# Provider Services

# Introduction

The Provider Services Department manages provider credentialing, contracting, value-based payment programs and general provider relations for providers.

This section of the HPSM Provider Manual includes information on the following topics:

- Provider credentialing and contracting
- Provider rights and responsibilities
- Provider education and training
- Provider after hours coverage and standards

# Credentialing and Contracting

To join the HPSM provider network, the provider must sign a Medical Services Agreement (contract) and complete HPSM's credentialing process. HPSM's credentialing standards are based on federal and California state requirements, which include but are not limited to DHCS, DMHC and NCQA. Providers are required to maintain active credentials with HPSM and will be required to go through the re-credentialing process at least every three years.

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

a. Review information submitted to support their credentialing application.

b. Correct erroneous information.

c. Receive the status of their credentialing or re-credentialing application, upon request.

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

1. Provider completes, signs, and returns the Medical Services Agreement, credentialing application, HPSM's Addendum Application, Addendum B and Tax Payer Identification Form (W-9), and attaches copies of all information requested below, as applicable:
   - Copy of current **medical license** or **business license**
   - Copy of current **DEA license**

- Copy of **professional liability insurance (malpractice) face sheet.** For CareAdvantage providers, required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate. For Medi-Cal and HealthWorx providers, required limits are $1,000,000 per person per occurrence.
- Copy of **property comprehensive general liability insurance (premises) face sheet.** For CareAdvantage providers, required limits are $100,000 per occurrence/$300,000 annual aggregate. For Medi-Cal and HealthWorx providers, required limits are $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 **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 or American Board of Podiatric Surgery (if applicable)
- Signed copy of "**Acknowledgment of Training" attestation**.

2. HPSM verifies provider information (including National Provider Identifier, license status, etc.)

3. 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, RPD, etc.

4. The application and supporting documentation are reviewed by HPSM's Credentialing Review Committee including the Credentialing Specialist, Credentialing Manager, Medical Director and Chief Executive Officer.

5. Credentialing applicants are reviewed by HPSM's Peer Review Committee, an external committee of community physicians who advise HPSM on credentialing decisions.

6. Upon approval of the above-mentioned parties, the Chief Executive Officer countersigns the contract after approval of credentialing.

7. A copy of the completed contract is then returned to the physician/provider. A new provider orientation and training must be delivered by HPSM within 10 days of the credentialing approval.

8. Primary Care Physicians and certain other provider types may also have a site review before the credentialing process is finalized.

9. 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 the State of California. Additionally, you represented that you are qualified and in good standing in terms of all applicable legal, professional and regulatory standards as a participating Medi-Cal provider and / or Medicare provider.

Physicians who are excluded from participation in Medi-Cal or Medicare programs by the U.S. Department of Health and Human Services may not provide services under the Medi-Cal and HealthWorx programs.

Physicians who are excluded from participating in Medicare programs by the U.S. Department of Health and Human Services may not provide services to HPSM CareAdvantage members.

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

You are required to notify us within fourteen (14) calendar days in writing if the following actions are taken against you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification or clinical privileges.
- A peer review action, inquiry or formal corrective action proceeding, or investigation.

- A malpractice action or governmental action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action.
- Any material change in any of the credentialing information 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 to provide 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 Physician Application, you certify that you are eligible to participate in our program and receive funds provided by the government. This form must be signed and returned with your agreement. Pursuant to this certification and your agreement with HPSM, should you or any provider with whom you hold a sub- contract become suspended or ineligible you shall notify HPSM immediately.

## General Rights and Responsibilities

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 on the basis of membership in HPSM, age, national origin, sex, sexual preference, race, color, creed, marital status, religion, health status, source of payment, economic status or disability.
- Provider will provide grievance, disputes and appeals information as required by the California Department of Health Care Services and other appropriate regulatory agencies.
- Medical information shall be provided to HPSM 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 Provider or 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 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 fourteen (14) calendar days of receipt thereof, notice of any malpractice claims involving any current or former members to which provider is a party as well

as notice and information specifying settlement of adjudication within fourteen (14) calendar days of the provider being notified of such action.

- Provider agrees to comply with all applicable local, state and federal laws governing the provision of medical services to members.
- Provider will uphold all applicable member rights & responsibilities as outlined in Section 2 of the Provider Manual.
- Provide for timely transfer of member clinical records if a member selects a new primary care physician, or if the provider's participation in the HPSM network terminates.
- Respond to surveys to assess provider satisfaction with HPSM and identifying opportunities for improvement.
- Participate on a Quality Improvement or Utilization Management Committee, or act as a specialist consultant in the utilization management or peer review processes.
- Notify HPSM in advance of any change in office address, telephone number or office hours.
- Notify HPSM at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with HPSM or with the participating provider or practitioner group. HPSM will assist in notifying affected members of termination and will assist in arranging coordination of care needs.
- Maintain standards for documentation of medical records and confidentiality for medical records.
- Provider agrees to retain all medical records for a minimum of ten (10) years from the last contracting period or last audit, whichever is latest.
- Maintain appointment availability in accordance with HPSM standards.

Provider agrees that in no event including, but not limited to, nonpayment by HPSM, insolvency of HPSM or breach of providers agreement, shall provider or its personnel bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have recourse against a member or persons (other than HPSM) acting on the member's behalf. This provision shall not prohibit provider from collecting from members for co-payments, or coinsurance or fees for non-covered services delivered on a fee-for-service basis to members, provided that member has agreed prospectively in writing to assume financial responsibility for the non-covered services.

# Primary Care Physician Rights and Responsibilities

The Primary Care Physician (PCP) is responsible for providing primary care services and managing all health care needed by HPSM members assigned to 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 health care services and coordination of care, the PCP must:

- Provide for all primary health care services that do not require specialized care. These include, but are not limited to: routine preventive health screenings, physical examinations, routine immunizations, child/teen health plan services (as appropriate), reporting communicable and other diseases as required by Public Health Law, behavioral health screening (as appropriate), routine/urgent/emergent office visits for illnesses or injuries, clinical management of chronic conditions not requiring a specialist, and hospital medical visits (when applicable).
- Maintain appropriate coverage for members twenty-four (24) hours a day, seven (7) days a week, and three hundred sixty-five (365) days a year.
- 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:
  - **a.** Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (D);
  - **b.** Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (D);
  - **c.** Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (D) and (E);
  - **d.** The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member;
  - **e.** Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring

for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the PCP acting within the scope of his or her practice.

- 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

- Refer all members for services in accordance with HPSM's referral policies and procedures. Documentation of the referral must be noted in the member's medical record. In the event there is no appropriate network provider or facility for a medically necessary covered service, the PCP shall contact the HPSM Medical Director for coordination of provision of such covered service. When medically necessary, and only with the prior approval of the Medical Director, unless otherwise required by law, referrals may be made to providers who have not contracted with HPSM.
- Provide services of allied health professionals and support-staff that are available in your office.
- Provide supplies, laboratory services, and specialized or diagnostic tests that can be performed in your office.
- Assure members understand the scope of specialty or ancillary services, which have been referred and how/where the member should access the care.
- Communicate a member's clinical condition, treatment plans, and approved authorizations for services with appropriate specialists and other providers.
- Provide access and information to sensitive services (i.e. family planning, sexually transmitted disease, and confidential HIV/AIDS testing) and minor consent services.
- Consult and coordinate with members regarding specialist recommendations.
- Safeguard member privacy and confidentiality and maintain records accurately and in a timely manner.
- Ensure services are provided in a linguistic and culturally sensitive manner.
- Document in a prominent place in the medical record if a member has executed an advance health care directive.
- Maintain procedures to inform members of follow-up care or provide training in self-care as necessary.

# Referral Provider (Specialists) Rights and Responsibilities

When a member has been referred to a Referral Provider (Specialist), the Referral Provider is responsible for diagnosing the member's clinical condition and managing treatment of the condition, up to the number of visits identified on the referral authorization. When providing specialty care, the Referral Provider must:

- Keep the PCP informed of the member's general condition with prompt verbal and written consult reports.
- Obtain PCP authorization for subsequent referrals for tests, hospitalization, or additional covered services.
- Deliver all medical health care services available to members through self-referral benefits.
- Notify the member's PCP when the member requires the services of other specialists or ancillary providers for further diagnosis, specialized treatment, or if the member requires admission to a hospital, rehabilitation facility, skilled nursing facility or an outpatient surgical facility.
- 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:
  - **a.** Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (D);
  - **b.** Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (D);
  - **c.** Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (D) and (E);
  - **d.** The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member;
  - **e.** Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally

recognized standards of practice as determined by the PCP acting within the scope of his or her practice.

- 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.

# Primary Care Physician After-Hours Coverage and Standards

All PCPs shall provide access to medical advice or treatment even when not in the office, including after hours, holidays and weekends. HPSM requires PCPs to have twenty-four (24) hour coverage for their practices, seven (7) days a week, three hundred and sixty-five (365) days a year.

- PCPs shall provide HPSM with a list of the covering physicians.
- PCPs shall notify HPSM if the list of covering physicians changes and provide HPSM with the changes.

## Standards

- Provider shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and that the triage or screening waiting time does not exceed 30 minutes.
- Provider shall maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff.
- Covering physicians should be contracted and credentialed by HPSM. If there are members of the coverage group that do not participate with HPSM, the participating practice must inform them of the HPSM policies and procedures (i.e., billing procedures, address, and prior approval). In addition, when billing for services, the non-participating provider must clearly identify the name of the HPSM provider for which they are covering. All providers must make good faith efforts to ensure coverage by a HPSM provider. Non-contracted providers covering for HPSM providers are prohibited from balance billing.
- A method to communicate issues, calls, and advice, from covering providers to the PCP and the member's file, must be in effect at the time of coverage.

- This communication method should be documented or evidenced by policies and procedures.

## Evaluation

- HPSM staff or designees may ask for the instructions given to the answering service or to hear the after-hours message during site visits for medical record reviews. Clarity and content will be assessed by the above criteria.
- Evidence of adequate communication of coverage will be assessed at the site reviews.
- Quality Improvement staff or Provider 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. It will offer an appropriate choice of providers sufficient to deliver covered services by determining that there are a satisfactory number of geographically and physically accessible participating providers.

## General considerations

Provider selection is based on the availability of providers meeting minimum criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act, and availability of culturally and linguistically competent staff to meet the needs of the member population. In the event that a participating physician is not available with the skills required to meet a member's needs, within the accessibility or mileage/timeframe standard, the plan will authorize a non-participating provider at no additional out of pocket expense to the member.

## Established Patients Only (EPO)

A **new patient** is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care 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 health care professional or another physician/ qualified health care 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.

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

# Provider Trainings and Communications

## Provider Training

All newly credentialed and contracted HPSM providers must complete the HPSM new provider training within 30 days of becoming a contracted provider with HPSM.

New providers are required to submit a completion attestation once the new provider training has been completed.

## Ongoing Provider Training

HPSM contracted providers will be educated on new and updated operational and administrative policies and procedures. The ongoing education of providers will be achieved through 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, and a variety of public health and other topics of relevance to our network
- Office visits
- In person and online trainings and education
- HPSM website: www.hpsm.org