Ancillary Services

Special Note to Providers Regarding CareAdvantage

- Items in this section are not inclusive of benefit coverage under CareAdvantage.
- CareAdvantage members are eligible for both Medicare and Medi-Cal. Medi-Cal benefits will apply to those CareAdvantage members who are full scope Medi-Cal beneficiaries.
- For CareAdvantage members coverage requirements and rules for a dual eligible under Title XVII and XIX should be transparent.

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

Laboratory Testing

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

HPSM has relationships with the following vendors:

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

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

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

Providers of CLIA-certified office-based testing are expected to maintain the necessary certification to ensure quality control and consistency of results. Services will only be covered for members who are otherwise under the care of a provider in that practice. Most of these services are covered under the PCP capitation agreement. Please refer to Section 4 – Primary Care Capitation Code List for details. Services not on the list will be reimbursed based on the Medicare or Medi-Cal fee schedule depending on the member's coverage.

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

Prescription Drugs

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

The DST customer service and help desk telephone number is 888-635-8362. You may contact DST directly at any time (24 hours a day, 7 days a week).

HPSM Pharmacy staff is available to answer your questions regarding pharmacy services, formularies, and prior authorization process. They can be reached at **650-616-2088**, from 8:00 AM to 5:00 PM, Monday through Friday. (Please note: On Wednesdays, the Pharmacy Services department is closed from 8 a.m. to 1 p.m.)

HPSM Drug Formularies

HPSM maintains three separate drug formularies. There is one formulary for HPSM-Medi-Cal, and HealthWorx; one for the Medicare Prescription Drug Plan Part D benefit of CareAdvantage, and another formulary for the Access and Care for Everyone (ACE) program. The HPSM-Medi-Cal and CareAdvantage formularies are reviewed by the HPSM Pharmacy and Therapeutics Committee. The committee is comprised of pharmacists and physicians within the community and includes representation from various specialties. It meets bi-monthly and systematically reviews the formulary on a periodic basis. HPSM's formulary management 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. The CareAdvantage formulary also includes preferred and non-preferred branded drugs that may be available through prior authorization or step therapy. Provider requests for consideration of new drugs to be added to the HPSM formularies must be submitted in writing

using the HPSM Request for Formulary Modification form, available online at www.hpsm.org. A copy of this form is included in the Forms section. Completed forms may be sent to:

Health Plan of San Mateo
Attn: Pharmacy and Therapeutics Committee.
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

650-829-2045 Fax

The HPSM formularies are available on the HPSM website. 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. If you have any questions regarding the HPSM drug formularies, please contact the HPSM Pharmacy staff at 650-616-2088.

Non-Formulary Drugs

HPSM participating providers and pharmacies are highly encouraged to prescribe drugs that available on HPSM formularies first. If there is a need to prescribe a drug that is not on the formulary, a pharmacist may call 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 Prescription Drug Prior Authorization or Step Therapy Exception Request Form to HPSM at 650-829-2045. (See Pharmacy Prior Authorization (PA) Process for information on submitting a Medication Request Form).

Changes in Drug Formularies

If a member is on a drug, and HPSM removes the drug from its formulary, the prescriber will be asked to consider formulary alternatives. If formulary alternatives cannot be utilized, a Prescription Drug Prior Authorization or Step Therapy Exception Request Form must be submitted to HPSM providing reasons as to why a formulary alternative is not appropriate.

Psychotherapeutic Drugs & Lab Tests for Medi-Cal Members

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

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

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

Important Reminder: Claim submission to DST for HPSM Medi-Cal members requires the members' CIN numbers or HealthSuite (HS) numbers. Do NOT use the BHRS assigned Client ID numbers for HPSM-Medi-Cal members. The CIN numbers or HS numbers are required for billing all pharmacy claims (non-mental health and mental health) for HPSM-Medi-Cal members. If you encounter claim submission related problems, please do not hesitate to contact **DST** Pharmacy Help Desk at **800-522-7487.**

Psychiatrists, submitting prior authorization requests for any HPSM membership, should fax or mail the requests on a Prescription Drug Prior Authorization or Step Therapy Exception Request Form to HPSM Pharmacy Services for review.

Laboratory Blood Tests ordered by psychiatrists will be reimbursed by HPSM. LabCorp is the lab vendor at the County Regional Clinics. Members requiring outpatient laboratory tests as part of their mental health treatment should be referred to a County Reginal Clinics where LabCorp is available.

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

Pharmacy Prior Authorization (PA) Process

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

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

A Prior Authorization (PA) request must also be used when Plan or formulary restrictions and limits (e.g. quantity limitations or step therapy) are not met or exceeded or if the drug requires prior authorization. The details must be well explained and documented on the request form. HPSM uses the Department of Managed Health Care (DMHC) Services mandated Prescription Drug Prior Authorization or Step Therapy

Exception Request Form. There is one pharmacy prescription form for CareAdvantage requests, and a separate pharmacy prescription form for all other lines of business. Copies of these forms are available in the Forms section. They are also available online on the HPSM website www.hpsm.org

The prescription approval process for pharmacy services

The provider completes a Prescription Drug Prior Authorization or Step Therapy Exception Request Form and submits it via fax to HPSM at (650) 829-2045. Providers may also call (650) 616-2088 with this information.

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

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

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

The prescription deferral process for pharmacy services

For all lines of business, a decision on a prescription request form may be deferred if it is submitted with insufficient medical justification or incomplete information.

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

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

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

The prescription denial process for pharmacy services

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. The clinician reviewer may discuss the determination with the prescribing physician, if necessary; to ensure that appropriate patient care is not delayed.

If a request for a drug is denied, a Denial Letter is sent to the requesting provider and 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.

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

Authorization Processing Time for PAs

Prior Authorization and Continuing Service PAs

For CareAdvantage, approval decisions for prior authorization and continuing pharmacy requests are made within 72 hours of the request for standard decisions. For all other lines of business, approval decisions for prior authorization and continuing pharmacy requests are made within 24 hours of the receipt of the information reasonably necessary to make a decision.

Processing Time for Retroactive Service PAs

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

Processing Time for Medically Urgent and Faxed Pharmacy PAs

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

Evening and Weekend Prior Authorization Requests

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

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

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

Authorization Exception Request Forms

Completing a Pharmacy Prescription Drug Prior Authorization or Step Therapy Exception Request Form

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

Important Reminder on Charging Cash to HPSM Members

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

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

Appeals Process

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

Quality Review

The Director of Pharmacy under the guidance of the CMO will monitor utilization patterns for quality of care by reviewing trends such as the following:

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

Reports on the various utilization trends will be monitored through various internal and external channels, such as department workgroups and P&T Committee.

Pharmacy Management Programs

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

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

Pharmacy Network

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

Pharmacy Benefits

Each program has a detailed description of the pharmacy benefits coverage and exclusions in the member's EOC. For full scope Medi-Cal there are no member co-pays for pharmacy benefits. For all other members, pharmacy co-pays will vary. The co-pay will also vary depending on whether the prescription is for a generic or brand name drug and whether it is a preferred drug in the HPSM formulary. For some members, there may be annual drug cap amount. For questions on eligibility, pharmacy benefits, or co-pays call DST's Customer Service at (888) 635-8362. They are available 24 hours per day, 7 days per week.

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

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

HPSM will cover for medically necessary enteral formulas and for modified solid food products through pharmacy prior authorization, in accordance with California State Law, for the treatment of certain inherited diseases. This benefit is subject to any pharmacy benefit cap limitations depending on the program.

Co-payments and Cost Sharing

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

Prior Authorization and Medical Exceptions

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

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

Exception Process

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

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

Drug Utilization Review (DUR)

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

Concurrent Drug Utilization Review (CDUR)

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

Safety and Alert Programs

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

Mental Health and Substance Abuse

San Mateo County Behavioral Health and Recovery Services

For Medi-Cal members, all mental health services are covered by the BHRS. For all other programs (CareAdvantage, and HealthWorx), HPSM has subcontracted the mental health services to the BHRS. Emergency psychiatric services and mental health services provided by a member’s PCP, within the scope

of his or her licensure, are covered by HPSM. With these exceptions, all other mental health services for HPSM members are provided through the BHRS.

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

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

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

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

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

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

How the BHRS Can Help

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

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

How to Refer a Patient to BHRS

To refer a patient to BHRS, follow these steps:

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

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

Diagnostic Radiology and Advanced Imaging

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

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

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

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

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

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

General Guidelines for Submitting PARs for MRI Studies

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

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

MRI cervical spine

a. History consistent with cervical radicular disease process
b. Physical exam with description of neurologic exam consistent with cervical radicular disease
c. Plain radiographs AP/Lateral/oblique have been obtained in last 6 months with reading
d. Any supporting laboratory tests (i.e. EMG)

e. Tentative diagnosis or differential

f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI thoracic spine

a. History consistent with thoracic disease process

b. Physical exam with description of thoracic spine findings

c. Plain radiographs AP/Lateral have been obtained in last 6 months with reading

d. Any supporting laboratory tests

e. Tentative diagnosis or differential

f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI lumbar spine

a. History consistent with lumbar radicular disease process

b. Physical exam with description of neurologic exam consistent with lumbar radicular disease

c. Plain radiographs AP/Lateral/oblique have been obtained in last 6 months with reading

d. Any supporting laboratory tests

e. Tentative diagnosis or differential

f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

g. MRI lumbar spine for chronic back pain will be authorized following North American Spine Society Guidelines.

MRI brain

a. History consistent with central neurologic disease process

b. Physical exam with description of neurologic exam consistent with central neurologic disease

c. CT scan of head – if not done, explanation why CT head is not suitable

d. Any supporting laboratory tests

e. Tentative diagnosis or differential

f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI chest

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

MRI abdomen

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

MRI pelvis

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

MRI shoulder

a. History consistent with shoulder injury
b. Physical exam with description of findings related to shoulder injury, excluding cervical radicular symptoms

c. Plain radiographs of shoulder AP/lateral/axillary and cervical spine AP/lateral/oblique have been obtained within the last 6 months

d. Tried and failed conservative therapy, including steroid injection(s), NSAIDs, and/or physical therapy – if not done, why conservative therapy not tried

e. Any supporting laboratory tests

f. Tentative diagnosis or differential

g. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI knee

a. History consistent with knee injury

b. Physical exam with description of findings related to knee injury, excluding lumbar radicular symptoms

c. Plain radiographs of knee AP/lateral/notch view and lumbar spine AP/lateral/oblique have been obtained within the last 6 months

d. Tried and failed conservative therapy, including steroid injection(s), NSAIDs, and/or physical therapy – if not done, why conservative therapy not tried

e. Any supporting laboratory tests

f. Tentative diagnosis or differential

g. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

Radiology Authorization Summary Information Sheet

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

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

One PAR number is required for each procedure. A PAR is valid for the timeframe indicated on the PAR.

Settings Requiring a PAR:

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

Information Required:

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

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

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

Chiropractic Care and Acupuncture

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

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

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 PAR; however, all other physical and occupational therapy services do require

a prospectively submitted PAR. The initial therapy PAR must include a copy of the initial evaluation, as well as a copy of the physician's prescription for therapy.

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

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

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

Speech Therapy

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

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

Podiatry (CareAdvantage and Medi-Cal only)

CareAdvantage

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

Medi-Cal and HealthWorx

Podiatry benefits are provided for HPSM Medi-Cal and HealthWorx members.

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

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

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

Vision Care

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

CareAdvantage

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

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

Medi-Cal

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

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

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

HealthWorx

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

Durable Medical Equipment

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

CareAdvantage

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

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

Exclusions:

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

Medi-Cal

Covered items include, but are not limited to:

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

Excluded items include, but are not limited to:

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

HealthWorx

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

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

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

Covered items include:

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

- Ostomy bags, urinary catheters, and related supplies
- Insulin pumps and all related supplies

Excluded items include:

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

Wheelchairs

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

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

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

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

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

Audiology/Hearing Aids

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

CareAdvantage

Diagnostic hearing and balance exams are a covered benefit.

Exclusion:

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

Medi-Cal

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

Exclusions:

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

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

HealthWorx

Covered services include:

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

Exclusions:

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

Prosthetics/Orthotics

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

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

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

CareAdvantage

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

Exclusion:

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

Medi-Cal

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

HealthWorx

Prosthetics and orthotics are covered as follows:

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

Excluded items:

- Over-the-counter items
- Corrective shoes, shoe inserts and arch supports, except for therapeutic footwear for diabetics
- Non-rigid devices, such as elastic knee supports, corsets, elastic stocking, and garter belts
- Dental appliances
- Electronic voice producing machines
- More than one device for the same part of the body, unless medically necessary

California Children's Services (CCS)

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

The California Children's Services (CCS) program is responsible for determining eligibility and providing case management and authorization of services for children enrolled in CCS. The Health Services Utilization Management team works closely with the CCS staff to coordinate care for these special needs children. It is important to note that while CCS may authorize certain services (e.g., inpatient days), however it is HPSM's responsibility to determine level of care.

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

CCS

801 Gateway Blvd., Suite 100
South San Francisco, CA 94080
(650) 616-2500 Main
(650) 616-2598 Fax

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

Golden Gate Regional Center (GGRC)

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

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

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

Please send referrals to:

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

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

If necessary, the Assessment Social Worker will arrange for assessments to determine eligibility. For infants and toddlers between birth and three years of age, assessments regarding eligibility are performed within

45 days following the initial intake. For persons three years of age and older, assessments are performed within 60 days following initial intake. Assessments may include - but are not limited to - psychological, medical or developmental evaluations.

Eligibility determinations are made by a group of regional center professionals of differing disciplines, such as psychologist, physician and social worker. Eligibility for ongoing regional center services is established upon determination that the person has a developmental disability with a substantial handicap, or for infants from birth to three years of age, is at risk of having a developmental disability.

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

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