

Provider Training

801 Gateway Blvd, # 400
South San Francisco, CA 94080

Hosted by the

Provider Services Department

Phone (650) 616-2106 Fax (650) 616-8046

psinquiries@hpsm.org



About Us



The Health Plan of San Mateo (HPSM) is a managed care health plan that provides health care benefits to San Mateo County's underserved residents. We are a County Organized Health System (per state designation).

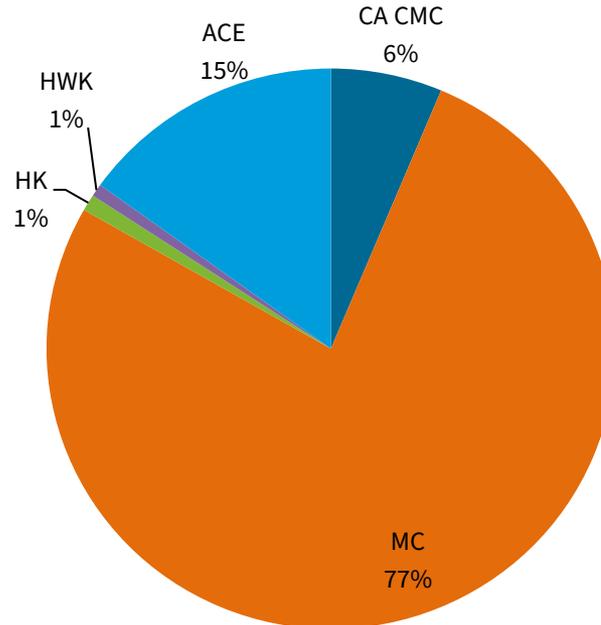
HPSM is governed by the San Mateo Health Commission. Members of the Commission represent community advocates, physicians, pharmacists, and elected officials who serve on the San Mateo County Board of Supervisors.

HPSM's Lines of Business:

- Medi-Cal
- California Children's Services
- HealthWorx
- CareAdvantage

The Health Plan of San Mateo manages the below programs that provide health care to more than **145,000** San Mateo County residents. There are more than 20 languages spoken in San Mateo County – the most common among our members are: English, Spanish, Mandarin, Cantonese, Tagalog, and Russian.

HPSM Members by Program



We serve 1 out of every 5 San Mateo County residents.

Program Info. & Eligibility Determination



- **Medi-Cal** is based on household components along with member income in relation to Federal Poverty Levels. Eligibility workers determine qualification for the programs.
- **California Children's Services** (children ages 0-21) is a State program for children with qualifying medical diagnoses and qualifying financial and residential status that is administered through San Mateo County. HPSM is the payor for CCS services.
- **HealthWorx-** is a program for *In Home Support Services (IHSS) Workers and some County Employees*. Public Authority (SEIU #715) determines eligibility.
- **CareAdvantage** is the Medicare HMO option. Members are eligible for Medicare Parts A, B, D and Medi-Cal. Members may opt in and out.

Member ID Numbers- All HPSM members are assigned a nine digit numeric ID number unique to HPSM known as the HEALTHsuite member ID number.

Once enrolled into HPSM, members receive a member welcome packet and are asked to select a Primary Care Provider (PCP). If they do not respond to our letter and provider listings, they are auto-assigned based on member demographics, primary language spoken, etc.

In the event members are auto-assigned to a PCP they do not want, and they wish to select a different PCP, the PCP selection form should be completed, signed by the member and faxed to the Member Services Department or the member may call them to request the PCP change.

San Mateo County ACE

Access and Care for Everyone (ACE)

- The San Mateo Access & Care for Everyone (ACE) Program is offered by the San Mateo Medical Center to expand healthcare coverage for low-income residents of San Mateo County. **San Mateo ACE is NOT Insurance.**
- The ACE Provider network is limited to the San Mateo Medical Center (SMMC) clinics and specific non-SMMC providers.
- ✓ All services performed by non-SMMC providers require prior authorization.
- * **Services performed by a non-SMMC provider to an ACE Participant without prior authorization will NOT be reimbursed.**
- HPSM is serving as the Third Party Administrator for San Mateo ACE offering these services:
 - Claims processing - Utilization Management
 - Grievance and Appeals - Customer Service
 - Provider Relations

Member Eligibility Verification

By Phone:

- HPSM's Automated Telephone Eligibility (ATEV) (800) 696-4776
–24 hours a day (**All lines of business**)
- State Medi-Cal's Automated Eligibility Verification System
(800) 456-2387 24 hours a day (**Medi-Cal Only**)
- HPSM's Claims Department – (650) 616-2056 or 1-833-694-7761 during regular business hours
(**All lines of business**)
- California Children's Services: (650) 616-2500

By Web:

- HPSM's Website www.hpsm.org, (**All lines of business**)

<https://www.hpsm.org/provider-portal/provider-portal-login.aspx>

- To obtain access and a password, you may request access by utilizing “New User Registration”
- DHCS/State Medi-Cal Website www.medi-cal.ca.gov (**Medi-Cal only**)

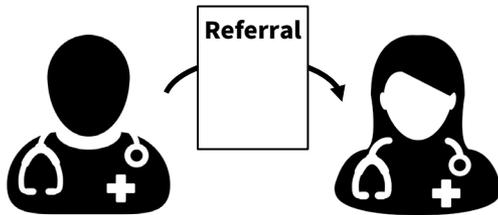
or:

- Ask member for ID card and check the effective date
- Point Of Service (POS) Device
- PCPs receive monthly Member Eligibility lists

✓ **Note: Member eligibility can change monthly. Best practice is to verify eligibility at every visit.**

There are three (3) types of authorizations that providers submit to HPSM

1



Referral Authorization Form (RAF)

HPSM-contracted providers may refer to other HPSM-contracted providers without prior authorization.

However, authorization is required to refer to an out-of-network provider, and may be denied if any in-network provider is available.

2



Prior Authorization Request form (PAR)

HPSM requires prior approval for many non-emergency services.

Emergency services never require prior authorization.

HPSM provides a list of services that require PAR on our website; it is typically updated quarterly.

3



Medication Request Form (MRF)

HPSM requires pre-approval to prescribe certain drugs.

Authorization is required for any drug not on our formulary, and for drugs with certain initials next to them in our formulary (NF, PA, QL or ST)

1 Referral Authorization Form (RAF)

When should I use the RAF?

- When you need to refer a member to a provider who is not contracted with HPSM, for that member's particular Line of Business (e.g., if a specialist you wish to refer to is not contracted for Medi-Cal)
- The referral is medically necessary, and there is not an in-network provider available
- The member has Medi-Cal, ACE or HealthWorx
- *Exception: CareAdvantage members may be referred to any provider who is Medicare eligible – they do not need to be contracted with HPSM; however we encourage you refer to a contracted provider whenever possible to support care coordination*

How do I know if the provider I want to refer to is “out of network”?

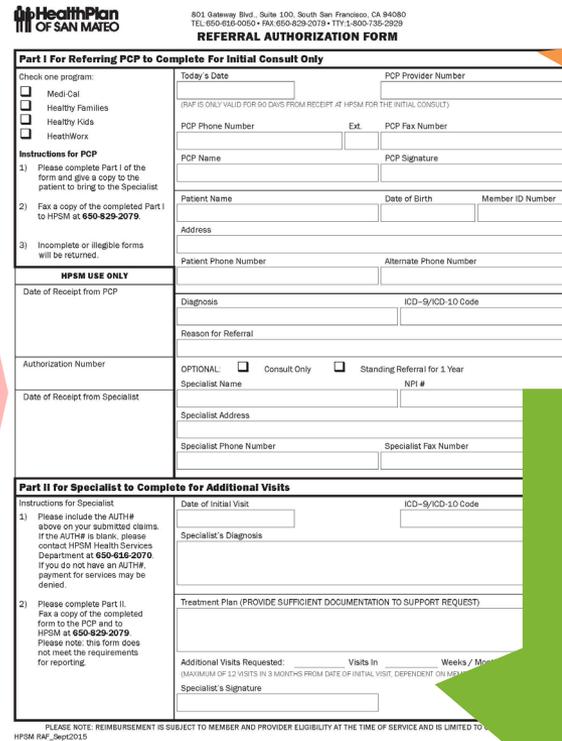
- Search HPSM's online provider directory, available at: <https://www.hpsm.org/provider/directory-search>

Anatomy of the RAF Form

We've automated the intake process for RAF forms, to speed up our response time to you. This means that you must make sure:

- You're using the current version of the form (posted to our website at <https://www.hpsm.org/provider/authorizations/referrals>)
- You Part 1 using the fillable PDF (typed, not handwritten)
- The Specialist completes Part 2 for additional visits.
- Completed RAFs are to be fax to the UM Department at 650-829-2079.

The RAF form allows you to refer members to non contracted specialists



801 Gateway Blvd., Suite 100, South San Francisco, CA 94080
TEL: 650-616-6050 • FAX: 650-829-2079 • TTY: 1-800-735-2029

REFERRAL AUTHORIZATION FORM

Part I For Referring PCP to Complete For Initial Consult Only

Check one program:
 Medi-Cal
 Healthy Families
 Healthy Kids
 HealthWorx

Today's Date _____ PCP Provider Number _____
(RAF IS ONLY VALID FOR 90 DAYS FROM RECEIPT AT HPSM FOR THE INITIAL CONSULT)
 PCP Phone Number _____ Ext. _____ PCP Fax Number _____
 PCP Name _____ PCP Signature _____
 Patient Name _____ Date of Birth _____ Member ID Number _____
 Address _____
 Patient Phone Number _____ Alternate Phone Number _____

HPSM USE ONLY

Date of Receipt from PCP _____ Diagnosis _____ ICD-9/ICD-10 Code _____
 Reason for Referral _____
 Authorization Number _____ OPTIONAL: Consult Only Standing Referral for 1 Year
 Specialist Name _____ NPI # _____
 Date of Receipt from Specialist _____ Specialist Address _____
 Specialist Phone Number _____ Specialist Fax Number _____

Part II for Specialist to Complete for Additional Visits

Instructions for Specialist:
 1) Please include the AUTH# above on your submitted claims. If the AUTH# is blank, please contact HPSM Health Services Department at 650-616-2070. If you do not have an AUTH#, payment for services may be denied.
 2) Please complete Part II. Fax a copy of the completed form to the PCP and to HPSM at 650-829-2079. Please note: this form does not meet the requirements for reporting.

Date of Initial Visit _____ ICD-9/ICD-10 Code _____
 Specialist's Diagnosis _____
 Treatment Plan (PROVIDE SUFFICIENT DOCUMENTATION TO SUPPORT REQUEST) _____
 Additional Visits Requested: _____ Visits in _____ Weeks / Months
(MAXIMUM OF 22 VISITS IN 3 MONTHS FROM DATE OF INITIAL VISIT, DEPENDENT ON MEMBER'S PLAN)
 Specialist's Signature _____

PLEASE NOTE: REIMBURSEMENT IS SUBJECT TO MEMBER AND PROVIDER ELIGIBILITY AT THE TIME OF SERVICE AND IS LIMITED TO HPSM RAF_sep12015

Typically, the PCP referring to the specialist is the one responsible for submitting the RAF Form.

Please review the HPSM Provider Directories to confirm a RAF is required and the specialist is not in network

② Prior Authorization Request (PAR)

When should I use the PAR?

- Prior to delivering a non-emergency service, providers are expected to check the Medi-Cal Provider Manual (www.medi-cal.ca.gov), and also review HPSM's Prior Authorization Required list: <https://www.hpsm.org/provider/authorizations>
- The Prior Authorization Required list indicates which codes require or do not require prior authorization
- Authorization is based on medical necessity, and is not a guarantee of coverage or eligibility
- If a service is not included on this list, the service does not require prior authorization. However, this does not mean it is a covered benefit
- Please note, outpatient authorization requirement guidelines are applicable to HPSM CareAdvantage, Medi-Cal, HealthWorx and ACE programs.

How often do I need to check the Prior Authorization Required list?

- It's best to check regularly; our PAR list is typically updated quarterly but additional updates may occur
- Make sure you're on our email and fax distribution list to be notified of changes – check with your HPSM Provider Services Rep to confirm your fax number and email are up to date

Authorization Time frames & Corrections

Authorization Review Time Frames

Urgent Requests for all lines of business- 72 hours from receipt.

Standard Requests for Medi-Cal, HealthWorx & ACE- Five (5) business days from receipt.

Standard Requests for CareAdvantage- 14 calendar days from receipt.

Retrospective requests and corrections are allowed to existing, approved authorizations.

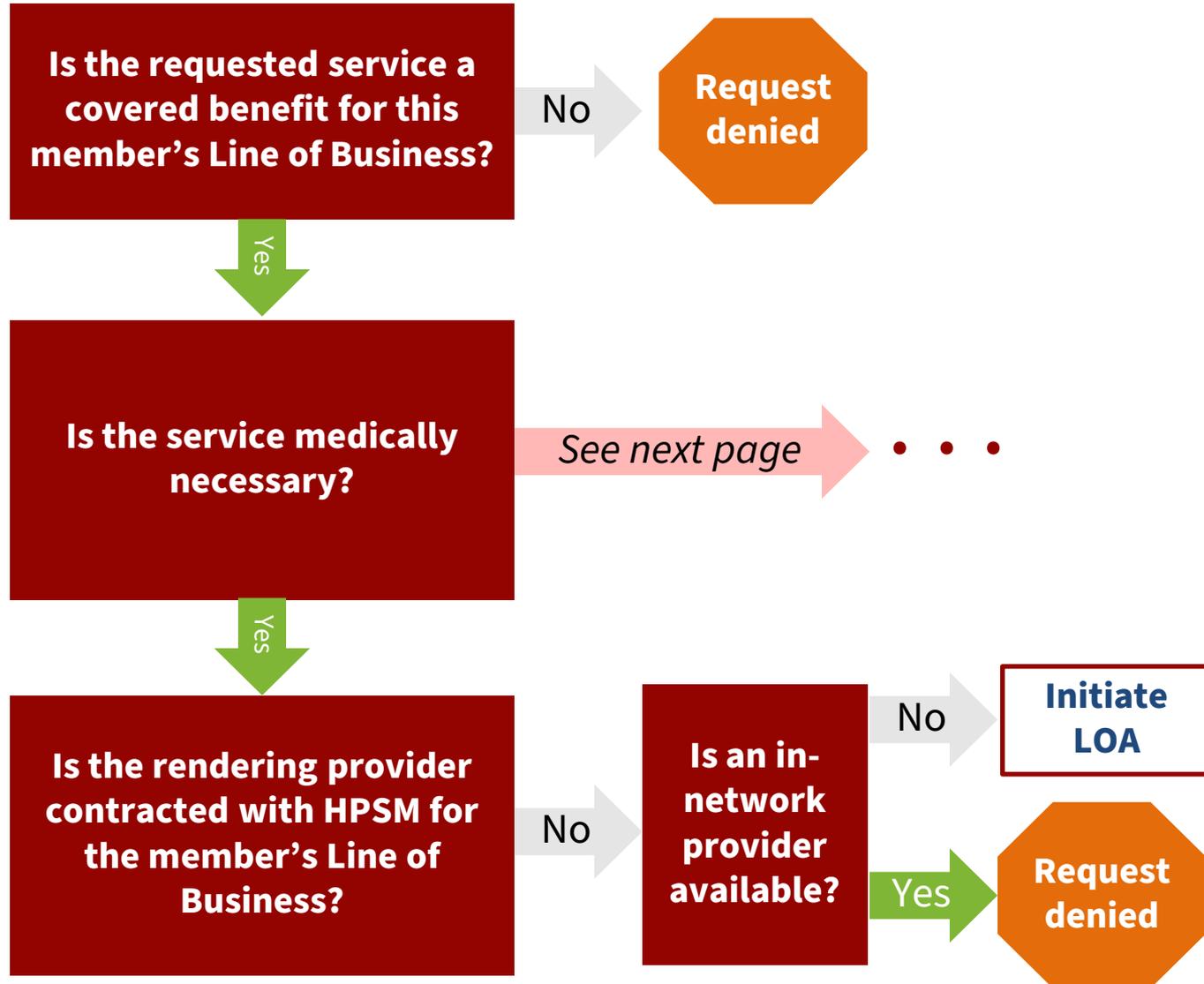
HPSM recognizes that a retro review process is necessary in certain rare cases. Examples include:

- Emergency services
- Urgent out of area services

UM Dept. Fax Numbers:

- Prior Authorization 650-829-2079
- Retro Authorization/Correction 650-829-2062
- Inpatient/Face Sheet 650-829-2060

Decision workflow: Medi-Cal, ACE, CCS and HealthWorx



Determining Medical Necessity: Medi-Cal, ACE, CCS, and HealthWorx

**Is the
service
medically
necessary?**

Review Medi-Cal
guidelines

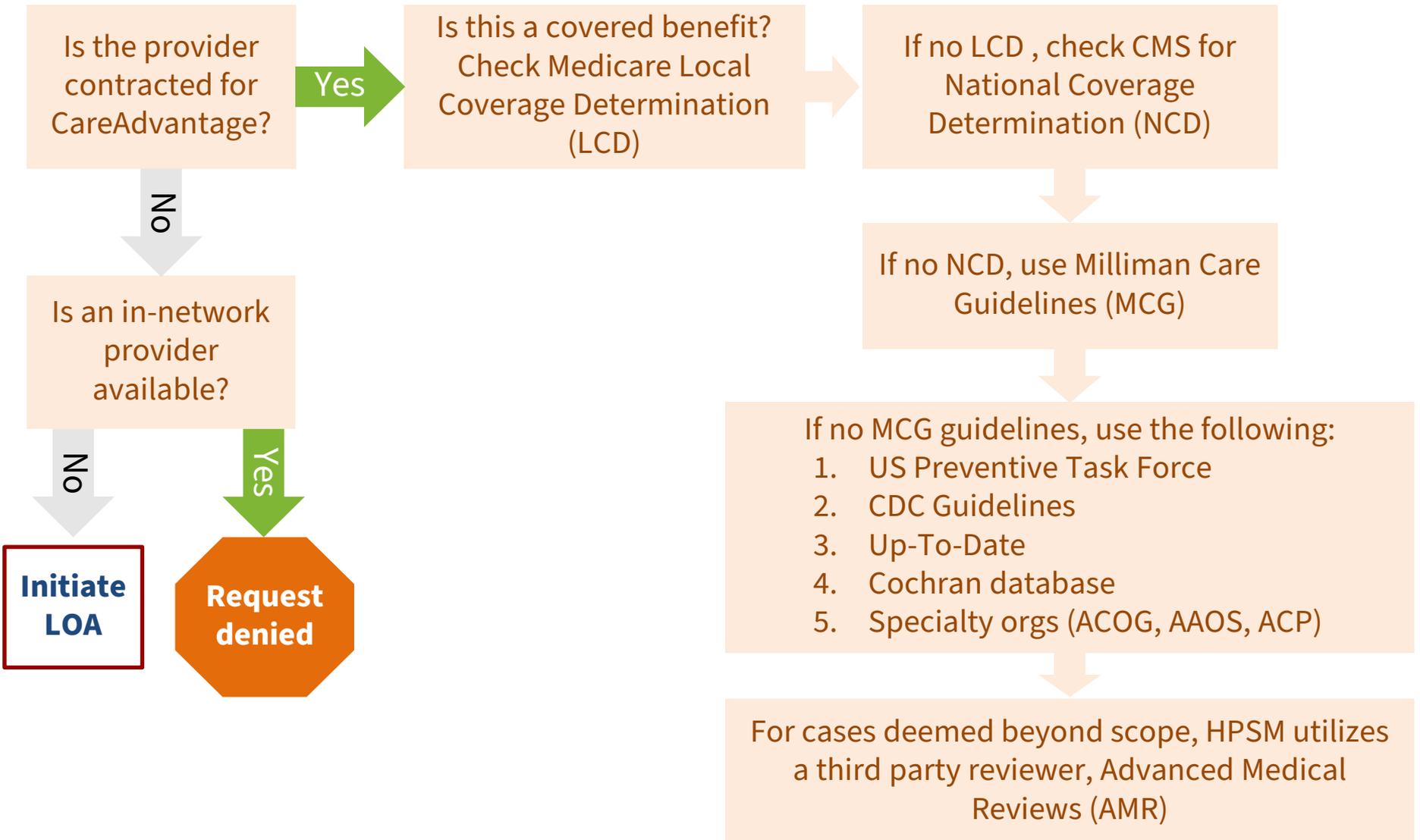
If no Medi-Cal
guidelines, use
Milliman Care
Guidelines (MCG)

If no MCG guidelines, use the following :

1. US Preventive Task Force
2. CDC Guidelines
3. Up-To-Date
4. Cochran database
5. Specialty orgs (ACOG, AAOS, ACP)

For cases deemed beyond scope, HPSM utilizes a
third party reviewer, Advanced Medical Reviews
(AMR)

Decision workflow: CareAdvantage



3 Medication Request Form(MRF)

When should I use the MRF?

- Medication Request Forms (MRFs) are used to request prior authorization for prescribing off-formulary medications.
- MRFs, along with complete HPSM Formularies and Quick Reference Guides, are available at www.hpsm.org.
- Access the Search the Formulary Tool: <https://www.hpsm.org/provider/formulary-search>

Who reviews MRFs?

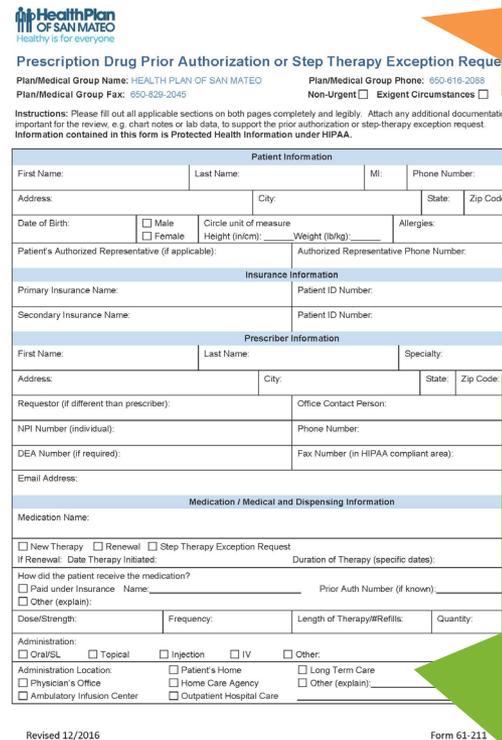
- HPSM's Pharmacy Authorization Unit : Phone 650-616-2880, Fax 650-829-2045.
- Pharmacy network and prescription claims are processed by the Pharmacy Benefit Manager: Argus Health Systems 888-635-8362
- Specialty Pharmacy for HPSM Medi-Cal and HealthWorx : Alphascript Specialty Pharmacy 800-780-3584

Anatomy of the MRF Form

We've automated the intake process for MRF forms, to speed up our response time to you. This means that you must make sure:

- You're using the current version of the form (posted to our website at <https://www.hpsm.org/provider/authorizations/prescription-drugs>)
- You complete all fields using the fillable PDF (typed, not handwritten)
- Information is accurate
- Completed MRFs may be fax the HPSM Pharmacy Unit, Fax 650-829-2045

The MRF allows you to request approval for non formulary drugs



Health Plan OF SAN MATEO
Healthy is for everyone

Prescription Drug Prior Authorization or Step Therapy Exception Request

Plan/Medical Group Name: HEALTH PLAN OF SAN MATEO Plan/Medical Group Phone: 650-616-2088
Plan/Medical Group Fax: 650-829-2045 Non-Urgent Exigent Circumstances

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. Information contained in this form is Protected Health Information under HIPAA.

Patient Information			
First Name:	Last Name:	MI:	Phone Number:
Address:		City:	State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): Weight (lb/kg):	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	
Insurance Information			
Primary Insurance Name:		Patient ID Number:	
Secondary Insurance Name:		Patient ID Number:	
Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:		City:	State: Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			
Medication / Medical and Dispensing Information			
Medication Name:			
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request			
If Renewal: Date Therapy Initiated:		Duration of Therapy (specific dates):	
How did the patient receive the medication?			
<input type="checkbox"/> Paid under Insurance Name: _____		Prior Auth Number (if known): _____	
<input type="checkbox"/> Other (explain): _____			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration: <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____			
Administration Location:		<input type="checkbox"/> Long Term Care	
<input type="checkbox"/> Physician's Office		<input type="checkbox"/> Home Care Agency	
<input type="checkbox"/> Ambulatory Infusion Center		<input type="checkbox"/> Outpatient Hospital Care	

Revised 12/2016 Form 61-211

Typically, the prescribing physician submitting the MRF Form.

***Please verify the medication requirements by reviewing the formulary for the specific line of business or program.**

Other Referrals

- Behavioral Health Services
 - Medically necessary mental health services are provided by the San Mateo County Behavioral Health and Recovery Services (BHRS). For information about mental health providers and access to care, call BHRS at 1-800-686-0101. PCPs may use the BHRS Referral Form to refer cases to BHRS. https://www.hpsm.org/documents/BHRS_Referral_Form.pdf
- Long Term Supportive Services
 - Services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. Services may include:
 - Home healthcare
 - Translation services
 - Personal care
 - Transportation
 - Alert systems
 - Meals
 - Housing assistance
 - Accessibility services, modifications and repairs
 - Adult day programs, Community-Based Adult Services (CBAS)
 - Respite care
 - Alzheimer’s day programs
 - Mental health access
 - Legal assistance
 - For referral information, please contact the County of San Mateo at 800-675-8437 or HPSM’s Health Services Department at 650-616-2070 or Provider Services at 650-616-2106.

Other Referrals - LTSS (cont.)

- Long Term Supportive Services needs include:
 - Person centered planning processes;
 - Linguistic, cultural, and cognitive competencies;
 - Core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate;
 - Accessibility and accommodations; independent living;
 - Wellness principles;
 - Criteria for safe transitions, transition planning, care plans after transitioning
 - Understanding dementia; its symptoms and progression;
 - Understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,
 - Community resources for patients and caregivers

Other Referrals

PCPs may also utilize:

CBAS & MSSP Referral Form

https://www.hpsm.org/documents/CBAS_and_MSSP_Referral_Form.pdf

PCP Referral for Behavioral Health & Recovery Services

https://www.hpsm.org/documents/BHRS_Referral_Form.pdf

Complex Care Management PCP Referral Form

https://www.hpsm.org/documents/Complex_Case_Management_Referral_Form.pdf

For referral information, please contact the County of San Mateo at 800-675-8437 or HPSM's Health Services Department at 650-616-2070 or the Care Coordination Department 650-616-2060.

Other Referrals

Additional Services Available to CareAdvantage Members:

Matrix- HPSM CareAdvantage members may receive one annual home based health visit, by NPs, per benefit year. The assessment reports are shared by Matrix via fax with the assigned PCP. If you'd like to speak to an NP about a patient they visited, or if you or your patient have questions, please call Matrix at 1-877-561-7335 5 a.m. to 5 p.m. local time, Monday through Friday.

Landmark- HomeAdvantage- Physician based house call program, which is only available to CareAdvantage members who have 5+ chronic conditions from a list of eligible chronic conditions, is the program described in the attached materials.

Landmark also manages the Post Acute Care Pilot: this is pilot program we launched to have Landmark be our preferred SNFist for rounding in a set of 6 high-volume SNF/LTC facilities. We've asked facilities and discharge teams to assign HPSM members to Landmark as the default, however if the patient prefers a different in-network physician, the patient's choice is always the priority. To contact Landmark Health, please call (650) 826-2937.

Model of Care

- HPSM's Model of Care is the plan for delivering case management and services for CareAdvantage members with special needs. It sets guidelines for:
 - Staff structure and Care Management roles
 - The interdisciplinary care team
 - Provider network having special expertise and use of Clinical Practice Guidelines
 - A member health risk assessment
 - Assessment and case management of members
 - Communication among members, caregivers, and providers
 - Integration of the primary care physician
 - Model of Care training
 - Measurable program goals
- Our Model of Care training materials are available upon request and on our website at <http://www.hpsm.org/providers/provider-resources/training.aspx>

Cultural Competency for Providers

- HPSM provides disability, literacy, and competency training for its medical, behavioral, LTSS, and pharmacy providers, including information about the following:
 - Various types of chronic conditions prevalent within the target population
 - Awareness of personal prejudices
 - Legal obligations to comply with the Americans with Disabilities Act (ADA) requirements and Section 504 of the Rehabilitation Act
 - Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs
 - Types of barriers encountered by the target population
 - Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model

Cultural Competency for Providers (cont.)

- Use of evidence-based practices and specific levels of quality outcomes
- Use of culturally sensitive practices and access for beneficiaries requiring threshold languages
- Working with enrollees with mental health diagnoses, including crisis prevention and treatment
- Working with enrollees with substance use conditions, including diagnosis and treatment
- Reference: “**Serving Seniors and People with Disabilities**” training presentation

Reimbursement

- **Medi-Cal** PCP services are capitated. Any PCP Services rendered outside of the scope of capitated services are reimbursed fee for service. Medi-Cal PCPs may also receive incentive payments for billing and reporting services reimbursed by the Pay for Performance (P4P) Program. All services rendered by a PCP for **HealthWorx** and **CareAdvantage** are reimbursed fee for service.
- **All** services rendered by a Specialist are reimbursed **fee for service**.
- Contracted **PCPs** and **Specialists** receive:
 - **Medi-Cal = 123%** of the Medi-Cal fee schedule, Qualifying Specialists 175%
 - **HealthWorx = 133%** of the Medi-Cal fee schedule, Qualifying Specialists 175%
 - **CareAdvantage = 80%** of the Medicare fee schedule + **10%** Medi-Cal fee schedule
 - **CCS** = Paneled CCS providers receive payment in accordance with the CCS schedule

Qualifying contracted specialists with HPSM Medi-Cal and HealthWorx may receive higher reimbursement due to the “Specialists Incentive Program” valid through 6/30/2020. <https://www.hpsm.org/provider/resources/specialists-incentive>
- *Non-Contracted PCPs and Specialists receive:*
 - **Medi-Cal = 100%** of the Medi-Cal fee schedule
 - **HealthWorx = 105%** of the Medi-Cal fee schedule
 - **CareAdvantage = 80%** of the Medicare fee schedule

Reimbursement (cont.)

- **Contracted Other Service Providers:** Chiropractors, Acupuncturists, Audiologists & Hearing Aid Dispensers, Dialysis Clinics, DME Providers, Laboratories, Medical Transportation, Physical & Occupational Therapists, Optometrists and Podiatrists receive:
 - **Medi-Cal** = 100% of the Medi-Cal fee schedule
 - **HealthWorx** = 100% of the Medi-Cal fee schedule
 - **CareAdvantage** = 80% of the Medicare fee schedule + 10% Medi-Cal fee schedule

Balance Billing Prohibited

- Providers who offer services or supplies to HPSM Medi-Cal and CareAdvantage members are prohibited from balance billing the member for any cost-sharing not related to the member's share of cost. This includes deductibles, co-insurance, co-payments and non-covered charges.
- Balance billing the member violates state and federal law that stipulates Medicare (i.e., CareAdvantage and/or Medicaid (i.e., Medi-Cal) payments should be considered payment in full to the provider for services and supplies provided.
- When reconciling payments, please note: CareAdvantage and Medi-Cal claims details appear on separate Remittance Advice (RA)
- CareAdvantage payments might be reduced due to Medicare co-insurance and/or deductible. Depending on your contract status, these amounts may be offset when the claim is processed by HPSM.

If you have any questions about your remittance advice or claims payments, please contact HPSM's Claims Department at 650-616-2056 or 1-833-694-7761.

Submitting Claims & Timeliness Guidelines

- For *Medi-Cal* and *HealthWorx*, utilize **Medi-Cal** coding and modifiers if applicable.
 - Outpatient services are processed using CPT/HCPCS Coding.
 - Inpatient services are processed using a Per Diem Rate.
- For *CareAdvantage*, utilize **Medicare** coding and modifiers if applicable.
 - Outpatient services are processed using APC methodology.
 - Inpatient services are processed using DRG methodology.
- For the Medi-Cal & HealthWorx lines of business:
 - Claims must be received within 6 months from the date of service.
 - Claims received after 6 months are subject to reductions.
 - Claims received 1 year after the date of service are subject to automatic denial.
- For CareAdvantage:
 - Claims must be received within 12 months from the date of service.
 - Claims received over 12 months after the date of service will be denied.

Common Billing Errors

- Not entering members correct member ID number
- Not using appropriate coding depending upon line of business
- Not verifying other insurance
- No Prior Authorization on file
- No RAF or incomplete RAF
- No Rendering NPI in box 24J of CMS-1500
- Not utilizing the “Billing” or Incorporated NPI in Box 33A of CMS-1500
- No NPI in:
 - Box 33a of CMS-1500
 - Box 56 of UB-04

Coordination of Benefits (COB)

- COORDINATION OF BENEFITS APPLICABILITY
 - Members who have other health insurance and Medi-Cal, the other insurance will be the primary insurance and Medi-Cal will be the secondary insurance. The primary insurance will always be billed first, before Medi-Cal.
- BENEFIT COORDINATION WITH OTHER COVERAGE
 - Members who are covered by more than one health insurance plan, the benefits will be coordinated according to California regulations.
- RECOVERY FROM THIRD PARTY LIABILITY
 - Members who were in an accident of any kind and need medical care should inform their provider and/or hospital how they were hurt and where. HPSM will provide covered benefits for members who were injured in an accident.

For additional information about coordination of benefits, please contact HPSM's Provider Services Department at 650-616-2106.

Provider Dispute Resolution (PDR)

- HPSM offers a PDR process to resolve claims issues. The following claims issues can be addressed through HPSM's PDR process:
 - Claims believed to be inappropriately denied, adjusted, or contested.
 - Resolution of a billing determination or other contract dispute.
 - Disagreement with a request for reimbursement of an overpayment of a claim.
 - Retrospective review of an authorization request accompanying a claim.
- Providers should submit their dispute through submission of a PDR form. The form requests the following information:
 - Provider name
 - NPI
 - Contact information
 - Identification of the disputed item, including
 - the original claim number
 - date of service
 - a clear description of the basis upon which the provider believes the payment amount, request for additional information, request for the overpayment of a claim, denial, adjustment or other actions is incorrect.
 - Retro authorization request along with medical justification

PDR continued...

- Time Period for Submission

- Disputes should be sent within 365 days of the last determination for timely consideration. HPSM will return any PDR that is lacking the information required if it is not readily accessible to HPSM. In this case, HPSM will clearly identify in writing the missing information necessary to resolve the dispute. A provider may submit an amended PDR within 30 working days of the date of receipt of a returned provider dispute requesting additional information.

- Time Frames for Resolution

- HPSM will send an acknowledgement letter to the provider within 15 working days of receipt of the dispute.
- HPSM will resolve a PDR or amended PDR and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt.

PDR continued..

Completed PDRs can be mailed or faxed to:

Health Plan of San Mateo
Attn: Provider Disputes
801 Gateway Blvd., # 100
So. San Francisco, CA 94080

Fax (650) 829-2051

Contact the Claims Dept. at (650) 616-2056 or 1-833-694-7761

Provider Grievances

If a provider is dissatisfied with any aspect of HPSM operations or any actions taken by HPSM staff, members, vendors, or other providers the provider may file a grievance. A provider grievance is a formal complaint stating the providers' dissatisfaction. Providers may submit grievances orally or in writing. HPSM will process all provider grievances, regardless of whether any remedial action is requested by the provider.

You may contact your designated Provider Network Liaison or contact the Provider Services Department at 650-616-2106 or 1-833-694-7761 or via email, fax or mail:

Health Plan of San Mateo
Attn: Provider Services
801 Gateway Blvd., Suite 100
So. San Francisco, CA 94080
Fax (650) 616-8046
psinquiries@hpsm.org

Provider Request for Member Panel Dis-enrollment

PCPs may request member re-assignment from their panel once all attempts outlined in the policy and procedure have been met. Please be sure to review the policy and procedure to ensure that member termination requests are carefully reviewed and care is taken to preserve member rights against retaliation and discrimination due to age, race, gender, or health status.

Once all attempts have been made to reconcile, improve or salvage the member/provider relationship, and the attempts do not confirm resolution, the PCP has the opportunity to complete and submit the “Complex Case Management” referral form to request member outreach assistance. Final step if no resolution, the PCP may complete and submit the “Provider Request for Member Termination” form to request removal from their panel. The provider may email or fax the form directly to Provider Services psinquiries@hpsm.org Fax 650-616-8046 . The requests are reviewed and concluded by the HPSM Medical Director. An approval or denial letter is shared with the requesting PCP. When approved the HPSM Member Services/CareAdvantage department will contact the member to assist with PCP re-assignment.

Policy & Procedure: https://www.hpsm.org/docs/default-source/compliance/hpsm_policy_provider_request_to_disenroll_members.pdf?sfvrsn=f39279d6_9

Complex Case Management Program Referral Form: https://www.hpsm.org/docs/default-source/provider-forms/complex_case_management_referral_form.pdf?sfvrsn=43e96270_15

Member Termination Request Form: https://www.hpsm.org/docs/default-source/provider-forms/provider_request_for_termination_form.pdf?sfvrsn=58fde7cb_15

Feel free to contact your designated Provider Network Liaison with any questions or concerns regarding the policy and procedure.

Member Grievances

As a contracted provider you are required to respond to member grievance response requests. This may include requests for medical records. Per CMS and DHCS guidelines, HPSM must research, gather details and conclude grievances in a timely fashion.

It is imperative that you reply to the Grievance Coordinator that contacts your office directly or you may contact your designated Provider Network Liaison.

Please note, the inquiries are based on gathering details to conclude resolution amongst the involved parties.

Contact Provider Services at 650-616-2106 or the Grievance & Appeals Unit at 650-616-2850 with any questions.

Language Assistance

HPSM ensures access to interpreter services for all limited English proficient members to reduce the effect of language barriers on quality of care. HPSM provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact. In addition, HPSM members can also utilize sign language interpreter services with advance notice. All interpreter services are provided free of charge to providers and members.

- Telephonic Interpreters
 - Certified Languages International at **(800) 225-5254**, Access Code **64095**
- Sign Language Interpreters
 - Bay Area Communication Access at (415) 356-0405

For questions regarding Language Assistance, please call HPSM's Health Educators at (650) 616-2165.

HPSM Electronic Access



Provider Portal- Eligibility verification, PCP data & Other Health Coverage information, Check claim status & submit claims (CMS1500 format only), Check co pay amounts if applicable, New User Registration, request a new password. <https://www.hpsm.org/Home/provider/provider-portal-ereports>

eReports - Allows providers access to view, save or print over sixteen months of Remittance Advice data, Capitation Reports, Member Eligibility Lists and other important documents via HPSM's secured web portal. Primary Care providers also have access to Pay for Performance utilization reports & personalized patient engagement data.

Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)- Receive payments faster by signing up for direct deposit/electronic funds transfer (EFT). Simply complete the form, include a voided check or bank letter and send to HPSM's Provider Services Department. Provider will no longer receive checks or RAs. ERA access will occur with your confirmed vendor or we will create an eREPORTS account. The form is available online:

https://www.hpsm.org/docs/default-source/provider-forms/era-eft_authorization_form.pdf?sfvrsn=101c2e0d_13

Provider Data Information Verification or Change Form- Based on SB137 requirements, providers are required to provide updated, accurate practice information to HPSM for the published provider directory purposes. Quarterly mailings are sent to providers, however you have the ability to submit any updates electronically from the HPSM website: <http://providers.hpsm.org/ChangeRequestProvider/>

-Also available:

Electronic Claim Submission- Office Ally 866-575-4120 or Emdeon 877-469-3263

Provider News & Updates....

SB137 HPSM Contracted Providers

To ensure that provider directories are current and up to date, the directory must be searchable electronically, to include: name, practice address, city, zip code, license number, NPI, admitting privileges, languages spoken in office, provider group and hospital or facility name. To update information with Health Plan of San Mateo (HPSM), please go to the following link: <http://providers.hpsm.org/ChangeRequestProvider/>. Click on the “Submit Changes” link. We encourage you to view the current data on file with HPSM for your office to assure accuracy. If you have any questions, please contact HPSM’s Provider Services Department at 650-616-2106 or psinquiries@hpsm.org.

Do You Know Your Credentialing Rights?

HPSM oversees credentialing activities for our provider network, and directly credentials and re-credentials many of our providers (such as independent practitioners). As a contracted provider, you always have the right to:

1. Review information submitted to support your credentialing application
2. Correct erroneous information
3. Receive the status of your credentialing or re-credentialing application upon request To learn more, read section 8 of HPSM’s Provider Manual (available online at hpsm.org/provider-manual).

Pediatric PT/OT/ST Therapy

Effective January 1, 2018, HPSM requests prior authorization for outpatient Physical Therapy (PT), Occupational Therapy (OT), or Speech Therapy (ST) for members under 21 years old. Prior authorizations for these therapy types will be **required beginning 2/1/2018**: claims with a date of service of 2/1/2018 or later that do not have an approved prior authorization will be denied. This effectively aligns the policies for authorizing pediatric therapy visits between Members who qualify for California Children’s Services (CCS) and those who do not.

As a Medi-Cal payer, HPSM cannot authorize duplicative services that are already available to members through other settings. Eligible pediatric members often have access to Early Start or school based therapy services. HPSM has dedicated resources to ensuring our pediatric members who qualify are receiving appropriate services. For the benefit of all our pediatric members, HPSM will be reviewing all requests for therapy to ensure appropriate delivery of services to those in need.

Health Plan of San Mateo (HPSM) and San Mateo County CCS have created resources to assist providers in understanding the Therapy Prior Authorization process. Prior Authorization forms submitted incorrectly can cause delays with approving services. Please review and adhere to the checklist on the following page to ensure that authorization requests are processed in a timely manner.

Prior Authorization Check List for HPSM/CCS San Mateo – Therapy Requests

All HPSM members under 21 will need prior authorization for physical, occupational and speech therapies.

Request should be completed on [HPSM Prior Authorization Request Form](#) and faxed to HPSM/CCS at 650-616-2598.

Request will be denied or returned without the required documents.

Provider News & Updates....

Instructions for Home Health Agencies: Caring for Homebound HPSM Members

How should a provider request home care visits?

Visit HPSM members to start care and conduct an assessment within 48 hours of receiving a physician's order.

After the start of care visit has been conducted, compose a care plan for the entire 60 day certification period. See example below.

The care plan should contain any services already delivered (at least the start of care visit, but possibly more) and those future services that will be required.

Services delivered within the initial 10 calendar day period (counting from date of service of start of care visit) from start of care *will be authorized*.

Any services delivered from calendar day 11 to day 60 of the certification period will be subject to full utilization review and potentially denied if not deemed medically necessary by HPSM staff.

Fax the Prior Authorization Request Form to HPSM within 10 days from start of care, or risk denial of some or all services (including those already delivered).

Fax should include the following documents:

[HPSM Prior Authorization Request Form](#)

[Home Health Physician Order Form](#)

[Clinical Summary](#)

Other supportive clinical documentation

Expect a response from HPSM regarding authorization request within:

3 business days for urgent or expedited authorization requests

5 business days for routine authorization requests

Example Care Plan

Physician order received: Monday (day one)

Start of Care SN visit: Tuesday (day two)

Subsequent visits occurring prior to submission of authorization request: Thursday for OT (day four), Saturday for PT & SN (day six)

Submission of authorization: Sunday (day seven)

Additional visit: Monday for SN (day eight)

Guaranteed approved visits: 5 (Tuesday, Thursday, Saturday x2, Monday)

Visits subject to review and potential denial: any occurring after calendar day ten (the following Wednesday)

HPSM will be retrospectively reviewing visit requests during the initial 10 day period looking for patterns of unnecessary or excessive requests for services within that period. Any observed patterns of this nature will put provider at risk for denial of future requests.

As always, HPSM reserves the right to deny any claims for services delivered after the initial 10 day period if abuse, fraud or waste is suspected.

<https://www.hpsm.org/Home/provider/authorizations/specialty-provider-authorizations>

Provider News & Updates....

HPSM New Website!

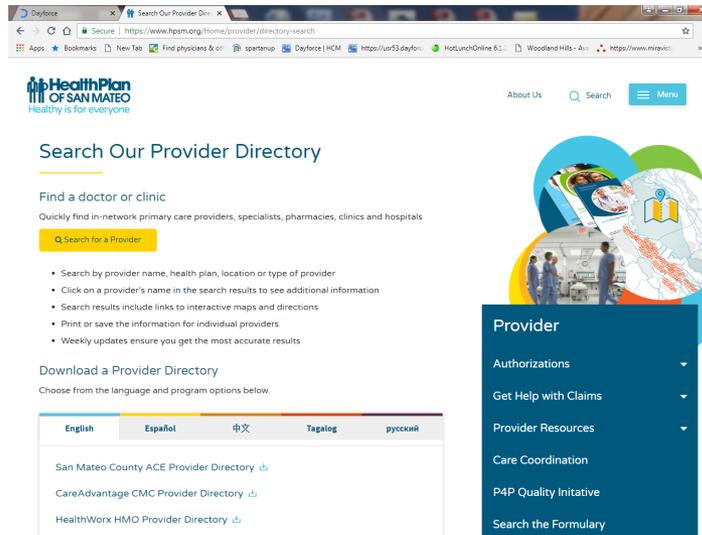
We are pleased to announce that HPSM's brand-new website has officially launched! It is live online at www.hpsm.org.

Specialists Incentive Program

Effective 7/1/2016 through **6/30/2020**, HPSM will implement enhancements to reimbursements for Medi-Cal contracted qualifying specialty providers. Recently, Health Plan of San Mateo sent letters to contracted Medi-Cal, HealthWorx, CareAdvantage and Primary Care Providers to notify them that there will be an incentive program to increase Medi-Cal allowable rates of **175%** for certain Medi-Cal specialties. HPSM developed the program to improve access to specialty care, increase utilization and payment data, align reimbursement with market trends and respond to findings from the Provider Satisfaction Survey conducted last year. Initially, this incentive program will require providers to list taxonomy codes when submitting claims for the first year and gradually develop into a quality program the second year. Claims submitted without the appropriate taxonomy code and qualifier code (ZZ or PXC), will pay at the current rate (123% of allowable Medi-Cal). HPSM Claims Department will not accept claims resubmitted to include the taxonomy code. Website Link: <https://www.hpsm.org/provider/resources/specialists-incentive>

New Online Provider Search tool

<https://www.hpsm.org/Home/provider/directory-search>



The screenshot shows a web browser window displaying the HPSM Provider Directory Search tool. The page features the HPSM logo and tagline "Healthy is for everyone". The main heading is "Search Our Provider Directory". Below this, there is a search bar with the placeholder text "Search for a Provider". A list of search criteria is provided: "Search by provider name, health plan, location or type of provider", "Click on a provider's name in the search results to see additional information", "Search results include links to interactive maps and directions", "Print or save the information for individual providers", and "Weekly updates ensure you get the most accurate results". There is also a section for "Download a Provider Directory" with a note to "Choose from the language and program options below." Below this, there are tabs for "English", "Español", "中文", "Tagalog", and "русский". The "Español" tab is selected. Below the tabs, there are three links: "San Mateo County ACE Provider Directory", "CareAdvantage CMC Provider Directory", and "HealthWorx HMO Provider Directory". On the right side of the page, there is a "Provider" menu with several options: "Authorizations", "Get Help with Claims", "Provider Resources", "Care Coordination", "P4P Quality Initiative", and "Search the Formulary".

Provider News & Updates....

Health Matters MD Newsletter

Take a look at the latest HPSM Provider Newsletter Spring 2019:

https://www.hpsm.org/docs/default-source/health-matters-newsletter/health_matters_md_2019-q1.pdf?sfvrsn=e697fd31_8

Toll Free Number for Claims/Provider Services

Health Plan of San Mateo has a new toll free phone number dedicated to assisting providers. You can now obtain assistance for questions regarding claims and authorizations or contact the Provider Services Department at 1-833-MY-HPSM-1 (1-833-694-7761).

New Phone Line Hours for HPSM Claims/Provider Services - Effective September 24, 2018

HPSM's Claims/ Provider Services phone line hours are changing, effective September 24th. HPSM regularly monitors our phone volume, and we hope this adjustment will help better meet your needs. Our new hours of operation for our main phone line 650-616-2106 or 1-833-MY-HPSM-1 (1-833-694-7761) are as follows:

Mondays, 1pm - 5pm Pacific Standard Time

Tuesday-Friday, 8am-5pm Pacific Standard Time

Have a question for HPSM but not sure who to call? Our staff directory is also available online at:

<https://www.hpsm.org/Home/provider/provider-services>

Many frequently asked questions are answered in our Provider Manual, available online at:

<https://www.hpsm.org/Home/provider/provider-resources/provider-manual>

Our Provider Manual includes topics such as:

What are HPSM's UM criteria and guidelines? *Section 7, Page 35*

What are my members' rights and responsibilities? *Section 2, Page 3*

What are my rights and responsibilities when it comes to HPSM credentialing and re-credentialing? *Section 8, page 2*

How do I file an electronic claim? *Section 4, Page 1.*

Encourage Your Colleagues to Join HPSM's Provider Network

HPSM's provider network is more than 5,000 PCPs and Specialty Care Providers strong. But we're always looking to expand it to better serve our members' diverse medical and geographical needs. If you know qualified clinicians in San Mateo County who are certified for Medi-Cal and/or Medicare, please encourage them to apply to HPSM's provider network. We especially want to recruit clinicians and office staff who speak Spanish, Tagalog, Mandarin and Cantonese. Contracted providers receive better rates and the opportunity for bonus payments through our Specialists Incentive and pay-for-performance programs. Please recommend HPSM to your colleagues so they can enjoy these advantages while providing health care to our community's most underserved residents. Apply to HPSM's network by contacting Provider Services at 650-616-2106 or 833-694-7761 or psinquiries@hpsm.org <https://www.hpsm.org/Home/provider/join-our-network>

Provider News & Updates....

Prior Authorization List Updates – Q1 2019 - All changes effective April 1, 2019

The HPSM Prior Authorization Required List states which service codes do, and do not, require prior authorization. It is expected that all services requiring prior authorization must be authorized *prior* to providing the service, with the exception of services that might be necessary on an emergent or urgent basis. The list of codes requiring prior authorization is updated regularly to reflect current clinical guidelines and regulatory requirements. HPSM recommends that our providers visit our website for the most current Prior Authorization Required Services List. This list is available in both PDF and XLSX format, at <https://www.hpsm.org/Home/provider/authorizations>.

This notice is a courtesy reminder to highlight upcoming changes to our Prior Authorization Required Services List. The following changes will be **effective April 1st, 2019:**

Prior authorization requirements for 17 codes will be removed (Y to N):

E0602, E0603, 01480, 11042, 11043, 11044, 11047, 14040, 17110, 17111, 20605, 27650, 28124, 28193, 28415, 73700, Z7506

Comments will be adjusted for 5 codes:

“CareAdvantage only code” comment was removed for G0475, G0480, G0481, G0482, G0483

Regulatory update: over 50 new codes have been added (prior authorization required):

Q9995, 10004 – 10012, 11102 – 11107, 76391, 77046-77049, 81163 – 81167, 81173, 81174, 81204, 81177 - 81190, 81234, 81239, 81271, 81274, 81284 – 81286, 81289, 81306, 81312, 81329, 81336, 81337, 81343 - 81345, 81518, 81216, V5171, V5172, V5181, V5211 – V5215, V5221, A9513, C9038, J9044, J9057, J9173, J9311, J9312, Q2042, C9036, J0517, J0567, J1301, J1628, J1746, J3316, J3398, J7170, J9312, Q5109

Regulatory update: over 40 codes have been discontinued

10022, 11100, 11101, 20005, 27370, 33282, 33284, 43760, 50395, 64508, 64550, 66220
81211, 81213, 76001, 77058, 77059, 78270-78272, 92275, 95975, 95978, 95979, 96111, 96118, V5170, V5180 V5210, V5220, J9310, J0833, Q5102, C9275, C9497, C9741, K0903, Q4131, Q4172, C8904, C8907, C9744

Please contact HPSM Health Services at 650-616-2070 with questions.

Important Claims Submission Reminder -HPSM Contracted Transportation Providers

In 2016, Medi-Cal changed the way wheelchair and litter van transportation services are to be coded and billed. The new codes used for billing these services are:

- A0130-Non-emergency transportation: wheelchair van
- A0380-Basic Life Support per mile (used for wheelchair and litter van transports only)

Through claims processing, we have discovered that some of our transportation providers have been using CPT code A0425 (Ground mileage, per statute mile) instead of code A0380 (basic life support mileage). Recent configuration of our claims system has been updated to deny code A0425 with the message “another code is available”. If you have received denial notices for claims billed for transportation services, you may rebill or dispute the denied claim through our claims correction process, which can be found on our website at:

<https://www.hpsm.org/provider/claims/disputes-and-appeals>

Should you have questions regarding this notice, please contact our Claims Department at 833-694-7761.

Provider News & Updates....

Five (5) Urgent Care Centers Added to HPSM Network!

<https://www.hpsm.org/member/urgent-care/find-my-nearest-urgent-care-center>

Dignity Providers, Including GoHealth Urgent Care, Now in HPSM's Network

HPSM is excited to announce that Dignity Health – including Dignity GoHealth Urgent Care – joined the HPSM network in October of 2018. This expands access to hospital, specialty and primary care for HPSM Medi-Cal and Care Advantage members by adding:

Three Dignity GoHealth urgent care locations:

GoHealth Daly City

325 Gellert Blvd 650-270-2394

GoHealth San Bruno

1310 El Camino Real, Unit I/J 650-270-2395

GoHealth Redwood City 830 Jefferson Avenue 650-381-0616

These three clinics are open Monday to Friday 8:00 a.m. to 8:00 p.m., Saturday and Sunday 9:00a.m. – 5:00 p.m.

Covered plans: HPSM Medi-Cal, CareAdvantage

Three Dignity hospitals:

Sequoia Hospital

170 Alameda de las Pulgas Redwood City

Includes birth center, ED, Heart and Vascular Institute, Orthopedics & Health and Wellness Center

St. Francis Memorial Hospital

900 Hyde St, San Francisco Includes cancer care, ED, da Vinci Robotic Surgery, Orthopedic & Sports Medicine Institute

St. Mary's Medical Center

450 Stanyan St, San Francisco Includes cancer care, Total Joint Center, cardiology, spine center & rehab

Dignity Health Medical Group Sequoia- DHMG-Sequoia physicians serve San Mateo County with expertise in:

Primary care, Cardiology, Cardiovascular surgery, Neurology, Sports medicine, Orthopedic surgery

Provider News & Updates....

Pediatrics Urgent Care Now In HPSM Network

After Hour Pediatrics (AHP), a walk-in urgent care clinic for children and teens with **Medi-Cal** in the city of San Mateo, is also now part of HPSM's provider network. HPSM encourages pediatricians to tell the parents of their HPSM Medi-Cal patients that these new urgent care services are available for their children's care.

AHP is staffed by a team of clinicians that includes pediatricians, nurse practitioners and physician assistants with specialized training in pediatrics. Within one to two hours after an HPSM member's visit, the clinic faxes a visit summary to the member's PCP which includes lab results and follow-up suggestions.

After Hour Pediatrics (AHP)

Location: 210 Baldwin Avenue

(at South San Mateo Drive)

in the city of San Mateo

Hours: Monday - Friday 5:00 p.m. to 10:00 p.m., weekends & holidays 10:00 a.m. to 10:00 p.m.

Phone: 650-579-6581

Website: www.afterhourpeds.net

Walk-ins welcome – no appointments needed

Covered plans: HPSM Medi-Cal (members under 18)

Afterours Urgent Care

650-918-4027

[1098 Foster City Blvd. Suite 104 Foster City, CA 94404](https://www.1098foster.com)

afteroursinc.com

Monday through Friday, 12:00 p.m. to 8:00 p.m.

Saturday and Sunday, 9:00 a.m. to 5:00 p.m.

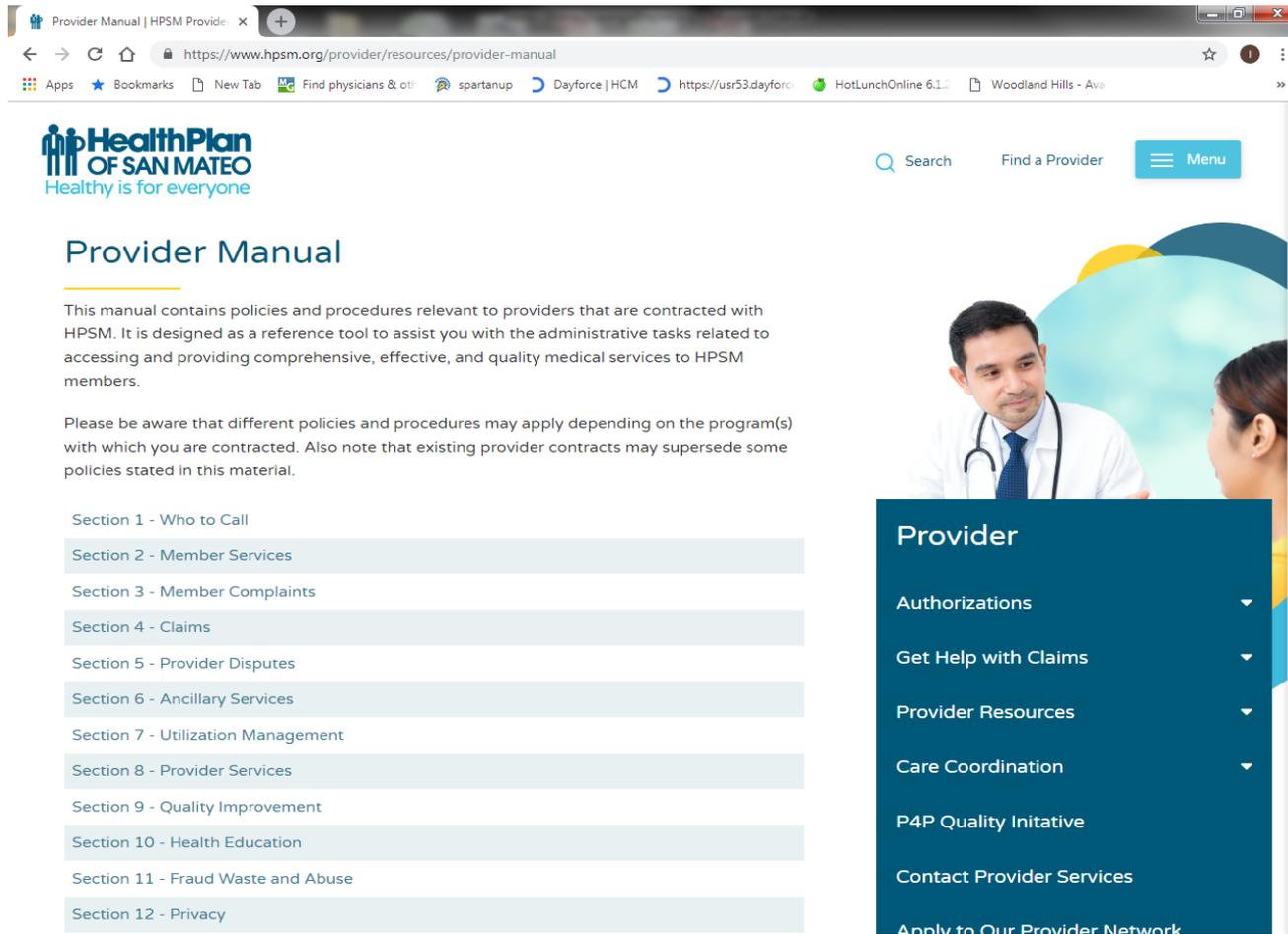
*Call to schedule an appt.

Covered plans: HPSM Medi-Cal, CareAdvantage, HealthWorx

Provider News & Updates....

Review HPSM policies and procedures referenced in the Provider Manual:

<https://www.hpsm.org/provider/resources/provider-manual>



The screenshot shows a web browser displaying the HPSM Provider Manual website. The browser's address bar shows the URL <https://www.hpsm.org/provider/resources/provider-manual>. The website header includes the HealthPlan OF SAN MATEO logo, a search bar, and a "Find a Provider" button. The main content area features the title "Provider Manual" and a brief introduction: "This manual contains policies and procedures relevant to providers that are contracted with HPSM. It is designed as a reference tool to assist you with the administrative tasks related to accessing and providing comprehensive, effective, and quality medical services to HPSM members." Below this, a paragraph states: "Please be aware that different policies and procedures may apply depending on the program(s) with which you are contracted. Also note that existing provider contracts may supersede some policies stated in this material." A table of contents lists 12 sections, with "Section 1 - Who to Call" highlighted. On the right side, a dark blue sidebar menu is open, showing a "Provider" dropdown menu with the following items: "Authorizations", "Get Help with Claims", "Provider Resources", "Care Coordination", "P4P Quality Initiative", and "Contact Provider Services".

Provider Manual | HPSM Provider

<https://www.hpsm.org/provider/resources/provider-manual>

Apps Bookmarks New Tab Find physicians & ot: spartanup Dayforce | HCM https://usr53.dayfor: HotLunchOnline 6.1 Woodland Hills - Ave

HealthPlan OF SAN MATEO Healthy is for everyone

Search Find a Provider Menu

Provider Manual

This manual contains policies and procedures relevant to providers that are contracted with HPSM. It is designed as a reference tool to assist you with the administrative tasks related to accessing and providing comprehensive, effective, and quality medical services to HPSM members.

Please be aware that different policies and procedures may apply depending on the program(s) with which you are contracted. Also note that existing provider contracts may supersede some policies stated in this material.

- Section 1 - Who to Call
- Section 2 - Member Services
- Section 3 - Member Complaints
- Section 4 - Claims
- Section 5 - Provider Disputes
- Section 6 - Ancillary Services
- Section 7 - Utilization Management
- Section 8 - Provider Services
- Section 9 - Quality Improvement
- Section 10 - Health Education
- Section 11 - Fraud Waste and Abuse
- Section 12 - Privacy

Provider

- Authorizations
- Get Help with Claims
- Provider Resources
- Care Coordination
- P4P Quality Initiative
- Contact Provider Services
- Apply to Our Provider Network

Hand Outs

Member Rights and Responsibilities

EFT/ERA Form

Provider Toolkit- Certified Languages International

Provider Quick Reference Guide

Member ID Card Examples

Seniors with Disabilities Training

Model of Care Training

Member Dis-enrollment Policy & Procedure / Form

Materials Available at www.hpsm.org

- Provider Manual
 - Provider Change/Selection & Established Patients Only (EPO) Forms
 - Claim Message Code List
 - Quick Reference Formulary Guide
 - HPSM Provider Directories
 - Clinical Guidelines
 - Referral Authorization Form (RAF)
 - Prior Authorization Form (PAR)
 - Provider Newsletters
 - Provider Updates/Notifications/Weekly Announcements
 - Prior Authorization Required Services List
- ✓ **New information is being added all the time. Visit often.**

Provider Services Staff

- Colleen Murphey, Network and Strategy Officer
- Kati Phillips, Provider Network Manager
- Monica Raj, Provider Contract Manager
- Luarnie Bermudo, Credentialing Manager
- Clarissa Rivera- Loo, Network Liaison
- Paul Dela Cruz, Credentialing Specialist
- Molly Carter, Program Specialist
- Manila Shrestha, Provider Data Steward
- Julian Aldana, Provider Communications Specialist

Important Numbers

- HPSM Member Services:
 - Medi-Cal, ACE and HealthWorx (650) 616-2133 or (800) 750-4776
 - CareAdvantage (650) 616-2174 or (866) 880-0606
- Authorizations: (650) 616-2070
- Claims & Billing: (650) 616-2056 or 1-833-MY-HPSM-1 (1-833-694-7761) or claimsinquiries@hpsm.org
- Provider Services: (650) 616-2106 or 1-833-MY-HPSM-1 (1-833-694-7761) or psinquiries@hpsm.org
- HPSM Nurse Advice Line: 1-833-846-8773 (1-833-84-NURSE)
- California Children's Services: (650) 616-2500
- Certified Languages International at (800) 225-5254, Access Code 64095
- Argus - Pharmacy Benefit Manager (888) 635-8362
- Emdeon (WebMD) (877) 469-3263
HPSM Payer ID: **SX174**
- Office Ally- FREE Electronic Claim Submission (866) 575-4120 or visit www.officeally.com
HPSM Payer ID: **HPSM1**