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HPSM Behavioral Health Non-Specialty (Mild to Moderate) Providers:

Frequently Asked Questions

Updated May 2022

Topics:

Basics/Getting Started

1. **Does the Health Plan of San Mateo (HPSM) offer new providers trainings to learn about HPSM processes?**

   HPSM offers on-going provider trainings as a courtesy to providers, so make sure your email is up to date to receive invites. You can update your email here: https://providers.hpsm.org/ChangeRequestProvider/

   HPSM has several recorded trainings and tutorials on the behavioral health provider webpage: https://www.hpsm.org/provider/behavioral-health/

   Also be sure to check out the HPSM provider Learning Lab, which has other provider training videos, as well: https://www.hpsm.org/provider/learning-lab

2. **What is the role of the ACCESS Call Center?**

The ACCESS Call Center is the San Mateo County community line for mental health services. The ACCESS Call Center has partnered closely with HPSM and is an important resource for HPSM members to be screened and routed to the appropriate behavioral health services. Upon a member's call or submission of a referral form by a provider, the ACCESS Call Center will conduct a screening to identify whether the member meets criteria for specialty mental health care, non-specialty (mild to moderate) mental health care and/or substance use treatment and will direct the member accordingly.

Members should not be directly referred to a mental health clinician; they must first be screened through the ACCESS Call Center to ensure they are routed to appropriate services. Reach them toll free at 800-686-0101.

3. **What is the difference between specialty (BHRS) and non-specialty (mild to moderate) mental health care?**

HPSM manages the non-specialty (mild to moderate) Medi-Cal benefit and Behavioral Health and Recovery Services (BHRS) manages the specialty mental health for serious issues and substance use treatment. HPSM provides non-specialty (mild to moderate) care only. Please review the Medi-Cal Provider Manual for detailed information https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf

4. **What if a members care needs are beyond the HPSM non-specialty (mild to moderate) benefit?**

If a member needs a higher level of care (IOP, PHP, residential or case management to maintain or improve their functioning) they may need to be assessed and transitioned to specialty services with BHRS.

For referrals for higher level of care for members aged 18 and older, non-specialty (mild to moderate) providers should use this form: https://www.hpsm.org/docs/default-source/provider-forms/referral-for-higher-level-of-care---adult-03-26-21-fillable_final.pdf?sfvrsn=fa4ed618_4

For referrals for higher level of care for members aged 6-17, non-specialty (mild to moderate) providers should use this form: https://www.hpsm.org/docs/default-source/provider-forms/youth-referral-for-higher-level-of-care-pdf-filable-final.pdf?Status=Temp&sfvrsn=8e2d3966_4

5. **How does HPSM match members screened as non-specialty (mild to moderate) and HPSM providers?**

   HPSM's primary goal is to match members with available providers in our network. After members are screened by the ACCESS Call Center as non-specialty (mild to moderate), HPSM matches to the best of our ability by line of business, service type, age, location and provider availability. When we do not have a provider available that speaks the member's language, we will match members to care with a provider that will need to use the services of an interpreter. Please see interpreter resources here: https://www.hpsm.org/provider/resources/language-services

   HPSM receives basic information on members during the matching process. We are not able to make matches based on provider preferences for diagnosis types, history of symptoms and presentation, appointment times, or other preferred criteria. Remember members have only been screened when they are matched to you. Upon assessment if you determine they meet a specialty criteria, please use the Higher Level of Care form.

6. **What information can I find on the provider portal and how do I sign up?**

   The provider portal can help you check claims payment status and authorization request status, verify a members' eligibility, locate some member demographics and contact information, submit claims, and more.

   You can sign up for HPSM's provider portal here: https://www.hpsm.org/provider/portal

7. **How often should I send my availability/What happens if I run out of availability to see additional members?**

   Please provide your availability to HPSM_BH_Provider_Availability@hpsm.org. Please update us when you have availability to take on new members or whenever your availability changes.

   You can also review these tips for managing your patient load if you run out of availability:

   - **Prioritizing Highest Need Individuals:** https://www.hpsm.org/videos/default-source/provider-education/behavioral-health/strategies-for-managing-behavioral-health-demand-1.mp4

- **Engaging Providers and Partners:** https://www.hpsm.org/videos/default-source/provider-education/behavioral-health/strategies-for-managing-behavioral-health-demand-2.mp4

8. **My client is demonstrating {description of behavior/condition}, what should I do?**

   HPSM is not able to provide clinical consultation. Please consult your clinical supervisor with members consent, you may want to connect with the members care team, which could include their PCP, family members, or other providers.

   If you think the member needs a higher level of care please use the HLOC forms found on our provider website. For referrals for higher level of care for members aged 18 and older, non-specialty (mild to moderate) providers should use this form: https://www.hpsm.org/docs/default-source/provider-forms/referral-for-higher-level-of-care---adult-03-26-21-fillable_final.pdf?sfvrsn=fa4ed618_4

   For referrals for higher level of care for members aged 6-17, non-specialty (mild to moderate) providers should use this form: https://www.hpsm.org/docs/default-source/provider-forms/youth-referral-for-higher-level-of-care-pdf-filable-final.pdf?Status=Temp&sfvrsn=8e2d3966_4

   If you are not able to continue to provide care for this non-specialty (mild to moderate) member, please let the member know and have them call the HPSM matching line at 650-616-2557 to be matched with a new provider. Please be sure you address all safety issues within clinical best practices and in consult with your clinical supervisor before ending care.

9. **What if a member I am seeing for non-specialty (mild to moderate) therapy will benefit from an assessment for medication support? How do I get them connected to this service?**

   Most importantly talk to the member about your recommendation. Some members may want to speak with their primary care physicians (PCP) about this before receiving medication assessment. Some PCPs can prescribe basic medications that support mental health symptoms. If a member is in non-specialty (mild to moderate) treatment with you and ready to receive a medication assessment, they can call HPSM's BH matching team 650-616-2557 and request a medication provider.

Member Eligibility

1. **Why do I need to check member's eligibility and how often should I check?**

   Checking a member's eligibility allows you to see if the member is an HPSM 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.

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

2. **If a patient loses Medi-Cal eligibility, will they still be covered for a period?**

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

3. **What is the process for receiving non-specialty (mild to moderate) member matches?**

   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 outgoing voicemail message identifies your name and/or practice name).

4. **Wouldn't a match or an authorization also clarify if a member is an HPSM member?**

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

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

   Members are eligible for covered services if they remain medically necessary. 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.

   Please review the Medi-cal Provider Manual for detailed information:

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf

You can also review these tips for understanding medical necessity and care planning:

- **Prioritizing Highest Need Individuals:** https://www.hpsm.org/videos/default-source/provider-education/behavioral-health/strategies-for-managing-behavioral-health-demand-1.mp4
- **Engaging Providers and Partners:** https://www.hpsm.org/videos/default-source/provider-education/behavioral-health/strategies-for-managing-behavioral-health-demand-2.mp4

HPSM Benefit Questions

1. **How do I know what mental health benefits are covered for each line of business (Medi-Cal, CareAdvantage, and HealthWorx)?**

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

   Please review the Medi-cal Provider Manual for detailed information https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf

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

   Please refer to your HPSM contract with HPSM, where you indicated which lines of business you would like to contract with.

Authorizations

1. **What is prior authorization?**

   Prior authorization is a process through which HPSM verifies that a service is medically necessary before you are authorized to provide the service.

HPSM will only require prior authorization for certain services. Most non-specialty (mild to moderate) services do not require prior authorization. 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.

2. **Do I need an authorization? (or requests for authorization number?)**

   HPSM does not require prior authorization for most non-specialty (mild to moderate) behavioral health services. Please view our prior authorization required list to see which codes require prior authorization: https://www.hpsm.org/provider/authorizations

   However, please make sure you receive a member match from HPSM for each member before you begin services. HPSM staff will leave you a voicemail including the member's name and contact information. This ensures that you are seeing members that have been screened as non-specialty (mild to moderate). Please contact the member and then check member eligibility prior to rendering services.

3. **Where do I check the status of prior authorization requests and claims?**

   You can check both using our provider portal: https://www.hpsm.org/provider/portal. Remember, Requests for Prior authorization are very uncommon for non-specialty (mild to moderate) services.

Claims

1. **Where do I direct questions about claims issues?**

   You can contact HPSM's Claims Department at 650-616-2106 or by emailing ClaimsInquiries@hpsm.org.

2. **Is any given code covered?**

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

- If yes, the code will be covered for CareAdvantage, Medi-Cal and HealthWorx.
- 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
- If yes, the code will be covered for CareAdvantage, Medi-Cal and HealthWorx.
- If still not listed under Medi-Cal, the code is not covered for CareAdvantage, Medi-Cal and HealthWorx.

Once you've identified that the code is covered, next check code descriptions/limitations by member line of business:

- For CareAdvantage check Noridian: https://med.noridianmedicare.com/web/jeb/specialties/mentalhealth
- For Medi-Cal and HealthWorx check: (Including for codes covered by Medicare) https://files.medical.ca.gov/pubsdoco/Publications.aspx

3. **How do I know what rates I will receive?**

   Please consult your contract for rate information.

4. **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 type written. We recommend submitting them online using eHealthSuite. You can submit claims electronically through our provider portal. You can log in or sign up here: https://www.hpsm.org/provider/portal