

Enhanced Care Management and Community Supports
Provider List and Authorization Tips

Provider List

This list should be used as a reference for Providers and Care Managers submitting Prior Authorizations. Always review capacity and eligibility criteria (<https://www.hpsm.org/provider/calaim-at-hpsm>) before submitting prior authorization forms.

ENHANCED CARE MANAGEMENT PROVIDERS						
CPT Code	Capacity	Name	Populations of Focus	NPI	Address	Numbers
ECM00	Open	Bridges to Wellness	- Adults that are homeless with a medical issue. - Adults with high utilization. - Adults with serious mental health issues or substance use issues with case management needs.	1336809359	225 37th Avenue San Mateo, CA 94403	Phone: 650-573-4799 Fax: 833-218-8864
ECM00	Closed	Institute on Aging (IOA)	- Adults that are homeless with a medical issue. - Adults with high utilization. - Adults with serious mental health issues or substance use issues with case management needs. - Adult at risk for institutionalization.	1255730222	3575 Geary Boulevard San Francisco, CA 94118	Phone: 628-239-3565 Fax: 415-750-5338
ECM00	Open	Aging and Adult Services - Enhanced Care Management	- Adults at risk of institutionalization. - Adults with high utilization.	1609290030	225 37th Avenue San Mateo, CA 94403	Phone: 650-573-3900 Fax: 833-522-0986

COMMUNITY SUPPORT PROVIDERS						
CPT Code	Capacity	Name	Service Option	NPI	Address	Numbers
H0043	Open	Brilliant Corners	Housing Transition Navigation Services	1356687354	1390 Market Street San Francisco, CA 94102	Phone: 415-618-0012 Fax: 877-320-8164
H0044	Open	Brilliant Corners	Housing Deposits	1356687354	1390 Market Street San Francisco, CA 94102	Phone: 415-618-0012 Fax: 877-320-8164
T2040	Open	Brilliant Corners	Housing Tenancy	1356687354	1390 Market Street San Francisco, CA 94102	Phone: 415-618-0012 Fax: 877-320-8164
S5165	Open	Brilliant Corners	Environmental Accessibility Adaptations	1356687354	1390 Market Street San Francisco, CA 94102	Phone: 415-618-0012 Fax: 877-320-8164
S5165	Closed	Institute on Aging	Environmental Accessibility Adaptations	1255730222	3575 Geary Boulevard San Francisco, CA 94118	Phone: 628-239-3565 Fax: 415-750-5338
T2038	Closed	Institute on Aging	Nursing Facility Transition/Diversion to Assisted Living Facilities	1255730222	3575 Geary Boulevard San Francisco, CA 94118	Phone: 628-239-3565 Fax: 415-750-5338
T2038	Closed	Institute on Aging	Community Transition Services/ Nursing Facility Transition to a Home	1255730222	3575 Geary Boulevard San Francisco, CA 94118	Phone: 628-239-3565 Fax: 415-750-5338
S5170	Open	Mom's Meals	Medically Tailored Meals	1093834020	3210 SE Corporate Woods Drive Ankeny, IA 50021	Phone: 866-716-3257 Fax: 866-942-7873

Authorization Form Tips

Here are some critical steps for filling out the Prior Authorization request form for ECM and Community Supports services – filling the form out accurately will help the process go smoothly.

1. Follow instructions on the authorization form:
https://www.hpsm.org/docs/default-source/provider-forms/prior_authorization_request_form.pdf
2. Include the available ECM or CS provider information for “Servicing Provider Name,” “Street Address,” “City,” “State,” “Zip,” “NPI,” “Phone Number,” and “Fax.” Use the table above to complete this request accurately.
3. If you are not the servicing provider, please include your name/facility/practice and NPI in the “referring provider” section. If you want to receive a notification of outcome HPSM must have your NPI number and adjoining fax number on record. If you are not sure if this is on record, please be sure your fax number or email is clearly stated in attached documents or in the optional comments box at the bottom of the form.
4. Use correct CPT Codes listed in the table above.
 - a. **Enhanced Care Management:** HPSM has adopted a simplified ECM00 code for authorization purposes.
 - b. **Community Support :** HPSM has a unique CPT code for each CS service option.
5. Diagnosis Codes: include primary diagnosis that indicate population of focus or service option qualification (example: Z codes for housing issues).
6. Attach any information, including recent appointment notes, care plan, summary of needs, or forms that demonstrate members qualifying criteria. If you do not include information that demonstrates qualifying criteria, the member may not be approved for services.
 - a. For ECM requests, please specify which Population of Focus the member qualifies for in the comments on the PA form.
 - b. For CS requests you will need to attach the Community Supports Request Information Form.
7. “Requested Service Dates From” and “To” should not overlap any existing Authorization of the same type of services. Authorizations cannot exceed one year.
8. For “Units of service” please enter numbers only and do not write any words in the box.
 - a. ECM Authorizations only need to request one unit.
 - b. For Community Supports (CS), see table below for guidance on units per each CS service type. Dates of service Authorization Start and End Date is within 12 month span:

CPT Code	CS Service Option	Units of Service	Days/Quantity
H0043	Housing Navigation/Transition Services	Up to 6 units	1 unit = 1 month
H0044	Housing Deposits	Up to 1 unit	1 unit = 3 months
T2040	Housing Tenancy	Up to 12 units	1 unit = 1 month
S5165	Environmental Accessibility Adaptations	Up to 1 unit	1 unit = 3 months
T2038	Nursing Facility Transitions/Diversion to Assisted Living Facilities	Up to 12 units	1 unit = 1 month
T2038	Community Transitions/Nursing Facility to Home	Up to 12 units	1 unit = 1 month
S5170	Medically Tailored Meals	Up to 168 units	1 unit = 1 meal

For a list of all HPSM providers, please visit our HSPM Provider Directory: <https://www.hpsm.org/provider/directory-search>

Note: Do not use a cover sheet. This form should be the FIRST page of your fax.

CLEAR FORM



Prior Authorization Request Form

Fax completed form to 650-829-2079. Please type into PDF form and fill out all fields.

REQUEST	LINE OF BUSINESS
<input type="checkbox"/> URGENT	<input type="checkbox"/> CAREADVANTAGE
<input checked="" type="checkbox"/> ROUTINE	<input checked="" type="checkbox"/> MEDI-CAL
	<input type="checkbox"/> ACE
	<input type="checkbox"/> HEALTHWORX

Mark ✓ or X

Most CalAIM requests should be marked ROUTINE. URGENT should only be used when our turnaround time can/may cause serious harm to a member's life and health.

Today's Date: 04-04-2022 MM-DD-YYYY

Is member currently in the hospital? YES NO IF YES, FAX Facesheet to 650-829-2060

Member Last Name: Pym First Name, M.I.: Hank
Street Address: 601 Buena Vista Avenue City, State, ZIP: San Francisco, CA 94117
Phone: (415) 867-5309 Member ID#: 82496 DOB: 06-06-1994 Age: 28

Service Provider Name: Bridges to Wellness NPI: 1336809359
Street Address: 225 37th Avenue City, State, ZIP: San Mateo, CA 94403
Phone: (650) 743-7272 Fax: (650) 573-1023 Office Contact:

Complete using the provider list on page 1 of this guide.

Additional Provider (if needed): SHIELD NPI: 45678932165

Primary Diagnosis Code: F33.2 Description: Major Depressive Disorder

Secondary Diagnosis Code: F60.9 Description: Personality Disorder, unspecified

Tertiary Diagnosis Code: Description:

Include if you are the REFERRING provider different from the servicing provider.

Line No.	Procedure Code (CPT/HCPCS Code/Modifier if applicable)	Specific Services Requested	Units of Service (Days/Quantity)
1	ECM00	ECM	1
2			
3			
4			
5			
6	T2038	Nursing Facility Transitions/Diversion to Assisted Living Facilities	2
7	Please see the chart on page 2 of this guide for CPT codes, service options, and units of service for CS services.		
8			
9			
10			

ECM authorizations only need to request 1 unit.

Enter numbers only and do not write any words in the box.

Optional comments for medical justification. Requesting Provider please attach required medical records/supporting documents.

Member is a high utilizer that could use extra support establishing regular care with a PCP, especially as they transition to an assisted living facility.

Please see #6 on page 2 of this guide for more information.

SHIELD Fax Number for Notification: (415)678-9123

INPATIENT ONLY - LTC Required Information (Mark ✓ or X):
 Transfer Initial Reauthorization Bed Hold Skilled Nursing ICF-DD Sub-Acute

Requested Service Dates FROM: 06-04-2022 MM-DD-YYYY TO: 01-04-2023 MM-DD-YYYY

To the best of my knowledge, the above information is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Phil Coulson Case Manager 04/04/2022
Signature of Physician or Provider Title Date MM-DD-YYYY

PRINT FORM

Please see #3 on page 2 of this guide for more information.

Please fill in the requested dates of service. Not to exceed 1 year.