

October 6, 2020

Behavioral Health and Recovery Resources Training & FAQ

Dear **HPSM Behavioral Health Individual Providers and Agencies,**

Just some friendly reminders and updates for the week:

1. We have updated our **External FAQ document and Training slides** and attached them to this notice. Please review the attachments as these will have the most recent updates and answers to your questions.
2. Just a reminder that **MFT's currently cannot bill under HPMS's CareAdvantage (HPSM Medi-Cal/Medicare) LOB** due to CMS guidelines.
3. Many of you have asked, "**how you identify a member's Line of Business (LOB)**".
 - a. You can check the Provider Portal to identify the member's LOB. This is also indicated in the updated FAQ document.
4. A common question this week has been, "**What member identifier do I use?**". Please use the **member's HPSM ID**. Do not submit claims with the BHRS "MRN" number- this number is unique to BHRS ONLY. The BHRS MRN number and member's HPSM ID are not the same.
 - a. **How can I find the member's HPSM ID? (This is also indicated in the updated FAQ document.)**
 - i. You can ask the member (e.g. at time of service) and it will be located on the member's HPSM insurance card.
 - ii. You can check the **Provider Portal** and enter the member's name and date of birth. The HPSM ID will be indicated in the member search.

Should you have any additional questions, we ask that you please look at the FAQ and training slides to see if your questions have already been answered. Feel free to contact us as Psinquiries@hpsm.org.

Sincerely,
HPSM Team

FAQ

Basics

1. When do I need to start following HPSM processes (e.g. Claims, Prior Auths, etc.)?

For any dates of service (DOS) prior to your HPSM contract effective date, you should follow BHRS processes. Once your HPSM contract starts, all DOS on or after that date will be handled by HPSM and you should follow HPSM processes.

2. How do we get confirmation of attending HPSM's training?

HPSM offers on-going provider trainings as a courtesy to providers; attendance during these Provider Training sessions are voluntary. Though we do recommend attending, no proof of attendance is needed.

3. What member identifier should I use going forward?

Please use the HPSM Member ID to search for member eligibility on the provider portal and submit claims to HPSM. This may also be called the HealthSuite ID. They are the same number. You will no longer use the BHRS Medical Record Number. You can find the HPSM Member ID by asking the member (they should have the number on their HPSM ID card). You can also find the Member ID on the HPSM provider portal if you search using the member's name and date of birth.

4. How do I sign up for the provider portal?

You can sign up on HPSM's website: <https://www.hpsm.org/provider/portal>, email claimsinquiries@hpsm.org, or call 650-616-2106 to register for the portal.

5. Do I need to get a release of information from each client to communicate with HPSM?

No, you do not need a release of information from each client to communicate with HPSM. As their health insurer, HPSM is an authorized party to receive PHI.

6. What are HealthWorx and ACE?

HealthWorx is a health insurance program for In-Home Services and Support (IHSS) providers and eligible employees of the city of San Mateo. ACE is a locally funded health care program for low- income adults who do not qualify for other health insurance. HPSM serves as the third-party administrator. You can learn more at <https://www.hpsm.org/about-us/programs>

7. Do HealthWorx and ACE patients have mental health benefits?

Please consult HPSM's member handbooks to determine which benefits are offered for these programs: <https://www.hpsm.org/provider/resources/member-handbooks>.

8. How do we know if we are a Medi-Cal, CareAdvantage or HealthWorx provider?

You will check a box on your contract to indicate which lines of business you would like to contract with. This is your choice.

9. Why can't MFTs serve CareAdvantage clients?

This follows CMS guidelines. MFTs are not allowable providers for Medicare at this time.

10. What is the process for receiving new Mild to Moderate referrals, starting October 1st, 2020?

New clients will continue to call the ACCESS Call Center at 1-800-686-0101. The ACCESS Call Center will then coordinate with HPSM, who will identify a provider match for the client.

Upon receiving a request from a member, the ACCESS Call Center will conduct a screening to confirm the member's insurance eligibility, and level of care.

After the screening by ACCESS, HPSM will identify a provider for the member. HPSM will call your office and leave a voicemail with the name, DOB, and phone number of the member from whom you should expect a call. (Please ensure your voicemail identifies your name and/or practice name.)

11. Who should I send my availability to now?

Please provide your availability to HPSM by emailing HPSM_BH_Provider_Availability@hpsm.org.

Credentialing and Medi-Cal Enrollment

1. How long does the credentialing process take?

During this transition, we are processing credentialing applications as fast as we can. If you submit all of the required information successfully and there are no issues with the file or any type of verification review, you may receive a decision within a week or two. However, if there are discrepancies with the file, verification sources, etc. this will delay the process.

2. Who do I reach out to if I have a HPSM credentialing question?

You can reach out to the HPSM Provider Credentialing Team directly:

Provider Credentialing Manager, Luarnie Bermudo at Luarnie.Bermudo@hpsm.org Provider Credentialing Specialists, Treschere Lowery at Treschere.Lowery@hpsm.org and Paul Dela Cruz at Paul.Delacruz@hpsm.org.

3. How long does it take the state to review a Medi-Cal application?

The state has up to 180 days to review Medi-Cal applications, however in many cases review of applications happens sooner.

4. What happens if I've submitted my Medi-Cal enrollment application, but have not yet received an approval. Can I still contract and get credentialed by HPSM?

Yes, you will have to complete the Non- Medi-Cal enrolled contract in which you will receive a 12 month grace period. You will still be required to submit your Medi-Cal enrollment application on the PAVE portal by August 1, 2020 and provide proof of submission.

5. How does the HPSM portal interact with the Medi-Cal portal?

They do not interact- the Medi-Cal portal is a different portal and is managed by the state.

Authorizations and Eligibility

1. Why do I need to check member's eligibility?

This allows you to check if the member is a Medi-Cal member- this is important particularly from a claims standpoint. If the member is not an active Medi-Cal member at the date of service, your claim may be denied.

2. When should I check member eligibility and benefits?

Medi-Cal eligibility is determined monthly. However, to reduce your risk of claims denial we recommend checking prior to each session.

3. If a patient loses Medi-Cal eligibility, will they still be covered for any period of time?

No, HPSM cannot make payments for dates of service outside of member's eligibility.

4. What is a prior authorization?

When you were working with BHRS, they referred to this as the referral and continuation authorization process. HPSM calls this prior authorization. This is a process through which HPSM verifies that a service is medically necessary before you are authorized to provide the service. BHRS required prior authorization for all services. HPSM will only require prior authorization for certain services. Please refer to HPSM's prior authorization list on our website: <https://www.hpsm.org/provider/authorizations>. Note: Currently initial assessments and individual therapy do not require prior authorization.

5. Where do I check the status of prior authorizations and claims?

You can check both of these items on HPSM's Provider Portal.

6. I just faxed my prior auth, when am I notified of a decision?

It can take up to 24 hours for the auth to show up in our system. You should expect to receive a confirmation of receipt or rejection within 24 hours. If you haven't received a confirmation or rejection after 24 hours, you can call the number on the form to request a status update. Decisions on authorizations are made within 5 business days. You and the member will receive a letter with notification of the outcome.

7. Wouldn't an authorization also clarify if a member is an HPSM member?

No, an authorization only validates that the benefit is valid on the date of authorization. The provider is responsible for making sure the member is eligible on the date of service.

8. What determines how long you can see someone for individual therapy?

HPSM will not authorize a "number of sessions" that you can see a member for, as BHRS did. However, you should check the prior authorization list, Medi-Cal/Medicare manual and HPSM member handbooks for any possible frequency limitations based on a member's benefit. If you determine the treatment is not medically necessary, further services should not be rendered. HPSM has a process for researching Fraud, Waste and Abuse (FWA), please ensure services rendered are medically necessary.

9. What type of clinical information do I need to provide for Prior Authorization?

Clinical information is typically included with the requests for prior authorizations to demonstrate that the service is medically necessary. Clinical information may later be requested for claims

validation. This often includes diagnosis, assessment, treatment plan, goal and any progress. HPSM uses Milliman Care Guidelines to determine medical necessity. Please review the Provider Manual Section on Prior Authorization for more information.

Claims and Reimbursement

1. Is *any given code* covered?

Please consult Medi-Cal and Medicare resources to determine if individual codes are covered.

1. Check the Medicare website to determine if the code(s) you plan to use are covered by Medicare:
<https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>
 - a. If yes, the code will be covered for CA, MC and HW.
 - b. If no, check the Medi-Cal procedure code list to determine if the code is covered by Medi-Cal: <https://files.medi-cal.ca.gov/rates/rateshome.aspx>

- c. If yes, the code will be covered for CA, MC and HW.
 - d. If still not listed under Medi-Cal, the code is **not covered** for CA, MC or HW
- 2. Once you've identified that the code is covered, next check code descriptions/limitations by member line of business:
 - a. For CA check Noridian: <https://med.noridianmedicare.com/web/jeb/specialties/mental-health>
 - b. For MC and HW check: (Including for codes covered by Medicare)
<https://files.medical.ca.gov/pubsdoco/Publications.aspx>

2. Are the reimbursement rates we will receive different?

Please consult your contract for rate information.

3. Are we going to use the CMS 1500 form on paper? Or is there now an electronic version?

You can submit claims on paper via mail, but they must be typewritten. We recommend submitting them online using eHealthSuite.

4. Will we receive payment for no shows?

HPSM is not reimbursing for no shows at this time.

5. I'm providing individual therapy to a child that also needs family therapy, is this covered?

Family therapy is now a covered Medi-Cal benefit. Please always ensure services rendered are medically necessary.