing/counseling services, or for emergencies. RAFs are not needed for audiology services, optometry services (except for Willow Clinic Optometry) or therapy services. Treatment Authorization Requests (TARs), not RAFs are needed for certain advanced radiology studies, therapy treatments and surgical procedures (see next section).

The following services do not require a RAF:

- E&M codes rendered in a SNF
- Emergency care
- Services to “special members” (see Section Two for definition of “special member”)
- Preventive services
- Minor Consent services – Minors without their parents’ consent may receive the following services:
 - Services related to sexual assault
 - Pregnancy and pregnancy related services
 - Family planning services
 - Drug and alcohol abuse counseling*
 - Outpatient mental health services*
- Obstetrical services and family planning services
 - Pregnancy planning
 - Birth control
 - Prevention of sexually transmitted diseases
 - Confidential testing for venereal disease
 - HIV counseling and testing

- Abortion services
- Services from an Indian Health Services (IHS) provider
- “Limited Services”
 - Chiropractic
 - Podiatry
 - Acupuncture (Medicare non-covered benefit)
 - Prayer or Spiritual Healers (Medicare non-covered benefit)
 - Vision/Eyeglasses limited with Medicare

Medi-Cal members are limited to two office visits for each of these specialist services in a single month. For additional visits in a single month or for any procedures (other than office visits), the specialist provider must obtain preauthorization by submitting a TAR to HPSM (see section on “Prior Authorization for Medical Services” below).

Minor consent services: Member must be 12 years old or greater to be able to consent for drug and alcohol abuse treatment. Member must be 12 years old or greater and mature enough to consent and is the victim of incest or child abuse or would present a threat of serious physical or mental harm to self or other without treatment for outpatient mental health services.

RAFs Required - San Mateo County ACE Program

San Mateo County ACE is a program available to uninsured residents of San Mateo County who are not eligible for coverage through Medicare, Medi-Cal, private insurance or other third-party coverage. **ACE is a coverage program and is not considered health insurance.** Services are primarily available through the San Mateo Medical Center and Ravenswood Family Health Center. **A referral to other providers is only through the RAF process.**

Specialty Referral Process: PCPs

The HPSM Specialty Referral Process enables the Primary Care Physician (PCP) to coordinate the process by which his/her patients receive care from specialists (also known as referral providers). When a PCP identifies the need for a specialty referral, the PCP may refer the member to a participating specialist provider without a Referral Authorization Form (RAF). Referrals to non participating plan providers require a RAF from the PCP. To initiate the referral process, the PCP will complete a Referral Authorization Form which is available on the HPSM website www.hpsm.org Sample forms are attached in Section 10 of this manual and are available from your Provider Services Representative.

The Referral Authorization Form (RAF) is a valuable tool for physician case-management and control of specialty referrals. When in the opinion of the Primary Care Physician (PCP), a member needs to see a specialist provider; the member’s PCP will refer the member to a Specialist for consultation and treatment. The PCP is responsible for identifying the specialist provider and contacting the Specialist to assure that the

member will be seen on a timely basis and will make arrangements for follow-up with the PCP. The PCP will refer to Specialists who are contracted with HPSM. In cases where the contracted Specialists are not available, the PCP may seek the Plan's assistance in obtaining access to contracted Specialist Providers and/or the PCP may elect to refer to a Specialist that is non-participating (see "Referral to Non-Participating Providers" section below).

All of the following items in Part I of the RAF **must** be completed. If any of the following is missing or illegible, it will be returned to the PCP's office for completion/clarification. This will delay the processing of the RAF. The required information includes:

- Check the appropriate program on the left hand column (one box)
 - CareAdvantage
 - Medi-Cal
 - Healthy Families
 - HealthWorx
 - Healthy Kids
- Date of the referral
- PCP's name and provider number
- PCP's phone number
- PCP's fax number
- PCP's signature
- Member's name and date of birth
- Member's address and phone number(s)
- Member's ID number (please do not use the member's Social Security Number)
- Diagnosis and ICD-9 code
- Reason for referral
- Specialist's name
- Specialist's address
- Specialist's phone number

If the PCP also has the Specialist's fax number, that may be included, but it is **optional**.

In addition, there are two **optional** boxes located just above the area where the Specialist's name is indicated. These are the "**Consult only**" box and the "**Standing Referral for 1 Year**" box.

The "**Consult only**" box should only be checked if the PCP does not want the Specialist to determine the number of additional visits he/she needs in order to complete his/her treatment and evaluation of the referred member. **If this box is checked, any additional visit to the Specialist must be accompanied by a new RAF issued by the member's assigned PCP.** This optional box allows the PCP maximum control of Specialist provider visits. When a PCP issues a follow-up RAF for additional visits to the Specialist provider, please include in the "Reason for Referral" section that this is a follow-up visit.

The “**Standing Referral for 1 Year**” box should only be checked if the PCP has determined that the member has a chronic disease condition that requires the ongoing care of a Specialist for at least a period of 1 year. Chronic disease conditions that are eligible for standing referrals include:

- HIV infection/AIDS
- Chronic Hepatitis B/C infection
- Uncontrolled diabetes
- Uncontrolled hypertension
- Rheumatoid arthritis
- Parkinson’s disease
- Multiple sclerosis
- Other degenerative neurologic diseases
- Chronic obstructive pulmonary disease
- Asthma
- Congestive heart failure
- Chronic pain syndrome
- Chronic renal failure
- Cancer
- Other chronic conditions will be considered on a case-by-case basis. This list will be updated periodically.

Upon completion of the required elements in Part I, the RAF should be faxed to HPSM Health Services at (650) 829-2079. Upon receipt of the RAF, the PCP will receive an auto-reply message indicating that HPSM Health Services has received the RAF. Please note: The auto-reply will only work if the PCP’s fax number is not blocked. (If the PCP does not wish to receive an auto-reply message, the PCP should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) The auto-reply message will include a statement as to the number of pages received in that particular fax transmission as well as a copy of a portion of the first page of the fax. If the number of pages that HPSM receives is not the same number of pages that the PCP has sent, the PCP should resend the fax and indicate that the second fax is a “duplicate” or a “re-send.” If the PCP does not receive an auto-reply after faxing a RAF, HPSM Health Services did not receive the RAF. Please re-fax the RAF.

IMPORTANT: RAFs faxed to other fax numbers at HPSM **will not be forwarded to Health Services** and will not receive an auto-reply. Please use the HPSM Health Services fax line for RAFs.

RAFs can also be mailed to HPSM Health Services. HPSM Health Services mailing address is:

Health Plan of San Mateo
Health Services Department
ATTN: RAF Authorization
701 Gateway Boulevard, Suite 400
South San Francisco, California 94080

Mailed RAFs will not receive a response indicating that HPSM Health Services received the RAF.

How long does it take for HPSM to process a RAF?

RAF processing generally takes two (2) business days. If a PCP has arranged for the specialist provider visit and knows that the visit will occur within two (2) business days, then the PCP should fax the RAF to the HPSM Health Services Urgent Fax line: (650) 829-2021. RAFs received on the HPSM Health Services Urgent Fax line will also receive an auto-reply message (see above) and the RAF will be processed within four (4) business hours of receipt. The PCP must include the date of initial visit (under Part II) on the RAF. This date must fall within two (2) business days of the date of receipt at HPSM Health Services, or the RAF will be processed with the normal turn-around time.

PLEASE NOTE: Urgent RAFs will be end-dated on the date of initial visit as indicated on the RAF.

All RAFs are authorized for a single specialist provider visit within three (3) months from the date of receipt at HPSM Health Services (except for urgent RAFs, which are end-dated on the date of initial visit as indicated on the RAF). A specialist provider visit must occur within the three (3) month time period. If a PCP knows that the specialist provider visit will be beyond the three month time period, the PCP may extend the RAF expiration to the known date of the initial specialist visit. In order to do this, the PCP must complete the date of initial visit (under Part II) on the RAF. Upon receipt at HPSM Health Services, the authorization staff will end-date the RAF on the date of initial visit (under Part II) as indicated on the RAF. HPSM Health Services will send a report to the PCP listing all expired RAFs that have not had a specialist claim.

Upon receipt of a completed Part I RAF, HPSM Health Services authorization staff review the RAF for the following:

- Member eligibility
- RAF issuing PCP is PCP of record
- Specialist provider to whom the member is being referred is a participating provider

If the RAF meets all three criteria, then it will be authorized and an authorization number will be affixed to the RAF. No specialist referral by an eligible member's PCP of record to a participating specialist will ever be denied. The authorized RAF will be faxed to the

specialist provider's office as well as to the issuing PCP's office. PCP offices should not send unauthorized RAFs to the specialist provider's office since this generates confusion at the specialist's office and unnecessary phone calls to HPSM Health Services. HPSM Health Services will fax all authorized RAFs to the respective specialist's offices.

Specialty Referral Process: Specialist Providers

Upon receipt of an authorized RAF, the specialists should make the appointment with the member for the consultation. The specialist must check member eligibility on the date of service, as the RAF authorization is subject to member eligibility.

Unless either of the optional boxes ("Consult only" or "Standing Referral for 1 Year") is checked, after the initial consultation, the specialist can determine the number of additional visits required to complete the evaluation and treatment of the member's condition. This is limited to up to 12 additional visits within a 3 month time period. For visits beyond this limit, an additional RAF from the member's PCP will be required. The Specialist must complete Part II of the RAF and fax it to HPSM Health Services, in order to receive authorization for the additional visits.

Upon receipt of the faxed RAF, the Specialist will receive an auto-reply message indicating that HPSM Health Services has received the RAF. Please note: The auto-reply will only work if the Specialist's fax number is not blocked. (If the Specialist Provider does not wish to receive an auto-reply message, he/she should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) The auto-reply message will include a statement as to the number of pages received in that particular fax transmission as well as a copy of a portion of the first page of the fax. If the number of pages that HPSM receives is not the same number of pages that the Specialist has sent, the Specialist should resend the fax and indicate that the second fax is a "duplicate" or a "re-send." If the Specialist Provider does not receive an auto-reply after faxing a RAF, HPSM Health Services did not receive the RAF. Please re-fax the RAF.

IMPORTANT: RAFs faxed to other fax numbers at HPSM **will not be forwarded to Health Services** and will not receive an auto-reply. Please use the HPSM Health Services fax line for RAFs.

If the "Consult only" box is checked, the Specialist must request additional visits from the member's PCP. If the "Standing Referral for 1 Year" box is checked, the Specialist does not need to complete Part II of the RAF. A standing RAF will allow for unlimited Specialist visits within a period of 1 year from the receipt of the RAF at HPSM Health Services. Standing RAFs are only valid for the evaluation and treatment of members with chronic diseases (see list above). The Specialist Provider who accepts a standing RAF will be required to provide a report to the referring PCP at least on a quarterly basis, detailing the member's progress. This quarterly reporting is subject to auditing by the Medical Director, to prevent abuse of the standing referral policy.

The answers to frequently asked questions (FAQs) about the PCP Specialty Referral process are available in an HPSM publication entitled "PDF Instructions," available on the HPSM website www.hpsm.org or from your Provider Services Representative. In addition, information booklets about the RAF process are available for members in English and Spanish. Please ask your Provider Services Representative for more details.

Referrals to Non-Participating Providers

PCPs should make every effort to refer HPSM members to a participating provider listed in our provider directory. The HPSM provider directory, updated annually, is available on our website www.hpsm.org and also in hard copy format. Please ask your Provider Services Representative for a hard copy.

HPSM realizes that there are unique circumstances in which our participating provider network may not cover a particular specialized medical service that is medically necessary for evaluation and/or treatment of a member. In these situations, a referral to a non-participating provider may be authorized. Please indicate on the RAF the reason why a participating provider is unable to provide the requested service. If this information is not provided, the RAF processing may be delayed.

UCSF Medical Center and physicians belonging to the UCSF Medical Group are a special exception to the non-participating provider policy. At the request of UCSF, any referral to specialists at UCSF Medical Center or to a physician belonging to the UCSF Medical Group requires the authorization of Ms. Ruth Boerger, Manager, Medical Group Provider Services & Contracting, Office of Health Plan Strategy. Her number is: (415) 353-4454. If a referral is needed to UCSF, please contact Ms. Boerger and obtain her authorization, the date of authorization and name of the person obtaining the authorization **before** submitting the RAF to HPSM.

Automated Electronic Web-Based RAF Processing

An automated electronic web-based RAF processing program is currently being developed. This will be a HIPAA-compliant online referral authorization system which will allow PCPs to enter RAFs directly into the system and receive instantaneous authorizations. It will also allow Specialists to query the RAF system to ensure that a member's visit has been authorized. HPSM will notify providers when this system will be operational.

RAF Processing Status

In general, it takes two (2) business days for a properly completed RAF to be processed. When RAFs are authorized, the issuing PCP and the referred Specialist Provider are faxed a copy of the authorized RAF with the authorization number. If a PCP or Specialist has a question regarding the status of a submitted RAF, please contact HPSM Health Services at (650) 616-2079. Ask to speak to a RAF Authorization Specialist and they should be able to answer your question concerning RAF processing.

Administrative RAFs for Specialty Providers

For all product lines (CareAdvantage, Medi-Cal, Healthy Families, Healthy Kids and HealthWorx) there will be a RAF free holiday for in network referrals. The RAF free holiday does not apply to out of network referrals.

RAF requirements will resume upon notification by the HPSM. The following information is provided for reference only and will be updated over the next few months.

Under special circumstances, members may seek healthcare services from a specialist provider without a referral from their assigned PCP. Specialist providers may request that HPSM authorize these services by submitting an Administrative Referral Authorization Form (AdminRAF) to Health Services for approval.

The following are some examples that would require Plan authorization of Specialist Provider Services with an AdminRAF:

- A member was discharged from an Emergency Room within three (3) calendar days prior to a Specialist visit. This exception to the normal RAF rule is to allow for ER urgent referrals to specialists without the need for a PCP visit. If the Specialist visit is beyond three (3) days, it will require a regular RAF, issued by the member's PCP.
- A member is a resident of a long-term care facility and is unable to see his/her PCP for a RAF. In this case, a Specialist's visit may be authorized with an AdminRAF.

Requests for Plan authorization of Specialist Provider Services must be in writing, using the "Administrative Referral Authorization Form (AdminRAF)." The AdminRAF is downloadable from the HPSM website, under the Provider section. A copy of this form can also be found in Section 10. Completed AdminRAF forms may be faxed to the Health Services Department at (650) 829-2079. The AdminRAF must be received within thirty (30) calendar days of the service date.

All requests for Administrative Referral Authorizations are reviewed on a case-by-case basis by the Medical Director or designee.

Specialist Providers rendering healthcare services to members who qualify under the above listed situations, with an approved "Admin RAF," will receive fee-for-service reimbursement for their services. Please remember that it is the **medical provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to member's eligibility on the date of service.

Prior Authorizations for Medical Services

Prior Authorization is intended to ensure that the requested service is covered by the member's scope of benefits, that the provider of service is participating, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our Care Coordination programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service.

An authorization must be obtained from HPSM **prior** to rendering the requested service to ensure reimbursement (see "Retro authorization policy" section on page 15). Reimbursement is still subject to member eligibility on the date of service. Please check the member's eligibility before providing any service using any of the methods listed in Section 2 of this manual. In the event of an emergency, HPSM must be contacted within 24 hours, or on the next business day.

Medi-Cal, Healthy Families, Healthy Kids, HealthWorx: TAR requirements apply to these programs.

CareAdvantage Plan: There will be no authorization request requirement for the CareAdvantage Plan for the first six months, starting 1/1/2006 through 12/31/2009, except for DME, Skilled Nursing, inpatient transplants, non-emergency medical transportation and Home Health Care. All other services will be directly. Effective 7/1/2006, a authorization request (prior authorization) will be required for certain procedures following HPSM authorization guidelines. CareAdvantage requires ERs, hospitals and SNFs to fax admission face sheets upon admission of a CareAdvantage member. A tracking number will be issued and faxed back to the facility for billing purposes.

Where do I obtain a Treatment Authorization (TAR) Form?

For Medi-Cal members, please contact the State Medi-Cal Provider Support Center (PSC) office for 50-1 (outpatient) or 18-1 (inpatient) forms. They can be reached at (800) 541-5555. In addition, information on how to order these forms can be obtained through the State Medi-Cal website:

http://files.medi-cal.ca.gov/pubsdoco/pubsframe.asp?hURL=/pubsdoco/io_search.asp under "Inpatient Services (IPS)," Forms reorder request section.

For all other programs, please visit the HPSM website to download the 50-1 and 18-1 equivalent forms. Samples of these forms are included in Section 10.

For CareAdvantage members only, Emergency Departments, Hospitals and SNFs can use admission face sheets as a notification of admission.

What medical services require a TAR?

Prior authorization requirements for Medi-Cal, Healthy Families, Healthy Kids and HealthWorx generally follow State Medi-Cal guidelines. However, HPSM has lifted

some of the prior authorization requirements imposed by the Medi-Cal program in order to provide more efficient member access to these services. The lists of TAR required and TAR lifted procedures can be found on the HPSM website under the Provider Information section). Please note the list of TAR not-required procedures is exhaustive, but the list of TAR required procedures is not. Any procedure code that is not listed on the TAR not-required list can be assumed to be TAR required.

For those procedures that are TAR not-required, a TAR may or may not be required for an assistant. Please check the list for details. If the provider requests an assistant for a TAR not-required procedure, but the list indicates that an assistant is not automatically authorized, the provider will need to submit a TAR for the assistant. If a TAR not-required procedure is an inpatient procedure, the inpatient stay will be authorized by the on-site concurrent UM review nurse. These authorization requests should be submitted to the on-site concurrent UM review nurse on an 18-1 form or equivalent inpatient authorization request form.

In general, prior authorization is required for the following services:

- Inpatient Care - including hospital and rehabilitation services.
- Home Care and Home IV Therapy
- Hospice Care - General Inpatient
- Durable Medical Equipment, prosthetics and orthotics.
- Cardiac Rehabilitation after initial assessment (Note: HPSM physician referral required for the first visit.)
- Incontinence Supplies
- Services requiring Care Management Support: Care outside the HPSM service area
- Care at centers of excellence or specialty care centers. Specialists acting as the Primary Care Coordinator
- Transition of care situations for new members or for members when their provider has left the HPSM provider network (see section on "Continuity of Care")
- Biofeedback
- Physical Therapy/Occupational Therapy/Speech Therapy – initial evaluation does not require authorization but an HPSM physician prescription is required.
- Podiatry
- Chiropractic Services beyond the two services per month limit
- Advanced Imaging Studies: Pre-authorization is required for the following procedures when performed on an outpatient basis in Outpatient Hospital Facilities, Free Standing Radiology Facilities, and Non-Radiology Office-Based Settings: MRI, MRA, Nuclear Medicine, PET Scans and Obstetrical Ultrasounds (in excess of three (3) during a pregnancy) – see Section 5 – Ancillary Services – Diagnostic Radiology and Imaging for general criteria for MRI authorization.

Prior Authorization Process

Primary Care Physicians, specialty care providers and ancillary providers who identify a need for medical services for an eligible HPSM member that requires a prior authorization should complete a TAR form.

The TAR is to be used to document needed identification information. Depending on the complexity of the request, clinical information sufficient to make a medical necessity determination should be documented on this form. In most cases, a copy of a recent office note or consultation summarizing the medical needs of your patient will help us to rapidly process the request. Information, which can facilitate prior authorization determinations, includes the following elements, as relevant to each individual case:

- Patient characteristics such as age, sex, height, weight, or other historical and physical findings pertinent to the condition proposed for treatment
- Precise information confirming the diagnosis or indication for the proposed medical service
- Details of treatment for the index condition, or any related condition, including names, doses and duration of treatment for pharmacotherapy, and/or detailed surgical notes for surgical therapy
- Appropriate laboratory or radiology results
- Office or consultation notes related to the proposed medical service
- Peer-reviewed medical literature, national guidelines, or consensus statements of relevant expert panels
- The medical need for care by a provider outside of the HPSM network
- Applicable CPT-4 and ICD-9 diagnosis codes
- Complete facility and service information (including facility provider number and location)

Whenever possible, we ask that providers submit requests for prior authorization to HPSM seven (7) to ten (10) business days in advance of scheduled procedures. This will ensure that our Utilization Management staff have enough time to process and review your requests, and if needed, obtain appropriate additional information, without a need to potentially delay care to your patient. Fax all standard TAR request to fax number: (650) 829-2079.

Urgent Requests receive special attention. HPSM makes every effort to return authorization determinations quickly. Urgently needed care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the Medical Director if you have any concerns that our process is interfering with the care your patient requires. Urgent TARs may be faxed to the HPSM Health Services Urgent Fax line: (650) 829-2021.

The "Urgent" designation is intended for cases in which the requested service must be provided as quickly as possible to avoid harm to the patient. At times, requests may be received as urgent because elective services were scheduled, but authorizations were not requested in advance. We will do our best to respond to such requests but may

have to ask that such procedures be rescheduled if there is insufficient time to obtain the clinical information and complete the required review.

Definition of an “urgent TAR” is one in which the requested service is medically needed within three (3) business days of submission. Abuse of the Urgent Fax line will be monitored. Faxed urgent TARs will receive an auto-reply message upon receipt at HPSM Health Services indicating the number of pages received and will include a copy of a portion of the first page of the fax transmission. Please note: The auto-reply will only work if the provider’s fax number is not blocked. (If the provider does not wish to receive an auto-reply message, he/she should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) If the indicated number of pages received does not match the number of pages sent, please re-send the fax. If you do not receive an auto-reply message, then HPSM Health Services did not receive your fax. Please re-fax the urgent TAR.

IMPORTANT: Urgent TARs faxed to other fax numbers at HPSM **will not be forwarded to Health Services** and will not receive an auto-reply. Please use the HPSM Health Services Urgent Fax line for urgent TARs.

For questions regarding the status of a submitted TAR, or questions regarding the authorization process, you may call HPSM Health Services Department at (650) 616-2079. Calls are answered by Prior Authorization Assistants to facilitate communication of essential information. Peak telephone call volume typically occurs in the late morning or early afternoon on Mondays and Fridays. Telephone response times are generally best at other times of the day.

HPSM Health Services Department hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding company holidays. The Health Services Department is closed on Wednesdays 8:00 a.m. to 12 noon.

Completed Treatment Authorization Request (TAR) forms with supporting documentation should be mailed to:

Health Plan of San Mateo
Health Services Department
ATTN: TAR Processing
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Deferred or Extension of a TREATMENT AUTHORIZATION REQUEST (TAR)

Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx

After a submitted TAR is reviewed by a UM Review nurse and determined to require additional information in order to evaluate the medical necessity of the requested service, a notice will be sent to the originator of the TAR requesting the specific information needed. This notification will be sent within two (2) business days of reaching the decision to defer the TAR and in any case, no later than five (5) business days of receipt of the submitted TAR. The member is also notified of the deferral.

The provider has twenty-one (21) calendar days, from the date of the deferral notice, to respond to the deferral with the requested information. If no information is received or the information received does not address the requested information, the TAR will be denied. Providers will receive a second written request for the needed information approximately two (2) weeks prior to the twenty-eight (28) day deadline. Please respond to the request for additional information accurately and timely, as HPSM is only allowed to defer a TAR once. Notifications of a TAR administrative denial are sent to both the originator of the TAR as well as the member.

Denied TARs

TARs denied for medical necessity must be reviewed by the Medical Director. Medically necessary health care services are those services provided by a licensed health care provider to diagnose or treat an illness, injury, or medical condition which the HPSM Medical Director determines to be:

- Appropriate and necessary for the diagnosis, treatment, or care of a medical condition;
- Not provided for cosmetic purposes;
- Not primarily custodial care (including domiciliary and institutional care);
- Not provided for the convenience of the member, the member's attending or consulting physician or another provider;
- Performed in the most efficient setting or manner to treat the member's condition
- Necessary as determined by an order of the court;
- Being within standards of good medical practice as recognized and accepted by the medical community.

Non-acute care and treatment rendered when there is no reasonable expectation of the member's improvement or recovery as determined by the HPSM Medical Director, using generally accepted medical standards shall be considered not medically necessary. Denial letters will be issued in accordance with DMHC/DHS and CMS mandates and time frame standards.

Care Coordination Program

The HPSM Care Coordination program strives to proactively coordinate complex care to enable the best clinical and functional outcomes for our members. The Care Coordination staff work with members, their families, Primary Care Physicians (PCPs), specialists and community resources to coordinate a comprehensive plan of care. HPSM Care Coordination staff understands the benefits available to each member, and can facilitate the optimal use of those benefits.

The Care Coordination staff regularly assists providers and patients by providing for prospective, concurrent, telephonic reviews, and planning and care coordination services for patients confined to a hospital or a Skilled Nursing Facility, as well as for members receiving home care or rehabilitation services. These activities are provided on an episodic basis.

Not all patients benefit from Care Coordination services. Patients receiving care from a single physician often do not need an outside coordinator for that care. However, with increasing case complexity, and increasing numbers of loosely affiliated care providers, many patients with complex care needs benefit by having a designated Care Coordination staff member.

HPSM identifies cases for Care Coordination prospectively through health status surveys and referrals from care providers and concurrently through the analysis of claims and hospital admissions history. We also request that providers notify our Care Coordination staff of complex cases amenable to Care Coordination.

Once a case is identified, the Care Coordination staff will contact the treating providers to establish a case file. The Care Coordination staff member will work with the provider to coordinate services, identify benefits that have not been fully utilized and can advise the treatment team of important coverage limitations that may apply. Treating physicians are encouraged to call the Health Services Department and ask for the Care Coordination Manager to obtain assistance in arranging/coordinating care, or in advising on resources that might be available to meet a member's needs.

Care Coordination staff will generally become involved with:

- Inpatient Admissions - providing concurrent review, discharge planning and care management services
- Transfers to tertiary care facilities or centers of excellence;
- Admissions or referrals to non-participating providers or facilities;
- Members with ongoing care needs in a rehabilitation center, SNF or home care.
- Members with frequent ER visits;
- Continuing care following discharge against medical advice; and
- Members with ongoing complex care needs or high cost diagnosis including but not limited to:
 - End Stage Renal Disease Requiring Dialysis or transplant
 - Chronic Pain

- Multiple Sclerosis, ALS, and other debilitating neurologic conditions
- Hemophilia
- High Risk Pregnancies
- Cancer
- HIV/AIDS, chronic viral infections
- Coordination of care for members requiring services from community agencies such as: the Early Intervention Program through Golden Gate Regional Center, rehabilitation programs, TB treatment programs and HIV special needs programs.

Self-Referred Care

HPSM members who meet the criteria outlined below do not need a referral for the following health services provided through a participating provider:

Screening Mammography

The United States Preventive Services Task Force recommends a screening mammography every one to two years with or without clinical breast examination among women age 40 and older. HPSM covers screening mammography for women over the age of 40, and encourages women to discuss the potential risks and benefits of mammography with her PCP. Women members of HPSM may self refer for mammography after the age of 40. A participating diagnostic imaging provider must be used for this service. The testing center will require a prescription from a requesting physician.

OB/GYN Services

HPSM members may self-refer for routine primary and preventive OB/GYN services, care related to a pregnancy, or for the care of acute gynecological conditions, if that care is provided by a participating OB/GYN provider. HPSM will also cover the cost of care for conditions identified in the self referred visit. It is expected that the OB/GYN physician will send to the member's PCP a summary of the services and treatment plan as well as copies of screening (Pap smear, mammogram) or diagnostic tests performed.

Selected Routine Outpatient Diagnostic Services

The following procedures, when performed at a participating HPSM outpatient hospital or free-standing radiology facility do not require prior authorization. The ordering physician simply issues a prescription to the member and sends them to participating facility. The PCP simply sends a referral to the participating specialist for the service to be provided.

- Audiology evoked potential studies (limited service under CareAdvantage)
- Cardiac procedures (electrocardiography and cardiac stress tests)
- OB/GYN testing (fetal non-stress test, amniocentesis, cordocentesis, chorionic villus sampling, fetal contraction test, fetal scalp blood sampling)

- Neurological studies (electroencephalograms, EMG, nerve conduction studies)
- Pulmonary function tests
- Imaging services (routine x-rays, mammography, ultrasound) - These imaging services may also be performed at a participating HPSM freestanding Imaging/Radiology facility with a prescription from the referring provider and do not require prior authorization or a referral. **Please note:** *Pre-authorization by HPSM is required for the following procedures when performed on an outpatient basis in Outpatient Hospital Facilities, Free Standing Radiology Facilities, and Non-Radiology Office-Based Settings:*
 - MRI, MRA, Nuclear Medicine, PET Scans and Obstetrical Ultrasounds (in excess of three (3) during a pregnancy).

Medi-Cal, HealthWorx, Healthy Kids and Healthy Families Members have the option to self-refer for additional services listed below.

Family Planning

Members may self refer for family planning services through a participating provider. Family planning services include advice for birth control, pregnancy tests, sterilization, or an abortion, tests for sexually transmitted infections, HIV testing and counseling, a breast cancer exam or a pelvic exam. Medi-Cal members may go outside of the HPSM network to any provider that accepts Medi-Cal.

HIV Testing and Counseling

Members can self refer for HIV testing and counseling any time they have family planning services, or through one of the participating family planning providers. Medi-Cal members may go outside of the HPSM network to any provider that accepts Medi-Cal.

TB Diagnosis and Treatment

Members may self refer for TB Diagnosis and Treatment to a county public health agency for diagnosis and/or treatment. Members can choose to use either their HPSM provider or the county public health agency for diagnosis and/or treatment, including Directly Observed Therapy (DOT).

Immunizations

Members may receive immunizations through the PCP or self refer to public health clinics for immunizations. Public health clinics will make every effort to verify with the member's PCP that the member has not already received the immunization, and supply the health plan with documentation of services along with the claim.

Emergency and Urgent Care

The PCP is responsible for the care of their patients 24 hours a day, seven days a week. The PCP or designee must be available in their office or via phone or answering service to appropriately triage and evaluate all non-emergent care as defined in the "Access to Care and Services Policy" in Section 7 - Administrative Policies of this Manual.

HPSM members with a medical emergency should go to the nearest emergency room for care. HPSM provides coverage for emergency services that meet the "prudent layperson" standard without prior authorization of these services. In addition, HPSM will provide coverage for any ER service authorized by the PCP or HPSM authorized representative. The Member Contract requests that members notify their PCP and HPSM within 48 hours of receiving care for an emergency. Conditions that do not meet the specified definition of medical emergency below including urgent care services require a referral by the member's PCP.

HPSM and the prudent layperson standard defines a medical emergency as the sudden, unexpected onset of a medical or behavioral condition causing symptoms of sufficient severity that a prudent layperson with an average knowledge of medicine and health could reasonably expect, in the absence of immediate medical attention, to result in:

- Serious jeopardy to the afflicted person's life or health; or
- Serious jeopardy to the life or health of a pregnant woman's unborn child; or
- In the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or
- Serious impairment to the afflicted person's bodily functions; or
- Serious dysfunction of any bodily organ; or
- Disfigurement.

Some examples of Medical Emergency include: apparent heart attack/stroke, difficulty in breathing, severe bleeding, blackout, convulsions, apparent poisoning, or fracture. If a member self-refers to the emergency room, the HPSM Medical Director/designee will determine whether the presentation of symptoms was consistent with the above prudent layperson criteria and will state reasons in writing whenever this coverage is denied.

PCP notification is not required for emergency care but coverage can be ensured if the PCP authorizes such care. Please call the Health Services Department at (650) 616-2079 to notify us that you have authorized an emergency room service.

Long Term Care

Definition

Beginning February 1, 2010, HPSM is responsible for long term care (LTC) authorizations, utilization management and payment of facility room and board charges. Approximately 1,300– 1,400 HPSM members are residents of long term care facilities. HPSM has over 100 contracted LTC facilities in San Mateo County and surrounding counties. HPSM administers these services in accordance with current Medi-Cal guidelines.

HPSM is administratively and financially responsible for the authorization of LTC Treatment Authorization Requests (LTC TAR) for all Medi-Cal eligible beneficiaries with a County Code of 41 (San Mateo) and health plan number(HCP) 503. LTC nursing facilities send all TARs for services for facility room and board services provided to HPSM members to HPSM's Health Services Department. HPSM's Health Services Department processes TARs for members who require admission to LTC facilities, including free standing or distinct part Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), ICF/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N) or sub-acute Facilities-Adult/Pediatric. TARs are processed in accordance with the applicable requirements of the California Code of Regulations, Manual of Criteria for Medi-Cal Authorization, the California Welfare and Institutions Code and HPSM's Policies and Procedures in accordance with contractual agreements.

Financial Responsibility Related to LTC

The daily rate charge for LTC services is the responsibility of HPSM. The admitting facility is responsible for obtaining the necessary authorization for the facility daily rate from HPSM's Health Services Department according to the LTC TAR submission requirements. HPSM continues to be responsible for authorizing, monitoring, and reimbursing medically necessary Medi-Cal covered services that are not included in the daily rate.

Preadmission Screening Preadmission Screening and Resident Review (PAS/PASARR)

Each HPSM Medi-Cal recipient applying for Nursing Facility (NF) admission is subject to PAS/PASARR Level I screening or evaluation either prior to admission or on the first day for which HPSM Medi-Cal reimbursement is requested. The admitting NF is responsible for performing the evaluations. The admitting NF is also responsible for making a referral for Level II evaluation when appropriate. Welfare and Institutions Code Section 9390.5 has required Preadmission Screening for every Medi-Cal recipient applying for admission to a Nursing Facility to determine if the recipient's condition requires institutionalization in a NF or whether he/she could remain in the community with support services. The NF will utilize PAS/PASARR Level I Screening Document (DHS 6170), Long Term Care Treatment Authorization Request (Form 20-1), Minimum Data Set (MDS) Full Assessment Form) or Minimum Data Set (MDS) Quarterly

Assessment Form, and PAS/PASARR Monthly Statistical Report. The NF will comply with applicable regulations in the Code of Federal Regulations, the Medi-Cal Long Term Care Provider Manual, the Welfare and Institutions Code and Title 22.

Plan of Care in Long Term Care

All HPSM members admitted to LTC facilities shall have an individually written Plan of Care completed, approved and signed by a physician pursuant to Title 42, Code of Federal Regulations. The Plan of Care shall be maintained in the member's medical record at the LTC facility.

TAR Process and Criteria for Admission to, Continued Stay in, and/or Discharge from a SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, and Subacute Adult/Pediatric Facility

HPSM's Health Services Department will process all request for admission to, continued stays in, or discharge from any LTC facility in accordance with the California Department of Health Services (DHS) standard clinical criteria for levels of services. Each level of care TAR processing procedure will be in compliance with applicable regulatory requirements.

On Site TAR Review, Long Term Care

HPSM's Health Services Department may perform on site review for DP-NFs, Intermediate Care Facilities and sub-acute sites. On-site review may also be done at free standing NFs, when indicated; e.g., patterns of high service utilization, frequent acute hospitalization of members, large numbers of member complaints/concerns. TAR requirements will be in compliance with Title 22 California Code of Regulations and DHS Manual of Criteria for Medi-Cal Authorization.

Retroactive Authorization for TAR for Long Term Care Facility Daily Rate

HPSM's Health Services Department shall process all requests for LTC retroactive authorizations and or continued stays for HPSM members in an SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, sub-acute facility–adult or sub-acute facility-pediatric pursuant to the California Department of Health Services standard clinical criteria for a skilled level or care. The LTC will submit the request for LTC TAR with the required clinical information and completed forms to the HPSM Health Services by mail or fax in accordance with applicable requirements of the California Code of Regulations, Title 22.

Quality Improvement Activities for Long Term Care

HPSM's Quality Improvement program systematically manages the provision and continuous improvement in the quality and care of service provided to all HPSM members. Measures of quality care and service include the following: access to care, appropriateness of care, process of caring, health outcomes, and member and provider satisfaction.

Quality Assessment and Improvement (QAI) activities as related to members residing in Long Term Care facilities will comply with all state and federal requirements as specified

in the contract between the state and HPSM. The QAI program focuses on evaluation and improvement of the quality of member care in all settings or levels of care and with primary care and specialty physicians. HPSM is not responsible for any facility oversight as currently carried out by the California Department of Licensing and Certification, or for the California Department of Health Services Field office responsibilities related to the Inspection of Care Adults.

HPSM assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for members in LTC facilities including, but not limited to, CCS, Mental Health, and Golden Gate Regional Center. In addition communication to Licensing and Certification, Medi-Cal Operations Division and the LTC Ombudsman Office for potential quality of care issues may be a part of the QAI activities as indicated.

Complaints and Grievances

LTC facility room and board charges are a Medi-Cal benefit now administered by HPSM. All HPSM members and providers have access to HPSM's state-approved Complaint and Grievance process. Members also have access to the State Fair Hearing process at any time. The mechanism by which a LTC facility can resolve member or provider issues related to the provision of Medi-Cal facility services to HPSM members will be amended as needed to include the LTC program services.

Occurrence Reporting to Licensing and Certification

HPSM's Health Services and Quality Improvement Departments shall respond to occurrences, situations and complaints that affect or potentially affect the safety and well being of HPSM members in LTC facilities by reporting the events to the appropriate regulatory agency for investigation.

Process for Transferring Health Plan of San Mateo Members from Long Term Care Facilities to Acute Care Facilities

A LTC facility shall be responsible for coordinating an emergent/urgent transfer of a HPSM member to an acute care facility. A LTC facility shall collaborate with all appropriate multidisciplinary team members to facilitate either a planned or emergent/urgent transfer of a HPSM member from a LTC facility to an acute care facility. The LTC facility shall notify HPSM's Health Services Department of the admission of a HPSMM member to the acute care facility on the next business day.

Process for Transferring Health Plan of San Mateo Members from Acute Care Facilities to Long Term Care Facilities

The acute care facility in collaboration with HPSM shall be responsible for all discharge planning aspects of a HPSM member's transfer to a LTC facility. HPSM's Health Services Department shall assist in coordinating the discharge planning of the member from an acute care facility to a LTC facility. The acute care facility shall collaborate with all appropriate multidisciplinary team members to facilitate the transfer of the member. The admitting LTC facility shall notify HPSM's Health Services Department of the

admission of the member. The admitting LTC facility shall coordinate the medical and ancillary services with HPSM's Health Services Department and/or appropriate agency; e.g., California Children Services (CCS) and the local Regional Care Center, as appropriate.

Distinct Part Nursing Facility Authorization

The Hudman vs. Kizer court order applies to all eligible Medi-Cal recipients/HPSM members in need of long term skilled nursing care.

Distinct Part/Nursing Facilities (DP/NF) shall be reimbursed at the DP/NF rate when the medical necessity for long term nursing care has been documented and all administrative requirements have been met as described in the Department of Health Care Services (DHCS) Long Term Care manual.

Leave of Absence

A Leave of Absence (LOA) may be granted to a recipient in a Nursing Facility (NF) Level A or NF Level B, NF Level A-DD-N and NF Level A-DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined in the DHCS Long Term Care manual.

Leaves of absence may be granted for the following reasons: a) a visit with relatives or friends; b) participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons.

Bed Hold for Acute Hospitalization

If a recipient is admitted to an acute care hospital, a Bed Hold (BH) may be permissible under the conditions outlined in the DHCS Long Term Care manual.

Summer Camp Leave Bed Hold Reimbursement

Skilled nursing and intermediary care facilities may receive reimbursement for developmentally disabled (DD) recipients attending summer camp.

To qualify for reimbursement, the facility must meet the following criteria: a) the patient's attendance at camp is prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled; b) the patient is not discharged from the facility while attending camp; c) the facility holds the patient's bed during the period of absence; d) the term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year.

The bed hold will terminate and discharge status will take effect under the following circumstances: a) if a patient dies while at camp, the bed hold terminates on the day of death (discharged date is the day of death); b) if a patient is admitted to an acute care hospital from camp, the bed hold terminates on the day of departure from camp; c) if the patient leaves camp and does not return to the skilled nursing facility, the bed hold terminates on the day of departure from camp.

Patient Plan of Care

Skilled nursing and intermediate care facilities must include written Plans of Care in each patient's medical record.

Patient Plan of Care Requirements

Individual written plans are required by Title 42, Code of Federal Regulations (CFR) to be approved and signed by a physician. They should include: a) diagnosis, symptoms, complaints and complications; b) description of individual's functional level; c) objectives; d) orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures; e) plans for continuing care; and f) plans for discharge.

Skilled Nursing Facility Written Plan of Care

Before admission of a patient to a SNF or before authorization for payment, the attending physician must establish a written Plan of Care for each applicant or recipient in a SNF. The Plan of Care must include: a) diagnoses, symptoms, complaints, and complications indicating the need for admission; b) a description of the functional level of the individual; c) objectives; d) any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient; e) plans for continuing care, including review and modification to the Plan of Care; f) plans for discharge.

The attending or staff physician and other personnel involved in the recipient's care must review and sign each Plan of Care at least every 60 days.

Intermediate Care Facility Written Plan of Care

Before admission of a patient to an ICF or before authorization for payment, a physician or staff physician must establish a written Plan of Care for each applicant or recipient.

The Plan of Care must include: a) diagnoses, symptoms, complaints, and complications indicating the need for admission; b) a description of the functional level of the individual; c) objectives; d) any orders for: medications, treatments, restorative or rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objective of the Plan of Care; e) plans for continuing care, including review and modification of the Plan of Care; f) plans for discharge. The team must review and sign each Plan of Care at least every 90 days.

Child Health and Disability Program (CHDP)

Program Description

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

Effective July 1, 2010 HPSM is responsible for the processing and reimbursement of the PM 160 claims for all HPSM eligible Medi-Cal members. Providers will not submit claims to State CHDP for HPSM eligible Medi-Cal members.

Reimbursement

HPSM reimburses at the current the CHDP maximum allowable rates.

Claims and Claims Processing

Providers must use the *PM 160 Information Only* (brown form) for HPSM eligible Medi-Cal members. Providers will continue using the *PM 160* (green form) for Gateway eligible Medi-Cal beneficiaries and submit these claims to State CHDP for processing.

PM 160 claim information and payments are included in HPSM's regular Explanation of Payment (EOP). During claims processing, PM 160 claim codes are converted to their corresponding CPT codes and shown on the EOP service lines. PM 160 claim services lines are identified with Explanation Code CH "CHDP Claim – Paid at Maximum Allowable"

Mail completed *PM 160 Information Only* (brown forms) to:

Health Plan of San Mateo
Attn: Claims Department
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Section 8

Provider Services

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Introduction

The Provider Services Department is responsible for recruiting and credentialing providers; personal provider support; education and training; field visits to provider offices; provider issues resolution; and provider newsletters.

This Section discusses general HPSM provider information including provider rights and responsibilities, credentialing and contracting, provider training and communications.

Credentialing and Contracting

To become a provider in the HPSM network, the provider must sign a Medical Services Agreement (contract) and complete HPSM's credentialing process. The following describes the required steps for a physician/provider to complete this process:

1. Physician/Provider completes, signs, and returns the Medical Services Agreement, Application, HPSM's Addendum Application, Addendum B and Tax Payer Identification Form (W-9), and attaches copies of all information requested below, as applicable.
 - Copy of current Medical License or Business License
 - Copy of current DEA License
 - Copy of Professional Liability Insurance (Malpractice) face sheet (required limits are \$1,000,000 per occurrence/\$3,000,000 annual aggregate) for CareAdvantage providers
 - Copy of Property Comprehensive General Liability Insurance (Premises) face sheet (required limits are \$100,000 per occurrence/\$300,000 annual aggregate) for CareAdvantage providers
 - Copy of Professional Liability Insurance (Malpractice) face sheet (required limits are \$1,000,000 per person per occurrence) for Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx providers
 - Copy of Property Comprehensive General Liability Insurance (Premises) face sheet (required limits are \$300,000 per person per occurrence) for Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx providers
 - Completed and signed Attestation Questionnaire
 - Signed Release of Information/Acknowledgments Form
 - Curriculum Vitae
 - Copy of current Clinical Laboratory Improvement Amendments (CLIA) or Waiver (if applicable)
 - Copy of current Child Health and Disability Prevention (CHDP) Certificate (if applicable)
 - Copy of current Comprehensive Perinatal Services Program (CPSP) Certificate (if applicable)

- Copy of Educational Council of Foreign Medical Graduates (ECFMG) Certificate (if applicable)
 - Copy of current Board Certification from the American Board of Medical Specialties or American Board of Podiatric Surgery (if applicable)
2. The Plan verifies the information provided (National Provider Identifier, license status, etc.)
 3. The application and supporting documentation are reviewed by HPSM's Credentialing Specialist, Provider Services Manager, Health and Provider Services Director, Associate Medical Director and/or Medical Director and Executive Director.
 4. Upon approval of the above-mentioned parties, the Executive Director or Chairperson of the San Mateo Health Commission/San Mateo Community Health Authority countersigns the contract after approval of credentialing.
 5. The contract effective date shall be the first day of the month following countersignature by the Chairperson of the San Mateo Health Commission/San Mateo Community Health Authority.
 6. A copy of the completed contract is then returned to the physician/provider. A new provider orientation and training must be scheduled within 10 days of the credentialing approval.
 7. Primary Care Physicians and Referral Physicians must also have a site review, conducted by a HPSM Quality Improvement Nurse, before the credentialing process is finalized.
 8. Providers are re-credentialed every three years, based on the date of contract execution.

CONTRACTUAL REQUIREMENTS FOR CREDENTIALING AND REGULATORY COMPLIANCE

In your contract you agreed that you and any providers working for you are and will continue to be properly licensed by the State of California. Additionally, you represented that you are qualified and in good standing in terms of all applicable legal, professional and regulatory standards as a participating Medi-Cal provider. Physicians who are excluded from participation in Medi-Cal or Medicare programs by the U.S. Department of Health and Human Services may not provide services under the Medi-Cal, Healthy Families, Healthy Kids and HealthWorx programs.

As a contracted CareAdvantage provider, you agreed that you and any providers working for you are and will continue to be properly licensed by the State of California. Additionally, you represented that you are qualified and in good standing

in terms of all applicable legal, professional and regulatory standards as a participating Medicare provider. Physicians who are excluded from participating in Medicare programs by the U.S. Department of Health and Human Services may not provide services to HPSM CareAdvantage members.

Additionally, each applicable provider is required to maintain active medical staff privileges at one of the HPSM's contracted hospitals and all clinical privileges necessary to perform necessary services.

You are required to notify us within fourteen (14) calendar days in writing if the following actions are taken against you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification or clinical privileges.
- A peer review action, inquiry or formal corrective action proceeding, or investigation.
- A malpractice action or governmental action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action.
- Any material change in any of the credentialing information.
- Sanctions under the Medicare or Medi-Cal programs.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.

If you fail to meet the credentialing standards or, if your license, certification or privileges are revoked, suspended, expired or not renewed HPSM must ensure that you do not provide any services to our members. Any conduct that could adversely affect the health or welfare of a member will result in written notification that you are not to provide services to our members until the matter is resolved to our satisfaction.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION

Your contract references this certification in Section 2 of the Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx Agreements, and Section 6 of the CareAdvantage Agreement. HPSM qualifies as a contractor receiving funding from the Federal Government. Any such contractor is required to represent to the government that they and their subcontractors have not been debarred, suspended, or made ineligible. By completing and signing Section XVI (Attestation Questionnaire) and the Release of Information/Acknowledgements Form of the California Participating Physician Application, you certify that you are eligible to participate in our program and receive funds provided by the government. This form must be signed and returned with your agreement. Pursuant to this certification and your agreement with HPSM should you or any provider with whom you hold a sub contract become suspended or ineligible you

shall notify HPSM immediately.

General Rights and Responsibilities

For All Providers: Must render medically necessary services in accordance with the provider's scope of practice, the HPSM contract, the applicable benefit plan, HPSM's policies and procedures and other requirements set forth in the Provider Manual. Provider shall also openly discuss treatment options, risks and benefits with members without regard to coverage issues.

- Provider will participate in all programs in which the provider is qualified and has been requested to participate.
- Provider will not unfairly differentiate or discriminate in the treatment of members or in the quality of services delivered to members on the basis of membership in HPSM, age, national origin, sex, sexual preference, race, color, creed, marital status, religion, health status, source of payment, economic status or disability.
- Provider will provide grievance, disputes and appeals information as required by the California Department of Health Care Services and other appropriate regulatory agencies.
- Medical information shall be provided to HPSM, as appropriate, and without violation of pertinent State and Federal laws regarding the confidentiality of medical records. Such information shall be provided without cost to HPSM.
- Provider will actively participate in and comply with all aspects of HPSM's Quality Improvement and Utilization Management programs and protocols.
- Provider understands and acknowledges that various governmental agencies with appropriate jurisdiction's have the right to monitor, audit, and inspect reports, quality, appropriateness and timeliness of services provided under your contract with HPSM.
- Provider will comply fully and abide by all rules, policies and procedures that HPSM has established regarding credentialing of network providers.
- Provider will cooperate with HPSM's member grievance and appeals procedures.
- Provider remains responsible for ensuring that services provided to members by provider and its personnel comply with all applicable federal, state and local laws, rules and regulations, including requirements for continuation of medical care and treatment of members after any termination or other expiration of providers HPSM agreement. Nothing contained herein shall be construed to place any limitations upon the responsibilities of the provider and its personnel under

applicable laws with respect to the medical care and treatment of patients or as modifying the traditional physician/patient relationship.

- Provider will not advise or counsel any subscriber group or member to dis-enroll from HPSM and will not directly or indirectly solicit any member to enroll in any other health plan, PPO, or other health care or insurance plan.
- Provider will permit representatives of HPSM, including utilization review, quality improvement and provider services staff, upon reasonable notice, to inspect provider's premises and equipment during regular working hours.
- Provider will provide HPSM, within fourteen (14) calendar days of receipt thereof, notice of any malpractice claims involving any current or former members to which provider is a party as well as notice and information specifying settlement of adjudication within fourteen (14) calendar days of the provider being notified of such action.
- Provider agrees to comply with all applicable local, state and federal laws governing the provision of medical services to members.
- Provider will uphold all applicable Member Rights & Responsibilities as outlined in Section 2 of the Provider Manual.
- Provide for timely transfer of member clinical records if a member selects a new primary care physician, or if the provider's participation in the HPSM network terminates.
- Respond to surveys to assess provider satisfaction with HPSM and identifying opportunities for improvement.
- Participate on a Quality Improvement or Utilization Management Committee, or act as a specialist consultant in the utilization management or peer review processes.
- Notify HPSM in advance of any change in office address, telephone number or office hours.
- Notify HPSM at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with HPSM or with the participating provider or practitioner group. HPSM will assist in notifying affected members of termination and will assist in arranging coordination of care needs.
- Maintain standards for documentation of medical records and confidentiality for medical records.

- Provider agrees to retain all medical records for a minimum of ten (10) years from the last contracting period or last audit, whichever is latest.
- Maintain appointment availability in accordance with HPSM standards.
- Provider agrees that in no event including, but not limited to, nonpayment by HPSM, insolvency of HPSM or breach of providers agreement, shall provider or its personnel bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have recourse against a member or persons (other than HPSM) acting on the member's behalf. This provision shall not prohibit provider from collecting from members for co-payments, or coinsurance or fees for non-covered services delivered on a fee-for-service basis to members, provided that member has agreed prospectively in writing to assume financial responsibility for the non-covered services.

Primary Care Physician Rights and Responsibilities

The Primary Care Physician (PCP) is responsible for providing primary care services and managing all health care needed by HPSM members assigned to them. Maintaining an overall picture of a member's health and coordinating all care provided is key to helping members stay healthy while effectively managing appropriate use of health care resources. When providing primary health care services and coordination of care, the PCP must:

- Provide for all primary health care services that do not require specialized care. These include, but are not limited to: routine preventive health screenings, physical examinations, routine immunizations, child/teen health plan services (as appropriate), reporting communicable and other diseases as required by Public Health Law, behavioral health screening (as appropriate), routine/urgent/emergent office visits for illnesses or injuries, clinical management of chronic conditions not requiring a specialist, and hospital medical visits (when applicable).
- Maintain appropriate coverage for members twenty-four (24) hours a day, seven (7) days a week, and three hundred sixty-five (365) days a year.
- Provide timely access to care. Provider shall provide covered health care services in a timely manner appropriate for the nature of a Member's condition consistent with good professional practice and offer Members appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (D);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (D);

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (D) and (E);

(D) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member;

(E) Preventive care services, and periodic follow up care, including but not limited

to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the PCP acting within the scope of his or her practice.

- Refer all members for services in accordance with HPSM's referral policies and procedures. Documentation of the referral must be noted in the member's medical record. In the event there is no appropriate network provider or facility for a medically necessary covered service, the PCP shall contact the HPSM Medical Director for coordination of provision of such covered service. When medically necessary, and only with the prior approval of the Medical Director, unless otherwise required by law, referrals may be made to providers who have not contracted with HPSM.
- Provide services of allied health professionals and support-staff that are available in your office.
- Provide supplies, laboratory services, and specialized or diagnostic tests that can be performed in your office.
- Assure members understand the scope of specialty or ancillary services, which have been referred and how/where the member should access the care.
- Communicate a member's clinical condition, treatment plans, and approved authorizations for services with appropriate specialists and other providers.
- Provide access and information to sensitive services (i.e. family planning, sexually transmitted disease and confidential HIV/AIDS testing) and minor consent services
- Consult and coordinate with members regarding specialist recommendations.
- Safeguard member privacy and confidentiality, and maintain records accurately and in a timely manner.
- Ensure services are provided in a linguistic and culturally sensitive manner.
- Document in a prominent place in the medical record if a member has executed an advance health care directive.
- Maintain procedures to inform members of follow-up care or provide training in self care as necessary.

Referral Provider (Specialists) Rights and Responsibilities

When a member has been referred to a Referral Provider (Specialist), the Referral Provider is responsible for diagnosing the member's clinical condition and managing treatment of the condition, up to the number of visits identified on the referral authorization. When providing specialty care, the Referral Provider must:

- Keep the PCP informed of the member's general condition with prompt verbal and written consult reports.
- Obtain PCP authorization for subsequent referrals for tests, hospitalization, or additional covered services.
- Deliver all medical health care services available to members through self-referral benefits.
- Notify the member's PCP when the member requires the services of other specialists or ancillary providers for further diagnosis, specialized treatment, or if the member requires admission to a hospital, rehabilitation facility, skilled nursing facility or an outpatient surgical facility.
- Provide timely access to care. Provider shall provide covered health care services in a timely manner appropriate for the nature of a Member's condition consistent with good professional practice and offer Members appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (D);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (D);

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (D) and (E);

(D) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member;

(E) Preventive care services, and periodic follow up care, including but not limited

to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the PCP acting within the scope of his or her practice.

Primary Care Physician After Hours Coverage and Standards

All PCPs shall provide access to medical advice or treatment even when not in the office, including after hours, holidays and weekends.

HPSM requires PCPs to have twenty-four (24) hour coverage for their practices, seven (7) days a week, three hundred and sixty-five (365) days a year.

- PCPs shall provide HPSM with a list of the covering physicians.
- PCPs shall notify HPSM if the list of covering physicians changes and provide HPSM with the changes.

STANDARDS

- Provider shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the Member's condition, and that the triage or screening waiting time does not exceed 30 minutes.
- Provider shall maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff.
- Covering physicians should be contracted and credentialed by HPSM. If there are members of the coverage group that do not participate with HPSM, the participating practice must inform them of the HPSM policies and procedures (i.e., billing procedures, address, and prior approval). In addition when billing for services, the non-participating provider must clearly identify the name of the HPSM provider for which they are covering. All providers must make good faith efforts to ensure coverage by a HPSM provider. Non-contracted providers covering for HPSM providers are prohibited from balance billing.
- A method to communicate issues, calls, and advice, from covering providers to the PCP and the member's file, must be in effect at the time of coverage.

- This communication method should be documented or evidenced by policies and procedures.

EVALUATION

- HPSM staff or designees may ask for the instructions given to the answering service or to hear the after-hours message during site visits for medical record reviews. Clarity and content will be assessed by the above criteria.
- Evidence of adequate communication of coverage will be assessed at the site reviews.
- Quality Improvement staff or Provider Services Representatives will follow-up with offices regarding improvements or corrective actions when needed.

NETWORK ACCESS AND CAPACITY

HPSM will maintain a network of providers adequate to meet the comprehensive and diverse health needs of its members. It will offer an appropriate choice of providers sufficient to deliver covered services by determining that there are a satisfactory number of geographically and physically accessible participating providers.

GENERAL CONSIDERATIONS

Provider selection is based on the availability of providers meeting minimum criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act, and availability of culturally and linguistically competent staff to meet the needs of the member population. In the event that a participating physician is not available with the skills required to meet a member's needs, within the accessibility or mileage/timeframe standard, the plan will authorize a non-participating provider at no additional out of pocket expense to the member.

Provider Trainings and Communications

PROVIDER TRAINING

HPSM is responsible for the quality of care and satisfaction of its members as well as the satisfaction of its network of contracted providers. HPSM's Provider Services Representatives delivers all necessary topics of information to providers after acceptance as an HPSM contracted provider. In addition, Provider Services Representatives will perform educational training to providers on an ongoing basis.

ORIENTATION FOR NEWLY CONTRACTED PROVIDER OFFICES

Upon notification of a provider's acceptance in HPSM's provider network, the Provider Services Department will contact the office to schedule an orientation meeting. The

following items will be included in the orientation:

- HPSM overview
- Provider Manual
- Comprehensive Provider Directory
- Lines of business
- Authorizations and claims
- Member eligibility and verification
- Instructions for using HPSM's website and other helpful websites
- Provider dispute resolution process
- Quality improvement initiatives
- Special Programs
- Improving systems of care at the provider office level
- Reducing health disparities
- Language assistance programs for HPSM members
- HPSM contacts
- Forms

ONGOING PROVIDER TRAINING

HPSM contracted providers will be educated on new and updated operational and administrative policies and procedures. The ongoing education of providers will be achieved through provider newsletters/bulletins, broadcast fax, individual meetings, and/or group presentations. Ongoing provider training may include focused topics. Providers who have a change in office staff may request training for new staff members.

PROVIDER COMMUNICATIONS

HPSM values the importance of effective and open communication with its provider network. To ensure and encourage that all providers and HPSM are sharing information, the Provider Services Department provides the following services, including but not limited to:

- Provider Services Newsletter – “Health Matters MD” published bi-annually
- Broadcast Faxes
- Comprehensive Provider Directory
- Explanation of Payment (EOP) Inserts
- Printed Materials
- Direct Telephone Calls
- Provider Services Representative Office Visits
- Notifications and Correspondence
- Training Sessions
- Mailings
- Website: www.hpsm.org
- Provider Services Department Telephone: (650) 616-2106

Section 9

Quality Assessment and Improvement

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Introduction

The purpose of the Health Plan of San Mateo's (HPSM's) Quality Assessment and Improvement Program (QAIP) or Quality Program (QP) is to establish methods for systematically working to ensure that all HPSM members receive high quality health care and to help optimize their health status. Through the QP and in collaboration with HPSM providers, HPSM strives to continuously improve the structure, processes and outcomes of its health care delivery system.

HPSM's QP has a commitment to quality that relies on HPSM senior management oversight and accountability, and integrates the activities of all departments in meeting program goals and objectives. The QP involves members, participating providers, regulators, plan sponsors and evaluators in the development, evaluation, and planning of quality activities.

HPSM incorporates continuous quality improvement methodology that focuses on the specific needs of HPSM customers. It is organized to identify and analyze significant opportunities for improvement in care and services, to develop improvement strategies and to systematically track whether these strategies result in progress towards established benchmarks or goals. Focused QP activities are carried out on an ongoing basis to ensure that quality of care issues are identified and corrected. Quality studies and monitoring activities are reported through the quality committee structure to HPSM's governing body. The QAI Program Description is reviewed and updated annually and is posted on our website at: [www.hpsm.org/documents/providers/Quality Assessment and Improvement Program.pdf](http://www.hpsm.org/documents/providers/Quality_Assessment_and_Improvement_Program.pdf) Detailed information about the provider network, the quality initiatives, credentialing, site review statistics, and so forth, can be found in this document.

Provider Site and Medical Record Review

The purpose of the provider site and medical record review is to ensure that primary care providers, obstetricians/gynecologists (OB/GYN), and network referral providers are in compliance with applicable local, state, federal and HPSM standards. HPSM conducts provider site reviews for all new providers as a pre-contractual requirement prior to completion of initial credentialing. HPSM conducts provider site reviews triennially for Primary Care Providers and OB/GYN providers as a requirement of participation in the California Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications. This is a requirement of HPSM's contract with the State.

A full scope review is conducted utilizing the criteria and guidelines of the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD). The criteria is outlined in a 2002 Policy Letter¹ or updates, and summarized here. In addition to the criteria noted in the policy letter, supplemental criteria may be used by HPSM to address additional requirements applicable for quality studies. A full scope site review is not required automatically as a part of the re-credentialing process. Re-credentialing includes information from other sources pertinent to the credentialing process such as quality improvement criteria and may include medical record reviews.

Full Scope Facility Site Review

Initial Reviews

All primary care sites serving HPSM managed care members undergo an initial site review prior to completion of credentialing and assignment of members to the prospective provider. The schedule for performing a facility site review is determined by Quality Program staff and the prospective provider. It is based on the prospective credentialing date as well as the provider's availability and preference. A copy of the Site Review Survey Tool is mailed to each provider with notification of the review date. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

Recertification Reviews

Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with HPSM and Medi-Cal criteria and guidelines.

Moving to or Adding a New Site

Providers who move to a new site or open an additional office site must have a full scope site review at their new location. The site review must be completed as soon as

¹ (MMCD Policy Letter 03-02 Dated June 23, 2003, MMCD Policy Letter 02-03 Dated May 16, 2002, MMCD Policy Letter 02-02 Dated May 16, 2002 or superseding Policy Letter 96-6) Full Scope Site Review Survey and Medical Record Survey Tool.

possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), but no later than 30 calendar days after the date the new site was opened for business (or HPSM's notification date). The site review for relocated offices must be completed prior to the provider's re-credentialing date.

Adding a New Provider

Providers who move into an office which has a current site review will only require a medical record review to be credentialed.

When More Frequent Site Reviews May Be Necessary

HPSM reviews sites more frequently when it determines this to be necessary, based on findings from monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed pursuant to a request from the Peer Review Committee, the Quality Assessment and Improvement Committee, or the Commission. Additional reviews may also be done at the discretion of the Medical Director or the Quality Nurse, after discussion with the Medical Director, if patient safety or compliance with applicable standards is in question.

The Site Review Survey Tool is mailed to providers prior to an on-site audit. Relevant information is presented and shared with provider office staff at the time of the site review.

Medical Record Review

Ten (10) medical records are reviewed initially for each primary care provider as part of the initial site review process and every three years thereafter. During any medical record survey, reviewers have the option to request additional records for review. If additional records are reviewed, scores must be calculated as outlined below. Medical records of new providers are reviewed within 90 calendar days of the date on which members are first assigned to the provider. An extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient HPSM members assigned to complete a review of 10 medical records. If there are still fewer than 10 records for assigned members at the end of six months, a medical record review is completed on the total number of records available and the scoring is adjusted according to the number of records reviewed.

Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records are reviewed if two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.

Site Review Survey and Medical Record Scoring

A minimum passing score of 80% on **both** the Site Review Survey and Medical Record Review Survey is required. Scores are computed based on the following checklist of categories and assigned values:

Full Scope Site Reviews

Site Review Survey:

Access/Safety	29 points
Personnel	22 points
Office Management	25 points
Clinical Services	25 points
Preventive Services	13 points
Infection Control	27 points
Total	141 points

Medical Record Review Survey:

Format	80 points
Documentation	70 points
Continuity/Coordination	70 points
Pediatric Preventive (if applicable based on case mix)	50 or 100 points
Adult Preventive (if applicable based on case mix)	50 or 100 points
OB/CPSP Preventive (if applicable based on case mix)	50 points
Total	320 points

The Site Review survey is scored in the following manner:

1. Exempted Pass: 90% or above, *without* deficiencies in critical elements.
2. Conditional Pass: 80-89%, or 90% or above *with* deficiencies in critical elements.
3. Not Pass: below 80%

The Medical Record Survey is scored in the following manner:

1. Full Pass: 100%
2. Conditional Pass: 80-99%
3. Not Pass: below 80%

Critical Elements for Scoring

There are *nine critical elements* related to the potential for adverse effect on patient health or safety. These have a scored “weight” of two points. All other survey elements are weighted at one point. A full point is given if the scored element meets the applicable criterion. Zero points are given for any scored element that is considered only “partially” met by the reviewer. Zero points are given if an element does not meet criteria. The nurse reviewer determines the “not applicable” (N/A) status of each criterion based on the site-specific assessment. The reviewer must explain all criteria that are scored as zero or N/A.

The nine critical elements are:

- 1) Exit doors and aisles are unobstructed and egress (escape) accessible.
- 2) Airway management equipment, appropriate to practice and populations served, are present on site.

- 3) Only qualified/trained personnel retrieve, prepare or administer medications.
- 4) Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- 5) Only lawfully-authorized persons dispense drugs to patients.
- 6) Personal Protective Equipment (PPE) is readily available for staff use.
- 7) Needle stick safety precautions are practiced on-site.
- 8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazard non-sharps) are placed in appropriate, leak-proof, labeled containers for collection, processing, storage, transport or shipping.
- 9) Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results.

An acceptable corrective action plan must be submitted within 10 business days of the survey date for any deficiencies found during any monitoring visits for any of these critical elements. This is regardless of the survey score attained. Corrections must be made within 30 calendar days of the survey date.

Corrective Action Plans (CAPs)

Sites that receive an Exempted Pass (90% or above, *without* deficiencies in critical elements) are not required to complete a corrective action plan (CAP) unless determined necessary by HPSM. However, all sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) must complete an acceptable CAP to address the cited deficiencies.

HPSM staff provides a written report of site survey findings that specifies any deficiencies for all critical and non-critical elements. For all critical and non-critical elements requiring immediate correction, providers must submit an acceptable CAP that attests that corrections were completed within 10 business days of the survey date. Within 30 days of the survey date, HPSM staff verifies corrections of critical elements and other survey deficiencies requiring immediate correction. For all other non critical deficiencies, providers must submit an acceptable CAP by 30 calendar days from the date of the written CAP request.

Providers' CAP documentation must identify the specific deficiency, an acceptable plan of corrective action(s) needed, projected and actual date(s) of the correction, re-evaluation timelines/dates, and responsible persons(s). HPSM staff, with oversight by HPSM's Medical Director, will review the CAP to determine if it is acceptable. HPSM's Peer Review Committee may be consulted for advice on standards of practice issues as necessary.

If the CAP cannot be verified and approved within 60 days from the date of the written CAP request, an on-site visit may be scheduled. If the CAP cannot be closed, the provider will be referred to the Medical Director. The reasons for a late CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

Providers may request a time-specific extension period to complete corrections if extenuating circumstances that prevented completion of corrections can be demonstrated, and if agreed to by HPSM. (This period may not exceed 90 calendar days from the survey findings report and CAP notification date unless a longer extension is approved by the State of California Department of Health Care Services.). HPSM will perform a focused review at any site that required an extension period beyond 90 calendar days to complete corrections prior to closing the CAP.

Once a CAP is approved, it will be reviewed by the Medical Director as part of the Credentialing Review process.

Non-Passing Providers

A pre-contractual provider who scores below 80% on the full scope site review survey will not be recommended for credentialing completion or contract approval until a passing score is achieved and correction of any missed critical elements is verified. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the full scope site review survey. After achieving a score of 80% or higher, a CAP must be completed as previously described.

Contracted providers who fail the site review upon recertification survey are notified of the survey score, all cited deficiencies and CAP requirements at the time of the failed survey. Providers who do not complete a CAP that addresses the deficiencies completely will be referred to the Medical Director for review and possible referral to the Peer Review Committee. The reasons for an unacceptable CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

HPSM may suspend any contracted provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain in the provider network, survey deficiencies must be corrected by the provider and verified by HPSM staff within the CAP timelines previously noted. New members will not be assigned to the provider until a score of 80% is achieved on a subsequent full scope site review and required corrections are verified and the CAP is closed.

Non-Compliant Provider

Any network provider who does not comply with survey criteria within the established timelines will be subject to Peer Review action and may be recommended for removal from the network. In such an instance, HPSM members will be re-assigned to other network providers following plan policies and procedures.

Provider Appeal Process

Providers removed from the network may appeal the decision. HPSM has a formal process to resolve grievances submitted by providers. Please refer to Section 5 - Provider Disputes and Grievances for additional information. If verified evidence of corrections is accepted by HPSM and the removal decision is reversed, a Site Survey may be repeated. If the current survey and CAP are accepted, the site will be re-

surveyed no later than 12 months following closure of the CAP. If HPSM does not reverse the decision, and the provider would like to again become an HPSM provider, he/she may re-apply through HPSM's application process. As previously noted, all applicants must undergo and pass an initial Full Scope Survey.

Facility Site Focused Review

Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. The focused review is a "targeted" audit of one or more specific site or medical record review survey areas and is not substituted for the full scope survey. Reviewers may use appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review require the completion and verification of corrective actions according to CAP timelines previously described.

Facility Site Monitoring

HPSM staff monitors any contracted HPSM physician practice site between regularly scheduled full scope site review surveys. This may include visits for quality activities or follow up on member complaints. Indications of site deficiencies discovered through monitoring activities will require on-site inspection according to site review requirements. As a result, HPSM may schedule a full scope site review audit, conduct an additional focused onsite review, or conduct a medical record review. When non-compliance with the nine (9) Critical Elements is identified through monitoring processes, HPSM will determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner.

Healthcare Effectiveness Data and Information Set (HEDIS)

HPSM is required by the State of California Department of Health Care Services (DHCS) to perform quality measure studies for our Medi-Cal line of business and by the State Managed Risk Medical Insurance Board (MRMIB) for Healthy Families. The Centers for Medicare and Medicaid Services (CMS) require HPSM to perform quality studies for HPSM's CareAdvantage program as well. In addition, as the Third Party Administrator for the Access to Care for Everyone (ACE) program, San Mateo County's indigent care program, and insurer for the county's Healthy Kids program, HPSM collects quality measures for these programs also. The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers of health care services have the information they need to compare the performance of managed health care plans. DHCS, MRMIB and CMS use HEDIS measures as one way to assess how well HPSM is providing quality services for our members. The funders of Healthy Kids and ACE have asked that we use select HEDIS measures to demonstrate level of quality of care for these

populations as well.

There are two phases to each HEDIS study. HPSM's data analysts perform the first phase by examining HPSM's administrative data (e.g. claims data and enrollment information). This type of information may not fully reflect the actual care provided to our members when the services are capitated and not separately billed to HPSM. In phase two, HPSM staff, or contracted vendor staff, undertakes an extensive examination of the relevant members' medical records in provider offices. In these ways, data is collected that provides information to DHCS, MRMIB, CMS and San Mateo County about the level of clinical care, preventive care, access to care and utilization of services that HPSM members receive, based on claims and chart review data, in specific areas.

Clinical Practice Guidelines and Best Practices

Clinical practice guidelines help to improve the quality of care for our members by providing HPSM physicians with systematically developed, evidence-based best practice guidelines to assist both physicians and patients in decision-making regarding appropriate health care for specific clinical circumstances.

The practice guidelines used by HPSM are evidence-based; they have been developed using nationally recognized scientific evidence as published in peer reviewed journals, released by Specialty Societies or Academies or promulgated by national advisory committees.

The National Guidelines Clearinghouse (NGC) is the primary source of HPSM's guidelines. The NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, and was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America's Health Insurance Plans [AHIP]). By using guidelines from the NGC, HPSM ensures the "pedigree" and thus, the validity/reliability of the guidelines we promote to our providers.

The guideline topics and resources are evaluated and updated at least annually, with the input of HPSM's Physician Advisory Group (PAG), the Quality Assessment and Improvement Committee (QAIC) and any other interested HPSM provider. These are then disseminated to providers via HPSM's website and its provider newsletter.

The Clinical Practice Guidelines are listed on HPSM's website at www.hpsm.org and are as follows:

HPSM Clinical Guidelines:

Asthma guidelines

Decision making tools from HPSM and Institute for Clinical Systems Improvement

- Algorithm: Asthma Diagnosis and Outpatient Management
www.guideline.gov/algorithm/4295/NGC-4295.html
- Table: Approaching Asthma Diagnosis and Treatment
Source: www.hpsm.org/Documents/Providers/Approach%20to%20patients%20with%20asthma.pdf

Chronic obstructive pulmonary disease (COPD) guidelines

Decision making tool from the Institute for Clinical Systems Improvement

- Algorithm: COPD Diagnosis and Treatment
Source: www.guideline.gov/algorithm/4744/NGC-4744.html

Diabetes guidelines

Guidelines and notes developed by the California Diabetes Program

- Basic Guidelines for Diabetes Care and Notes
Source: www.hpsm.org/documents/providers/2005-06BasicGuidelinesandExplanatoryNotes.pdf

Heart disease guidelines

Recommendations from the National Heart Lung and Blood Institute

- Guidelines and tools: Detection, Evaluation, and Treatment of High Blood Cholesterol
Source: www.nhlbi.nih.gov/guidelines/cholesterol/index.htm
- Algorithm: Stages of Development of Heart Failure and Recommended Therapy
Source: www.hpsm.org/Documents/Providers/algorithm.ppt

High blood pressure guidelines

Recommendations from the National Heart Lung and Blood Institute

- Reference card: Detection, Evaluation, and Treatment of High Blood Pressure
Source: www.nhlbi.nih.gov/guidelines/hypertension/phycard.pdf
- Guidelines from the Institute for Clinical Systems Improvement
www.guideline.gov/summary/summary.aspx?doc_id=13481

Immunization guidelines

Recommended vaccination schedules from the Centers for Disease Control

- Table: Adult 2010 Immunization Schedule
Source: www.hpsm.org/documents/providers/Immunizations-Recommended_Adult_Schedule_2010.pdf
- Table: Child 0-6 Years Old Immunization 2010 Schedule
Source: www.hpsm.org/documents/providers/Immunizations-Recommended_Schedule_Child_0-6_2010.pdf
- Table: Child 7-18 Years Old Immunization 2010 Schedule

Source: www.hpsm.org/documents/providers/Immunizations-Recommended_Schedule_Child_7-18_2010.pdf

- Catch up Immunization 2010 Schedule for ages 4 months to 18 Years Old

Source: www.hpsm.org/documents/providers/Immunizations-Recommended_Catchup_Schedule_4mo-18_2010.pdf

- Immunization Updates from the Centers for Disease Control

Source: www.cdc.gov/vaccines/

Obesity guidelines for adults and children

Recommendations from the National Heart Lung and Blood Institute

Clinical Guidelines: Identification, Evaluation, and Treatment of Obesity in Adults

Source: www.nhlbi.nih.gov/guidelines/obesity/ob_exsum.htm

Tools for Calculating Body Mass Index

- Table: Body Mass Index for Adults

Source: www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm

- Calculator for Adults: Measuring Body Mass Index

Source: www.nhlbisupport.com/bmi/bmicalc.htm

- Calculator for Children: Ages 2 to 20: Measuring Body Mass Index

Source: www.shapeup.org/oap/entry.php

Sexually transmitted infections: guidelines and reporting form

- CDC Sexually Transmitted Disease Treatment Guidelines

Source: www.cdc.gov/std/treatment/default.htm

- Confidential Morbidity Report for STDs in San Mateo County

Source: www.co.sanmateo.ca.us/Attachments/health/pdfs/Public%20Health/cd_program/CMR/CMR_12_09.pdf

- San Mateo County STD Quarterly Report

Source: www.hpsm.org/documents/providers/STD-HIV_Quarterly_Report.pdf

Additional resources

National Guidelines Clearinghouse: www.guidelines.gov/

National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov/guidelines/index.htm

United States Preventive Services Task Force: www.ahrq.gov/clinic/uspstfix.htm

Quality Committees

HPSM has multiple avenues for physicians to contribute to its quality program. The most important way is through providing high quality and preventive care to HPSM members. Without our providers, HPSM could not offer services to our members. HPSM's Medical Directors and Provider Services Manager have an "open door" policy. Contact information is freely available to physicians. When any physician has a quality

improvement suggestion or a quality concern, they are encouraged to contact these or any other HPSM staff to share their thoughts, via phone, e-mail or letter.

There are also formalized ways for HPSM providers to participate in quality activities with the plan. These are through the San Mateo Health Commission quality advisory groups.

Physician Advisory Group (PAG)/Peer Review Committee (PRC)

Purpose/Responsibilities

- Serves in an advisory capacity to HPSM, providing community physician insight and feedback on the quality initiatives of the plan.
- Reviews areas in need of quality improvement identified via HEDIS or other comparable measurements and assists HPSM in developing potential interventions.
- After quality improvement initiatives are developed, provides feedback on the tools, materials, incentives, etc. that are developed to implement the initiative.
- As HPSM practicing physicians, provide real-world feedback on how they, their colleagues and their patients are accepting/participating in HPSM's quality initiatives, to help HPSM continuously improve its efforts and outcomes.
- The PRC meets regularly to review all HPSM credentialing recommendations, and to address HPSM credentialing concerns (e.g. when a potential provider does not appear to meet or no longer appears to meet HPSM credentialing requirements). The PRC meets confidentially to provide a peer-based resource for reviewing provider issues related to credentialing, quality of care issues or similar concerns.
- Where indicated, the PRC makes recommendations (e.g. regarding sanctions) to the San Mateo Health Commission for final decision-making. Any sanctions or actions affecting individual providers are protected by Evidence Code 1157.

Membership

- Committee membership is reflective of the provider network. It includes a physician member of the San Mateo Health Commission, a physician of the San Mateo Medical Center, a maximum of nine HPSM contracting physicians, the majority of whom are primary care physicians from the adult and pediatric community (representing care of adults and children) and at least three

specialists representing different disciplines.

Quality Assessment and Improvement Committee (QAIC)

Purpose/Responsibilities

- Serves in an advisory capacity to the Commission on the overall functions of the quality assessment and improvement process to ensure that activities are consistent with the purposes of the program.
- Reviews and makes recommendations about best practice clinical guidelines for quality of medical care and services.
- Provides input and feedback on the ongoing development and implementation of a systematic, comprehensive and integrated program for quality improvement activities, including review of the QP work plan and associated documents as applicable.
- Reviews quality activities, measurements, results, and follow-up related to quality improvement initiatives, assisting with the assessment of the overall impact of these efforts and identifying additional opportunities to improve care.
- Uses clinical and administrative experiences in their practice settings to advise the QP on ways to optimize quality activities internally at HPSM and externally in the provider network.

Membership

- Committee members include a physician member of the Commission, a public/consumer member of the Commission, a physician provider of the San Mateo Medical Center, a pharmacist, at least four additional physicians representative of the primary care physician community in San Mateo County, and two specialty physicians.

San Mateo Health Commission

Purpose/Responsibilities

- Delegates management of the QP to HPSM's Executive Director while retaining overall authority and responsibility for program implementation, continuity and effectiveness.
- Monitors QP strategies and activities outlined in HPSM's QP Annual Report/Evaluation and Work Plan, and at the time of any substantive revision.

- Monitors and reviews HEDIS results and establishes activities/opportunities for improvement
- Reviews the identification of Quality of Care issues and development of Quality Improvement Projects to establish interventions/activities
- Reviews quarterly reports about monitoring and evaluation activities performed as a result of the QP implementation, discusses these reports as necessary, raises any issues of concern and requests follow-up as indicated.
- Identifies opportunities to improve care and service, directs action to be taken, or resolves problems when indicated, independent of any other quality activities.

Membership

- Members are appointed by the San Mateo County Board of Supervisors and include: two members of the San Mateo County Board of Supervisors; the San Mateo County Manager or his/her designee; an HPSM contracted physician; a public representative of senior and/or minority communities in San Mateo County; a representative beneficiary served by the commission; a San Mateo County hospital staff physician; an HPSM contracted pharmacist, and a member of the public at large.

Quality Improvement Projects

HPSM is required by the State of California to conduct and/or participate in at least two Quality Improvement Projects (QIPs) annually. These projects may be based on HEDIS measures or other measures that have been identified by HPSM that require intervention to improve quality. Of the required QIPs, HPSM may choose plan specific measures, but must participate in a state-wide collaborative.

The Center for Medicare and Medicaid Services (CMS) requires HPSM to conduct a quality improvement project yearly as well. CMS dictates that each QIP run for three consecutive years and consist of three phases: baseline assessment, intervention, and evaluation.

Even when QIPs focus on member activities, they cannot succeed without our provider network participation, so HPSM always appreciates provider input and feedback on the QIPs. All QIPs are presented at the Physician Advisory Group and Quality Assessment and Improvement Committee meetings, as well, to ensure that the tools and interventions planned appear feasible and useful from a provider perspective.

A few of our ongoing QIPs are summarized below. A full description of HPSM's current QIPs is available on HPSM's website at <http://www.hpsm.org/providers/quality-programs/default.aspx>.

Reducing Avoidable Emergency Room Visits

HPSM is participating in the Medi-Cal Managed Care Division's collaborative to reduce avoidable ER visits. This collaborative, among the State of California and all 22 California Medi-Cal managed health care plans, will continue through 2011. Since 80% of ER use by Medi-Cal beneficiaries is for non-emergency health conditions and most of these avoidable visits are for URI-related symptoms in children, the campaign focuses on educating families on appropriate ER use by children less than nine years of age with URIs. The "Not Sure It's An Emergency?" brochures and posters, available in English and Spanish to all HPSM providers for their patients, advises patients to talk with their doctor about when to go to the emergency room and what to do if the doctor's office is closed. For brochures and posters, please contact Provider Services at (650) 616-2106.

A second component of the campaign involves HPSM partnering with a local contracted hospital to share data on avoidable ER visits of health plan members. The project explores whether notifying the member's primary care physician (PCP) and intervening with the member after an avoidable ER visit reduces avoidable visits. This is an ongoing project, and we hope to expand this pilot to other hospitals in San Mateo County in the future.

HPSM has also been piloting a Nurse Advice Line (NAL) for members who have San Mateo Medical Center clinics as their primary care provider. This effort is another intervention to try and reduce avoidable ER visits, with the hope that members will call the NAL for common problems when their clinic is closed instead of just going to the ER.

The Living Healthy Women's Program

The Living Healthy Women's Program supports women's efforts to stay healthy. The Living Healthy Women's Program provides the following services to HPSM's female members:

- Information and education about routine breast and cervical cancer screening exams
- Reminders if the member is overdue for a screening test
- Help in finding an HPSM gynecologist
- Emotional support and motivation
- A \$15 Target gift card incentive when a member has received a verified Pap test and/or mammogram

For Living Healthy Women's Program brochures or more information about the program call the Health Promotion Specialist at (650) 616-2173 or (800) 750-4776.

Improving Diabetes Management

Our diabetes management quality improvement program (QIP) aims to both assist providers as they work to achieve better health outcomes for HPSM members with diabetes as well as support diabetic members in managing their disease. The provider component of this initiative includes providing up-to-date clinical guidelines on diabetes management on the HPSM provider website, and also offering opportunities for provider input on tools for diabetes care at our Physician Advisory Group and Quality Assessment and Improvement Committee meetings. In January 2008, we instituted a new provider outreach and education campaign that includes a Pay for Performance (P4P) component for six key HEDIS-based diabetes care measures: retinal eye exam, kidney function test, hemoglobin A1c and LDL cholesterol tests, hemoglobin A1c test value of 8% or less, and LDL cholesterol test value of 100 or less. Our Medi-Cal P4P program is discussed in detail later in this chapter. Our hope is that in working together with providers, we can improve the comprehensiveness and timeliness of care that HPSM members with diabetes receive.

The member education component for improved diabetes management includes promoting free individual counseling and group diabetes self-management classes for HPSM members through our community partners, and sending targeted mailings of focused educational materials on diabetes to members with a diagnosis of diabetes.

Immunization Registry Program

HPSM is collaborating with the San Mateo County Health Department to facilitate the participation of providers in the Bay Area Regional Immunization Registry (BARR). BARR serves as a single population-based data source on immunizations for all health care providers in the Bay Area. The registry significantly reduces staff time by providing immediate access to complete immunization histories, even when shots were administered by different providers. It can be used to print out yellow cards as well as produce various vaccination reports. It also has an algorithm that will calculate and recommend the immunizations that are due at each visit.

Our goal is to have all San Mateo County children fully immunized by age two. HPSM has implemented a reminder system to support this goal. Providers who are participating in the registry receive a monthly list of their 18 month old patients who are past due for immunizations and are asked to follow up. These patients also receive a reminder postcard from HPSM. Additionally, HPSM has included participation in the registry as an incentive in our Medi-Cal Pay for Performance program.

Asthma Program

HPSM's Asthma Program has multiple components aimed toward increasing asthma control and decreasing morbidity of this chronic disease among our children and adult members with asthma. One component of our asthma program is to increase the use of inhaled corticosteroids (ICS) and decrease the use of/reliance on short-acting beta

agonist medications for members with persistent asthma. We identify members based on pharmacy claims data. If a member has received four or more refills of a short-acting beta agonist over the past year and has no history of ICS use, his/her assigned PCP is notified. PCPs receive a prescription form pre-printed with our preferred controller medication (QVAR) along with an asthma toolkit that contains provider tools and patient education materials.

To further expand our asthma program and improve clinical outcomes, we have developed an asthma registry that identifies our high risk members. If a member falls in our high risk classification, which is based on hospitalizations, ER visits, and medication usage, the assigned provider will receive a report that he/she can use to follow up with these members. Providers will also receive a packet of patient education materials and a referral slip if they would like HPSM's Health Educator to also follow up with the patient. We expect this level of care management with the provider to help improve health outcomes for our members. Additionally, completion of Asthma Action Plans is another important measure in our Pay for Performance program. We hope that this will encourage more comprehensive asthma care, and improve the self-management skills of our members.

Prenatal Care

HPSM's Prenatal Care QIP aims at improving the health of pregnant women and their babies. These outcomes are measured through the HEDIS timeliness of early entry into prenatal care, and the rate of post-partum visits. The program also has provider and member incentives to help achieve these outcomes. Providers can receive P4P incentives for meeting the HEDIS measures and members can receive gifts from the Prenatal Care Program for starting care within the first trimester, attending regular prenatal visits and completing the post-partum visit in the required timeframe (21-56 days after delivery).

Prenatal Care Program

The Prenatal Care Program encourages HPSM members to receive early and regular prenatal care. When the member's doctor has confirmed her prenatal care visits she will receive the following gifts.

- After the first prenatal care visit within the first 12 weeks of pregnancy, she will receive a \$15 gift card to Target.
- After three (3 months) of confirmed prenatal care visits she will receive the book, "What to Do When You're Having a Baby".
- After six (6) months of confirmed prenatal care visits she will receive a \$50 Target gift card.
- After a confirmed visit between 3-8 weeks after the birth (post-partum visit) she will receive a \$40 gift card to Safeway.

Prenatal Social Marketing Campaign-Go Before You Show

HPSM, the San Mateo County Family Health Services Department of the San Mateo County Health System and the Prenatal Social Marketing Committee, have collaborated on developing the Go Before You Show campaign. The committee looked at HEDIS data on timely entry into prenatal care and saw that a disparity existed in Latina, African

American and Pacific Islander communities in comparison to Caucasian women. This led to the development of the social marketing campaign, Go Before You Show (GBYS). The goal of the campaign is to create materials that reflect the culture and language of the women in these ethnic groups and in turn increase their early entry into prenatal care. A brochure and variety of posters were developed and available for display. The brochure and website include information on how to access Presumptive Eligibility (PE, or temporary Medi-Cal) so that women can access care as soon as they think they are pregnant.

For more information or to request materials please contact Liliana Ramirez at 650-616-2170.

You can view more information on the website: www.gobeforeyoushowsanmateo.org

Individual Health Assessment (IHA)

An IHA is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her PCP. HPSM is required by the California Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), the Centers for Medicare and Medicaid and funders of Healthy Kids to ensure that new members receive an Initial Health Assessment (IHA) within 120 days of becoming an HPSM member. HPSM encourages providers to use the DHCS Staying Healthy Assessment (SHA) tool to receive an additional incentive, and help meet this requirement (see below).

Assessment Components

The IHA consists of a comprehensive history, physical, mental status assessment and where age appropriate, developmental exam, diagnosis and plan of care, preventive services and the Individual Health Education Behavioral Assessment.

Staying Healthy Assessment (SHA) Tool

The Staying Healthy Assessment (SHA) Tool assists PCPs in:

- identifying and tracking individual health risks and behaviors
- targeting health education counseling interventions
- providing referral and follow-up.

The SHA tool should become a permanent part of the member's medical record and be referred to annually. When potentially high risk health behaviors are identified, PCPs are expected to ask appropriate follow-up assessment questions to identify patient's health education needs and facilitate focused educational counseling that addresses health behavior changes. If providers identify concerns that need additional evaluation, referrals to resources such as behavioral health, substance treatment, other specialty providers, etc should be made.

Facilitating health education intervention

Information provided on the Staying Healthy Assessment tool combined with the patient's medical history, conditions, problems, testing results, and other related factors, can help a provider recommend appropriate health education interventions. If a member is in need of a health education service that is not outlined in the HPSM provider manual, or quarterly list of Health Education Community Classes and Resources, the provider is encouraged to contact the Health Education Unit at (650) 616-2165 for information about other community resources.

Provider Incentive: Completing the IHA and the Assessment Tool Pay for Performance (P4P)

The Initial Health Assessment incentive is available for completing the IHA visit and administering the SHA tool within 120 days for Medi-Cal, Healthy Kids, Healthy Families and HealthWorx new members only.

HPSM will reimburse a flat amount (currently \$90.00) under these conditions:

- (a) The IHA is rendered within the first 120 days of a member becoming eligible for HPSM, and
- (b) An IHA has not been completed by another PCP within the last year for the same member.

New members are identified on the top of your case management list with an asterisk. *Please be aware that HPSM may not be able to notify you that you have a new member and verify the member's eligibility until 30 days after they have become eligible with HPSM. Thus, you would have 90 days after this notification to complete the IHA visit and SHA tool.*

To receive the P4P incentive, you need to bill using procedure (CPT) codes based on the member's age

(initial comprehensive preventive medicine):

- Code 99381: Under age 1
- Code 99382: Age 1-4 years
- Code 99383: Age 5 -11 years
- Code 99384: Age 12 -17 years
- Code 99385: Age 18 -39 years
- Code 99386: Age 40 -64 years
- Code 99387: Age 65 and older

Preventive care visits are not separately reimbursable for HPSM Medi-Cal PCPs

Subsequent preventive medical office visits for Medi-Cal members, including review and updating of the SHA, are an expected part of clinical care that a primary care provider renders, **and are reimbursed overall by the monthly capitation a provider receives.** The only exceptions are when additional services (such as an annual adolescent visit) are performed because these services are separately payable beyond the capitated amount providers receive monthly, as P4P incentives.

Who to contact for questions:

Staying Healthy Assessment (SHA) Tool - Liliana Ramirez, (650) 616-2170
Individual Health Assessment and P4P – Nicole Ford (650) 616 -2169
General Provider Questions - Provider Services (650) 616 – 2106

Adolescent Annual Well Visit Incentive

HPSM encourages adolescents ages 12-18 to receive an **annual** well visit once a year with his/her Primary Care Provider (PCP). Adolescents who receive a verified annual well visit from their PCP can get two free movie tickets to Century Theaters.

Please note: this is *in addition to* the periodic visits determined by CHDP. Do **NOT** confuse this incentive with CHDP. This annual incentive occurs in accordance with the periodicity guidelines of the American Academy of Pediatrics. Thus, providers should schedule these annual visits and the incentive **WILL BE PAID** if billed correctly to HPSM, separate from CHDP.

Components of a Well Visit

- Assessment of interval history, what has occurred since the previous well check-up with an evaluation of physical, behavioral and emotional growth and development
- Complete physical exam
- Age specific anticipatory guidance
- Medically necessary lab testing and immunizations
- Completion/review of age appropriate SHA tool (see above)

Provider Incentive for Annual Adolescent Well Visits

HPSM will reimburse \$90 for an annual adolescent well visit. Providers should bill using procedure (CPT) codes (comprehensive preventive medicine) based on the member's age:

- Code 99384 for a new patient, age 12-17
- Code 99385 for a new patient age 18
- Code 99394 for an established patient age 12-17
- Code 99395 for an established patient age 18

HPSM has helpful tools to assist the primary care provider in delivering teen-centered care, including bookmarks with HEADSS tips, health guidance folders for teens, etc. If you would like these materials, please call Health Education Services at 650-616-2165.

3 to 6 Year Old Well Child Annual Well Visit Incentive

HPSM encourages children ages 3 to 6 to receive a well visit once a year with his/her

Primary Care Provider (PCP). Children who receive a verified annual well visit from their PCP can get a \$15 Target gift card.

Please note: this is *in addition to* the periodic visits determined by CHDP. Do NOT confuse this incentive with CHDP. This annual incentive occurs in accordance with the periodicity guidelines of the American Academy of Pediatrics. Thus, providers should schedule these annual visits and the incentive WILL BE PAID if billed correctly to HPSM, separate from CHDP.

The components of a well child exam are the same as those listed above for adolescents. HPSM will reimburse \$90 for a well child exam for 3 to 6 year olds. To receive reimbursement, providers must bill with the appropriate CPT code and one of the associated ICD-9 codes below:

- CPT code:
 - 3-4 years: 99382 for new patients
99392 for established patients
 - 5-6 years: 99283 for new patients
99393 for established patients
- ICD-9 code: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

CareAdvantage Initial Health Assessments

HPSM is required to have each member complete an initial health assessment survey within 90 days of enrolling in CareAdvantage. The survey helps determine the member's health risk and whether the member should be enrolled into HPSM's Care Coordination programs. A PCP's members who are determined to be high risk based on the member's survey responses are referred to HPSM's Care Coordination Unit for admission into the Case Management program. HPSM contacts the PCP about this enrollment and notifies the member to make an appointment with the PCP as soon as possible, if there has not been a recent visit with the PCP. For members identified as moderate risk, HPSM contacts both the PCP and the member and recommends the member see his/her PCP within 30 days. For members identified as low risk, HPSM contacts the PCP and the member and recommends the member see his/her PCP within 60 days. The PCP is expected to appropriately case manage the member based on the risk assignment in conjunction with other information available to them.

Medi-Cal Pay for Performance (P4P) Program

In January of 2008, HPSM initiated the Pay for Performance (P4P) program to help focus its Medi-Cal primary care physicians' involvement on quality of care activities. The program replaced the former "risk surplus sharing" program, and financially aligns HPSM's interest in quality of care services and outcomes for our members with

physicians' commitment to quality of care in an ever-busy and demanding office practice environment.

Only Primary Care Providers (PCPs), Obstetricians (OBs) and Gynecologists (Gyns) contracted with HPSM's Medi-Cal line of business, where specified, are eligible to participate in the P4P program. The incentives apply to services performed for enrolled Medi-Cal members (including dual eligible Medi-Cal/Medicare members). Please contact the P4P Project Specialist at P4Phelp@hpsm.org or (650) 616-2169 for any P4P-related inquires.

Pay for Performance Incentives:

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Encounter Forms	<p>Bill each office visit with an HPSM member on the appropriate claim form.</p> <p>Note: Even though the member is capitated, send in a claim for this visit to get the incentive.</p>	<p>An incentive of \$3.00 per paper claim submitted</p> <p>An incentive of \$5.00 per electronic claim submitted</p>
Extended Office Hours	Offer extended hours in accordance with the requirements of the Medi-Cal PCP Contract.	An incentive of 10% of your monthly capitation payment.
Patient Auto-Assignment	Accept auto-assignment of patients in accordance with the requirements of the Medi-Cal PCP Contract.	An incentive of 20% of your monthly capitation payment.
Initial Health Assessment	<ol style="list-style-type: none"> 1. Perform an initial health assessment (IHA) of new members within 120 days of HPSM enrollment. (See <i>Components of an IHA</i> above) 2. Complete the Staying Healthy Assessment (SHA) Tool (or history form with approval from HPSM's Medical Director). 3. Bill the visit with the appropriate CPT code for a new visit. Coding tip sheet for IHA visits available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx 	An incentive of \$90 per claim .

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Annual Child Well Visit	<ol style="list-style-type: none"> 1. Perform an annual well visit for children <u>ages 3-6 years old</u>. 2. Complete the SHA Tool (or history form with approval from HPSM's Medical Director). 3. Bill the visit with the appropriate CPT code for a child well visit. Coding tip sheet for child well visits available at http://www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx 	<p>An incentive of \$90 per claim.</p> <p>Available once per eligible member per year.</p>
Annual Teen Visit	<ol style="list-style-type: none"> 1. Perform an annual well visit for adolescents ages 12-18 years old. (See <i>Components of a Well Visit</i> above) 2. Complete the SHA tool (or history form with approval from HPSM's Medical Director). 3. Bill the visit with the appropriate CPT code for an teen well visit. Coding tip sheet for teen well visits available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx 	<p>An incentive of \$90 per claim.</p> <p>Available once per eligible member per year.</p>
Women's Health Exam	<p>For Women 20-64 years old:</p> <ol style="list-style-type: none"> 1. Perform each of the following: <ol style="list-style-type: none"> a. Cervical (Pap smear) or vaginal cancer screening b. Full pelvic exam c. Clinical breast exam 2. Bill HPSM with procedure (HCPCS) code G0101 and an appropriate diagnosis code 	<p>An incentive of \$90 per claim.</p> <p>Available to you once per eligible member per year.</p>

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Asthma Action Plan	<ol style="list-style-type: none"> 1. Complete an asthma action plan (AAP) annually for any asthma patient with <u>persistent</u> asthma (adult or child) 2. Fax the completed AAP to HPSM at (650) 829-2071. 3. Bill HPSM with CPT code 99411 and modifier AP <p>Note: AAP forms available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx</p>	<p>An incentive of \$25 per AAP claim.</p> <p>Available once per eligible member per year.</p>
Body Mass Index (BMI)	<ol style="list-style-type: none"> 1. Measure the BMI of each of your patients (adult or child). 2. Complete a BMI form annually, provided by HPSM. 3. Fax the completed BMI form to HPSM at (650) 829-2009. <p>Bill HPSM with CPT code , modifier WT and the appropriate diagnosis code – see below for billing codes</p> <p>Note: BMI forms (Adult / Child) available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx For PCPs who see pediatric patients, growth charts are also available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx BMI wheels are available by contacting the P4P Project Specialist at (650) 616-2169 or P4Phelp@hpsm.org.</p>	<p>An incentive of \$25 per BMI claim.</p> <p>Available once per eligible member per year.</p>

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Referrals by PCP to OB physicians	<ol style="list-style-type: none"> 1. Identify pregnant women as early in pregnancy as possible. 2. Refer the pregnant woman to an OB provider immediately. 3. Help the pregnant woman make an appointment with an OB provider in the woman's first trimester. 4. Complete the HPSM OB referral verification form. 5. Fax the verification form to HPSM at (650) 829-2009. <p>Note: Verification forms available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx</p>	An incentive of \$50 for each verification form received.
OB Visit by OB physician	<ol style="list-style-type: none"> 1. See HPSM pregnant women as early in pregnancy as possible. 2. Accept referrals from PCPs or other entities to see HPSM pregnant women in their first trimester. 3. Complete the HPSM OB visit verification form. 4. Fax the verification form to HPSM at (650) 829-2009. <p>Note: Verification forms available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx</p>	An incentive of \$100 for each verification form received documenting a prenatal assessment occurred in the first trimester.
Postpartum exam by OB/Gyn physician	<ol style="list-style-type: none"> 1. Perform a postpartum exam for HPSM members within 21 to 56 days after delivery. 2. Bill HPSM with CPT code 59430, modifier PP and indicate the date of delivery in the remarks section of the claim. 	An incentive of \$50 per postpartum exam claim.

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Diabetes Program	1. Order and ensure completion of annual recommended tests/check-ups: HbA1C, LDL-C, retinal eye screening by an eye specialist, and nephropathy screening .	Receive an incentive for each test per patient once a year when HPSM receives lab results, clinical notes or claims, evidence that these tests have been completed, <ul style="list-style-type: none"> • HbA1C = \$30 • LDL-C = \$30 • Nephropathy screening = \$30 • Retinal eye exam = \$30

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
<p>Diabetes Program cont.</p>	<p>2. Monitor test results and achieve the following range:</p> <p><u>HbA1C</u></p> <p>Adults: < 8%</p> <p>Pediatric: Ages < 6: ≤ 8.5%;</p> <p style="padding-left: 40px;">Ages 6-12: ≤ 8%;</p> <p style="padding-left: 40px;">Ages 13-19: ≤ 7.5%</p> <p><u>LDL-C < 100</u></p> <p>Note - Blood and Urine Tests/Results: HPSM is working diligently to get lab results directly from our hospital labs and the most utilized private outpatient labs. This is an ongoing project.</p> <p>Note - Other Evidence of Nephropathy Screening: Treatment with an ACE or ARB inhibitor is considered de facto evidence of nephropathy screening. A chart note* or copy of a prescription* of these medications faxed to HPSM at (650) 829-2009 serves as evidence of this component.</p> <p>Note - Evidence of Ophthalmology Screening: If a patient's ophthalmology consultant bills HPSM for a retinal eye exam, that will be sufficient evidence of the screening. Documentation in the patient's chart of a consult note from the specialist indicating this test was done and faxed to HPSM at (650) 829-2009 also serves as evidence of this component.*</p>	<p>Receive an incentive for each result per patient once a year when HPSM receives lab results have the HbA1C and LDL-C in the desired ranges,</p> <p>HbA1C result = \$65</p> <p>LDL-C result = \$65</p> <p>*Any lab results, chart notes or prescriptions faxed to HPSM must be signed and dated to be eligible for the incentive.</p>

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Immunization Registry	<p>1. Any PCP caring for pediatric patients needs to join the San Mateo County Immunization Registry. Contact Daisy Liu at (650) 616-2156.</p> <p>2. After a practice is signed up and trained, each patient's record must be entered and updated in the registry with each new immunization administered.</p> <p>Note: The \$500 startup payment is a onetime incentive.</p>	<p>After your practice is signed up, trained, on board, and actively using the registry for at least 2 months, you will get an incentive of \$500.</p> <p>Once you are actively updating patient records, you will get an incentive of \$1.00 for every HPSM Medi-Cal member ages 0-19 years old per month.</p>

Incentive Billing Summary

Below are tables of the procedure (CPT) and diagnosis (ICD-9) codes necessary to bill for some of the P4P incentives.

P4P Incentive Billing Procedure Codes:

Incentive	CPT Code	Modifier	Description	Pay
Body Mass Index (BMI)	99411	WT	Incentive payment for completing and submitting BMI forms to HPSM	\$25
Asthma Action Plan (AAP)	99411	AP	Incentive payment for completing and submitting AAP forms to HPSM	\$25
Postpartum Exam	59430	PP	Incentive payment for providing a postpartum exam within 21- 56 days after delivery. Indicate the date of delivery in the remarks section of the claim.	\$50
Child Well Visit	99392	—	Established Patient, Child (Age 3 - 4 years) – Well Visit	\$90
	99393	—	Established Patient, Child (Age 5 - 6 years) –Well Visit	\$90
Teen Well Visit	99394	—	Established Patient, Adolescent (Age 12-17 years) – Well Adolescent Visit	\$90
	99395	—	Established Patient, use for 18-21 year olds – Well Visit	\$90
Initial Health Assessment (IHA)	99381	—	Initial Comprehensive Preventive Visit (Under 1 year of age) – 1 st Well Baby Visit	\$90
	99382	—	New Patient, Early Childhood (Age 1 - 4 years) – Well Baby Visit	\$90
	99383	—	New Patient, Late Childhood (Age 5 - 11 years) – Well Child Visit	\$90
	99384	—	New Patient, Adolescent (Age 12 - 17 years) – Well Adolescent Visit	\$90
	99385	—	New Patient, Adult (Age 18 - 39) – Well Adult Visit	\$90
	99386	—	New Patient, Adult (Age 40 - 64) – Well Adult Visit	\$90
	99387	—	New Patient, Adult (Age 65+) – Well Adult Visit	\$90

Body Mass Index (BMI) diagnosis (ICD-9) codes:

ADULT Body Mass Index (BMI)

BMI adult codes are for use for persons **over 20 years old** and **some require 5 digit specificity**.

BMI	ICD-9 Code
< 19	V85.0
19-24	V85.1
25.0-25.9	V85.21
26.0-26.9	V85.22
27.0-27.9	V85.23
28.0-28.9	V85.24
29.0-29.9	V85.25
30.0-30.9	V85.30
31.0-31.9	V85.31
32.0-32.9	V85.32
33.0-33.9	V85.33
34.0-34.9	V85.34
35.0-35.9	V85.35
36.0-36.9	V85.36
37.0-37.9	V85.37
38.0-38.9	V85.38
39.0-39.9	V85.39
40+	V85.4

PEDIATRIC Body Mass Index (BMI)

Note: BMI pediatric codes are for **persons 2-20 years old**. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC) All diagnosis codes **require 5 digit specificity**.

BMI Percentile	ICD-9 Code
< 5th % for age	V85.51
5% to < 85% for age	V85.52
85% to < 95% for age	V85.53
≥ 95% for age	V85.54

Diagnosis Codes to use with IHA and Adolescent Well Visits:

ICD-9 Code	Definition
V20.2	<ul style="list-style-type: none"> • Routine infant or child health check • Developmental testing of infant or child • Immunizations appropriate for age • Routine vision and hearing testing
V70.0	<input type="checkbox"/> Routine general medical examination at a health care facility
V70.3	<ul style="list-style-type: none"> • Other medical examination for administrative purposes • General medical examination for: <ul style="list-style-type: none"> ○ Adoption ○ School admission ○ Sports competition ○ Camp ○ Driver's license ○ Immigration and naturalization ○ Insurance certification ○ Marriage
V70.5	<ul style="list-style-type: none"> • Health examination of defined subpopulations <ul style="list-style-type: none"> ○ Preschool children ○ School children ○ Students ○ Inhabitants of institutions • Occupational health examinations • Pre-employment screening • Armed forces personnel
V70.6	<ul style="list-style-type: none"> • Health examination in population surveys
V70.8	<ul style="list-style-type: none"> • Other specified general medical examinations • Examination of potential donor of organ or tissue
V70.9	<ul style="list-style-type: none"> • Unspecified general medical examination

Pay for Performance Reports

Each quarter, PCPs receive a P4P report that details their progress in the program. The report indicates how much money they have received in incentives and how much money they can still earn within the calendar year. The report also includes lists of members whom the provider has billed or submitted a form/documentation for the incentive as well as lists of members who are still eligible for incentives that calendar year.

These reports serve as a “registry” in each area of the quality initiatives for providers. They inform HPSM’s physicians participating in the P4P program of 1)who your patients are with a particular diagnosis (e.g. asthma, diabetes); 2)which members have had a particular intervention and who have not (e.g. received an asthma action plan or had a HbA1c) OR whether or not you have billed HPSM for something you have done (e.g. BMI).

This information helps to provide you with a plan of action so that you know which of your health plan members have specific conditions, and so you can better manage your patients with specific chronic conditions.

If you have any comments, suggestions or ideas for how to improve HPSM’s P4P

program, please contact our P4P Project Specialist at P4Phelp@hpsm.org or (650) 616-2169.

Section 10

Health Education and Cultural, Disabilities & Linguistic Services

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Introduction

At the Health Plan of San Mateo (HPSM) we believe that healthy is for everyone. We offer a variety of health education classes and materials to help our members learn how to live well and be healthy. Topics include asthma, diabetes, weight management, pregnancy, and smoking cessation.

Health Education Classes

The HPSM Health Education Resource Guide is published biannually and mailed to members and providers. It contains information about classes, support groups, member incentive programs, and some community resources. Please encourage your patients to sign up to classes appropriate for them. **The medical literature confirms that if a patient's physician recommends health classes or healthy behavior changes to the patient, he/she is more likely to make that change than if the patient is left to try and initiate the change by him/herself.** Encourage your patients to make healthy changes!

Providers may refer members to HPSM's health education resources by having them call the number listed in the Health Education Resource Guide or contact HPSM's Health Educators to obtain a copy of the Resource Guide. **Prior authorization is not required.**

Below is a sample of classes available. To obtain a complete listing, visit www.hpsm.org or contact our Health Educators at (650) 616-2165 or healthedu@hpsm.org.

Asthma

The Asthma class is designed to help members learn how to control their asthma and feel better. Topics covered include asthma physiology, early warning signs, symptoms, triggers, medicines, peak flow meters, spacers, and asthma action plans.

- Sequoia Hospital, Redwood City, (650) 367-5550
- Seton Hospital, Daly City, (650) 991-6776
- Kaiser Permanente, Daly City, (650) 301-4450, for pediatrics only

Childbirth Preparation

Childbirth classes provide our pregnant members with a wealth of information about pregnancy, childbirth and early parenting. Members learn about breathing, relaxation techniques, pain management options, the role of a coach, hospital procedures, and what to expect before, during, and after delivery.

- Mills Health Center, San Mateo, (650) 696-5600
- Sequoia Hospital, Redwood City, (650) 368-2229
- Seton Hospital New Life Center, Daly City, (650) 301-8875
- St. Luke's Hospital, San Francisco, (415) 626-2229

Child/Adolescent Weight Management—In English AND Spanish

HPSM provides children and adolescents ages 6-18 with the opportunity to enroll in the **Shapedown** program at no cost. Shapedown focuses on promoting family support as the key to making gradual lifestyle changes without adopting a depriving diet. It is medically proven and effective for children and families who complete the program. Family members receive a comprehensive family assessment to determine specific needs. Then weekly classes are held to support lifestyle changes. Call (650) 616-2162 for more information.

Update: HPSM is NOW offering Shapedown in **Spanish!** You can refer your Spanish-speaking families to Shapedown as well as English-speaking families. Classes are being scheduled in both languages, call (650) 616-2162 to enroll your patients!

Diabetes

Members recently diagnosed with diabetes or who are having difficulty following diabetes health guidelines are good candidates for group education or individual nutrition counseling. The goal is to improve the member's knowledge, skill level and motivation for diabetes self-management. A doctor's referral is required to see a dietitian.

- Mills Health Center, San Mateo, (650) 696-4089
- San Mateo Medical Center, San Mateo, (650) 573-2481
- Sequoia Hospital, Redwood City, (650) 367-5213
- Seton Hospital, Daly City, (650) 991-6607
- St. Luke's Hospital, San Francisco, (415) 641-6826 (individual counseling only)

Diabetes in Pregnancy

The following programs are especially designed for pregnant women with diabetes. The programs include individual counseling with a dietitian and nurse.

- Sweet Success, Sequoia Hospital, Redwood City, (650) 367-5213
- Sweet Success, Peninsula Medical Center, Burlingame, (650) 696-5469

Physical Activity

HPSM members who are interested in physical activity are referred to San Mateo County Park and Recreation Department programs. For more information, contact our Health Educators at (650) 616-2165 or email healthedu@hpsm.org.

Smoking Cessation

The goals of the Smoking Cessation classes offered to HPSM members are to educate

and guide members through a process which helps them make a decision to quit and provides techniques to help make their efforts successful. Members also learn about the health risks of tobacco and second-hand smoke. Classes address issues of stress reduction, barriers to quitting, weight management, relapse, nutrition and exercise.

Nicotine Replacement Therapies

Nicotine patches and gums are covered for HPSM members at no charge. Members may only receive the smoking cessation therapies if they have verification of participation in a smoking cessation program. The use of the nicotine patch or gum requires a physician's prescription for one six week supply per year. Nicotine replacement therapy in excess of six weeks per year requires a prescription and prior authorization. For more information call the Health Education Unit at (650) 616-2165.

- Breathe California, (650) 994-5868
- California Smokers Helpline, (800) NO-BUTTS (English line)
(800) 456-6386 (Spanish line)

Health Education Materials

At HPSM, we place a great emphasis on primary prevention in all our work because we believe preventing a disease is the most effective way to keep a person healthy. The key point of contact to reach our members is when they are in the doctor's office. We strongly encourage our providers to distribute health education materials to patients during office visits.

We try to make the process of obtaining health education information easier by creating different ways members can communicate with us. Our members can call us, email us, complete our online request form, or obtain some of these resources from their provider offices.

We have brochures available in English and Spanish.

- Asthma
- Birth Control
- Breast Health
- Children's Health
- Diabetes
- Drugs/Alcohol Use
- Healthy Aging
- High Blood Pressure
- High Cholesterol
- Immunizations
- Men's Health
- Nutrition
- Pregnancy
- Prenatal Care
- Smoking Cessation
- STDs
- Weight Management
- Women's Health

Additionally, there is a section on our website containing *Take Action* messages on various health topics that will educate members on key behavioral changes or actions that will improve their health or keep them healthy.

Member Newsletter

Health Matters is HPSM's quarterly member newsletter. It includes articles on a variety of topics to help keep our members healthy. We have a special section called *Ask Dr. G* where HPSM's Medical Director answers general health questions submitted from our members. One or two questions are selected to be published in each newsletter. To view current and past issues of *Health Matters*, visit www.hpsm.org

Member Incentive Programs

HPSM offers incentives to members to promote the adoption of healthy behaviors, such as obtaining healthcare services in a timely manner and attending health education classes. All of our member incentives are part of health promotion programs that are tied to our quality initiatives. For more information regarding specific member incentives, please contact our Health Educators at (650) 616-2165 or healthedu@hpsm.org.

Prenatal Care Program

The Prenatal Care Program rewards HPSM's pregnant women for getting early and continuous prenatal care. HPSM pregnant members may enroll in the program and receive free gifts throughout their pregnancy. For more information about the Prenatal Care Program or to enroll a member, call the Health Promotion Specialist at (650) 616-2173.

The Prenatal Care Program provides:

- Referral to Ob/Gyn providers.
- Information and pamphlets about pregnancy, fetal development, nutrition, breast-feeding, infant safety, danger of alcohol, drugs and cigarette smoke.
- Referral to community resources.
- Referral to childbirth education classes.
- Information to help mom choose a pediatrician before the baby is born.

Member Incentives

- After receiving a prenatal visit within the first trimester (within first 12 weeks of pregnancy) the member receives a \$15 Target gift card
- After receiving three months of confirmed prenatal care visits, the member receives a book, *What To Do When You're Having a Baby*.
- After six months of confirmed prenatal care, the member receives a \$50 Target gift card.
- After receiving the postpartum visit (within 3-8 weeks after delivery), the member receives a \$40 Safeway gift card.

The prenatal and postpartum visits must be verified by the member's Ob/Gyn providing care during the pregnancy in order to receive the incentives.

Diabetes Management

HPSM members with diabetes can receive free individual counseling and group diabetes self-management classes through our community partners.

The Living Healthy Women's Program

The Living Healthy Women's Program supports women's efforts to stay healthy. It provides the following services to HPSM female members:

- Information and education about routine breast and cervical cancer screening exams
- Reminders if the member is overdue for a screening test
- Help in finding an HPSM Gynecologist
- Emotional support and motivation
- A \$15 Target gift card incentive when a member has received a verified Pap test and/or mammogram

For Living Healthy Women's Program brochures or more information about the program call the Health Promotion Specialist at (650) 616-2173 or 1-800-750-4776.

Immunizations

To promote timely immunizations, members who are up to date with their recommended vaccinations by age two, will receive a \$15 Target gift card.

3 to 6 Year Old Well Visit

HPSM encourages members ages 3 to 6 years to receive a well visit once a year with his/her Primary Care Provider (PCP). 3-6 year olds who receive a verified annual well visit from their PCP can get a \$15 Target gift card.

Adolescent Well Visit

HPSM encourages members ages 12 to 18 years to receive a well visit once a year with his/her Primary Care Provider (PCP). Adolescents who receive a verified annual well visit from their PCP can get two free movie tickets to Century Theaters.

Cultural & Linguistic Services

HPSM appreciates that its members represent a diverse mix of language, ethnicities, cultures, and countries of origin, each of which may be accompanied by a variety of attitudes, beliefs, and behaviors regarding health and health care. HPSM is committed to accommodating this diversity in a manner that accepts and respects differences while also promoting optimal health outcomes. Moreover, HPSM is committed to ensuring that all members receive high quality health care that is culturally and linguistically appropriate.

Provider Responsibility

HPSM acknowledges the role that language barriers can play in reducing the quality of care Limited English Proficient (LEP) members may receive. The following cultural and linguistic standards are required of HPSM and its provider network in order to comply with Title 6 of the Civil Rights Act of 1964 [42 USC Section 200(d)], SB 853 and 45 CFR (Part 80), which are all interpreted to mean: that Limited English Proficient (LEP) individuals are entitled to equal access and participation in federally and state funded programs through the provision of language assistance services.

Providers shall ensure equal access to health care services of members of all ethnic and cultural populations, members with limited English proficiency and members with hearing or speech impairments. The primary care provider (PCP) shall, in policies, administration and services, practice the values of:

- (a) respecting the member's beliefs, traditions and customs;
- (b) recognizing individual differences within a culture;
- (c) creating an open, supportive and responsive space in which differences are valued, respected and managed;
- (d) through cultural competency training, fostering in staff attitudes and interpersonal communication styles which respect the member's cultural backgrounds and are sensitive to their special needs.

Providers shall ensure equal access to HPSM's limited English proficient, hearing or speech impaired members in the following ways:

- Utilization of HPSM's interpreter services, bilingual providers or bilingual clinical staff during discussions of medical information such as diagnosis of medical conditions and proposed treatment options. Untrained or non-clinical staff should not be used to interpret during discussions of medical information
- Providers shall not encourage the use of family or friends as interpreters, especially minors.
- Providers should not subject members to unreasonable delays in receiving care when the need for interpreter services is identified by the provider or requested by the member.
- Providers shall document the member's preferred language, if other than English, in the member's medical chart.

- Providers shall document a member's request or need for interpreter services in the medical chart.
- Providers shall document a member's refusal of interpreter services in the member's medical chart.
- Providers shall provide member informing materials in English and Spanish (HPSM's threshold languages).
- Providers shall inform a member of his/her right to file a grievance in the member's primary language.
- Providers should ensure that provider staff who provide interpretation to members have been assessed and are capable of health care interpretation.
- Providers should refer members to culturally appropriate programs and services, as needed.

HPSM Responsibility

In order to comply with the California Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), the Centers for Medicare and Medicaid Services (CMS), SB 853 and Title 6 of the Civil Rights Act of 1964 (42 USC Section 200(d) and 45 CFR Part 80), HPSM has developed policies that correspond with these mandates and that assist members in receiving services which meet their cultural and linguistic needs. HPSM provides the following services to facilitate effective communication between members, providers and HPSM staff:

- Bilingual Member Services Representatives.
 - All of HPSM's Member Services Representatives are bilingual in Spanish, Tagalog, Cantonese, Mandarin or Russian.
- Use of telephonic interpreters.
 - Members who speak other languages can communicate with a Member Services Representative through Language Line Services.
- Services for hearing impaired or speech impaired members
 - Members can utilize the California Relay Services or TTY to communicate with a Member Services Representative or with their doctor.
 - HPSM provides hearing/speech impaired members access to sign language interpreters to accompany them to an appointment or health education class.
- Use of face-to-face interpreters for limited English proficient (LEP) members
 - Members who speak other languages can request the use of face-to-face interpreters when the use of telephonic interpreters would be unsuitable/inappropriate. Each request will be reviewed on a case-by-case basis
- Bilingual materials.
 - All of HPSM's materials are available in English and Spanish.
 - Most of the CareAdvantage materials are available in English, Spanish, Tagalog, Chinese and Russian.
- Diverse provider network

- HPSM annually assesses provider and provider office staff's language capabilities in order to provide members with information so that they can identify providers who speak their language
- Member Education
 - Members are informed about their right to file a grievance in their primary language.

Access to Interpreter Services

HPSM ensures access to interpreter services for all limited English proficient (LEP) members to reduce the effect of language barriers on quality of care. HPSM provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact. In addition, HPSM members can also utilize in-person sign language interpreter services with advance notice. Further, face-to-face interpreters for LEP members are available on a case-by-case basis, when the particular circumstances of the individual's condition make telephonic interpretation unsuitable/inappropriate. All HPSM interpreter services are provided free of charge to members.

HPSM interpreter services are only available for patients who are eligible HPSM members. Federal law requires any provider receiving federal funding to provide any services to all patients in his/her preferred language standards¹.

Telephonic Interpreter Services

Telephonic interpretation is available to HPSM members through Language Line Services. Telephonic interpretation can be accessed through provider office exam room phones. If these are not available, any phone, such as a cell phone, can be used. If phone access is an issue contact HPSM's Health Educator at (650) 616-2170 for assistance.

How to Use Language Line Services

Providers may access telephonic interpretation for HPSM members by calling Language Line at 1-800-523-1786. The Language Line operator will request the following information, (1) language needed, (2) HPSM Client ID number: 201254, (3) Organization name: Health Plan of San Mateo, (4) Personal Code: Provider name, Member ID number, Member name and date of birth.

For more information on how to access Language Line, contact HPSM's Health Educator at (650) 616-2170.

Sign Language Interpreter Services

To request a sign language interpreter for an HPSM member, providers may contact

¹ U.S. Department of Health and Human Services-Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). Executive Summary. March, 2001.

HPSM's Member Services Department at 1-800-750-4766. The following information is required to schedule a sign language interpreter, (1) member name, and HPSM Member ID number, (2) date, time, duration and address of appointment, (3) contact person and phone number at provider site, (4) description/type of appointment. A confirmation with the interpreter information will be faxed to your office. Please provide at least 5 days notice to request an interpreter.

Face-to-Face Language Interpreter Services

On rare occasions, the use of telephonic interpreter services for a particular patient might be unsuitable/inappropriate due to the patient's condition or circumstances (e.g. explaining diagnosis of terminal cancer). In such instances, HPSM can authorize face-to-face interpreter services on a case-by-case basis. To arrange such services, providers may contact HPSM's Health Educator at (650) 616-2170. Please provide at least 5 days notice to request an interpreter whenever possible.

Cultural and Diversity Awareness

HPSM recognizes that the ability to provide services in a culturally and linguistically appropriate manner must be cultivated through training and experience. HPSM is therefore committed to providing cultural and diversity awareness information and materials for HPSM network providers. In addition, HPSM is also committed to ensuring that providers are informed and aware of ways in which providers enhance the cultural responsiveness and improve access and quality of care for HPSM members. If you would like additional information in this area, please contact HPSM's Health Educator for assistance at (650) 616-2170.

HPSM also has tip sheets and training information for physicians on providing culturally sensitive care to members, available on our website. CME is available. Please go to: www.hpsm.org/providers/provider-resources/language-assistance.aspx for more information.

Monitoring and Enforcement

HPSM recognizes that the provision of culturally and linguistically appropriate health care services is challenging and requires a great deal of coordination. To ensure that HPSM's employees and providers adhere to its cultural and linguistic services policies and procedures, HPSM conducts regular monitoring and enforcement activities regarding staff, provider, and interpreter performance that include, but are not limited to, consumer satisfaction surveys, review of member grievances, annual provider assessments, and provider site-reviews. Specifically, HPSM monitors documentation in member's medical charts on requests or refusals of language interpreter services through Facility Site Review.

Assessment of Member Cultural and Linguistic Needs

HPSM acknowledges that the ability to provide culturally and linguistically appropriate care to a member population is predicated on understanding that population's cultural and linguistic needs. Accordingly, HPSM is committed to conducting regular assessments of its members' cultural and linguistic needs, including language

preferences, use of interpreters, use of alternative medicines, traditional health beliefs, and beliefs and practices regarding health and health care utilization. The results of these assessments are shared with providers as they become available.

Further, if providers have any suggestions, comments or ideas to improve HPSM's activities on addressing member cultural and linguistic needs, HPSM welcomes these ideas.

Needs of Members with Disabilities

HPSM recognizes that our members with disabilities have specific needs in addition to their general medical needs. For this reason, we provide services that are integrated within our daily activities of every department, such as access to TTY for our hard-of-hearing members, large-print materials for our visually-impaired members, information on which of our providers have wheelchair accessible offices in our provider directory for our wheelchair-using members, to name a few. We also have a care coordination unit in our Health Services Department to assist our members with complex chronic conditions to ensure they receive the care management they need to optimize their health outcomes.

If you have HPSM members with disabilities who need additional services, please notify HPSM Member Services at 1-800-750-4766. Staff will assist you in directing your request to the appropriate department.