Provider Manual 2027

Health Plan of San Mateo

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Section 1: About the Health Plan of San Mateo (HPSM)

The Health Plan of San Mateo (HPSM) provides medical, dental, and behavioral health services to thousands of residents in San Mateo County. All HPSM programs are designed to emphasize easy access to quality care for our members.

The purpose of this manual is to familiarize network providers and their staff with HPSM operations: it 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 programs you are contracted with. It is designed as a reference tool to assist you with the administrative tasks related to accessing and providing comprehensive, effective, and quality healthcare 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 contact the Provider Services Department at **PSInquiries@hpsm.org**.

Mission Statement

Healthy is for everyone!

HPSM's mission is to provide members with access to quality healthcare services delivered in a cost-effective and compassionate manner. That means our primary concern is keeping our members healthy and ensuring they have access to high-quality healthcare when they need it.

Our Website

Providers may access plan information by visiting **https://www.hpsm.org**. 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, population health management programs, authorization forms, and the latest HPSM news, health tips, plan history, and organizational philosophy.

HPSM maximizes the use of technology to assist our providers to better serve our members. HPSM's website also offers resources for development with the Provider Learning Lab. The Learning Lab is updated frequently with tutorial videos and other useful content to help HPSM providers serve our community. Access the Provider Learning Lab here: **https://www.hpsm.org/provider/learning-lab**

Provider Manual Updates

This manual is updated annually as policies, programs, and procedures change. Annual updates are published on January 1 each year. 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.

Programs

The following section briefly describes HPSM's three lines of business and our HPSM Dental benefit. Our lines of business include Medi-Cal, San Mateo County Access and Care for Everyone (ACE) Program, and CareAdvantage (Medicare Advantage Dual Eligible Special Needs Plan, or D-SNP). 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.

Medical programs

Medi-Cal

HPSM was originally created and began operations in 1987 to serve San Mateo County Medi-Cal beneficiaries in a managed care environment. HPSM is a County Organized Health System (COHS). 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 covered services. 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. Medi-Cal members cannot be balance billed.

CareAdvantage Dual Eligible Special Needs Plan (D-SNP)

In January 2006, HPSM began a Medicare Advantage Prescription Drug Plan (MA-PD). Members must have both Medicare Part A (hospital insurance) and Part B (medical insurance) and full-scope Medi-Cal through HPSM and must live in San Mateo County. HPSM offers one MA-PD program: HPSM CareAdvantage, a Dual Eligible Special Needs Plan (D-SNP).

Some 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 (MA) plan. In both cases, the member will retain their Medi-Cal eligibility with HPSM but will not be enrolled in CareAdvantage.

CareAdvantage members are only responsible for a prescription drug co-payment per prescription which conforms to Medicare guidelines. CareAdvantage members cannot be balance billed.

San Mateo County Access and Care for Everyone (ACE) Program

San Mateo County ACE is a program available to uninsured residents of San Mateo County, age 19 and older, with low income. 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. For a complete list of clinics that provide services to ACE members, please refer to the San Mateo County ACE Participant Handbook on our website **https://www.hpsm.org**.

Referral to other providers is only through an authorized referral process.

HPSM Dental

As part of an effort to improve oral care access, quality, and utilization, as well as lower medical cost, California passed Senate Bill (SB) 849 on June 27, 2018, authorizing a Dental Integration Program in San Mateo County. This means that dental care services will be a covered benefit under Health Plan of San Mateo Medi-Cal managed care contract. The overall goal of the program is to align oral health with overall health. There will be a formal evaluation of the program to demonstrate the benefits of integrating medical and dental services. The program was effective January 1, 2022.

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 email the Provider Services Department at **PSInquiries@hpsm.org** if you have suggestions or comments. Please note that existing provider contracts may supersede some policies stated in this material.

Service Area

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

- Atherton
- Belmont
- Brisbane
- Foster City
- Half Moon Bay
- Hillsborough
- Redwood City
- San Bruno
- San Carlos

- Burlingame
- Colma
- Daly City
- East Palo Alto
- El Granada
- Pacifica
- Portola Valley
- Menlo Park
- Millbrae
- Montara
- San Mateo
- South San Francisco
- Woodside
- Unincorporated Areas of San Mateo County

Who to Contact

Department	When to Call	Contact Information
Provider Services	Contracts and contract terms, credentialing and re-credentialing, value-based payments and pay for performance program, provider directory information and rosters, requests for provider training.	**PSInquiries@hpsm.org** **650-616-2106** **HPSM Contracting: HPSMcontracting@hpsm.org** **HPSM Credentialing: HPSMCredentialing@hpsm.org** **Provider Directory:** If you find an error, please call **650-616-2106 extension 5** (for TTY:**800-735-2929** or **711**).
CareAdvantage Unit	Check benefits, PCP selection/change, prescription coverage, member education/outreach for members enrolled in CareAdvantage D-SNP	**650-616-2174** **1-866-880-0606** **CareAdvantageSupport@hpsm.org**
Integrated Care Management	Integrated Care Management services, complex care management, linkage with plan programs and community resources, development of a personalized care plan, and participation in	**650-616-2060**

	interdisciplinary care team meetings. Integrated Care Management focuses on developing an individualized plan of care which can include care coordination, complex care management and linkage with plan programs and community resources.	
Claims	Claim submission, claim status, claim payment inquiries, member eligibility, provider portal account setup, balance billing resolution, provider dispute resolution, encounter data submission.	**650-616-2106**
Dental Services/HPSM Dental	General questions, or inquiries about dental benefits and/or member care coordination.	**dental@hpsm.org** **650-616-2106** **650-616-1522** *(referrals)*
Grievances and Appeals	For grievances and appeals related to care and/or services received.	**650-616-2850**
	For grievances and appeals related to Medi-Cal outpatient	**800-977-2273**

	pharmacy: Medi-Cal Rx Customer Service and Help Desk, 24 hours per day/seven days per week.	
Cultural and Linguistic Services	For information on interpreter services.	**Interpreters@hpsm.org** **https://www.hpsm.org/provider/resources/language-services**
Health Promotion	For information on wellness programs, community resources and health education materials.	**healtheducationrequest@hpsm.org** **650-616-2165**
Member Eligibility	To check a member's eligibility, visit our provider portal or call an HPSM line (depending on member's line of business).	**https://www.hpsm.org/provider/portal** *Medi-Cal Members:* **650-616-2106** **https:// mcweb.apps.prd.cammis.medi-cal.ca.gov**
Member Services	For Medi-Caland ACE members: check benefits, PCP selection/change, Health Insurance Premium Payment (HIPP) Program.	**650-616-2133** **800-750-4776** **Memberservicessupport@hpsm.org**
Pharmacy Services	Medi-Cal: For members, pharmacies, or providers needing help with outpatient pharmacy benefits, contact Medi-Cal Rx Customer Service and Help Desk. They are available 24	**800-977-2273** **https://medi-calrx.dhcs.ca.gov/home/**

	hours per day/seven days per week.	
	CareAdvantage and ACE:	**888-635-8362**
	For pharmacies needing help with claims submissions for outpatient pharmacy benefits, contact SS&C (HPSM's pharmacy benefit manager). They are available 24 hours per day/seven days per week.	
	For providers and pharmacies needing information on prior authorizations, formulary, or other outpatient pharmacy benefit questions or issues, reach out to the HPSM Pharmacy Services Department. They are available from 8:00 AM to 5:00 PM, Monday through Friday.	**650-616-2088** **https://www.hpsm.org/provider/authorizations/prescription-drugs**
Quality Department	Provider Site and Medical Record Review, peer review, and quality improvement projects/data collection (HEDIS).	**650-616-2106**
Utilization Management	Prior authorization requests for medical	**650-616-2070**

services, inpatient authorizations, out-of-area authorizations, outpatient services, durable medical equipment, utilization management, referral authorizations (RAF) for specialist referrals.	
Prior authorization requests for physician administered drugs (PADs – managed by HPSM's Pharmacy Services Department).	**650-616-2088**

Section 2: Customer Support

The Health Plan of San Mateo (HPSM) provides customer support to its members through two dedicated call centers. The Customer Support staff can assist members who have questions about:

- HPSM coverage and benefits.
- Selecting or changing a primary care provider (PCP).
- Problems or complaints getting healthcare, pharmacy services, or billing issues.

Member Services assists members that are enrolled in the Medi-Cal and San Mateo County ACE programs.

- Members can call **1-800-750-4776** or **650-616-2133**. Hearing impaired members can use the California Relay Service (CRS) at **1-800-735-2929** (TTY) or dial **7-1-1**.
- Office hours are Monday through Friday, 8:00 AM to 4:00 PM.
- Phone hours are Monday through Friday, 8:00 AM to 6:00 PM.
- Member Services Customer Service Navigators speak Cantonese, English, Mandarin, Spanish, and Tagalog and can access telephone interpreters to assist members with other language needs.

The Medi-Cal Rx Customer Service Center can assist members enrolled in the Medi-Cal program regarding their pharmacy benefits (for all non-pharmacy-related questions, please refer to the Member Services Unit).

- Members can call **1-800-977-2273**.
- Lines are open 24 hours a day, seven days a week.

The CareAdvantage Unit assists members who are enrolled in CareAdvantage Dual Eligible Special Needs Plan (D-SNP). CareAdvantage is HPSM's Medicare Advantage-Prescription Drug (MA-PD) plan.

- Members can call the CareAdvantage Unit at **1-866-880-0606** or **650-616-2174**, Monday through Sunday from 8:00 AM to 8:00 PM. Hearing impaired members can use the California Relay Service (CRS) at **1-800-735-2929** (TTY) or dial **7-1-1**.
- Office hours are Monday through Friday, 8:00 AM to 4:00 PM.
- Phone hours are Monday through Sunday, 8:00 AM to 8:00 PM.
- CareAdvantage Navigators speak Cantonese, English, Mandarin, Spanish, and Tagalog and can access telephone interpreters to assist members with other language needs.

HPSM members can also use the Member Portal to change their primary care physician, order a new ID card, change their address on file, and check their immunization records:
https://www.hpsm.org/member-portal-login

HPSM mails each new member a New Member Guide that includes the ID card for their assigned program and Materials Request Form to request member materials. The member materials that can be requested are Summary of Benefits, the Member Handbook, the Provider Directory, and Formularies for CareAdvantage, and ACE. For copies of materials related to Medi-Cal Rx, members can visit **https://www.medi-calrx.dhcs.ca.gov/home/.**

Member Rights and Responsibilities

Member Rights and Responsibilities are established by the Centers for Medicare and Medicaid Services (CMS), The Department of Health Care Services (DHCS), and HPSM Policies and Procedures.

HPSM members have these rights:

- To be treated with respect and recognition of your dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan, its services, practitioners, and providers, including covered services and member's rights and responsibilities.
- To be able to choose a primary care provider within HPSM's network (unless you have other primary health coverage).
- To participate in decision making with your providers about your own health care, including the right to refuse treatment.
- To voice complaints, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive oral interpretation services for your language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To request a state hearing, including information on the circumstances under which an expedited hearing is possible.
- To access Minor Consent Services.
- To receive written member-informing materials in alternative formats (such as braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, regardless of cost or benefit coverage, presented in a manner appropriate to your condition and ability to understand.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by HPSM, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Service Facilities, midwifery services, Rural Health Centers, sexually transmitted disease services and Emergency Services outside HPSM's network pursuant to the federal law.
- To make recommendations about HPSM's member rights and responsibilities.

HPSM members have these responsibilities:

- Carefully read all HPSM Member materials so that you understand how to use your benefits and what procedures to follow when you need care.
- Do your best to keep provider appointments; if you need to cancel or reschedule an appointment, call your provider at least 24 hours in advance or as soon as possible.
- Show your HPSM ID card or remember to tell your provider (your doctor, hospital, or pharmacy) that you are an HPSM member before receiving care.
- Follow the treatment plan that you and your provider have agreed upon.
- Provide accurate and complete information about your health care needs to HPSM and to your provider. Tell your provider if you have a medical condition.
- As best as you can, understand your health care needs and participate in developing treatment plans and goals with your providers.
- Follow the plans and instructions for care that you have agreed upon with your provider. Ask your provider questions if you do not understand something or are not sure about the advice that you are given.
- See specialists to whom your primary care provider refers you.
- Actively participate in health care programs that keep you well.
- Work with your providers to build and maintain a good working relationship.
- Use the emergency room only in case of an emergency or as directed by your provider.
- Follow-up with your primary care provider after getting care at an emergency facility.
- Report lost or stolen ID cards to HPSM Customer Support and do not let anyone else use your HPSM ID card.
- Call HPSM Member Services or CareAdvantage Unit if you do not understand how to use your benefits or have any problems with the services that you received.
- Tell HPSM if you move and/or change your phone number. Call HPSM Member Services or CareAdvantage Unit and the San Mateo County Human Services Agency. If you receive SSI, call Social Security Administration. We all need to have your correct address and phone number on file.
- Follow the HPSM grievance procedure if you want to file a complaint.
- Treat all HPSM staff and your health care providers respectfully and courteously.

Missed Appointments

HPSM advises members if they cannot keep an appointment, they need to call their provider to cancel or reschedule the appointment as soon as possible. Providers can send HPSM Provider Services information about members that have missed multiple appointments. HPSM staff will contact the member and remind the member about the importance of calling to cancel appointments in advance.

Provider Selection

Primary Care Physician (PCP)	An HPSM member's care is managed by the member's assigned PCP. 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.
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 the PCP or members may self-refer to any contracted OB/GYN or PCP within the HPSM network for OB/GYN services.
Pregnancy Care	HPSM 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 arrange to coordinate appropriate services for these members.
Doula Benefit	HPSM provides doula benefits for prenatal members, and postpartum members up to 12 months after delivery. Doula services can be provided to HPSM Medi-Cal and CareAdvantage virtually or in-person in any settings including, but not limited to, homes, office visits, hospitals during labor, or alternative birth centers. Additional information regarding member eligibility for doula services can be found in, **"Section 6: Ancillary Services"** of the Provider Manual.

Primary Care Physician (PCP) Selection Process

HPSM members are encouraged to self-select a primary care physician as soon as they become eligible for or are enrolled in an HPSM program. Customer Services Navigators and CareAdvantage Navigators are available to assist members with the PCP selection process. HPSM members can also select a PCP on the HPSM Member Portal: **https://www.hpsm.org/member-portal-login**

When Medi-Cal members become HPSM eligible, "New Member Guides" are mailed to the member, requesting that they select a PCP. New HPSM Medi-Cal members are not assigned to a PCP for the first 30 days of their HPSM eligibility to allow them time to self-select a PCP. Members who do not self-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. Members that have primary other health coverage, including Original Medicare, are not assigned to a PCP.

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

Auto-Assignment to a PCP (for Medi-Cal members only)

If a Medi-Cal member does not self-select a PCP within the first 30 days of HPSM enrollment, the member will be auto-assigned to a PCP based on geographic location, member age and PCP capacity.

If a member is auto assigned to a PCP, the member is informed that they have the option to change their assigned PCP.

Changing Primary Care Providers

Members can request a PCP change at any time by calling HPSM Member Services or CareAdvantage. Members can also change their PC on the HPSM Member Portal here: **https://www.hpsm.org/member-portal-login**

HPSM must receive requests for PCP changes by the last day of the current month. PCP changes are effective the first of the following month. Medi-Cal, and ACE members will receive a confirmation letter with the name of the new PCP. Only CareAdvantage members will receive a new HPSM ID card with the name of their new PCP.

Provider Request for Member Reassignment

Physician requests for member reassignment to the care of another provider must be pre-approved by the HPSM Chief Medical Officer or designee. Physicians requesting member reassignment must complete a Provider Request for Member Reassignment form posted on the HPSM website at **https://www.hpsm.org**. The form must include documentation of the reasons for the request and actions taken to resolve the issues with the member. The form and any attachments can be emailed to HPSM Provider Services at **PSInquiries@hpsm.org** or sent via fax to **650-616-8046**.

The provider should not notify the member that a request for reassignment has been submitted to HPSM. The Provider Request for Member Reassignment form will be reviewed by HPSM's Chief Medical Officer (CMO) or designee. Provider Services will notify the provider in writing within 14 business days of the CMO or designee's decision to approve or deny the request.

HPSM follows regulatory guidelines and retains sole and final authority to review and act upon the requests from providers to terminate a member. Members are not transferred against their will until HPSM carefully reviews the matter, determines that transfer is appropriate, and confirms that HPSM's internal procedures have been followed.

All reassignment requests are carefully reviewed, and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

If the reassignment is approved, HPSM will send a letter to the member (certified, return receipt). The reassignment notification letter will inform the member that a reassignment request was made by the primary care physician and that the member can select another. The letter outlines the reasons why the request was made and informs the member that if they do not select a new primary care physician within 30 days of the date the letter was mailed, the member will be auto assigned to a new one.

The member will be reassigned from the requesting provider once the written notice is sent to the member and is effective the first of the following month. When a member is assigned to a new primary care physician, the previous provider must supply patient records, reports, and other documentation at no charge to the new one. The transferring provider must continue to coordinate care through the end date of the reassignment.

Providers Leaving the Network

HPSM will provide continuity of care for covered services rendered to a member by a provider whose HPSM affiliation has ended in the following circumstances:

- **An acute condition:** Completion of covered services will be provided for the duration of the acute condition.
- **A serious chronic condition:** Completion of covered services for a period necessary to complete a course of treatment and to arrange for a safe transfer to another HPSM 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 12 months from the date that the provider left HPSM.
- **A pregnancy:** Including postpartum care, for the duration of the pregnancy.
- **A terminal illness:** Completion of covered services for the duration of the terminal illness.
- **A surgery or other procedure:** Approved by HPSM as part of a documented course of treatment and occurs within 180 days from the date that the provider left HPSM.
- **Covered services for a child:** The child should be between ages birth and 36 months for up to 12 months from the date that the provider left HPSM.

The terminating 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.

HPSM does not provide continuity of care services if:

- The provider is unwilling to continue to treat the member or accept HPSM's payment or other terms.
- HPSM discontinued a contract based on a professional review action or a medical disciplinary cause or reason or for fraud or other criminal activity.
- Services are not covered by HPSM.
- The continuity of care request is for Durable Medical Equipment, transportation or other ancillary services or carved-out service.

Programs and Enrollment Information

Medi-Cal is California's Medicaid health care program. Medi-Cal covers a variety of medical services for children and adults with limited income and resources. Eligibility is determined by the San Mateo County Human Services Agency or through Supplemental Security Income (SSI) administered by Social Security Administration (SSA). Eligibility information is available at the Human Services Agency website at **https://hsa.smcgov.org/.** Prospective members can also call the San Mateo County Human Services Agency at **1-800-223-8383** to find out if they are eligible to receive Medi-Cal health benefits.

Medi-Cal eligible beneficiaries with qualifying Medi-Cal aid codes are automatically enrolled in HPSM. Every HPSM Medi-Cal member receives an HPSM ID card and a Medi-Cal Benefits Identification Card (BIC) issued by DHCS. Sample ID cards are included later in this section.

Types of Medi-Cal Members

PCP-Assigned Members	These are members that are assigned to a Primary Care Provider (PCP) and appear on the PCP's case management list.
Unassigned Members	Unassigned members are not assigned a PCP and do not require referrals to see contracted, in-network PCPs. Members that have Other Health Coverage (OHC), including Original Medicare, in addition to Medi-Cal are not assigned to a PCP; the OHC is usually the member's primary coverage.
Share of Cost Members	Some Medi-Cal recipients must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This amount is called the Medi-Cal Share-of-Cost (SOC). A Medi-Cal recipient's SOC is like a private insurance plan's out-of-pocket deductible. Share-of-Cost members are not assigned to a PCP. Medi-Cal recipients with a SOC are not eligible for full-scope Medi-Cal until they have met their SOC amount for the month. Members with a Medi-Cal SOC appear in suspense status in the HPSM Provider Portal. After a recipient meets the SOC for the month, HPSM will pay for covered medical expenses for the rest of the month. More information about the Medi-Cal SOC, including how a provider should collect and clear a share of cost, can be found on the Medi-Cal provider website at **https://files.medi-cal.ca.gov/**.
Whole Child Members	The Whole Child Model is a partnership between HPSM and San Mateo County to deliver coordinated care and services to eligible children with complex

medical conditions. The Whole Child Model was known as the California Children's Services (CCS) Pilot until 2018.

HPSM Medi-Cal members under 21 years old who are eligible for CCS are enrolled into the Whole Child Model program. These HPSM Medi-Cal members receive a dedicated case manager who oversees the member's total care. This includes coordinating medical, social, and mental health services for the member, or their family as needed.

For more information about the Whole Child Model and to make a referral, call the San Mateo County CCS staff at **650-616-2500**.

CareAdvantage Dual Eligible Special Needs Plan (D-SNP)

CareAdvantage is a Medicare Advantage-Prescription Drug (MA-PD) plan for people who have both Medicare and Medi-Cal. CareAdvantage contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees with the goal of a seamless service delivery experience for CareAdvantage beneficiaries. To enroll in CareAdvantage, members must have Medicare Part A (hospital insurance) and Part B (medical insurance), full-scope Medi-Cal and must live in San Mateo County.

Members that want to enroll in CareAdvantage should call a licensed HPSM CareAdvantage Medicare Specialist at **1-888-252-3153** or **650-616-1500**.

Enrollment in CareAdvantage is optional. Some members with Medicare and Medi-Cal may decide to remain in Original (Fee-For-Service) Medicare and enroll in a Part D Prescription Drug Plan (PDP) or join another Medicare Advantage Plan. The member will keep their HPSM Medi-Cal eligibility but will not be enrolled in CareAdvantage.

Anyone with questions about Medicare can call the San Mateo County Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**.

San Mateo County ACE Program

The San Mateo County ACE (Access and Care for Everyone) Program is a county-sponsored program that provides health care coverage to uninsured residents of San Mateo, age 19 and older, with low income. HPSM administers the San Mateo ACE Program under a contract with San Mateo County. Prospective enrollees can call the Health Coverage Unit at **650-616-2002** for more information.

San Mateo County ACE is not insurance. The San Mateo County 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 (SMMC), North East Medical Services (NEMS) and the Ravenswood Family Health Center.

ACE enrollees can only receive emergency services at SMMC.

Identifying Members

HPSM members are enrolled in either Medi-Cal, CareAdvantage Dual Eligible Special Needs Plan (D-SNP), or San Mateo County ACE. All HPSM members have an HPSM ID card showing the program that they are enrolled in. Examples of HPSM ID cards can be found later in this section.

PCP Active Engagement Reports

Lists of empaneled patients are published once monthly for each primary care clinic. These "Active Engagement Reports" are available for download in HPSM's eReports portal and include all members assigned to the PCP that month and information such as assigned member name, HPSM ID number, preferred language, program, date assigned to the PCP, contact information, and some utilization information. For more information on registering for or using eReports, please reference the "eReports User Guide – Primary Care" available at **https://www.hpsm.org/provider/value-based-payment**.

Member Eligibility

Providers should verify HPSM member eligibility at the time of each visit. A member's eligibility can change at any time for any number of reasons, including a change in Medi-Cal status or change in residence address.

How to Check Eligibility

Monthly Active Engagement Reports for Primary Care Providers (PCP)	PCPs should check for the member's name on the list published to eReports and available for download at the beginning of the month. For more information on how to register for or use eReports, refer to the "eReports User Guide – Primary Care" at **https://www.hpsm.org/provider/value-based-payment**
Via eReports Portal	Providers can verify member's eligibility, submit claims using eHEALTHsuite and check payment status on the provider portal. To register: **https://www.hpsm.org/provider/portal.**

Medi-Cal DHCS Website

Medi-Cal and Medicare/Medi-Cal members only. Eligibility information is available on California's Medi-Cal website, **https://mcweb.apps.prd.cammis.medi-cal.ca.gov**. For assistance in obtaining a login and password for the State of California Medi-Cal website, please call the POS/Internet Help Desk at **1-800-427-1295** for more information.

Medi-Cal Point of Service (POS) Device *(for Medi-Cal members only)*

Swiping the patient's Medi-Cal Beneficiary Identification Card (BIC) in the State's 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 12 months. To learn more, please call the DHCS Telephone Service Center at **1-800-541-5555**.

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 also verify eligibility on the date that the service is rendered. A referral or authorization does not guarantee that the member is eligible on the date of service.

ID Cards by Line of Business

Medi-Cal ID Card

HealthPlan OF SAN MATEO
Healthy is for everyone
Medi-Cal
www.hpsm.org
Member
DOB
Medi-Cal ID
Assigned to PCP as of
Group Plan (80840)
7740 283 982
HPSM Member as of
PCP
Medicare
HPSM Member Services: 1-800-750-4776

In case of emergency, call 9-1-1 or seek appropriate emergency care.
Emergency services do not require pre-authorization.
For information about Mental Health Services call 1-800-686-0101
24-Hour Nurse Advice: 1-833-846-8773 (toll free)
FOR PROVIDER USE ONLY
Providers with a PIN can check member eligibility verification 24 hours a day at 1-800-696-4776, or online at www.hpsm.org.
Submit pharmacy manual claims to:
Argus Health Systems
Department 586
P.O. Box 419019
Kansas City, MO 64141
1-888-635-8362
Submit medical claims to:
HPSM Claims Department
801 Gateway Blvd, Suite 100
South San Francisco, CA 94080
Claims Department: 650-616-2056
Provider Services: 650-616-2106

CareAdvantage D-SNP ID Card

HealthPlan OF SAN MATEO
Healthy is for everyone

CareAdvantage
Dual Eligible Special Needs Plan (D-SNP)

Member Name:
Member ID:
Date of Birth:
Plan Effective Date:
Care Manager Phone #: 650-616-2174
H6619-001

MedicareRx
Prescription Drug Coverage
RxBin 012353
RxPCN 06850000

HPSM Dental
1-866-880-0606

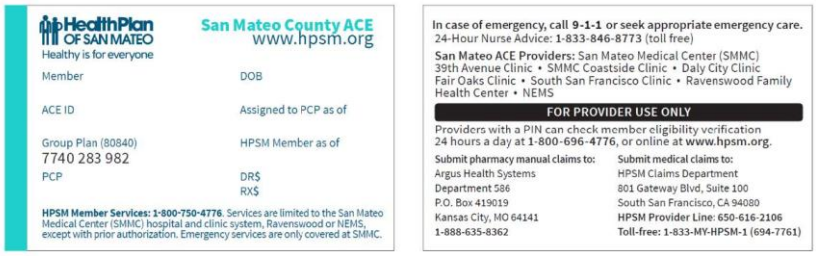
In case of emergency, call 9-1-1 or seek appropriate emergency care.
CareAdvantage Unit: 1-866-880-0606 (toll free) or 650-616-2174
CareAdvantage Unit TTY: 1-800-735-2929 (toll free) or 7-1-1
Pharmacy Help Desk: 1-888-635-8362
Behavioral Health: 1-800-686-0101 (toll free)
24-Hour Nurse Advice: 1-833-846-8773 (toll free)
Website: www.hpsm.org/careadvantage

Send claims to:

Submit pharmacy manual claims to:
SS&C Health
Attn: Dept Customer 6586
P.O. Box 419019
Kansas City, MO 64141
1-888-635-8362

Submit medical claims to:
HPSM Claims Department
801 Gateway Blvd, Suite 100
South San Francisco, CA 94080
HPSM Provider Line: 650-616-2106
Toll-free: 1-833-MY-HPSM-1 (694-7761)

Access and Care for Everyone (ACE)


HealthPlan OF SAN MATEO
Healthy is for everyone

San Mateo County ACE
www.hpsm.org

Member
DOB
ACE ID
Assigned to PCP as of
Group Plan (80840)
7740 283 982
HPSM Member as of
PCP
DR$
RX$

HPSM Member Services: 1-800-750-4776. Services are limited to the San Mateo Medical Center (SMMC) hospital and clinic system, Ravenswood or NEMS, except with prior authorization. Emergency services are only covered at SMMC.

In case of emergency, call 9-1-1 or seek appropriate emergency care.
24-Hour Nurse Advice: 1-833-846-8773 (toll free)
San Mateo ACE Providers: San Mateo Medical Center (SMMC) 39th Avenue Clinic • SMMC Coastside Clinic • Daly City Clinic Fair Oaks Clinic • South San Francisco Clinic • Ravenswood Family Health Center • NEMS

FOR PROVIDER USE ONLY

Providers with a PIN can check member eligibility verification 24 hours a day at 1-800-696-4776, or online at www.hpsm.org.

Submit pharmacy manual claims to:
Argus Health Systems
Department 586
P.O. Box 419019
Kansas City, MO 64141
1-888-635-8362

Submit medical claims to:
HPSM Claims Department
801 Gateway Blvd, Suite 100
South San Francisco, CA 94080
HPSM Provider Line: 650-616-2106
Toll-free: 1-833-MY-HPSM-1 (694-7761)

Medi-Cal Benefits ID Card (BIC)

Section 3: Member Complaints

This section describes the procedures that members and their authorized representatives may use to submit complaints to the Health Plan of San Mateo (HPSM). The Centers for Medicare and Medicaid Services (CMS) and the state of California have regulations that give health care consumers the right to file a complaint whether the consumer is covered by Medicare, Medi-Cal, or a private insurance plan.

HPSM must follow these federal and state regulations in processing HPSM member complaints. HPSM handles complaints for members in all lines of business: CareAdvantage Dual Eligible Special Needs Plan (D-SNP), Medi-Cal, and San Mateo County ACE.

Information about the complaints process is included in the Provider Manual because, providers may file complaints on behalf of members or assist members in filing a complaint. HPSM may also ask providers for assistance in resolving member complaints through requests for additional medical information or the provider's perspective on a complaint. Providers must obtain verbal consent from the member before the complaint is processed.

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. HPSM members may be dually eligible for both Medicare and Medi-Cal, but not be enrolled in CareAdvantage, HPSM's Medicare line of business. If dually eligible members are covered under Original Medicare, the CareAdvantage procedures described in this section will not apply.

Overview of Member Complaints

Members have the right to submit complaints to HPSM. A complaint is any verbal or written expression of dissatisfaction with any HPSM service a member receives. A complaint may also be about reimbursement for a bill that a member has paid. A complaint can be a grievance or an appeal.

Grievance

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. Examples of grievances include member concerns about:

- Quality of the care that was provided.
- Customer service that was perceived as rude or unhelpful.
- Difficulty accessing care and/or the timeliness of care.
- Billing related issues such as receipt of a balance bill or collections notice.
- Other issues, such as HIPAA violations or potential instances of fraud, waste, or abuse.

Member grievances related to Medi-Cal outpatient pharmacy services are handled by Medi-Cal Rx. Members can submit a grievance either in writing or by telephone by going to **https://www.medi-calrx.dhcs.ca.gov/home/** or calling Medi-Cal Rx Customer Service at **1-800-977-2273**.

Appeal

A complaint about HPSM's denial of coverage or reimbursement. In an appeal, a member or provider, with written member consent, requests HPSM to reconsider its decision regarding services that were denied, limited, or taken away, such as:

- A denied request for services (i.e., prior authorization).
- A denied request for payment to a provider (i.e., claim).
- A denied request for reimbursement to a member.

Member appeals related to Medi-Cal outpatient pharmacy services are handled through the State Fair Hearing Process (see "State Fairing Hearing for Medi-Cal Members" section for additional details.

Timeframes in the Member Complaint Process

The following are the timeframes that must be followed when processing a grievance and/or an appeal. Timeframes for filing a grievance or appeal vary by line of business and are regulated by CMS and the state.

Timeframes for CareAdvantage D-SNP

For Filing	Type	Timeframe
	Part C Appeal	65 calendar days from denial notice
	Part D Appeal	65 calendar days from denial notice
	All grievances	No time limit

For Processing	Type	Appeal	Grievance
	Part C – Standard	30 calendar days *(7 days for Part B drug requests)*	30 calendar days
	Part C – Expedited	72 hours *(72 hours for Part B drug requests)*	24 hours
	Part D – Standard	7 calendar days	30 calendar days
	Part D – Expedited	72 hours	24 hours

Timeframes for Medi-Cal

Non-Pharmacy (through HPSM)

For Filing	Type	Timeframe
	All appeals	60 calendar days from denial notice
	All grievances	No time limit

For Processing	Type	Appeal
	Standard	30 calendar days
	Expedited	72 hours

Pharmacy (through Medi-Cal Rx)

For Filing	Type	Timeframe
	All appeals	90 calendar days from denial notice (State Fair Hearing Process)
	All grievances	No time limit

For Processing	Type	Timeframe
	All appeals	60 calendar days
	All grievances	30 calendar days

Timeframes for and ACE

For Filing	Type	Timeframe
	All appeals	180 calendar days from denial notice
	All grievances	180 calendar days from incident

For Processing	Type	Appeal	Grievance

Standard	30 calendar days	30 calendar days
Expedited	72 hours	72 hours

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's CareAdvantage Dual Eligible Special Needs Plan (D-SNP) 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 for all services can be submitted through the following routes:

In-person	Health Plan of San Mateo 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080
Online	Members may submit a grievance online at **https://www.hpsm.org/member/file-a-complaint**
Telephone Member Services (*for Medi-Cal and ACE)*	**650-616-2133**
Telephone CareAdvantage Unit *(for CareAdvantage)*	**650-616-2174**
Fax	**650-829-2002**
Mail	Health Plan of San Mateo Attn: Grievance and Appeals 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080

Filing a Grievance for Medi-Cal Outpatient Pharmacy Benefits

Member Grievances for Medi-Cal outpatient pharmacy benefits are handled by Medi-Cal Rx and can be submitted through the following routes:

Telephone	Call Medi-Cal Rx Customer Service Center at **1-800-977-2273**
Email	Log onto **https://www.medi-calrx.dhcs.ca.gov/home/** to securely email a complaint.
Fax	Fax the Medi-Cal Rx Complaint Form (available at **https://medi-calrx.dhcs.ca.gov/home/** to Medi-Cal Customer Service Center at **1-800-869-4325**.
Mail	Mail the Medi-Cal Rx Complaint Form (available at **https://medi-calrx.dhcs.ca.gov/home/** to the following: Medi-Cal Rx Customer Service Center Attn: Complaints and Grievances Unit P.O. Box 730 Rancho Cordova, California 95741-0730

Timing

Medi-Cal members may file a grievance at any time regarding services they received while covered under Medi-Cal.

CareAdvantage members may file a grievance at any time regarding services they received while covered under CareAdvantage.

All other members must file a grievance within 180 calendar days from the date of occurrence. HPSM may allow an exception to this timeframe requirement for good cause.

Additional Details on Grievances

If filing a grievance in writing, members may submit a grievance online at **https://www.hpsm.org/member/file-a-complaint.** Members may also fill out a grievance form, found on HPSM's website, or write a letter or other statement stating the reason for their dissatisfaction. Members can also submit grievances through provider offices. Providers are required to send these to HPSM on the same business day that the grievance was received. Providers will send this information to HPSM via fax at **650-829-2002**.

Member grievances may be received by HPSM's Member Services Unit, the CareAdvantage Unit, Integrated Care Management Unit, or Grievance and Appeals Unit. If a grievance is received by Member Services or CareAdvantage Unit, staff will make every effort to resolve the grievance within 24 hours.

If the grievance cannot be resolved in 24 hours, the complaint will be forwarded to Grievance and Appeals for further processing.

Providers may submit grievances against members, HPSM and/or other providers by contacting HPSM's Provider Services Department at **PSInquiries@hpsm.org.**

Providers can also submit Potential Quality Issues (PQIs) using the HPSM PQI Referral Form: **https://www.hpsm.org/docs/default-source/provider-forms/provider_toolkit_pqi_referral_form.pdf**

For grievances related to Medi-Cal outpatient pharmacy services: Please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**.

Canceling/Withdrawing a Grievance

Members or their authorized representatives may cancel their grievance at any time by contacting HPSM's Grievance and Appeals Unit.

To cancel grievances related to Medi-Cal outpatient pharmacy services handled by Medi-Cal Rx, please call the Medi-Cal Rx Customer Service Center at **1-800-977-2273**.

Processing and Resolving Standard Grievances

Once a grievance is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter to the member within five calendar days. The Grievance and Appeals Coordinator will investigate the grievance, which may include notifying the member's provider, if applicable.

For grievances related to Medi-Cal outpatient pharmacy services, Medi-Cal Rx will automatically send an acknowledgement letter to the member within one business day if their Customer Service Center cannot fully resolve the grievance immediately.

Provider Response and Timing

A critical part of resolving a member complaint involves getting a provider's perspective about the situation under review. Requests for a provider's perspective are not an accusation of wrongdoing. HPSM understands that many complaints arise because of a difference in perception or misunderstanding about a situation. We want to get your honest opinion about what transpired.

To meet the strict timeframes for processing a complaint, providers must submit their response within five calendar days from the date the Grievance and Appeals Coordinator sends the request to the provider.

For grievances related to Medi-Cal outpatient pharmacy services filed by a member, Medi-Cal Rx may contact a prescriber for additional information. Providers should respond to any inquiries from Medi-Cal Rx to expedite processing timeframes for a grievance.

Resolving a Grievance

For standard complaints, the Grievance and Appeals Coordinator will issue a resolution letter within 30 calendar days of receipt of the grievance. The resolution letter will be the result of the research and review conducted by the Grievance and Appeals Coordinator. The resolution letter will be mailed to the member or the member's representative. If the grievance involves a provider, a copy of the resolution letter will also be sent to the provider.

If a grievance is related to quality-of-care concerns, HPSM will request medical records and a written response from all relevant providers. These medical records and responses will be reviewed by HPSM's Clinical Review Nurse and by an HPSM Medical Director. Providers will be informed in writing of any concerns or deficiencies found by HPSM's Quality Improvement Department. For questions regarding the quality-of-care review process, please contact the Quality Department at **650-616-2170**.

For grievances related to Medi-Cal outpatient pharmacy services, Medi-Cal Rx will usually issue a resolution letter within 30 business days of receipt of the grievance.

Non-Retaliation Policy for Filing a Grievance

Members have the right to file a complaint about HPSM or the care that they receive from a provider without the complaint adversely affecting how the member is treated by HPSM and/or the member's providers. Retaliation against members for filing a complaint is strictly prohibited.

HPSM does not discriminate against or disenroll members for filing complaints.

Examples of prohibited retaliation by providers include:

- Terminating or threatening to terminate a member from your practice after the member has filed a complaint.
- Refusing to provide treatment or needed prescription refills to a member because of a complaint filed.
- Treating the member in a disrespectful, hostile, or otherwise negative manner in response to the member filing a complaint.

Grievance to the Department of Managed Health Care

Members can call DMHC at **888-466-2219** or complete an Independent Medical Review/Complaint Form online, which can be accessed at **https://www.dmhc.ca.gov/FileaComplaint.aspx.**

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

All grievances related to Medi-Cal outpatient pharmacy services should not be submitted to DMHC and instead should be submitted to Medi-Cal Rx.

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 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.

This does not apply to grievances related to Medi-Cal outpatient pharmacy services which must be submitted to Medi-Cal Rx.

Expedited Grievances

For Medi-Cal and ACE members: If processing a grievance under the standard 30 calendar day timeframe would have an adverse impact on a member's life, health, or ability to regain maximum function, a member or provider can request that a grievance be processed under an expedited, 72 hour timeframe. If a member, a physician, or other provider request expedited grievance processing, HPSM clinical staff will determine whether the request meets the criteria for expedited processing. If the request does not meet the criteria for expedited processing, the HPSM Grievance and Appeals Unit will notify the member or the requestor of this decision verbally, and in writing.

There is no expedited process for grievances related to Medi-Cal outpatient pharmacy benefits and all processing timeframes are usually resolved within 30 days.

For CareAdvantage members: CareAdvantage members have the option of requesting an expedited grievance under limited circumstances. Unlike the other lines of business, the decision to expedite processing of a CareAdvantage grievance is not based on clinical criteria. The circumstances in which an expedited grievance may be filed by or for a CareAdvantage member are:

- HPSM refused to expedite an authorization request.
- HPSM extended the timeframe to process an authorization request.
- HPSM refused to expedite an appeal.
- HPSM extended the timeframe to process an appeal.

In these cases, CareAdvantage members may request an expedited grievance. The Grievance and Appeals Coordinator will consult with the appropriate HPSM staff and respond to the grievance within 24 of HPSM's receipt of the expedited grievance.

Appeals

The following applies to services billed and requested under the medical benefit including physician administered drugs. For details surrounding appeals related to the outpatient pharmacy benefit, please refer to the **"Section 3: Member Complains"** Pharmacy Appeals for Drug/Medication Denials section.

Denied Services/Authorization Requests

Any member who is denied services may request an appeal of this decision if they disagree with the denial reason. As an HPSM contracted provider, you may file an appeal on behalf of a HPSM member, but you cannot charge the member for filing an appeal on their behalf. Providers who file on behalf of a member are required to obtain the member's written consent. An authorized representative of the member may also file an appeal.

Provider Payment Appeals

For providers disputing payment, please refer to the Provider Dispute Resolution Process described in **"Section 5: Provider Disputes"** of this manual.

Authorization Appeals

You may ask HPSM to reconsider a denial of an authorization request for services if you or your patient disagree with HPSM's decision to deny the request. 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 decide on an appeal.

For CareAdvantage members: If you are a physician and you appeal the decision on behalf of a member, the member will not need to submit documentation designating you as the member's authorized representative. However, if you are a provider other than a physician (e.g. DME provider, SNF, physical therapist, etc.), the member will need to provide documentation designating you as the member's authorized representative.

Filing an Appeal

Appeals can be filed through the following routes:

Providers	**Telephone**	**650-616-2850**
	Fax	**650-829-2002**
	Mail	Health Plan of San Mateo

		Attn: Grievances and Appeals 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080
Members	**In-person**	Health Plan of San Mateo 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080
	Telephone	**650-616-2133** *(For Medi-Cal and San Mateo County ACE)* **650-616-2174** *(For CareAdvantage)*
	Fax	**650-829-2002**
	Mail	Health Plan of San Mateo Attn: Grievance and Appeals 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080

Appeals may be received by HPSM's Member Services Department, CareAdvantage Unit, Integrated Care Management, or by a Grievance and Appeals Coordinator.

Timing

For Medi-Cal members, an appeal must be filed within 60 calendar days from the date of HPSM's Notice of Denial.

For CareAdvantage members, an appeal must be filed within 65 calendar dates from the date of HPSM's Notice of Denial.

All other members must file an appeal within 180 calendar days of this date. HPSM may allow an exception to this timeframe requirement for good cause.

Cancelling/Withdrawing an Appeal

Members or their authorized representatives may cancel their request for an appeal at any time by contacting HPSM's Grievance and Appeals Unit.

Processing a Standard Appeal

Once the appeal is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter to the member within 5 calendar days and work with the appropriate HPSM staff to begin investigation of the

case. Additional information for the service may be required from providers involved in the member's treatment. Providers should provide this information within 5 calendar days of the request.

After all relevant documentation is collected, the case is forwarded to an HPSM Medical Director for review. The Medical Director that made the initial decision to deny the authorization request will not be involved in the appeal process.

Using all available information, the HPSM Medical Director will decide on the appeal request. HPSM will notify the provider and the member within 30 calendar days of the initial request. HPSM will call both the member and the provider to inform them of the appeal decision. The member and provider will also receive a letter confirming the decision.

Requesting an Expedited Appeal

You may request an expedited appeal of an HPSM authorization denial if you or the member believes that applying the standard 30 calendar day timeframe for processing an appeal will jeopardize the member's life, health, or ability to regain maximum function. HPSM will also expedite an appeal for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

CareAdvantage requests for expedited appeals that are submitted by telephone during non-business hours are received by HPSM's answering service. The answering service will immediately page an HPSM Medical Director to provide expedited review.

Requests submitted by fax during non-business hours will be processed the following business day. If you are submitting an expedited appeal on a weekend or holiday, please do not submit the request by fax.

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

In addition to HPSM's expedited appeals process, Medi-Cal 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 appeals process before contacting the DMHC. Requests for urgent review by the Department of Managed Health Care can be submitted by calling **888-466-2219**.

Processing an Expedited Appeal

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

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

If the appeal qualifies for expedited review, a Grievance and Appeals staff member will immediately notify you and the member of the decision and of the member's right to contact the DMHC. He/she will work with the appropriate HPSM staff to collect all relevant information about the member's condition and forward the case file to an HPSM Medical Director for review within 48 hours of receiving the request.

Using all available information, HPSM will decide and notify you and the member as expeditiously as the member's health requires, but no later than 72 hours of HPSM's receipt of the request. HPSM will notify you and the member of the decision by phone and in writing. If the original denial is upheld, HPSM's written notification will include the reason for denial and information about additional levels of appeal that may be available.

Denials of CareAdvantage Part C Benefits

If a denial is upheld on appeal, HPSM will auto-forward the appeal to the Independent Review Entity (IRE) for a secondary, independent review. The IRE will render a decision within 30 days of receiving the appeal from HPSM. HPSM will comply with the decision by the IRE and notify the member and provider if the IRE instructs HPSM to overturn the denial, in full or in part.

For all appeals HPSM may extend the timeframe for up to 14 calendar days if requested, or if such extension is in the best interest of the member.

Independent Medical Review (IMR) For Medi-Cal

If you or your patient disagrees with a decision HPSM has made on an appeal based on medical necessity, or if HPSM does not decide within the standard 30 calendar day timeframe, 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 appeals process before requesting an IMR.

Information on requesting an IMR can be obtained by calling **888-466-2219**, or by visiting the DMHC website at **https://www.dmhc.ca.gov/FileaComplaint/FrequentlyAskedQuestions.aspx.**

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 the care requested is medically necessary. DMHC will render a decision on an IMR within 30 days of DMHC's receipt of the IMR application for standard appeals, or within three 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 five business days.

State Hearing (Medi-Cal Members 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 denial 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.

A Medi-Cal member must first exhaust HPSM's appeals process prior to proceeding with a state hearing. Requests for state hearings must be submitted within 120 calendar days of an action with which the member is dissatisfied. For standard state hearings, the state will decide within 90 days of the request. For expedited state hearings, the state will decide within 72 hours.

Requests for state hearings can be submitted by:

- **Phone:** 1-800-743-8525 (TTY: 1-800-952-8349)
- **Fax**: 916-309-3487 or toll-free at 1-833-281-0903
- **Mail**: California Department of Social Services
  Attn: State Hearing Division
  Post Office Box 944243, Mail Station 937-17-433
  Sacramento, California 94244-2430
- **Online:** **https://www.cdss.ca.gov** or fill out and submit the form below.

For a list of forms in different languages or in large print, please visit:
https://www.hpsm.org/member/file-a-complaint/

Fast-Track Appeals to a Quality Improvement Organization (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) which the Medicare program has contracted. In California, the QIO is Livanta.

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 to avoid financial liability during the contested time. The QIO will decide within 24 hours. If the member misses the deadline for a QIO fast-track appeal, he/she may still request an expedited appeal from HPSM. The QIO is responsible for review even if the member missed the deadline.

Pharmacy Appeals for Drug/Medication Denials

The following section pertains to drugs and items covered under the outpatient pharmacy benefit. For drugs paid for through the medical benefit (i.e., physician administered drugs), please see the **"Section 3: Member Complaints"** section on Appeals.

For Medi-Cal

Providers who wish to appeal a denied decision related to Medi-Cal outpatient pharmacy services, an appeal must be submitted to Medi-Cal Rx. For more information regarding the appeal submission process, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**.

For Medi-Cal members or their authorized representatives who wish to file an appeal for pharmacy services, they must do so through the State Fair Hearing process. Appeals must be submitted within 90 days from the denial notification.

For CareAdvantage and ACE

Appeals for medications or drugs are processed by HPSM's Pharmacy Services. Although the appeal process is similar, the timelines for prescription drug appeals differ:

- For CareAdvantage: Pharmacy appeals must be submitted within 65 calendar days from the denial notification. HPSM will decide and will notify the member and provider within seven calendar days for standard appeals and within 72 hours for expedited appeals.
- For ACE: Pharmacy appeals must be submitted within 180 days from the denial notification. HPSM will decide and will notify the member and provider within 30 calendar days for standard appeals and within 72 hours for expedited appeals.

Filing a Pharmacy Appeal

Providers can file a pharmacy appeal as follows which differ based on the line of business:

Medi-Cal

- Provider PA appeals are accepted via the Medi-Cal Rx Provider Portal fax, or U.S. Mail.

  -**Medi-Cal Rx Provider Portal Submission** (available **https://medi-calrx.dhcs.ca.gov/home/**: Select the appeal option.

  -**Fax/U.S. Mail Submission:** Fill out the Medi-Cal Rx Prior Authorization Request Form available at **https://medi-**

calrx.dhcs.ca.gov/home/. State the word "appeal" on the form and fax or mail to the number listed on the form.

- Providers have 180 days to submit a PA appeal from the date of the initial denial.
- Medi-Cal Rx will ensure PA appeal requests are reviewed within 60 calendar days and the PA submitter receives notification of determination of the PA appeal request.

Note: Unless specifically noted as an appeal, a second PA request submitted for a previously denied request is treated as a new review only if new information is provided. If no new information is provided, the request is treated as a duplicate. If a PA request has been denied due to no response on a deferred PA request and a PA appeal request has been submitted, the request will be treated as new. Provider appeal requests must contain the date or service being appealed, the reason the appeal should be granted, and any additional documentation to support the appeal. Medi-Cal Rx will review claims history, all past clinical information, and new information submitted to decide on the appeal request. Medi-Cal Rx issues PA Appeal Acknowledgement correspondences to the provider via fax or mail (when fax is not available) within 1 calendar day of an appeal request.

CareAdvantage and ACE	**Telephone** **650-616-2088** **Fax** **650-829-2045** **Mail** Health Plan of San Mateo Attn: Pharmacy Services 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080

Members can file pharmacy appeals as follows which differ based on the line of business:

Medi-Cal (through the State Hearing process)	**Telephone** **800-743-8525** *(Voice)* **800-952-5253** **800-952-8349** *(TDD)*

Fax
833-281-0905 *(Complete the "Request for State Hearing" form on the back of the Notice of Action)*

Mail
California Department of Social Services
State Hearing Division
Post Office Box 944243, Mail Station 9-17-433
Sacramento, California 94244-2430
(Complete the "Request for State Hearing" form on the back of the Notice of Action)

Online
https://acms.dss.ca.gov/acms/login.request.do

CareAdvantage

Telephone
1-866-880-0606 *(toll free)* or **650-616-2174**

Fax
650-829-2045

In person or Mail
Grievance and Appeals Unit
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100
South San Francisco, California 94080

ACE

Telephone
1-800-750-4776 *(toll free)* or **650-616-2133**

Fax
650-829-2045

In person or Mail
Grievance and Appeals Unit
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100
South San Francisco, California 94080

External Appeals for CareAdvantage Members Only

HPSM CareAdvantage members have access to successive levels of appeal to contest adverse denials and appeals. These include:

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

Independent Review Entity (IRE)

If HPSM upholds its original denial, a member, authorized representative, or physician may request external review by the IRE. Unlike appeals for Part C benefits, appeals for Part D covered drugs will not be automatically forwarded to the IRE for review. To file a second-level appeal with the IRE, the provider or member should fill out the form attached to the written notification from HPSM.

For a Part D appeal denial to be reviewed by the IRE, the member must submit a written request to the IRE within 65 days of the date of the appeal denial decision. In this case, the IRE is required to solicit the prescribing physician's views on the case.

The IRE will decide on the case within the same timeframes as HPSM:

- Seven (7) days for a Part D appeal.
- 30 days for a standard Part C pre-service authorization appeal (7 days for Part B drug).
- 60 days for a Part C payment appeal.
- 72 hours for an expedited Part D or Part C 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.
- 24 hours for an expedited Part D appeal.
- 14 calendar days for a standard Part C pre-service authorization.
- 72 hours for an expedited Part C pre-service authorization.
- 30 calendar days for a standard Part C payment appeal.

Administrative Law Judge Hearing

In cases where the denied 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 unfavorable 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 Part C appeals.

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

Medicare Appeals Council (MAC)

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

Before filing any claim, be sure to confirm the member's eligibility. It is essential to include the member's correct identification number. Do not bill with a Social Security number. (Please see **"Section 2: Customer Support"**).

Data Quality and Accuracy

Effective healthcare claims processing and payment are highly contingent upon accurate, complete, and timely submission of claims and encounter data by the Health Plan of San Mateo's (HPSM) provider network. This data not only reflects services rendered and payment details, but also provides insight into the potential complexity of patient populations. HPSM is obligated to ensure the complete, accurate, reasonable, and timely submission of all encounter data, whether obtained directly as claims data or through subcontracts and other capitated arrangements, to the Centers for Medicare and Medicaid (CMS) and California Department of Health Care Services (DHCS) in accordance with existing standards and requirements.

Dental

To be eligible for payment, all paper claims must be typed and filed on fully and accurately completed ADA dental claim form with the current CDT procedure codes. If using the ADA dental claim form, please use version 2012 or later. Claims may be suspended or denied when data items included on claim forms are incomplete or incorrect.

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-10 diagnosis codes (at the highest level of specificity) and CPT-4 or HCPCS procedure codes (including applicable modifiers). Claims may be suspended or denied when data items on claim forms are incomplete or incorrect.

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 suspended or denied when data items on claim forms are incomplete or incorrect.

Paper Claims

Paper claims should be submitted to the following address:

Health Plan of San Mateo

Attention: Claims Department

801 Gateway Boulevard, Suite 100

South San Francisco, California 94080

Paper dental claims should be submitted to the following address:

HPSM Dental

PO Box 1798

San Leandro, California 94577

You can check status for a claim on the provider portal after 15 days from receipt.

You may also obtain Claim Status by contacting HPSM's Claims Department at **650-616-2106**, or by email at **ClaimsInquiries@hpsm.org.**

For CMS-1500 Form Field Descriptions and Requirements: **https://www.hpsm.org/docs/default-source/provider-services/claims_submission_cms1500.pdf**

For UB-04 Form Field Descriptions and Requirements: **https://www.hpsm.org/docs/default-source/provider-services/claims_submission_cms_ub_04.pdf**

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 National Uniform Billing Committee UB-04 form. Claims may be suspended or denied when data items included on claim forms are incomplete or incorrect.

Learn more about this change here: **https://www.hpsm.org/docs/default-source/provider-notices/20240430---new-claims-form-when-billing-for-long-term-care-services.pdf**

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

For guidance on completing the UB-04 form: **https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/47C902AC-C16D-4CD3-B378-191077DC99D8/ubsub.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO**

Timelines for Claims Submission

Medi-Cal Claims

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

Your claims must be submitted within 180 days from the date of service 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.

See Medi-Cal manual for acceptable billing delay reasons.

CareAdvantage Claims

Your claims must be submitted within one year from the date of service.

Additional Documentation

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 (National Drug Codes) number and dose of medication administered.
- Same procedure performed multiple times on the same date of service.
- Unlisted codes or codes that are “Not otherwise classified” usually ending in "99": Submit procedure, office or operative notes describing the procedure performed.
- 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 pended for reimbursement consideration.
- DME and Medical supplies requiring invoice and/or MSRP for pricing purposes.
- Services requiring consent.
- Dental claims: Please refer to the Prior Authorization Required list on the HPSM website.

- Claims submitted to HPSM for secondary payment require the primary remittance advice or reason for denial.

Important Billing Guidelines

It is especially 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 with the corresponding Medi-Cal Delay Reason Code. Providers are prohibited from refusing a covered Medi-Cal service to a Medi-Cal member, regardless of the presence of other healthcare coverage (OHC).

Note: 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.

For claims for members with other health insurance as primary coverage and HPSM as secondary coverage, claim and primary insurance remittance advice must be submitted to HPSM. Please submit these documents within six months of the date of service or 60 days of the primary remittance advice date and the corresponding Medi-Cal delay reason code to avoid timely filing penalties.

Electronic Claims

Advantages

- **Cost-Efficiency.** Handling of paper claims is eliminated.
- **Accuracy.** Your claims are formatted and submitted directly into our host system. This prevents the original claim data from having to be re-keyed.
- **Expediency.** Claims enter our system in real time and are processed faster.

Requirements

- 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”).

Electronic Claims Options

Clearinghouses	With the use of proprietary software or through integration of your current claims' software clearinghouses all needed information will be gathered and

sent to HPSM electronically using an 837 file. HPSM currently partners with three different clearinghouses, Waystar (HPSM1), Office Ally (HPSM1) and Change Healthcare (Payer ID SX174 for 837 Professional and 12X74 for 837 Institutional and WayStar (HPSM1).

To get set up with a clearinghouse, please contact the Provider Services department at **650-616-2106** or **PSDataRequests@hpsm.org**.

eHEALTHsuite

Providers can submit an electronic CMS 1500 claim through eHEALTHsuite, one of HPSM's provider portals. The easy-to-use system claims are entered directly into HPSM's claim system for processing.

To get set up in eHEALTHsuite, visit the HPSM Provider Portal at **https://www.hpsm.org/provider/portal** and click on "New User Registration."

Providers can receive payment through Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERAs) by signing up via our provider portal at **https://www.hpsm.org/provider/portal**.

EFTs allow funds to be deposited directly into the bank account the provider specifies and can decrease the wait time for payments. ERAs are an electronic description of services billed and paid.

Providers can sign up for one, both, or neither service. If a provider does choose to sign up, the provider must be registered for the provider portal. Once logged on, they can sign up for one or both by filling out all the required fields. A voided check or bank letter is required to receive EFTs. Providers can update bank information at any time by logging back into the provider portal.

Register for Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA)

EFTs send claims payments directly to your bank account, while ERAs make it easier to access and reconcile payment information. EFT and ERA are fast, secure and more accurate than paper checks, and reduce paper waste.

1. Log into our provider portal: **https://www.hpsm.org/provider-portal-login**
2. Click the yellow "SIGN UP FOR EFT/ERA" button the landing page.
3. Complete the form. The form can take up to 30 days to process.

Claims Tips and Reminders

- Be sure that you have a valid NPI number. This is extremely 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.
- Be sure to include both Billing NPI and Rendering NPI, particularly on claims for CareAdvantage enrollees.
- Make sure you receive confirmation that HPSM has your claim. Electronic claims are acknowledged via e-mail within two working days. HPSM will reject claims if there is an invalid Medi-Cal Provider ID Number, or no NPI number.
- Include both the billing and rendering taxonomy code for professional services.
- Dental electronic claims are acknowledged via EDI (Electronic Data Interchange) response within one working day. Payer ID for electronic dental claims is: HPSMD
- If your clearinghouse for dental claims is Change Healthcare, payer ID is: HPSM1

All electronic claims must comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The deadline for HIPPA 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 **650-616-2017**.

Methods of Reimbursement

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 (fee-for-service or capitation).

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 365 days of the date of service to qualify for the payment. A pro-rated amount will be paid by the Medi-Cal plan if the claim is submitted more than 180 days to 365 from the date of service, without a valid Medi-Cal delay reason code, 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 on the monthly Active Engagement Report. This payment covers the cost of all capitated procedures performed and is received whether 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 fee-for-service covered services and encounter data for all capitated services must be submitted to HPSM within 365 days of the date of service unless a valid Medi-Cal delay reason code is provided, as per contract provisions. Encounter data for capitated services is submitted to HPSM using the same submission process(es) as fee-for-service claims.

Claims and encounter data reflective of services provided to patients cared for under capitated payment arrangements are used to inform utilization and service monitoring and state and federal regulatory reporting requirements including, but not limited to, annual Healthcare Effectiveness Data Information Set (HEDIS) and ongoing Encounter Data submissions. Complete and accurate submission of claims and encounter data will significantly reduce the need for on-site Medical Record review or requests for medical records to be mailed to HPSM. (For more information about HEDIS, see **"Section 8: Provider Services"**).

HPSM Fee Schedule

Medi-Cal

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 or contracted 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 **https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates?tab=rates**. The HPSM Fee Schedule for primary care physicians, specialists a.k.a. referral providers (non-OB), OB specialists, other service providers, hospitals, and pharmacies are described below.

CareAdvantage

For CareAdvantage, HPSM uses the Medicare Participating Fee schedule. To review current professional rates, please see the Noridian website at **https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules/mpfs.** All other claims are paid using the applicable Medicare fee schedule for the service or item provided.

Payment Policies, Rules, & Non-Standard Coding Methodologies

HPSM follows the payment policies and rules outlined in the Medi-Cal Provider Manuals for Medi-Cal including modifier and diagnosis requirements. HPSM applies National Correct Coding Initiative (NCCI)

edits HPSM follows the current Medicare guidelines for the CareAdvantage line of business including NCCI edits.

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, waste, and abuse. 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 Optum CES as a technologically advanced tool for reviewing billing practices. Using nationally recognized payment and coding guidelines, Optum CES allows HPSM's claims system to pend, edit, or deny claim entries based on CMS, DHCS and AMA guidelines.

Your HPSM remittance advices outlines 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.

Vaccines For Children (VFC)Medi-Cal Program

You must be a VFC provider to be reimbursed through VFC and to be reimbursed for eligible vaccines. The VFC program, operated by the California Department of Health Care 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, 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. VFC eligible vaccines will not be reimbursed when submitted with the Medi-Cal required modifiers since these were provided at no cost.

For CareAdvantage

Vaccines should be billed directly to HPSM.

Reimbursement Guidelines

Claims are required to have accurate and specific ICD-10 diagnosis codes and CPT-4 procedure codes and/or HCPCS codes. Dental claims are required to have accurate and specific CDT procedure codes. Claims are reviewed for the following items and reimbursement for covered services will be based on the most appropriate coding:

Taxonomy Codes

A taxonomy code is a 10-character alphanumeric code that identifies a healthcare provider's specialty and type when submitting claims. *Example: 207RS0012X = Internal Medicine – Sleep Medicine*

HPSM requires taxonomy numbers on professional claims for both billing and rendering providers

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

A hospital 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, it is best practice to 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 re-bundled 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 of 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.

Multiple Modifiers

Billing guidance when billing multiple modifiers on a single line: Modifiers are grouped into categories based on their purpose. They should generally be listed in the following order when billing HPSM.

- 1st: Pricing modifiers impacting payment or processing (e.g., -26, -TC, -51, -50).
- 2nd: Informational modifiers (e.g., -59, -76, -77, -91).
- 3rd: Anatomical modifiers used to provide additional context but don't typically impact payment (e.g., -RT and -LT).

Repeat service Modifiers

A denial can be expected if the same service is submitted on more than one claim or more than one claim line for the same DOS without utilizing the "Days/Units" field or appropriate modifier.

- Use repeat service modifiers (76, 77, 59, 91) when the same service is performed multiple times on the same day.
  Use anatomical modifiers when the procedure is performed on different body parts.Do not use modifier 59 when a more specific repeat or anatomical modifier is available. Claims missing required modifiers may be denied or subject to additional review.

Modifier	Description
Modifier 59	**Distinct Procedural Service (use only when none of the Modifiers in the rest of this table apply)** : Used when the repeated service is separate and distinct from the initial service and not normally reported together. Example: A provider performs ultrasound-guided joint injections at two different anatomical sites during the same visit. The second injection should be billed with modifier 59 if it is not typically bundled.
Modifier 76	**Repeat Procedure by Same Physician or Other Qualified Healthcare Professional:** Used when the same provider performs the same service more than once on the same day. Example: A provider performs chest X-rays (CPT 71046) at 10:00 AM and again at 4:00 PM for the same patient. The second service should be billed as 71046-76.
Modifier 77	**Repeat Procedure by Another Physician or Other Qualified Healthcare Professional:** Used when a different provider performs the same procedure on the same day.

	Example: A patient undergoes a Doppler ultrasound of the extremities (CPT 93925) in the morning performed by Dr. A. Later that day, the patient's condition changes, and another Doppler ultrasound is required and performed by Dr. B. The second service should be billed as 93000-77.
Modifier 91	**Repeat Clinical Diagnostic Laboratory Test:** Used when the same lab test is repeated on the same day for medical necessity (not due to lab error). Example: A glucose tolerance test requiring multiple blood draws throughout the day. Each repeat test should be billed with modifier 91 (e.g., 82947, 82947-91).
Site Modifiers	When billing procedures are performed on different anatomical sites, anatomical modifiers should be used to distinguish each service: - Eyelids: E1 – Upper left, E2 – Upper right, E3 – Lower left, E4 – Lower right - Fingers: FA – Left hand, thumb, F1-F5 – Left hand, index to little finger, F6-F9 – Right hand, index to little finger - Toes: Left foot- TA-T4/Right foot T5-T9 - LT / RT: Left or right Side of the body Example: - 28010 (Tenotomy, percutaneous, toe; single tendon)– T1

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.

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 Care 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 MCG Guidelines. A procedure which always requires the use of an assistant surgeon according to the MCG 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 surgeons allowed procedures. For these exceptions, a TAR (Treatment Authorization Request) will be required and documentation supporting the medical justification for an assistant surgeon must be submitted for preauthorization. The list of procedures for which an assistant surgeon is allowed is downloadable from the HPSM website or you may contact your Provider Services liaison 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 if the day is covered by the accommodation quantity authorized on the TAR).

Long Term Care Reimbursement

Payment to nursing facility for skilled nursing facility services provided in accordance with 22 CCR § 51123 shall be as set forth below:

- Provider shall furnish all equipment, drugs, supplies, and services necessary to provide nursing facility services. 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.
- 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 (may not apply in instances where the member is receiving skilled nursing level of care):
    - 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.

- 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.
- 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 the provider also renders intermediate care services, the 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 the health 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.

a) Notwithstanding (e) above, should the state, through an Operating Instruction Letter (OIL) or some other instrument, require HPSM 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, HPSM reserves the right, but does not have the obligation, to make said adjustments. In the event that HPSM does elect to make such an adjustment, HPSM shall be obliged only to do so back to the beginning of the current fiscal year.
b) Based on valid claims submitted by a nursing facility, HPSM shall multiply the number of approved inpatient days by the applicable rates, set out above, to determine the amount due. HPSM shall pay the amount due within thirty (30) days of receipt of valid claims.

Facility should submit UB 04 Claim forms and include Medi-Cal LTC accommodation codes.

The parties agree that the nursing facility shall be reimbursed by HPSM when it receives clean claims for services billed with Medi-Cal accommodation codes at the per diem rate for the level of care provided.

HPSM shall multiply the number of approved ICF/LTC days at the rate set forth above to determine the amount due based on valid claims submitted by the nursing facility. HPSM shall pay the amount due within 30 calendar days of receipt of valid claims.

Intermediate Care Services

Developmentally Disabled and Nursing Level-A Facilities

- Intermediate Care Facilities (ICF) 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. 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.

- 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 (may not apply in instances where the member is receiving skilled nursing level of care):
    - 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.
- 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.
- Payment to ICF facilities for inpatient services for developmentally disabled members 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 HPSM at the time agreement is signed.

Nursing facility shall be reimbursed by HPSM when it receives clean claims for intermediate care services billed per DHCS policy at the ICF's daily state Medi-Cal rate.

Based on valid claims submitted by a nursing facility, HPSM shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. HPSM shall pay the amount due within thirty (30) days of receipt of valid claims.

Full Payment: The rates as set forth above for both Developmentally Disabled and Nursing Facility Level A services are to be the only payments made by HPSM to ICF for inpatient services provided to members.

((e) Not withstanding (d) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require HPSM 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, HPSM reserves the right, but does not have the obligation, to make said adjustments. In the event HPSM does elect to make such an adjustment, HPSM 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 HPSM reimburses ICF at the per diem rate, HPSM shall multiply the number of approved inpatient days by the applicable rates, set out above, to determine the amount due. HPSM 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

Automatic Crossover Claims: Medicare uses a consolidated Coordination of Benefits Agreement (COBA) to automatically cross over to HPSM claims billed to any Medicare contractor for Medicare/Medi-Cal eligible recipients assigned to HPSM.

Note: Providers do not need to rebill to Medi-Cal on paper or electronically claims that automatically cross over. See Medi-Cal manual for exceptions to this process.

When HPSM is a secondary plan, and the claim is not eligible to automatically crossover, a copy of the primary payer's EOB must 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 it to HPSM.

Standard timely filing limits may be exceeded if the claim is submitted within 60 days of payment on the primary payer's Explanation of Benefits (EOB) form.

Prior authorization: Prior authorization is not required when HPSM is the secondary insurance and the primary payer approved the claim. The exception to this is when the primary carrier is a non-Medicare payer and HPSM's liability after coordinating benefits is over $25,000.

Medicare Non-Covered Services – Direct Billable

The Department of Health Care Services (DHCS) maintains a list of Medi-Cal codes that may be billed directly to Medi-Cal/HPSM for Medicare/Medi-Cal recipients. These codes are considered direct billable. To be considered direct billable the billing code must be included in the Medicare Non Covered Services charts for direct billing provided by DHCS. If a service or supply is not included in the chart, submit the corresponding Medicare MRN showing the services or supplies that are not allowed by Medicare when billing Medi-Cal. Refer to the Medicare Non-Covered Services: CPT® Codes and Medicare Non-Covered Services: HCPCS Codes sections in the appropriate Part 2 manual for additional instructions. A single claim form cannot be used when billing for the combination of Medicare non-covered/direct billable and non-direct billable charges.

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:

1. Plan of the parent with custody pays first.
2. Plan of stepparent with custody pays secondary.
3. Plan of parent without custody pays third.
4. 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 Medi-Cal or Medicare provider with HPSM you are prohibited from billing HPSM members according to the terms of your contract and California State Law.

Should you have any questions regarding billing HPSM members, please contact HPSM at **650-616-2106** or via email at **ClaimsInquiries@hpsm.org.**

Contacting the Claims Department

Providers should check HPSM's website for member eligibility and claims status. The Claims Department is available by phone **650-616-2106** Monday, Tuesday, Thursday and Friday from 8:00 AM to 5:00 PM. (closed from 12:00PM to 1:30PM), and Wednesdays from 8:00 AM to 12:00 PM or via email at **claimsinquiries@hpsm.org.**

Claims Disputes

Please refer to **"Section 5: Provider Disputes"** 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 Claims Department at **650-616-2106** or by email at **ClaimsInquiries@hpsm.org** for assistance.

Section 5: Provider Disputes

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 noncontracted providers with one exception. This exception is for non-contracted providers who have a dispute regarding a claim for services provided to a 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 providers, or member's activities or behaviors, the provider may contact HPSM's Provider Services Department at **650-616-2106**.

If a provider wants to submit an appeal of a denial of a service authorization on behalf of a member, please refer to the Member Complaints Section of this Manual. HPSM's PDR process must not be used to resolve member appeals of pre-service authorization denials. Such appeals should be submitted through the member appeals process described in "**Section 3: Member Complaints.**"

Updates and Claim Corrections

Corrected Claims

Corrections by providers to previously submitted claims are not considered provider disputes. Corrections can be submitted using one of the following options.

Rebill Claims

Most denied claims and service lines can be rebilled as a new claim or updated/corrected when the claim is submitted in a timely manner.

Rebill when HPSM denies a claim because of incorrect information supplied on the claim form. In such cases, you can rebill these claims by submitting a new claim form that has corrected the issue that triggered the denial. For example, you can rebill for claims that HPSM denied because of:

- Lack of required information (e.g., NDC, primary insurance information, rendering NPI, modifiers, medical records/invoice, and HIPPS codes).
- Invalid data (e.g., ICD-10 codes or sets, invalid modifier for the service/item).

How to Rebill Claims

You can rebill HPSM using the same method used to submit claims. Please submit denials requesting additional documentation on paper and address to:

Health Plan of San Mateo

Attn: Claims Processing

801 Gateway Blvd., Suite 100

South San Francisco, California 94080

Dental Claims

For dental claims, please submit denials requesting additional documentation on paper and address to:

HPSM Dental

PO Box 1798

San Leandro, California 94577

Rebill Submission Timeframes

Medi-Cal	Rebill within six months of service date
CareAdvantage	Within 12 months of service date

HPSM's Claims Correction Request Form

Update claims using the Claims Correction Request Form when you want to modify a previously submitted claim line that has already been processed. For example, you can correct or update claim(s) or claim line(s) when you want to:

- Make changes to paid service line(s).
- Report overpayments (including retro application of share of cost deductions).
- Request reimbursement for a claim or service line that was originally denied as a duplicate.

How to Correct or Update Claims

a. Complete the Claims Correction Request Form found here: **https://www.hpsm.org/docs/default-source/provider-forms/claim_correction_request_form.pdf**
b. Attach a copy of the corrected claim form.
c. Submit the form to HPSM by fax or mail.
    a. Fax: **650-829-2051**

b. Mail: Health Plan of San Mateo
   Attn: Claim Corrections
   801 Gateway Boulevard, Suite 100
   South San Franciso, California, 94080

Provider Refunds

Providers are required to refund overpayments in accordance with federal and state law, Medi-Cal and Medicare program requirements, and the Health Plan of San Mateo (HPSM) Provider Manual.

When to submit a refund

Submit a refund when your office identifies an overpayment or when HPSM issues an overpayment notice. Providers must not delay refunds while awaiting rebilling unless instructed by HPSM.

Medi-Cal and Medicare requirements

Medi-Cal providers must report and return identified overpayments within 60 calendar days of identification in accordance with California Department of Health Care Services (DHCS) requirements. Medicare CareAdvantage providers must comply with Centers for Medicare & Medicaid Services (CMS) overpayment reporting and refund requirements, including applicable 60-day return timelines.

See HPSM's PDR processing for disputing an overpayment reported by HPSM.

How to submit a refund

Refunds must be submitted by check unless otherwise directed by HPSM. Checks must be payable to Health Plan of San Mateo. Refunds may not be combined across multiple provider entities or tax identification numbers.

Required documentation

Include provider name, National Provider Identifier (NPI), Federal Tax ID (TIN), claim number(s), member name, date(s) of service, refund amount per claim, and reason for refund. Refunds submitted without sufficient detail may be delayed or returned.

Mailing address:

Health Plan of San Mateo

Attention: Provider Refunds

801 Gateway Boulevard, Suite 100

South San Francisco, CA 94080

Please note: HPSM may offset overpayments against future claim payments when permitted by contract or law. Providers are responsible for retaining proof of refund submission.

Provider Dispute Resolution

HPSM offers Provider Dispute Resolution (PDR) for Providers to resolve claims issues. This process includes a written notice to HPSM requesting reconsideration of a claim or a bundled group of substantially similar claims. 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.
- If a claim has been underpaid.
- A procedure was denied as inclusive to another procedure in error.
- Utilization management decisions once a service has been provided.

Note: The PDR process should not be used to request retroactive authorization. Instead, retroactive authorization requests should be submitted directly to HPSM's Health Services department.

If the dispute is not about a claim, a provider should provide a clear explanation of the issue. If a provider dispute is submitted on behalf of a member or group of members, the dispute will be resolved through the member grievance process and not through the provider dispute resolution process. HPSM will, however, verify the member's authorization to proceed with the grievance.

Providers should submit their dispute through submission of a Provider Dispute Resolution Request form, including the following information:

- Provider name.
- NPI billed on claim.
- 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 this section. The form is also available on HPSM's website at **https://www.hpsm.org.** You may fax your PDR request to **650-829-2051** or if you want to print the form and send it via mail, please send your PDR to the address below:

Health Plan of San Mateo

Attn: Provider Disputes

801 Gateway Boulevard, Suite 100

South San Francisco, California 94080

Time Periods for Submission

Provider disputes should be sent within 365 days from the initial Remittance Advice (RA) date. 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 and still meet the 365 days limit. If the additional information is not submitted, the dispute will be closed.

Time Frames for Resolution

HPSM will send an acknowledgement letter to the provider within 15 working days of receipt of the dispute mail.

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 for Medi-Cal and 60 calendar days for CareAdvantage disputes from Contracted providers 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 for a service that has not been provided, the Provider should appeal this through HPSM's Appeal Process. To understand how to appeal, please refer to the **"Section 3: Member Complaints"** section of this manual.

Non-Contracted Provider Disputes —CareAdvantage Only

Non-Contracted providers who want to submit a CareAdvantage Appeal of a benefit determination on behalf of a member, must submit the appeal and waiver of liability (see attachment below) to the Grievance and Appeals Department according to **"Section 3: Member Complaints."** 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 for HPSM to process the appeal.

Non-Contracted providers, who want to submit a dispute regarding a payment decision, must submit the dispute through the Provider Dispute Resolution process.

Provider Grievances

If a provider is dissatisfied with aspects of HPSM's operations or with a member's behavior, the provider may contact HPSM's Provider Services Department at **650-616-2106**.

Section 6: Ancillary Services

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 under Title XVII and XIX should be transparent.

If you have questions or need to verify benefit coverage for CareAdvantage members, contact the Provider Services Department at **650-616-2106**.

Laboratory Testing

The Health Plan of San Mateo (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 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, where 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 also integrated. As a result, HPSM will also support office-based diagnostic testing that adheres to office Clinical Laboratory Improvement Amendments (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 4: Claims”** 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.

Pharmacy Benefits

The following section applies to drugs and items covered under the outpatient pharmacy benefit and does not pertain to physician-administered drugs (PADs) which are billed and managed under HPSM's medical benefit.

Medi-Cal

Outpatient pharmacy benefits are covered under the Medi-Cal fee-for-service delivery system, collectively referred to as "Medi-Cal Rx". As a result, pharmacy claims should be billed to Medi-Cal Rx. This includes medications, some diabetic testing supplies, and medically necessary enteral formulas.

CareAdvantage and ACE

HPSM manages outpatient pharmacy benefits for CareAdvantage and ACE. HPSM pharmacy staff are available to consult with providers about plan benefits and exclusion, drug formularies, the prior authorization process, and other clinical pharmacy issues related to HPSM members. Each program has a detailed description of the pharmacy benefits coverage and exclusions in the member handbook/evidence of coverage (EOC). All pharmacy claims should be billed through HPSM's pharmacy benefits manager, SS&C.

Medications and some diabetic supplies are billed through HPSM's pharmacy benefits manager, SS&C. These supplies and medications may be subject to a co-pay depending on which program the member is eligible for.

For CareAdvantage, HPSM covers medically necessary enteral formulas through the pharmacy benefit in accordance with Medicare laws.

Who to Contact

Medi-Cal	Medi-Cal Rx is primarily responsible for processing outpatient pharmacy claims and assisting with day-to-day pharmacy billing problems and issues. All prior authorization requests are reviewed and processed by Medi-Cal Rx's pharmacy staff. For billing questions or questions regarding pending or submitted prior authorization requests, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**.
CareAdvantage and ACE	HPSM contracts with SS&C Health Solutions (previously known as Argus or DST) as our Pharmacy Benefits Manager (PBM) to administer the outpatient

pharmacy benefit through its network of retail, home infusion and long-term care pharmacies. SS&C is primarily responsible for processing pharmacy claims and assist with day-to-day pharmacy billing problems and issues. The SS&C customer service and help desk telephone number is **888-635-8362**. You may contact SS&C directly at any time (24 hours a day, seven days a week).

HPSM pharmacy staff are available to answer your questions regarding pharmacy services, formularies, and prior authorization process. All prior authorization requests are reviewed and processed by HPSM pharmacy staff. They can be reached at **650-616-2088**, from 8:00 AM to 5:00 PM, Monday through Friday.

Drug Formularies

Medi-Cal

DHCS maintains the formulary for pharmacy services related to Medi-Cal members, called the Medi-Cal Rx Contract Drug List (CDL). This list is posted on the Medi-Cal Rx website, available at **https://medi-calrx.dhcs.ca.gov/provider/forms** under the "Covered Product Lists" tab.

CareAdvantage and ACE

HPSM maintains three separate drug formularies. There is one formulary for HPSM CareAdvantage and one for the ACE program. The CareAdvantage formulary is reviewed by the HPSM Pharmacy and Therapeutics Committee. The committee is comprised of pharmacists and physicians within the community and includes representation from various specialties. It meets quarterly and its approach is to consider the efficacy, safety, and cost-effectiveness of drugs when making formulary changes. References that inform formulary recommendations include but are not limited to evidence-based clinical practice guidelines, clinical studies, peer-reviewed medical literature, FDA package inserts, clinical compendia, and more. In most situations, this may result in the preference towards formulary coverage of generic medications. 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:

Fax	**650-829-2045**
Mail	Health Plan of San Mateo
	Attn: Pharmacy and Therapeutics Committee
	801 Gateway Boulevard., Suite 100
	South San Francisco, California 94080

The HPSM formularies are available on the HPSM website at **https://www.hpsm.org/provider/formulary-search.** Hard copies of the HPSM formularies are also available from the Provider Services Department. The HPSM formularies list all drugs by either the chemical name, brand name (if one exists), and/or the name of the generic equivalent. The formularies will also have information regarding any restrictions that may apply such as prior authorization, step therapy, or quantity limit. If you have any questions regarding the HPSM drug formularies, please contact the HPSM pharmacy staff at **650-616-2088**.

Non-Formulary Drugs

Medi-Cal	HPSM participating providers and pharmacies are highly encouraged to prescribe drugs that available on the Medi-Cal Rx Contract Drug List (CDL). If there is a need to prescribe a drug that is not on this list, a pharmacist may contact the prescribing provider to recommend switching to a formulary alternative, when appropriate. If an alternative is not available or inappropriate for a member's condition, the provider must submit a prior authorization request to Medi-Cal Rx. For more information regarding how to submit prior authorization requests, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**. You may also submit a prior authorization request via **https://covermymeds.com.**
CareAdvantage and ACE	HPSM participating providers and pharmacies are highly encouraged to prescribe drugs that are available on HPSM formularies first. If there is a need to prescribe a drug that is not on the formulary, a pharmacist may contact the prescribing provider to recommend switching to a formulary alternative, when appropriate. If an alternative is not available or inappropriate for a member's condition, the provider should submit a Prescription Drug Prior Authorization or Step Therapy Exception Request Form to HPSM at **650-829-2045**. (See Pharmacy Prior Authorization Process for information on submitting a Prescription Prior Authorization form).

Changes in Drug Formularies

Medi-Cal	Please refer to Medi-Cal Rx website, available at **https://medi-calrx.dhcs.ca.gov/home/**, for details regarding changes to the Medi-Cal Rx drug list.
CareAdvantage and ACE	If a member is on a drug, and HPSM removes the drug from its formulary, the prescriber would need to consider changing their patient to a formulary alternative. If none of the formulary alternatives can be utilized, a Prescription Drug Prior Authorization or Step Therapy Exception Request

Form should be submitted to HPSM providing reasons as to why a formulary alternative is not appropriate.

Pharmacy Prior Authorizations (PA)

Medi-Cal

For more information regarding how to submit prior authorization requests, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**. You may also submit a prior authorization request via **https://covermymeds.com**.

CareAdvantage and ACE

Prior authorization provides access to drugs and/or products that are either non-formulary or are on the formulary with restrictions.

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

Please refer to our website for the most current prior authorization & referral forms at **https://www.hpsm.org/provider/resources/forms**.

Completing and Submitting Pharmacy Prior Authorization Requests

Medi-Cal	For more information regarding how to submit a pharmacy prior authorization request to Medi-Cal Rx, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**.
CareAdvantage and ACE	Once the appropriate form has been completed, providers should fax it to HPSM at **650-829-2045**. Providers may also call **650-616-2088** with this information. For CareAdvantage, pharmacies must also fill out a CMS Appointment of Representative (AOR) Form and include it with each request submitted. This form is available in the Forms section and is also available online on the HPSM website. It is important to fill out the prescription request form completely. The following data items are frequently not completed by providers and results in returned request forms.

- Prescribing Provider's Name, NPI, Address, Phone Number and Fax Number
- ICD-10-CM Diagnosis Code
- Medical Justification (including formulary alternatives tried)
- Specific Services Requested
- Specific Directions for Use

Once the prior authorization request form has been received, HPSM pharmacy staff will review the clinical information submitted to render a decision. The criteria used to make these decisions have been developed and approved by HPSM's Pharmacy and Therapeutics Committee.

Processing Time for Pharmacy Prior Authorizations

Medi-Cal	Decisions for prior authorization are usually made by Medi-Cal Rx within 24 hours.
CareAdvantage and ACE	For standard CareAdvantage and ACE requests, decisions for prior authorizations are made within 72 hours of the request for standard requests. For all expedited/urgent CareAdvantage and ACE requests, decisions for prior authorization and continuing pharmacy requests are made within 24 hours of the receipt of the information reasonably necessary to decide.

Prescription Deferral Process

Medi-Cal

The deferral process does not apply to Medi-Cal Rx.

CareAdvantage

A decision on a prescription request form may be deferred or "tolled" for up to 14 days if it is submitted with insufficient medical justification or incomplete information. In the event this occurs, HPSM pharmacy staff will make attempts to contact the provider to obtain the additional medical information needed.

If no additional information is received after the tolling period of 14 days, HPSM staff will make a final determination based on the information available.

ACE

The deferral process does not apply to ACE.

Prescription Denial Process

Medi-Cal

For more information regarding the denial process for Medi-Cal outpatient pharmacy services, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **1-800-977-2273**.

CareAdvantage and ACE

A licensed clinician reviewer (medical director or clinical pharmacist) may deny certain prior authorization requests when the request is not determined to be medically necessary. Cases reviewed by a clinician reviewer may involve consultation with appropriate specialists as needed prior to denial. If necessary, the clinician reviewer may discuss the determination with the prescribing physician 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 a Denial Notice of Action Letter is sent 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.

Pharmacy Appeals Process

Medi-Cal

The process for submitting pharmacy related appeals differ depending on whether it is the member or provider that is submitting the appeal.

- Member must go through the State Fair Hearing Process and usually must submit their request within 90 days from the original denial notification.
- Providers must submit appeal requests to Medi-Cal Rx. For more information regarding the appeals process, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **800-977-2273**.

CareAdvantage and ACE

Members and providers may request that HPSM reconsider an initial adverse determination. The request must be made in writing within sixty-five (65) days of the date of the original adverse determination notice for CareAdvantage appeals, within sixty (60) days for ACE.

Evening and Weekend Pharmacy Prior Authorization Requests

Medi-Cal

For more information regarding how evening and weekend prior authorization requests are handled, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **800-977-2273**.

CareAdvantage and ACE

Evening, weekend/holidays prior authorization requests are reviewed by HPSM's on-call pharmacist within usual processing timeframes.

Emergency Medication Supply

Medi-Cal

For more information regarding how to obtain an emergency medication supply, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **800-977-2273**.

CareAdvantage and ACE

For emergency situations, HPSM's Pharmacy Services department can provide up to at least a 72-hour supply of most medication(s) without restriction. This includes prescriptions awaiting the submission or approval of a prior authorization request. Certain limitations apply. For additional information or assistance, please contact us at one of the following:

- The Pharmacy Help Desk line at **888-635-8362** any time (24/7).
- HPSM's Pharmacy Services at **650-616-2088** during business hours (Monday through Friday, 8:00 AM to 5:00 PM).

Pharmacy Network

Medi-Cal

Under Medi-Cal fee-for-service (FFS), most California-licensed pharmacies are enrolled in the FFS network. For helping a pharmacy, you can use the Medi-Cal Rx Pharmacy Locator online at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **800-977-2273**.

CareAdvantage

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

ACE

Only select pharmacies serve ACE members. For more information regarding which pharmacies are included in the ACE network, please contact the ACE Program Unit help desk at **650-616-2194**.

Co-Payments and Cost-Sharing

Medi-Cal

For full scope Medi-Cal members, there are no co-pays for pharmacy benefits.

CareAdvantage and ACE

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, whether it is a preferred drug on the HPSM formulary, and, for CareAdvantage members, the member's income level. Programs may have annual drug cap amounts as well. For questions on eligibility, pharmacy benefits, or co-pays, call SS&C's Customer Service at **888-635-8362**, available 24 hours per day, seven days per week.

Important Reminder on Charging Cash to HPSM Members

Never bill a member in place of submitting a prior authorization. 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 prior authorization process unless it is a specific exclusion of the program.

Safety and Alert Programs

Affected physicians and members will be notified by mail with 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.

Behavioral Health: Mental Health and Substance Use Disorder Services

Primary care providers are responsible for supporting their patient's behavioral health needs within their scope of practice, which may include diagnosis and treatment. All HPSM members in need of behavioral health support should be encouraged to speak with their primary care provider. Please note: some primary care providers have behavioral health services or providers available in their practices.

If a member has a behavioral health treatment need that cannot be managed through primary care, providers should refer member to the ACCESS Call Center using the Behavioral Health Referral form. The most up-to-date referral form can be found here: **https://www.hpsm.org/provider/behavioral-health/mental-health-and-substance-use-treatment**

Members may call the ACCESS Call Center at **800-686-0101** to be screened and routed to the correct benefit and network provider including for therapy, psychiatry/medication management and/or substance use treatment. A provider referral is not needed for a member to call the ACCESS Call Center; a member may self-refer.

Coverage and services available can vary by line of business and symptom severity. For Medi-Cal members, behavioral health services are covered by three separate systems of care. Where the member receives service and coverage depends on severity of symptoms and treatment need and may vary by line of business.

- **HPSM Managed Care Plan**, for non-specialty mental health (more details below).
- **BHRS Mental Health Plan**, for specialty mental health (more details below).
- **BHRS Drug Medi-Cal Organized Delivery System (DMC-ODS)**, for substance use disorder services (more details below).

San Mateo County Behavioral Health and Recovery Services (BHRS) ACCESS Call Center

The BHRS ACCESS Call Center is the San Mateo County primary contact number for mental health services and substance use treatment referrals for all HPSM members. Reach them toll free at **800-686-0101** (TDD: 800-855-7100). Staff are available during normal business hours (Monday through Friday, 8:00 AM to 5:00 PM). After-hours support is also available. The ACCESS Call Center is an important resource for HPSM members to be screened and routed to the appropriate behavioral health services. Upon a member's call, the ACCESS Call Center will conduct a screening (standardized questions) to identify whether the member should be connected to specialty mental health care, non-specialty (mild to moderate) mental health care

and/or substance use treatment and will link the member accordingly. When ACCESS receives the behavioral health referral form from providers, they do a review of the documentation and clinical information provided and route the members to the appropriate system of care.

HPSM Managed Care Plan

HPSM's non-specialty mental health network provides outpatient non-specialty (mild to moderate) mental health services for members. HPSM also covers emergency room psychiatric and mental health services and Medication Assisted Treatment for substance use provided by a member's primary care provider, within the scope of their licensure.

If a member in the non-specialty (mild to moderate) level of treatment has a change in symptoms the mental health providers should assess the member for specialty mental health criteria and will need to use the Referral for Higher Level of Care Form or transition tool to link the member to specialty mental health. Forms and process details are posted on HPSM's website. HPSM non-specialty mental health providers and HPSM primary care providers can use the HPSM provider behavioral health website for helpful forms, processes, and information: **https://www.hpsm.org/provider/behavioral-health/mental-health-and-substance-use-treatment**

San Mateo County Behavioral Health and Recovery Services (BHRS) County Mental Health Plan

BHRS is responsible for services for HPSM members with severe mental health issues and treatment needs. They also have several community-based programs that extend beyond Medi-Cal coverage. BHRS services are aimed at helping members and community members with mental illness maintain their independence and helping children with serious emotional problems become educated and stay with their families.

BHRS has specialty outpatient service centers in Daly City, San Mateo, the Coastside, Redwood City and East Palo Alto; in school-based locations; and through a network of community agencies and independent providers. BHRS also operates the Cordilleras Mental Health Center, a 120-bed skilled nursing facility in Redwood City (through a contract with Telecare Corporation).

Drug Medi-Cal Organized Delivery System (BHRS) Substance Use Treatment

Behavioral Health and Recovery Services provides services for substance use treatment ranging from intensive outpatient treatment to residential care and detox. Primary Care providers can refer patients for substance use treatment by using the Behavioral Health Referral Form and faxing it into the ACCESS Call Center. Members can also self-refer by calling the ACCESS Call Center at **800-686-0101**.

How Providers Refer a Member to Behavioral Health Services

To refer a patient to behavioral health services, follow these steps:

1. Assess patients regularly for mental health and substance use issues, paying special attention to people in high-risk groups.
2. Discuss your recommendation for mental health or substance use treatment with the patient, including enlisting their existing supports or services.
    a. If a patient is not ready to be referred to or start treatment, inform them they can self-refer when they are ready by calling the ACCESS call center **800-686-0101**.
3. Complete the Behavioral Health Referral Form and fax it to the ACCESS call center. For hospital discharges only, call BHRS Access Team at **800-686-0101**.
    a. If the ACCESS Call center identifies the situation as an emergency, or you assessed the situation to be life-threatening, refer the patient immediately to the nearest emergency room or to call 911.
    b. If you choose to use a youth trauma screening tool as part of your assessment of members under 21 years of age, you must use a DHCS-approved youth trauma screening tool. Please see here for a list of DHCS-approved youth trauma screening tools: **https://www.dhcs.ca.gov/wp-content/uploads/2026/04/APL26-002AttachmentA.pdf**
4. A BHRS clinician will review the referral and may call you for more information to determine the most appropriate system of care. Staff will route the patient to HPSM (mild to moderate treatment needs,) or BHRS (specialty mental health or substance use treatment) network provider or community resources accordingly.

Note: 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.

Behavioral Health: Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services

Behavioral Health Treatment (BHT) is a DHCS term that describes the specific Medi-Cal benefit for members under 21 years old with Autism or Autism-like similar symptoms. The benefit includes Comprehensive Diagnostic Evaluation (CDE), Functional Behavioral Assessment (FBA), and Applied Behavioral Analysis (ABA). To qualify, members must be under 21 years of age, have a qualified provider recommending these services, must be medically stable and not have a need for 24 hour medical monitoring.

Primary care providers are responsible for supporting their patient's behavioral health needs within their scope of practice, which may include developmental screenings and assessment. HPSM members in need of behavioral health treatment support should be encouraged to speak with their primary care provider.

Referral is required for BHT services. Providers can refer using the Behavioral Health Treatment (BHT) Referral Form. Additional information about the BHT benefit and the most up-to-date referral form and can be found here: **https://www.hpsm.org/provider/behavioral-health/behavioral-health-treatment-applied-behavioral-health-analysis**

Note: Your role in the referral process is very important. Your discussion with the family about possible developmental diagnoses and the corresponding treatment recommendations may help the family better prepare and manage expectations about services, thereby supporting engagement in future treatment.

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 contracts with several free-standing radiology facilities. Please refer to the provider directory to find the most convenient location for your patient.

Please refer to the HPSM website for the most current prior authorization requirements for diagnostic radiology and advanced imaging 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 prior authorization request for technical services.

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

HPSM will determine medical necessity only. Always verify eligibility, benefits, and co-payments for a member directly with HPSM Member Services.

Remember the applicable modifier(s) when submitting prior authorization requests for these services.

Chiropractic Care and Acupuncture

HPSM contracts with local chiropractic providers for the provision of chiropractic services for HPSM members. Acupuncture services are available for Medi-Cal members. In both cases benefits are subject to program coverage and limitations. In general, visits are limited to two 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.

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 prior authorization request. Please refer to the HPSM website for the most up-to-date information on prior authorization requirements for continuing therapy services.

Speech Therapy

All HPSM members have access to outpatient speech therapy services. Initial evaluations do not require a prior authorization. Please refer to the HPSM website for the most up-to-date information regarding prior authorization requirements for continuing therapy services.

For patients who may be eligible for a school-based speech therapy program (three 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).

Podiatry

Medi-Cal

Podiatry benefits are provided for HPSM Medi-Cal members.

Podiatry services are provided through our contracted providers located throughout San Mateo County. Services are limited to two office visits a month. Please refer to the HPSM website for the most up-to-date information regarding prior authorization requirements for podiatry services.

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).

Dental (Medi-Cal and CareAdvantage only)

Dental services are covered through HPSM's Medi-Cal dental benefit. Dental services are provided through our contracted Dental providers located throughout San Mateo County and neighboring counties. Medi-Cal and CareAdvantage members are eligible for certain dental services including cleanings, fillings, and dentures.

All medically necessary dental treatment will be reviewed and authorized by HPSM. Please refer to the HPSM website for the most up-to-date information regarding prior authorization requirements for covered dental services.

Vision

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.

Medi-Cal

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

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 members 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.

Durable Medical Equipment

Durable medical equipment (DME), when prescribed by a licensed practitioner, is covered when medically necessary. 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. For

the most up-to-date information regarding prior authorizations for DME requests, please refer to the HPSM website.

	Included items	Excluded items
Medi-Cal	• Oxygen and oxygen equipment. • Blood glucose monitors. • Apnea monitors. • Nebulizer machines, tubing and related supplies, and 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).	• 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.
CareAdvantage	• 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.	• Orthopedic shoes or supportive devices for the feet (certain exceptions apply).

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 determined that the proposed wheelchair is medically necessary.

3. The wheelchair provider has received an authorization via an authorized prior authorization request 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.

Please refer to the HPSM website for information regarding prior authorization requirements for wheelchair requests. 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 HPSM programs, subject to specific program limitations described below. Please refer to the HPSM website for the most up-to-date information regarding prior authorization requirements for audiology services. 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.

	Included items	Excluded items
Medi-Cal	• Screenings 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.	• 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.
CareAdvantage	• Diagnostic hearing and balance exams.	• Hearing aids and hearing exam for the purpose of fitting a hearing aid.

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 and dispensed by an HPSM contracted provider. Please refer to the HPSM website for the most up-to-date information regarding prior authorization requirements for prosthetic and orthotic devices.

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.

	Included items	Excluded items
Medi-Cal	• All requested items must be determined by HPSM to be medically necessary.	• All requested items must be determined by HPSM to be medically necessary.
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.	• Orthopedic shoe or supportive devices for the feet (certain exceptions apply).

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) for Medi-Cal members offers a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost members. This is done through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes; and

- Decreasing inappropriate utilization and duplication of services.

ECM will be offered to specific target populations of focus. Authorized members will be sent notices to learn about these services, but more information about ECM, and requests for services can be made by accessing the appropriate ECM referral form via HPSM's website at **https://www.hpsm.org/provider/calaim.**

Interested members can also be directed to contact HPSM's Integrated Care Management at **650-616-2060** during Monday through Friday, 8:00 AM to 6:00 PM.

HPSM administers this benefit through a partnership with San Mateo County and ECM contracted providers who are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the populations of focus.

Community Supports

Community Supports are optional services or settings that are offered to Medi-Cal and CareAdvantage members in place of services or settings covered under Medi-Cal. Community Supports is not a benefit but are medically appropriate and cost-effective alternative services with the goal to improve the health outcomes and quality of life experienced by high risk Medi-Cal recipients by addressing Social Determinants of Health (SDOH). Community Supports services or settings are administered by HPSM contracted Community Support providers.

To learn more about the Community Supports service options offered by HPSM or to request services, please access HPSM's website at **https://www.hpsm.org/provider/calaim.** Interested members can also contact HPSM's Integrated Care Management at **650-616-2060** during business hours, Monday through Friday, 8:00 AM to 5:00 PM.

Community Health Workers

Community Health Workers (CHWs) offer services that are medically necessary for our highest-needs members that include the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and other preventive services. CHWs can help members receive services related to perinatal care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services to prolong life and promote physical and mental health.

CHWs have lived experience and may include individuals known by a variety of job titles, such as community health representatives, navigators, and other non-licensed public health workers.

CHW services require a written recommendation submitted to HPSM by a physician or other licensed practitioner of the healing arts within their scope of practice.

Doula Services

To be eligible for doula services, a member must be a current HPSM Medi-Cal or CareAdvantage member, be pregnant or pregnant within the past 12 months. The member must also either request or benefit from doula services and meet the medical necessity criteria for doula services.

Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy. Eligible members should work with doulas contracted with HPSM, which can be found in HPSM's provider directory: **https://www.hpsm.org/member/choose-a-provider/find-a-provider**

Learn more about what the doula benefit covers on our website: **https://www.hpsm.org/member/health-tips/pregnancy/doula-services**

Doula services do not include diagnosis of medical conditions, provision of medical advice, any type of clinical assessment, exam, or procedure, or services not covered by Medi-Cal.

If a member requests or requires pregnancy-related services that are available through Medi-Cal, then the doula should work with the member's primary care provider (PCP) or work with HPSM to refer the member to a network provider who is able to render the service.

Doulas may provide assistive or supportive services in the home during a face-to-face prenatal or postpartum visit. For example, the doula may help the postpartum member fold laundry while providing emotional support and offering advice on infant care.

Due to a standing order, doula services do not require a written recommendation from a provider. If a member needs more care after birth than what the doula benefit covers, a written recommendation by a physician or other licensed practitioners of the healing arts acting within their scope of practice under state law is required. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a network provider.

Doulas must document the dates, time, and duration of services provided to members. Documentation must also reflect information on the service provided and the length of time spent with the member that day.

The documentation should be integrated into the member's medical record and should include the doula's National Provider Identifier (NPI). The documentation must be available for encounter data reporting and must be accessible to HPSM and to DHCS upon request.

The following services are not covered under Medi-Cal or as doula services: belly binding (traditional/ceremonial), birthing ceremonies (i.e., sealing, closing the bones, etc.), group classes on babywearing, massage (maternal or infant), photography, placenta encapsulation, shopping, vaginal steams, yoga.

State and County Programs

Program Name	About	Contact
Whole Child Model (WCM)/ 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. In San Mateo County, children who are eligible for CCS and HPSM Medi-Cal are enrolled into the Whole Child Model. The WCM program is a partnership between HPSM and San Mateo County CCS. Except for pharmacy benefits (which are covered through Medi-Cal Rx), services under the Whole Child Model are covered by the Health Plan of San Mateo. Utilizing the standard Medi-Cal Prior Authorization process, submit any necessary Prior Authorization to HPSM. San Mateo County CCS works closely with HPSM to receive referrals to CCS, authorize services for WCM eligible members, and provide case management services to these children with special health care needs.	**Hours** Monday through Friday 8:00 AM to 5:00 PM **Fax** **650-616-2598** **Mail** CCS 801 Gateway Boulevard., Suite 100 South San Francisco, California 94080 **Website** **https://www.smchealth.org/ccs**
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	**Fax** **650-345-2361** **Mail** GGRC 3130 La Selva Drive, Suite 202-107 San Mateo, California 94403 **Phone** **650-574-9232** **Website** **http://www.ggrc.org/**

	developmental disabilities may apply for services directly or be referred by others.
Comprehensive Perinatal Services Program (CPSP)	The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal reimbursement program that provides a wide range of culturally competent services to pregnant individuals from conception through 60 days postpartum. Services include standard obstetric services as well as enhanced services in the areas of health education, psychosocial, and nutrition. This approach has been shown to produce positive outcomes, including a reduction in low birth weight rates and health care costs. To learn more, go to the CPSP website at **https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx** or call the San Mateo County Health Department at **(650) 573-2629.**

Transportation Ride Benefit

Medi-Cal and CareAdvantage members who have no means of transportation to approved health care visits can use HPSM's Ride Benefit at no cost.

Approved health care visits include medical, dental, mental health and substance use disorder appointments covered under Medi-Cal, as well as pharmacy visits. The benefit does not cover trips to non-healthcare locations (such as schools, government offices and grocery stores). HPSM members can schedule rides by calling our vendor, American Logistics (AL): **https://www.hpsm.org/member/ride-benefit/how-hpsm-s-ride-benefit-works** Providers can also request rides for members.

Non-Emergency Medical Transportation (NEMT) is also covered

NEMT is specifically for members who require a litter, gurney or wheelchair van for transportation, and provides door-to-door assistance for all modes of transportation. Like HPSM's Ride Benefit, it is for medically necessary services covered by Medi-Cal (including picking up prescriptions authorized by Medi-Cal Rx at the pharmacy). NEMT requests must be prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider or physician extender: **https://www.hpsm.org/docs/default-source/provider-forms/hpsm-nemt-authorization-form.pdf**

Scheduling NEMT rides on behalf of a member must be coordinated by HPSM's Integrated Care Management team. Providers are not permitted to schedule NEMT rides directly with members.

Members can contact HPSM's Member Services to request NEMT or receive assistance with NEMT. Member Services triage NEMT requests to HPSM's Transportation Program Manager and Integrated Care Management team (ICM).

Member Services

- Toll free: **1-800-750-4776**
- Local: **650-616-2133**
- TTY: **1-800-735-2929** or dial **7-1-1**

Phone hours: Monday–Friday 8:00 a.m. to 6:00 p.m.

Office hours: Monday–Friday 8:00 a.m. to 4:00 p.m.

Email: **Memberservicessupport@hpsm.org**

Learn more about:

- HPSM's Ride Benefit: **https://www.hpsm.org/member/ride-benefit**
- NEMT services: **https://www.hpsm.org/provider/authorizations/specialty-provider#nemt**
    - If you have questions about HPSM's Ride Benefit, email **transportationprogram@hpsm.org**.

Section 7: Utilization Management

HPSM's Utilization Management Program ("the UM Program") encompasses 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, pharmaceuticals, durable medical equipment, 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.

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.

Contact

UM staff are available by telephone between 8:00 AM and 5:00 PM, Monday through Friday. For inpatient requests please call **650-616-2828**. For outpatient requests please call **650-616-2070**. For physician administered drugs (PADs), Pharmacy Services staff are available by telephone between 8:00 AM and 5:00 PM, Monday through Friday at **650-616-2088**.

After-hours requests for expedited review will be reviewed by the on-call clinical manager. Communications received after business hours are returned on the next business day. Communications received after midnight on Monday through Friday are responded to on the same business day. HPSM can also accept toll-free calls by calling **800-750-4776**.

Delivery System

HPSM fulfills its mission in San Mateo County because of its successful partnership with outstanding healthcare delivery partners. Medical services are delivered to our members through our directly contracted provider network. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager, SS&C for CareAdvantage, and ACE members. For Medi-Cal members, outpatient pharmacy benefits are managed by Medi-Cal Rx.

Scope of Services

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

- Outpatient pharmacy benefits for Medi-Cal members are administered by Medi-Cal Rx. This does not apply to Medi-Cal pharmacy services billed as a medical and/or institutional claim which are still administered by HPSM.
- Certain mental health services are administered by the San Mateo County Behavioral Health and Recovery Services (BHRS)for Medi-Cal. HPSM contracts with San Mateo County's Behavioral Health and Recovery Services division for services for its other lines of business.
- 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 medical services and equipment provided by specific 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.
- Enhanced Care Management (ECM) is a benefit for managed care Medi-Cal members. ECM offers a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM will be offered to specific target populations. HPSM administers this benefit through ECM contracted providers who are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
- Community Supports are optional services or settings that are offered to Medi-Cal and CareAdvantage members in place of services or settings covered under managed care Medi-Cal. Community Supports is not a benefit but are medically appropriate and cost-effective alternative services with the goal to improve the health outcomes and quality of life experienced by high risk Medi-Cal recipients by addressing Social Determinants of Health (SDOH). Community Supports services or settings are administered by HPSM contracted Community Support providers.
- 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) and the Golden Gate Regional Center (GGRC).

Authority, Accountability and Responsibility

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 Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The CMO ensures separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced.

The CEO allocates financial and employee resources to fulfill the program objectives. The CEO delegates authority, when appropriate, to the CMO. The CEO shall ensure that the QMP satisfies all remaining requirements of the Quality Improvement (QI) Plan, as specified in the state contract.

The CMO:

- Is responsible for the Utilization Management Program. The CMO is also responsible for the Quality Management Program. At least quarterly, the CMO presents reports on Health Services activities to the Utilization Management Committee. The CMO chairs the Utilization Management Committee that reports to the Senior Executive team. The CMO works in conjunction with the CEO to oversee the quality reporting matrix that includes Utilization Management oversight, development of QI studies, and follow up on identified quality of care issues.
- Is the CEO's designee in the day-to-day implementation of Utilization Management and is responsible for ensuring that the program is properly developed, implemented, and coordinated.
- Is responsible for day-to-day management and oversight of the utilization review process for all product lines for all members. The CMO works closely with the CHO 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.
- 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 CMO works in collaboration with the Chief Compliance officer to ensure 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). HPSM's Compliance and Regulatory Affairs Department works in collaboration with HPSM's functional areas, such as Utilization Management and Grievance and Appeals, to evaluate the results of performance audits and to determine the appropriate course of action to achieve desired results. In addition, the CMO oversees the development and amendment of HPSM policies and procedures related to Utilization Management and Health Services to ensure adherence to state and federal requirements. Lastly, functions relating to fraud investigations are handled by the Compliance and Regulatory Affairs Department.

HPSM's Health Services Division includes an Integrated Care Management (ICM) unit. This unit is responsible for administering care coordination benefits and collaborating with providers to address the care plan needs of HPSM members. The Integrated Care Management Unit's primary focus is on high-risk members as identified through emergency and inpatient recidivism and those members requiring complex care management. The Integrated Care Management Unit 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 Disability Services.

The Director of Pharmacy has management responsibility for overseeing outpatient pharmacy benefits operations activities for CareAdvantage, including formulary management, cost containment and reimbursement strategies, program administrative leadership, supervision of pharmacy staff, program development and policy enhancement. The Director of Pharmacy also foresees management of physician administered drugs for CareAdvantage, Medi-Cal, and ACE.

The Department of Health Care Services (DHCS) oversees the outpatient pharmacy benefit operations for Medi-Cal members through Medi-Cal Rx.

The Provider Network 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 can efficiently deliver services to members and receive prompt reimbursement for services performed. The Provider Network Liaisons perform provider education and assist providers in problem resolution.

About 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, MCG Health Guidelines).
- HPSM Health Services UM review staff, that includes physicians, licensed nurses, and unlicensed trained employees, carry 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.
- For physician administered drugs (PADs), the Pharmacy Services department staff utilize recognized standard criteria and informational resources to determine the medical necessity of healthcare services provided (e.g., Medi-Cal Manual of Criteria issued by the State of California, Micromedex DrugDex, Medicare Coverage Guidelines). The Pharmacy Services department includes pharmacists and pharmacy technicians. At least annually, Pharmacy Services reviews its policies and procedures at the Pharmacy and Therapeutics Committee.
- The Integrated Care Management unit plays a role in supporting Utilization Management by helping ensure members have access to the appropriate care and services within their health plan benefits. Integrated Care Management staff are knowledgeable about each member’s benefits and

work to facilitate optimal use of those benefits keeping the member at the center of their care while overseeing that services are appropriately utilized and meeting the member's needs.

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 to:

- 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 CMO.
- Ensure compliance with regulatory agencies.

UM staff work collaboratively with contracted healthcare providers in the community to ensure 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 special projects identify members with special needs and ensure that appropriate care is delivered to them. An example is the HomeAdvantage program, which provides home-based medical care at no cost to select members of HPSM's CareAdvantage program. To learn more about HPSM's community collaborations, partnerships, and special programs please visit https://www.hpsm.org/about-us/community-impact.

The Health Services Department is responsible for all UM processing for members in all programs. Leadership is provided by the CMO, who directly supervises the Utilization Review Manager. The Utilization Review Manager directly supervises the UM Nursing review staff and Authorization Specialists. The Director of Pharmacy supervises the pharmacy staff and day to day operations of pharmacy benefit management except for outpatient pharmacy benefits for Medi-Cal members which is managed by the Department of Health Care Services. The Integrated Care Management Unit leadership is composed of Director(s), Manager(s), and Supervisor(s), who oversee Clinical Care Managers, Care Management Specialists, Community Health Workers, Program Specialists, and the day-to-day activities within the Integrated Care Management 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 Management Program is reviewed and evaluated for effectiveness at least annually by the CMO. 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.

Care Coordination Meetings

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 Behavioral Health and Recovery Services (BHRS), Golden Gate Regional Center (GGRC), and Aging and Disability Services (ADS). HPSM does not provide CHDP services but works closely with this agency to coordinate services. Memoranda of Understanding (MOU) exists between each of these community partners, which require quarterly meetings to clarify systems issues and to coordinate the care of complex cases. The MOU clarifies responsibilities and establishes 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 Responsibilities

- 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-to-Specialist Referral Process

For Non-ACE Members

Referrals are only required for members to see non-participating (out-of-network) plan specialist providers for evaluation and treatment. If you believe a member needs to see a specialist, the PCP is responsible for coordinating that referral for the member. The PCP is to use their facility or practice's standard referral process. For out-of-network specialists, it will be their responsibility to follow HPSM's prior authorization process to request services for the member.

PCPs should make every effort to refer HPSM members to a participating specialist listed in our provider directory. The HPSM provider directory, updated annually, is available on our website and in hard copy format. Please ask HPSM Provider Services 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, the non-participating provider will need to follow HPSM's prior authorization process.

Referrals through HPSM 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.

The following services do not require a referral:

- E&M codes rendered in a Skilled Nursing Facility (SNF).

- Emergency care.
- 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.
    - Vision (Medicare non-covered benefit).
    - Eyeglasses** (Medicare non-covered benefit).

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), please refer to the HPSM website for the most up-to-date prior authorization requirements.

*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.

ACE members

The San Mateo County ACE program is 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 any other provider is only through the RAF prior authorization process DME, home health care services, and medical supplies do not require a Referral Authorization Form (RAF). You can find the ACE referral authorization form here: **https://www.hpsm.org/provider/authorizations/referrals**

Prior Authorizations

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 Integrated Care Management Unit 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. Reimbursement is still subject to member eligibility on the date of service.

For authorization requests submitted prior to the date of service (pre-service), expect a response from HPSM:

- 72 hours for urgent (a delay in care could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function and/or a delay in care would subject the member to severe pain that cannot be adequately managed without the care or treatment requested in the prior authorization).
- 5 business days for routine (all other requests).

For authorization requests submitted after the date of service (retrospective), expect a response from HPSM within 30 calendar days. Please check the member's eligibility using any of the methods listed in **"Section 2: Customer Support"** before providing any service. In the event of an emergency, HPSM must be contacted within 24 hours, or on the next business day.

Prior authorization requirements may apply to all lines of business. Please refer to the HPSM website for the most up-to-date information about prior authorization requirements.

Prior authorization is not required when HPSM is secondary, and the primary payer approved the claim unless the primary carrier is a non-Medicare payer and HPSM's liability after coordinating benefits is over $25,000.

Providers have a right to receive a free copy of any criteria used to make prior authorization and appeal decisions by HPSM. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. Call the UM department at **650-616-2133** for non-drug authorization decisions or **650-616-2088** for drug decisions.

Medical Services

Primary care physicians, specialty care providers, and ancillary providers who identify a need for medical services for an eligible HPSM member should submit their orders or prescriptions to a rendering provider. The rendering provider should complete a prior authorization form (PAR) for medical services that require a prior authorization.

The PAR 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-10 diagnosis codes.
- Applicable CPT/HCPCS code(s) for the requested service/procedure.
- Complete facility and service information (including facility provider number and location).
- Requested length of stay for all inpatient requests.
- Proposed date of procedure for all outpatient surgical requests.

Whenever possible, we ask that providers submit requests for prior authorization to HPSM seven to 10 business days in advance of scheduled procedures. This will ensure that our UM 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 PAR requests 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 CMO if you have any concerns that our process is interfering with the care your patient requires. Urgent prior authorization requests may be faxed to **650-829-2079**.

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 Request” is one in which the requested service is medically needed within 72 hours of submission. Abuse of urgent prior authorization requests will be monitored. Please note: The autoreply, or automated confirmation of receipt, 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.)

Note: Urgent prior authorization requests faxed to other fax numbers at HPSM will not be forwarded to Health Services and will not receive an autoreply. Please use the HPSM Health Services Fax line for urgent prior authorization requests.

For questions regarding the status of a submitted prior authorization request, or questions regarding the authorization process, you may call HPSM Health Services Department at **650-616-2070**. Calls are answered by Prior Authorization Specialists 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 AM to 5:00 PM Monday through Friday, excluding company holidays.

For questions related to medical Injectable drug requests, you may call the HPSM Pharmacy Services Department at **650-616-2088**. The HPSM Pharmacy Services Department hours are from 8:00 AM to 5:00 PM Monday through Friday, excluding company holidays (closed between 8:00 AM and 10:00 AM on Wednesdays).

Completed Prior Authorization Request (PAR) forms and documentation should be mailed to:

Health Plan of San Mateo
Health Services Department ATTN: PAR Processing
801 Gateway Boulevard, Suite 100
South San Francisco, California 94080

Communication of approval of Urgent Requests will be via call.

Dental Services

Primary care dental providers and specialty dental providers who identify a need for covered dental services can proceed with completing treatment without need for prior authorization. The dental provider should reach out to the dental team for questions related to member dental history for covered restorative services. A prior authorization can be submitted for services not covered when provider sends additional information to support medical necessity for benefit exception consideration. Additional information is requested to make determination which can include but not limited to: dental x-rays, dental images, periodontal chart, and/or a narrative.

Orthodontists in network do not need to send prior authorization for members aged 7-21 that have met Handicapping Labio-lingual deviation (HLD) score of 21+ or an automatic qualifying option.

For members 21 and under with HLD auto qualifier or score 21 and up, the HLD score sheet be noted on the billing form or attached with claim. And provider should retain HLD scoresheets, and all other clinical records related to the start and progression of the case.

Orthodontists should send prior authorization for members that do not meet HLD score and/or meet an EPSDT exception.

All dental prior authorizations can be sent electronically or sent via mail.

For urgent authorizations or to check the status of a submitted prior authorization, please call **650-616-1522** or email **dental@hpsm.org.** You can also check the status of an authorization through the provider portal.

For paper dental prior authorization requests, please submit to:

HPSM Dental
PO Box 1798
San Leandro, California 94577

Outpatient Pharmacy Benefits

Medi-Cal

For more information regarding the prior authorization process related to Medi-Cal outpatient pharmacy services, please visit the Medi-Cal Rx website at **https://medi-calrx.dhcs.ca.gov/home/** or contact the Medi-Cal Rx Customer Service Center at **800-977-2273**.

CareAdvantage

HPSM has a process in place to ensure that procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and to make medical necessity exceptions to the HPSM formulary (HPSM Approved Drug List).

The HPSM Pharmacy Staff and the Pharmacy and Therapeutics Committee are responsible for development of HPSM CareAdvantage Approved Drug Lists, which are based on sound clinical evidence and reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the HPSM CareAdvantage Approved Drug Lists are posted on the HPSM website.

If the following situations exist, HPSM will consider the appropriateness of non-formulary drugs if requested through the prior authorization process when:

- No formulary alternative is appropriate, and the drug is medically necessary.
- Member has failed treatment or experienced adverse effects on formulary drugs.
- Member's treatment has been stable on a non-formulary drug and change to formulary drug is medically inappropriate.

To request a prior authorization for outpatient medication not on the HPSM CareAdvantage Approved Drug List, the physician or physician agent must provide documentation to support the request for coverage. Documentation

should be provided on the prescription request form, available on the HPSM website, which is submitted to HPSM's pharmacy unit for review. The initial review is based on prior authorization guidelines approved and established by HPSM.

The pharmacy review staff profiles drug utilization by member to identify instances of polypharmacy that may pose a health risk to the member. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Extension of a Prior Authorization Request

After a submitted prior authorization request is reviewed by a UM Review nurse or other applicable healthcare provider (e.g., pharmacist for physician administered drugs or dentist for dental-related requests) and determined to require additional information to evaluate the medical necessity of the requested service, a notice will be sent to the originator of the request for the specific information needed within 14 days. The member is also notified of the deferral.

If no information is received or the information received does not address the requested information, the prior authorization request will be denied. Please respond to the request for additional information accurately and timely, as HPSM is only allowed to extend a prior authorization request once. Requests with insufficient clinical information result in denial when medical necessity can't be determined. Notifications of a prior authorization request denial are sent to both the originator of the request as well as the member. Note: For physician-administered drugs covered under CareAdvantage's medical benefit, prior authorization extensions do not occur. Instead, the pharmacy team will decide within the required regulatory deadline.

Denied Requests

Prior authorization requests denied for medical necessity must be reviewed by the Medical Director or Clinical Pharmacist (for physician administered drugs). 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 or Clinical Pharmacist 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 CMO, using generally accepted medical standards shall be considered not medically necessary. Denial letters will be issued in accordance with DMHC/DHCS and CMS mandates and time frame standards.

Retroactive authorizations

Retroactive authorization requests are reviewed to determine if the service was medically necessary using the clinical information submitted by the provider. Providers must also submit documentation about why the request was unable to be submitted prospectively.

Retrospective reviews for inpatient services with appropriate documentation will be accepted up to six months from the date of admission. Retrospective reviews for outpatient services must be submitted, with appropriate documentation, no later than one year from the beginning date of service.

Retrospective authorization decisions shall be communicated to the member who received the services, or the member’s designee, within 30 days of the receipt of information that is reasonably necessary to make the determination and shall be communicated to the provider in a manner that is consistent with current regulations.

Integrated Care Management Program

The HPSM Integrated Care Management program coordinates services and complex care for the best clinical and functional outcomes for members. Through the inpatient concurrent review process, Care and Transition Coordination staff work with members, their families, Primary Care Physicians (PCPs), specialists and community resources to coordinate a comprehensive plan of care. HPSM Integrated Care Management staff understand the benefits available to each member and can facilitate the optimal use of those benefits. Participation in Integrated Care Management is voluntary, and a member can opt in or out at any time.

Not all patients benefit from Integrated Care Management 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 Integrated Care Management staff member.

HPSM identifies cases for Integrated Care Management 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 Integrated Care Management staff of complex cases amenable to Integrated Care Management.

Once a case is identified, the Integrated Care Management staff will contact the treating providers to establish a case file. The Integrated Care Management staff 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.

Integrated Care Management staff will generally become involved with:

- 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, skilled nursing facility or home care.
- Members with frequent emergency room visits.
- Continuing care following discharge against medical advice.
- 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, amyotrophic lateral sclerosis, 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, tuberculosis treatment programs and HIV special needs programs.

Providers may contact HPSM's Integrated Care Management Unit directly at **650-616-2060** or utilize the Care Management Referral form located on our website. Integrated Care Management staff can aid in arranging care and/or in advising on resources that meet a member's needs.

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 two years with or without clinical breast examination among women age 50-74. 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 primary care provider. 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 primary care provider 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 freestanding radiology facility do not require prior authorization. The ordering physician simply issues a prescription to the member and sends them to a participating facility. The primary care physician 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.

Medi-Cal 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.

Tuberculosis Diagnosis and Treatment

Members may self-refer for Tuberculosis 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 primary care provider, at an in-network pharmacy, or self-refer to public health clinics for immunizations. Public health clinics will make every effort to verify with the member's primary care provider 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 primary care provider is responsible for the care of their patients 24 hours a day, seven days a week. The primary care provider or designee must be available in their office or via phone or answering service to appropriately triage and evaluate all non-emergent care.

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 emergency room service authorized by the primary care provider or HPSM authorized representative. The member contract requests that members notify their primary care provider 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 primary care provider.

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.
- Serious jeopardy to the life or health of a pregnant woman's unborn child.
- In the case of a behavioral condition, placing the health of such person or others in serious jeopardy.
- Serious impairment to the afflicted person's bodily functions.
- Serious dysfunction of any bodily organ.
- 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.

Primary care provider notification is not required for emergency care, but coverage can be ensured if the primary care provider authorizes such care.

Behavioral Health Management

HPSM ensures that members with coexisting medical and behavioral health needs have adequate coordination and continuity of care throughout the network.

HPSM works closely with the San Mateo County Behavioral Health and Recovery Services (BHRS), as well as other county programs such as Golden Gate Regional Center and California Children's Services to coordinate medical and behavioral care for members.

Continuity and coordination of behavioral health care may involve HPSM staff or HPSM providers communicating directly and/or coordinating care between primary care providers and behavioral health providers. HPSM staff and contracted providers are responsible for coordinating services with San Mateo County Behavioral Health and Recovery services to ensure that individual members with coexisting medical and behavioral disorders receive appropriate treatment in the appropriate ambulatory and/or inpatient setting.

Long Term Care

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 prior authorization requests 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 prior authorization requests for services for facility room and board services provided to HPSM members to HPSM's Health Services Department. HPSM's Health Services Department processes prior authorization requests 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. Prior authorization requests 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 Long Term Care

The daily rate charge for long term care 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 long term care prior authorization request 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 and Resident Review (PAS/PASARR)

Each HPSM Medi-Cal recipient applying for nursing facility 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 nursing facility is responsible for performing the evaluations. The admitting nursing facility 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 nursing facility or whether he/she could remain in the community with support services. The nursing facility will utilize PAS/PASARR Level I Screening Document (DHS 6170), Long Term Care Prior 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

nursing facility 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 long term care 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 long term care facility.

Long Term Services and Supports (LTSS) Liaison for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)

LTSS liaisons are trained to identify and understand the full spectrum of Medi-Cal long-term institutional care, including payment and coverage rules. LTSS liaisons serve as a single point of contact for service providers in both a provider representative role and to support care transitions as needed. LTSS liaisons assist in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support member needs. Please direct questions to our LTSS liaisons at **PSInquiries@hpsm.org** or **Melissa.Robbins@hpsm.org**.

Prior Authorization Required Process and Criteria for Admission

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 long term care facility in accordance with the California Department of Health Services (DHS) standard clinical criteria for levels of services. Each level of care prior authorization requests processing procedure will comply with applicable regulatory requirements.

On Site Prior Authorization 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 nursing facilities, when indicated, e.g., patterns of high service utilization, frequent acute hospitalization of members, large numbers of member complaints/concerns. Prior authorization request requirements will follow Title 22 California Code of Regulations and DHS Manual of Criteria for Medi-Cal Authorization.

Retroactive Authorization for PAR for Long Term Care Facility Daily Rate

HPSM's Health Services Department shall process all requests for long term care 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 long term care will submit the request for long term care prior authorization request 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 long term care 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

Long term care 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 an long term care 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 long term care 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 long term care facilities by reporting the events to the appropriate regulatory agency for investigation.

Process for Transferring HPSM Members

From long term care facilities to acute care facilities: A long term care facility shall be responsible for coordinating an emergent/urgent transfer of a HPSM member to an acute care facility. A long term care facility shall collaborate with all appropriate multidisciplinary team members to facilitate either a planned or emergent/urgent transfer of a HPSM member from a long term care facility to an acute care facility. The long term care facility shall notify HPSM's Health Services Department of the admission of a HPSM member to the acute care facility on the next business day.

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 an long term care facility. HPSM's Health Services Department shall assist in coordinating the discharge planning of the member from an acute care facility to an long term care facility. The acute care facility shall collaborate with all appropriate multidisciplinary team members to facilitate the transfer of the member. The admitting long term care facility shall notify HPSM's Health Services Department of the admission of the member. The admitting long term care 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 v. 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.

Long Term Care Clinical Management

HPSM's Clinical Management 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. The clinical management activities as related to members residing in long term care facilities comply with all state and federal requirements as specified in the contract between the state and HPSM. The clinical management 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 does assist in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for members in long term care 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 long term care facility Ombudsman Office for potential quality of care issues may be a part of the QAI activities as indicated.

Policy Reminders for Long Term Care Facilities

Federal law prohibits long-term care (LTC) facilities from transferring or discharging Medi-Cal members due to a change in the member's insurance coverage, such as from managed care to Medi-Cal fee-for-service (FFS).

For more information on admission, transfer, and discharge rights please visit this webpage: **https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.15**

To learn more about how you can support members who may have transitioning coverage please visit: **https://www.dhcs.ca.gov/providers-partners/medi-cal-fee-for-service-transition/**

Plan of Care

Patient Requirements

Skilled nursing and intermediate care facilities must include written Plans of Care in each patient's medical record.

Individual written plans are required by Title 42, Code of Federal Regulations (CFR) to be approved and signed by a physician. They should include:

- diagnosis, symptoms, complaints, and complications.
- description of individual's functional level.
- objectives.
- orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures.
- plans for continuing care.
- plans for discharge.

Skilled Nursing Facility Written Plan of Care

Before admission of a patient to a skilled nursing facility or before authorization for payment, the attending physician must establish a written Plan of Care for each applicant or recipient in a skilled nursing facility. 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 intermediate care facility 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:

- Diagnoses, symptoms, complaints, and complications indicating the need for admission.
- A description of the functional level of the individual.
- Objectives.
- 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.
- Plans for continuing care, including review and modification of the Plan of Care and plans for discharge. The team must review and sign each Plan of Care at least every 90 days.

Programs for Children, Minors, and Young Adults

Child Health and Disability Program (CHDP)

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.

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

801 Gateway Boulevard, Suite 100

South San Francisco, California 94080

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

EPSDT is codified in federal law and creates a benefit that provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting.

HPSM may not impose service limitations other than medical necessity. Medical necessity for children is defined as necessary health care, diagnostic, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether such services are covered under the plan. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. Since medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements. Additional services must be provided if determined to be medically necessary for an individual child. HPSM must provide case management and targeted case management.

HPSM has a responsibility to provide health education, including anticipatory guidance, to members under age 21 and to their parents or guardians to effectively use those resources, including screenings and treatment. HPSM must conduct outreach to ensure providers are trained and adhere to Bright Futures guidance.

Providers are required to refer Members to appropriate diagnostic and treatment services following either a preventative screening or other visit that identifies the need for follow-up.

EPSDT covers:

- Early and periodic screening, diagnostic, and treatment (EPSDT) services.
- Well-child visits which are a comprehensive set of preventive, screening, diagnostic, and treatment services.
- HPSM will make appointments and provide transportation to help children get the care they need.
- Preventive care can be regular health check-ups and screenings to help find problems early. Regular check-ups aid in identifying any problems with medical, dental, vision, hearing, mental health, and any substance use disorders. HPSM covers screening services any time there is a need for them, even if it is not during the regular check-up. Preventive care can also include shots; HPSM must make sure that all children enrolled get needed shots at the time of any health care visit.
    - Screening: (i) comprehensive health and development history (inc. assessment of physical and mental health development); (ii) a comprehensive unclothed exam; (iii) appropriate immunizations according to age and health history; (iv) lab test (including BLL); (v) health education (inc. anticipatory guidance).
    - Screening services must identify developmental issues as early as possible.
- When a problem is found during a check-up or screening, HPSM covers the care that is medically necessary to correct or help any physical or mental health issues. These services are at no cost to the member and include:
    - Doctor, nurse practitioner, and hospital care.
    - Shots to keep the member healthy.
    - Physical, speech/language, and occupational therapies.
    - Home health services, which could be medical equipment, supplies, and appliances.
    - Treatment for vision and hearing, which could be eyeglasses and hearing aids.
    - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities.
    - Case management, targeted case management, and health education.
    - Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.
- If the care is medically necessary and HPSM is not responsible for paying for the care, then HPSM will coordinate care to help members get the right care they need. These services include:
    - Treatment and rehabilitative services for mental health and substance use disorders.
    - Treatment for dental issues, which could be orthodontics.
    - Private duty nursing services.

Complex Care Management

Complex care management uses proactive care management principles. High risk members are identified through a predictive model and health risk assessment and other screening tools. Complex/high risk care management programs focus on providing well-coordinated community-based services, including limiting gaps in care between inpatient and outpatient and community-based services. The framework of the care management programs addresses the complexity of the healthcare system and the difficulty our member's encounter navigating the health care system- Limited ability to access services negatively affects health status. Goals of our care management programs include a) improving quality of care, b) improving member satisfaction and c) promoting the provision of medically appropriate care through a multidisciplinary, comprehensive approach in a cost-effective manner. For our dually eligible population, Care Advantage, each member receives a health risk screening assessment annually. In addition to the member's subjective health risk assessment screening tool, a comprehensive assessment is performed on high risk medically complex members. The integration of the comprehensive assessment with the health risk assessment screening tool serves as a basis in development of individualized care plans. Individualized care coordination interventions are documented in a relational database that fosters centralized information and standardization. Care management interventions are developed in conjunction with the member and include a point of contact at the plan responsible for communications with the member. The health risk assessment screening is communicated with the member's primary care physician. Collaboration and coordination of care with the primary care physician is an integral component of the care management program.

Complex Care Management activities include the following:

- Comprehensive health risk assessments are performed for each Care Advantage member and high risk Special Needs Medi- Cal members. This tool is the foundation of the case management process. Assessment and data gathering includes but is not limited to member demographics, primary care physician and specialty physician care information, living status, hospitalization and ED utilization, a review of physiological health systems, past medical history, a medication history and medication regimen, medication therapy management eligibility, social/emotional status, functional status/disability rating, activities of daily living assessment, exercise assessment, fall risk, community resource utilization and assessment, and primary care giver assessment, durable medical equipment (DME) and medical supply assessment and a needs assessment summary.
- The clinical history documents the members' health status, clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history and current and past medication.
- Activities of daily living evaluate the members' functional status related eating, bathing, walking, toileting, and transferring.
- Mental health status evaluates the members' mental health status, including psychosocial factors and cognitive functions such as ability to communicate, understand instructions and process information about their illness.
- Cultural and linguistic needs include an assessment of cultural and linguistic needs, preference or limitations.

- Caregiver resources are evaluated to assess family involvement in the care plan and the caregiver potential for burn-out.
- Life planning assessment addresses life planning issues such as living wills/ advance directives/ durable power of attorney.
- A benefit assessment is also conducted.
- Individualized care plans are developed from the findings and analysis of the comprehensive health risk assessments.

In-Home Physician Program Through HomeAdvantage

The In-Home Physician program is a system of care that provides 24/7 access to in-home physician visits for the plan's most medically vulnerable and complex members. This program supports proactive cost management and enhances medical care by treatment through a home delivery system by optimizing care in the home. The services that In-Home Physician program provides include:

- 24/7 patient access to a visiting physician.
- Regularly scheduled in- home and facility visits and anytime as needed.
- Coordinated care with primary care physicians, specialists, and the plan's nurse Care Manager.
- Clinical and pharmacy management.
- Education to the patient about their medical conditions and anticipated outcomes.

Care Transitions

The plan also incorporates a care transition model in the Care and Transition program. The intent of the care transition model is to improve health care outcomes and reduce re-hospitalization risk when members encounter a care transition. Members experiencing a care transition from the home to an acute care setting or to a skilled nursing facility are identified and followed by a care manager through the continuum of care. The care manager serves as a point of contact to the member and the member's health care team. For each care transition, the case manager also initiates communication to the member's primary care physician. The primary goal of the case manager is to support the member and the member's healthcare team to ensure appropriate communication and benefit coordination occurs in a timely manner.

Medication Therapy Management (MTM)

Medication Therapy Management is the analytical, consultative, educational, and monitoring services provided by pharmacists to Care Advantage members in order to facilitate the achievement of positive therapeutic and economic results from medication therapy. MTM services allow pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication

compliance, address medication needs, and provide healthcare to plan members in a cost-effective manner.

HPSM contracts with a vendor, MedWatchers, to administer MTM services. MTM services include comprehensive medication review (CMR), prescriber communications, member compliance consultations, and member education and monitoring.

Comprehensive medication review (CMR) is performed annually. During the CMR, a pharmacist will review the member's prescription and nonprescription medication, vitamins, minerals, herbal products, and dietary supplements for potential interactions. As part of the review, a master medication list will be provided to the member to bring to future office visits.

Prescriber communications assist physicians and other prescribers to coordinate care and resolve potential medication- related complications. These communications may include a phone call or fax to the prescriber's office with information and/or recommendations concerning a member's drug therapy regimen.

Member compliance consultations assist members with compliance issues. MTM pharmacists monitor plan members for compliance with prescribed medications. When an overuse, underused, or administration issue is identified, the pharmacist will educate the member on the importance of compliance and monitor the member to ensure that compliance improves.

Member education and monitoring is performed when a member is prescribed a new medication therapy or experiences a change in therapy. MTM pharmacists monitor the member for improvement in reportable symptoms, the occurrence of the side effects and compliance with therapy.

Indian Health Care Providers (IHCPs) Rights and Protections

Existing rights and protections for IHCPs, on the topics of enrollment, contracting, credentialing and site review, and claims payment are described here: **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-002.pdf**

Effective January 1, 2024, HPSM is required to have an identified tribal liaison dedicated to working with each contracted and non-contracted IHCP in its service area. The tribal liaison is responsible for coordinating referrals and payment for services provided to American Indian members who are qualified to receive services from an IHCP. IHCPs can direct questions to the Tribal Liaison at **PSInquiries@hpsm.org**.

The role and responsibilities of the tribal liaison include, but are not limited to the following:

- Providing information to IHCPs regarding enrollment and disenrollment of American Indian members.
- Coordinating care with in- and out-of-network IHCPs for American Indian members.
- Ensuring access to care with in- and out-of-network IHCPs for American Indian members.

- Providing assistance to IHCPs and American Indian members with accessing appropriate transportation given logistical and geographical barriers unique to tribal communities.
- Providing case management for American Indian members that involves in- and out-of-network IHCPs.
- Assisting IHCPs with provider services, claims and payment assistance and resolution, and member services.
- Providing support in obtaining grievance, appeal, and State Hearing services to IHCPs in cases that impact American Indian members.
- Providing benefits and services navigation and coordination, such as those for foster care, Community-Based Adult Services, Enhanced Care Management, Community Supports, behavioral health, health education, home and community-based services, California Children's Services (CCS), etc. This is to ensure IHCPs provide full-spectrum services to American Indian Members.
- Assisting internal liaisons in instances that involve IHCPs and/or American Indian Members and the other liaison's respective services and program, in particular the foster care liaison; as well as the liaisons for Long-Term Services and Supports, transportation, California Children's Services, Regional Center, dental, and IHSS.
- Help IHCPs regarding Medi-Cal program provider enrollment and HPSM contracting, credentialing, and Facility Site Reviews.

The tribal liaison, including new tribal liaison staff, will attest to the completion of and document completion of the following trainings:

- Cultural humility training from the California Governor's Office of the Tribal Advisor.
- Overview of trauma-informed care and historical trauma training from the Indian Health Service (IHS).
- Other relevant trainings as they are developed and noted by DHCS.

DHCS encourages tribal liaisons to commit to the following activities to enhance relationships between HPSM, IHCPs, and American Indian Members:

- Providing assistance to the Member Services department in situations involving American Indian Members.
- Representing HPSM and providing assistance to subcontractors to address inquiries and/or instances involving American Indian members.
- Participating in the HPSM Community Advisory Committee and other HPSM committees that potentially impact American Indian members.
- Attending and participating in tribal consultations involving tribes within the service area.
- Attending and participating in DHCS' Tribal and Designees of Indian Health Programs Quarterly Meeting, and other relevant meetings.
- Developing tribal specific outreach and educational materials.
- Hosting marketing events and developing marketing materials focused on tribal health as permitted.
- Collaborating with other managed care plans' tribal liaisons to discuss best practices, lessons learned, and sharing of information and resources.

- Collaborating with local tribal communities on the development of regional and culturally appropriate trainings for HPSM staff.
- Having knowledge and consideration of Indigenous Determinants of Health when determining quality metrics and data reporting.

Terminated Providers

HPSM has a mechanism to continue appropriate and timely care for members whose physicians are terminating from the network. This process includes a 90-day notification from the practitioner of the intent to terminate. Members under current care and those with approved prior authorizations, not yet utilized, are identified so that their care can be managed and coordinated with the receiving physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, dialysis-dependent members, those awaiting transplants, late-term pregnancies, pending surgeries, acute rehabilitation, and any other members that might have their ongoing care negatively impacted by the termination of the group are identified. When members are identified as possibly benefiting from coordination of care both within and outside of the network, the case is referred to complex care management team for further interventions. Complex care management actively engages in activity that monitors and assesses continuity and coordination of clinical care. Complex care management works closely with the member, physicians and any other associated ancillary providers involved in the case, to provide timely, quality-based care meeting the needs of the individual member.

Monitoring and Reviewing

Monitoring for Consistent Review Criteria

The Health Services Utilization Review Manager performs ongoing monitoring of UM nurse reviewer application of criteria/guidelines to:

- Measure the reviewers' comprehension of the review criteria and guideline application process.
- Ensure accurate and consistent application of the criteria among staff reviewers, and ensure criteria and guidelines are utilized per policy/ procedure.
- Ensure a peer review process for inter-rater reliability.

The Health Services staff is responsible for identification of potential or actual quality of care issues, and cases of over- or under-utilization of healthcare services for HPSM members during all components of review and authorization.

For pharmacy benefits, including physician administered drugs (PADs), the Director of Pharmacy performs ongoing monitoring of Clinical Pharmacist reviewer application of criteria/guidelines to ensure accuracy and consistency.

Monitoring for Over and Under Utilization

To review appropriateness of care provided to members, HPSM tracks and trends various data elements to determine over- and/or under- utilization patterns. The industry benchmark rates are used as guidelines for comparison. Some of the elements reviewed include:

- Hospital admits/1,000.
- Re-admissions.
- Pharmacy utilization.
- Bed days/1,000, using HPSM performance standards.
- Emergency room visits.
- Encounters per enrollee per year.
- Behavioral Health inpatient admissions.
- Prior authorization denials.
- Frequency of selected procedures, as determined by utilization patterns.
- Medi-Cal Medical Directors Utilization Reports.
- Industry Collaborative Effort Utilization Reports.
- Cultural/Linguistic reports that reflect barriers for access to care or delivery of care.

HPSM enacts actions to improve performance because of these clinical data analysis, and feedback is provided to both entities and individual practitioners so that corrective actions can be taken. HPSM continues to monitor for compliance with corrective action plans and improvements in the care delivery process.

Review Criteria, Guidelines, and Standards

Standards, criteria, and guidelines are the foundation of an effective Utilization Management Program. They offer the licensed UM and Pharmacy Services staff explicit and objective "decision support tools," which are utilized to assist during evaluation of individual cases to determine the following:

- If services are medically necessary.
- If services are rendered at the appropriate level of care.
- Quality of care meets professionally recognized industry standards.
- Consistency of UM decisions.

The following standards, criteria, and guidelines are utilized by the Health Services UM review staff. Medical Directors, and Pharmacy Services staff as resources during the decision-making process:

- Medical necessity review criteria and guidelines.
- Length of stay criteria and guidelines.
- Clinical practice guidelines.
- Policies and procedures.

Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment and application of individual case information and local geographical practice patterns.

Licensed nursing review staff applies professional judgment during all phases of decision-making regarding HPSM members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria and guidelines with respect to the decisions regarding medical necessity of healthcare services, and not as a substitute for important professional judgment.

The HPSM Medical Director evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/ denial determinations.

HPSM's Health Services UM review staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. If a provider should question a medical necessity/ appropriateness determination made, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

For physician administered drugs (PADs), licensed clinical pharmacists use similar decision-making tools and clearly document the Review Criteria/Guidelines utilized in making authorization decisions. The clinical pharmacists evaluate cases that do not meet review criteria/guidelines and are responsible for authorization/ denial determinations. HPSM Medical Directors are sometimes relied upon in certain situations such as when a second opinion is requested by the clinical pharmacist.

The following approved department "Decision Support Tools" have been implemented and are evaluated and updated at least annually:

Criteria and Guidelines	Approved HPSM Guidelines shall be used for all medical necessity determinations. HPSM uses the following criteria sets: Medi-Cal Manual of Criteria, published by the State of California, American Academy of Pediatric Guidelines (AAP), MCG Health Guidelines, Micromedex DrugDex Compendia (for pharmaceuticals), Medicare Coverage manual and the HPSM Medical Policy and Medi-Cal Benefits Guidelines (Medi-Cal Provider manuals- Allied

Health, Inpatient/Outpatient, Medical, Vision, Pharmacy). HPSM may also use its own internally developed guidelines which are based on clinical evidence and guideline recommendations.

Due to the dynamic state of medical/healthcare practices, each medical decision must be case-specific based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care such as OB/GYN, surgery, etc. are primarily appended for guidance concerning medical care of the condition or the need for the referral.

Medi-Cal Manual

The State of California publishes Medi-Cal Manual of Criteria, which is the basis for Medi-Cal benefit interpretation and used as a UM guideline.

MCG Health Guidelines Criteria

MCG Health Guidelines are developed by generalists and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry.

MCG Health's clinical staff of physicians, nurses, and other healthcare professionals create initial drafts of the criteria based on input from consultants, as well as an exhaustive review of existing guidelines and medical literature. Physicians and other providers from all disciplines relevant to the subject then review, revise, and re-review these versions in an iterative, consensus-building process (a modification of the Delphi method). Criteria acknowledge controversial areas where agreement cannot be reached and provide a rationale for the stance that has been chosen. Detailed notes and literature references provide the clinical basis for decisions. The criteria therefore provide a synthesis of evidence-based data, literature-supported medicine, and national consensus. MCG Health's criteria enable health plans and providers to capture data about the intervention requested and the rationale for each request. The criteria also provide a clinical reference for managing the dialogue between provider and reviewer, provider and payer, and provider and patient. MCG Health's criteria support an explicit, clinical rationale for care decisions.

MCG Health's guidelines update cycles are done at a minimum on an annual basis. MCG Health states that update reviews include development of new procedures, new technology, requests from clients, criteria incorporating high frequency, high risk, high visibility and high variation, literature review and analysis, new clinical practice. (MCG, 2007)

Utilization Management Appeals Process

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 organizational determination is made in response to a Prior Authorization Request or a request for Prior Authorization submitted by a provider and may include approval, denial, deferral, or modification of the request. HPSM has a comprehensive review system to address matters when members or providers (on behalf of members for services yet to be provided) wish to exercise their rights to appeal an organizational determination that denied, deferred, or modified a request for services.

The administration of HPSM's reconsideration of an organization determination and appeals process is the responsibility of the Grievance and Appeals Coordinator under the direct supervision of the Grievance and Appeals Manager. All investigation efforts are geared to protect the enrollee's privacy and confidentiality and to achieve rapid resolution.

Confidentiality

Due to the nature of routine UM operations, HPSM has implemented policies and procedures to protect and ensure confidential and privileged medical record information. Upon employment, all HPSM employees, including contracted professionals who have access to confidential or member information sign a written statement delineating responsibility for maintaining confidentiality.

Both the HPSM UM staff voice mail phone message line for utilization review information and the computer network system is controlled by a secured password system, accessible only by the individual employee.

The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by HPSM UM staff. HPSM has implemented Health Information Portability and Accessibility Policies and Procedures to guide the organization in HIPAA compliance. All records and proceedings of the UM Committee related to member or provider specific information are confidential and are subject to applicable law regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58.

Conflict of Interest

HPSM maintains a conflict-of-interest policy to ensure that conflict of interest is avoided by staff and members of Committees. This policy precludes using proprietary or confidential HPSM information for

personal gain, or the gain of others, as well as a direct or indirect financial interest on or relationship with a current or potential provider, supplier, or member; except when it is determined that the financial interest does not create a conflict.

Fiscal and clinical interests are separated. HPSM and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Staff Orientation, Training and Education

HPSM seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions.

Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program as applicable to specific job description:

- HPSM New Employee Orientation.
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.).
- Utilization Management Program, policies/procedures, etc.
- Integrated Care Management Model of Care, policies, and procedures.
- MIS data entry.
- Application of review criteria/guidelines.
- Appeal Process.
- Orientation to specific programs of each delegated entity.

HPSM encourages and supports continuing education and training for employees, which increases competency in present jobs and/or prepares employee for career advancement within the HPSM. Each year, a specific budget is set for continuing education employees.

Licensed nursing staff and pharmacy staff are monitored for appropriate application of Review Criteria/ Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of proficiency. Training, including seminars and workshops, are provided to all UM and Pharmacy Services staff regularly during regularly scheduled meetings and ongoing.

Section 8: Provider Services

The Provider Services Department manages provider credentialing, contracting, value-based payment programs, provider directory, and general provider services.

This section of the Provider Manual includes information on provider credentialing and contracting, rights and responsibilities, education and training, and coverage and standards.

Credentialing and Contracting

To participate in the HPSM provider network, a provider must maintain a fully executed Medical Services Agreement with HPSM, and each individual provider employed by, contracted with, and/or affiliated with the group, whether current or added during the term of the Agreement, must complete HPSM's credentialing application process and receive credentialing approval from HPSM before providing services to or treating HPSM Members. HPSM's credentialing standards are based on applicable federal and state requirements, including, but not limited to, the Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC) and the National Committee for Quality Assurance (NCQA).

Provider groups and each individual provider employed by, contracted with, and/or affiliated with the group shall maintain active credentialing status with HPSM throughout the term of the Agreement and comply with HPSM's recredentialing requirements, which occur at least every three (3) years or as otherwise required by applicable law, regulatory requirements, accreditation standards, or HPSM policies. No provider may render services to HPSM Members unless and until credentialing approval has been granted by HPSM.

As part of the credentialing and re-credentialing process providers have the right to:

- Review information submitted along with any of the Primary Source Verification obtained to support their credentialing application.
- Correct erroneous information in writing to a Credentialing Specialist by updating the online credentialing application or via email within 14 days of the request.
- Receive the status of their credentialing or re-credentialing application, upon request. Requests for the status of the application will be emailed to the provider within two to three business days.
- Have a credentialing specialist contact the provider to clarify discrepancies in the file, either by phone and/or email. The communication will be documented, and notes will be included in the provider's file.
- Receive the status of their credentialing or re-credentialing application upon request directly to a Credentialing Specialist. The Credentialing Specialist may provide information related to whether the application is currently being reviewed by HPSM's Credentialing Committee; this can be done either via phone or email.

The following describes the required steps for a provider to complete the credentialing and recredentialing process:

- Provider completes, signs, and returns the Medical Services Agreement, HPSM online Credentialing Application, HPSM's Addendum Application, Addendum B and Taxpayer 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, including the expiration date and the amount coverage minimum $1,000,000 per occurrence/$3,000,000 annual aggregate. Copy of property comprehensive general liability insurance (premises) face sheet, including the amount coverage minimum is $300,000 per person per occurrence.
    - Completed and signed attestation questionnaire.
    - Signed Supervisory Letter for Nurse Midwives, Physician Assistants, and Nurse Practitioners, if applicable, signed Behavioral Health Board Supervisory letter for associate behavioral health providers (e.g., AMFT, APCC, ACSW), if applicable.
    - Signed release of Information/acknowledgments form.
    - Curriculum Vitae (C.V.).
    - 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, American Dental Association (ADA), California Dental Board (CDA), American Board of Podiatric Surgery, etc. (if applicable).
    - Signed copy of "Acknowledgment of Training" attestation as related to the Regulatory Provider Training materials
    - Sedation and/or Anesthesia permits, if applicable.
- HPSM verifies provider information (including National Provider Identifier, license status, etc.).
- HPSM conducts a comprehensive assessment across state and federal sanctions databases that include but are not limited to: LEIE (OIG), SAM, State Exclusion Lists, DHCS Exclusion lists, DHCS Suspended and Ineligible lists, RPD, Preclusion list, etc.
- The application and supporting documentation are reviewed by HPSM's Credentialing Review Committee including the Credentialing Specialist, Provider Operations Manager, Medical Director and Chief Executive Officer.
- Credentialing applicants are reviewed by HPSM's Peer Review Committee, an external committee of community physicians who serve as HPSM's Peer Review Body on credentialing decisions.

- Upon approval of the above-mentioned parties, the Chief Executive Officer or Chief Finance Officer countersigns the contract after approval of initial credentialing application.
- A copy of the completed contract is then returned to the physician/provider. A new provider orientation and onboarding must be delivered by HPSM within 10 days of the credentialing approval.
- Primary care physicians and certain other provider types may also have a site review before the credentialing process is finalized. Primary care physicians and other applicable providers must achieve a passing score on the Medical Record and Facility Site Review conducted by the Quality Program Department before the credentialing process is finalized.

Providers are typically re-credentialed every three years, although re-credentialing may occur more frequently. The timeline for re-credentialing is based on the approval date of credentialing and recommendations of HPSM's credentialing committees.

Contractual Requirements for Credentialing and Regulatory Compliance

In your contract you agreed to several important and binding terms. These include that you and any providers working for you are, and will continue to be, properly licensed by 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 and/or Medicare provider.

Providers 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 program.

Providers 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.

Providers will not be terminated or otherwise penalized based solely on the following:

- A civil judgement, criminal conviction, or disciplinary action in another state if the judgement, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.
- The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful in California.

Additionally, each applicable provider is required to maintain active medical staff privileges at one of HPSM's contracted hospitals, and all clinical privileges necessary to perform necessary services.

You are required to notify us within 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 changes in any of the credentialing information submitted to HPSM.
- 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 providing services to our members until the matter is resolved to our satisfaction.

Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion

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 the Attestation Questionnaire and the Release of Information/ Acknowledgements Form of the California Participating Practitioner 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.

Rights and Responsibilities

General

All HPSM 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. Providers shall also openly discuss treatment options, risks, and benefits with members without regard to coverage issues. In addition:

- 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 based on 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 or HPSM's designees/subcontractors, as appropriate, and without violation of pertinent state and federal laws regarding the confidentiality of medical records. Such information shall be provided by the provider or the provider's subcontractors without cost to HPSM, HPSM's designees/subcontractors, or HPSM members.
- Provider will actively participate in and comply with all aspects of HPSM's Quality Improvement and Utilization Management programs and protocols.
- Provider will allow HPSM to use their performance data for quality improvement activities.
- Provider understands and acknowledges that various governmental agencies with appropriate jurisdictions 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 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 and responsibilities as outlined in Section 2 of the Provider Manual, including the right to an Advance Health Care Directive.

- Provider will comply with all relevant and applicable timely access appointment standards, including those outlined by the Department of Managed Health Care (DMHC), the Department of Healthcare Services (DHCS), the National Committee for Quality Assurance (NCQA), and Centers for Medicare and Medicaid Services (CMS).
- 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 identify opportunities for improvement.
- Participate on a Quality Improvement or Utilization Management committees, 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 90 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 10 years from the last contracting period or last audit, whichever is latest.
- Maintain appointment availability in accordance with HPSM standards.
- Provider will practice proper infection prevention and control and report communicable and other diseases as required by Public Health Law.

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 if 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 is responsible for providing primary care services and managing all health care needed by HPSM members assigned to their panel. 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 healthcare services and coordination of care, the primary care physician must:

- Provide for all primary healthcare 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 services (as appropriate), reporting communicable and other

diseases as required by Public Health Law, documenting alcohol misuse screenings, 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).

- Ensure they submit all patient vaccination records to local health departments and appropriate immunization registries. All immunization records must be reported within 14 days of vaccine administration, in accordance with state and federal law.
- Maintain appropriate coverage for members 24 hours a day, seven days a week, and 365 days a year.
- Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2), HPSM is obligated to ensure its provider network offers members timely access to care in a manner appropriate for the nature of a member's condition consistent with good professional practice. Member's appointments should meet the following timeframes:
    - Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (d).
    - Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (d).
    - Non-urgent appointments for primary care: within 10 business days of the request for appointment, except as provided in (d) and (e).
    - 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.
    - 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 primary care physician acting within the scope of his or her practice.
    - First prenatal visit must be offered within two weeks upon request.
    - If a provider or office must schedule or reschedule an appointment past the designated timely access appointment (10 days for primary care physicians, 15 days for specialty providers, etc.), they must first triage the patient to determine if it would not adversely affect the member's health to wait more than the required time for an appointment. This triage must be performed by a licensed health care professional acting within the scope of their practice. Scheduling may be extended as clinically appropriate.
- Providers are required to have a protocol for missed-appointment follow-up when patients do not already have a rescheduled appointment.

- Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2) when it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice.
- 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 to 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 accurate records.
- Ensure services are provided in a linguistic and culturally sensitive manner.
- Provide information to members on what an advance health care directive is and how to put a valid advance directive in place. Provide this information at least every five years and as appropriate to the member's circumstances. Include documentation in the medical record of when this information was shared and reviewed with the member. Include documentation of the member's response (i.e. the member plans to create an advance health care directive or declines creation of one, etc). 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.
- Request that a member be re-assigned to a different primary care physician for specific and compelling reasons, with the final reassignment decision to be rendered by HPSM's Medical Director (Provider Request for Member Reassignment form is found on the HPSM's website).

Dental Provider Rights and Responsibilities

When a member receives care from a dental provider, the dental provider is responsible for diagnosing the member's dental treatment needs, managing, and monitoring the member's adherence to recommended treatment, and contacting HPSM when referral to specialist is needed. When providing dental care, the Provider must:

- Practice proper infection prevention and control and report communicable and other diseases as required by Public Health Law.
- Employ such assistants and employees as provider deems necessary to perform covered services for members in the provider's office. HPSM may not control, direct, or supervise provider's assistants and employees in the performance of those covered services. The provider warrants

that all such assistants and employees shall be properly licensed, certified and/or registered, and shall comply with all applicable federal, state and municipal laws. Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2), HPSM is obligated to ensure its provider network offers members timely access to care in a manner appropriate for the nature of a member's condition consistent with good professional practice. Member's appointments should meet the following timeframes:

  - Urgent care appointments for services that do not require prior authorization: within 72 hours of the request for appointment.
  - Non-urgent appointments: within 36 business days of the request for appointment.
  - Preventive dental care appointments: within 40 business days of the request for appointment.
- Providers are required to have a protocol for missed-appointment follow-up when patients do not already have a rescheduled appointment. Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2) when it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice.
- Providers understand that HPSM will manage all referrals to specialists. HPSM will refer a member to an out-of-network provider for specialized services not available/performed by an in- network provider when medically necessary.

Specialist Rights and Responsibilities

When a member has been referred to a specialist, the specialist is responsible for diagnosing the member's clinical condition and managing treatment of the condition. When providing specialty care, the specialist must:

- Keep the primary care physician informed of the member's condition with prompt verbal and written consult reports.
- Deliver all medical healthcare services available to members through self-referral benefits.
- Notify the member's primary care physician 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.
- Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2), HPSM is obligated to ensure its provider network offers members timely access to care in a manner appropriate for the nature of a member's condition consistent with good professional practice. Member's appointments should meet the following timeframes:
  - Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (d)

  - Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (d)
  - Non-urgent appointments for specialty care: within fifteen (15) 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 primary care physician acting within the scope of his or her practice.
  - First Prenatal visit must be offered within two weeks upon request.
- Providers are required to have a protocol for missed-appointment follow-up when patients do not already have a rescheduled appointment. Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2) when it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice.

After-Hours Coverage and Standards

Providers shall provide access to medical advice or treatment even when not in the office, including after hours, holidays and weekends. HPSM requires primary care physician to have 24 hour coverage for their practices, seven days a week, three 365 days a year.

- Providers are required to provide triage and/or screening 24/7 by telephone within 30 minutes and inform the caller how to obtain emergency care.
- Primary care providers shall provide HPSM with a list of the covering physicians.
- Primary care providers shall notify HPSM if the list of covering physicians' changes and provide changes to HPSM.
- 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 and dental providers 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 primary care provider 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 of After-Hours Coverage

- 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 facility site reviews.
- HPSM may gather member survey data to assess after hours coverage.
- Quality Improvement staff or provider network liaisons 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. HPSM 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.

If 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.

Established Patients Only (EPO)

HPSM may assign a member to a primary care provider panel designated as EPO if the member meets the established patient definition and the primary care provider panel has open capacity.

A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified healthcare professional or another physician/ qualified healthcare professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

HPSM uses claims (utilization) data to determine established patient status by reviewing whether a member has had prior utilization with a provider.

Provider Trainings

New Provider Training

All newly credentialed and contracted HPSM providers must complete the HPSM Provider Training within 30 calendar days of becoming a contracted provider with HPSM.

New providers are required to submit a completion attestation once the Provider Training has been completed.

Ongoing Provider Training

HPSM contracted providers will be educated on new and updated operational and administrative policies and procedures; as well as complete the HPSM Regulatory Provider Training on a regular basis as required by applicable state and federal laws, at time of re-credentialing with HPSM, and/or at least annually. Providers are required to submit a completion attestation once the Provider Training has been completed at least annually. The ongoing education of providers will be achieved through the provider communications channels listed in the section below. Ongoing Provider Training may include focused topics. Providers who have a change in office staff may request training for new staff members.

Provider Communications

To ensure that HPSM keeps our provider network up to date with important information, the Provider Services Department provides the following services, including but not limited to:

- Provider Newsletter – "Health Matters MD."
- Fax and email notifications.
- An online, searchable provider directory.
- A dedicated Provider section of HPSM's website (www.hpsm.org/provider) with current information about authorization requirements, claims requirements, Pay for Performance programs, a Provider Learning Lab, and a variety of public health and other topics of relevance to our network.
- On-site visits.
- In person and online trainings and education.
- HPSM website.

Section 9: Quality Improvement

The purpose of the Health Plan of San Mateo's (HPSM's) Quality Improvement (QI) Program is to establish methods for systematically ensuring all members receive high quality health care. Through the QI Program and in collaboration with HPSM providers, HPSM strives to continuously improve the structure, processes, and outcomes of its health care delivery system.

HPSM's QI Program 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 QI Program 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 QI Program 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 QI Program Description is reviewed and updated annually.

Site Reviews

HPSM conducts site reviews to ensure that all primary care provider sites are in compliance of the standards of the California Department of Health Care Services (DHCS)/Managed Care Quality and Monitoring Division (MCQMD). Additionally, site reviews are performed to ensure that the site provides appropriate primary health care services, has consistent processes that support the coordination of care, maintains patient safety standards and practices, and operates in compliance with local, state, and federal regulations. Site reviews are performed using the guidance provided in DHCS's All Plan Letter (APL), 22-017, which can be found here:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-017.pdf

There are three components of the site review process:

1. Facility Site Review (FSR)
2. Medical Record Review (MRR)
3. Physical Accessibility Review (PAR)

HPSM conducts Facility Site Reviews (FSRs) for new Medi-Cal primary care physicians at the time of initial credentialing, at least every three years thereafter per California Department of Health Care Services (DHCS) guidelines, and as part of the re-credentialing process, regardless of the status of other accreditation and/or certifications.

The FSR and MRR are scored reviews. DHCS-Certified Nurse Reviewers conduct the FSR and MRR and score them with standardized DHCS guidelines and audit tools.

The FSR focuses on physical aspects of the site for basic regulatory requirements in areas including:

- Access/Safety.
- Personnel.
- Office Management.
- Clinical Services.
- Preventative Services.
- Infection Control.

The MRR is conducted three to six months following initial member assignment, and every three years thereafter. The MRR focuses entirely on the medical record for regulatory requirements in areas including:

- Format.
- Documentation.
- Coordination of Care.
- Pediatric Preventative Health Services.
- Adult Preventative Health Services.
- OB/CPSP Preventative Health Services.

HPSM conducts a Physical Accessibility Review for all existing and new primary care providers. The Physical Accessibility Review is not a scored review and focuses entirely on the physical accessibility of the site that provides care to all HPSM members, including Seniors and Persons with Disabilities (SPDs). Sites include:

- Primary care provider sites.
- Community-based adult service sites.
- High-volume specialist sites.
- Other ancillary sites as appropriate.

A Physical Accessibility Review is generally conducted in conjunction of the FSR process, however, it is also required as an independent review process for specialists and allied providers serving a high volume of members who are part of the SPD population. Physical Accessibility Reviews are completed during the initial site review process and every three years thereafter. The onsite evaluation includes these areas:

- Parking.
- Exterior building.
- Interior building.
- Restroom.
- Exam Room.
- Exam table/weight scales.

The review establishes if the facility has basic access, or limited access for members with disabilities.

FSR and MRR Scoring

A minimum passing score of 80% on both the FSR and MRR is required. Primary care provider sites that score 79% and below in either the FSR or MRR survey for two consecutive reviews must score a minimum passing score in the next/third review for both the FSR and MRR. Sites who do not score a minimum of 80% for the third consecutive review are subject to removal from the HPSM network. Additionally, new members cannot be assigned to primary care providers that score 79% or below in either the FSR or MRR on a subsequent site review until HPSM has verified that the provider has corrected the deficiencies, and the corrective action plan is closed.

A pre-contractual provider who scores 79% and below will not be recommended for credentialing completion or contract approval until a passing score is achieved and correction of any identified deficiencies are verified. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the FSR and MRR.

Corrective Action Plans

Any Corrective Action Plans (CAPs) that result from the scored FSR and MRR surveys must be addressed within the established CAP timelines. HPSM is dedicated to the success of its partnering providers and assists with CAPs as needed by providing resources, education, and answering any questions. Primary care providers that are non-compliant or do not meet the CAP timelines established in the regulatory requirements may not be recommended for credentialing/re-credentialling and/or are subject to removal from HPSM's network.

Additional Considerations

Providers who move to a new site or open an additional office site must undergo a site review at their new location. The site review must be completed as soon as 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.

Providers who are added to a practice site, which has a current site review, will only require a medical record review to be credentialed.

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 Improvement and Health Equity 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.

DHCS conducts separate site reviews to validate HPSM's site review and medical record review processes. HPSM is notified approximately four weeks in advance of DHCS-conducted site reviews, and HPSM will notify the selected providers in advance of the site reviews, whether the site review is conducted by DHCS or by HPSM. However, all primary care providers enrolled in the Medi-Cal program through HPSM are subject to unannounced onsite site reviews.

"Focused Site Reviews" may be performed in between the three-year review period to investigate problems identified through monitoring activities, or to follow up and validate the resolution of corrective action plans (CAPs). 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.

For more information on the Site Review Process including regulatory guidelines, audit tools and standards, and additional resources, please visit: **https://www.hpsm.org/provider/resources/medical-record-and-facility-site-reviews/**

Initial Health Appointment (IHA)

The Initial Health Appointment (IHA) is a requirement for all new Medi-Cal members enrolled with the Health Plan of San Mateo (HPSM). An IHA is a comprehensive assessment completed during a new member's initial encounter with their primary care provider. HPSM requires providers to schedule an IHA visit with all new members on their panel list. This office visit helps establish care with new patients and helps providers understand the patient's medical history and to assess any specific needs.

During the IHA, the primary care provider assesses and manages the acute, chronic, and preventative health needs of the member. The IHA must be completed within 120 days of enrollment into HPSM and documented in the medical record (an exception is made if member's record contains complete information updated within the previous 12 months as determined by the primary care provider).

Components of an IHA

To meet DHCS's requirements, an IHA must be performed by a provider within the primary care medical setting and be provided in a way that is culturally and linguistically appropriate and documented in the member's medical record. An IHA must include a history of a member's present illness, past medical history, social and behavioral health history and review of organ systems including an oral assessment. The IHA must also include an identification of risks, an assessment of need for preventative screens or services and health education, and the diagnosis and plan for treatment of any disease.

Primary care providers are required to make at least three attempts and document efforts to contact a member to schedule an IHA. These attempts must include at least one telephone contact and one written contact. If the provider is unable to reach the member or the member refuses an appointment, contact HPSM Member Services for assistance. The primary care provider should attempt to perform the IHA at subsequent member office visits, even if the 120-day period has lapsed.

For more information on IHA requirements and finding newly assigned members, please visit **https://www.hpsm.org/provider/resources/initial-health-assessment**

Healthcare Effectiveness Data and Information Set (HEDIS)

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. HPSM is required by the Department of Health Care Services (DHCS) to perform quality measure studies for our Medi-Cal line of business. The Centers for Medicare and Medicaid Services (CMS) requires HPSM to perform quality studies for HPSM's CareAdvantage program as well. Beginning in 2024, the Department of Managed Healthcare (DMHC) requires HPSM to conduct quality studies on our Medi-Cal line of busines. DHCS, DMHC and CMS use HEDIS measures to assess how well HPSM is providing quality services for our members.

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 and/or cannot be captured via claims or encounter submission. In phase two, HPSM staff, or contracted vendor staff, undertake an extensive examination of the relevant members' medical records in provider offices. In these ways, data is collected that provides information to DHCS, DMHC, CMS and San Mateo County about the level of clinical care, preventive care, access to care and utilization of services that HPSM members receive. HPSM network providers are expected to provide timely access to medical records for members selected for HEDIS review.

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 guidelines on best practices.

These guidelines assist both physicians and patients in decision-making regarding appropriate health care for specific clinical circumstances.

HPSM promotes the use of practice guidelines that have been developed using nationally recognized scientific evidence published in peer reviewed journals, released by specialty societies or academies, or promulgated by national advisory committees.

The guideline topics and resources are evaluated and updated at least annually, with the input of HPSM's Quality Improvement and Health Equity Committee (QIHEC) and any other interested HPSM provider. Providers can access the clinical guidelines in the Provider Resources section of the HPSM website: **https://www.hpsm.org/provider/resources/guidelines**

Additional resources

- National Heart, Lung, and Blood Institute: **https://www.nhlbi.nih.gov/resources**
- United States Preventive Services Task Force: **https://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 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 Network 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, email 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.

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 Improvement and Health Equity Committee (QIHEC)

Purpose/Responsibilities:

- Establishes strategic direction, recommends policy decisions, analyzes, and evaluates the results of QI activities, and ensures practitioner participation in the QI Program through planning, design, implementation, or review.
- 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 because of the QI Program 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.
- Ensures that appropriate actions and follow-up are implemented and evaluates improvement opportunities. The QIHEC meets and reports at least quarterly to the Commission.

Membership: The QIHEC is a multi-disciplinary committee, the membership includes:

- At least one Commission member.
- Practicing network clinicians.
- Support staff and guests will be invited to attend the meetings as reporting requirements dictate.

San Mateo Health Commission

Purpose/Responsibilities:

- Delegates management of the QI Program to HPSM's Chief Executive Officer while retaining overall authority and responsibility for program implementation, continuity, and effectiveness.
- Monitors QIP strategies and activities outlined in HPSM's QI Program Annual Report/Evaluation and Work Plan, and at the time of any substantive revision.

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.
- a member of the public at large.

Quality Improvement Projects

HPSM is required by California to conduct and/or participate in at least two Performance Improvement Projects (PIPs) annually. These projects may be based on HEDIS measures or other measures that have been identified by HPSM as opportunities for improvement.

The Center for Medicare and Medicaid Services (CMS) requires HPSM to conduct a Quality Improvement Project (QIP) 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 PIPs and QIPs. All projects are presented at the Quality Improvement and Health Equity Committee meetings, as well, to ensure that the tools and interventions planned appear feasible and useful from a provider perspective.

The QI Department works on a variety of topics including but not limited to the following:

- Asthma.
- Blood Lead Screening.
- Cancer Screening.
- Chlamydia Screening.
- Comprehensive Diabetes Care.
- Controlling High Blood Pressure.
- Depression Screening
- Prenatal & Postpartum Care.
- Reducing Health Disparities.
- Reducing 30 Day Hospital Readmissions.
- Transitions of Care Management.
- Well Visits for Children and Adolescents.

Providers are encouraged to contact HPSM if they are currently working on any of these topics to discuss ways that HPSM can provide support for these efforts.

Facilitating health education intervention

If a member needs a health education service that is not outlined in the HPSM provider manual, the provider is encouraged to contact the Health Promotion Unit at **650-616-2165** for information about other community resources that may be available.

Incentive Payment Programs

Medi-Cal and CareAdvantage Pay for Performance (P4P) Programs

HPSM has Pay for Performance programs for contracted Medi-Cal and CareAdvantage primary care providers. Additional program information can be found in the program guidelines on the HPSM website: **https://www.hpsm.org/provider/value-based-payment**

Medi-Cal Panel Engagement Capitation Bonus Incentive

HPSM has an incentive payment program for contracted capitated clinics to earn additional dollars based on panel engagement. Learn more about this program on HPSM's website: **https://www.hpsm.org/provider/value-based-payment**

Potential Quality Issues (PQI)

Potential Quality Issues (PQI) HPSM has a Potential Quality Issue (PQI) Program that identifies deviations from provider performance, clinical care, and/or issues with outcome of care. The reporting and processing of PQIs determines opportunities for improvement in the provisions of care and services to HPSM members. Appropriate actions for improvement are taken based on the PQI outcomes.

How are PQI's Identified?

- Information gathered through concurrent, prospective, and retrospective utilization review.
- Referrals by health plan staff or providers.
- Facility site reviews.
- Claims and encounter data.
- Pharmacy utilization data.
- HEDIS medical record abstraction process.

- Medical/dental records audits.
- Phone log detail.
- Grievances.

Scope of PQI reporting includes services provided by, but not limited to:

- Contracted providers including subcontractors that provide inpatient and outpatient services.
- Non-contracted providers.
- Durable medical equipment (DME) and medical supply providers.
- Pharmacy providers.
- Home health providers.
- Dental providers.
- Skilled nursing, long term care and rehabilitation facilities.
- Ancillary service providers including, but not limited to, laboratory, pharmacy, radiology, and ambulance.

PQIs may be reported for concerns relating to:

- Access/Availability.
- Assessment/Treatment/Diagnosis.
- Communications/Conduct.
- Continuity of Care.
- Mental health.
- Pharmacy/Utilization Management Authorizations.
- Readmissions.
- Safety.
- Surgical Services.

Provider Responsibilities

Upon receipt of a PQI, medical records and/or initial provider responses are usually requested from the provider. Providers are expected and required to respond and provide supporting documentation [as requested] within the timeframe provided.

Following a comprehensive review of the PQI, if an HPSM Medical Director determines the presence of a quality of a care concern, a corrective action plan or other follow-up may be requested from the provider of concern. The provider of concern must institute the corrective action plan and provide a response within the timeframe provided.

Based on the severity or complexity of the case, the PQI can be referred to the Peer Review Committee (PRC) for additional review and determination.

Who can refer a PQI?

- HPSM staff.
- Providers.
- HPSM Members/Members of the community.

How can a PQI be referred?

Please use the PQI Referral Form. The form can be downloaded from the Provider Forms page on **https://www.hpsm.org/provider/resources/potential-quality-issues.** You can also request a copy of the form via email at **pqireferralrequest@hpsm.org** or by calling **650-616-5016**. Complete forms can be returned by fax to **650-616-8235**.

Provider Preventable Conditions (PPCs)

The Department of Health Care Services (DHCS) requires HPSM to report and to adjust payment for Provider Preventable Conditions (PPCs). Providers must report the occurrence of any PPC in any Medi-Cal patient that did not exist prior to the provider initiating treatment. Providers must report the occurrence regardless of whether the provider seeks Medi-Cal reimbursement for the services to treat the PPC.

Providers must report PPCs by completing and submitting the Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form. Providers must submit the form within five days of discovering the event and confirming the patient is a Medi-Cal beneficiary. Online reporting guidance including the definitions of recognized PPCs can be found by visiting: **http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx**

Reporting a PPC for a Medi-Cal beneficiary does not preclude the reporting of adverse events, pursuant to Health and Safety Code (H&S Code), Section 1279.1 to the California Department of Public Health (CDPH).

In addition to provider reporting, HPSM reviews encounter data for evidence of PPCs and reports any PPCs to the DHCS Audits and Investigations Division.

Section 10: Health Education Resources & Language Assistance Services (LAS)

At the Health Plan of San Mateo (HPSM) we believe that healthy is for everyone. We offer a variety of wellness programs and resources to help our members learn how to live well and be healthy. Topics include: diabetes, pre-diabetes, high blood pressure, exercise, nutrition, pregnancy, and tobacco cessation.

Physician Authority

No action of notice by HPSM shall require a participating physician to provide to the member, or order on behalf of the member, covered services which, in the professional opinion of the physician, are not medically necessary. Participating physicians may freely communicate with members about their treatment, regardless of benefit coverage and limitations. When a physician determines that a member-requested service is not medically necessary and the member does not agree with the provider's decision, the physician shall inform the member of their appeal rights through HPSM.

HPSM's Health Promotion Unit

HPSM's Health Promotion Unit supports members with general health information, tips and resources to stay healthy. This unit does not offer medical advice. This unit connects to wellness programs and services at no cost to members.

Programs and Services

Diabetes Prevention Program (DPP)	HPSM provides DPP to eligible **Medi-Cal and CareAdvantage** members with pre-diabetes at no cost to them. This evidence-based 12-month lifestyle change program is designed to prevent or delay the onset of type 2 diabetes. It includes weekly one-hour sessions for the first six months and monthly sessions in the last six months, provided either in person or online. Sessions are led by a trained Lifestyle Coach who provides support on eating healthy, exercising regularly and managing weight. They also provide educational materials to help people meet their personal

health goals. Plus, program participants get group support from other participants.

DPP participants can use HPSM's Ride Benefit to get to their in-person DPP sessions and back home. Eligible Medi-Cal members who enroll in DPP can also enroll in HPSM's Fitness Membership Program at no cost while enrolled in DPP.

Referring members

- To learn more about eligibility requirements and to access the DPP Provider Referral Form, providers can visit **https://www.hpsm.org/provider/resources/diabetes-prevention-program**. Forms can be submitted online, by email or fax.

- Members can visit **https://www.hpsm.org/health-tips/health-conditions/diabetes/diabetes-prevention-program** or can contact our Health Promotion Unit at **650-616-2165** to learn more and see if they are eligible. After joining, members can opt out at any time by calling our Health Promotion Unit.

Baby + Me Program

HPSM's Baby + Me program promotes timely care and health from the start of pregnancy to birth and beyond. HPSM members who are pregnant or who recently gave birth are eligible for this program.

Through the program, HPSM **Medi-Cal members** can qualify for up to $100 in gift cards for going to two appointments with their perinatal care provider within specific timeframes. Members can also learn more about programs and services that can support them during and after pregnancy, such as doula services and nutrition supports.

Referring members

- Providers can refer members by submitting a contact form on our website. Learn more about the Baby+Me program and how to refer members: **https://www.hpsm.org/member/health-tips/pregnancy/baby-and-me**
- Members can join by calling our Health Promotion Unit at **650-616-2165.** After joining, members can opt out by calling our Health Promotion Unit.

Teen Wellness Rewards Program

HPSM **Medi-Cal members** who are 12-21 years old and are assigned to San Mateo Medical Center (SMMC) Clinics can get a $25 gift card for completing an annual well-visit. Once members complete their well visit, a letter with instructions on how to redeem their gift card will be mailed to the address they provided HPSM. For more information, members can contact our Health Promotion Unit at **650-616-2165**.

Cancer Screening Rewards Program

HPSM **CareAdvantage members** who complete their breast and/or colorectal cancer screening can get a Cinemark Prepaid Movie Ticket for each screening they complete. Once members complete their screening, the Cinemark Prepaid Movie Ticket will be shipped to the address they provided HPSM. It should arrive within 90 days of when they got their screening. For more information, members can visit **https://www.hpsm.org/member/health-tips/health-conditions/breast-cancer/cancer-screening-program** or contact our Health Promotion Unit at **650-616-2165**.

Fitness Membership Program

The Fitness Membership Program offers a YMCA membership to **CareAdvantage members** at no cost to them. The membership includes access to:

- YMCA locations throughout San Francisco, San Mateo, and Santa Clara counties. Locations may include exercise equipment, basketball courts, indoor or outdoor fitness studios, and indoor or outdoor swimming pools.
- More than 600 group exercise classes led by certified instructors in yoga, Pilates, Zumba, cycling, aqua fitness, and more. Some locations may have online classes available.
- Wellness coaching to help members meet their health goals. Some locations may have online coaching options available.

Members can enroll by visiting a YMCA location near them and showing their HPSM CareAdvantage ID card. Members can also enroll online and learn more about the program by visiting: **https://www.hpsm.org/fitness**. CareAdvantage members enrolled in the Fitness Membership Program can use HPSM's Ride Benefit to get 12 one-way rides per month to the YMCA gyms.

Diabetes Management Services

Members recently diagnosed with diabetes or who are having difficulty managing their diabetes can contact our Health Promotion Unit at **650-616-2165** for information on covered services and community resources available to support diabetes management. To get more information about diabetes, members can also go to our online Health Tips pages at **https://www.hpsm.org/health-tips/health-conditions/diabetes**.

Hypertension Management Services

Members recently diagnosed with hypertension or who are having difficulty managing their hypertension can contact our Health Promotion Unit at **650-616-2165** for information on covered services and community resources available to support hypertension management.

Tobacco Cessation Services

Learning how to quit tobacco is essential to keeping our members and their loved ones healthy. Providers are required to ask about tobacco use at the first visit, annually, and at any

relevant visit. Providers are encouraged to recommend tobacco cessation by:

- Asking permission to talk about tobacco use and readiness to quit.
- Advising patients to quit.
- Offering brief counseling.
- Discussing and prescribing cessation medication.
- Connecting patients to additional resources, like a quit line.
- Following up with continuous support to help prevent relapse.

Information and Resources for Providers

To help you help your patients quit tobacco, visit our Tobacco Cessation Information and Resources microsite: **https://www.hpsm.org/provider/resources/tobacco-cessation-resources**. The website has recommendations, requirements and resources for providers on the following topics:

- Identifying patients who use or have used tobacco.
- Treating patients who use tobacco: covers counseling, treatment, and additional resources that can help your patients quit, such as coaching and quitlines.
- Provider education and training: covers clinical guidelines, toolkits and ongoing trainings for continuing medical education credit (CME/CE) to support your patients in their quitting journey.
- Vulnerable populations: Covers clinical recommendations and guidelines for tobacco use and prevention in children, adolescents and pregnant people, including resources to help adolescent patients quit.

Information and Resources for Members

For more information and resources on quitting tobacco, members can go to our online Health Tips pages at **https://www.hpsm.org/health-tips/quit-smoking** or can contact our Health Promotion Unit at **650-616-2165**.

Health Education Member 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. Our online Health Tips pages offer a wide variety of health information, tips and self-management tools for staying healthy. Members can access our online Health Tips pages at **https://www.hpsm.org/health-information.**

Topics covered include:

- Alcohol and Drugs
- Asthma
- Breast Cancer
- Children's Health
- COVID-19
- Diabetes
- Exercise
- Flu
- Heart Disease and Stroke
- LGBTQIA+ Health
- Medication Management
- Mental Health
- Nutrition
- Older Adults
- Pain Management
- People with Disabilities
- Pregnancy
- Preventive Care
- Quitting Tobacco Use
- Sexual and Reproductive Health
- Teen Health
- Weight Management
- Self-Management Tools

For more information, members can contact our Health Promotion Unit at **650-616-2165**.

Member Newsletter

HealthMatters is HPSM's member newsletter. It includes articles on a variety of topics to help keep our members healthy. To view current and past issues of Health Matters, visit **https://www.hpsm.org/member/resources/newsletter**.

Our special edition "Be Healthy" newsletters provide members with tips and resources about different health topics, including diabetes, mental health, tobacco cessation and child health. To view our current special edition newsletters, visit **https://www.hpsm.org/member/resources/member-education-materials**.

Culturally and Linguistically Appropriate Services (CLAS)

The Health Plan of San Mateo (HPSM) is committed to delivering culturally and linguistically appropriate services to all members and/or their medical decision makers. HPSM complies with Title IV of the Civil Rights Act of 1964, which states, any agency, program, or activity that receives funding from federal government may not discriminate on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification.

Understanding these requirements will help you provide quality care to our members and meet federal and state requirements.

Provider Responsibility

All HPSM contracted providers are required to provide linguistically appropriate services to members and their medical decision makers with limited English proficiency (LEP) and with a hearing impairment. At each point of contact, HPSM members must be provided information on:

- Their right to a qualified interpreter at no cost in all non-English languages, including sign language and how to access those services.
- Their right not to be required to provide their own interpreter.
- Their right not to be required to coordinate interpreter services by conducting additional outreach.
- How to file complaints pertaining to interpreter services (see Member Grievances section).

If providers are unable to provide linguistically appropriate services to a member through their own program or service, HPSM's Language Assistance Program can assist.

Learn about our Language Assistance program at **https://www.hpsm.org/provider/resources/language-services.**

Interpreter Services

All HPSM Network Providers must maintain a procedure for accessing telephone interpreters. Please contact **interpreters@hpsm.org** for a sample clinic policy document. Additionally, interpreter services

must be offered in a way that does not violate HIPAA requirements for exchanging PHI and ePHI and in ways that comply with federal and state privacy laws. If providers are unable to provide interpreter services to a member through their own program or service, HPSM's Interpreter Services can assist.

As a reminder, HPSM interpreter services are meant to be used only for HPSM members and/or their medical decision makers. Vendor utilization is monitored, and education is provided should HPSM interpreter services appear to be utilized incorrectly.

How to Access HPSM Interpreter Services

HPSM contracts with two vendors to meet the needs of our members with LEP and with a hearing impairment, Certified Languages International (CLI) and Avid Translation LLC (Avid). **Providers should prioritize using CLI's on-demand phone and video services.** Avid in-person and special circumstance video services are processed on a case-by-case basis, and should only be requested for certain circumstances, such as:

- Sensitive discussion (e.g. trauma, abuse)
- Complex or life-threatening diagnoses
- End-of-life discussions
- Group sessions/meetings
  Large community forums/town halls

CLI Phone Interpreters (Should be used first)	**CLI Video Interpreters** (Use if CLI phone services do not meet member's need)	**Avid In-Person and Special Circumstance Video Interpreters** (Use only if CLI services do not meet member's need)
• On-demand access • Over 200 Languages • Available 24 hours/7 days a week	• On-demand access OR option to schedule appointments • American Sign Language and Spanish available 24 hours/7 days a week • Additional 20 languages available Monday through Friday from 5:00 AM to 7:00 PM	• Must submit requests to HPSM Interpreter Services at least 5 business days in advance • Available in over 50 languages

Below outlines the steps to access HPSM's interpreter services. This information can also be found on our website: **https://www.hpsm.org/provider/resources/language-services**.

Phone Interpreter Services

To access the service:

- Dial CLI at **800-225-5254**.
- Provide:
  - Provider Access Code: 64095
  - Provider type (Dental, Medical, Therapy (physical/speech/behavioral), DME or Vendor)
  - Language needed
  - Clinic name
  - HPSM member ID
  - HPSM member date of birth
- Begin the conversation once connected
- For an office visit, start conversation after the CLI operator connects you to an interpreter.
- For telemedicine visit, provide HPSM patient phone number. After you have briefed the interpreter, dial # to call the HPSM patient at the number you provided the CLI operator. Start conversation once you are connected to the HPSM patient.

Video Interpreter Services

Ensure you have Wi-Fi at the office/clinic for online access to CLI platform. For a telemedicine visit, also ensure HPSM member has internet access to receive telemedicine appointment link.

To access the on-demand services:

- Using either Chrome, Firefox, or Safari web browser, go to CLI platform: **https://hpsm.cli-video.com.**
- Enter access code: 64095hpsm
- Enter the following information:
  - Provider Type
  - Member Full Name
  - Member DOB
  - Clinic Name
  - Language needed
  - Channel
  - Schedule: No
- For telemedicine visits, inform interpreter that you will be inviting your member to the session.
  - Click the “Add Expert” button and enter the patient’s email or cell number.
  - Click “Invite” and then “Send Link”.

    - When your patient clicks on the link you sent, and your patient allows access to video and microphone on their device, they will be connected to the session.
- When the appointment is done, click the red "End Call" button in the upper-right corner of the screen. Instructions and a video tutorial can be found at **https://www.hpsm.org/provider/resources/language-services/phone-and-video-interpreters**

To **schedule an appointment** for services:

- Follow the steps above to access the platform
    - Using either Chrome, Firefox, or Safari web browser, go to CLI platform: **https://hpsm.cli-video.com.**
    - Enter access code: 64095hpsm
- For the **Schedule**, select 'Yes'
- Select the grey 'Schedule' button
- Fill out the following information
    - Email address – your email address to send appointment confirmation to
    - Phone number
    - Language
    - Schedule Date & Time
    - Expected Duration
    - Channel
    - Special Instructions
- Select the grey 'Schedule' button
- You will receive an email with a reference number and link for you to click at your scheduled appointment time. Or you can scroll to the bottom of the expert selection screen, click the "Go to an appointment" button and enter your reference number.

In-person Interpreter Services

All in-person spoken language or sign language interpreter services should be scheduled through HPSM **at least five days in advance.** To schedule an in-person interpreter:

- Complete the Online Interpreter Request Form: **https://www.hpsm.org/provider/resources/language-services/language-interpreter-services/interpreter-services-request**
    - If you are submitting a request for a **recurring appointment,** please be sure to include the following information in the "Please describe the purpose of the visit:" section:
        - The day and time of the appointments
        - The end date for the appointment
        - Any days the recurring appointment will not occur (e.g. holidays)

        - Example of a request: *Recurring appointment starting on 09/10/26 for Thursday at 2:30 PM with an end date of 12/05/26. No appointment on 11/26/26 due to holiday.*
- You will receive an email confirmation from the HPSM Interpreter Services team (**interpreters@hpsm.org**) once your request is scheduled.
- Note: you may receive secure emails from the HPSM Interpreter Services team if there are questions regarding the request.

Provider Language Documentation Requirements for Members with Limited English Proficiency and Hearing Impairment

1. Document the member's language needs and language services that were offered (other than English).
    a. For members with LEP, document their language in their medical record.
    b. At every point of care (onsite or virtual) inform members that they have access to phone or video interpreters free of charge and offer to get an interpreter.
    c. Document the date that interpreter services were offered and indicate whether member agreed or declined assistance.
2. Document your staff's bilingual capabilities and keep HPSM informed of changes. Because HPSM publishes the language capabilities of all network providers in its provider directories, providers must inform Provider Services about:
    a. The availability of practitioners and staff who are fluent in the preferred languages of assigned members, including:
        i. Demonstration of proficiency in preferred languages.
        ii. Assessment of language proficiency.
        iii. Number of years' experience working as a qualified medical interpreter (if any).
        iv. Changes to staff's language proficiencies (e.g., if a staff member who speaks a preferred language no longer works for the practice)
    b. You can update your provider directory listing in the provider portal.

Note: Except for an emergency involving an imminent threat to the safety or welfare of the individual or the public, Providers cannot suggest that HPSM members use family members (including children) or friends as informal interpreters. If an HPSM member refuses professional interpreter services and insists on using a family member or friend and the accompanying adult agrees to provide that assistance, the provider must document the member's preference in their medical record.

Best Practices for Working with an Interpreter

Interpreters are an important part of the care team for HPSM's members and should be treated as a respected healthcare professional. Below are a few tips for working with an interpreter during an appointment with a member.

Before the visit/appointment:

- Introduce yourself to the interpreter
- Meet with the interpreter prior to the appointment to provide a summary of the purpose of the visit, member information, and any procedures that will be discussed
- Allow extra time for the visit to ensure the interpreter has time to interpreter the conversation

During the visit/appointment:

- Speak to the member, not the interpreter, even if the member is looking at the interpreter
- Use first person, and ask the interpreter to do the same
- Use simple language and avoid acronyms or medical/healthcare jargon
- Take pauses between sentences so the interpreter has time to interpreter properly
- Observe what is going on before interrupting the interpreter

Services for Members with Disabilities

HPSM recognizes that our members with disabilities have specific needs in addition to their general medical needs. We provide services that are integrated within the 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 the physical accessibility of providers offices in our provider directory for our wheelchair-using members.

We also have an Integrated Care Management 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 Integrated Care Management unit at **650-616-2060**.

Section 11: Fraud, Waste, and Abuse

The Health Plan of San Mateo (HPSM) is committed to helping prevent, deter, and detect fraud, waste, and abuse (FWA) in our healthcare programs. To help eliminate FWA in our programs, HPSM relies on its plan partners, including network providers, in identifying and reporting suspected FWA.

This section of the Provider Manual seeks to help provide guidance for providers and other plan partners in identifying and reporting FWA to HPSM.

Definitions

Fraud

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347). This includes an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. (Title 42 CFR 455.2; W&I Code Section 14043.1(i).)

Waste

Waste is overutilization of services or inappropriate use of services and misuse of resources that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medi-Cal (Medicaid) programs. It is not considered to be caused by criminal or intentional actions, but by the misuse of resources.

Abuse

Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in one or more of the following:

- Unnecessary costs to the health care system, including the Medicare and Medi-Cal (Medicaid) programs.
- Improper payment for services.
- Payment for services that do not meet professionally recognized standards of care.
- Services that are medically unnecessary.

Abuse involves payment for items or services when there is no legal entitlement to payment and the entity supporting HPSM (e.g., health care provider or supplier) has not knowingly and/or intentionally misrepresented facts to obtain payment.

Abuse cannot always be easily found, because the difference between “abuse” and “fraud” depends on specific facts and circumstances, intent, prior knowledge, and available evidence, among other factors.

Examples

Fraud costs state and federal taxpayers a lot of money. Below are types of fraud you may encounter.

Member/Beneficiary/Recipient

Most members are honest people who need quality health care; however, there are people who commit fraud or become involved in fraudulent schemes. The following are some types of member fraud:

- **Recipient Exceeds Income or Asset Requirement:** Occurs when a member does not report income or assets to their county worker.
- **Identity Theft:** Someone uses another person's personal information to get Medi-Cal or Medicare benefits. Sometimes the person whose identity was stolen is not aware until they begin to receive mail from either program.
- **Drug Diversion:** Altering a doctor’s prescription, going to multiple doctors to get more of the same drug, or selling drugs to others.

Provider

Most providers are honest in their billing practices and provide quality health care to their patients. However, a few providers commit fraud directly or become involved in fraudulent schemes. The following are some types of known provider fraud:

- **Kickbacks:** When an individual recruits and pays patients money or offers gifts in exchange to take part in the Medicare or Medi-Cal program. It is also illegal for an individual to receive payment or gifts to participate in either program.
- **Balance Billing:** A provider charging a Medicare or Medi-Cal beneficiary for the difference between HPSM’s reimbursement rate and the customary charge for the service.

Provider Billing and Coding Issues

Some of the most common coding and billing issues are:

- Billing for services not rendered.
- Billing for services at a rate that indicates the provider is an outlier compared with their peers.

- Billing for non-covered services using an incorrect CPT, HCPCS, and/or diagnosis code to have services covered.
- Ordering unnecessary lab tests.
- Dentists perform unnecessary teeth extractions on both adults and children.
- Medical supply companies billing for equipment and products that were neither ordered nor delivered.
- Billing for services that are performed by another provider.
- Up-coding.
- Modifier misuse. For example, modifiers 25 and 59.
- Unbundling.
- Billing for more units than rendered.
- Lack of documentation in the records to support the services billed.
- Services performed by an unlicensed provider but billed under a licensed provider's name.
- Alteration of records to get services covered.
- Soliciting or receiving payment (in kind or in cash) in return for referring individuals, goods, or services.
- Employing or contracting with any excluded individual or entity for the provision of items or services that are reimbursable, directly, or indirectly, by any federal health care program.

Monitoring Potential Fraud Waste and Abuse

HPSM uses a combination of claims editing software and weekly oversight reports and edits integrated with the claims adjudication system to check claims prior to payment to identify billing issues such as unbundling, double billing, and the inappropriate use of modifiers.

On a post-paid claim basis, HPSM uses software that reviews claims and flags potentially suspect billing activity. HPSM reviews providers identified by the system and determines the next course of action. Actions taken can include provider education on correct billing procedures, medical record requests to review clinical justification for services provided, and requests for overpayment reimbursement.

HPSM is required to report suspected FWA cases to state and federal agencies, depending on which line of business is impacted. Agencies to be notified include the California Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC). HPSM also reserves the right to notify law enforcement if it is deemed appropriate.

HPSM appreciates your understanding and cooperation in any investigation we may undertake as we do our part to safeguard our members and state and federal healthcare dollars.

Reporting

If you suspect fraud, waste, or abuse with an HPSM member, service, or provider, you must report it to HPSM to investigate. Your actions can help to improve services and reduce costs for our members, customers, and plan partners.

To report suspected fraud, waste, or abuse, you can contact HPSM in one of these ways:

Compliance Hotline	**844-965-1241**
Phone	**650-616-0050**
Fax	**650-829-2050**
Email	**compliance@hpsm.org**
Mail	Health Plan of San Mateo Attn: Compliance Department 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080

You may remain anonymous, if you prefer, by calling the Compliance Hotline.

All information received or discovered by HPSM's Compliance Department will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state, and federal authorities, HPSM legal counsel, HPSM clinical reviewers, and/or senior management).

You can also report FWA to the following agencies, depending on the program affected:

Medicare and Medi-Cal

To report to the OIG:

Phone	**800-HHS-TIPS (800-447-8477)**
Online	**https://oig.hhs.gov/fraud/report-fraud/**

Medi-Cal

To report to the Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA):

Phone	**800-722-0432**
Online	**https://oag.ca.gov/bmfea/reporting**

To report to the Department of Health Care Services (DHCS):

Phone **800-822-6222**

Online **https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx**

Resources

Fraud Waste and Abuse (FWA) Training

If you would like additional resources on preventing, detecting, and reporting FWA, please visit the Medicare Learning Network online: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html**https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership**

DHCS Helpful Hints and Resources

https://www.dhcs.ca.gov/individuals/Pages/ai_hints_res.aspx

Section 12: Privacy

The Health Plan of San Mateo (HPSM) is committed to helping protect the privacy and integrity of our members' protected health information or "PHI" and personal information or "PI." As a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have an obligation and responsibility to protect your patients' and our members' PHI.

This section of the Provider Manual seeks to guide providers and other plan partners to secure HPSM's members' PHI and PII as well as identifying and reporting privacy incidents or security incidents to HPSM.

Privacy Incidents

Definition

A privacy incident is a situation in which an individual or organization has suspicion or believes PHI or PI may have been lost, sent in an unencrypted format, or otherwise released to, accessed by, or obtained by an individual or organization that does not have authorization to review or receive the PHI.

Examples of Privacy Incidents

Privacy incidents may be unintentional and accidental, or they may be intentional. The release of PHI may be in various formats: oral, written, and electronic. The list of examples below is not considered exhaustive. Potential incidents should always be reported to HPSM.

- **PHI sent to the wrong individual/organization**: Examples include sending a fax to the wrong number or mailing PHI to the wrong address/individual.
- **PHI left unencrypted:** Examples include PHI accessed electronically or sent to an unauthorized individual by email while unencrypted. This includes sending unencrypted emails containing PHI to HPSM.
- **Theft:** Examples include PHI that is stolen due to the theft of an unencrypted or unprotected computer, theft of hard drives or other media with PHI that is not encrypted, or theft of paper PHI.

Security Incidents

A security incident is the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or personal information (PI) or confidential data or interference with system operations in an information system. Incidents can affect one or more plan members.

Privacy and Security Safeguards

HPSM has adopted many safeguards to ensure our members' PHI and PHI is effectively used, disclosed, and safeguarded. The following are some communal areas of focus:

- Protect your computer passwords. Do not share passwords with your assistant, co-workers, or family members. Do not let anyone else use your password. Keep your passwords secret and confidential.
- Always secure your laptop or desktop computer. Sign off the computer when you are not using it. Install encryption software on your computer in case it is lost or stolen.
- Confirm that you are using the correct fax number and/or email before you fax or email any PHI or PI.
- Never add PHI within the subject line of the email and encrypt the email before sending out.
- Protect your paper medical records, and do not leave any PHI or PI in publicly accessible areas. Keep documents containing PHI or PI in a secure location such as locked file cabinets or rooms.
- Shred any PHI or PI in proper receptacles, and do not dispose of PHI or PI in regular trash cans.
- Make sure any electronic media with PHI or PI is disposed of properly, including CDs, thumb drives, and hard drives in laptops or desktop computers, printers, and copy machines.

This list of privacy and security practices is not exhaustive. If you have any questions or need more information, please contact HPSM's Privacy Officer at the number below.

Reporting Privacy Incidents

If you suspect or know about a privacy incident involving HPSM members' PHI or PI, you must immediately report it to HPSM to investigate. Your actions can help mitigate the potential negative impact of the incident on the member(s).

To report suspected privacy or security incidents, you can contact HPSM in one of these ways:

Compliance hotline	**844-965-1241**
Phone	**650-616-0050**
Fax	**650-829-2050**
Email	**compliance@hpsm.org**
Mail	Health Plan of San Mateo Attn: Privacy Officer 801 Gateway Boulevard, Suite 100 South San Francisco, California 94080

You may remain anonymous, if you prefer, by calling the Compliance Hotline.

All information received or discovered by HPSM's Compliance Department is treated as confidential, and the results of investigations are shared only with persons having a legitimate reason to receive the information (e.g., state, and federal authorities, HPSM legal counsel, HPSM clinical reviewers and/or senior management).

You can report potential breaches of PHI or PI to HPSM and the following agencies, depending on the program affected.

Resources

Office of Civil Rights Regional Office

Website	https://www.hhs.gov/ocr/about-us/contact-us/index.html
Address	Jamie Rahn Ballay, Regional Manager Office for Civil Rights U.S. Department of Health and Human Services 90 7th Street, Suite 4-100 San Francisco, California 94103

Customer Response Center

Phone	**800-368-1019**
Fax	**202-619-3818**
TDD	**800-537-7697**
Email	ocrmail@hhs.gov

HIPAA FAQs for Professionals

https://www.hhs.gov/hipaa/for-professionals/faq

DHCS Office of HIPAA Compliance – Information Protection Unit

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx