HealthPlan OF SAN MATEO
Healthy is for everyone

Provider Manual

Section 1

Who to Call

Introduction

The Health Plan of San Mateo (HPSM) provides health services to more than 100,000 residents of San Mateo County. All HPSM programs are designed to emphasize easy access to quality care for our members.

This Provider Manual contains policies and procedures relevant to providers that are contracted with HPSM. Please be aware that different policies and procedures may apply depending on the program(s) with which you are contracted.

The purpose of this manual is to familiarize participating providers and their staff with HPSM operations. 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. HPSM reserves the right to revise these policies and procedures at our sole discretion and at any time.

If you have any questions regarding the information contained within, please call your Provider Services Representative (see listing at the end of this section labeled "Who to Call Reference List").

Keeping Members Healthy

At HPSM, our primary concern is keeping our members healthy. Once a member chooses his or her Primary Care Physician (PCP) from our network, this highly skilled medical professional will provide the highest quality medical care, maintain medical records, and, when necessary, refer members to specialists.

Quality Improvement

HPSM is committed to excellence. HPSM's Quality Improvement team carries out the Plan's mission to constantly improve our healthcare delivery system and to measure our member's healthcare outcomes. Using the PDSA (Plan, Do, Study, Act) rapid cycle model for quality improvement, HPSM has implemented many innovative quality improvement projects, supporting our providers in delivering the highest quality care in the most cost-efficient, culturally sensitive and expedient manner.

HPSM Website

Providers may access a variety of plan information when visiting the HPSM web site; www.hpsm.org. The site offers information on HPSM programs, up-to-date participating provider information, (including a provider directory, Member Handbook/Evidence of Coverage for each line of business, eligibility verification, clinical guidelines, preventive health guidelines, disease management programs, results of satisfaction surveys, authorization and referral forms, the latest HPSM news as well as an electronic version of this provider manual), health tips, plan history, and organizational philosophy. HPSM maximizes the use of technology to assist our providers to better serve our members.

Provider Manual Updates

This manual will be updated regularly as policies, programs and procedures change. Updates and supplements will be distributed as they occur and will be available as downloadable documents from our website for your convenience.

Please be sure to replace the existing pages in the manual upon receipt of any updates. This will assure that the manual you have available is the most current.

Our Programs

The following section briefly describes HPSM's five lines of business. These include: Medi-Cal, Healthy Kids, HealthWorx, ACE and CareAdvantage.

Please remember that it is the **provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to member's eligibility on the date of service. Please see the Provider Manual Section 2 – Member Services for information on how to verify member eligibility.

 Medi-Cal

HPSM was originally created and began operations in 1987 to serve San Mateo County Medi-Cal beneficiaries in a managed care environment. HPSM is a County Organized Health System (COHS). California legislation and waivers to Federal Medicaid laws allow HPSM to be

the exclusive insurer of health care services for nearly all Medi-Cal beneficiaries in San Mateo County. This includes seniors and persons with disabilities.

Medi-Cal members must present their HPSM member identification card to access all covered services. The State of California also issues Medi-Cal beneficiaries an ID card (BIC Card). It is always best to ask to see the member's HPSM ID card since the identification numbers may differ. Medi-Cal members cannot be balance billed.

CareAdvantage

In January 2006, HPSM began a Medicare Advantage (MA)/Prescription Drug Plan (PD). Members must have both Medicare Part A (hospital insurance) and Part B (medical insurance) and full-scope Medi-Cal through HPSM and must live in San Mateo County. HPSM offers one CareAdvantage program: HPSM CareAdvantage Cal MediConnect Plan (Medicare-Medicaid Plan).

Some dual eligible members may elect to remain in Original (fee for service) Medicare and enroll in a Prescription Drug Plan (PDP); others may join another Medicare Advantage Plan. In both cases, the member will retain his/her Medi-Cal eligibility with HPSM but will not be members of CareAdvantage.

CareAdvantage members are only responsible for a prescription drug co-payment per prescription which conforms to Medicare guidelines. CareAdvantage members cannot be balance billed.

Healthy Kids (HMO)

The Healthy Kids program was developed by a coalition of community based organizations (CBO), local and State politicians, businesses, healthcare organizations and philanthropic leaders in San Mateo County, who all shared a common vision of universal access to health insurance coverage for all of San Mateo County's children. In August 2002, the San Mateo County Board of Supervisors established the Children's Health Initiative (CHI) Coalition as the decision-making body for a project to provide universal healthcare to children in San Mateo County. The County Health System was designated as the lead agency of the coalition that includes representatives from the San Mateo Hospital Consortium, First 5 San Mateo, San Mateo Labor Council, the Peninsula Community Foundation, the San Mateo County Health System, San Mateo County Human Services Agency, and HPSM.

Healthy Kids provides medical and dental services to San Mateo resident children from birth through age eighteen. Children enrolled in Healthy Kids are not eligible for full-scope Medi-Cal and their families' household income is up to 400% of the Federal Poverty Level (FPL).

Some Healthy Kids members have co-payments.

HealthWorx (HMO)

HealthWorx provides low cost health benefits for San Mateo County Public Authority In-Home Supportive Services (IHSS) Workers, San Mateo County Extra Help employees and City of San Mateo part-time employees. Eligibility for HealthWorx is determined by the employing entity.

The In-Home Supportive Services program provides domestic and personal care assistance to eligible aged or disabled persons who are at risk for institutionalization.

HealthWorx is also offered to San Mateo County Extra Help Employees. Eligibility for this program is determined by the San Mateo County Employee Benefits Division. HealthWorx for City of San Mateo part-time employees is determined by the City of San Mateo.

HealthWorx members have co-payments.

San Mateo County ACE Program

San Mateo County ACE is a program available to uninsured residents of San Mateo County who are not eligible for coverage through Medicare, Medi-Cal, private insurance or other third-party coverage. **ACE is a coverage program and is not considered health insurance**. Enrollment in the ACE program is processed through the San Mateo County Coverage Unit. Strict income and asset levels apply. For a complete list of clinics that provide services to ACE members, please refer to the San Mateo County ACE Participant Handbook on our website www.hpsm.org.

Referral to other providers is only through an authorized referral process.

Comments and Suggestions

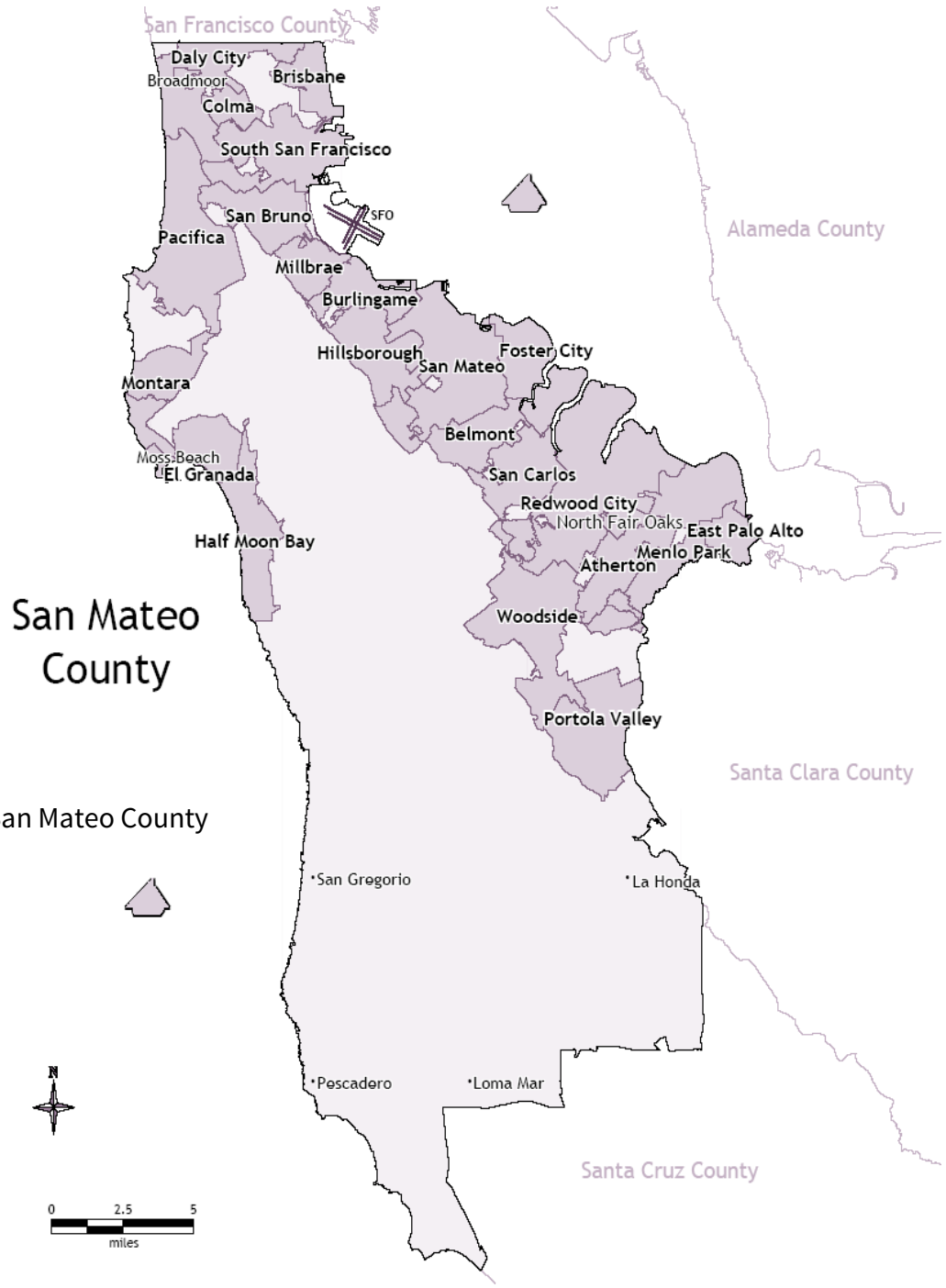
We welcome your feedback regarding this manual and hope that you will offer any suggestions on how we can improve either subject matter or layout. HPSM's goal is to make this manual as helpful and easy to use as possible. Please call the Provider Services Department at **650-616-2106** if you have suggestions or comments.

Please note that existing provider contracts may supersede some policies stated in this material.

Service Area

HPSM's service area covers the entire County of San Mateo, including the following communities:

Daly City
Brisbane
Colma
South San Francisco
San Bruno
Pacifica
Millbrae
Burlingame
Montara
El Granada
Half Moon Bay
Hillsborough
San Mateo
Foster City
Belmont
San Carlos
Redwood City
East Palo Alto
Menlo Park
Atherton
Woodside
Portola Valley
Unincorporated Areas of San Mateo County



Who to Call

Eligibility

Providers are encouraged to use these resources to verify member eligibility.

- **For all HPSM Programs**

  eHEALTHsuite (Eligibility, Claims, Claims status) **650-616-2106**
  www.hpsm.org

  24-Hour Automated Telephone Eligibility Verification (ATEV) **1-800-696-4776**

- **For Medi-Cal Program**

  24-Hour State Automated Eligibility Verification System **1-800-456-2387**
  Medi-Cal website www.medi-cal.ca.gov

Provider Services **650-616-2106**

- Capitation Questions
- Fee Schedule
- Contracts and Contract Terms
- Credentialing and Re-credentialing
- Member Eligibility
- Participation Request
- Participation Status
- Access and Availability
- Provider Survey

Claims **650-616-2056**

- Claim Submission
- Claim Status
- Claim Payment Inquiries

Provider Dispute Resolution **650-616-2836**

Quality Department **650-616-2166**

- Provider Site and Medical Record Review
- Peer Review
- Quality Improvement Projects/Data Collection (HEDIS)

Health Services **650-616-2070**

- Prior Authorization Requests (PAR) for Medical Services
  - Inpatient Authorizations
  - Out-of-Area Authorizations
  - Outpatient Services
  - Durable Medical Equipment
- Utilization Management
- Pharmacy Review
- Referral Authorizations (RAF) for Specialist Referrals
- Care Coordination Program
- Chronic Disease Management Program
- Clinical Practice Guidelines
- Preventive Care Management Program

Pharmacy Services & Prior Authorizations **650-616-2088**

Pharmacy Benefit Manager: **1-800-522-7487**

Argus Customer Service and Help Desk: 24 hours per day/7 days per week.

Health Promotions/Cultural & Linguistic Services **650-616-2165**

- Interpreter Services
- Health Education Brochures
- Health Education Classes
- Well Woman Program (Breast and Cervical Cancer screening)
- Prenatal Program

Grievance & Appeals (Member Complaints) **650-616-2850**

1-888-576-7227

Member Services

Medi-Cal, Healthy Kids, HealthWorx, ACE **650-616-2133**

- Benefits **1-800-750-4776**
- PCP Selection/Change
- Health Insurance Premium Payment (HIPP) Program
- Healthy Kids Enrollment/Disenrollment

CareAdvantage Unit **650-616-2174**

- Benefits **1-866-880-0606**
- PCP Selection/Change
- Enrollment/Disenrollment

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Section 2

Member Services

Introduction

The Health Plan of San Mateo provides customer service to its members through the following departments:

The HPSM Member Services Department assists members that are on the Medi-Cal, Healthy Kids, HealthWorx or San Mateo County ACE programs. Member Services Representatives can help members with questions about their HPSM coverage, assign a PCP and provide assistance in resolving problems related to healthcare services.

- The Member Services Department can be reached at **1-800-750-4776** or **650-616-2133,** Monday through Thursday from 8:00 a.m. to 6:00 p.m. and Friday from 9:30 a.m. to 6:00 p.m. Hearing impaired members can use the California Relay Service (CRS) at **1-800-735-2929** (TTY) or dial **7-1-1**.
- Office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.
- Member Services Representatives speak Spanish, Tagalog, Mandarin, and Cantonese and can access telephone interpreters to assist members with other language needs.

The HPSM CareAdvantage Unit assists members who are enrolled in CareAdvantage Cal MediConnect (Medicare-Medicaid Plan). CareAdvantage CMC is HPSM's Medicare Advantage/Prescription Drug Plan. CareAdvantage Navigators can help members with questions about their CareAdvantage CMC coverage and provide assistance in resolving problems related to healthcare services.

- The CareAdvantage Navigators can be reached at **1-866-880-0606** or **650-616-2174**, Monday through Sunday from 8:00 a.m. to 8:00 p.m. Hearing impaired members can use the California Relay Service (CRS) at 1**-800-735-2929** (TTY) or dial **7-1-1**.
- Office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.
- CareAdvantage Navigators speak Spanish, Tagalog, Mandarin, Cantonese and Russian and can access telephone interpreters to assist members with other language needs.

HPSM mails each new HPSM member a welcome packet which includes the Member Handbook for their program. The handbooks explain:

- How to choose a PCP or change his/her PCP
- How to receive care
- Program benefits
- What to do if a member has a question or a problem

The most recent handbook for each of the programs can be downloaded from the HPSM website at www.hpsm.org. There are links to the handbooks under the "Members" section of HPSM's website. The Provider Services staff can also give you a hard copy of the member handbooks.

Member Rights and Responsibilities

Each program's handbook includes a section on Members Rights and Responsibilities. These Member Rights and Responsibilities are established and enforced by California State Law, HPSM Policies and Procedures, and in provider contracts between you and HPSM. Some of the key Member Rights and Responsibilities are:

HPSM have these rights:

1. To be treated with respect and recognition of your dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
2. To be provided with information about the plan, its services, practitioners and providers, including Covered Services, and members' rights and responsibilities.
3. To be able to choose a primary care provider within the Contractor's network.
4. To participate in decision making with their providers about their own health care, including the right to refuse treatment.
5. To voice complaints, either verbally or in writing, about the organization or the care received.
6. To receive care coordination.
7. To request an appeal of decisions to deny, defer, or limit services or benefits.
8. To receive oral interpretation services for their language.
9. To receive free legal help at your local legal aid office or other groups.
10. To formulate advance directives.
11. To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
12. To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
13. To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record.
14. To access Minor Consent Services.

15. To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).
16. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
17. To receive information on available treatment options and alternatives, regardless of cost or benefit coverage, presented in a manner appropriate to your condition and ability to understand.
18. To receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
19. Freedom to exercise these rights without adversely affecting how you are treated by the Contractor, providers or the State.
20. To make recommendations about HPSM's member rights and responsibilities.

HPSM members have these responsibilities:

1. Carefully read all HPSM Member materials so you understand how to use your benefits and what procedures to follow when you need care.
2. Do your best to keep appointments; if you need to cancel or reschedule an Appointment, call your provider or clinic 24 hours in advance or as soon as possible.
3. Show your HPSM ID card or remember to tell your Provider (for example your doctor, hospital or pharmacy) you are an HPSM Member before receiving care.
4. Follow the treatment plan you and your provider have agreed upon.
5. Provide accurate and complete information about your health care needs to HPSM and to your provider. Let your provider know if you have a medical condition.
6. As best as you can, understand your health care needs and participate in developing treatment plans and goals with your providers.
7. Follow the plans and instructions for care that you have agreed upon with your provider. Ask your provider questions if you do not understand something or aren't sure about the advice you are given.
8. See the Specialists to whom your Primary Care Provider (PCP) refers you.
9. Actively participate in health care programs that keep you well.
10. Work with your provider to build and maintain a good working relationship.
11. Use the emergency room only in cases of an emergency or as directed by your provider.
12. Follow-up with your Primary Care Provider (PCP) after getting care at an emergency facility.
13. Report lost or stolen ID cards to the Health Plan of San Mateo's Member Services Department and do not let anyone else use your card.

14. Call HPSM Member Services if you do not understand how to use your benefits or have any problems with the services provided.
15. Tell HPSM if you move or change your phone number. Call HPSM Member Services and the San Mateo County Human Services Agency. If you receive SSI, call Social Security Administration. We all need to have your correct address and phone number.
16. Follow the HPSM Grievance procedure if you want to file a complaint.
17. Treat all HPSM staff and health care providers respectfully and courteously.

Missed Appointments by Members

The Member Handbook reminds members that if they cannot keep an appointment, they need to call their provider to cancel or reschedule the appointment as soon. A provider's office can send HPSM Provider Services information about members that have missed multiple appointments. HPSM staff will contact the member and remind the member about the importance of following his/her doctor's advice and calling to cancel appointments in advance.

Member's Right to Select a Provider

Primary Care Physician (PCP)

An HPSM member's care is managed by the PCP that the member has selected. A PCP may be a pediatrician, a general practitioner, a family practitioner, an internist, a Federally Qualified Health Care Clinic (FQHC), a Native American health service provider, a nurse practitioner, or in some cases, an OB/GYN provider.

The name and telephone number of each member's PCP is printed on the member's HPSM Identification (ID) Card.

Women's Services – OB/GYN Services

Female HPSM members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by the PCP or members may self-refer to any contracted OB/GYN or PCP within the HPSM network for OB/GYN services.

Pregnancy Care

The Health Plan of San Mateo encourages pregnant women to get early prenatal care. Members may select an Obstetrician or Certified Nurse Midwife for care during pregnancy. Members have the right

to select Certified Nurse Midwife services from an out-of-plan Medi-Cal Provider if they are not available through HPSM.

Indian Health Services

American Indians or Alaskan Natives who are HPSM members may choose any available Indian Health Service Provider available, as provided under Federal Law. The provider does not have to be an HPSM network provider and HPSM will make arrangements to coordinate appropriate services for these members.

Programs and Enrollment Information

The following programs are offered by the Health Plan of San Mateo. You may receive inquiries from existing or new patients asking how they can join the various programs offered by the Health Plan of San Mateo.

Medi-Cal

Medi-Cal is a government program administered through the State of California Department of Health Care Services. Eligibility is determined by the San Mateo County Human Services Agency or through Supplemental Security Income (SSI) administered by Social Security Administration (SSA). Eligibility guidelines and enrollment information is available at the Human Services Agency website at https://hsa.smcgov.org/ or prospective members can call the San Mateo County Human Services Agency at **1-800-223-8383** to find out if they are eligible to receive Medi-Cal health benefits.

Medi-Cal eligible beneficiaries with qualifying Medi-Cal aid codes are **automatically enrolled** in HPSM. Each member receives an HPSM ID card in addition to the Benefits Identification Card (BIC) issued by the State. Sample ID cards are included later in this section.

Types of Medi-Cal Members

- **PCP-assigned Members**
  These are members that are assigned to a Primary Care Provider (PCP) and appear on the PCP's case management list.

- **Special Members**
  Special members are not assigned a PCP and do not require referrals to see contracted, in-network specialists.

- **Share-of-Cost Members**
  Some Medi-Cal recipients must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This amount is called Share-of-Cost (SOC). A Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible. Share-of-Cost members are not assigned to a PCP.

  Medi-Cal recipients with an SOC are not eligible for full-scope Medi-Cal until he/she has met his/her SOC amount for the month. Members with a Medi-Cal SOC appear in suspense status in the HPSM Provider Portal. After a recipient meets the SOC for the month, HPSM will pay for covered medical expenses for the rest of the month. More information about the Medi-Cal SOC, including how a provider should collect and clear a share of cost, can be found on the Medi-Cal website at http://files.medi-cal.ca.gov/

California Children's Services (CCS)

California Children's Services (CCS) is a partnership between San Mateo County CCS and the Health Plan of San Mateo (HPSM). CCS coordinates care between specialists and primary care doctors and coordinates referrals and authorizations between CCS and HPSM.

A dedicated case manager oversees a child's total care. This includes coordinating social and mental health services for caregivers, in addition to a child's medical services.

For more information about the CCS and to make a referral, contact California Children's Services (CCS) at **650-616-2500**.

Healthy Kids

Healthy Kids is a San Mateo County based low cost insurance for children up to their 19th birthday. Uninsured children who are not eligible for coverage through Medi-Cal and fall within certain income guidelines may be eligible to enroll in the Healthy Kids program. Enrollment information can be found on the Health Coverage Unit website at http://smchealth.
https://www.smchealth.org/smchealthcoverage or prospective members may call the San Mateo County Health Coverage Unit at **650-616-2002** for more information.

CareAdvantage Cal MediConnect

CareAdvantage Cal MediConnect Plan (Medicare-Medicaid Plan) is a Medicare Advantage/Prescription Drug Plan for people who have both Medicare and Medi-Cal. Members must have Medicare Part A (hospital insurance) and Part B (medical insurance), full-scope Medi-Cal through HPSM and must live in San Mateo County.

Members that want to join CareAdvantage CMC should call a licensed CareAdvantage Sales Representative at **1-888-252-3153** or **650-616-1500**.

Enrollment in CareAdvantage CMC is optional. Some dual eligible members may elect to remain in Original (fee for service) Medicare and enroll in a Part D Prescription Drug Plan (PDP) or join another Medicare Advantage Plan. The member will retain his/her HPSM Medi-Cal eligibility but **will not** be a member of CareAdvantage CMC.

Anyone with questions about Medicare can also call the local Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**.

HealthWorx

San Mateo County Public Authority In-Home Support Services (IHSS) workers and City of San Mateo Per Diem employees are eligible for HealthWorx.

- IHSS Workers should call the San Mateo County Public Authority at **650-573-3733**.
- City of San Mateo part-time employees should call SEIU at **650-801-3501** (English); **650-801-3502** (Spanish) or **650-801-3503** (Chinese).

San Mateo County ACE Program

The San Mateo County ACE (Access and Care for Everyone) Program is a county-sponsored program that provides health care coverage to low-income adult residents of San Mateo County who meet eligibility requirements but **do not qualify** for Medi-Cal. HPSM administers the San Mateo ACE Program under a contract with San Mateo County. Prospective enrollees can call the Health Coverage Unit at **650-616-2002** for more information.

San Mateo County ACE is not insurance. The San Mateo County ACE Program covers a wide range of health care and pharmacy benefits under a coordinated system of care, but it is not an insurance product subject to state insurance requirements. It is a payer of last resort, which means it pays only

for certain services that are not covered by other existing coverage programs. Services are primary provided through the San Mateo Medical Center (SMMC) and the Ravenswood Family Health Center. ACE participants may be referred for specialty services to non-County providers but prior authorization is required.

ACE enrollees can only receive emergency services at SMMC.

Identifying HPSM Members

Health Plan of San Mateo (HPSM) members may be enrolled in one of HPSM programs. These programs are Medi-Cal, Healthy Kids, HealthWorx, San Mateo County ACE and CareAdvantage CMC. The majority of HPSM members are in the Medi-Cal program. All HPSM members are given HPSM Identification (ID) cards showing the program they are enrolled in and their assigned PCP. Examples of HPSM ID cards can be found later in this section.

PCP Case Management List

Case Management lists are distributed monthly to Primary Care Physicians. The list includes all members assigned to the PCP and information such as assigned member name, HPSM ID number, preferred language, date assigned to the PCP, and prior PCP if applicable.

Member Eligibility

It is important that providers verify HPSM member eligibility at the time of each visit. A member's eligibility can change at any time for any number of reasons, including a change in Medi-Cal status, change in residence address.

How to Check Eligibility

Monthly Primary Care Physician (PCP) Case Management List

PCPs should check for the member's name on the list sent at the beginning of each month. It is available in hard copy format or via encrypted email. . This listing will also let you know if any members have been added or removed from your practice, along with an effective date or termination date.

Provider Portal

www.hpsm.org/provider/portal

The website allows for both electronic billing and member eligibility information (including PCP Assignment) for dates of service within the prior six (6) months. To obtain a provider login and password, please contact the HPSM Provider Services Department at **650-616-2106**.

HPSM's ATEV/IVR

Eligibility information is also available by telephone, using the HPSM's 24-hour Automated Telephone Eligibility Verification/Interactive Voice Recognition (ATEV/IVR) system. To verify eligibility and PCP assignment for dates of service within the prior six (6) months, please call **1-800-696-4776**. Please have the member's ID number available. When a member is not assigned a PCP, the eligibility recording will state "Special Member." Since member status can change from month to month, it is important to verify a member's status for the month that the service was rendered.

Medi-Cal's 24-Hour State Automated Eligibility Verification System

Medi-Cal members only; please call **1-800-456-2387**.

Medi-Cal's Website

Medi-Cal and Medicare/Medi-Cal members only.

Eligibility information is available on the State of California's Medi-Cal website, https://www.medi-cal.ca.gov/Eligibility/Login.asp. For assistance in obtaining a login and password for the State of California Medi-Cal website, please call the POS Help Desk at **1-800-427-1295** for more information.

Point of Service (POS) Device

Medi-Cal members only.

Swiping the patient's Medi-Cal Beneficiary Identification Card (BIC) in the State's POS device will also enable you to determine eligibility. The POS device provides eligibility as well as Share-of-Cost liability information for dates of service within the prior twelve (12) months. To learn more about using POS devices, please call the State POS Help Desk at **1-800-427-1295**.

Please remember that verification of active enrollment is subject to retroactive adjustment in accordance with the terms and conditions of coverage described in the member's benefit plan.

Specialist providers, hospitals, and other service providers should also verify eligibility on the date that the service is rendered. A referral or authorization does not guarantee that the member is eligible on the date of service.

Identification Cards and Co-Payments

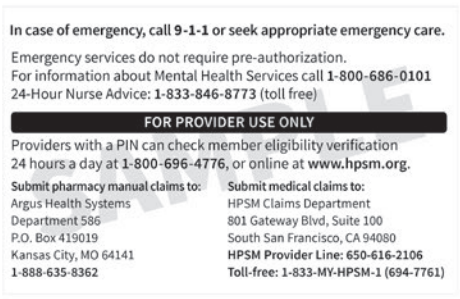
Each HPSM member is issued an identification card which gives specific information about the member. This information includes:

- Program name
- Member's name
- Member's date of birth
- Member's HSPM ID number (Effective date of the most current member information)
- Member's Primary Care Physician (PCP)
- PCP assignment date
- PCP's office phone number

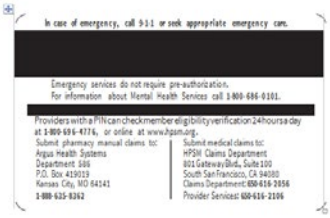
ID Cards by Line of Business

Medi-Cal

- **New Medi-Cal ID card**

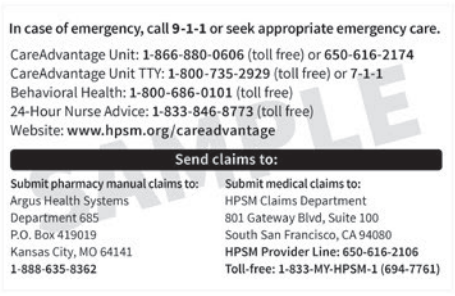


- **Old Medi-Cal ID card**



CareAdvantage

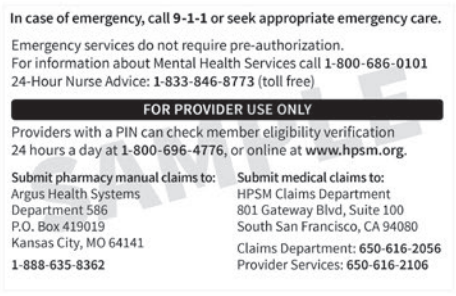
- **New CareAdvantage CMC ID card**



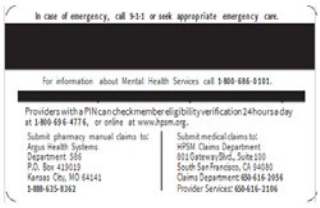
- **Old CareAdvantage CMC ID card**

Healthy Kids

- **New Healthy Kids ID card**

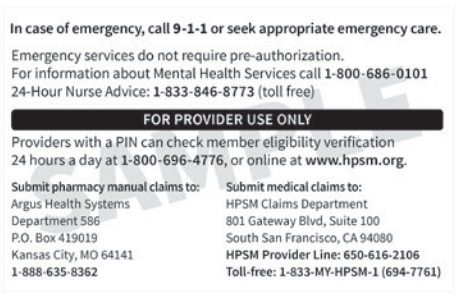


- **Old Healthy Kids ID card**

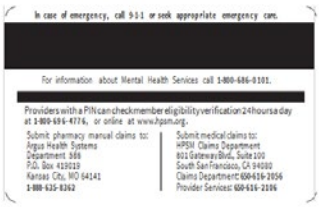


HealthWorx

- **New HealthWorx ID card**



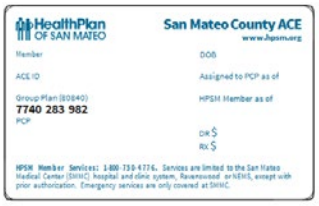
- **Old HealthWorx ID card**

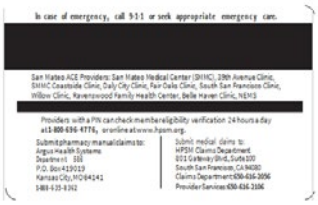


San Mateo County ACE

- **New San Mateo County ACE ID card**

- **Old San Mateo County ACE ID card**





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Provider Manual

Section 3

Member Complaints

Introduction

This section describes the procedures that members and their authorized representatives may use to submit complaints to HPSM. The Centers for Medicare and Medicaid Services (CMS) and the State of California have regulations that give health care consumers the right to file a complaint whether the consumer is covered by Medicare, Medi-Cal or a private insurance plan.

The Health Plan of San Mateo (HPSM) must follow these federal and state regulations in processing HPSM member complaints. HPSM handles complaints for members in all lines of business: CareAdvantage Cal MediConnect, Medi-Cal, Healthy Kids, HealthWorx and San Mateo County ACE.

Information about the complaints process is included in the Provider Manual because providers may file complaints on behalf of members, or offer assistance to members in filing a complaint. HPSM may also ask providers for assistance in resolving member complaints through requests for additional medical information or the provider's perspective on a complaint.

Members have different appeal rights depending upon the line of business in which the member is enrolled. These differences are described in the sections that follow. HPSM members may be dually eligible for both Medicare and Medi-Cal, but not be enrolled in CareAdvantage Cal MediConnect, HPSM's Medicare line of business. If dually eligible members are covered under Original Medicare, the CareAdvantage procedures described in this section will not apply.

Overview of Member Complaints

Members have the right to submit complaints to HPSM. A complaint is any **verbal or written expression of dissatisfaction** with any HPSM-covered service a member receives. A complaint may also be about reimbursement for a bill that a Member has paid. A complaint can be a grievance or an appeal.

Grievance : a complaint expressing dissatisfaction with any aspect of HPSM's or a provider's operations, activities, or behaviors, including quality of care concerns, regardless of whether any remedial action is requested or can be taken. Examples of grievances include member concerns about:

- Quality of the care that was provided
- Customer service that was perceived as rude or unhelpful
- Difficulty accessing care and/or the timeliness of care

- Billing-related issues such as receipt of a balance bill or collections notice
- Other issues, such as HIPAA violations or potential instances of fraud

Appeal: a complaint about HPSM's denial of coverage or reimbursement. In an appeal, a member or provider requests HPSM to reconsider its decision regarding services that were denied, limited, or taken away, such as:

- A denied request for services (i.e. prior authorization)
- A denied request for payment to a provider (i.e. claim)
- A denied request for reimbursement to a member

Timeframes in the Complaint Process

The following are the timeframes that must be followed when processing a grievance and/or an appeal. Timeframes for filing a grievance or appeal vary by line of business and are regulated by CMS and the State.

Timeframes for CareAdvantage Cal MediConnect

Timeframe for filing

Part C Appeal: 90 days	From denial notification
Part D Appeal: 90 days	From denial notification
Grievance: 180 days	From occurrence

Timeframe for processing

Type	Appeals Processing	Grievance Processing
Part C – Standard	30 calendar days	30 calendar days
Part C – Expedited	72 hours	24 hours
Part D – Standard	7 calendar days	30 calendar days
Part D – Expedited	72 hours	24 hours

Timeframes for Medi-Cal

Timeframe for filing

Appeal: 60 days	From denial notification
Grievance: No time limit	N/a

Timeframe for processing

Type	Appeals Processing	Grievance Processing
Standard	30 calendar days	30 calendar days
Expedited	72 hours	72 hours

Timeframes Healthy Kids, HealthWorx and ACE

Timeframe for filing

Appeal: 90 days	From denial notification
Grievance: 180 days	From occurrence

Timeframe for processing

Type	Appeals Processing	Grievance Processing
Standard	30 calendar days	30 calendar days
Expedited	72 hours	72 hours

Member Grievances

Members may submit a grievance to HPSM if they are dissatisfied with any aspect of HPSM's or a provider's operations, activities, or behaviors. Please note that the grievance procedures for members receiving Medicare benefits under HPSM CareAdvantage differ slightly from procedures for Members receiving benefits under HPSM's other lines of business. These differences are clearly indicated throughout this section.

Filing a Grievance

Member Grievances can be submitted through the following routes:

- **In-person** by visiting HPSM

  Call Member Services: **650-616-2133**
  CareAdvantage Unit: **650-616-2174**
- **Fax: 650-829-2002**
- **Mail:** Health Plan of San Mateo
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Timing

CareAdvantage Cal MediConnect members must file grievances within *180 calendar days* of the incident or action with which the member is dissatisfied.

Medi-Cal members may file a grievance at any time regarding services they received while covered under Medi-Cal.

How to Submit a Grievance

If filing a grievance in writing, Members may submit a grievance online at HPSM's website, www.hpsm.org. Members may also fill out a Grievance Form, found on HPSM's website, or write a letter or other statement stating the reason for their dissatisfaction.

Member Grievances may be received by HPSM's Member Services Department, the CareAdvantage Unit, Care Coordination Unit, or Grievance and Appeals Unit. If a complaint is received by Member Services or CareAdvantage Unit, staff will make every effort to resolve the complaint within 24 hours.

If the complaint cannot be resolved in *24 hours*, the complaint will be forwarded to Grievance and Appeals for further processing.

Cancelling/Withdrawing a Grievance

Members or their authorized representatives may cancel their grievance at any time by contacting HPSM's Grievance and Appeals Unit.

Processing and Resolving Standard Grievances

Once a grievance is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter to the member within 5 calendar days. He or she will investigate the grievance, which may include notifying the member's provider, if applicable.

Provider Response and Timing

A critical part of resolving a member complaint involves getting a provider's perspective about the situation under review. **Requests for a provider's perspective are not an accusation of wrong-doing.** HPSM understands that many complaints arise because of a difference in perception or misunderstanding about a situation. We want to get your honest opinion about what transpired.

In order to meet the strict timeframes for processing a complaint, **providers must submit their response within 5 days from the date the Grievance and Appeals Coordinator sends the request to the provider.**

Making a Decision on a Grievance

For standard complaints, the Grievance and Appeals Coordinator will issue a resolution letter within 30 days of receipt of the grievance. The resolution letter will be the result of the research and review conducted by the Grievance and Appeals Coordinator. The resolution letter will be mailed to the member or the member's representative. If the grievance involves a provider, a copy of the resolution letter will also be sent to the provider.

If a grievance is related to quality of care concerns, HPSM will request medical records and a written response from all relevant providers. These medical records and responses will be reviewed by HPSM's Quality Improvement Nurse and by an HPSM Medical Director. Providers will be informed in writing of any concerns or deficiencies found by HPSM's Quality Department. For questions regarding the quality of care review process, please contact the Quality Department at **650-616-2170**.

Non-Retaliation Policy for Filing a Grievance

Members have the right to file a complaint about HPSM or the care that they receive from a provider without the complaint adversely affecting how the member is treated by HPSM and/or the member's providers. **Retaliation against Members for filing a complaint is strictly prohibited.**

HPSM does not discriminate against or disenroll members for filing complaints.

Examples of prohibited retaliation by providers include:

- Terminating or threatening to terminate a member from your practice after the member has filed a complaint
- Refusing to provide treatment or needed prescription refills to a member because of a complaint filed
- Treating the member in a disrespectful, hostile, or otherwise negative manner in response to the member filing a complaint

Grievances to the Department of Managed Health Care

Members in Medi-Cal, Healthy Kids and HealthWorx may submit grievances to the Department of Managed Health Care (DMHC) under the following conditions:

- They disagree with the decision made by HPSM
- HPSM has not resolved their grievance within the 30-day time frame

Submitting Grievances to DMHC

Members can call DMHC at **1-888-466-2219** or complete an Independent Medical Review/Complaint Form online, which can be accessed at http://www.dmhc.ca.gov/FileaComplaint.aspx.

HPSM will abide by the decision made by the DMHC and will work to complete the actions recommended by the DMHC as quickly as possible.

Mediation

Prior to filing a grievance with the Department of Managed Health Care, a Member may request voluntary mediation with HPSM. A Member does not have to participate in voluntary mediation for longer than thirty (30) days before being able to submit a grievance to the Department of Managed Health Care. Expenses for mediation are paid for equally by HPSM and the member.

Expedited Grievances

Medi-Cal, Healthy Kids, HealthWorx and ACE Participants

If processing a grievance under the standard 30-day timeframe would have an adverse impact on a member's life, health, or ability to regain maximum function, a member or provider can request that a grievance be processed under an expedited, *72-hour timeframe*. If a Member requests expedited grievance processing, HPSM clinical staff will determine whether the request meets the criteria for expedited processing. If the request does not meet the criteria for expedited processing, an HPSM Grievance and Appeals Coordinator will notify the member of this decision verbally, by phone, and in writing. If this request is made by a member's physician or other provider, HPSM will process the grievance under the expedited timeframe.

CareAdvantage Cal MediConnect Members

CareAdvantage members have the option of requesting an expedited grievance under limited circumstances. Unlike the other lines of business, the decision to expedite processing of a CareAdvantage grievance is not based on clinical criteria. The circumstances in which an expedited grievance may be filed by or for a CareAdvantage member are:

- HPSM refused to expedite an authorization request.
- HPSM extended the time frame to process an authorization request.
- HPSM refused to expedite an appeal.
- HPSM extended the time frame to process an appeal.

In these cases, CareAdvantage members may ask to speak to the Grievance and Appeals Coordinator immediately. The Grievance and Appeals Coordinator will consult with appropriate HPSM staff and respond to the grievance within **24 hours** of HPSM's receipt of the original grievance.

Appeals of Denied Services/ Authorization Requests

Any member who is dissatisfied that HPSM has denied services may request an appeal of this decision. As an HPSM contracted provider, you may file an appeal on behalf of a HPSM member, but you cannot charge the member for filing an appeal on their behalf. An authorized representative of the member may also file an appeal.

Provider Payment Appeals

For providers disputing payment, please refer to the Provider Dispute Resolution Process described in Section 5 of this manual.

Pharmacy Appeals

For appeals of drugs covered under the pharmacy benefit, please refer to the section on pharmacy appeals on page 15.

Authorization Appeals

You may ask HPSM to reconsider a denial of an authorization request for services if you or your patient disagrees with HPSM's decision to deny the request. You may also be called upon to assist a member or authorized representative if he/she requests an appeal, or to forward relevant medical records to help us make a decision on an appeal.

For CareAdvantage Members: If you are a physician and you appeal the decision on behalf of a member, the member will not need to submit documentation designating you as the member's authorized representative. However, if you are a provider other than a physician (e.g. DME provider, SNF, physical therapist, etc.), the member will need to provide documentation designating you as the member's authorized representative.

Filing an Appeal

Appeals can be filed through the following routes:

- **Call** the Grievance & Appeals Unit at **650-616-2850**
- **Fax** **650-829-2002**
- **Mail** Health Plan of San Mateo
  Attn: Grievance and Appeals
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Members can file appeals through the following routes:

- **In-person** by visiting HPSM

  Call Member Services: **650-616-2133**
  CareAdvantage Unit: **650-616-2174**

- **Fax:** **650-829-2002**
- **Mail:** Health Plan of San Mateo
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Appeals may be received by HPSM's Member Services Department, Care Coordination or by a Grievance and Appeals Coordinator.

Timing

For Medi-Cal members, an appeal must be filed within *60 calendar days* from the receipt of HPSM's notice of a denied authorization request. All other members must file an appeal within 90 days of this date. HPSM may allow an exception to this time-frame requirement for good cause.

Cancelling/Withdrawing an Appeal

Members or their authorized representatives may cancel their request for an appeal at any time by contacting HPSM's Grievance and Appeals Unit.

Processing a Standard Appeal

Once the appeal is filed, a Grievance and Appeals Coordinator will send an acknowledgment letter to the member within 5 calendar days and work with appropriate HPSM staff to begin investigation of the case. Additional information for the service may be required from providers involved in the member's treatment. Providers should provide this information within 5 days of the request.

After all relevant documentation is collected, the case is forwarded to an HPSM Medical Director for review. The Medical Director that made the initial decision to deny the authorization request will not be involved in the appeal process.

Using all available information, the HPSM Medical Director will make a decision on the appeal request. HPSM will notify the provider and the member within 30 calendar days of the initial request. HPSM will call both the member and the provider to inform them of the appeal decision. The member and provider will also receive a letter confirming the decision.

For all appeals HPSM may extend the timeframe for up to 14 calendar days if requested, or if such extension is in the best interest of the member.

Requesting an Expedited Appeal

You may request an expedited appeal of an HPSM authorization denial if you or the member believes that applying the standard 30-day timeframe for processing an appeal will jeopardize the member's life, health, or ability to regain maximum function. HPSM will also expedite an appeal for decisions regarding termination or changes in level of care for inpatient stays, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

CareAdvantage requests for expedited appeals that are submitted by telephone during non-business hours are received by HPSM's answering service. The answering service will immediately page an HPSM Medical Director to provide expedited review.

Requests submitted by fax during non-business hours will be processed the following business day. **If you are submitting an expedited appeal on a weekend or holiday, please do not submit the request by fax**.

All requests for expedited review that have the support of a physician will automatically be approved.

In addition to HPSM's expedited appeals process, Medi-Cal, Healthy Kids, and HealthWorx members can also contact the California Department of Managed Health Care (DMHC) and request an urgent review. Members do not need to go through HPSM's expedited appeals process before contacting the DMHC. Requests for urgent review by the Department of Managed Health Care can be submitted by calling **1-888-466-2219**.

Processing an Expedited Appeal

Upon receiving the request for an expedited appeal, a Grievance and Appeals Coordinator will confer with HPSM clinical staff to determine if the request meets the clinical criteria for an expedited review. This decision will be made within 24 hours of receipt of the request.

If the appeal does not qualify for an expedited review, a Grievance and Appeals Coordinator will immediately notify you and the member of this decision and any Grievance and Appeal rights, including the right to contact the DMHC. The case will then be forwarded through the standard appeals process.

If the appeal qualifies for expedited review, a Grievance and Appeals Coordinator will immediately notify you and the member of the decision and of the member's right to contact the DMHC. He/she will work with appropriate HPSM staff to collect all relevant information about the member's

condition and forward the case file to a HPSM Medical Director for review within 48 hours of receiving the request.

Using all available information, HPSM will make a decision and will notify you and the member as expeditiously as the member's health requires, but no later than 72 hours of HPSM's receipt of the request. HPSM will notify you and the member of the decision by phone and in writing. If the original denial is upheld, HPSM's written notification will include the reason for denial and information about additional levels of appeal that may be available.

Denials of CareAdvantage Part C Benefits

If a denial is upheld on appeal, HPSM will auto-forward the appeal to the Independent Review Entity (IRE) for a secondary, independent review. The IRE will render a decision within 30 days of receiving the appeal from HPSM. HPSM will comply with the decision by the IRE and notify the member and provider if the IRE instructs HPSM to overturn the denial, in full or in part.

For all appeals HPSM may extend the timeframe for up to *14 calendar days* if requested, or if such extension is in the best interest of the member.

Independent Medical Review (IMR) For Medi-Cal, Healthy Kids, and HealthWorx

If you or your patient disagrees with a decision HPSM has made on an appeal based on medical necessity, or if HPSM does not make a decision within the standard 30-day time frame, the member can request an Independent Medical Review (IMR) by the Department of Managed Health Care (DMHC).

An IMR may also be requested if HPSM denies a treatment because it is experimental or investigational; in this case, the member does not need to complete HPSM's appeals process before requesting an IMR.

Information on requesting an IMR can be obtained by calling 1-888-466-2219, or by visiting the DMHC website at https://www.dmhc.ca.gov/FileaComplaint/FrequentlyAskedQuestions.aspx

Note: A Medi-Cal member who has already participated in a State Hearing (see below) is not eligible to receive an IMR from the DMHC.

The IMR will review the case to determine whether or not the care requested is medically necessary. The DMHC will render a decision on an IMR within 30 days of the DMHC's receipt of the IMR application for standard appeals, or within 3 business days for expedited appeals.

If the IMR determines that the service is medically necessary, HPSM will approve the requested service or make a payment within 5 business days.

State Hearing for Medi-Cal Members ONLY

Medi-Cal members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with HPSM's decision regarding approval of a requested service. A State Hearing is an appeal with an Administrative Law Judge from the Department of Social Services. Expedited State Hearings may also be requested.

Requests for State Hearings can be submitted by telephone at **800-952-5253** or in writing to:

California Department of Social Services
State Hearing Division
Post Office Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Fax: (916) 651-5210 or (916) 651-2789
Online: http://www.dss.cahwnet.gov/shd/PG1110.htm

A Medi-Cal member must first exhaust HPSM's appeals process prior to proceeding with a State Hearing. Requests for State Hearings must be submitted within *120 calendar days* of an action with which the member is dissatisfied. For standard State Hearings, the State will make a decision within 90 days of the request. For expedited State Hearings, the State will make a decision *within 72 hours*.

Fast-Track Appeals to a Quality Improvement Organization for CareAdvantage Members ONLY

If a member disagrees with HPSM's decision to terminate or change the level of care for services received in an inpatient stay, skilled nursing facility (SNF), home health agency (HHA), or a comprehensive outpatient rehabilitation facility (CORF), he/she may appeal the decision to the Quality Improvement Organization (QIO) with which the Medicare program has contracted. In California, the QIO is Livanta.

Members are notified of their right to submit this appeal to the QIO when they receive their Notice of Discharge and Medicare Appeal Rights for inpatient stays, their Notice of Medicare Non-Coverage for SNF, CORF, or HHA terminations, or other notice of non-coverage.

Members must request an appeal by noon of the first business day following receipt of the notice in order to avoid financial liability during the contested time. The QIO will make a decision within 24 hours. If the member misses the deadline for a QIO fast-track appeal, he/she may still request an expedited appeal from HPSM.

Pharmacy Appeals for Drug/ Medication Denials

Appeals for medications or drugs are processed by HPSM's Pharmacy Unit. Although the appeal process is similar, the timelines for prescription drug appeals differ.

Using all available information, HPSM will make a decision, and will notify the member and provider within 7 calendar days for standard pharmacy appeals. A member, physician, or authorized representative can request an expedited appeal. In that case, HPSM will notify you and the member within 72 hours of our decision.

Filing a Pharmacy Appeal

Providers can file pharmacy appeals through the following routes:

- **Call** the Pharmacy Unit at **650-616-2088**
- **Fax** **650-829-2002**
- **Mail** Health Plan of San Mateo
  Attn: Pharmacy Unit
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Members can file appeals through the following routes:

- **In-person** by visiting HPSM

  Call Member Services: **650-616-2133**
  CareAdvantage Unit: **650-616-2174**
- **Fax:** **650-829-2002**
- **Mail:** Health Plan of San Mateo
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

Independent Reviews for CareAdvantage Part D Benefits:

For CareAdvantage members only, if HPSM upholds its original denial, a member, authorized representative, or physician may request external review by the IRE. Unlike appeals for Part C benefits, appeals for Part D covered drugs will *not* be automatically forwarded to the IRE for review. To file a second-level appeal with the IRE, the provider or member should fill out the form attached to the written notification from HPSM.

External Appeals for CareAdvantage Members ONLY

HPSM CareAdvantage members have access to successive levels of appeal to contest adverse denials and appeals. These include:

- Review by an Independent Review Entity (IRE)
- Administrative Law Judge (ALJ) hearing
- Medicare Appeals Council (MAC) hearing
- Judicial review

Independent Review Entity (IRE)

As noted above, all adverse appeals except those regarding Part D benefits are automatically forwarded to and reviewed by the Medicare-contracted Independent Review Entity (IRE) for external review. For a Part D appeal denial to be reviewed by the IRE, the member must submit a written request to the IRE within *60 days* of the date of the appeal denial decision. In this case, the IRE is required to solicit the prescribing physician's views on the case.

The IRE will make a decision on the case within the same time frames as HPSM:

- 7 days for a Part D appeal;
- 30 days for a standard pre-service authorization appeal;
- 60 days for a payment appeal; and
- 72 hours for an expedited Part D or pre-service authorization appeal.

If the IRE overturns HPSM's decision, HPSM will authorize and/or provide service or payment within the following timeframes:

- 72 hours for a standard Part D appeal
- 14 calendar days for a standard pre-service authorization

- 30 calendar days for a standard retrospective authorization
- 72 hours for an expedited pre-service authorization
- 24 hours for an expedited Part D appeal

Administrative Law Judge Hearing

In cases where the service being contested has met minimal dollar amount standards (set annually), the member, provider, or authorized representative can request a hearing before an Administrative Law Judge (ALJ). This request must be made within 60 calendar days of receiving notice by the IRE and should be submitted to the Social Security Administration or the IRE. Upon request, HPSM can also forward members' requests for an ALJ hearing to the IRE.

If the ALJ overturns HPSM's decision, the following timeframes will apply:

- 72 hours to authorize and/or provide service for pre-service Part D appeals
- 72 hours to authorize payment for Part D appeals and 30 days to issue payment
- 60 calendar days to authorize and/or provide service or payment for non-Part D appeals

HPSM may request a review by the Medicare Appeals Council (MAC), in which case HPSM may wait for the MAC's decision before authorizing service or payment.

Medicare Appeals Council (MAC)

Any party to an appeal, including a member, provider, authorized representative, or HPSM, can request a hearing before the Medicare Appeals Council (MAC). This request must be made within 60 calendar days of receiving notice by the ALJ and should be submitted in writing to the MAC. Upon request, HPSM can also forward members' requests for a MAC review.

If the MAC overturns HPSM's decision, the same timeframes for acting upon the decision as are required for ALJ decisions will apply.

Judicial Review

Any party to an appeal, including a member, provider, authorized representative, or HPSM, can request judicial review of a MAC decision if: (1) the MAC denied the request for a review, and (2) the amount of the service in question meets the minimal dollar amount set annually. To request judicial review, the party must file a civil action in a U.S. District Court.

If judicial review overturns HPSM's decision, the same timeframes for acting upon the decision as are required for ALJ and MAC decisions will apply.

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Provider Manual

Section 4

Claims

Filing a Paper Claim

Before filing any claim, be sure to confirm the member's eligibility and correct identification number. Do not bill with a Social Security number.

Please see **Section 2 - Member Eligibility** for more information.

Non-Hospital

To be eligible for payment, all paper claims must be filed on *fully* and *accurately completed* CMS-1500 forms with the current ICD-10 diagnosis codes, using the highest level of specificity, and CPT-4 or HCPCS procedure codes including applicable modifiers. Claims may be suspended or denied when data items on claim forms are incomplete or incorrect.

Table 3 - 1 contains descriptions of field numbers and HPSM requirements corresponding to the standard CMS-1500 Claim Form.

Hospital

To be eligible for payment, inpatient and outpatient hospital paper claims must be submitted to HPSM using a *fully* and *accurately* completed **UB-04 claim form**. Claims may be suspended or denied when data items on claim forms are incomplete or incorrect.

Table 3 - 2 contains description of field numbers and HPSM requirements corresponding to the standard UB-04 Claim Form.

Long Term Care Paper Claims

To be eligible for payment, long term care paper claims must be submitted to HPSM using a *fully* and *accurately* completed **25-1 claim form**. Claims may be suspended or denied when data items on claim forms are incomplete or incorrect.

It is very important to include your appropriate NPI Number when submitting claims.

Paper claims should be submitted to the following address:

- Health Plan of San Mateo
  Attn: Claims Department
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080

The status of all submitted claims may be checked via HPSM's website (www.hpsm.org) once a User ID and Password have been established. Please contact the HPSM Provider Services Department at **650-616-2106** for assistance.

You may also obtain Claim Status by contacting HPSM's Claims Department at **650-616-2056**, or by email at ClaimsInquiries@HPSM.org.

Table 3-1: CMS-1500 Field Descriptions and Requirements

Field #	Description	Requirement
1	Medicaid/Medicare/Other ID	Enter an "X" in the Medicaid Box (for all programs except CareAdvantage)
1A	Insured's ID	Enter Member's HPSM ID number
2	Member's Name	Entered as it appears on the HPSM ID Card
3	Member's DOB/Sex	Enter Member's DOB in 8-digit format (MMDDYYYY)
4	Insured's Name	Use if billing for a newborn using Mom's ID
5	Member's Address and Telephone	Enter Member's Complete Address and Telephone Number
6	Patient Relationship to Insured	This field may be used when billing for an infant using the mother's ID by checking the "Child" box
7	Insured's Address	Not Required by HPSM
8	Patient Status	Not Required by HPSM
9	Other Insured's Name	"X" if applicable
9A	Other Insured's Policy/Group Number	Enter information, if applicable
9B	Other Insured's Policy/Group Number	Enter information, if applicable
9C	Employer's Name/School Name	Enter information, if applicable
9D	Insurance Plan Name/Program Name	Enter information, if applicable

Field #	Description	Requirement
10	Is Patient's Condition Related To:	Enter “X” in the appropriate box below.
10A	Employment	”X” Yes or No if applicable
10B	Auto Accident/Place	”X” Yes or No if applicable
10C	Other Accident	”X” Yes or No if applicable
10D	Reserved for Local Use	Enter the amount of patient's Share-of-Cost for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign ($) (e.g. if billing for $100, enter 10000 not 100).
11	Insured's Policy Group or FECA Number	Enter information if applicable
11A	Insured's Date of Birth/Sex	Enter information if applicable
11B	Employer's Name or School Name	Enter information if applicable
11C	Insurance Plan Name of Program Name	”X” if applicable “”
11D	Is There Another Health Benefit Plan?	Enter an "X" in the box if the recipient has other coverage.
12	Patient's or Authorized Person's Signature	Not Required by HPSM, use “Signature on File”
13	Insured's or Authorized Person's Signature	Not Required by HPSM, use “Signature on File”
14	Date of Current Illness/Injury/Pregnancy	Enter date, if applicable
15	Similar Illness	Not Required by HPSM
16	Date Unable to Work	Not Required by HPSM
17	Referring Provider	Physician name or other source
17A/B	ID Number of Referring Physician	Enter the referring or prescribing or ordering practitioner's NPI.

Field #	Description	Requirement
18	Hospitalization Dates	Enter dates of admission and discharge.
19	Reserved for Local Use	Use this area for providing additional information which may be necessary for HPSM to process your claim appropriately; such as “Baby using Mom’s ID”, anesthesia start/stop times, or proof of eligibility.
20	Outside Lab	”X” if applicable .Name of outside lab must be listed in box 32.
21.1	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers of the ICD-10-CM at its highest specificity. Do not use decimal point.
21.2	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code at its highest specificity, if present.
21.3	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code at its highest specificity, if present.
21.4	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code at its highest specificity, if present.
22	Medicaid Re-submission Code	Not Required by HPSM
23	Prior Authorization Number	For physician and pediatric services requiring a Prior Authorization Request (PAR). It is not necessary to attach a copy of the PAR to the claim. Recipient information and NPI on the claim must match the PAR. Only one PAR Control Number can cover the services billed on any one claim.
24A	Date(s) of Service	Enter the date or date span the service was rendered in the "From" and "To" boxes in the 6-digit, MMDDYY, format. Do not bill “future” dates – services cannot be billed until after the “from” date on the claim.
24B	Place of Service	Enter one code indicating where the service was rendered.
24C	Type of Service	Not Required by HPSM
24D	Procedures, Services, or Supplies Modifier	Enter the applicable procedure code (HCPCS or CPT-4) and modifier, if required.
24E	Diagnosis Code Pointer	Reference diagnosis code(s) from box 21 applicable to each service line.

Field #	Description	Requirement
24F	Charges	In full dollar amount, enter the usual and customary fee for service(s). Do not use the dollar sign ($). If an item is a taxable medical supply, include the applicable state and county sales tax.
24G	Days or Units	Enter the number of medical "visits", surgical lesions, hours of detention time, units of anesthesia time, etc.
24H	EPSDT Family Plan	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are CHDP-screening related. Leave blank if not applicable.
24I	ID Qualifier	Not required by HPSM
24J	Rendering Provider NPI	Enter NPI
24.1-24.6	Claim lines	Follow instructions for each claim line.
25	Federal Tax ID Number	Enter the 9-digit provider Tax ID number.
26	Patient's Account No.	This is an optional field that will help you to easily identify a recipient on RAs.
27	Accept assignment?	“X” Yes or No
28	Total Charge	In full dollar amount, enter the total for all services. Do not enter a decimal point (.) or dollar sign ($).
29	Amount Paid	Enter the amount of payment received from the other coverage (Box 10D). Do not enter Medicare payments in this box. Medicare payment amount will be calculated from the Medicare EOMB/RA when submitted with the claim.
30	Balance Due	Enter the difference between Total Charges and Amount Paid.
31	Provider Signature/Date	Not required for CareAdvantage claims
32	Service Facility Location Information	Can include Outside Lab. List location where service was rendered.
32a	NPI of Facility	NPI of location listed in Box 32.
32b		Not Required
33	Billing Provider Info and Phone Number	Required

Field #	Description	Requirement
33a	NPI of Billing Provider	Required
33b		Not Required

TABLE 3-2: UB-04 Field Descriptions and Requirements

Field #	Description	Requirement
1	Hospital Name, Address and Zip Code	Enter the hospital name, address and 5-digit zip code.
2	Alternate Address of Facility	Not Required by HPSM
3	Patient Control Number	This is an optional field that will help you easily identify a recipient on RTDs and RAs.
3b	Medical Record Number	This is an optional field that will help you easily identify a recipient on RTDs and RAs.
4	Type of Bill	Enter the appropriate Type of Bill code as specified in the UB-04 Manual Billing Procedures.
5	Federal Tax ID Number	Enter the 9-digit Federal Tax ID number.
6	Statement Covers Period (From-Through)	In 6-digit format MMDDYY, (Month, Day, Year) enter the dates of service included in this billing.
7	Blank	Not Required by HPSM
8	Patient Name	Required
8a	Blank	Not Required
8b	Patient Name	Last name, first name, middle initial
9	Patient Address	
9a	Patient's Street Address	Required
9b	City	Required
9c	State	Required

Field #	Description	Requirement
9d	Zip	Required
9e	Zip + 4	Not Required
10	Birth date	8-Digit, MMDDYYYY
11	Sex	Enter M or F
12	Admission Information - Date	Enter admit date as 6 digits, MMDDYY
13	Admission Hour	Enter as 2 digit - Eliminate the minutes, convert the hour of admission/discharge to 24-hour (00-23) format (for example, 3 p.m. = 15)
14	Admission Type	Enter the numeric code indicating the necessity for admission to the hospital. Emergency = 1, Elective = 3.
15	SRC	If the patient was transferred from another facility, enter the number code indicating the source of transfer. Hospital - 4, SNF - 5, another Health Care Facility - 6.
16	DHR	Discharge Hour, 1-2 digits - Eliminate the minutes, convert the hour of admission/discharge to 24-hour (00-23) format (for example, 3 p.m. = 15)
17	Status	Enter the numeric code explaining the patient's status of the "through" date (Box 6).
18 - 28	Condition Codes	Applicable HPSM codes are: Other Coverage, Emergency Certification, Family Planning, Billing Limit Exception etc.
29	ACDT State	Not Required
30	Blank Field	Not Required
31-36	Occurrence Codes	Not Required
37	Blank Field	
38	Name/Address of Patient	Required
39-41	Value Codes	Patient's Share-of-Cost code"23" or Medicare Deductible or End Stage Renal Claims.

Field #	Description	Requirement
42	Revenue Codes	Enter the appropriate accommodation or ancillary code
43	Description	Enter the description of the accommodation or ancillary code.
44	HCPCS/Rates	Required for services other than Inpatient Hospital
45	Service Date	Required for services other than Inpatient Hospital
46	Service Units	Enter the number of days of care by accommodation code.
47	Total Charges	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($).
48	Non-Covered Charges	Not Required by HPSM
49	Unlabeled	Not Required by HPSM
50A-C	Payer	Enter name of Coverage of Health Plan
51A-C	Member Health Plan ID	Required
52A-C	Release of Information Certification	Y or N
53A-C	Assignment of Benefits Certification Indicator	Y or N
54A-B	Prior Payment	Enter the full dollar amount of payment received from Other Coverage or Share of Cost if applicable.
55A-C	Estimated Amount Due	Enter the difference between “Total Charges” and any deduction.
56	NPI	Required
57	Unlabeled	Sometimes used for TIN
58A-C	Insured’s Name	Required
59A-C	Patient’s Relationship to Insured	If billing for an infant using the mother’s ID or for an organ donor, enter the code indicating the patient’s Relationship to the Medi-Cal recipient (e.g. 03 Child).
60A-C	Insured’s Unique ID	Enter the Member’s ID number.
61A-C	Insured Group Name	Not Required by HPSM

Field #	Description	Requirement
62A-C	Insurance Group Number	Not Required by HPSM
63A-C	Prior Authorization Codes	For services requiring a Prior Authorization Request (PAR) enter the PAR Control Number.
64A-C	Document Control Number	Not Required by HPSM
65A-C	Employer Name	Not Required by HPSM
66A-H	Diagnosis Codes	No entry can be made
67 A-Q	Diagnosis Codes	Enter all letters and/or numbers of the ICD-10-CM codes at their highest level of specificity, if present.
68	Blank	
69	Admit DX	Not Required by HPSM
70 a-c	Patient Reason DX	Not Required
71	PPS Code	Not Required
72 a-c	ECI	Not Required
73	Blank	
74	Principal Procedure Code and Date	Enter the appropriate Procedure code identifying the primary medical or surgical procedure.
75	Blank	
76	Attending Physician ID	Include physician name, NPI and qualifier
77	Operating Physician ID	Include physician name, NPI and qualifier
78-79	Other	If applicable
80	Remarks	Use this area for procedures that require additional information, e.g. enter Mother's name when the baby is using Mother's ID and the baby's birth date or proof of eligibility
81 a-d	CC	Not Required

For HOSPITAL OUTPATIENT SERVICES billed on a UB-04 form

The following fields are *NOT REQUIRED BY HPSM*: 16–22, 43, and 46. In addition, Field #44 requirement should read: Enter CPT-4 procedure code and appropriate modifiers, if needed.

TABLE 3-3: LTC 25-1 Field Description and Requirements

Field #	Description	Requirement
1	Claim Control Number	HPSM use only. DO NOT mark in this area. A unique 13-digit number, assigned by HPSM to track each claim, will be entered here when the claim is received by HPSM
1A	Provider Name, Address	Enter your name and address if this information is not pre-imprinted. Please confirm that this information is correct before submitting claims. **Zip Code** (Box 128). Enter the five-digit ZIP code
	Zip Code (Box 128).	Enter the five-digit ZIP code of the facility if this information is not already pre-imprinted.
2	Provider Number	Enter your Medi-Cal NPI number if it is not preprinted. Include all nine characters of the number. Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with other than the 10-character Medi-Cal NPI number will be denied.
3	Delete	If an error has been made for a particular patient, enter an "X" in this space to delete both the upper and lower line. Enter the correct billing information on another line. When the *Delete* box is marked "X", the information on both lines will be "ignored" by the system and will not be entered as a claim line.
4	Patient Name	Enter the patient's last name, first name and if known, middle initial. Avoid nicknames or aliases.
5	Medi-Cal Identification Number	Enter the 10-character recipient ID number as it appears on the Benefits Identification Card (BIC).
6	Year Of Birth	Enter the patient's year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years of age or older, enter the recipient's age and the full four-digit year of birth (CCYY) in the *Explanations* area (Box 126a).

Field #	Description	Requirement
7	Sex	Use the capital letter “M” for male, or “F” for female. Obtain the sex indicator from the BIC.
8	ARF Reference Number	For services requiring an ARF, enter the nine-digit ARF Reference Number. It is not necessary to attach a copy of the ARF to the claim. Recipient information on the ARF must match the claim. Be sure the billed dates fall within the ARF authorized dates.
9	Medical Record Number	This is an optional field that will help you to easily identify a recipient. Enter the patient’s medical record number or account number in this field (maximum of five characters – either numbers or letters may be used). Whatever you enter here will appear on the RA.
10	Attending M.D. Medi-Cal ID No.	Enter the physician’s nine-character Medi-Cal Provider Number. If the physician does not have a provider number, enter his/her State license number (not always nine characters). Be sure the attending physician’s ID number is entered on a(n): • Admit claim • Initial Medi-Cal claim for a Medi-Care/Medi-Cal crossover patient • Claim when there is a change in the attending physician’s provider number.
11	Billing Limit Exception	If there is an exception to the six-month billing limitations from the month of service, enter the appropriate reason code number and include the required documentation. The appropriate documentation must be supplied to justify the exception to the billing limitation.
12 / 13	Date Of Service	Enter the period billed using a six-digit MMDDYY [Month, Day, Year] format for the FROM and THRU dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the ARF cover the period billed. For example, September 1, 2003 is written 090103. **Note:** When a patient is discharged, the through date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.

Field #	Description	Requirement
14	Patient Status	Enter the appropriate patient status code from the list below. The patient status code must agree with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days). **Code Patient Status** 00 Still under care 01 Admitted 02 Expired 03 Discharged to acute hospital 04 Discharged to home 05 Discharged to another LTC facility 06 Leave of absence to acute hospital (bed hold) 07 Leave of absence to home 08 Leave of absence to acute hospital /discharged 09 Leave of absence to home/discharged 10 Admitted/expired 11 Admitted/discharged to acute hospital 12 Admitted/discharged to home 13 Admitted/discharged to another LTC facility 32 Transferred to TC status in same facility
15	Accommodation Code	Enter the appropriate accommodation code for the type of care billed, as listed in *the Long Term Care* Accommodation *Codes* **Note:** HPSM does not require that a copy of Form LTC 231 (*Certification for Special Program Services*) be attached to the *Payment Request for Long Term Care* (25-1).

Field #	Description	Requirement
16	Primary DX (Diagnosis) Code	Enter the Primary ICD-10-CM diagnosis Code (International Classification of Diseases 9th Revision, Clinical Modification) for the following: Admit claim Initial Medi-Cal claim for a Medi-Care/Medi-Cal crossover patient Change in diagnosis Note: ICD-10-CM coding must be three, four or five digits with the fourth and fifth digits included if present. The vertical line serves as the decimal point. Do not enter decimal point when entering this code. Current copies of the ICD-10-CM codes may be ordered from: PMIC 4727 Wilshire Blvd., Suite 300 Los Angeles, CA 90010 **1-800-633-7467**
17	Gross Amount	When billing for full Medi-Cal coverage, compute the gross amount by multiplying the number of days times the appropriate Medi-Cal daily rate for the accommodation code listed. When entering the gross amount, do not use symbols ($) or (.). The pre-imprinted vertical line serves as the decimal point. Use this method in entering all dollar amounts on the *Payment Request* form

Field #	Description	Requirement
18	Patient Liability / Medicare Deductible	Enter the recipient's net Share of Cost (SOC) liability. The recipient's net liability is determined by subtracting from the recipient's original SOC shown on the Medi-Cal card, the amount expended by the recipient that qualifies under Medi-Cal rules as expenditures which may be used to reduce the patient's SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items "not covered" by Medi-Cal. The recipient's net SOC liability is the amount billed to the recipient. This SOC is deducted from the Medi-Cal allowed amount. The PATIENT LIABILITY entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the *DHS 6114* form, *Item 15*. When billing the recipient for less than the SOC amount indicated by the Host, enter an explanation in the *Explanations* area on the claim form
19	Other Coverage	Enter the amount paid by other insurance carrier(s) for the period billed, if applicable. Other Coverage includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. **Note:** If the Host indicates a coverage code "L" for the recipient, providers must bill Other insurance carriers prior to billing Medi-Cal.
20	Net Amount Billed	Enter the amount requested for this billing. To compute the net amount, subtract patient liability and Other Coverage (if any) from the gross amount billed. If the net amount billed computes to $00.00, enter the amount as "0000". Do not leave blank.
21	M.D. Certification	Not required.
22	Additional Claim Lines	
116		The *Payment Request* form may be used to bill services for as many as six patients. Bill only one month's services on each line.

Field #	Description	Requirement
117	Attachments	Enter an “X” if attachments are included with the claim. Leave blank if not applicable. **Note:** If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied.
118	Provider Reference No.	Enter any number up to seven digits to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. This number will be referenced by HPSM on any forms sent to you that pertain to the billing data on the form. It will not be included on the *Remittance Advice*.
119	Date Billed	In six-digit format, enter the date the claim is submitted for HPSM payment.
120	FI USE ONLY	Leave blank.
126		Not applicable
126A	Explanations	Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area.
127	Signature of Provider Or Person Authorized by Provider (Representative)	The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ball-point pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file at HPSM.
127A	Affix Label Here	BIC cards do not have labels. Leave these boxes blank.

Timelines for Claims Submission

Medi-Cal

Claims Submission from Date of Service	Reimbursement Policy
0-6 months	100% of approved payment
7-9 months	75% of approved payment
10-12 months	50% of approved payment
> 1 year	0% of approved payment (without written justification)

Your claims must be submitted within 180 days from the date of service in order to qualify for the full approved payment amount. Claims received beyond 180 days from the date of service will be pro-rated according to the guidelines listed in the table above and the member may not be balance billed.

CareAdvantage, Healthy Kids, HealthWorx

Your claims must be submitted within 1 calendar year from the date of service.

Additional Documentation Needed

The following are common circumstances that will require additional documentation to be submitted with the claim:

- **Non-specific injection codes (i.e., 90782)**
  Indicate the name, NDC number and dose of medication administered.
- **Multiple procedures that are performed at the same session**
  Indicate the number of procedures performed in the narrative and in the Units section of the form.
- **Unlisted codes or codes that are “Not otherwise classified” usually ending in "99"**
  Submit procedure, office or operative notes describing the procedure performed.
- **Multiple surgical procedures**
  Submit an operative report with the claim.

- **Special supplies**
  Submit description (e.g., 99070). All special supplies should be coded utilizing their HCPC Level II codes. Special supplies coded 99070 will require adequate documentation to ensure that usual and customary supplies over and above the general and accepted practice were used. These claims may be suspended for reimbursement consideration.
- **High level (99285) Emergency Room claims.**

Billing Tips for Claims Submission

HPSM uses optical character recognition (OCR) technology to facilitate expedited turnaround time of your paper claims submission.

1. Verify member eligibility prior to submission of a claim. Use only the member's HPSM ID number, not Social Security or other numbers.
2. Be sure to indicate the National Practitioner Identifier (NPI) on your claim form under PIN # in Box 33 (CMS-1500).
3. Service dates cannot be in the future even when part of a date span
4. If you are billing claims for a physician in a group practice, use the group NPI in the PIN # section in Box 33 (CMS-1500) and not the rendering physician's individual NPI number.
5. Remember to include RAF and PAR numbers when needed. The NPI on the claim form should match the one used on the PAR
6. For CMS-1500 paper claims, remember to sign and date each claim legibly – no signature stamps. Please use blue or black ink only. Signatures are not required on UB-04 claims, all lines of business. **Signatures are not required for CareAdvantage claims.**
7. For paper claims, place any attachments that are smaller than 8½ x 11 on a piece of 8½ x 11 blank paper.
8. Remember procedure codes 10000-89999 require modifiers.
9. Vision claims require Modifiers. (Qualifying Codes not used after 07/06)
10. When billing more than one of the same procedures for Lab or X-Rays, enter on one line with the appropriate count and documentation.
11. "On-Call Providers" need to contact Provider Services so that their services/claims will be paid.
12. Submit claims electronically.

13. Paper claim submission requirements:

- No dry line or correction fluid.
- Printed information cannot touch the box edges or run outside of the numbered boxes.
- No Handwritten claims.
- No Super-bills.
- No Photocopies of claims

Important Billing Guidelines

It is very important that your billing staff check their error reports to guarantee timely claims submission. **A rejected claim will not be considered to have been submitted to HPSM.**

Claims for services provided to members who are later determined to be retroactively eligible with HPSM must be submitted *within 60 days of determination of eligibility* with the corresponding Medi-Cal Delay Reason Code.

Note: In order to avoid a denied claim for late submission, please note in the remarks section the date that Proof of Eligibility (POE) was received by the Provider.

Claims for services provided to members who have other insurance as primary coverage and HPSM as secondary coverage, claim and primary insurance remittance advice must be submitted to HPSM within one year of the month of service with the corresponding Medi-Cal Delay Reason Code to meet timeliness requirements.

The Advantages to Submitting Claims Electronically

1. **Reduces your administrative costs**
   Handling of paper claims is eliminated.

2. **Accurate Claims Data**
   Your claims are formatted and submitted directly into our host system. This prevents the original claim data from having to be re-keyed.

3. **Faster Claims Submission**
   Claims enter our system faster and, in turn, claims are processed quicker.

The Requirements of Submitting Claims Electronically

1. All existing claims data is still required
2. All information that is currently submitted on your paper claims must also be included on all electronic claims (see Filing a Paper Claim). Filing an Electronic Claim

Who Do We Contact at HPSM to Get Started?

To get started, please contact HPSM's Provider Services Department at **650-616-2106**.

HPSM supports the following batch claim file formats:

- CMC (Inpatient, Outpatient, Professional)
- UB-04 Version 4 of 6 Flat file (Inpatient, Outpatient)
- NSF 3.01
- ANSI X.12 EDI (3921) 837
- HIPAA 837 4010 (Professional and Institutional)

HPSM also has the ability to receive claims information over the web using our eHEALTHsuite portal.

Delivery Method	Directions
FTP (File Transfer Protocol)	FTP to www.hpsm.org. Dial-in number is **650-616-8062**. Plain text only, migrating to 128-bit SSL encryption. Please contact the HPSM MIS Department at **650-616-2025** to set up your User ID and Password and receive more detailed instructions.
E-mail	E-mail to ec@hpsm.org PGP encryption preferred.

eHEALTHsuite	CMS-1500 professional claims can be completed and submitted via HPSM's website at www.hpsm.org. Please contact the HPSM Provider Services Department at **650-616-2106** to set up your User ID and Password and receive more detailed instructions.
Clearinghouses	Change Healthcare (formerly Emdeon and WebMd): HPSM Payer ID code for Professional claims (CMS-1500) is: **SX174**; for Institutional (UB-04) is **12X74.** Call Emdeon Business Services Support at **877-469-3263**. Capario and Office Ally: **949-464-9129** to obtain an ID and password or visit www.officeally.com.

The status of all submitted claims, regardless of submission method, can be checked via HPSM's website (www.hpsm.org) once a User ID and Password have been established. Please contact the HPSM Provider Services Department at **650-616-2106** for assistance.

Important Reminders

Be sure that you have a valid NPI number.

This is very critical in the electronic process. It is imperative that your NPI number be included on all electronic claims. How Do I Know My Claims Have Made It Into HPSM's Claim System?

Electronic claims are acknowledged via e-mail within 2 working days.

Additionally, HPSM will **reject** claims with the following common errors:

- Invalid HPSM Member ID Number
- Member ineligible on date of service
- No NPI number

It is very important that your billing staff check their error reports to guarantee timely claims submission. **A rejected claim will not be considered to have been submitted to HPSM.**

If you are not currently filing claims electronically and wish to do so, please call the HPSM EC Coordinator at **650-616-2017** or send an email to: ec@hpsm.org.

All electronic claims must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The deadline for HIPAA compliance for electronic transactions and code sets for all covered entities was October 16, 2003.

For questions regarding electronic claim submission and testing, please call the HPSM EC Coordinator at **650-616-2017**.

Methods of Reimbursement

Fee-for-Service

Providers contracted under the fee-for-service reimbursement arrangement are paid for approved services based on the applicable HPSM fee schedule. All payments generated to fee-for-service providers are a direct result of claims submitted to HPSM. All claims must be submitted to HPSM within Three hundred and sixty (365) days of the date of service in order to qualify for the payment. A pro-rated amount will be paid by the Medi-Cal plan if the claim is submitted more than one hundred eighty (180) days to three hundred and sixty four five (365) from the date of service, without a valid Medi-Cal delay reason code, as per contract provisions.

Capitation

Providers contracted under a capitation payment arrangement are paid a monthly per member per month (PMPM) for each HPSM Medi-Cal member, including CareAdvantage members, on the monthly PCP Case Management List. This payment covers the cost of all capitated procedures performed. (See Primary Care Capitation Code List in the end of this section.)

The monthly payment is received whether or not the patient is seen by the provider in any given month. Capitated providers are reimbursed on a fee-for-service basis for approved covered services not included in the capitation arrangement. Claims for all services must be submitted to HPSM within three hundred sixty five (365) days of the date of service without a valid Medi-Cal delay reason code, as per contract provisions. This claims data is then used to determine among other things, encounter rates and utilization of preventive services and is the basis of our reporting of the Health Plan Employer Data Information Set (HEDIS) to the

California Department of Health Care Services and other state and Federal regulatory agencies. (For more information on HEDIS see Section 8). Proper submission of claims data will significantly reduce the need for on-site Medical Record review or requests for chart copies to be mailed to HPSM.

PLEASE NOTE: All practitioners should ensure that claim forms are submitted with appropriate CPT-4 procedure codes and/or Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes for each service rendered at the time of the visit regardless of payment methodology (i.e. monthly capitation payment or fee-for-service).

HPSM Fee Schedule

For most services, HPSM reimburses providers the lesser of the billed amount or the maximum allowable fee based on the California Department of Health Care Services (DHCS) Medi-Cal rates. Reimbursement rates may change during the year. Any code listed may have a service limitation associated with it or need prior authorization.

To review current Medi-Cal rates, please see the Medi-Cal website at www.medi-cal.ca.gov. The HPSM Fee Schedule for PCPs, Specialists a.k.a. Referral Providers (non-OB), OB Specialists, Other Service Providers, Hospitals, and Pharmacies are described below.

For Healthy Kids, and HealthWorx, HPSM uses the Medi-Cal Fee Schedule as the base. The main differences are that PCPs are paid Fee-For Service under these programs, not at a capitated rate, and these programs have higher co-pays as well. Co-pay amounts are subtracted from the total Fee Schedule amounts due before payment is released by HPSM.

For CareAdvantage, HPSM uses the Medicare Participating Fee schedule. To review current rates, please see the Noridian or CMS website at med.noridianmedicare.com/

Contracted PCPs

Primary Care Physicians are paid a capitation amount each month for each **Medi-Cal** member (including CareAdvantage) on their Case Management list. For HPSM, PCPs are Family Practice, General Practice, Internal Medicine, and Pediatric providers. OB/GYN providers are eligible to serve as PCPs should they enter into a contract with HPSM to serve as such.

Supplemental Notes for Payment to Primary Care Providers

1. Capitation rates are based on a defined Scope of Services that includes office visits, inpatient services, preventative services, minor surgical procedures, and some laboratory services. The Scope of Services can be found later in this Section.
2. Capitation rates may be adjusted for age/sex cost differences where deemed appropriate.
3. PCPs may receive an "Extended Hours" capitation rate which is 10% higher than the base capitation rate, if the PCP maintains eight (8) additional office hours per week, in any combination of weekday evenings after 6:00 p.m. and weekends.
4. PCPs may receive a 20% supplemental capitation payment quarterly if they are open to new members and accept new members who are automatically assigned to them.
5. If the PCP has joined the IZ Registry, they can receive extra payment for each member under 18.
6. For services provided to Medi-Cal members outside of the Capitation Scope of Services, PCPs are paid 123% State Medi-Cal rates for covered services.

PCP Fee Schedule for Other Programs

For other programs (Healthy Kids, and HealthWorx), PCPs are paid at 133% State Medi-Cal rates for covered services.

Contracted Specialists (non-OB) a.k.a. "Referral Providers"

Contracted Specialists (a.k.a. "Referral Providers") are reimbursed at 123% of State Medi-Cal rates for covered services for Medi-Cal and 133% for Healthy Kids and HealthWorx. CareAdvantage contracted specialists are paid at 90% of the Medicare Participating Fee Schedule.

Contracted Specialists (OB)

Contracted Obstetricians are paid a global fee for prenatal care, currently $1,600. Global Services include antepartum care, delivery, and post-partum care, including:

- Hospitalized admission
- Patient history
- Vaginal or Caesarean section delivery
- Physical examination after previous Caesarean section delivery

- Labor management
- Hospital discharge
- All applicable postoperative care

The postpartum office visit is reimbursed at $50.00

Global Billing Requires 4 OB Visits

In order to bill for global obstetrical care, providers must render services for at least four (4) OB visits, and submit claim with from - through billing format. Otherwise, services are paid for on a fee-for-service basis. Document services for global obstetrical care in the *Reserved for Local Use* field (Box 19) on the CMS-1500 claim form, or on an attachment, for reimbursement.

If you are billing electronically, provide at least 4 visit dates in the *Remarks* field. The initial pregnancy-related office visit may be counted as one of the 4 visits.

If fewer than 4 visits are rendered, providers must bill services on a per-visit basis. In the event you do not indicate the 4 visit dates, your claim will be denied

In the event a provider plans to bill a global fee but then does not perform the delivery, each antepartum visit (HCPCS code Z1034) must be billed separately.

Contracted Other Service Providers

Contracted Other Service Providers are reimbursed at 100% of State Medi-Cal rates for covered services for Medi-Cal, Healthy Kids, , and HealthWorx. CareAdvantage contracted Other Service Providers are reimbursed at 90% of the Medicare Participating Fee Schedule.

Contracted Hospitals

Contracted Hospitals are reimbursed on a per-diem basis for Medi-Cal, Healthy Kids, , and HealthWorx. Contracted Hospitals are paid the current DRG rate for CareAdvantage members.

Contracted Pharmacies

HPSM contracts with a pharmacy benefit manager, Argus, for pharmacy services. Contracted pharmacies bill Argus for drugs and HPSM for medical supplies.

HPSM Payment Policies, Rules, and Non-Standard Coding Methodologies

HPSM follows the payment policies and rules outlined in the Medi-Cal Provider Manuals for Medi-Cal, Healthy Kids and HealthWorx. HPSM follows Medi-Cal modifier requirements for these lines of business. HPSM follows the current Medicare guidelines for the CareAdvantage line of business.

The Center for Medicare and Medicaid Services (CMS) oversees Medicare and Medicaid plans on a national level. CMS requires health plan compliance programs to identify health care fraud, abuse, and waste. The goal of HPSM's compliance program is to focus on areas of government concern, such as unbundling, up-coding, medically unnecessary services, duplicate billing, and billing for services not rendered.

Your HPSM RAs outline the nature of the coding and edits that have been identified by HPSM's Claims Department. Please use this information as an instrument to review and align your billing practices.

HPSM's policy regarding consolidation of multiple services or charges, and payment adjustments due to coding changes:

In cases where a provider submits a claim to HPSM for an "unbundled" service, HPSM reimburses according to the bundled payment schedule.

HPSM's policy regarding multiple procedures:

HPSM will reimburse the allowable amount for multiple procedures with appropriate documentation.

HPSM's policy regarding reimbursement for assistant surgeons:

HPSM reimburses 20% of the Medi-Cal allowable amount for the procedure code. See the Medi-Cal rates schedule under procedure type "O".

HPSM's policy regarding reimbursement for the administration of immunizations and injectable medications:

For Medi-Cal

You must be a VFC provider to be reimbursed through VFC. The VFC program, operated by the California Department of Health Care Services, furnishes federally purchased pediatric

vaccines to health care providers at no cost to serve children birth-18 years whose parents cannot pay out of pocket for vaccines. Vaccines are used for children covered by Medi-Cal or CHDP, children without health insurance or whose insurance does not cover vaccine, and American Indian or Alaskan native children. For more information, contact the State toll free at 877-2 GET VFC (877-243-8832).

Use SL modifiers to get reimbursed for the administrative fee from HPSM. For high-risk adults, use the SK modifier.

For Healthy Kids, HealthWorx and CareAdvantage

Vaccines for Healthy Kids children, HealthWorx and CareAdvantage should be billed directly to HPSM.

HPSM'S Long Term Care Billing and Procedure Codes:

Claims shall be submitted according to established protocols as set forth in the EDS Medi-Cal Manual, in reference materials from PLAN, and/or as set forth in the Provider Manual. If the Member has other health insurance the other insurance must be billed prior to billing PLAN in accordance with §§ 4.5 and 4.8 of the Agreement.

Nursing Facility Provider shall bill using its National Provider Identifier (NPI) on and after May 23, 2007 and should include the ICD-10-CM diagnosis code(s) of the Member's condition on any Claim. An approved modifier must be included, wherever applicable.

Nursing Facility Provider who has rendered Covered Services to eligible Members shall submit Claim forms within three hundred and sixty five (365) days of the date of service, in accordance with the provisions of § 4.4(a) of the Agreement. Claims submitted for Medi-Cal members after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable.

Reimbursement Guidelines

Claims are required to have accurate and specific ICD-10 diagnosis codes and CPT-4 procedure codes and/or HCPCS codes. Claims are reviewed for the following items and reimbursement for covered services will be based on the most appropriate coding.

CHDP charges can be submitted using standard CPT-4 and HCPCS code on a CMS-1500 form. The PM 160 is not accepted by HPSM.

Health Plan of San Mateo will reimburse the providers at the current CHDP rates.

Evaluation and Management Services

Office visit codes for initial or new patients will be allowed for separate reimbursement, according to the CPT guideline, when billed in conjunction with a reimbursable procedure (see CPT-4 starred procedures).

Reimbursement will not be made when the services are considered part of the pre-operative and/or post-operative care provided as part of evaluation and management services of a major surgical procedure (global billing). Claims will be reviewed for claim history to determine appropriate Evaluation and Management visit codes in relation to initial versus established patient. In addition, reimbursement will not be made when the services provided are covered under a capitation arrangement.

Medical Services After Hours

After hours' codes are not reimbursable when billed in conjunction with an Evaluation and Management Service.

Hospital Discharge Day

Visit is not separately reimbursable when billed in conjunction with a reimbursable procedure and/or an Evaluation and Management Service performed on that same discharge date.

Incidental Procedures

Incidental procedures will not be separately reimbursed when billed separately on a claim for the same date of service as a primary procedure.

Unbundling

When submitting surgical or laboratory claims, use the single most comprehensive CPT -4 Procedure Code that accurately describes the entire service. When two or more procedure codes are used where a single code (or primary code) includes those codes billed, all codes will automatically be re-bundled and payment will be made for the primary code only.

Mutually Exclusive Procedures

When two or more codes appear on a claim for procedures that are usually not performed at the same operative session on the same patient on the same date of service, or when two or more codes describing the same type of procedure are submitted on the same claim, they are considered mutually exclusive and only one code will be reimbursed.

Unlisted Procedures

Unlisted procedures should not be billed unless a more specific and current CPT-4 procedure code is unavailable in the current CPT-4 reference for the year the procedure was performed. When billing with an unlisted code, a written description of the procedure must be submitted for consideration. Unlisted procedures may not be eligible for coverage under the Plan contract, and reimbursement will be based on the terms, limitations, and policies of the Plan. **Lack of documentation will result in denial for any unlisted procedure**.

Cosmetic Procedures

Cosmetic surgery can be described as any procedure performed to improve the general physical appearance, where a physical functional deficit is not documented and medical necessity is not substantiated. Cosmetic surgery is not a covered benefit. In following CMS guidelines and CPT-4 coding rationale, clinical indication for possible cosmetic surgery must be substantiated with a detailed history and physical findings, previous unsuccessful medical treatment, functional impairment or limitations following disease, infection, trauma or previous surgery. Psychological stress does not constitute medical necessity.

Special Supplies

All special supplies should be coded utilizing the HCPCS Level II codes. Special supplies coded 99070 will require adequate documentation to ensure that usual and customary supplies over and above the general and accepted practice were used. These claims may be suspended for reimbursement consideration.

Modifiers

Listed services may be modified under certain circumstances. When applicable, the modifying circumstance against general guidelines should be identified by the addition of the appropriate modifier code. Note that the utilization of modifiers will be reviewed, and supporting documentation may be requested. Inappropriate use of a modifier or using a modifier when it is not necessary will result in denial or a delay in claim payment. Some CPT-4 codes, by nature of their description, are for the professional or technical component only. In these cases, a modifier will make the claim suspend unnecessarily.

Additional Items

Claims will also be screened for the following: duplicate procedures, obsolete procedures, experimental procedures, age and sex discrepancies, and questionable necessity of an assistant surgeon.

Coverage Groups

It is required by HPSM that all contracted practitioners, both Primary Care Physicians (PCPs) and specialists, have seven days a week, 365 days a year call coverage for his/her practice.

All practitioners must provide HPSM with a list of the covering physicians as part of their credentialing or re-credentialing application. All practitioners must also notify HPSM if the list of covering physicians changes. Only one visit will be approved for the covering physician services, unless the office is closed for an extended period of time. Patients should be instructed to follow up with their PCP.

NOTE: If a practice is closed for more than 24 hours, the practice must notify the Provider Services Department (see Section 1 - Who to Call).

If there are members of your coverage group that do not participate with HPSM, your practice must inform them of the HPSM policies and procedures (i.e., billing procedures, address, prior approval) and the non-participating provider must agree in advance to accept the applicable HPSM reimbursement, as payment in full, for any covered services rendered. In addition, when billing for services, the non-participating practice-practitioner must clearly identify the name of the HPSM practice/practitioner for whom they are covering in Box 19 of the CMS-1500 claim form.

Surgical Reimbursements

The surgical fee for all therapeutic surgical procedures covers:

- The pre-operative evaluation and care beginning with the decision to perform surgery;
- The surgical procedure and intra-operative care;
- Anesthesia, if used, whether it is local infiltration, digital or regional block and/or topical;
- Normal uncomplicated follow-up care, including the routine post-operative hospital care and routine office visits within the post-operative period. Supplies that are considered usual and customary to the surgical procedure are not separately reimbursable.

Assistant Surgeons

When an assistant surgeon is used for a procedure, it should be noted on the claim by adding an assistant surgeon modifier (80) to the procedure code. All claims are subject to review pursuant to any applicable state or federal laws or regulation or any requirements of California Department of Health Care Services, Department of Managed Health Care or CMS.

The claim will then be reviewed to determine if there was a medical necessity for an assistant surgeon, consistent with Milliman Care Guidelines. A procedure which always requires the use of an assistant surgeon according to the Milliman Care Guidelines will automatically be approved for payment at a reduced rate. This is currently set at 20% of the fee payable to the primary surgeon.

Assistant surgeon fee may be payable for procedures which are not on the list of assistant surgeon allowed procedures. For these exceptions, a PAR will be required and documentation supporting the medical justification for an assistant surgeon must be submitted for pre-authorization. The list of procedures for which an assistant surgeon is allowed is downloadable from the HPSM website or you may contact your Provider Services Representative for a hard copy.

Hospital Discharge Day

If the day of discharge or death occurs with an emergency or regular admission, it is **not** reimbursable except when the discharge/death occurs on the day of admission – even though the day may be covered by the accommodation quantity authorized on the Prior Authorization Request (PAR).

LTC Reimbursement

Payment to Nursing Facility for Skilled Nursing Facility Services provided in accordance with 22 CCR § 51123 shall be as set forth below:

(a) Provider shall furnish all equipment, drugs, supplies, and services necessary to provide nursing facility services except as provided in subsection (c) below. Such equipment supplies and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and State licensing regulations.

(b) Services included but not limited to the following are those which are not included in the payment rate and which are to be billed separately by the Nursing Facility thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies:

(i) Allied health services ordered by the Attending Physician; (ii) Physician services; (iii) legend drugs and Insulin; (iv) laboratory services; (v) alternating pressure mattresses/pads with motor and therapeutic air/fluid support systems/beds; (vi) atmospheric oxygen concentrators and enrichers and accessories, oxygen (except emergency), liquid oxygen system, and portable

gas oxygen system and accessories; (vii) blood, plasma and substitutes; (viii) dental services; (ix) durable medical equipment as specified in 22 CCR § 51321(g) and medical supplies as specified in 22 CCR § 59998 and parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Member; (x) prescribed prosthetic and orthotic devices for exclusive use by Member; and (xi) X-rays.

(c) Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental. The Member shall be responsible for reimbursement for any such personal items.

(d) Payment to nursing facilities for inpatient services shall be the State's prevailing allowable rate for the Nursing Facility as may be set forth in 22 CCR § 51511.

If Provider also renders intermediate care services, Provider shall be reimbursed as set forth in Attachment A.

Full Payment. The rates agreed to in this Exhibit 1, are to be the only payments made by PLAN to Nursing Facility for inpatient services provided to Members except where otherwise may be provided hereunder in the Agreement on in this Exhibit 1.

(e) Not withstanding (e) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require PLAN to implement benefit changes that would result in reimbursement to Nursing Facility at a rate different than the rates set forth in (e) (ii) of this Exhibit 1 or, PLAN reserves the right, but does not have the obligation, to make said adjustments. In the event PLAN does elect to make such an adjustment, PLAN shall be obliged only to do so back to the beginning of the current fiscal year.

(f) Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved inpatient Days by the applicable rates, set out above, to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Accommodation Codes and Reimbursement

Facility should submit UB-04 Claim forms and include accommodation codes as follows:

- 21 Nursing Facilities Level A Regular Services
- 22 Nursing Facilities Level A Leave Days (non developmentally disabled patient)

The parties to this Agreement agree that Nursing Facility shall be reimbursed by PLAN when it receives Clean Claims for intermediate care services billed with accommodation codes 21 or 22 at the per diem rate of the ICF's daily State Medi-Cal rate.

Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Intermediate Care Services for the Developmentally Disabled and for Nursing Level A Intermediate Care Facilities

(a) Intermediate Care Facilities providing intermediate care services for the developmentally disabled shall furnish all equipment, drugs, services and supplies necessary to provide intermediate care services for the developmentally disabled except as provided in subsection (b) below. Such equipment, drugs, supplies, and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and State licensing regulations.

(b) Not included in the payment rate and to be billed separately by the ICF thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are as follows:

(i) Allied health services ordered by the attending physician; (ii) physician services; (iii) legend drugs and Insulin; (iv) laboratory services; (v) alternating pressure mattresses/pads with motor and therapeutic air/fluid support systems/beds; (vi) atmospheric oxygen concentrators and enrichers and accessories, oxygen (except emergency), liquid oxygen system, and portable gas oxygen system and accessories; (vii) blood, plasma and substitutes; (viii) dental services; (ix) durable medical equipment as specified in 22 CCR § 51321(g) and medical supplies as specified in 22 CCR § 59998 and parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Member; (x) prescribed prosthetic and orthotic devices for exclusive use of patient; and (xi) X-rays.

(c) Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental. The Member shall be responsible for reimbursement for any such personal items.

(d) Payment to ICF facilities for inpatient services for Developmentally Disabled shall be: (i) the State's allowable rate for the ICF; or (ii) the rate charged to the general public, whichever is lowest. ICF must complete the information set forth in Attachment A, attached hereto, and submit it to the PLAN at the time the Agreement is signed.

Description	Accommodation Code
• ICF Developmental Disability Program	41
• ICF/DD-H 4-6 beds	61
• ICF/DD-H 7-15 beds	65
• ICF/DD-N 4-6 beds	62
• ICF/DD-N 7-15 beds	66

Payment for inpatient services for Nursing Facility Level A as follows:

Description	Accommodation Code
• Nursing Facilities Level A Regular Services	21
• Nursing Facilities Level A Leave Days- (non developmentally disabled patient)	22

Nursing Facility shall be reimbursed by PLAN when it receives Clean Claims for intermediate care services billed with accommodation codes 21 or 22 at the ICF's daily State Medi-Cal rate.

Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Full Payment. The rates as set forth above for both Developmental Disabled and Nursing Facility Level A services are to be the only payments made by PLAN to ICF for inpatient services provided to Members except where otherwise may be provided hereunder in this Exhibit 1 or any attachment thereto.

(e) Not withstanding (d) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require PLAN to implement benefit changes that would result in reimbursement to ICF at a rate different than the rates set forth in (d) of this Exhibit 1, PLAN reserves the right, but does not have the obligation, to make said adjustments. In

the event PLAN does elect to make such an adjustment, PLAN shall be obliged only to do so back to the beginning of the current fiscal year.

(f) Based on valid Claims submitted by ICF, if PLAN reimburses ICF at the Per Diem Rate, PLAN shall multiply the number of approved inpatient Days by the applicable rates, set out above, to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Coordination of Benefits Billing Instructions

How to Submit Claims When HPSM is the Secondary Plan

All claims must be submitted within ninety (90) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB should be attached to the claim.

Medicare Part A and B member claims must be submitted with the Explanation of Medicare Benefits (EOMB) form attached to the claim.

If the primary plan denies services asking for additional information, that information must be submitted to that carrier prior to submitting to HPSM.

How to Define the Primary and Secondary Plans

Once it has been determined that coordination of benefits applies, the following rules are used to define the primary and secondary plans.

- Subscriber or dependent
- Active or retired
- Effective date
- Dependent children of non-divorced parents (gender rule and birthday rule)
- Children of divorced parents (parents who have remarried and parents who have not)
- Medicare (Primary and Secondary payer)

Subscriber or Dependent

The plan that covers the member as a subscriber pays before the plan that covers the member as a dependent.

Active or Retired

If one of the family members is retired and continues to hold group coverage through his or her previous employer, the subscriber vs. dependent rule holds true. The active plan is primary for all family members.

Medicare

Medicare is Primary payer when:

- Patient is 65 or older, retired, and/or disabled with no group health coverage from former employer or employer of family;
- Patient is 65 or older, retired, and has health plan from former employer;
- Patient is 65 or older, retired, and spouse is employed but doesn't have an employer group health plan;
- Patient is eligible for Medicare solely because of end stage renal disease (ESRD) and health plan of the current or former employer of patient or family has been billed for the first 30 months of Medicare eligibility. This applies regardless of whether the patient is under or over 65;
- Patient works for the military and is covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS will pay as secondary plan; or
- Patient is a veteran who rejects VA benefits.

Medicare is Secondary payer when:

- Patient is 65 or older, is actively employed and has coverage under an employer group health plan;
- Patient is 65 or older and is covered under an actively employed spouse;
- Patient is disabled, under the age of 65 and is covered with 100 or more employees;
- Patient is under 65 and eligible for Medicare solely because of end stage renal disease and the health plan of the current or former employer of the patient or family member has not yet been billed for the first 30 months of Medicare eligibility;
- Patient is "Working Aged". Retired patient who is Medicare eligible returns to work, even temporarily, and receives employee health benefits;
- Patient who is eligible for Medicare and has a retired spouse returns to work, even temporarily, and gets employee benefits that covers the patient services; or
- Patient who is eligible for Medicare has VA benefits that cover the services.

Effective Date

The effective date rule applies when one member has two active group coverages. This often occurs when a member has more than one job and has elected coverage through both employers or was offered two coverages from the same employer and elected to have both. When this happens, the plan with the earliest effective date is primary.

Dependent Children of Non-Divorced Parents

This rule states that the plan of the parent with the earlier birthday is primary and the plan of the parent with the later birthday is secondary. This applies only to the month and day of birth, not the year. The birthday rule is the most common rule that is used by health insurance plans today.

Children of Divorced Parents

When children of divorced parents are covered under both parents' plan, and there is a custody/divorce decree that states one parent has primary responsibility for medical expenses, the plan of the parent with the primary responsibility is primary.

If there is no court decree assigning medical expenses responsibility, or parents hold joint medical expense responsibility, the plan of the parent with custody of the children is primary and the plan of the parent without custody is secondary.

If the children are covered under the plans of their natural parents and stepparents, the order of benefits is as follows:

1. Plan of the parent with custody pays first.
2. Plan of stepparent with custody pays secondary.
3. Plan of parent without custody pays third.
4. Plan of stepparent without custody pays last.

Medi-Cal is not liable for the cost of HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. To establish Medi-Cal's liability, the provider must obtain an acceptable denial letter from the HMO. For additional information, refer to "HMO Denial Letters" in the Other Health Coverage (OHC).

Please remember, Medi-Cal is the payer of last resort in most cases.

Balance Billing

As a contracted provider with HPSM, there are circumstances in which you must not bill a HPSM member. You are generally prohibited by the terms of your contract and by California State Law from billing HPSM members for any costs related to services you provide, other than any applicable deductible, co-pay or co-insurance amount.

You Must Not Balance Bill A Member:

- For the difference between the charge amount and the HPSM fee schedule.
- When a claim has been denied for late submission, unauthorized service, or as not medically necessary.
- When claims are pending review by HPSM.

Please remember to obtain the member co-pays indicated on the HPSM member ID card or co-insurance at the time of service.

Should you have any questions regarding billing HPSM members, please contact HPSM Provider Services at **650-616-2106**.

Primary Care Medi-Cal Capitation Code List

Office Visits

99201- 99205	Office/outpatient visit, new, 10-40 minutes
99211- 99215	Office/outpatient visit, established, 10-40 minutes

Preventative Services (Capitated unless associated with P4P)

99381	Preventative Visit, new, infant
99382	Preventative Visit, new, age 1-4
99383	Preventative Visit, new, age 5-11
99384	Preventative Visit, new, age 12-17

99385	Preventative Visit, new, age 18-39
99386	Preventative Visit, new, age 40-64
99387	Preventative Visit, new, age 65-over
99391	Preventative Visit, est, infant
99392	Preventative Visit, est, age 1-4
99393	Preventative Visit, est, age 5-11
99394	Preventative Visit, est, age 12-17
99395	Preventative Visit, est, age 18-39
99396	Preventative Visit, est, age 40-64
99397	Preventative Visit, est, age 65-over
99401	Preventative Counseling, indiv
99402	Preventative Counseling, indiv
99403	Preventative Counseling, indiv
99404	Preventative Counseling, indiv
99432	Newborn care not in hospital

Immunization Administration

90465	IZ administration under 8 years of age (including subcutaneous and intramuscular routes) when physician counsels the patient/family; first injection, per day
90466	Each additional administration
90467	IZ administration under 8 years of age (including intranasal and oral routes) when physician counsels the patient/family; first administration, per day
90468	Each additional administration
90471	IZ administration, (including subcutaneous and intramuscular routes) one vaccine, single or combo

90472	Each additional administration
90473	IZ administration, (including intranasal and oral routes) one vaccine, single or combo
90474	Each additional vaccine, single or combo

Minor Surgical and Other Miscellaneous Procedures

10060	Drainage of boil
10080	Drainage of pilonidal cyst
10120	Removal, foreign body
10140	Drainage of hematoma
10160	Puncture drainage of lesion
11055	Trim skin lesion, two to four lesions
11056	Trim skin lesion, more than four lesions
11057	Puncture drainage of lesion
11100	Biopsy of lesion
11101	Biopsy, each additional lesion
11200	Removal of skin tags
11400 -11441	Removal of skin lesions: 0.05 cm to 1.0 cm
11719	Trimming of non-dystrophic nails
11720	Debridement of nails, one to five
11721	Debridement of nails, six or more
11732	Avulsion of nail plate, each addtional
11740	Drain blood from under nail
11900	Injection into skin lesion
16000	Initial treatment of burns

20612	Aspiration and/or injection of ganglion cysts
26720	Treatment of finger fracture: each
28490	Treatment of big toe fracture
30300	Removal of foreign body, intranasal (office procedure)
46600	Diagnostic anoscopy
46608	Anoscopy with removal of foreign body
46900	Destruction of of lesion(s), anus (e.g. condyloma, molluscum, etc.) simple, chemical
51100	Aspiration of bladder by needle
51701	Insertion of non-indwelling bladder catheter
51702	Insertion of temporary indwelling bladder catheter
51705	Change of cystotomy tube, simple
54050	Destruction of lesion(s), penis (e.g. condyloma, molluscum, etc.) simple, chemical
56501	Destruction of lesion(s), vulva, simple
57170	Diaphragm or cerval cap fitting with instructions
65205	Removal of foreign body, eye
69200	Clear outer ear canal
69210	Remove impacted ear wax
69400	Eustacian tube inflation, transnasal

Laboratory Services

36400	MD, Venipuncture, less than 3 years
36405	MD, Scalp Vein, less than 3 years
36406	MD, Other Vein, less than 3 years

36410	Venipuncture, adult
36415	Collection of venous blood by Venipuncture
36416	Collection of Capillary blood specimen
81000	Urinalysis, with microscopy
81001	Urinalysis, automated with microscopy
81002	Urinalysis: without microscopy
81003	Urinalysis: automated without microscopy
81005	Urinalysis: chemical, qualitative
81007	Urinalysis: bacteria screen, except culture or dipstick
81015	Urinalysis: microscopic only
81020	Urinalysis: two or three glass test
82270	Blood: Occult, feces: consecutive collected specimens
82272	Blood: Occult, feces, single specimen (e.g. from rectal exam)
82948	Stick Assay Blood Glucose
85004	Blood count, automated differential WBC count
85013	Blood count, spun microhematocrit
85014	Hematocrit
85018	Hemoglobin, Colorimetric
85025	Blood count, complete, automated or automated differential WBC count
85027	Blood count, completem automated
85041	Blood count, RBC count, automated
85048	Blood count, leukocyte (WBC), automated
85049	Blood count, platelet, automated
85650	RBC sedimentation rate: Wintrobe
86580	TB intradermal test

87081	Bacterial culture, screening only for single organism
87084	Culture with colony estimation from destiny chart
87086	Urine culture, colony count
87168	Macroscopic examination, artropod
87172	Pinworm exam (e.g. cellophane tape prep)
87205	Smear, stain and interpretation: Routine stain
87210	Smear, stain and interpretation: Wet mount
87220	Tissue examination for fungi (KOH Slide)
99000	Specimen handling, from physician's office to laboratory
99001	Specimen handling, other

ECG, Hearing Tests and Supplies

92551	Pure Tone Hearing Test: Air Only
92552	Pure Tone Audiometry: Air Only
92553	Audiometry, Air and Bone
92555	Speech Threshold Audiometry
92556	Speech Audiometry, Complete
93000	Electrocardiogram, Complete
93005	Electrocardiogram, Tracing
93010	Electrocardiogram Report
93040	Rhythm ECG with Report
93041	Rhythm ECG, tracing only
93042	Rhythm ECG, report only
99070	Special Supplies covered for any of the above CPT codes covered by capitation

Mental Health Services

90801	Psychiatric diagnostic interview
90802	Interactive psychiatric diagnostic interview
90804	Individual psychotherapy 20-30 minutes
90806	Individual psychotherapy 45-50 minutes
90810	Interactive individual psychotherapy 20-30 minutes
90812	Interactive individual psychotherapy 45-50 minutes
90805	Individual psychotherapy with E/M 20-30 minutes
90807	Individual psychotherapy with E/M 45-50 minutes
90808	Individual psychotherapy 75-80 minutes
90809	Individual psychotherapy with E/M 75-80 minutes
90811	Individual psychotherapy with E/M 75-80 minutes
90814	Interactive psychotherapy 75-80 minutes
90815	Interactive psychotherapy with E/M 75-80 minutes
90813	Interactive individual psychotherapy
90846	Family psychotherapy without patient present
90847	Family psychotherapy without patient present
90849	Multiple family group psychotherapy
90853	Group psychotherapy
90857	Interactive group psychotherapy
90862	Pharmacologic management and review
90875	Psychotherapy with biofeedback 20-30 minutes
90876	Psychotherapy with biofeedback 45-50 minutes
90880	Hypnotherapy

90885	Evaluation of records
90887	Consultation with family
90889	Preparation of psychiatric report
90901	Biofeedback training, any modality
90911	Biofeedback training perineal muscles, anal or urethral sphincter
96101	Psychological testing by PhD or MD, per hour
96102	Psychological testing by technician, per hour
96103	Psychological testing by computer, with qualified healthcare professional interpretation
96105	Assessment of aphasia, with interpretation and report, by hour
96116	Neuropsychological status exam
96118	Neuropsychological testing by PhD or MD per hour
96119	Neuropsychological testing by technician, per hour
96118	Neuropsychological testing by computer, with qualified healthcare professional interpretation

Contacting the Claims Department

Providers should check HPSM's website for member eligibility and claims status. Providers are encouraged to direct questions to the Claims Department via e-mail at claimsinquiries@hpsm.org.

The Claims Department is available by phone **650-616-2056** Monday, Tuesday, Thursday and Friday from 8am to 5pm (closed from 12-1:00), and Wednesdays from 8am to 12pm.

Claims Disputes

Please refer to Section 5 - Provider Disputes Resolution for information.

Claims Status Inquiries via HPSM's Web Claims System

Providers who are registered with HPSM's Web Claims System may review the status of their claims by logging on with their user ID and password.

Providers who are interested in using the Web Claims System should contact the HPSM Provider Services Department at **650-616-2106** for assistance.

Section 5

Provider Disputes

Introduction

If you have a dispute regarding a claim you submitted to HPSM, you may participate in HPSM's Provider Dispute Resolution (PDR). This process applies to all lines of business for contracted as well as non-contracted providers with one exception. This exception is for non-contracted providers who have a dispute regarding a claim for services provided a CareAdvantage member. In this case, the dispute must be resolved following federal guidelines that apply to Medicare managed care plans which are described at the end of this Section.

If a provider is dissatisfied with aspects of HPSM's operations, or with another provider's or member's activities or behaviors, the provider may contact HPSM's Provider Services Department at **650-616-2106**.

If a provider wants to submit anappeal of a denial of a service authorization on behalf of a member, please refer to the Member Complaints Section of this Manual. HPSM's PDR process must not be used to resolve member appeals of pre-service authorization denials. Such appeals should be submitted through the member appeals process described in Section 3 of this Manual.

Provider Dispute Resolution

HPSM offers the Provider Dispute Resolution (PDR) for Providers to resolve claims issues. This process includes a written notice to HPSM requesting reconsideration of a claim or a bundled group of substantially similar claims. (The PDR replaced the Claims Inquiry Form or CIF process.) You can address any of the following concerns through HPSM's Provider Dispute Resolution 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.

Examples of problems that can be resolved through the PDR:

- If a claim has been underpaid.
- A claim was overpaid due to a payment or billing error.
- A procedure was denied as inclusive to another procedure in error.
- Corrected claim where a previous payment was made.
- Utilization management decisions once a service has been provided

If the dispute is not about a claim, a Provider should provide a clear explanation of the issue. If a provider dispute is submitted on behalf of a member or group of members, the dispute will be resolved through the member grievance process and not through the provider dispute resolution process. HPSM will, however, verify the member's authorization to proceed with the grievance.

Providers should submit their dispute through submission of a Provider Dispute Resolution Request form. The form requests the following information:

- Provider name
- NPI billed on claim
- Provider contact information
- Identification of the disputed item, including
  - The original HPSM 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.

A sample of the Provider Dispute Resolution form is included in this section. The form is also available on HPSM's website at www.hpsm.org. Provider disputes can also be completed online. If you would like to submit PDRs online, please contact the Provider Dispute Resolution Unit at **650-616-2836** for assistance. Forms submitted through the website go directly to the Provider Disputes Unit, as do disputes that are faxed. If you want to print the form and send it via the mail or fax, please send your PDR to the address below or fax to **650-829-2051**.

Health Plan of San Mateo
Attn: Provider Disputes
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

Time Period for Submission

Provider disputes should be sent within 365 days of the date when a claim was denied. However, if a Provider resubmits a claim with additional information and and the claim is denied, the 365 days will be calculated from the denial of the resubmitted claim. HPSM will return any provider dispute that is lacking the information required (as previously noted) 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 provider dispute within 30 working days of the date of receipt of a returned provider dispute requesting additional information. If the additional information is not submitted, the dispute will be closed.

Time Frames for Resolution

HPSM will send an acknowledgement letter to the Provider within 15 working days of receipt of the dispute mail. If a Provider completes and submits the PDR form online, HPSM will send an acknowledgement letter *within 2 working* days of receipt.

HPSM will resolve a provider dispute or amended provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days for Medi-Cal and 30 calendar days for CareAdvantage disputes from Contracted providers after the date of receipt of the provider dispute or the amended provider dispute. If an investigation shows that a claim was originally denied or paid incorrectly due to HPSM error, any interest and penalty due for late payment will be included in the claim payment. Payment will be made within 5 working days from the issuance of HPSM's determination. If the dispute involves an issue of medical necessity or utilization management for a service that has not been provided, the Provider should appeal this through HPSM's Appeal Process. To understand how to appeal, please refer to the Member Complaints Section of this Manual. The chart on page 6 shows the PDR process described above.

Non-Contracted Provider Disputes —CareAdvantage Only

Non-Contracted providers who want to submit a CareAdvantage Appeal of a benefit determination on behalf of a member, must submit the appeal to the Grievance and Appeals Department according to Section 3 of this Manual. However, unlike other lines of business, providers must sign a waiver of liability statement attesting that they waive any right to collect payment from the member in order for HPSM to process the appeal. If the waiver is received timely, HPSM will process the dispute within *60 calendar days* from the date the waiver was received.

Non-Contracted providers who want to submit a dispute regarding a payment decision, must submit the dispute through the Provider Dispute Resolution process.

Provider Grievances

If a Provider is dissatisfied with aspects of HPSM's operations or with a member's behavior, Provider may contact the Provider Services Department at **650-616-2106**.

PROVIDER DISPUTE MECHANISM – Page 1

Written Provider Dispute Rec'd

- provider name
- provider ID#
- provider contact info

Is dispute regarding a claim or request for reimbursement of overpayment?

YES

For Contracted & Noncontracted Providers

- clear ID of the disputed item
- date of service
- clear explanation of basis for provider's feeling pymt request denial contest or pymt adj is incorrect

NO

For Contracted Providers

- clear explanation of issue and provider's position thereon

Is dispute being submitted on behalf of enrollee?

- name & ID of enrollee
- clear expl of disputed item
- date of service
- provider's position thereon

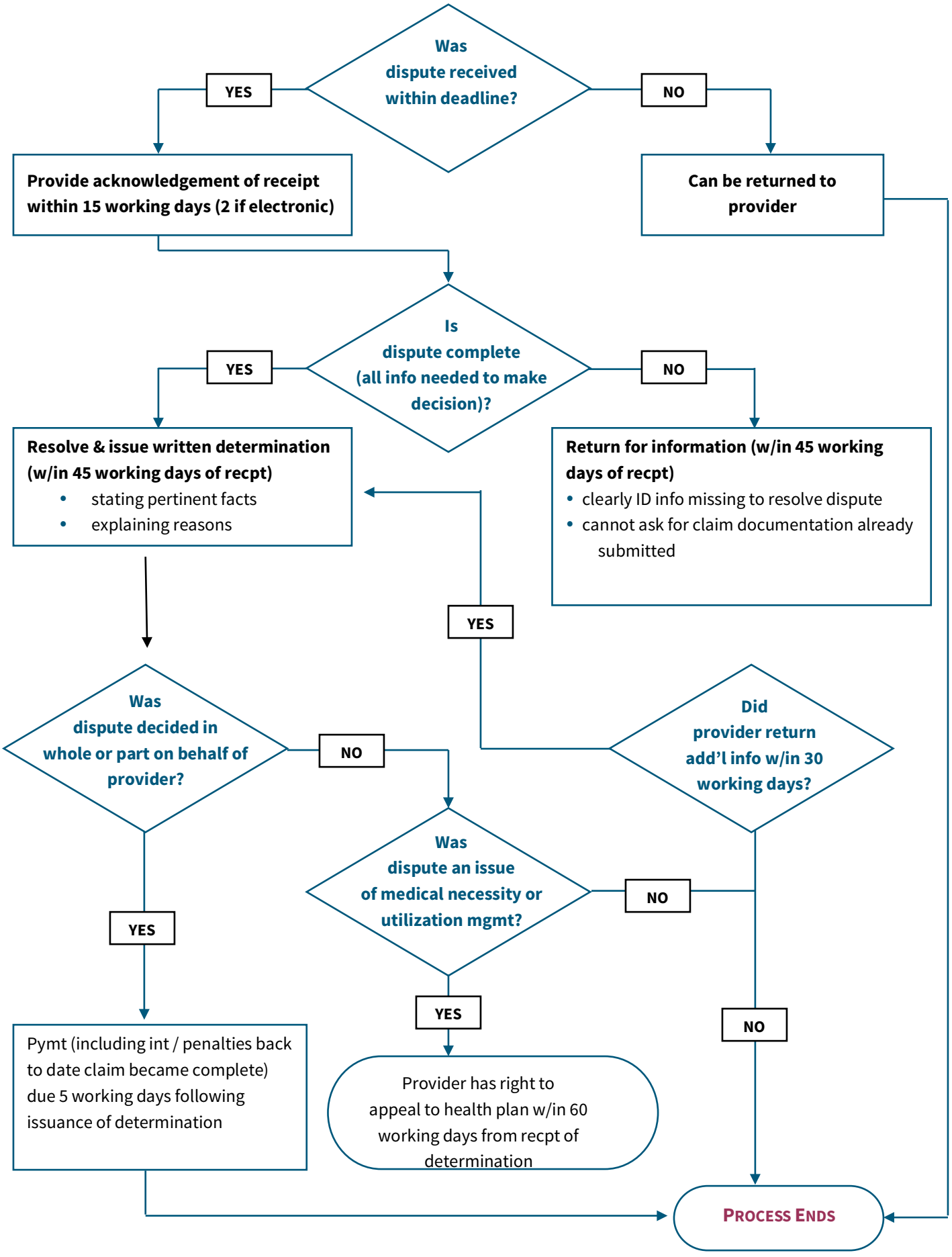
YES

Refer Dispute to HPSM's Grievance Process

- HPSM may verify the member's authorization to proceed with the grievance

NO

Date Stamp the dispute when received and process as a Provider Dispute (**SEE PAGE 2**).


Was dispute received within deadline?
YES
NO
Provide acknowledgement of receipt within 15 working days (2 if electronic)
Can be returned to provider
Is dispute complete (all info needed to make decision)?
YES
NO
Resolve & issue written determination (w/in 45 working days of recpt)
• stating pertinent facts
• explaining reasons
Return for information (w/in 45 working days of recpt)
• clearly ID info missing to resolve dispute
• cannot ask for claim documentation already submitted
YES
Was dispute decided in whole or part on behalf of provider?
NO
Did provider return add'l info w/in 30 working days?
Was dispute an issue of medical necessity or utilization mgmt?
NO
YES
YES
NO
Pymt (including int / penalties back to date claim became complete) due 5 working days following issuance of determination
Provider has right to appeal to health plan w/in 60 working days from recpt of determination
PROCESS ENDS

PROVIDER DISPUTE RESOLUTION REQUEST

By submitting this form, I agree not to bill the member(s) named on it.
***Initial here and sign at bottom of form*: _____**

INSTRUCTIONS

- **For routine follow-up,** please contact Health Plan of San Mateo's Claims Department at (650) 616-2056.
- **To request dispute resolution**, please complete the form below. **Fields with an asterisk (*) are required.**
- Be specific when completing the *Description of Dispute* and *Expected Outcome*.
- Provide additional information to support the description of the dispute. You do not need to include a copy of a claim that was previously processed.
- **Fax** the front and the back of the completed form to **(650) 829-2051** or **mail** it to:
  Attn: Provider Disputes
  Health Plan of San Mateo
  701 Gateway Boulevard, Suite 400
  South San Francisco, CA 94080

*Provider Name:	*NPI #:
Provider Address:	
Provider Type: ☐ PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other (please specify):	
Line of Business: ☐ Medi-Cal ☐ CareAdvantage ☐ ☐ HealthWorx ☐ ACE ☐ Healthy Kids	☐ Contracted ☐ Non-Contracted ***(see back of form, for CareAdvantage only)***

*Claim Information ☐ Single ☐ Multiple "like" claims (complete a Supplemental Form) *Total number of claims:* _____

*Member Name	Date of Birth:	
*Member ID Number:	Original Claim ID Number (if multiple claims, use attached spreadsheet):	
Service "From/To" Dates **Required for Claim, Billing, and Reimbursement of Overpayment Disputes*	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type ☐ Denied Claim ☐ Underpayment of a Claim ☐ Request for Reimbursement of Overpayment ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Contract Dispute ☐ Other (please specify):

* Description of Dispute (continue on back if needed):

Expected Outcome:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

☐ Check here if additional information is attached. *(Please do not staple additional information.)*

For Health Plan Use Only: Tracking #: Provider ID #:

HEALTH PLAN OF SAN MATEO PROVIDER DISPUTE RESOLUTION REQUEST (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name	Member ID / Member HIC Number
Provider Name	Dates of Service
Health Plan of San Mateo	
Health Plan	

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date
H5428_CA_3070_08 (approved 02/08/2008)	

Description of Dispute (continued)

For Health Plan Use Only: Tracking #: Provider ID #:

HealthPlan OF SAN MATEO

PROVIDER DISPUTE RESOLUTION REQUEST

Supplemental Form for Use with Multiple "Like" Claims

By submitting this form, I agree not to bill the member(s) named on it.

Initials of signatory on main form*: _____ *For CareAdvantage only, also see back of form.

This form provides additional information for the following dispute resolution request:

Provider Name	**To cross-reference this supplemental form with the main form, please give member's name from main form:**	**Date**

#	Member Last Name - - - - - - - - - - - - Member First Name	DOB	Health Plan ID #	Original Claim ID #	Service "From/To" Dates	Original Claim Amount Billed - - - - - - - - - - - Original Claim Amount Paid	Expected Outcome
1							
2							
3							
4							

☐ Check here if additional information is attached. *(Please do not staple additional information.)*
This is Supplemental Form # _____of _____ supplemental forms for this request.

For Health Plan Use Only
Tracking #:
Provider ID #:

HEALTH PLAN OF SAN MATEO
PROVIDER DISPUTE RESOLUTION REQUEST
SUPPLEMENTAL FORM (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name #1 from reverse side	Member ID / Member HIC Number
Member Name #2 from reverse side	Member ID / Member HIC Number
Member Name #3 from reverse side	Member ID / Member HIC Number
Member Name #4 from reverse side	Member ID / Member HIC Number
Member Name #5 from reverse side	Member ID / Member HIC Number
Provider Name	Dates of Service

Health Plan of San Mateo

Health Plan

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date

H5428_CA_3070_08 (approved 02/08/2008)

For Health Plan Use Only: Tracking #: Provider ID #:

HealthPlan OF SAN MATEO
Healthy is for everyone

Provider Manual

Section 6

Ancillary Services

Special Note to Providers Regarding CareAdvantage

- Items in this section are not inclusive of benefit coverage under CareAdvantage.
- CareAdvantage members are eligible for both Medicare and Medi-Cal. Medi-Cal benefits will apply to those CareAdvantage members who are full scope Medi-Cal beneficiaries.
- For CareAdvantage members coverage requirements and rules for a dual eligible under Title XVII and XIX should be transparent.

If you have questions or need to verify benefit coverage for CareAdvantage members, contact the Provider Services Department at (650) 616-2106.

Laboratory Testing

HPSM has relationships with recognized vendors of laboratory services, including free standing and hospital based laboratories, to ensure member access and the highest quality and consistency of care.

HPSM has relationships with the following vendors:

- Quest Laboratories (located in Burlingame and Palo Alto)
- Chinatown Medical Laboratory (located in San Francisco)
- Satellite Laboratory Services (located in Redwood City, dialysis related)

In addition, all of our contracted hospital facilities have outpatient laboratory services available for our members.

We do recognize that some testing is best completed while the patient is in the office, when a provider can most efficiently assess and develop a plan to address the patient's care needs. HPSM also appreciates that as health care systems and groups of providers have progressively integrated; the completion and communication of these diagnostic services are tightly woven into that integration. As a result, HPSM will also support office-based diagnostic testing that adheres to office CLIA certification at provider and member convenience.

Providers of CLIA-certified office-based testing are expected to maintain the necessary certification to ensure quality control and consistency of results. Services will only be covered for members who are otherwise under the care of a provider in that practice. Most of these services are covered under the PCP capitation agreement. Please refer to Section 4 – Primary Care Capitation Code List for details. Services not on the list will be reimbursed based on the Medicare or Medi-Cal fee schedule depending on the member's coverage.

Whether you choose to utilize the services of our preferred vendors or perform these services in your own office, our primary goal is to ensure our members receive the diagnostics they require in a manner that facilitates delivering high quality care.

Prescription Drugs

The HPSM Pharmacy staff is available to consult with providers about plan benefits and exclusions, drug formularies, prior authorization process, and other clinical pharmacy issues related to HPSM members. HPSM contracts with **Argus** as our Pharmacy Benefits Manager to administer the pharmacy benefit through its network of retail, home infusion and long-term care pharmacies. Argus is primarily responsible for processing pharmacy claims, and assist with day-to-day pharmacy billing problems and issues. All Prior Authorization (PA) requests are reviewed and processed by HPSM Pharmacy staff.

Argus telephone customer service and help desk phone number is 800-522-7487. You may contact Argus directly 24 hours per day, 7 days per week.

HPSM Pharmacy staff is available to answer your questions regarding pharmacy services, formularies, and prior authorization process. They can be reached at (650) 616-2088, from 8:00 AM to 5:00 PM, Monday through Friday. (Please note: On Wednesdays, the Health Services department is closed from 8 a.m. to 12 noon.)

HPSM Drug Formularies

HPSM maintains three separate drug formularies. There is one formulary for HPSM-Medi-Cal, Healthy Kids, and HealthWorx; one for the Medicare Prescription Drug Plan Part D benefit of CareAdvantage, and another formulary for the Access and Care for Everyone (ACE) program. The HPSM-Medi-Cal and CareAdvantage formularies are reviewed by the HPSM Pharmacy Review Committee. The committee is comprised of community pharmacists and physicians representing various medical/surgical and psychiatric specialties. It meets bi-monthly and systematically reviews

the formulary on a periodic basis. HPSM's approach to formulary management is to consider drugs to be included on the formulary if they are documented to be cost-effective, based on pharmacoeconomic analysis. As such, the HPSM drug formularies are mandatory generic enforced. The CareAdvantage formulary also includes preferred and non-preferred branded drugs that may be available through prior authorization or step therapy. Provider requests for consideration of new drugs to be added to the HPSM formularies must be submitted in writing using the HPSM Request for Formulary Modification form, available online at www.hpsm.org. A copy of this form is included in the Forms section. Completed forms may be sent to:

Health Plan of San Mateo
Attn: Pharmacy Review Committee.
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

650-829-2079 Fax

The HPSM formularies are available on the HPSM website. Hard copies of the HPSM formularies are also available from your Provider Services Representative upon request. The HPSM formularies list all drugs by either the chemical name, brand name (if one exists), and/or the name of the generic equivalent. If you have any questions regarding the HPSM drug formularies, please contact the HPSM Pharmacy staff at 650-616-2088.

Non-Formulary Drugs

HPSM participating providers and pharmacies are responsible for using the HPSM formularies first. If a prescribed drug is not on the formulary, the pharmacist will call the prescribing provider to request a change to a formulary alternative. If an alternative is not available or inappropriate for member's condition, the pharmacist must submit a Medication Request Form (MRF) to HPSM at 650-829-2045. (See Pharmacy Prior Authorization (PA) Process for information on submitting a Medication Request Form).

Changes in Drug Formularies

If a member is on a drug, and HPSM removes the drug from its formulary, the prescriber will be asked to consider the formulary alternatives. If the formulary alternatives cannot be utilized, a Medication Request Form (MRF) must be submitted to HPSM with the reasons the member cannot switch.

Psychotherapeutic Drugs & Lab Tests for Medi-Cal Members

For HPSM/Medi-Cal members, mental health drugs prescribed by psychiatrists for these members *had been the responsibility of the San Mateo Behavioral Health and Recovery Services (BHRS)* for many years. The mental health drugs carve-out arrangement to the BHRS program had ended June 30, 2010. Thus, MedImpact – the PBM for BHRS – has stopped adjudicating pharmacy claims after June 30, 2010.

Since **July 1, 2010**, HPSM had taken over the administration of the Medi-Cal covered Mental Health Pharmacy Benefits for HPSM-Medi-Cal members. **Argus** is the PBM that accepts online pharmacy claims for the Medi-Cal covered Mental Health drugs prescribed by psychiatrists for HPSM Medi-Cal members.

The BHRS mental health drug formulary (drug list prescribed by psychiatrists) has been integrated into the main HPSM-Medi-Cal Drug Formulary. However, the rules and restrictions of the BHRS formulary remain unchanged, and they will be applied the same way as in the past when a psychiatrist prescribes a mental health medication. For details of the BHRS Formulary, refer to page 123 of the 2010 HPSM-Medi-Cal Formulary Handbook.

Important Reminder: Claim submission to Argus for HPSM Medi-Cal members requires the members' CIN numbers or HealthSuite (HS) numbers. Do NOT use the BHRS assigned Client ID numbers for HPSM-Medi-Cal members. The CIN numbers or HS numbers are required for billing all pharmacy claims (non-mental health and mental health) for HPSM-Medi-Cal members. If you encounter claim submission related problems, please do not hesitate to contact **Argus** Pharmacy Help Desk at **800-522-7487.**

Psychiatrists, submitting prior authorization requests for any HPSM membership, should fax or mail the requests on a MRF to HPSM Pharmacy Services for review.

Laboratory Blood Tests ordered by psychiatrists will be reimbursed by BHRS. Bio-Cypher is the lab vendor at the County Regional Centers. Members requiring outpatient laboratory tests as part of their mental health treatment should be referred to a County Health Center where Bio-Cypher is available.

If you have additional questions or require further information on labs, please contact the BHRS at 650-599-1061.

Mental Health drugs prescribed by non-psychiatrist HPSM providers are covered by HPSM. The following psychotherapeutic drugs require prior approval of HPSM with the submission of a PA.

- Clozapine (Clozaril®)
- Risperidone (Risperdal®)
- Olanzapine (Zyprexa®)
- Quetiapine (Seroquel®, and Seroquel XR)
- Naltrexone (Revia®)
- Ziprasidone (Geodon®)
- Aripiprazole (Abilify ®)
- Paliperidone (Invega®)

Laboratory Blood Tests ordered by non-psychiatrist HPSM providers are covered by HPSM.

Pharmacy Prior Authorization (PA) Process

Prior authorization of selected pharmacy services allows HPSM to balance patient care, quality, safety, and cost objectives in a manner which facilitates the most efficient use of resources and results in favorable health status outcomes.

Prior authorization provides access to non-formulary drugs and supplies when the HPSM Formulary cannot meet the member's needs.

A Prior Authorization (PA) request must also be used when Plan or formulary restrictions and limits (e.g. code 1 and frequency of billing) are not met or exceeded. The details must be well explained and documented on the request form. HPSM uses Medication Request Forms (MRFs). There is one MRF for CareAdvantage requests, and a separate MRF for all other lines of business. Copies of these forms are available in the Forms section. They are also available online on the HPSM website www.hpsm.org

The MRF approval process for pharmacy services

The provider completes a Medication Request Form (MRF) and submits it via fax to HPSM at (650) 829-2045. Providers may also call (650) 616-2088 with this information.

NOTE: For pharmacies submitting MRFs for CareAdvantage members, a CMS Appointment of Representative (AOR) Form must also be submitted with each MRF. This form is available in the Forms section. It is also available online on the HPSM website.

HPSM Pharmacy staff will review the clinical information in the MRF, utilizing criteria developed and approved by HPSM's Pharmacy Review Committee. MRFs that are approvable based on meeting criteria established by HPSM Pharmacy Committee will usually be processed within 24 hours of submission for Medi-Cal requests, and CareAdvantage expedited requests. If a MRF is not approvable based on the information that is included on the MRF, HPSM Pharmacy staff will make attempts to request additional information from the provider. For all lines of business, if the additional information submitted is not sufficient to meet criteria or if no response is received from the provider within 1 day, the HPSM pharmacy technicians will issue a deferral notice of action to the provider and the member, informing them in writing what additional information is needed to approve the MRF. If after 21 days (for Medi-Cal), the information on hand is still not sufficient to meet criteria, the MRF will be forwarded to HPSM Medical Director and/or licensed pharmacists for final determination. For CareAdvantage standard PA requests, if the additional information is not sufficient to meet criteria or if no response is provided within 48 hours, HPSM Pharmacy staff will defer ("toll") the request to the requestor, and asks for additional information. If no additional information is received after the tolling period (deferral period) of 14 days (for a standard request) and 5 days (for an expedited request), HPSM staff will make a final determination based on the original submitted information.

Note: For CareAdvantage members, HPSM adheres to a 72-hour standard determination and a 24-hour expedited determination time frame, as mandated by CMS. For Medi-Cal plan members HPSM adheres to a 24 hour determination time frame. For San Mateo ACE Program, HPSM adheres to a 72 hour standard request timeframe only.

The MRF deferral process for pharmacy services

For all lines of business, a decision on a MRF will be deferred if it is submitted with insufficient medical justification or incomplete information.

Prior to sending a deferral notice to a provider for an incomplete MRF, the HPSM Pharmacy staff will make attempts to contact the provider to obtain the additional medical information needed to approve the MRF.

If HPSM Pharmacy staff is unable to obtain the necessary documentation, the MRF is returned to the provider with a Deferred Notice. The notice describes the specific information required in order to

make a determination regarding the medical necessity of the requested service/item. The Provider will be given additional business days to provide the requested information.

Members are notified in writing of deferrals within 24 hours of the receipt of the request for Medi-Cal.

The MRF denial process for pharmacy services

The Medical Director (or its designee) may make a denial of service determination based on medical necessity. The Medical Director consults with appropriate specialists as needed, before denying a MRF. The Medical Director may discuss the determination with the prescribing physician, if necessary; to ensure that appropriate patient care is not delayed.

If a request for a drug is denied, a Denial Letter is sent to the requesting provider and Denial Notice of Action Letter to the member. The Denial Letter and Notice of Action Letter explain the reason for the denial and provide information on how the member may file an appeal with HPSM regarding the Plan's decision.

Members are notified in writing within 24 hours of the receipt of the request for Medi-Cal members.

Plan Initiated MRFs

There may be some rare instances where HPSM is required to initiate a MRF for a provider (i.e., out-of-state services or treatment). Documentation of medical necessity is requested from the provider and the review process is the same as it is for a MRF initiated by a participating pharmacy provider.

Authorization Processing Time for PAs

Prior Authorization and Continuing Service PAs

For CareAdvantage, approval decisions for prior authorization and continuing pharmacy requests are made within 72 hours of the request for standard decisions. For all other lines of business, approval decisions for prior authorization and continuing pharmacy requests are made within 1 business day of the receipt of the information reasonably necessary to make a decision.

Processing Time for Retroactive Service PAs

Approval decisions for retroactive pharmacy requests are made within 1 day of receipt of the information reasonably necessary to make a decision. For CareAdvantage, retro requests are reviewed as a standard (72 hour) request only.

Processing Time for Medically Urgent and Faxed Pharmacy PAs

Approval decisions for medically urgent pharmacy PAs, as identified on the PA by the words "Medically Urgent", are made within 24 hours of the receipt of the request.

Evening and Weekend Prior Authorization Requests

For CareAdvantage, evening, weekend/holidays prior authorization requests are reviewed by HPSM's on-call pharmacist. If the on-call pharmacist is unable to approve an urgent Prior Authorization request, the request will be forwarded to HPSM's on-call physician for final determination within 24 hours of the original request. For standard requests, a determination will be made within 72 hours of the request.

For all other lines of business, the PA review process occurs on business days only. If a request is submitted on a weekend or holidays, eligible members may be given up to a one-time fill of three (3) day supply of medication. The PA request will be promptly reviewed on the next business day. Contact Argus' Customer Service at (800) 552-7487 for this one-time override procedure. HPSM will reimburse the pharmacy for up to a one-time fill of three (3) day supply of urgent medication, dispensed to an eligible member.

Emergency services are exempt from prior authorization but must be justified according to the following criteria:

- Any service classified as an emergency, which would have been subject to prior authorization had it not been an emergency, must be supported by a physician's, podiatrist's, dentist's, or pharmacist's statement which describes the nature of the emergency.
- The provider's statement must include comprehensive clinical information about the member's condition, and state why emergency services rendered were considered to be immediately necessary. A statement that an emergency existed is not sufficient.
- The statement must be signed by a physician, podiatrist, dentist, or pharmacist who had direct knowledge of the emergency described in the statement.

Completing a Medication Request Form

It is important to fill out the MRF completely. The following data items are frequently not completed by providers and result in pended or denied PAs.

- Prescribing Provider's Name, Phone Number and Fax Number
- ICD-10-CM Diagnosis Code
- Medical Justification (including formulary alternatives tried)
- Specific Services Requested
- Specific Directions for Use

Important Reminder on Charging Cash to HPSM Members

Never bill member in place of submitting a PA. You will be required to reimburse any money collected from an eligible HPSM member.

Members should never be told that a drug is not covered by Medi-Cal or HPSM unless a specific denied Prior Authorization Request has been obtained. All drugs are potentially covered through the PA process, unless it is a specific exclusion of the program.

Appeals Process

Members and Providers may request that HPSM reconsider an initial adverse determination. The request must be made in writing within ninety (90) days of the date of the original adverse determination notice for CareAdvantage appeals, within sixty (60) days for Medi-Cal appeals, and within ninety (90) days for all other lines of business. See Section 3 Member Complaints for more information on requesting an appeal.

Quality Review

The CMO, the Director of Pharmacy, and the Director of Health Services Operations will monitor utilization patterns for quality of care by reviewing the following:

- All claims paid for members that require prior authorization with a PA. Included in the review are checks for drug interactions and therapy duplication;
- Quarterly, standard and/or special MIS utilization/quality reports;

- PAs, on a daily basis, for initiation and completion of treatment/services;
- Potential problems noted by the Pharmacist Reviewer, or at on-site-reviews.

The Director of Pharmacy, the Director of Health Services Operations, and the CMO will present follow-up reports from the Health Services staff on this monitoring to the Pharmacy Review, Peer Review and the Quality Management and Oversight Committee.

Pharmacy Management Programs

HPSM has worked cooperatively with Argus to develop high quality, cost-effective pharmacy programs, which maximize the safe and appropriate use of pharmacy services while controlling costs that do not compromise the safety or effectiveness of pharmacy care for our members. The pharmacy management program includes:

- Pharmacy Network
- Pharmacy Benefits Plan which outlines coverage formulary co-payments and other requirements
- Generic Drug Substitution (Mandatory)
- Prior Authorization
- Step Therapy
- Quantity/Co-pay/Days limits
- Drug Utilization Review (DUR)
- Educational Programs

Pharmacy Network

An extensive network, which includes over 55,000 pharmacies throughout the United States, is available to members through the Argus network. Covered drugs filled at a participating pharmacy are subject to the patient's applicable co-pay(s) as defined by their pharmacy coverage.

Pharmacy Benefits

Each program has a detailed description of the pharmacy benefits coverage and exclusions in the member's EOC. For full scope Medi-Cal there are no member co-pays for pharmacy benefits. For all other members, pharmacy co-pays will vary. The co-pay will also vary depending on whether the

prescription is for a generic or brand name drug and whether it is a preferred drug in the HPSM formulary. For some members, there may be annual drug cap amount. For questions on eligibility, pharmacy benefits, or co-pays call Argus' Customer Service at (800) 522-7487. They are available 24 hours per day, 7 days per week.

Provider-administered medications in a physician's office or a clinic (those medications that cannot be self-administered, generally IM and IV) are covered subject to the member's medical benefits and are not subject to the pharmacy co-pay. These should be administered by the provider and billed directly to HPSM. A Prior Authorization Request (PAR) may be required.

Diabetic medications and supplies, in accordance with California State Law are administered under the patient's pharmacy benefits. These supplies and medications may be subject to a co-pay depending on which program the member is eligible for. Diabetic medication and supplies are not subject to any pharmacy benefit cap limitations.

HPSM will cover for medically necessary enteral formulas and for modified solid food products through pharmacy prior authorization, in accordance with California State Law, for the treatment of certain inherited diseases. This benefit is subject to any pharmacy benefit cap limitations depending on the program.

Co-payments and Cost Sharing

HPSM pharmacy benefits for some programs may require member co-payments/cost-sharing for prescriptions. The co-pay may also vary depending on whether the prescription is for a generic or brand name drug and whether it is a preferred drug on the HPSM formulary. Programs may have annual drug cap amounts as well.

Prior Authorization and Medical Exceptions

See previous section for details on "Pharmacy Prior Authorization (PA) Process."

A physician may request a re-consideration in writing. A member or physician may provide additional information to be considered for the review. Providers and members have the right to appeal the determination. An appeal regarding a denied prior authorization/exception is initiated by writing or by calling the HPSM Grievance and Appeals Coordinator.

Exception Process

A formulary exception process is maintained by HPSM and administered through HPSM for cases in which members cannot tolerate a formulary drug. The exception process will allow the member to receive non-formulary medications. All formulary exceptions are subject to medical necessity review similar to the PA process.

A benefit exception/override process is also maintained by HPSM. Examples of a benefit exception might include lost/stolen/or destroyed medications. HPSM Pharmacy staff reviews these requests, and maintains the authority to grant administrative overrides following review of the member's situation as appropriate.

Drug Utilization Review (DUR)

Drug Utilization Review is an Argus system based drug review process, which alerts the pharmacist and physicians to important therapeutic issues regarding the use of medication. Argus' DUR program safeguards members by verifying the safety of dispensing a medicine against the member's pharmaceutical history and providing education when the prescription is filled. The goals are to protect members against harmful drug events, avoid severe drug interactions, and reduce costs for our members, and prevent overuse of medications. The prescription being filled is evaluated and information may be provided before or after the prescription is filled to warn the pharmacist, member, or physician of a potential misadventure or a less expensive alternative.

Concurrent Drug Utilization Review (CDUR)

CDUR performs online analysis at the point of prescription dispensing, where each prescription is screened for a broad range of safety and economic considerations. CDUR helps to ensure safe and effective prescription drug therapy. Argus maintains a personal medication profile for each patient that keeps track of his/her drug history. This history includes prescriptions from multiple physicians, information on drug allergies and medical conditions. The profile helps to prevent drug interactions, identify both high quality and cost-effective alternatives to treatments, and assures that the individual patient is using the drug safely. To ensure safe prescription drug therapy, the Drug-to-Drug Interaction Program identifies potentially harmful or fatal drug interactions at the pharmacy. The pharmacist will receive a system edit when filling a prescription that has a potential severe drug-to-drug interaction.

Drug Quantity Management - Quantity/Days per Co-pay

This program focuses on selected drugs or drug categories that are high-cost, prone to overuse/misuse, and/or potentially unsafe in high quantities. The program establishes appropriate

threshold levels of utilization for these drugs based on clinically recommended dosing and/or duration recommendations and keeps drugs from being dispensed above appropriate thresholds. HPSM has identified a number of medications that have the potential for significant overuse, misuse, waste, or abuse.

HPSM has implemented a quantity per co-pay program which includes medications recommended to us by the HPSM Pharmacy Review Committee to ensure that patients receive the recommended, safe quantities for these drugs. Quantity or Days limits are based on the recommended dosage and duration approved by the Food and Drug Administration, the manufacturer, and supported by clinical literature.

Safety and Alert Programs

HPSM will mail affected physicians and members the appropriate information when a drug is withdrawn from the market due to safety concerns. The names of the physicians' patients may be included in the communication or can be provided upon request.

Mental Health and Substance Abuse

San Mateo County Behavioral Health and Recovery Services

For Medi-Cal members, all mental health services are covered by the BHRS. For all other programs (CareAdvantage, Healthy Kids, and HealthWorx), HPSM has subcontracted the mental health services to the BHRS. Emergency psychiatric services and mental health services provided by a member's PCP, within the scope of his or her licensure, are covered by HPSM. With these exceptions, all other mental health services for HPSM members are provided through the BHRS.

As an HPSM provider, you are a critical link to behavioral health care services for your patients. By working collaboratively, you, HPSM and the BHRS, can ensure that HPSM members are receiving specialized attention for their behavioral health care needs. The BHRS has a team of professional staff and a network of providers and facilities. The BHRS provides a full range of managed mental health care services from outpatient treatment to intensive inpatient treatment, customized to meet the individual needs of the member.

The BHRS has outpatient service centers in Daly City, San Mateo, the Coastside, Redwood City and East Palo Alto, in school-based locations, and through a network of community agencies and independent providers. Priority populations include seriously mentally ill adults and children, older

adults at risk of institutionalization, children in special education or at risk of out-of-home placement, and people of any age in major crisis. These county and community resources provide outpatient services, residential treatment, rehabilitation and other services for adults and children.

The BHRS operates the Cordilleras Mental Health Center, a 120-bed skilled nursing facility in Redwood City, through a contract with Telecare Corporation.

BHRS services are aimed at helping members with mental illness maintain their independence and helping children with serious emotional problems become educated and stay with their families.

The BHRS ACCESS Team & DUAL Team work collaboratively with the Substance Abuse Services and Providers in San Mateo County and evaluate the impact alcohol and other drugs may have on mental health, as part of the Mental Health clinical assessment.

When mental health services are not the most suitable resource for an individual seeking services, the BHRS ACCESS and DUAL teams attempt to provide information and referral to available resources in the larger San Mateo County community of agencies and organizations, along with information on how to best make use of such resources to meet members' individual needs.

How the BHRS Can Help

The BHRS Access Team can assist you with referrals for patients who have mental health needs, as well as for those patients whose physical illness is a result of a mental health problem. The BHRS staff are available to consult with you and share ideas on clinical treatment approaches, managing difficult cases (e.g. eating disorder), and using new treatment resources.

You can also expect close communication from the BHRS about your patient's care, subject to the patient's consent. If you initiated the call to the BHRS, you will be contacted when the patient has entered the outpatient treatment. Regardless of whether or not you initiated the call to the BHRS you will be contacted when medical evaluations or tests are required during inpatient treatment.

How to Refer a Patient to BHRS

To refer a patient to BHRS, follow these steps:

1. Call the BHRS Access Team at (800) 686-0101.
2. Inform the care coordinator that you are calling on behalf of your patient.

3. Let the care coordinator know why you are referring your patient to BHRS so he or she can further assist you.
4. Your call will be directed to a clinician who will discuss the situation with you and jointly determine the most appropriate treatment setting.
5. If the situation is life-threatening, the patient will be referred immediately to the nearest emergency room. When necessary, BHRS will coordinate transportation for the patient.
6. For emergencies that are not life-threatening, an appointment is scheduled for the member to meet with a BHRS network provider within 48 hours.
7. If the situation is not an emergency, you can call BHRS while the patient is in your office and BHRS will work with you to identify an appropriate network provider. You can also provide the patient with SMCMHP's toll-free number, and he or she can contact BHRS directly.

Your role in the referral process is very important. Your support and encouragement may help your patients approach their treatment with a better outlook, thereby increasing the likelihood of their successful recovery. For more information on how BHRS can help you in referring your patients to their Mental Health/Substance Abuse services, call BHRS toll free at (800) 686-0101. Staff is available during normal business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m.) to assist you.

Diagnostic Radiology and Advanced Imaging

HPSM members have many contracted facilities from which to choose for their diagnostic radiology and advanced imaging needs. All contracted hospital facilities provide outpatient radiology services. In addition, HPSM has contracted with a number of free-standing radiology facilities. Please refer to the Provider List to find the most convenient location for your patient.

In an effort to determine the most appropriate and cost-effective diagnostic imaging option, HPSM requires prior authorizations (PAR) for certain diagnostic radiology and advanced imaging studies. Refer to Section 7 – Utilization Management - Prior Authorization for general criteria for authorizations.

Prior Authorization Requests (PAR) will be required for HPSM members (Medi-Cal, Healthy Kids, and HealthWorx) for the following procedures when performed on an outpatient basis in Outpatient Hospital Facilities, Free Standing Radiology Facilities, and Non-Radiology Office-Based Settings:

- MRl

- MRA
- Nuclear Medicine
- PET Scans
- Obstetrical Ultrasounds in excess of three (3) during a pregnancy.

To ensure that the PAR process fully considers patients' symptoms and clinical findings, HPSM requires that the radiology facility obtain the PAR from HPSM Health Services prior to scheduling the patient for the requested services. Claims submitted by a participating provider or facility for diagnostic radiology and advanced imaging tests that have not been authorized through HPSM may be denied. The member is held harmless and balance billing is not permitted.

Exceptions: Radiology services provided to an HPSM member during an inpatient hospitalization or in the emergency department do not require a PAR for technical services.

General Guidelines for Submitting PARs for MRI Studies

PLEASE NOTE: These are general guidelines. Cases are reviewed on an individual basis – the more information that is provided on the PAR, the faster the authorization can be processed. Please remember, a PAR can only be deferred once.

If you have any questions or need assistance, please call Health Services at (650) 616-2079 and ask to speak to a Utilization Review nurse.

MRI cervical spine

a. History consistent with cervical radicular disease process
b. Physical exam with description of neurologic exam consistent with cervical radicular disease
c. Plain radiographs AP/Lateral/oblique have been obtained in last 6 months with reading
d. Any supporting laboratory tests (i.e. EMG)
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI thoracic spine

a. History consistent with thoracic disease process

b. Physical exam with description of thoracic spine findings
c. Plain radiographs AP/Lateral have been obtained in last 6 months with reading
d. Any supporting laboratory tests
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI lumbar spine

a. History consistent with lumbar radicular disease process
b. Physical exam with description of neurologic exam consistent with lumbar radicular disease
c. Plain radiographs AP/Lateral/oblique have been obtained in last 6 months with reading
d. Any supporting laboratory tests
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan
g. MRI lumbar spine for chronic back pain will be authorized following North American Spine Society Guidelines.

MRI brain

a. History consistent with central neurologic disease process
b. Physical exam with description of neurologic exam consistent with central neurologic disease
c. CT scan of head – if not done, explanation why CT head is not suitable
d. Any supporting laboratory tests
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI chest

a. History consistent with thoracic disease process
b. Physical exam with description of findings related to thoracic disease process
c. CT of chest – if not done, explanation why CT chest is not suitable
d. Any supporting laboratory tests
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI abdomen

a. History consistent with abdominal disease process
b. Physical exam with description of findings related to abdominal disease process
c. Ultrasound, CT or contrast study of abdomen – if not done, explanation why these other tests are not suitable
d. Any supporting laboratory tests
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI pelvis

a. History consistent with pelvic disease process
b. Physical exam with description of findings related to pelvic/lower abdominal disease process
c. CT of pelvis – if not done, explanation why CT pelvis is not suitable
d. Any supporting laboratory tests
e. Tentative diagnosis or differential
f. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI shoulder

a. History consistent with shoulder injury
b. Physical exam with description of findings related to shoulder injury, excluding cervical radicular symptoms
c. Plain radiographs of shoulder AP/lateral/axillary and cervical spine AP/lateral/oblique have been obtained within the last 6 months
d. Tried and failed conservative therapy, including steroid injection(s), NSAIDs, and/or physical therapy – if not done, why conservative therapy not tried
e. Any supporting laboratory tests
f. Tentative diagnosis or differential
g. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

MRI knee

a. History consistent with knee injury
b. Physical exam with description of findings related to knee injury, excluding lumbar radicular symptoms
c. Plain radiographs of knee AP/lateral/notch view and lumbar spine AP/lateral/oblique have been obtained within the last 6 months
d. Tried and failed conservative therapy, including steroid injection(s), NSAIDs, and/or physical therapy – if not done, why conservative therapy not tried
e. Any supporting laboratory tests
f. Tentative diagnosis or differential
g. Treatment plan following MRI study – addressing whether or not MRI will change treatment plan

Radiology Authorization Summary Information Sheet

PARs are required for the following diagnostic radiology and advanced imaging studies:

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET Scans)
- Nuclear Medicine
- OB Ultrasounds (in excess of three (3) during a pregnancy)

One PAR number is required for each procedure.

A PAR is valid for the timeframe indicated on the PAR.

Settings Requiring a PAR:

- Outpatient Hospital Facilities (In-Patient and Emergency Department are exempt)
- Free Standing Radiology Facilities
- Non-Radiology Office Based Settings

Information Required:

- Member's name, date of birth, Member ID number, the exam(s) requested and CPT procedure code, including all pertinent modifiers.
- Working diagnosis or rule out diagnosis (non-specific diagnoses will be returned).
- The signs and symptoms that call for the exam including how long they have been present.
- Any previous imaging studies that have been performed and the results, and any pertinent lab results.
- Any history of prior treatment, whether drugs, surgery, or other therapies, and for how long.
- Any other information that indicates the need for the exam.

Please note that HPSM will make a determination of medical necessity only. Always verify eligibility, benefits and co-payments for a member directly with HPSM Member Services.

Please remember the applicable modifier(s) when submitting PARs for these services.

Chiropractic Care and Acupuncture

HPSM contracts with local chiropractic providers for the provision of chiropractic services for HPSM members. **Benefits are subject to program coverage and limitations.** Acupuncture services are available for Medi-Cal, Healthy Kids, and HealthWorx members. **Benefits are subject to program limitations**. In general, visits are limited to 2 per month. These services are provided through contracted providers listed in the Provider Directory.

Both chiropractic and acupuncture services are self-referred and do not require authorization, subject to the limits of the program.

Physical, Occupational, & Speech Therapy

Physical and Occupational Therapy

All HPSM members are provided physical and occupational therapy services through our outpatient, hospital-based physical and occupational therapy units within the contracted hospital network. Initial evaluations do not require a PAR; however, all other physical and occupational therapy services do require a prospectively submitted PAR. The initial therapy PAR must include a copy of the initial evaluation, as well as a copy of the physician's prescription for therapy.

PARs for continuing therapy services should be submitted at least two weeks before the end of the current authorization in order to prevent a lapse in therapy services. Continuing therapy PARs must include a copy of the latest therapy evaluation and a copy of the physician's prescription for additional therapy. Requests for additional therapy without a specific diagnosis may be deferred for specialist evaluation.

If there is a long waiting time prior to the anticipated start of a therapy program, please indicate this on the initial therapy PAR. The additional waiting time will be added to the approved PAR to avoid the need to submit a time extension for an already approved PAR.

If therapy services are planned following a scheduled surgical procedure, please submit these requests along with the surgical PAR, in order to prevent any delays in obtaining authorization for post-operative outpatient rehabilitation services.

Speech Therapy

All HPSM members have access to outpatient speech therapy services. Initial evaluations do not require a PAR; however, all other speech therapy services do require a prospectively submitted PAR. The initial therapy PAR must include a copy of the initial evaluation, as well as a copy of the physician's prescription for therapy. In addition, the results of a recent hearing test should be included with the PAR.

For patients who may be eligible for a school-based speech therapy program (3 years of age and older), an evaluation by the school district will be required for additional therapy sessions. The school district evaluation requirement may be waived if there are extenuating circumstances which prevent the evaluation from taking place on a timely basis. Participation in a school-based speech therapy program, if the member is eligible, is required while school is in session (September through June).

Podiatry (CareAdvantage and Medi-Cal only)

CareAdvantage

Podiatry services are a covered benefit for the treatment of injuries and disease of the feet (such as hammer toe or heel spurs). Routine foot care is covered for members with certain medical conditions affecting the lower limbs (diabetes).

Medi-Cal and HealthWorx

Podiatry benefits are provided for HPSM Medi-Cal and HealthWorx members. Healthy Kids membersdo not have access to podiatry services unless the service requested is related to diabetes. For these cases, podiatry services may be authorized with a PAR.

Podiatry services are provided through our contracted providers located throughout San Mateo County. Services are limited to two office visits a month. All Medi-Cal podiatry procedures/surgeries require a PAR except for the following procedure codes:

11730	Avulsion of nail plate, partial or complete, simple; single
11732	Each additional nail plate (use in conjunction with 11730)

99321	New patient evaluation – domiciliary, rest home, custodial care – level 1
99331	Established patient evaluation – domiciliary, rest home, custodial care - level 1

Please refer to the Podiatry Supplement for information on frequency of service limits and qualifying diagnosis codes.

Vision Care

Vision care services are covered through a variety of different methods, depending on the specific program that the member is enrolled in. The section below describes each of the various programs and their associated vision care benefits.

CareAdvantage

Outpatient physician services for eye care is a covered benefit for people who are at high risk of glaucoma, such as people with a history of glaucoma, people with diabetes, and African-American who are age 50 and older are covered for glaucoma screening once per year.

Members are eligible for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

Medi-Cal

Members who need an examination for eye glasses may go directly to an optometrist for a visit once every two years (without the need for a referral from the PCP*). For other eye problems, members should see their PCP for a referral to an ophthalmologist.

Members are eligible for new eyeglass (frames and lenses) every two years. Lost, stolen, or broken glasses may be replaced under extenuating circumstances. If members repeatedly lose or break their eyeglasses, they may be responsible for replacement eyeglasses.

*Only Willow Clinic optometrists require a referral (RAF), since they do not have their own provider number.

Healthy Kids

Vision benefits are provided through HPSM's network of professional vision care providers. Members ***must*** select a provider for vision care from those listed in HPSM's Provider List. This list can be viewed and downloaded from the HPSM website (www.hpsm.org). It can also be obtained in hard copy format by writing or calling a Member Service Representative at (800) 750-4776.

If a Member obtains vision care services from an out-of-network provider, the Member is responsible for payment in full to the provider.

If Member obtains vision care services from one of HPSM's network providers, the Member is responsible for the following co-payments:

Cost to Member

Categories A & B: $5 co-payment per examination

Categories C & D: $10 co-payment per examination

Category E: $10 co-payment per examination

- Frames and Lenses - A frame allowance of $75. If Member chooses a frame that exceeds the plan allowance, the Member will pay the difference.
- Elective Contact Lenses - An allowance of $110 towards the cost of exam, contact lens evaluation, fitting costs, and materials. The Member is responsible for any costs exceeding this allowance.
- Necessary Contact Lenses- No co-payment
- Low vision benefits - Supplemental testing: no co-payment
- Supplemental care: $5 co-payment

Examinations: Each Member is entitled to a comprehensive vision examination; including a complete analysis of the eyes and related structures as appropriate, to determine the presence of vision problems or other abnormalities as follows:

- Case History: Review of Member's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
- Evaluation of the health status of the visual system including:
    1. external and internal examination, including that of direct and/or indirect ophthalmoscopy
    2. assessment of neurological integrity, including that of papillary reflexes and extraocular muscles
    3. biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes
    4. screening of gross visual fields
    5. pressure testing through tonometry
- Evaluation of refractive status including:
    1. evaluation of visual acuity
    2. evaluation of subjective, refractive, and accommodative function
    3. objective testing of a Member's prescription through retinoscopy
- Binocular function test
- Diagnosis and treatment plan, if needed
- Examinations are limited to once each twelve (12) month period, which begins with the date of the last exam.

Lenses: The Member's provider will order the proper lenses necessary for the Member's visual welfare. Lenses are limited to once each twelve (12) month period, which begins with the date of the last exam.

Frames: Frames are limited to once every twelve (12) month period, which begins with the date of the last exam.

Medically Necessary Contact Lenses: Medically necessary contact lenses may be prescribed for certain conditions with prior authorization from HPSM, such as:

- following cataract surgery,

- to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- certain conditions of Anisometropia; and
- keratoconus.

With approval, contact lenses are in lieu of eligible benefits for that eligibility period. Contact lenses are limited to once each twelve (12) month period, which begins with the date of the last exam.

Elective Contact Lenses (instead of corrective lenses and a frame): Limited to once each twelve (12) month period, this begins with the date of the last exam.

Low Vision: A low vision benefit is provided to Members with severe visual problems that are not correctable with regular lenses. This benefit requires prior authorization from HPSM. With authorization, supplemental testing and supplemental care, including low vision therapy as visually necessary or appropriate, will be provided.

Any cost associated with the selection of the items listed below will be the financial responsibility of the Member.

Exclusions:

- Benefits that are neither necessary nor appropriate
- Benefits that are not obtained in compliance with the rules and policies of HPSM's Vision Plan for Healthy Kids
- Vision training
- Aniseikonic lenses
- Plano lenses
- Two pairs of glasses in lieu of bifocals, unless medically necessary and with prior authorization
- Replacement or repair of lost or broken lenses or frames prior to being eligible for services
- Medical or surgical treatment of the eyes
- Services or materials for which the Member is covered under a Worker's Compensation policy
- Eye examinations or any corrective eyewear required as a condition of employment
- Services or materials provided by any other group benefit providing vision care

There is no benefit for professional services or materials connected with:

- Blended lenses (bifocals which do not have a visible dividing line)
- Contact lenses, except as specified above
- Oversized lenses (larger than standard lens blank to accommodate prescriptions)
- Progressive multifocus lenses
- Coated or laminated lenses
- UV protected lenses
- Other optional cosmetic processes
- Photocromic or tinted lenses

There are no out-of-network benefits.

HealthWorx

Vision Services are covered through the Services Employees International Union (SEIU), Local 715 for those IHSS workers who meet eligibility requirements. For more information about Vision Benefits, Members need to call the SEIU, at (408) 954-8715 ext. 186.

Durable Medical Equipment

Durable medical equipment (DME), when prescribed by a licensed practitioner, is covered when medically necessary to preserve bodily function essential to activities of daily living or to prevent significant physical disability. There are program specific limitations which are outlined below. DME may be obtained from any licensed DME provider who has a Medi-Cal provider number. HPSM contracted DME providers are listed in the HPSM provider directory. There are no co-payments required from members for these services.

CareAdvantage

*Note: PAR requirement remain in effect for DME request effective 1/1/2006.

- Crutches
- Hospital Beds
- IV Infusion pump
- Oxygen and oxygen equipment

- Nebulizers
- Walker
- Colostomy bags and supplies directly related to colostomy care
- Pacemakers
- Blood glucose monitor, test strips, lancets, lancets devices, and glucose control solution

Exclusions:

- Orthopedic shoe or supportive devices for the feet (certain exceptions apply)

Medi-Cal

Covered items include, but are not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors (must be obtained from a pharmacy)
- Apnea monitors
- Pulmoaides and related supplies
- Asthma related equipment – nebulizers, tubing and related supplies, spacer devices for metered dose inhalers
- Ostomy bags, urinary catheters and related supplies
- Insulin pumps and related supplies
- Other diabetic self-management supplies, as medically necessary (must be obtained from a pharmacy)

Excluded items include, but are not limited to:

- Comfort and convenience items
- Experimental or research equipment
- Devices not medical in nature, including modifications to the home or automobile
- More than one piece of equipment that serves the same function, unless medically necessary

Healthy Kids

Covered items include (but not limited to) medical equipment appropriate for use in the home which:

- primarily serves a medical purpose;
- is intended for repeated use; and
- is generally not useful to a person in the absence of illness or injury

The Health Plan of San Mateo may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss.

Covered items include:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes (must be obtained from a pharmacy)
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
- Ostomy bags, urinary catheters, and related supplies
- Insulin pumps and all related supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Podiatric devices to prevent or treat diabetes complications

Excluded items include:

- Comfort and convenience items
- Disposable supplies, except ostomy bags, urinary catheters and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile

- Deluxe equipment
- More than one piece of equipment that serves the same purpose, unless medically necessary

HealthWorx

Covered items include, but are not limited to medical equipment appropriate for use in the home which:

- primarily serves a medical purpose;
- is intended for repeated use; and
- is generally not useful to a person in the absence of illness or injury

The Health Plan of San Mateo may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss.

Covered items include:

- Oxygen and oxygen equipment
- Blood glucose monitors (must be obtained from a pharmacy)
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
- Ostomy bags, urinary catheters, and related supplies
- Insulin pumps and all related supplies

Excluded items include:

- Comfort and convenience items
- Disposable supplies, except ostomy bags, urinary catheters and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile

- Deluxe equipment
- More than one piece of equipment that serves the same purpose, unless medically necessary

Wheelchairs

Manual and powered wheelchairs are covered (must meet clinical criteria per product line) under all HPSM programs. The requirements for obtaining a wheelchair are:

1. The wheelchair is prescribed by a licensed medical provider;
2. HPSM has made a determination that the proposed wheelchair is medically necessary;
3. The wheelchair provider has received an authorization via an authorized prior authorization request (PAR) form from the HPSM Health Services Department

Wheelchairs may be obtained from any licensed DME provider who has a Medi-Cal provider number. HPSM contracted wheelchair providers are listed in the HPSM provider directory.

A Prior Authorization Request must be submitted to the Health Services Department in order to begin the process for obtaining a wheelchair. HPSM generally requires an independent member evaluation when a request for a wheelchair is submitted to Health Services. The HPSM contracted evaluator is a specialist who performs an onsite evaluation of the member. If the HPSM contractor is unable to perform the onsite member evaluation, the request for the wheelchair will be denied for administrative reasons.

HPSM reserves the right to determine whether to rent or purchase the proposed equipment.

Audiology/Hearing Aids

Audiology services, including hearing tests and hearing aids are covered under most of HPSM programs, subject to specific program limitations described below. All hearing aids require submission of a prior authorization request (PAR) form to the HPSM Health Services Department for approval. Audiology services may be obtained from any licensed provider who has a Medi-Cal provider number. Contracted HPSM audiology specialists and hearing aid dispensers are listed in the HPSM provider directory. There are no co-payments required from members for these services.

CareAdvantage

Diagnostic hearing and balance exams are a covered benefit.

Exclusion:

- Hearing aids and hearing exam for the purpose of fitting a hearing aid

Medi-Cal

HPSM covers screening and examinations. Hearing aids are covered when provided by an HPSM contracted specialist. A referral is required from the PCP if more visits are needed after the initial screening hearing evaluation.

Exclusions:

- Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.
- Charges for a hearing aid which is more than the prescribed correction for the hearing loss

Replacement parts for hearing aids and repair of hearing aids after the covered one year warranty period

Healthy Kids and HealthWorx

Covered services include:

- Audiological evaluation to measure the extent of hearing loss
- Hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Monoaural or binaural hearing aids, including ear mold(s), hearing aid instrument, initial battery, cords, and other medically necessary ancillary equipment
- Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid

Exclusions:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss

- Replacement parts for hearing aids and repair of hearing aids after the covered one year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices

Prosthetics/Orthotics

Prosthetic and orthotic devices are covered under all HPSM programs when such appliances are medically necessary for the restoration of function or replacement of body parts. Coverage is subject to specific program limitations as outlined below.

Covered items must be prescribed by a licensed physician or podiatrist, authorized by HPSM Health Services Department through a submitted prior authorization request (PAR) form and dispensed by an HPSM contracted provider.

A list of HPSM contracted prosthetists and orthotists can be found in the HPSM provider manual. HPSM reserves the right to determine whether to replace or repair a requested prosthetic or orthotic device. There are no co-payments required from members for these services.

CareAdvantage

- Prosthetic devices and related supplies (other than dental)
- Braces, Prosthetic shoes, artificial limbs
- Therapeutic shoes (includes shoe fitting or inserts) only with diagnosis of severe diabetic foot disease.
- Breast prosthesis (including surgical brassiere after mastectomy)
- Repair and replacement of prosthetic devices

Exclusion:

- Orthopedic shoe or supportive devices for the feet (certain exceptions apply)

Medi-Cal

All requested items must be determined by HPSM to be medically necessary.

Healthy Kids and HealthWorx

Prosthetics and orthotics are covered as follows:

- Medically necessary replacement prosthetic/orthotic devices as prescribed by a licensed practitioner acting within the scope of his/her licensure
- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetic conditions
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

Excluded items:

- Over-the-counter items
- Corrective shoes, shoe inserts and arch supports, except for therapeutic footwear for diabetics
- Non-rigid devices, such as elastic knee supports, corsets, elastic stocking, and garter belts
- Dental appliances
- Electronic voice producing machines
- More than one device for the same part of the body, unless medically necessary

California Children's Services (CCS)

California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. California Department of Health Care Services manages the CCS program. San Mateo County operates its own CCS program

with offices located in San Mateo. The program is funded with state, county and federal tax monies, along with some fees paid by parents.

The California Children's Services (CCS) program is responsible for determining eligibility and providing case management and authorization of services for children enrolled in CCS.

The Health Services Utilization Management team works closely with the CCS staff to coordinate care for these special needs children. It is important to note that while CCS may authorize certain services (e.g., inpatient days), however it is HPSM's responsibility to determine level of care.

Questions concerning which diagnoses and what services are covered under the CCS program, should be directed to CCS at:

CCS

801 Gateway Blvd., Suite 100

South San Francisco, CA 94080

(650) 616-2500 Main

(650) 616-2598 Fax

Hours of operation are Monday through Friday 8:00 a.m. to 5:00 p.m.

Golden Gate Regional Center (GGRC)

Golden Gate Regional Center serves individuals with developmental disabilities and their families who reside in Marin, San Francisco and San Mateo counties. In addition, GGRC provides early intervention services to infants between birth and three years of age who are developmentally delayed or believed to be at high risk of having a developmental disability, and genetic counseling and testing for individuals at high risk of having a child with a disability.

Regional centers are the hub of a comprehensive network which links people to services, acts as a community focus for individuals with developmental disabilities, their families and service providers. GGRC provides lifelong support for their clients and their families.

Any HPSM member may be referred for GGRC services via telephone or letter. The request goes to the San Mateo County Intake Supervising Social Worker who conducts a basic screening to determine if further assessment and diagnostic services are appropriate. Persons with developmental disabilities may apply for services directly or be referred by others.

Please send referrals to:

Golden Gate Regional Center of San Mateo County

3130 La Selva Drive, Suite 202

San Mateo, CA 94403

(650) 574-9232

(650) 345-2361 Fax

The Supervising Social Worker will assign an Assessment Social Worker who will schedule an initial appointment with the member to be held within 15 working days following the initial contact (or request for services). This appointment takes place in the member's home or at the regional center, at which time the member and his/her family are given an overview of the regional center and its services.

If necessary, the Assessment Social Worker will arrange for assessments to determine eligibility. For infants and toddlers between birth and three years of age, assessments regarding eligibility are performed within 45 days following the initial intake. For persons three years of age and older, assessments are performed within 60 days following initial intake. Assessments may include - but are not limited to - psychological, medical or developmental evaluations.

Eligibility determinations are made by a group of regional center professionals of differing disciplines, such as psychologist, physician and social worker. Eligibility for ongoing regional center services is established upon determination that the person has a developmental disability with a substantial handicap, or for infants from birth to three years of age, is at risk of having a developmental disability.

Referred HPSM members are notified of their eligibility by letter within 10 days after the determination is made. Any applicant who is not eligible for ongoing regional center services will be informed of his/her appeal rights and the fair hearing process, and will also be referred to other appropriate resources.

Additional information about Golden Gate Regional Center can be obtained from its website: http://www.ggrc.org

Section 7

Utilization Management

Utilization Management Overview

PROGRAM SCOPE

The Health Plan of San Mateo (HPSM) Utilization Management Program ("the UM Program") encompasses management and evaluation of care across the continuum of care. This includes pre-service review and authorization, concurrent and retrospective review of inpatient care including acute care, rehabilitation and skilled nursing, pharmaceuticals, DME, and ambulatory services.

The UM Program is designed to promote the provision of medically appropriate care; to monitor, evaluate, and manage resource allocation; and to monitor cost effectiveness and quality of the healthcare delivered to our members through a multidisciplinary, comprehensive approach and process. The Utilization Management Program supports the HPSM mission.

- The mission of HPSM is to provide members with access to quality healthcare services delivered in a cost effective and compassionate manner.

Utilization and Resource Management functions are performed by HPSM's Health Services Department. The Health Service Department's vision is that services are designed around the member's journey in the healthcare system with the goal to improve the member's experience and health outcome.

ORGANIZATION

Background

The Health Plan of San Mateo (HPSM) was created in the mid-1980s by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a County Organized Health System (COHS) authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Because it is based within the community it serves, HPSM is especially sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County's Medi-Cal beneficiaries. In 2006, HPSM began a Special Needs Medicare Advantage Plan (MA SNP) which allows HPSM to offer the Medicare and Medi-Cal benefits under one umbrella to all dually eligible individuals. HPSM's mission is to provide members with access to high quality services delivered in a cost-effective and compassionate manner.

Since opening its doors in October of 1987, HPSM has greatly improved access to healthcare for San Mateo County beneficiaries. At its inception, the organization's primary focus was to serve the health care needs of San Mateo County Medi-Cal beneficiaries including nearly all Medi-Cal eligible individuals in the county, with membership including the TANF population as well as aged and disabled recipients.

Over the years, HPSM has added two additional product lines in response to community needs; Healthy Kids and HealthWorx. Healthy Kids serves low-income children while HealthWorx serves In-Home Supportive Services (IHSS) workers and eligible San Mateo county temporary employees. In January 2009, HPSM became a third party administrator for San Mateo County's Access and Care for Everyone (ACE) program and in 2010 the Medicaid Coverage Expansion (MCE) Program was added. The San Mateo ACE and MCE Programs are coverage programs provided by the County of San Mateo, which is committed to providing health care coverage to uninsured residents of the county. By taking on these additional groups and a state licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid

Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.

HPSM's Delivery System

HPSM is able to fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly contracted provider network. HPSM's network includes over 800 primary care physicians and over1200 specialists. In addition, HPSM's network includes hospitals and medical centers located in San Mateo County and in neighboring San Francisco as well. While HPSM does not contract directly with its pharmacy network, HPSM's delegates this responsibility to its contracted pharmacy benefits manager, Argus.

SCOPE OF SERVICES

HPSM provides a comprehensive scope of acute and preventive care services for San Mateo County's Medi-Cal, Healthy Kids, HealthWorx and dually eligible population. Certain services are not covered by HPSM or may be provided by a different agency. These are:

- Mental Health services are administered by the San Mateo County Health Services Agency (HSA) for Medi-Cal. HPSM contracts with San Mateo County's Behavioral Health and Recovery Services division for services for its other lines of business.
- Dental services are provided through California's Denti-Cal program for Medi-Cal members. Delta Dental contracts with HPSM to provide services for Healthy Kids and Care Advantage members.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for medical services and equipment provided by specific specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.
- Childhood Health and Development Program (CHDP) is managed at the County level.
- HPSM works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOU) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

1. The San Mateo Health Commission (SMHC) and the San Mateo Community Health Authority (SMHA) have ultimate accountability and responsibility for the quality of care and services provided to HPSM members. The Commission holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The CMO ensures separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced.

2. The CEO allocates financial and employee resources to fulfill the program objectives. The CEO delegates authority, when appropriate, to the CMO. The CEO shall ensure that the QMP satisfies all remaining requirements of the Quality Improvement (QI) Plan, as specified in the State Contract.
3. The CMO in collaboration with the Director of Health Services Operations is responsible for the Utilization Management Program. The CMO is also responsible for the Quality Management Program. At least quarterly, the CMO presents reports on Health Services activities to the Utilization Management Committee. The CMO chairs the Utilization Management Committee that reports to the Senior Executive team. The CMO works in conjunction with the CEO to oversee the quality reporting matrix that includes Utilization Management oversight, development of QI studies, and follow up on identified quality of care issues.
4. The Director of Health Services Operations is responsible for management of the Health Services Department. The CMO and the Director of Health Services Operations are the CEO's designees in the day-to-day implementation of Utilization Management and are responsible for ensuring that the program is properly developed, implemented and coordinated.
5. The CMO and the Director of Health Services Operations are responsible for day to day management and oversight of the utilization review process for all product lines for all members. The CMO and the Director of Health Services Operations work closely with the Care Coordination Unit Manager to assure members receive high quality, medically necessary care in a way that balances individual need and cost effectiveness in the short and long term.
6. The Care Coordination Unit Manager is accountable to plan, organize, develop and manage the care coordination system in Health Services. The Care Coordination Unit Manager's primary focus is on high risk members as identified through emergency and inpatient recidivism and also those members requiring complex medical care coordination. The Care Coordination Unit Manager interacts regularly with the provider community and outside agencies including but not limited to the Regional Centers, California Children's Services, County Mental Health, the County public hospital and Aging and Adult Services.
7. The Director of Pharmacy has management responsibility for overseeing pharmacy benefits operations activities, including Medi-Cal and Medicare Part D programs, formulary management, cost containment and reimbursement strategies, program administrative leadership, supervision of pharmacy staff, program development and policy enhancement.
8. The Provider Services Manager is responsible for provider network development, contracting, and provider relations management for contracted and non-contracted providers. The Provider Services Department is responsible for assuring that providers are able to efficiently deliver services to members and receive prompt reimbursement for services performed. The Provider Services Representatives perform provider education and assist providers in problem resolution.
9. The CMO is responsible for the overall coordination of planning and evaluation services, including contract requirements and coordination of external quality review requirements. As part of this function, the CMO works in collaboration with the Chief Compliance officer to ensure that HPSM meets the requirements set forth by the Department of Health Care Services (DHCS), Department of Health Services Managed Medi-Cal Division (DHS/MMCD), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid (CMS), and the Managed Risk Medical Insurance Commission (MRMIB). HPSM's Compliance and Regulatory Affairs Department works in collaboration with HPSM's functional areas, such as Utilization Management and Grievance and Appeals, to

evaluate the results of performance audits and to determine the appropriate course of action to achieve desired results. In addition, the CMO and the Director of Health Services Operations oversee the development and amendment of HPSM policies and procedures related to Utilization Management and Health Services to ensure adherence to state and federal requirements. Lastly, functions relating to fraud investigations are handled by the Compliance and Regulatory Affairs Department.

PURPOSE OF THE UTILIZATION MANAGEMENT PROGRAM

The purpose of the Utilization Management Program is to define and describe HPSM's multidisciplinary, comprehensive approach to managing resource allocation through systematic monitoring of medical necessity and quality while maximizing the cost effectiveness of the care and service provided to members.

The Utilization Management Program will ensure that:

- HPSM Health Services Utilization Management (UM) review staff utilize nationally recognized standard criteria and informational resources to determine the medical necessity of healthcare services to be provided (e.g., Medi-Cal Manual of Criteria issued by the State of California, Milliman Care Guidelines).
- HPSM Health Services UM review staff, that includes physicians, licensed nurses, and unlicensed trained employees, carries out the responsibilities designated for their level of expertise within their respective scope of practice, and as defined in their Job Position Descriptions.
- HPSM Utilization Management Program collaborates with the HPSM Quality Assessment and Improvement program to ensure ongoing monitoring and evaluation of quality of care and service, and continuous quality improvement.
- At least annually, the Utilization Management Program description, policies, and procedures are reviewed at one of the monthly medical management meetings, attending by senior management and it is also reviewed at the Quality Management Oversight Committee meeting. The UM Program is revised if necessary.

Care Coordination Activities include the following:

- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under and over utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service.
- Ensuring that members have access to the appropriate care and service within their health plan benefits and consistent with accepted standards of medical practice.
- Retaining the ultimate responsibility for the determination of medical necessity for HPSM members and ensuring that authorization requests are handled efficiently according to HPSM UM timeliness standards.
- Evaluating the results of the Utilization Management Program utilizing data includes:
    - Membership statistics
    - Quality and utilization management reports, such as bed day utilization, ambulatory care and ancillary utilization patterns.

    - Conducting regular monitoring visits with follow-up for quality improvement activities or corrective actions to ensure continued compliance with HPSM standards.

- Monitoring of services to evaluate utilization patterns.
- Monitoring performance to ensure qualified healthcare professionals perform all components of utilization review. Maintaining a process for a licensed physician to conduct reviews on all cases that do not meet medical necessity criteria, or service requests that are not addressed by criteria.
- Maintaining a process to ensure that all Health Services UM reviewers have access to appropriate board certified specialists to assist in determining medical necessity as needed.
- Ensuring inter- and intra-rater reliability through a defined internal process.
- Ensuring the confidentiality of member and provider information.

UM Program Goals

The Utilization Management Program shall endeavor to promote the delivery of high quality care in the most cost-effective manner for HPSM's members, and thus contribute to the achievement of the HPSM mission. The Utilization Program goals and objectives are:

- Improve the quality of care delivered to members by ensuring they receive the appropriate level and mix of medical services in the most appropriate setting- The right service at the right time at the right place for the right reason.
- Facilitate communication and develop positive relationships between members and contracted providers by providing timely appropriate utilization review processing.
- Identify members with special needs and ensure that appropriate care is delivered to them through collaboration with county partners. This will reduce overall healthcare expenditures by developing and implementing effective preventive care and health promotion programs.
- Identify actual and/or potential quality issues during utilization review activities and refer to the CMO.
- Ensure compliance with regulatory agencies.

Program Structure

The Utilization Management Staff work collaboratively with contracted healthcare providers in the community, in an effort to assure the delivery of appropriate, cost effective, quality evidence-based healthcare. The Utilization Management Program necessitates the cooperative participation of all HPSM contracted healthcare providers, including physicians, allied healthcare professionals, hospitals, outpatient facilities as well as members to ensure timely and effective delivery of healthcare services. Several collaborative projects between the plan and our county partners have been implemented. These collaborative projects identify members with special needs and ensure that appropriate care is delivered to them. Collaborative projects include but are not limited to, the Care Transition program. The Care Transition project focuses on providing well-coordinated community-based senior services, including limiting gaps in care between inpatient and outpatient and community-based senior services. The Care Transition project's model is to improve transitional care between the hospital and home or skilled nursing facilities.

The Health Services Department is responsible for all UM processing for members in all programs. Leadership is provided by the Director of Health Services Operations, who directly supervises the Utilization

Manager and Inpatient Review and Care Transition Supervisor. The Utilization Manager directly supervises the UM Nursing review staff and Authorization Assistants. The Director of Pharmacy supervises the pharmacy staff and day to day operations of pharmacy benefit management. The Care Coordination Unit Manager supervises the Nurse Case Managers, Care Coordination Technician and the day to day management of the Care Coordination unit.

The Health Services Department collaboratively contributes to the development and implementation of the HPSM Utilization Program, as well as supporting policies and procedures. This Utilization Management Program is developed in compliance with the California Department of Health Services, the Center for Medicare and Medicaid Services (CMS) regulations for Medi-Cal and Knox-Keene regulations 1300.70, and SB 59.

The Utilization Program is reviewed and evaluated for effectiveness at least annually by the CMO and the Director of Health Services Operations. Recommendations for revisions and improvement are made as appropriate and the subsequent annual Utilization Program is based on the findings of the annual program evaluation.

The Utilization Management Staff work collaboratively with contracted healthcare providers in the community, in an effort to assure the delivery of appropriate, cost effective, quality evidence-based healthcare. The Utilization Management Program necessitates the cooperative participation of all HPSM contracted healthcare providers, including physicians, allied healthcare professionals, hospitals, outpatient facilities as well as members to ensure timely and effective delivery of healthcare services. Several collaborative projects between the plan and our county partners have been implemented. Using a proactive approach, these collaborative projects identify members with special needs and ensure that appropriate care is delivered timely and efficiently. Collaborative projects include, but are not limited to, complex care management programs that address high risk care management of the medically frail dually eligible Care Advantage population, the Care Transitions program, and developmentally disabled targeted case management. Additionally the program integrates a Clinical Pharmacy Outreach Program (CPOP), the Long Term Care Clinical Management program, In Home Physician program, Medication Therapy Management and disease management.

COMMITTEE ORGANIZATION AND REPORTING STRUCTURE

The structure of the Utilization Management Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of the HPSM healthcare delivery. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization.

The Organization Chart and the Program Committees Reporting Structure outlines HPSM's governing body, HPSM senior management, as well as committee reporting structure and lines of authority. Position job descriptions and Committee policies/ procedures define associated responsibilities and accountability.

HPSM Utilization Management Workgroup

The Utilization Management Workgroup promotes the optimal utilization of healthcare services while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The Workgroup monitors the utilization of healthcare services by HPSM members in all programs to

identify areas of under or over utilization that may adversely impact member care. The Workgroup meets bi-weekly.

Role and Responsibility

- Provides coordination UM functions.
- Provides oversight for appropriateness and clinical criteria used to monitor care and services provided to HPSM members.
- Monitors data and reports and identifies opportunities for improvement of internal processes and systems.
- Measures and documents effectiveness of actions taken.
- Review and evaluation of data to identify under or over utilization patterns.
- Review care management issues related to continuity and coordination of care for members.

CARE COORDINATION MEETINGS

Role and Responsibility

HPSM meets at least quarterly with other community partners to address issues regarding the coordination of healthcare delivery services involving the San Mateo County Mental Health Plan, California Children's Services (CCS), and Aging and Adult Services (AAS). HPSM does not provide Mental Health services for Medi-Cal members; the Department of Health Services utilizes other contracts to provide this care. HPSM also does not provide CHDP services, but works closely with this agency to coordinate services. HPSM does reimburse for CCS services through its contracted providers. Memoranda of Understanding (MOU) exist between each of these community partners, which require quarterly meetings to clarify systems issues and coordinate the care of complex cases. The MOU clarifies responsibilities and establish protocols and procedures for the exchange of information and maintaining confidentiality. These quarterly coordination meetings are attended by representatives of each of the respective organizations.

- System-wide issues and specific cases are addressed to promote continuity and coordination of care between the medical and behavioral healthcare providers.

PEER REVIEW COMMITTEE/PHYSICIAN ADVISORY GROUP (PRC/PAG)

The PRC/PAG provides guidance and peer input into the HPSM practitioner and provider selection process and determines corrective actions as necessary to ensure that all practitioners and providers that serve HPSM members meet generally accepted standards for their profession or industry. The PRC/PAG shall review, investigate, and evaluate the credentials of all internal HPSM medical staff for membership and maintain a continuing review of the qualifications and performance of all internal medical staff. The PRC/PAG includes practicing physicians from the contracted healthcare provider network. The PAG meets on a bimonthly basis while appropriate peer review committees meet on an ad-hoc basis as needed. The Chairperson of this committee is a physician member of the Commission.

Role and Responsibility

- Provides linkage with practicing physicians in the community for input to HPSM Quality and Utilization Programs.

- Reviews of quality of care issues.
- Peer Review.
- Reviews provider trends as related to UM and Quality issues.
- Takes corrective actions, when necessary, to improve provider performance and optimize systems and processes.

PCP Specialty Referral Process

WHAT SERVICES REQUIRE A RAF?

For HPSM Insurance product lines (CareAdvantage, Medi-Cal, Healthy Kids and HealthWorx) there is a "RAF free holiday" for *in network referrals.* The "RAF free holiday" does not apply to out of network referrals. For CareAdvantage, the RAF free holiday has been in effect since January 1, 2006. For all other lines of business, the RAF free holiday has been in effect since February 1, 2006.

RAF requirements will resume upon notification by the HPSM.

RAFs are only required for members to see non-participating plan specialist providers for evaluation and treatment. The covered service CPT codes are: All CPT codes ranging from 90000-99499 (except: EEG and other testing codes such as 93000, 93015, and 93236).

RAFs are not needed for members to see doctors for sensitive services, like OB/GYN services, family planning services, sexually transmitted disease/HIV testing/counseling services, or for emergencies. RAFs are not needed for audiology services, optometry services (except for Willow Clinic Optometry) or therapy services. Prior Authorization Requests (PARs), not RAFs are needed for certain advanced radiology studies, therapy treatments and surgical procedures (see next section).

The following services do not require a RAF:

- E&M codes rendered in a SNF
- Emergency care
- Services to "special members" (see Section Two for definition of "special member")
- Preventive services
- Minor Consent services – Minors without their parents' consent may receive the following services:
    - Services related to sexual assault
    - Pregnancy and pregnancy related services
    - Family planning services
    - Drug and alcohol abuse counseling* (see page 12)
    - Outpatient mental health services* (see page 12)
- Obstetrical services and family planning services
    - Pregnancy planning
    - Birth control
    - Prevention of sexually transmitted diseases
    - Confidential testing for venereal disease

    - HIV counseling and testing
- Abortion services
- Services from an Indian Health Services (IHS) provider
- "Limited Services"
    - Chiropractic**
    - Podiatry
    - Acupuncture** (Medicare non-covered benefit)
    - Prayer or Spiritual Healers
    - Vision (Medicare non-covered benefit)
    - Eyeglasses** (Medicare non-covered benefit)

Medi-Cal members are limited to two office visits for each of these specialist services in a single month. For additional visits in a single month or for any procedures (other than office visits), the specialist provider must obtain preauthorization by submitting a PAR to HPSM (see section on "Prior Authorization for Medical Services" below).

*Minor consent services: Member must be 12 years old or greater to be able to consent for drug and alcohol abuse treatment. Member must be 12 years old or greater and mature enough to consent and is the victim of incest or child abuse or would present a threat of serious physical or mental harm to self or other without treatment for outpatient mental health services.

RAFs Required - San Mateo County ACE/MCE Programs

San Mateo County ACE & MCE are programs available to uninsured residents of San Mateo County who are not eligible for coverage through Medicare, Medi-Cal, private insurance or other third-party coverage. ACE & MCE are coverage programs and are not considered health insurance. Services are primarily available through the San Mateo Medical Center and Ravenswood Family Health Center. A referral to other providers is only through the RAF prior authorization process.

Specialty Referral Process: PCPs

The HPSM Specialty Referral Process enables the Primary Care Physician (PCP) to coordinate the process by which his/her patients receive care from specialists (also known as referral providers). When a PCP identifies the need for a specialty referral, the PCP may refer the member to a participating specialist provider without a Referral Authorization Form (RAF). Referrals to non-participating plan providers require a RAF from the PCP. To initiate the referral process, the PCP will complete a Referral Authorization Form which is available on the HPSM website www.hpsm.org. Sample forms are attached in Section 10 of this manual and are available from your Provider Services Representative.

The Referral Authorization Form (RAF) is a valuable tool for physician case-management and control of specialty referrals. When in the opinion of the Primary Care Physician (PCP), a member needs to see a specialist provider; the member's PCP will refer the member to a Specialist for consultation and treatment. The PCP is responsible for identifying the specialist provider and contacting the Specialist to assure that the member will be seen on a timely basis and will make arrangements for follow-up with the PCP. The PCP will refer to Specialists who are contracted with HPSM. In cases where the contracted Specialists are not available, the PCP may seek the Plan's assistance in obtaining access to contracted Specialist Providers

and/or the PCP may elect to refer to a Specialist that is non-participating (see "Referral to Non-Participating Providers" section below).

All of the following items in Part I of the RAF must be completed. If any of the following is missing or illegible, it will be returned to the PCP's office for completion/clarification. This will delay the processing of the RAF. The required information includes:

- Check the appropriate program on the left hand column (one box)
  - CareAdvantage
  - Medi-Cal
  - HealthWorx
  - Healthy Kids
- Date of the referral
- PCP's name and provider number
- PCP's phone number
- PCP's fax number
- PCP's signature
- Member's name and date of birth
- Member's address and phone number(s)
- Member's ID number (please do not use the member's Social Security Number)
- Diagnosis and ICD-10 code
- Reason for referral
- Specialist's name
- Specialist's address
- Specialist's phone number

If the PCP also has the Specialist's fax number, that may be included, but it is optional.

In addition, there are two optional boxes located just above the area where the Specialist's name is indicated. These are the "Consult only" box and the "Standing Referral for 1 Year" box.

The "Consult only" box should only be checked if the PCP does not want the Specialist to determine the number of additional visits he/she needs in order to complete his/her treatment and evaluation of the referred member. If this box is checked, any additional visit to the Specialist must be accompanied by a new RAF issued by the member's assigned PCP. This optional box allows the PCP maximum control of Specialist provider visits. When a PCP issues a follow-up RAF for additional visits to the Specialist provider, please include in the "Reason for Referral" section that this is a follow-up visit.

The "Standing Referral for 1 Year" box should only be checked if the PCP has determined that the member has a chronic disease condition that requires the ongoing care of a Specialist for at least a period of 1 year. Chronic disease conditions that are eligible for standing referrals include:

- HIV infection/AIDS
- Chronic Hepatitis B/C infection
- Uncontrolled diabetes

- Uncontrolled hypertension
- Rheumatoid arthritis
- Parkinson's disease
- Multiple sclerosis
- Other degenerative neurologic diseases
- Chronic obstructive pulmonary disease
- Asthma
- Congestive heart failure
- Chronic pain syndrome
- Chronic renal failure
- Cancer
- Other chronic conditions will be considered on a case-by-case basis.

Upon completion of the required elements in Part I, the RAF should be faxed to HPSM Health Services at **650-829-2079**. Upon receipt of the RAF, the PCP will receive an auto-reply message indicating that HPSM Health Services has received the RAF. Please note: The auto-reply will only work if the PCP's fax number is not blocked. (If the PCP does not wish to receive an auto-reply message, the PCP should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) The auto-reply message will include a statement as to the number of pages received in that particular fax transmission as well as a copy of a portion of the first page of the fax. If the number of pages that HPSM receives is not the same number of pages that the PCP has sent, the PCP should resend the fax and indicate that the second fax is a "duplicate" or a "re-send." If the PCP does not receive an auto-reply after faxing a RAF, HPSM Health Services did not receive the RAF. Please re-fax the RAF.

IMPORTANT: RAFs faxed to other fax numbers at HPSM will not be forwarded to Health Services and will not receive an auto-reply. Please use the HPSM Health Services fax line for RAFs.

RAFs can also be mailed to HPSM Health Services. HPSM Health Services mailing address is:

Health Plan of San Mateo
Health Services Department
ATTN: RAF Authorization
801 Gateway Boulevard, Suite 100
South San Francisco, California 94080

Mailed RAFs will not receive a response indicating that HPSM Health Services received the RAF.

How long does it take for HPSM to process a RAF?

RAF processing generally takes two (2) business days. If a PCP has arranged for the specialist provider visit and knows that the visit will occur within two (2) business days, then the PCP should fax the RAF to the HPSM Health Services Fax line: **650-829-2079**. RAFs received on the HPSM Health Services Urgent Fax line will also receive an auto-reply message (see above) and the RAF will be processed within four (4) business hours of receipt. The PCP must include the date of initial visit (under Part II) on the RAF. This date must fall within two (2) business days of the date of receipt at HPSM Health Services, or the RAF will be processed with the normal turn-around time.

PLEASE NOTE: Urgent RAFs will be end-dated on the date of initial visit as indicated on the RAF.

All RAFs are authorized for a single specialist provider visit within three (3) months from the date of receipt at HPSM Health Services (except for urgent RAFs, which are end-dated on the date of initial visit as indicated on the RAF). A specialist provider visit must occur within the three (3) month time period. If a PCP knows that the specialist provider visit will be beyond the three month time period, the PCP may extend the RAF expiration to the known date of the initial specialist visit. In order to do this, the PCP must complete the date of initial visit (under Part II) on the RAF. Upon receipt at HPSM Health Services, the authorization staff will end-date the RAF on the date of initial visit (under Part II) as indicated on the RAF. HPSM Health Services will send a report to the PCP listing all expired RAFs that have not had a specialist claim.

Upon receipt of a completed Part I RAF, HPSM Health Services authorization staff review the RAF for the following:

- Member eligibility
- RAF issuing PCP is PCP of record
- Specialist provider to whom the member is being referred is a participating provider

If the RAF meets all three criteria, then it will be authorized and an authorization number will be affixed to the RAF. No specialist referral by an eligible member's PCP of record to a participating specialist will ever be denied. The authorized RAF will be faxed to the specialist provider's office as well as to the issuing PCP's office. PCP offices should not send unauthorized RAFs to the specialist provider's office since this generates confusion at the specialist's office and unnecessary phone calls to HPSM Health Services. HPSM Health Services will fax all authorized RAFs to the respective specialist's offices.

Specialty Referral Process: Specialist Providers

Upon receipt of an authorized RAF, the specialists should make the appointment with the member for the consultation. The specialist must check member eligibility on the date of service, as the RAF authorization is subject to member eligibility.

Unless either of the optional boxes ("Consult only" or "Standing Referral for 1 Year") is checked, after the initial consultation, the specialist can determine the number of additional visits required to complete the evaluation and treatment of the member's condition. This is limited to up to 12 additional visits within a 3 month time period. For visits beyond this limit, an additional RAF from the member's PCP will be required. The Specialist must complete Part II of the RAF and fax it to HPSM Health Services, in order to receive authorization for the additional visits.

Upon receipt of the faxed RAF, the Specialist will receive an auto-reply message indicating that HPSM Health Services has received the RAF. Please note: The auto-reply will only work if the Specialist's fax number is not blocked. (If the Specialist Provider does not wish to receive an auto-reply message, he/she should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) The auto-reply message will include a statement as to the number of pages received in that particular fax transmission as well as a copy of a portion of the first page of the fax. If the number of pages that HPSM receives is not the same number of pages that the Specialist has sent, the Specialist should resend the fax and indicate that the second fax is a "duplicate" or a "re-send." If the Specialist Provider does not receive an auto-reply after faxing a RAF, HPSM Health Services did not receive the RAF. Please re-fax the RAF.

IMPORTANT: RAFs faxed to other fax numbers at HPSM will not be forwarded to Health Services and will not receive an auto-reply. Please use the HPSM Health Services fax line for RAFs.

If the "Consult only" box is checked, the Specialist must request additional visits from the member's PCP. If the "Standing Referral for 1 Year" box is checked, the Specialist does not need to complete Part II of the RAF. A standing RAF will allow for unlimited Specialist visits within a period of 1 year from the receipt of the RAF at HPSM Health Services. Standing RAFs are only valid for the evaluation and treatment of members with chronic diseases (see list above). The Specialist Provider who accepts a standing RAF will be required to provide a report to the referring PCP at least on a quarterly basis, detailing the member's progress. This quarterly reporting is subject to auditing by the CMO and Director of Health Services Operations, to prevent abuse of the standing referral policy.

The answers to frequently asked questions (FAQs) about the PCP Specialty Referral process are available in an HPSM publication entitled "PDF Instructions," available on the HPSM website or from your Provider Services Representative. In addition, information booklets about the RAF process are available for members in English and Spanish. Please ask your Provider Services Representative for more details.

Referrals to Non-Participating Providers

PCPs should make every effort to refer HPSM members to a participating provider listed in our provider directory. The HPSM provider directory, updated annually, is available on our website and also in hard copy format. Please ask your Provider Services Representative for a hard copy.

HPSM realizes that there are unique circumstances in which our participating provider network may not cover a particular specialized medical service that is medically necessary for evaluation and/or treatment of a member. In these situations, a referral to a non-participating provider may be authorized. Please indicate on the RAF the reason why a participating provider is unable to provide the requested service. If this information is not provided, the RAF processing may be delayed.

Automated Electronic Web-Based RAF Processing

An automated electronic web-based RAF processing program is currently being developed. This will be a HIPAA-compliant online referral authorization system which will allow PCPs to enter RAFs directly into the system and receive instantaneous authorizations. It will also allow Specialists to query the RAF system to ensure that a member's visit has been authorized. HPSM will notify providers when this system will be operational.

RAF Processing Status

In general, it takes two (2) business days for a properly completed RAF to be processed. When RAFs are authorized, the issuing PCP and the referred Specialist Provider are faxed a copy of the authorized RAF with the authorization number. If a PCP or Specialist has a question regarding the status of a submitted RAF, please contact HPSM Health Services at **650-616-2070**. Ask to speak to a RAF Authorization Specialist and they should able to answer your question concerning RAF processing.

Administrative RAFs for Specialty Providers

For all product lines (CareAdvantage, Medi-Cal, Healthy Kids and HealthWorx) there will be a RAF free holiday for in network referrals. The RAF free holiday does not apply to out of network referrals.

RAF requirements will resume upon notification by the HPSM. The following information is provided for reference only and will be updated over the next few months.

Under special circumstances, members may seek healthcare services from a specialist provider without a referral from their assigned PCP. Specialist providers may request that HPSM authorize these services by submitting an Administrative Referral Authorization Form (AdminRAF) to Health Services for approval.

The following are some examples that would require Plan authorization of Specialist Provider Services with an AdminRAF:

- A member was discharged from an Emergency Room within three (3) calendar days prior to a Specialist visit. This exception to the normal RAF rule is to allow for ER urgent referrals to specialists without the need for a PCP visit. If the Specialist visit is beyond three (3) days, it will require a regular RAF, issued by the member's PCP.
- A member is a resident of a long-term care facility and is unable to see his/her PCP for a RAF. In this case, a Specialist's visit may be authorized with an AdminRAF.
- A member is referred to an out of network provider for specialized services not available/performed by an in network provider.

Requests for Plan authorization of Specialist Provider Services must be in writing, using the "Administrative Referral Authorization Form (AdminRAF)." The AdminRAF is downloadable from the HPSM website, under the Provider section. A copy of this form can also be found in Section 10. Completed AdminRAF forms may be faxed to the Health Services Department at **650-829-2079**. The AdminRAF must be received within thirty (30) calendar days of the service date.

All requests for Administrative Referral Authorizations are reviewed on a case-by-case basis by the Medical Director or designee.

Specialist Providers rendering healthcare services to members who qualify under the above listed situations, with an approved "Admin RAF," will receive fee-for-service reimbursement for their services. Please remember that it is the **medical provider's responsibility to verify the member's eligibility at the time of service** as reimbursement for rendered services is subject to member's eligibility on the date of service.

Prior Authorizations for Medical Services

Prior Authorization is intended to ensure that the requested service is covered by the member's scope of benefits, that the provider of service is participating, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our Care Coordination programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service.

An authorization must be obtained from HPSM prior to rendering the requested service to ensure reimbursement (see "Retro authorization policy" section). Reimbursement is still subject to member eligibility on the date of service. Please check the member's eligibility before providing any service using any of the methods listed in Section 2 of this manual. In the event of an emergency, HPSM must be contacted within 24 hours, or on the next business day.

Medi-Cal, Healthy Kids, HealthWorx: PAR requirements apply to these programs.

CareAdvantage Plan: All Inpatient Admissions, DME, Skilled Nursing, non-emergency medical transportation and Home Health Care require a PAR. Other services may be directly billable. HPSM follows Medicare coverage guidelines. CareAdvantage requires ERs, hospitals and SNFs to fax admission face sheets upon admission of a CareAdvantage member.

Where do I obtain a Prior Authorization (PAR) Form?

For Medi-Cal members, please contact the State Medi-Cal Provider Support Center (PSC) office for 50-1 PAR (Prior Authorization Request) or 18-1 PAR (Extension of Stay in Hospital) forms. They can be reached by telephone at **800-541-5555**. In addition, information on how to order these forms can be obtained through the State Medi-Cal website under "Inpatient Services (IPS)," Forms reorder request section.

For all other programs, please visit the HPSM website to download the 50-1 and 18-1 equivalent forms. Samples of these forms are included in Section 10.

For CareAdvantage members only, Emergency Departments, Hospitals and SNFs can use admission face sheets as a notification of admission.

What medical services require a PAR?

Prior authorization requirements for Medi-Cal, Healthy Kids and HealthWorx generally follow State Medi-Cal guidelines. However, HPSM has lifted some of the prior authorization requirements imposed by the Medi-Cal program in order to provide more efficient member access to these services. The lists of PAR required and PAR lifted procedures can be found on the HPSM website under the Provider Information section). Please note the list of PAR not-required procedures is reviewed annually and is comprehensive at date of review but the list of PAR required procedures is not. Any procedure code that is not listed on the PAR not-required list can be assumed to be PAR required.

For those procedures that are PAR not-required, a PAR may or may not be required for an assistant. Please check the list for details. If the provider requests an assistant for a PAR not-required procedure, but the list indicates that an assistant is not automatically authorized, the provider will need to submit a PAR for the assistant. If a PAR not-required procedure is an inpatient procedure, the inpatient stay will be authorized by the on-site concurrent UM review nurse. These authorization requests should be submitted to the on-site concurrent UM review nurse on an 18-1 form or equivalent inpatient authorization request form.

In general, prior authorization is required for the following services:

- Inpatient Care - including hospital and rehabilitation services.
- Home Care and Home IV Therapy
- Hospice Care - General Inpatient
- Durable Medical Equipment, prosthetics and orthotics.
- Cardiac Rehabilitation after initial assessment (Note: HPSM physician referral required for the first visit.)
- Incontinence Supplies
- Services requiring Care Management Support: Care outside the HPSM service area
- Care at centers of excellence or specialty care centers. Specialists acting as the Primary Care Coordinator
- Transition of care situations for new members or for members when their provider has left the HPSM provider network (see section on "Continuity of Care")
- Biofeedback
- Physical Therapy/Occupational Therapy/Speech Therapy – initial evaluation does not require authorization but an HPSM physician prescription is required.
- Podiatry
- As of May 1, 2012 Non-Emergency Medical Transportation with the exception of hospital to home and hospital to skilled nursing or long term care facility.
- Advanced Imaging Studies: Pre-authorization is required for the following procedures when performed on an outpatient basis in Outpatient Hospital Facilities, Free Standing Radiology Facilities, and Non-Radiology Office-Based Settings: MRI, MRA, Nuclear Medicine, PET Scans and Obstetrical Ultrasounds (in excess of three (3) during a pregnancy) – see Section 5 – Ancillary Services – Diagnostic Radiology and Imaging for general criteria for MRI authorization.

Prior Authorization Process

Primary Care Physicians, specialty care providers and ancillary providers who identify a need for medical services for an eligible HPSM member that requires a prior authorization should complete a PAR form.

The PAR is to be used to document needed identification information. Depending on the complexity of the request, clinical information sufficient to make a medical necessity determination should be documented on this form. In most cases, a copy of a recent office note or consultation summarizing the medical needs of your patient will help us to rapidly process the request. Information, which can facilitate prior authorization determinations, includes the following elements, as relevant to each individual case:

- Patient characteristics such as age, sex, height, weight, or other historical and physical findings pertinent to the condition proposed for treatment
- Precise information confirming the diagnosis or indication for the proposed medical service
- Details of treatment for the index condition, or any related condition, including names, doses and duration of treatment for pharmacotherapy, and/or detailed surgical notes for surgical therapy
- Appropriate laboratory or radiology results
- Office or consultation notes related to the proposed medical service

- Peer-reviewed medical literature, national guidelines, or consensus statements of relevant expert panels
- The medical need for care by a provider outside of the HPSM network
- Applicable CPT-4 and ICD-10 diagnosis codes
- Complete facility and service information (including facility provider number and location)

Whenever possible, we ask that providers submit requests for prior authorization to HPSM seven (7) to ten (10) business days in advance of scheduled procedures. This will ensure that our Utilization Management staff have enough time to process and review your requests, and if needed, obtain appropriate additional information, without a need to potentially delay care to your patient. Fax all standard PAR request to fax number: **650-829-2079**.

Urgent Requests receive special attention. HPSM makes every effort to return authorization determinations quickly. Urgently needed care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the CMO or the Director of Health Services Operationsif you have any concerns that our process is interfering with the care your patient requires. Urgent PARs may be faxed to the HPSM Health Services Fax line: **650-829-2079**.

The "Urgent" designation is intended for cases in which the requested service must be provided as quickly as possible to avoid harm to the patient. At times, requests may be received as urgent because elective services were scheduled, but authorizations were not requested in advance. We will do our best to respond to such requests but may have to ask that such procedures be rescheduled if there is insufficient time to obtain the clinical information and complete the required review.

Definition of an “Urgent PAR” is one in which the requested service is medically needed within three (3) business days of submission. Abuse of the Urgent Fax line will be monitored. Faxed urgent PARs will receive an auto-reply message upon receipt at HPSM Health Services indicating the number of pages received and will include a copy of a portion of the first page of the fax transmission. Please note: The auto-reply will only work if the provider’s fax number is not blocked. (If the provider does not wish to receive an auto-reply message, he/she should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) If the indicated number of pages received does not match the number of pages sent, please re-send the fax. If you do not receive an auto-reply message, then HPSM Health Services did not receive your fax. Please re-fax the urgent PAR.

IMPORTANT: Urgent PARs faxed to other fax numbers at HPSM **will not be forwarded to Health Services** and will not receive an auto-reply. Please use the HPSM Health Services Urgent Fax line for urgent PARs.

For questions regarding the status of a submitted PAR, or questions regarding the authorization process, you may call HPSM Health Services Department at **650-829-2079**. Calls are answered by Prior Authorization Assistants to facilitate communication of essential information. Peak telephone call volume typically occurs in the late morning or early afternoon on Mondays and Fridays. Telephone response times are generally best at other times of the day.

HPSM Health Services Department hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding company holidays.

The Health Services Department is closed on Wednesdays 8:00 a.m. to 12 noon.

Completed Prior Authorization Request (PAR) forms with supporting documentation should be mailed to:

Health Plan of San Mateo
Health Services Department
ATTN: PAR Processing
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

DEFERRED OR EXTENSION OF A PRIORAUTHORIZATION REQUEST (PAR)

Medi-Cal, Healthy Kids, and HealthWorx

After a submitted PAR is reviewed by a UM Review nurse and determined to require additional information in order to evaluate the medical necessity of the requested service, a notice will be sent to the originator of the PAR requesting the specific information needed. This notification will be sent within two (2) business days of reaching the decision to defer the PAR and in any case, no later than five (5) business days of receipt of the submitted PAR. The member is also notified of the deferral.

The provider has twenty-one (21) calendar days, from the date of the deferral notice, to respond to the deferral with the requested information. If no information is received or the information received does not address the requested information, the PAR will be denied. Providers will receive a second written request for the needed information approximately two (2) weeks prior to the twenty-eight (28) day deadline. Please respond to the request for additional information accurately and timely, as HPSM is only allowed to defer a PAR once. Notifications of a PAR administrative denial are sent to both the originator of the PAR as well as the member.

Denied PARs

PARs denied for medical necessity must be reviewed by the Medical Director. Medically necessary health care services are those services provided by a licensed health care provider to diagnose or treat an illness, injury, or medical condition which the HPSM Medical Director determines to be:

- Appropriate and necessary for the diagnosis, treatment, or care of a medical condition;
- Not provided for cosmetic purposes;
- Not primarily custodial care (including domiciliary and institutional care);
- Not provided for the convenience of the member, the member's attending or consulting physician or another provider;
- Performed in the most efficient setting or manner to treat the member's condition
- Necessary as determined by an order of the court;
- Being within standards of good medical practice as recognized and accepted by the medical community.

Non-acute care and treatment rendered when there is no reasonable expectation of the member's improvement or recovery as determined by the HPSM CMO, using generally accepted medical standards shall be considered not medically necessary. Denial letters will be issued in accordance with DMHC/DHS and CMS mandates and time frame standards.

Care Coordination Program

The HPSM Care Coordination program strives to proactively coordinate complex care to enable the best clinical and functional outcomes for our members. The Care Coordination staff work with members, their families, Primary Care Physicians (PCPs), specialists and community resources to coordinate a comprehensive plan of care. HPSM Care Coordination staff understands the benefits available to each member, and can facilitate the optimal use of those benefits.

The Care Coordination staff regularly assists providers and patients by providing for prospective, concurrent, telephonic reviews, and planning and care coordination services for patients confined to a hospital or a Skilled Nursing Facility, as well as for members receiving home care or rehabilitation services. These activities are provided on an episodic basis.

Not all patients benefit from Care Coordination services. Patients receiving care from a single physician often do not need an outside coordinator for that care. However, with increasing case complexity, and increasing numbers of loosely affiliated care providers, many patients with complex care needs benefit by having a designated Care Coordination staff member.

HPSM identifies cases for Care Coordination prospectively through health status surveys and referrals from care providers and concurrently through the analysis of claims and hospital admissions history. We also request that providers notify our Care Coordination staff of complex cases amenable to Care Coordination.

Once a case is identified, the Care Coordination staff will contact the treating providers to establish a case file. The Care Coordination staff member will work with the provider to coordinate services, identify benefits that have not been fully utilized and can advise the treatment team of important coverage limitations that may apply. Treating physicians are encouraged to call the Health Services Department and ask for the Care Coordination Manager to obtain assistance in arranging/coordinating care, or in advising on resources that might be available to meet a member's needs.

Care Coordination staff will generally become involved with:

- Inpatient Admissions - providing concurrent review, discharge planning and care management services
- Transfers to tertiary care facilities or centers of excellence;
- Admissions or referrals to non-participating providers or facilities;
- Members with ongoing care needs in a rehabilitation center, SNF or home care.
- Members with frequent ER visits;
- Continuing care following discharge against medical advice; and
- Members with ongoing complex care needs or high cost diagnosis including but not limited to:
    - End Stage Renal Disease Requiring Dialysis or transplant
    - Chronic Pain
    - Multiple Sclerosis, ALS, and other debilitating neurologic conditions
    - Hemophilia
    - High Risk Pregnancies
    - Cancer
    - HIV/AIDS, chronic viral infections

- Coordination of care for members requiring services from community agencies such as: the Early Intervention Program through Golden Gate Regional Center, rehabilitation programs, TB treatment programs and HIV special needs programs.
- Providers may contact HPSM's Care Coordination Unit directly at **650-616-2060** or utilize the Case Management Referral form located on our website.

Self-Referred Care

HPSM members who meet the criteria outlined below do not need a referral for the following health services provided through a participating provider:

Screening Mammography

The United States Preventive Services Task Force recommends a screening mammography every one to two years with or without clinical breast examination among women age 40 and older. HPSM covers screening mammography for women over the age of 40, and encourages women to discuss the potential risks and benefits of mammography with her PCP. Women members of HPSM may self refer for mammography after the age of 40. A participating diagnostic imaging provider must be used for this service. The testing center will require a prescription from a requesting physician.

OB/GYN Services

HPSM members may self-refer for routine primary and preventive OB/GYN services, care related to a pregnancy, or for the care of acute gynecological conditions, if that care is provided by a participating OB/GYN provider. HPSM will also cover the cost of care for conditions identified in the self-referred visit. It is expected that the OB/GYN physician will send to the member's PCP a summary of the services and treatment plan as well as copies of screening (Pap smear, mammogram) or diagnostic tests performed.

Selected Routine Outpatient Diagnostic Services

The following procedures, when performed at a participating HPSM outpatient hospital or free-standing radiology facility do not require prior authorization. The ordering physician simply issues a prescription to the member and sends them to participating facility. The PCP simply sends a referral to the participating specialist for the service to be provided.

- Audiology evoked potential studies (limited service under CareAdvantage)
- Cardiac procedures (electrocardiography and cardiac stress tests)
- OB/GYN testing (fetal non-stress test, amniocentesis, cordocentesis, chorianic villis sampling, fetal contraction test, fetal scalp blood sampling)
- Neurological studies (electroencephalograms, EMG, nerve conduction studies)
- Pulmonary function tests
- Imaging services (routine x-rays, mammography, ultrasound) - These imaging services may also be performed at a participating HPSM freestanding Imaging/Radiology facility with a prescription from the referring provider and do not require prior authorization or a referral. Please note: Pre-authorization by HPSM is required for the following procedures when performed on an outpatient

basis in Outpatient Hospital Facilities, Free Standing Radiology Facilities, and Non-Radiology Office-Based Settings:

- MRI, MRA, Nuclear Medicine, PET Scans and Obstetrical Ultrasounds (in excess of three (3) during a pregnancy).

Medi-Cal, HealthWorx, Healthy Kids Members have the option to self-refer for additional services listed below.

Family Planning

Members may self-refer for family planning services through a participating provider. Family planning services include advice for birth control, pregnancy tests, sterilization, or an abortion, tests for sexually transmitted infections, HIV testing and counseling, a breast cancer exam or a pelvic exam. Medi-Cal members may go outside of the HPSM network to any provider that accepts Medi-Cal.

HIV Testing and Counseling

Members can self-refer for HIV testing and counseling any time they have family planning services, or through one of the participating family planning providers. Medi-Cal members may go outside of the HPSM network to any provider that accepts Medi-Cal.

TB Diagnosis and Treatment

Members may self-refer for TB Diagnosis and Treatment to a county public health agency for diagnosis and/or treatment. Members can choose to use either their HPSM provider or the county public health agency for diagnosis and/or treatment, including Directly Observed Therapy (DOT).

Immunizations

Members may receive immunizations through the PCP or self-refer to public health clinics for immunizations. Public health clinics will make every effort to verify with the member's PCP that the member has not already received the immunization, and supply the health plan with documentation of services along with the claim.

Emergency and Urgent Care

The PCP is responsible for the care of their patients 24 hours a day, seven days a week. The PCP or designee must be available in their office or via phone or answering service to appropriately triage and evaluate all non-emergent care as defined in the "Access to Care and Services Policy" in Section 7 - Administrative Policies of this Manual.

HPSM members with a medical emergency should go to the nearest emergency room for care. HPSM provides coverage for emergency services that meet the "prudent layperson" standard without prior authorization of these services. In addition, HPSM will provide coverage for any ER service authorized by the PCP or HPSM authorized representative. The Member Contract requests that members notify their PCP and HPSM within 48 hours of receiving care for an emergency. Conditions that do not meet the specified definition of medical emergency below including urgent care services require a referral by the member's PCP.

HPSM and the prudent layperson standard defines a medical emergency as the sudden, unexpected onset of a medical or behavioral condition causing symptoms of sufficient severity that a prudent layperson with an average knowledge of medicine and health could reasonably expect, in the absence of immediate medical attention, to result in:

- Serious jeopardy to the afflicted person's life or health; or
- Serious jeopardy to the life or health of a pregnant woman's unborn child; or
- In the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or
- Serious impairment to the afflicted person's bodily functions; or
- Serious dysfunction of any bodily organ; or
- Disfigurement.

Some examples of Medical Emergency include: apparent heart attack/stroke, difficulty in breathing, severe bleeding, blackout, convulsions, apparent poisoning, or fracture.

If a member self-refers to the emergency room, the HPSM Medical Director/designee will determine whether the presentation of symptoms was consistent with the above prudent layperson criteria and will state reasons in writing whenever this coverage is denied.

PCP notification is not required for emergency care but coverage can be ensured if the PCP authorizes such care. Please call the Health Services Department at **650-616-2079** to notify us that you have authorized an emergency room service.

Long Term Care

Definition

Beginning February 1, 2010, HPSM is responsible for long term care (LTC) authorizations, utilization management and payment of facility room and board charges. Approximately 1,300– 1,400 HPSM members are residents of long term care facilities. HPSM has over 100 contracted LTC facilities in San Mateo County and surrounding counties. HPSM administers these services in accordance with current Medi-Cal guidelines.

HPSM is administratively and financially responsible for the authorization of LTC Prior Authorization Requests (LTC PAR) for all Medi-Cal eligible beneficiaries with a County Code of 41 (San Mateo) and health plan number (HCP) 503. LTC nursing facilities send all PARs for services for facility room and board services provided to HPSM members to HPSM's Health Services Department. HPSM's Health Services Department processes PARs for members who require admission to LTC facilities, including free standing or distinct part Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), ICF/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N) or sub-acute Facilities-Adult/Pediatric. PARs are processed in accordance with the applicable requirements of the California Code of Regulations, Manual of Criteria for Medi-Cal Authorization, the California Welfare and Institutions Code and HPSM's Policies and Procedures in accordance with contractual agreements.

Financial Responsibility Related to LTC

The daily rate charge for LTC services is the responsibility of HPSM. The admitting facility is responsible for obtaining the necessary authorization for the facility daily rate from HPSM's Health Services Department according to the LTC PAR submission requirements. HPSM continues to be responsible for authorizing,

monitoring, and reimbursing medically necessary Medi-Cal covered services that are not included in the daily rate.

Preadmission Screening Preadmission Screening and Resident Review (PAS/PASARR)

Each HPSM Medi-Cal recipient applying for Nursing Facility (NF) admission is subject to PAS/PASARR Level I screening or evaluation either prior to admission or on the first day for which HPSM Medi-Cal reimbursement is requested. The admitting NF is responsible for performing the evaluations. The admitting NF is also responsible for making a referral for Level II evaluation when appropriate. Welfare and Institutions Code Section 9390.5 has required Preadmission Screening for every Medi-Cal recipient applying for admission to a Nursing Facility to determine if the recipient's condition requires institutionalization in a NF or whether he/she could remain in the community with support services. The NF will utilize PAS/PASARR Level I Screening Document (DHS 6170), Long Term Care Prior Authorization Request (Form 20-1), Minimum Data Set (MDS) Full Assessment Form) or Minimum Data Set (MDS) Quarterly Assessment Form, and PAS/PASARR Monthly Statistical Report. The NF will comply with applicable regulations in the Code of Federal Regulations, the Medi-Cal Long Term Care Provider Manual, the Welfare and Institutions Code and Title 22.

Plan of Care in Long Term Care

All HPSM members admitted to LTC facilities shall have an individually written Plan of Care completed, approved and signed by a physician pursuant to Title 42, Code of Federal Regulations. The Plan of Care shall be maintained in the member's medical record at the LTC facility.

PAR Process and Criteria for Admission to, Continued Stay in, and/or Discharge from a SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, and Subacute Adult/Pediatric Facility

HPSM's Health Services Department will process all request for admission to, continued stays in, or discharge from any LTC facility in accordance with the California Department of Health Services (DHS) standard clinical criteria for levels of services. Each level of care PAR processing procedure will be in compliance with applicable regulatory requirements.

On Site PAR Review, Long Term Care

HPSM's Health Services Department may perform on site review for DP-NFs, Intermediate Care Facilities and sub-acute sites. On-site review may also be done at free standing NFs, when indicated; e.g., patterns of high service utilization, frequent acute hospitalization of members, large numbers of member complaints/concerns. PAR requirements will be in compliance with Title 22 California Code of Regulations and DHS Manual of Criteria for Medi-Cal Authorization.

Retroactive Authorization for PAR for Long Term Care Facility Daily Rate

HPSM's Health Services Department shall process all requests for LTC retroactive authorizations and or continued stays for HPSM members in an SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, sub-acute facility–adult or sub-acute facility-pediatric pursuant to the California Department of Health Services standard clinical criteria for a skilled level or care. The LTC will submit the request for LTC PAR with the required clinical information and completed forms to the HPSM Health Services by mail or fax in accordance with applicable requirements of the California Code of Regulations, Title 22.

Quality Improvement Activities for Long Term Care

HPSM's Quality Improvement program systematically manages the provision and continuous improvement in the quality and care of service provided to all HPSM members. Measures of quality care and service include the following: access to care, appropriateness of care, process of caring, health outcomes, and member and provider satisfaction.

Quality Assessment and Improvement (QAI) activities as related to members residing in Long Term Care facilities will comply with all state and federal requirements as specified in the contract between the state and HPSM. The QAI program focuses on evaluation and improvement of the quality of member care in all settings or levels of care and with primary care and specialty physicians. HPSM is not responsible for any facility oversight as currently carried out by the California Department of Licensing and Certification, or for the California Department of Health Services Field office responsibilities related to the Inspection of Care Adults.

HPSM assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for members in LTC facilities including, but not limited to, CCS, Mental Health, and Golden Gate Regional Center. In addition communication to Licensing and Certification, Medi-Cal Operations Division and the LTC Ombudsman Office for potential quality of care issues may be a part of the QAI activities as indicated.

Complaints and Grievances

LTC facility room and board charges are a Medi-Cal benefit now administered by HPSM. All HPSM members and providers have access to HPSM's state-approved Complaint and Grievance process. Members also have access to the State Fair Hearing process at any time. The mechanism by which a LTC facility can resolve member or provider issues related to the provision of Medi-Cal facility services to HPSM members will be amended as needed to include the LTC program services.

Occurrence Reporting to Licensing and Certification

HPSM's Health Services and Quality Improvement Departments shall respond to occurrences, situations and complaints that affect or potentially affect the safety and well-being of HPSM members in LTC facilities by reporting the events to the appropriate regulatory agency for investigation.

Process for Transferring HPSM Members from Long Term Care Facilities to Acute Care Facilities

A LTC facility shall be responsible for coordinating an emergent/urgent transfer of a HPSM member to an acute care facility. A LTC facility shall collaborate with all appropriate multidisciplinary team members to facilitate either a planned or emergent/urgent transfer of a HPSM member from a LTC facility to an acute care facility. The LTC facility shall notify HPSM's Health Services Department of the admission of a HPSMM member to the acute care facility on the next business day.

Process for Transferring HPSM Members from Acute Care Facilities to Long Term Care Facilities

The acute care facility in collaboration with HPSM shall be responsible for all discharge planning aspects of a HPSM member's transfer to a LTC facility. HPSM's Health Services Department shall assist in coordinating the discharge planning of the member from an acute care facility to a LTC facility. The acute care facility shall collaborate with all appropriate multidisciplinary team members to facilitate the transfer of the member. The admitting LTC facility shall notify HPSM's Health Services Department of the admission of the member. The admitting LTC facility shall coordinate the medical and ancillary services with HPSM's Health

Services Department and/or appropriate agency; e.g., California Children Services (CCS) and the local Regional Care Center, as appropriate.

Distinct Part Nursing Facility Authorization

The Hudman vs. Kizer court order applies to all eligible Medi-Cal recipients/HPSM members in need of long term skilled nursing care.

Distinct Part/Nursing Facilities (DP/NF) shall be reimbursed at the DP/NF rate when the medical necessity for long term nursing care has been documented and all administrative requirements have been met as described in the Department of Health Care Services (DHCS) Long Term Care manual.

Leave of Absence

A Leave of Absence (LOA) may be granted to a recipient in a Nursing Facility (NF) Level A or NF Level B, NF Level A-DD-N and NF Level A-DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined in the DHCS Long Term Care manual.

Leaves of absence may be granted for the following reasons: a) a visit with relatives or friends; b) participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons.

Bed Hold for Acute Hospitalization

If a recipient is admitted to an acute care hospital, a Bed Hold (BH) may be permissible under the conditions outlined in the DHCS Long Term Care manual.

Summer Camp Leave Bed Hold Reimbursement

Skilled nursing and intermediary care facilities may receive reimbursement for developmentally disabled (DD) recipients attending summer camp.

To qualify for reimbursement, the facility must meet the following criteria: a) the patient's attendance at camp is prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled; b) the patient is not discharged from the facility while attending camp; c) the facility holds the patient's bed during the period of absence; d) the term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year.

The bed hold will terminate and discharge status will take effect under the following circumstances: a) if a patient dies while at camp, the bed hold terminates on the day of death (discharged date is the day of death); b) if a patient is admitted to an acute care hospital from camp, the bed hold terminates on the day of departure from camp; c) if the patient leaves camp and does not return to the skilled nursing facility, the bed hold terminates on the day of departure from camp.

Patient Plan of Care Requirements

Skilled nursing and intermediate care facilities must include written Plans of Care in each patient's medical record.

Individual written plans are required by Title 42, Code of Federal Regulations (CFR) to be approved and signed by a physician. They should include: a) diagnosis, symptoms, complaints and complications; b) description of individual's functional level; c) objectives; d) orders for medication, treatments, restorative

and rehabilitative services, activities, therapies, social services, diet and special procedures; e) plans for continuing care; and f) plans for discharge.

Skilled Nursing Facility Written Plan of Care

Before admission of a patient to a SNF or before authorization for payment, the attending physician must establish a written Plan of Care for each applicant or recipient in a SNF. The Plan of Care must include: a) diagnoses, symptoms, complaints, and complications indicating the need for admission; b) a description of the functional level of the individual; c) objectives; d) any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient; e) plans for continuing care, including review and modification to the Plan of Care; f) plans for discharge.

The attending or staff physician and other personnel involved in the recipient's care must review and sign each Plan of Care at least every 60 days.

Intermediate Care Facility Written Plan of Care

Before admission of a patient to an ICF or before authorization for payment, a physician or staff physician must establish a written Plan of Care for each applicant or recipient.

The Plan of Care must include: a) diagnoses, symptoms, complaints, and complications indicating the need for admission; b) a description of the functional level of the individual; c) objectives; d) any orders for: medications, treatments, restorative or rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objective of the Plan of Care; e) plans for continuing care, including review and modification of the Plan of Care; f) plans for discharge. The team must review and sign each Plan of Care at least every 90 days.

Long Term Care Clinical Management

The Health Plan of San Mateo's Clinical Management program systematically manages the provision and continuous improvement in the quality and care of service provided to all HPSM members. Measures of quality care and service include the following: access to care, appropriateness of care, process of caring, health outcomes, and member and provider satisfaction. The clinical management activities as related to members residing in Long Term Care facilities comply with all state and federal requirements as specified in the contract between the state and Health Plan of San Mateo. The clinical management program focuses on evaluation and improvement of the quality of member care in all settings or levels of care and with primary care and specialty physicians. HPSM is not responsible for any facility oversight as currently carried out by the California Department of Licensing and Certification, or for the California Department of Health Services Field office responsibilities related to the Inspection of Care Adults.

HPSM does assist in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for members in LTC facilities including, but not limited to, CCS, Mental Health, and Golden Gate Regional Center. In addition communication to Licensing and Certification, Medi-Cal Operations Division and the LTC Ombudsman Office for potential quality of care issues may be a part of the QAI activities as indicated.

Child Health and Disability Program (CHDP)

Program Description

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

Effective July 1, 2010 HPSM is responsible for the processing and reimbursement of the PM 160 claims for all HPSM eligible Medi-Cal members. Providers will not submit claims to State CHDP for HPSM eligible Medi-Cal members.

Reimbursement

HPSM reimburses at the current the CHDP maximum allowable rates.

Claims and Claims Processing

Providers must use the *PM 160 Information Only* (brown form) for HPSM eligible Medi-Cal members. Providers will continue using the *PM 160* (green form) for Gateway eligible Medi-Cal beneficiaries and submit these claims to State CHDP for processing.

PM 160 claim information and payments are included in HPSM's regular Explanation of Payment (EOP). During claims processing, PM 160 claim codes are converted to their corresponding CPT codes and shown on the EOP service lines. PM 160 claim services lines are identified with Explanation Code CH "CHDP Claim – Paid at Maximum Allowable"

Mail completed *PM 160 Information Only* (brown forms) to:

Health Plan of San Mateo
Attn: Claims Department
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

Complex Care Management

Complex care management uses proactive care management principles. High risk members are identified through a predictive model and health risk assessment screening tools. Complex/high risk care management programs focus on providing well-coordinated community-based services, including limiting gaps in care between inpatient and outpatient and community-based services. The framework of the care management programs address the complexity of the healthcare system and the difficulty our member's encounter navigating the health care system- Limited ability to access services negatively affects health status. Goals of our care management programs include a) improving quality of care, b) improving member satisfaction and c) promoting the provision of medically appropriate care through a multidisciplinary, comprehensive approach in a cost effective manner. For our dually eligible population, Care Advantage, each member receives a health risk screening assessment annually. In addition to the member's subjective health risk assessment screening tool, a comprehensive assessment is performed on high risk medically complex members. The integration of the comprehensive assessment with the health risk assessment

screening tool serves as a basis in development of individualized care plans. Individualized care coordination interventions are documented in a relational database that fosters centralized information and standardization. Care management interventions are developed in conjunction with the member and include a point of contact at the plan responsible for communications with the member. The health risk assessment screening is communicated with the member's primary care physician. Collaboration and coordination of care with the primary care physician is an integral component of the care management program.

Complex Care Management/Care Coordination Activities include the following:

- Comprehensive health risk assessments are performed for each Care Advantage member and high risk Medi-Cal members. This tool is the foundation of the case management process. Assessment and data gathering includes but is not limited to member demographics, primary care physician and specialty physician care information, living status, hospitalization and ED utilization, a review of physiological health systems, past medical history, a medication history and medication regimen, medication therapy management eligibility, social/emotional status, functional status/disability rating, activities of daily living assessment, exercise assessment, fall risk, community resource utilization and assessment, and primary care giver assessment, durable medical equipment (DME) and medical supply assessment and a needs assessment summary.
    - The clinical history documents the members' health status, clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history and current and past medication.
    - Activities of daily living evaluate the members' functional status related eating, bathing, walking, toileting, and transferring.
    - Mental health status evaluates the members' mental health status, including psychosocial factors and cognitive functions such as ability to communicate, understand instructions and process information about their illness.
    - Cultural and linguistic needs include an assessment of cultural and linguistic needs, preference or limitations.
    - Caregiver resources are evaluated to assess family involvement in the care plan and the caregiver potential for burn-out.
    - Life planning assessment addresses life planning issues such as living wills/ advance directives/ durable power of attorney.
    - A benefit assessment is also conducted.
- Individualized care plans are developed from the findings and analysis of the comprehensive health risk assessments.
- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under and over utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service.
- Ensuring that members have access to the appropriate care and service within their health plan benefits and consistent with accepted standards of medical practice.

- Retaining the ultimate responsibility for the determination of medical necessity for HPSM members and ensuring that authorization requests are handled efficiently according to HPSM UM timeliness standards.
- Evaluating the results of the Utilization Management Program utilizing data includes:
    - Membership statistics
    - Quality and utilization management reports, such as bed day utilization, ambulatory care and ancillary utilization patterns.
    - Conducting regular monitoring visits with follow-up for quality improvement activities or corrective actions to ensure continued compliance with HPSM standards.
- Monitoring of services to evaluate utilization patterns.
- Monitoring performance to ensure qualified healthcare professionals perform all components of utilization review. Maintaining a process for a licensed physician to conduct reviews on all cases that do not meet medical necessity criteria, or service requests that are not addressed by criteria.
- Maintaining a process to ensure that all Health Services UM reviewers have access to appropriate board certified specialists to assist in determining medical necessity as needed.
- Ensuring inter- and intra-rater reliability through a defined internal process.
- Ensuring the confidentiality of member and provider information.

In-Home Physician Program

The In-Home Physician program is a system of care that provides 24/7 access to in-home physician visits for the plan's most medically vulnerable and complex members. This program supports proactive cost management and enhanced medical care by treatment through a home delivery system by optimizing care in the home. The services that In Home Physician program provides include:

- 24/7 patient access to a visiting physician.
- Regularly scheduled in- home and facility visits and anytime as needed.
- Coordinated care with primary care physicians, specialists, and the plan's nurse Care Manager.
- Clinical and pharmacy management.
- Education to the patient about their medical conditions and anticipated outcomes.

Care Transitions

The plan also incorporates a care transition model in the UM program. The intent of the care transition model is to improve health care outcome and reduce re-hospitalization risk when members encounter a care transition. Members experiencing a care transition from the home to an acute care setting or to a skilled nursing facility are identified and followed by the nurse case manager through the continuum of care. The nurse case manager serves as a point of contact to the member and the member's health care team. For each care transition, the nurse case manager also initiates communication to the member's primary care physician. The primary goal of the nurse case manager is to support the member and the

member's healthcare team to ensure appropriate communication and benefit coordination occurs in a timely manner.

Medication Therapy Management (MTM)

Medication Therapy Management is the analytical, consultative, educational and monitoring services provided by pharmacists to Care Advantage members in order to facilitate the achievement of positive therapeutic and economic results from medication therapy. MTM services allow local pharmacist to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs, and provide healthcare to plan members in a cost-effective manner.

HPSM contracts with the vendor, Outcomes, to administer MTM services. MTM services include comprehensive medication review (CMR), prescriber consultations, member compliance consultations, and member education and monitoring.

Comprehensive medication review is performed annually. During the CMR, the pharmacist will review the member's prescription and nonprescription medication, vitamins, minerals, herbal products, and dietary supplements for potential interactions. As part of the review, the pharmacist will provide a master medication list for the member to bring to future office visits.

Prescriber consultations assist physicians and other prescribers to coordinate care and resolve potential medication- related complications. Participating MTM pharmacists will consult the plan's formulary to assist members in selecting the most cost-effective and clinically appropriate medications. Potential cost saving opportunities is discussed with the member and prescribing physician.

Member compliance consultations assist members with compliance issues. MTM pharmacists monitor plan members for compliance with prescribed medications. When an overuse, underused, or administration issue is identified, the pharmacist will educate the member on the importance of compliance and monitor the member to ensure that compliance improves.

Member education and monitoring is performed when a member is prescribed a new medication therapy or experiences a change in therapy. MTM pharmacists monitor the member for improvement in reportable symptoms, the occurrence of the side effects and compliance with therapy.

Clinical Pharmacy Outreach Program (CPOP)

The Clinical Pharmacy Outreach Program (CPOP) was launched in June 2007. The Pharmacy team launched this new service designed to outreach, educate and help our providers in their offices with all pharmacy-related issues encountered on a day-to-day basis. Pharmacists provide direct assistance and support to physicians on pharmacy issues such as:

- General pharmacy benefits and formulary questions
- Generic drugs awareness
- Prior authorization (PA) process
- Claims submission process for physician administered medications (ex. Vaccines)
- Medicare Part D program (CareAdvantage) questions
- Patient-specific drug therapy issues

A key educational component of this program is the one to one education our plan pharmacist provides to our community physicians regarding our formularies and PA process. This service is aimed at supporting member care so that our members will receive their medications without unnecessary delay.

Our clinical pharmacists also work closely with physicians on specific drug therapy issues with their patients so that the best therapeutic options are available for our members.

Terminated Providers

HPSM has a mechanism to continue appropriate and timely care for members whose physicians are terminating from the network. This process includes a 60 day notification from the practitioner of the intent to terminate. Members under current care and those with approved prior authorizations, not yet utilized, are identified so that their care can be managed and coordinated with the receiving physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, dialysis-dependent members, those awaiting transplants, late-term pregnancies, pending surgeries, acute rehabilitation, and any other members that might have their ongoing care negatively impacted by the termination of the group are identified. When members are identified as possibly benefiting from coordination of care both within and outside of the network, the case is referred to the CCM for further interventions. The CCM actively engages in activity that monitors and assesses continuity and coordination of clinical care. The CCM works closely with the member, physicians and any other associated ancillary providers involved in the case, in an effort to provide timely, quality-based care meeting the needs of the individual member.

Behavioral Health Management

HPSM ensures members, with coexisting medical and behavioral healthcare needs, have adequate coordination and continuity of their care throughout the network. It is carved-out of HPSM's program for Medi-Cal and is a delegated service for HPSM's other programs (CA, HK, & HW)

Members with complex medical conditions and conditions requiring coordination with other county programs such has SM County Behavioral Health and Recovery Services, Golden Gate Regional Center, California Children's Services psychiatric diagnoses through various means, including but not limited to internal resources such as through Health Services UM review staff, pharmacist review staff and Member Services staff. These members are managed throughout the continuum of care and communication with both the medical and behavioral health specialists occurs as needed to enhance continuity, to ensure members get timely and appropriate care and to facilitate communication between the medical and behavioral health providers involved in the care. HPSM works closely with the San Mateo County Mental Health Plan to coordinate these services for members.

Continuity and coordination of behavioral healthcare may involve HPSM communicating and coordinating care directly between PCPs and Behavioral Health specialists. The licensed Care Coordination Manager and Health Services Clinical Manager is responsible for coordinating services with San Mateo County Mental Health to assure that individual members with coexisting medical and behavioral disorders receive appropriate treatment in the appropriate ambulatory and/or inpatient setting.

Prescription Medication Prior Authorizations

HPSM has a process in place to ensure that procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and to make medical necessity exceptions to the HPSM formulary (HPSM Approved Drug List).

The HPSM Pharmacy Staff and the Pharmacy Review Committee are responsible for development of HPSM Approved Drug List, which is based on sound clinical evidence and reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the HPSM Approved Drug List are communicated to both members and providers.

If the following situations exist, HPSM will consider the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate and the drug is medically necessary
- Member has failed treatment or experienced adverse effects on formulary drugs
- Member's treatment has been stable on a non-formulary drug and change to formulary drug is medically inappropriate.

To request a prior authorization (PA) for outpatient medication not on the HPSM Approved Drug List, the physician or physician agent must provide documentation to support the request for coverage. Documentation is provided on a HPSM Medication Request Form (MRF), which is submitted to HPSM's pharmacy unit for review. The initial review is based on PA guidelines approved and established by HPSM.

The pharmacy review staff profiles drug utilization by member to identify instances of poly-pharmacy that may pose a health risk to the member. Medications profiles for members on eight (8) or more medications are reviewed by a clinical pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Monitoring for Consistent Review Criteria

The Health Services Clinical Manager and Care Coordination Manager perform ongoing monitoring of UM nurse reviewer application of criteria/guidelines to:

- Measure the reviewers' comprehension of the review criteria and guideline application process.
- Ensure accurate and consistent application of the criteria among staff reviewers, and ensure criteria and guidelines are utilized per policy/ procedure.
- Ensure a peer review process for inter-rater reliability.

The Health Services staff is responsible for identification of potential or actual quality of care issues, and cases of over- or under-utilization of healthcare services for HPSM members during all components of review and authorization.

Monitoring for Over and Under Utilization

In an effort to review appropriateness of care provided to members, HPSM tracks and trends various data elements to determine over- and/or under- utilization patterns. The industry benchmark rates are used as guidelines for comparison. Some of the elements reviewed include:

- Hospital admits/1,000
- Re-admissions
- Pharmacy utilization
- Bed days/1,000, using HPSM performance standards
- Emergency room visits
- Encounters per enrollee per year
- Behavioral Health inpatient admissions
- Denials
- Frequency of selected procedures, as determined by utilization patterns
- Medi-Cal Medical Directors Utilization Reports
- Industry Collaborative Effort Utilization Reports
- Cultural/Linguistic reports that reflect barriers for access to care or delivery of care

HPSM enacts actions to improve performance as a result of these clinical data analysis, and feedback is provided to both entities and individual practitioners so that corrective actions can be taken. HPSM continues to monitor for compliance with corrective action plans and improvements in the care delivery process.

Review Criteria, Guidelines, and Standards

Standards, criteria and guidelines are the foundation of an effective Utilization Management Program. They offer the licensed UM staff explicit and objective "decision support tools," which are utilized to assist during evaluation of individual cases to determine the following:

- If services are medically necessary
- If services are rendered at the appropriate level of care
- Quality of care meets professionally recognized industry standards
- Consistency of UM decisions

The following standards, criteria, and guidelines are utilized by the Health Services UM review staff and Medical Director as resources during the decision making process:

- Medical necessity review criteria and guidelines
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Policies and Procedures

Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment and application of individual case information and local geographical practice patterns.

Licensed nursing review staff applies professional judgment during all phases of decision-making regarding HPSM members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria and guidelines with respect to the decisions regarding medical necessity of healthcare services, and not as a substitute for important professional judgment.

The HPSM Medical Director evaluates cases that do not meet review criteria/guidelines, and is responsible for authorization/ denial determinations.

HPSM's Health Services UM review staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. In the event that a provider should question a medical necessity/ appropriateness determination made, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following approved department "Decision Support Tools" have been implemented and are evaluated and updated at least annually.

Criteria and Guidelines

Approved HPSM Guidelines shall be used for all medical necessity determinations. HPSM uses the following criteria sets: Medi-Cal Manual of Criteria, published by the State of California, American Academy of Pediatric Guidelines (AAP), Milliman Care Guidelines, Medicare Coverage manual/ St. Anthony's Guidelines to Medicare Coverage, and the HPSM Medical Policy and Medi-Cal Benefits Guidelines (Medi-Cal Provider manuals- Allied Health, Inpatient/Outpatient, Medical, Vision, Pharmacy) .

Due to the dynamic state of medical/healthcare practices, each medical decision must be case-specific based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care such as OB/GYN, surgery, etc. are primarily appended for guidance concerning medical care of the condition or the need for the referral.

Medi-Cal Manual

The State of California publishes *Medi-Cal Manual of Criteria,* which is the basis for Medi-Cal benefit interpretation and used as a UM guideline.

Milliman Care Guidelines Criteria

Milliman Care Guidelines are developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry.

Milliman's clinical staff of physicians, nurses, and other healthcare professionals creates initial drafts of the criteria based on input from consultants, as well as an exhaustive review of existing guidelines and medical literature. Physicians and other providers from all disciplines relevant to the particular subject then review, revise, and re-review these versions in an iterative, consensus-building process (a modification of the Delphi

method). Criteria acknowledge controversial areas where agreement cannot be reached, and provide a rationale for the stance that has been chosen. Detailed notes and literature references provide the clinical basis for decisions. The criteria therefore provide a synthesis of evidence-based data, literature-supported medicine, and national consensus. Milliman criteria enable health plans and providers to capture data about the intervention requested and the rationale for each request. The criteria also provide a clinical reference for managing the dialogue between provider and reviewer, provider and payer, and provider and patient. Milliman criteria support an explicit, clinical rationale for care decisions.

Milliman guidelines update cycles are done at a minimum on an annual basis. Milliman states that update reviews include: development of new procedures, new technology, requests from clients, criteria incorporating high frequency, high risk, high visibility and high variation, literature review and analysis, new clinical practice. (Milliman, 2007)

St. Anthony's Guidelines to Medicare Coverage

Medicare national and local coverage guidelines must be utilized, by federal regulation, when reviewing services for Medicare / Medi-Cal members. The national coverage guidelines may be found in St. Anthony's Complete Guide to Medicare Coverage Issues or at the CMS website at http://www.cms.hhs.gov/. The website is updated on an ongoing basis and contains the complete Coverage Issues Manual. There is a subscription fee for St. Anthony's, but the website is free. Local and regional coverage issues may be found at http://medicare.transamerica.com

Utilization Management Appeals Process

An organization determination is any decision made by or on behalf of HPSM regarding the payment or provision of a service a Member believes he or she is entitled to receive. An organizational determination is made in response to a Prior Authorization Request or a request for Prior Authorization submitted by a provider and may include approval, denial, deferral, or modification of the request. HPSM has a comprehensive review system to address matters when members or providers (on behalf of members for services yet to be provided) wish to exercise their rights to appeal an organizational determination that denied, deferred or modified a request for services.

The administration of HPSM’s reconsideration of an organization determination and appeals process is the responsibility of the Grievance and Appeals Coordinator under the direct supervision of the Grievance and Appeals Manager. All investigation efforts are geared to protect the enrollee’s privacy and confidentiality and to achieve rapid resolution.

Confidentiality

Due to the nature of routine UM operations, HPSM has implemented policies and procedures to protect and ensure confidential and privileged medical record information. Upon employment, all HPSM employees, including contracted professionals who have access to confidential or member information sign a written statement delineating responsibility for maintaining confidentiality.

Both the HPSM UM staff voice mail phone message line for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee.

The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by HPSM UM staff. HPSM has implemented Health Information Portability and Accessibility Policies and Procedures to guide the organization in HIPAA compliance. All records and proceedings of the UM Committee related to member or provider specific information are confidential and are subject to applicable law regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58.

Conflict of Interest

HPSM maintains a Conflict of Interest policy to ensure that conflict of interest is avoided by staff and members of Committees. This policy precludes using proprietary or confidential HPSM information for personal gain, or the gain of others, as well as a direct or indirect financial interest on or relationship with a current or potential provider, supplier, or member; except when it is determined that the financial interest does not create a conflict.

Fiscal and clinical interests are separated. HPSM and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Staff Orientation, Training and Education

HPSM seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program as applicable to specific job description:

- HPSM New Employee Orientation
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Utilization Management Program, policies/procedures, etc.
- Care Coordination Model of Care , policies and procedures
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeal Process
- Orientation to specific programs of each delegated entity.

HPSM encourages and supports continuing education and training for employees, which increases competency in present jobs and/or prepares employee for career advancement within the HPSM. Each year, a specific budget is set for continuing education employees.

Licensed nursing staff is monitored for appropriate application of Review Criteria/ Guidelines, processing referrals/ service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of proficiency. Training, including seminars and workshops, are provided to all UM staff regularly during regularly scheduled meetings and on an ad-hoc basis as need arises.

HealthPlan OF SAN MATEO
Healthy is for everyone

Provider Manual

Section 8

Provider Services

Introduction

The Provider Services Department is responsible for recruiting and credentialing providers; personal provider support; education and training; field visits to provider offices; provider issues resolution; and provider newsletters.

This Section discusses general HPSM provider information including provider rights and responsibilities, credentialing and contracting, provider training and communications.

Credentialing and Contracting

To become a provider in the HPSM network, the provider must sign a Medical Services Agreement (contract) and complete HPSM's credentialing process. The following describes the required steps for a physician/provider to complete this process:

1. Physician/Provider completes, signs, and returns the Medical Services Agreement, 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 (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate) for CareAdvantage providers
    - Copy of Property Comprehensive General Liability Insurance (Premises) face sheet (required limits are $100,000 per occurrence/$300,000 annual aggregate) for CareAdvantage providers
    - Copy of Professional Liability Insurance (Malpractice) face sheet (required limits are $1,000,000 per person per occurrence) for Medi-Cal, Healthy Kids, and HealthWorx providers
    - Copy of Property Comprehensive General Liability Insurance (Premises) face sheet (required limits are $300,000 per person per occurrence) for Medi-Cal, Healthy Kids, and HealthWorx providers
    - Completed and signed Attestation Questionnaire
    - Signed Release of Information/Acknowledgments Form
    - Curriculum Vitae

- 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. The Plan verifies the information provided (National Provider Identifier, license status, etc.)
3. The application and supporting documentation are reviewed by HPSM's Credentialing Specialist, Provider Services Manager, the Director of Health Services Operations, Associate Medical Director and/or Chief Medical Officer.
4. Upon approval of the above-mentioned parties, the Chief Executive Officer countersigns the contract after approval of credentialing.
5. A copy of the completed contract is then returned to the physician/provider. A new provider orientation and training must be scheduled within 10 days of the credentialing approval.
6. Primary Care Physicians and Referral Physicians must also have a site review, conducted by a HPSM Quality Improvement Nurse, before the credentialing process is finalized.
7. Providers are re-credentialed every three years, based on the date of contract execution.
8. In regards to HPSM's credentialing and recredentialing 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 recredentialing application, upon request.

Contractual requirements for credentialing and regulatory compliance

In your contract you agreed 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. 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, Healthy Kids and HealthWorx programs.

As a contracted CareAdvantage provider, you agreed 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 Medicare provider. 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 the 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.
- 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

Your contract references this certification in Section 2 of the Medi-Cal, Healthy Kids, and HealthWorx Agreements, and Section 6 of the CareAdvantage Agreement. 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 Section XVI (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

For All 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. Provider shall also openly discuss treatment options, risks and benefits with members without regard to coverage issues.

- 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, as appropriate, and without violation of pertinent State and Federal laws regarding the confidentiality of medical records. Such information shall be provided without cost to HPSM.
- 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 jurisdiction's 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 them. 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 it's 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. Members 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.
- 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 it's 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. Members 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.

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 Services Representatives 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.

Provider Trainings and Communications

Provider Training

HPSM is responsible for the quality of care and satisfaction of its members as well as the satisfaction of its network of contracted providers. HPSM's Provider Services Representatives delivers all necessary topics of information to providers after acceptance as an HPSM contracted provider. In addition, Provider Services Representatives will perform educational training to providers on an ongoing basis.

Orientation for newly contracted provider offices

Provider training is included with a contract and credentialing application that is mailed to all new providers. Providers are required to sign an "Acknowledgment of Training" attesting that they have received training. Upon notification of a provider's acceptance in HPSM's provider network, the Provider Services Department will also contact the office to schedule an orientation meeting. The following items will be included in the orientation:

- HPSM overview
- Provider Manual
- Comprehensive Provider Directory
- Lines of business
- Authorizations and claims
- Member eligibility and verification
- Instructions for using HPSM's website and other helpful websites
- Provider dispute resolution process
- Quality improvement initiatives
- Special Programs
- Improving systems of care at the provider office level
- Reducing health disparities
- Language assistance programs for HPSM members
- HPSM contacts
- Forms

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 provider newsletters/bulletins, broadcast fax, individual meetings, and/or group presentations. Ongoing provider training may include focused topics. Providers who have a change in office staff may request training for new staff members.

Provider communications

HPSM values the importance of effective and open communication with its provider network. To ensure and encourage that all providers and HPSM are sharing information, the Provider Services Department provides the following services, including but not limited to:

- Provider Services Newsletter – "Health Matters MD" published bi-annually
- Broadcast Faxes
- Comprehensive Provider Directory
- Remittance Advice (RA) Inserts
- Printed Materials
- Direct Telephone Calls
- Provider Services Representative Office Visits
- Notifications and Correspondence
- Training Sessions
- Mailings
- Website: www.hpsm.org
- Provider Services Department Telephone: (650) 616-2106

Section 9

Quality Improvement

Introduction

The goal of the Health Plan of San Mateo's (HPSM's) Quality Improvement (QI) Program is to ensure that all HPSM members receive high quality health care to optimize their health status. The HPSM QI Department, in collaboration with HPSM providers, strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The QI Department relies on HPSM senior management's oversight and accountability, and integrates the activities of all departments in meeting QI program goals and objectives. The QI Program also involves members, participating providers, regulators, plan sponsors and evaluators in the development, evaluation, and planning of quality activities.

HPSM utilizes continuous quality improvement methodology to identify opportunities for improvement, develop improvement strategies and to systematically track whether these strategies result in progress towards achieving goals. Quality studies and monitoring activities are reported up through the QI committee structure to HPSM's governing body. The QI Program Description is reviewed and updated annually.

Provider Site and Medical Record Review

The purpose of the provider site and medical record review is to ensure that primary care providers (PCPs), pediatricians, obstetricians/gynecologists and high volume SPD (seniors and persons with disabilities) network referral specialty providers, Community-Based Adult Services (CBAS) Centers and high volume SPD ancillary services, are in compliance with applicable local, state, federal and HPSM standards. HPSM conducts provider site reviews for all new Medi-Cal PCPs, pediatricians, and OB/GYNs, as a pre-contractual requirement prior to completion of initial credentialing. HPSM conducts provider site reviews triennially for PCPs, pediatricians, and OB/GYN providers as a requirement of participation in the California Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications. This is a requirement of HPSM's contract with the State.

A full scope review is conducted utilizing the criteria and guidelines of the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD). The criteria are outlined in a MMCD Policy Letter 14-004dated May 22, 2014 and MMCD DPL 14-005 dated September 29, 2014. In addition to the criteria noted in the policy letter, supplemental criteria may be used by HPSM to address additional requirements applicable for quality studies.

A full scope site review is not required automatically as a part of the re-credentialing process. Re-credentialing includes information from other sources pertinent to the credentialing process such as QI criteria and may include medical record reviews.

Full Scope Facility Site Review

Initial Reviews

All primary care sites serving HPSM managed care members undergo an initial site review prior to completion of credentialing and assignment of members to the prospective provider. The schedule for performing a facility site review is determined by QI Department staff and the prospective provider. It is based on the prospective credentialing date as well as the provider's availability and preference. A copy of the Facility Site Review Survey Tool, Medical Record Review Survey Tool, FSR Guidelines, MRR Guidelines, and Physical Accessibility Review, is mailed to each provider with notification of the review date. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

Recertification Reviews

Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with HPSM and Medi-Cal criteria and guidelines.

Moving to or Adding a New Site

Providers who move to a new site or open an additional office site must have a facility site review at their new location. The site review must be completed as soon as possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), but no later than 30 calendar days after the date the new site was opened for business (or HPSM's notification date). The site review for relocated offices must be completed prior to the provider's re-credentialing date.

Adding a New Provider
Providers who move into an office which has a current site review will only require a medical record review to be credentialed.

When More Frequent Site Reviews May Be Necessary
HPSM reviews sites more frequently when it determines this to be necessary, based on findings from monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed pursuant to a request from the Peer Review Committee, the Quality Improvement Committee, or the Commission. Additional reviews may also be done at the discretion of the Medical Director or the Quality Nurse, after discussion with the Medical Director, if patient safety or compliance with applicable standards is in question.

The Site Review Survey Tool is mailed to providers prior to an on-site audit. Relevant information is presented and shared with provider office staff at the time of the site review.

Medical Record Review

A minimum of ten (10) medical records are reviewed initially for each primary care provider as part of the initial site review process and every three years thereafter. During any medical record survey, reviewers have the option to request additional records for review. If additional records are reviewed, scores must be calculated as outlined below.

Medical records of new providers are reviewed within 90 calendar days of the date on which members are first assigned to the provider. An extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient HPSM members assigned to complete a review of 10 medical records. If there are still fewer than 10 records for assigned members at the end of six months, a medical record review is completed on the total number of records available and the scoring is adjusted according to the number of records reviewed.

Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records are reviewed if two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.

Site Review Survey and Medical Record Scoring

A minimum passing score of 80% on **both** the Site Review Survey and Medical Record Review Survey is required. Scores are computed based on the following checklist of categories and assigned values:

Full Scope Site Reviews
Site Review Survey:

Access/Safety	29 points
Personnel	22 points
Office Management	25 points
Clinical Services	34 points
Preventive Services	13 points
Infection Control	27 points
Total	**150 points**

Medical Record Review Survey:

Format	80 points
Documentation	70 points
Continuity/Coordination	80 points
Pediatric Preventive (if applicable based on case mix)	(19) X # of records
Adult Preventive (if applicable based on case mix)	(15) X # of records
OB/CPSP Preventive (if applicable based on case mix)	(20) X # of records
Total	**Points possible will differ from site to site**

The Site Review survey is scored in the following manner:

1. Full Pass: 100%
2. Exempted Pass: 90% or above, *without* deficiencies in critical elements, Infection Control, Pharmacy, or any one section scoring below 90%.
3. Conditional Pass: 80-89%, or 90% or above *with* deficiencies in critical elements, scoring below 90% in a section, or a deficiency in pharmaceutical services, or infection control.
4. Not Pass: below 80%

The Medical Record Survey is scored in the following manner:

1. Full Pass: 100%
2. Exempted Pass: 90% or above: (Total score is greater than or equal to 90%, and all section scores are 80% or above).
3. Conditional Pass: Total MRR is 80-89% or any section(s) score is <80%
4. Not Pass: Below 80%

Critical Elements for Scoring

There are *nine critical elements* related to the potential for adverse effect on patient health or safety. These have a scored "weight" of two points. All other survey elements are weighted at one point. A full point is given if the scored element meets the applicable criterion. Zero points are given for any scored element that is considered only "partially" met by the reviewer. Zero points are given if an element does not meet criteria. The nurse reviewer determines the "not applicable" (N/A) status of each criterion based on the site-specific assessment. The reviewer must explain all criteria that are scored as zero or N/A.

The nine critical elements are:

1) Exit doors and aisles are unobstructed and egress (escape) accessible.
2) Airway management equipment, appropriate to practice and populations served, are present on site.
3) Only qualified/trained personnel retrieve, prepare or administer medications.
4) Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
5) Only lawfully-authorized persons dispense drugs to patients.
6) Personal Protective Equipment (PPE) is readily available for staff use.
7) Needle stick safety precautions are practiced on-site.
8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazard non-sharps) are placed in appropriate. leak-proof, labeled containers for collection, processing, storage, transport or shipping.
9) Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results.

An acceptable corrective action plan must be submitted within 10 business days of the survey date for any deficiencies found during any monitoring visits for any of these critical elements. This is regardless of the survey score attained. Corrections must be made within 30 calendar days of the survey date.

Corrective Action Plans (CAPs)

Sites that receive an Exempted Pass (90% or above, *without* deficiencies in critical elements, pharmaceutical services, or infection control, or less than 90% in a section) are not required to complete a corrective action plan (CAP) unless determined necessary by HPSM. However, all sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements, less than 90% in a section, or a deficiency in pharmaceutical services, or infection control) must complete an acceptable CAP to address the cited deficiencies.

HPSM staff provides a written report of site survey findings that specifies any deficiencies for all critical and non-critical elements. For all critical and non-critical elements requiring immediate correction, providers must submit an acceptable CAP that attests that corrections were completed within 10 business days of the survey date. Within 30 days of the survey date, HPSM staff verifies corrections of critical elements and other survey deficiencies requiring immediate correction. For all other non critical

deficiencies, providers must submit an acceptable CAP by 30 calendar days from the date of the written CAP request.

Providers' CAP documentation must identify the specific deficiency, an acceptable plan of corrective action(s) needed, projected and actual date(s) of the correction, re-evaluation timelines/dates, and responsible persons(s). HPSM staff, with oversight by HPSM's Medical Director, will review the CAP to determine if it is acceptable. HPSM's Peer Review Committee may be consulted for advice on standards of practice issues as necessary.

If the CAP cannot be verified and approved within 60 days from the date of the written CAP request, an on-site visit may be scheduled. If the CAP cannot be closed, the provider will be referred to the Medical Director. The reasons for a late CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

Providers may request a time-specific extension period to complete corrections if extenuating circumstances that prevented completion of corrections can be demonstrated, and if agreed to by HPSM. (This period may not exceed 90 calendar days from the survey findings report and CAP notification date unless a longer extension is approved by the State of California Department of Health Care Services.). HPSM will perform a focused review at any site that required an extension period beyond 90 calendar days to complete corrections prior to closing the CAP.

Once a CAP is approved, it will be reviewed by the Medical Director as part of the Credentialing Review process.

Non-Passing Providers

A *pre-contractual provider* who scores below 80% on the full scope site review survey will not be recommended for credentialing completion or contract approval until a passing score is achieved and correction of any missed critical elements is verified. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the full scope site review survey. After achieving a score of 80% or higher, a CAP must be completed as previously described.

Contracted providers who fail the site review upon recertification survey are notified of the survey score, all cited deficiencies and CAP requirements at the time of the failed survey. Providers who do not complete a CAP that addresses the deficiencies completely will be referred to the Medical Director for review and possible referral to the Peer Review Committee. The reasons for an unacceptable CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

HPSM may suspend any contracted provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain

in the provider network, survey deficiencies must be corrected by the provider and verified by HPSM staff within the CAP timelines previously noted. New members will not be assigned to the provider until a score of 80% is achieved on a subsequent full scope site review and required corrections are verified and the CAP is closed.

Non-Compliant Provider

Any network provider who does not comply with survey criteria within the established timelines will be subject to Peer Review action and may be recommended for removal from the network. In such an instance, HPSM members will be re-assigned to other network providers following plan policies and procedures.

Provider Appeal Process

Providers removed from the network may appeal the decision. HPSM has a formal process to resolve grievances submitted by providers. Please refer to Section 5 - Provider Disputes and Grievances for additional information. If verified evidence of corrections is accepted by HPSM and the removal decision is reversed, a Site Survey may be repeated. If the current survey and CAP are accepted, the site will be re-surveyed no later than 12 months following closure of the CAP. If HPSM does not reverse the decision, and the provider would like to again become an HPSM provider, he/she may re-apply through HPSM's application process. As previously noted, all applicants must undergo and pass an initial Full Scope Survey.

Facility Site Focused Review

Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. The focused review is a "targeted" audit of one or more specific site or medical record review survey areas and is not substituted for the full scope survey. Reviewers may use appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review require the completion and verification of corrective actions according to CAP timelines previously described.

Facility Site Monitoring

HPSM staff monitors any contracted HPSM physician practice site between regularly scheduled full scope site review surveys. This may include visits for quality activities or follow up on member complaints. Indications of site deficiencies discovered through monitoring activities will require on-site inspection according to site review requirements. As a result, HPSM may schedule a full scope site review audit, conduct an additional focused onsite review, or conduct a medical record review. When non-compliance with the nine (9) Critical Elements is identified through monitoring processes, HPSM will determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner.

Healthcare Effectiveness Data and Information Set (HEDIS)

HPSM is required by the State of California Department of Health Care Services (DHCS) to perform quality measure studies for our Medi-Cal line of business. The Centers for Medicare and Medicaid Services (CMS) require HPSM to perform quality studies for HPSM's CareAdvantage and Cal MediConnect programs as well. The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that purchasers and consumers of health care services have the information they need to compare the performance of managed health care plans. DHCS and CMS use HEDIS measures to assess how well HPSM is providing quality services for our members.

There are two phases to each HEDIS study. HPSM's data analysts perform the first phase by examining HPSM's administrative data (e.g. claims data and enrollment information). This type of information may not fully reflect the actual care provided to our members when the services are capitated and not separately billed to HPSM. In phase two, HPSM staff, or contracted vendor staff, undertakes an extensive examination of the relevant members' medical records in provider offices. In these ways, data is collected that provides information to DHCS, CMS, San Mateo County and HPSM about the level of clinical care, preventive care, access to care and utilization of services that HPSM members receive, as well as for use in quality improvement activities.

Clinical Practice Guidelines and Best Practices

Clinical practice guidelines are recommendations on patient care for specific conditions intended to assist clinicians in providing optimal patient care. Clinical guidelines are informed by systematic review of the best available research and practice experience.

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HPSM's website provides links to clinical guidelines from the National Guidelines Clearinghouse (NGC, which is a database of current evidence-based clinical practice guidelines that have been developed, reviewed, or revised within the last 5 years. The NGC is produced bythe Agency for Healthcare Research and Quality (AHRQ), Links on HPSM's website provide access to guidelines for these health conditions and topics: cancer, diabetes, obesity, immunization, respiratory disease, cardiovascular health, behavioral health, sexually transmitted diseases, and prenatal care.

HPSM's Quality Improvement Committee (QIC) reviews the guideline topics and website linksannually, to provide input on necessary updates and additions.).

The Clinical Practice Guidelines are listed on HPSM's website at http://www.hpsm.org/providers/clinical-guidelines.aspx
http://www.hpsm.org/providers/provider-resources/clinical-guidelines.aspx - stds#stds

Quality Committees

HPSM has various ways that physicians can contribute to its Quality Improvement Program. The most important way is by providing high quality care to HPSM members.

HPSM's Medical Directors and Provider Services Manager have an "open door" policy. Contact information is freely available to physicians. When any physician has a quality improvement suggestion or a quality concern, they are encouraged to contact HPSM's Provider Services department to share their thoughts, via phone, e-mail or letter.

There are also formalized ways for HPSM providers to participate in quality activities with HPSM. These are through the San Mateo Health Commission quality advisory groups.

Physician Advisory Group (PAG)/Peer Review Committee (PRC)

Purpose/Responsibilities

- Serves in an advisory capacity to HPSM, providing community physician insight and feedback on the quality initiatives of the plan.
- Reviews areas in need of quality improvement identified via HEDIS or other comparable measurements and assists HPSM in developing potential interventions.
- After quality improvement initiatives are developed, provides feedback on the tools, materials, incentives, etc. that are developed to implement the initiative.
- As HPSM practicing physicians, provide real-world feedback on how they, their colleagues and their patients are accepting/participating in HPSM's quality initiatives, to help HPSM continuously improve its efforts and outcomes.
- The PRC meets regularly to review all HPSM credentialing recommendations and to address HPSM credentialing concerns (e.g. when a potential provider does not appear to meet or no longer appears to meet HPSM credentialing requirements). The PRC meets confidentially to provide a peer-based resource for reviewing provider issues related to credentialing, quality of care issues or similar concerns.
- Where indicated, the PRC makes recommendations (e.g. regarding sanctions) to the San Mateo Health Commission for final decision-making.

Any sanctions or actions affecting individual providers are protected by Evidence Code 1157.

Membership

- Committee membership is reflective of the provider network. It includes a physician member of the San Mateo Health Commission, a physician of the San Mateo Medical Center, a maximum of nine HPSM contracting physicians, the majority of whom are primary care physicians from the adult and pediatric community (representing care of adults and children) and at least three specialists representing different disciplines.

Quality Improvement Committee (QIC)

Purpose/Responsibilities

- Serves in an advisory capacity to the Commission on the overall functions of the quality assessment and improvement process to ensure that activities are consistent with the purposes of the program.

- Reviews and makes recommendations about best practice clinical guidelines for quality of medical care and services.

- Provides input and feedback on the ongoing development, implementation and evaluation of a comprehensive quality improvement program, including annual review of the QIP Work Plan and associated documents as applicable.

- Reviews quality activities, measurements, results, and follow-up related to quality improvement initiatives, assisting with the assessment of the overall impact of these efforts and identifying additional opportunities to improve care.

- Uses clinical and administrative experiences in their practice settings to advise the QIP on ways to optimize quality activities internally at HPSM and externally in the provider network.

Membership

Selected contracted practitioners and providers are invited to serve as members of a QIP Committee by the chairperson or co-chair. Selection is based on the following attributes:

- Availability/accessibility
- Board certification
- Communication skill/diplomacy
- Credentials/re-credentials verification
- Interest/enthusiasm

- Knowledge/expertise
- Managed care knowledge/experience
- Medical/surgical experience
- Peer/personal recommendation
- Previous quality committee experience
- QM audit results greater than average
- Reputation/ethical standards
- Specialty type
- A practitioner representative selected to participate on any QIP Committee continues to serve as long as he/she continues to qualify as a contracted practitioner whose specialty is required on the Committee panel and meets acceptable standards of behavior, with the following exceptions:
- Practitioner requests voluntary removal or
- Involuntary request for removal may be made when a provider:
- Is no longer qualified
- Is repeatedly unavailable (unexcused absences from three consecutive meetings)
- Develops a conflict of interest
- Behavior is disruptive and not conducive to effective, professional discussions and performance of business
- Fails to meet QIP expectations

San Mateo Health Commission

Purpose/Responsibilities

- Delegates management of QI to HPSM's Executive Director while retaining overall authority and responsibility for program implementation, continuity and effectiveness.

- Monitors QI strategies and activities outlined in HPSM's QI Program Description, Evaluation and Work Plan, and at the time of any substantive revision.

- Monitors and reviews HEDIS results and establishes activities/opportunities for improvement.

- Reviews the identification of Quality of Care issues and development of Quality Improvement interventions/activities.

- Reviews quarterly reports about monitoring and evaluation of activities, discusses these reports as necessary, raises any issues or concerns, and requests follow-up as appropriate.

- Identifies opportunities to improve care and service, directs action to be taken, or resolves identified issues, independent of any other quality activities.

Membership

Members are appointed by the San Mateo County Board of Supervisors and include: two members of the San Mateo County Board of Supervisors; the San Mateo County Manager or his/her designee; an HPSM contracted physician; a public representative of senior and/or minority communities in San Mateo County; a representative beneficiary served by the commission; a San Mateo County hospital staff physician; an HPSM contracted pharmacist, and a member of the public at large.

Quality Improvement Projects

HPSM is required by the State of California to conduct and/or participate in at least two Quality Improvement Projects (QIPs) annually. These projects may be based on HEDIS measures or other measures that have been identified by HPSM as opportunities for improvement.

The Center for Medicare and Medicaid Services (CMS) requires HPSM to conduct a quality improvement project yearly as well. CMS dictates that each QIP run for three consecutive years and consist of three phases: baseline assessment, intervention, and evaluation.

Even when QIPs focus on member activities, they cannot succeed without our provider network participation, so HPSM always appreciates provider input and feedback on the QIPs. All QIPs are presented at the Quality Improvement Committee meetings, as well, to ensure that the tools and interventions planned appear feasible and useful from a provider perspective.

The QI Department works on a variety of topics including but not limited to the following:

- Asthma
- Cancer Screening
- Controlling High Blood Pressure
- Prenatal & Postpartum Care
- Reducing Health Disparities
- Reducing 30 Day Readmissions

Providers are encouraged to contact HPSM if they are currently working on any of these topics to discuss ways that HPSM can provide support for these efforts.

Individual Health Assessment (IHA)

An IHA is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her PCP. HPSM is required by the California Department of Health Care Services (DHCS), the Centers for Medicare and Medicaid and funders of Healthy Kids to ensure that new members receive an Initial Health Assessment (IHA) within 120

days of becoming an HPSM member. HPSM encourages providers to use the DHCS Staying Healthy Assessment (SHA) tool to receive an additional incentive, and help meet this requirement (see below).

Assessment Components
The IHA consists of a comprehensive history, physical, mental status assessment and where age appropriate, developmental exam, diagnosis and plan of care, preventive services and the Individual Health Education Behavioral Assessment.

Staying Healthy Assessment (SHA) Tool

The Staying Healthy Assessment (SHA) Tool assists PCPs in:

- Identifying and tracking individual health risks and behaviors
- Targeting health education counseling interventions
- Providing referral and follow-up.

The SHA tool should become a permanent part of the member's medical record and be referred to annually. When potentially high risk health behaviors are identified, PCPs are expected to ask appropriate follow-up assessment questions to identify patient's health education needs and facilitate focused educational counseling that addresses health behavior changes. If providers identify concerns that need additional evaluation, referrals to resources such as behavioral health, substance treatment, other specialty providers, etc. should be made.

Facilitating health education intervention

Information provided on the Staying Healthy Assessment tool combined with the patient's medical history, conditions, problems, testing results, and other related factors, can help a provider recommend appropriate health education interventions. If a member is in need of a health education service that is not outlined in the HPSM provider manual, , the provider is encouraged to contact the Health Education department at (650) 616-2165 for information about other community resources.

Medi-Cal Pay for Performance (P4P) Program

HPSM has two Pay for Performance programs for contracted Medi-Cal primary care providers. Additional program information can be found in the program guidelines on the HPSM website, www.hpsm.org.

Potential Quality Issues (PQI)

What is a PQI?

A Potential Quality Issue (PQI) is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care concern exists.

Purpose: To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue to determine opportunities for improvement in the provision of care and services to Health Plan of San Mateo (HPSM) members, and to direct the appropriate actions for improvement based upon outcome, risk, frequency and severity.

How are PQI's Identified?

- Member grievances
- Concurrent, prospective and retrospective utilization review
- Claims and encounter data
- Care coordination
- Medical record audits

What happens when a quality issue is identified?

- Medical records/initial provider responses are usually requested. Note that HPSM contracted providers are mandated to response to requests. .
- A Quality Improvement Nurse conducts an initial and an RN clinical quality review and refers cases to an HPSM Medical Director for review and case leveling.
- The provider of concern is notified if the HPSM Medical Director finds that a quality of care issue has occurred. A corrective action plan or other follow ups may be requested from the provider of concern.
- Due to the nature or complexity of the case, it can be referred to the Peer Review Committee (PRC) for final determination. The PRC is comprised of HPSM network providers who represent multiple disciplines.

Who can refer a PQI?

- Health plan staff
- Health plan members
- Any contracted or non-contracted provider and staff
- Any member of the community

When should a PQI be referred?

Any time there is a suspected quality of care concern; some examples may include:

- A delay in obtaining a referral
- Rudeness from clinical providers or clinical staff members
- Possible inadequate assessment of an adult or child
- Complication in the delivery of a child
- Unexpected death of an adult or child

How can a PQI be referred?
Please use the PQI Referral Form. The form can be downloaded from the Provider Forms page on hpsm.org, or email pqireferralrequest@hpsm.org or call 650-616-2170 to have one sent to you. Completed forms can be returned by fax to 650-616-8235.

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Provider Manual

Section 10

Health Education

Cultural, Disabilities & Linguistic Services

Introduction

At the Health Plan of San Mateo (HPSM) we believe that healthy is for everyone. We offer a variety of resources to help our members learn how to live well and be healthy. Topics include asthma, diabetes, weight management, pregnancy, and smoking cessation.

Physician Authority

No action of notice by Health Plan of San Mateo shall require a participating physician to provide to the Member, or order on behalf of the Member, Covered Services which, in the professional opinion of the physician, are not medically necessary. Participating physicians may freely communicate with Members who are patients about their treatment, regardless of benefit coverage and limitations. When a physician determines that a Member-requested service is not medically necessary, and if the Member does not agree with the PCP's decision, the Physician shall inform the Member of his/her appeal rights through Health Plan of San Mateo.

Health Education

Diabetes Classes

Members recently diagnosed with diabetes or who are having difficulty following diabetes health guidelines are good candidates for group education classes. The goal is to improve the member's knowledge of nutrition and exercise and provide tools to help the member live a healthy life with diabetes.

- Fair Oaks Wellness Clinic, (650) 578-7141 – only for assigned members
- Mills Health Center, San Mateo, (650) 696-4772
- San Mateo Medical Center, San Mateo, (650) 573-3702
- Seton Hospital, Daly City, (650) 991-6607
- St. Luke's Hospital, San Francisco, (415) 641-6826 (individual counseling only)

Sweet Success Program

The program is designed for pregnant women with diabetes. Must be assigned to Mills-Peninsula doctor, (650) 696-5469

Physical Activity

HPSM members who are interested in physical activity are referred to San Mateo County Park and Recreation Department programs. Check out the theFree and/or low cost classes available in your city by reviewing the Parks and Recreation Guides in your city. For more information, contact our Health Education department at (650) 616-2165.

Tobacco Use and Smoking Cessation

Providers are required annually to identify and track all tobacco for each adolescent and adult member. They are also encouraged to refer members to the California Smokers Helpline. The Helpline educates and guides members through a process to help them quit and provides techniques to make their efforts successful.

California Smokers Helpline, (800) NO-BUTTS (800-662-8887)

Nicotine Replacement Therapies

HPSM covers all FDA-approved tobacco cessation medications for adults who use tobacco products. HPSM provides a 90 day supply of treatment medications without other requirements. This includes over-the-counter medications with a prescription from the provider. At least one FDA-approved tobacco cessation medication must be available without prior authorization. HPSM does not require members to receive a particular form of tobacco cessation service as a condition of receiving any other form of tobacco cessation service. HPSM does not require members to provide proof of counseling to a pharmacist, or other Medi-Cal provider in order to obtain tobacco cessation medications.

For more information call the Health Education department at (650) 616-2165.

Health Education Materials

At HPSM, we place a great emphasis on primary prevention in all our work because we believe preventing a disease is the most effective way to keep a person healthy. The key point

of contact to reach our members is when they are in the doctor's office. We strongly encourage our providers to distribute health education materials to patients during office visits.

Brochures are available in English and Spanish. DVDs are also available in specific topic. Call the Health Education department at (650) 616-2165 to request for materials:

- Asthma
- Bone Health
- Diabetes
- High Blood Pressure
- High Cholesterol
- Medications
- Nutrition
- Pregnancy
- Prenatal Care
- Smoking Cessation
- Weight Management

Member Newsletter

Health Matters is HPSM's biannual member newsletter. It includes articles on a variety of topics to help keep our members healthy.

Culturally and Linguistically Appropriate Services (CLAS)

The Health Plan of San Mateo (HPSM) is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible members with limited English proficiency (LEP) or sensory impairment. Understanding these requirements will help you meet federal and state requirements and provide quality care to our members.

Provider Responsibility

HPSM's Cultural and Linguistic Services comply with Title IV of the Civil Rights Act of 1964 that states, any agency, program or activity that receives funding from federal government may not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, health status, disabilities, and regardless of gender, sexual orientation or gender identity.

HPSM requires its contracted providers to provide culturally and linguistically appropriate services to our members. Therefore, we offer free telephonic, in-person and American Sign Language services provided by professionally trained interpreters. Understanding these services will help you meet regulatory requirements and provide quality care to your patients. Visit Provider Language Services | Health Plan of San Mateo to learn how to use the services.

Access to Interpreter Services

HPSM offers three types of interpreting services to help you communicate effectively with your limited English speaking patients. Telephonic, in-person and American Sign Language services are ***free*** and are meant to improve the quality of care provided to our members. In-person interpretation is available on a case-by-case basis, when the particular circumstances of the individual's condition make telephonic interpretation unsuitable/inappropriate.

Telephonic Interpreter Services (24 hours a day 7 days a week)

Steps to request an interpreter for a HPSM member:

1. Dial Certified Languages International (CLI) at 1-800-225-5254.

2. Provide the CLI operator with the following information:

- Access Code: 64095
- Language needed
- Provider Office Name
- HPSM Member Name
- HPSM Member Date of Birth

In-person and/or American Sign Language Services

Requires 5-days advance notice

You can download the in-person Sign Language Request form from the Language Services web page on hpsm.org. Instructions for completing the form are included. Fax the completed request form to the HPSM Quality Department at 650-616-8335.

Services for Disabled Members

HPSM recognizes that our members with disabilities have specific needs in addition to their general medical needs. For this reason, we provide services that are integrated within our daily activities of every department, such as access to TTY for our hard-of-hearing members, large-print materials for our visually-impaired members, information on the physical accessibility of our providers offices in our provider directory. We also have a Care Coordination unit in our Health Services Department to assist our members with complex chronic conditions to ensure they receive the care management they need to optimize their health outcomes.

If you have HPSM members with disabilities who need additional services, please notify HPSM Care Coordination at 650-616-2060.

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Section 11

Fraud Waste and Abuse

Introduction

HPSM is committed to helping prevent, deter and detect fraud, waste and abuse (FWA) in our healthcare programs.

In order to help eliminate FWA in our programs, HPSM relies on its plan partners, including its network providers in identifying and reporting suspected FWA.

This section of the Provider Manual seeks to help provide guidance for providers and other plan partners in identifying and reporting FWA to HPSM.

Definitions

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Abuse includes any action(s) that may, directly or indirectly, result in one or more of the following:

- Unnecessary costs to the health care system, including the Medicare and Medicaid programs
- Improper payment for services
- Payment for services that fail to meet professionally recognized standards of care
- Services that are medically unnecessary

Abuse involves payment for items or services when there is no legal entitlement to that payment and the entity supporting HPSM (e.g. health care provider or supplier) has not knowingly and/or intentionally misrepresented facts to obtain payment.

Abuse cannot always be easily identified, because what is “abuse” versus “fraud” depends on specific facts and circumstances, intent, and prior knowledge, and available evidence, among other factors.

Examples of FWA

The different types of fraud costs State and federal taxpayers a lot of money. Below are types of fraud you may encounter.

Member/Beneficiary / Recipient

Most members are honest people who need quality health care. However, there are people who commit fraud or become involved in fraudulent schemes. The following are some types of possible member fraud:

- **Recipient Exceeds Income or Asset Requirement:**Occasions where a member does not report income or assets to their county worker.
- **Identity Theft:** Someone using another person's personal information to get Medi-Cal or Medicare benefits. Sometimes the person whose identity was stolen is not aware until they begin to receive mail from either program.

Provider

Most providers are honest in their billing practices and provide quality health care to their patients. However, a relatively small number of providers commit fraud directly or become involved in fraudulent schemes. The following are some types of known provider fraud:

- **Capping:** When an individual recruits and pays patients money or offers gifts in exchange to participate in the Medicare or Medi-Cal program. It is also illegal for an individual to receive payment or gifts to participate in the either program.
- **Balance Billing:** A provider charging a Medicare or Medi-Cal beneficiary for the difference between HPSM’s reimbursement rate and the customary charge for the service.

Provider Billing and Coding Issues:

Some of the most common coding and billing issues are:

- Billing for services not rendered
- Billing for services at a frequency that indicates the provider is an outlier as compared with their peers.

- Billing for non-covered services using an incorrect CPT, HCPCS and/or Diagnosis code in order to have services covered
- Billing for services that are actually performed by another provider
- Up-coding
- Modifier misuse, for example modifiers 25 and 59
- Unbundling
- Billing for more units than rendered
- Lack of documentation in the records to support the services billed
- Services performed by an unlicensed provider but billed under a licensed providers name
- Alteration of records to get services covered

Reporting FWA

If you suspect fraud, waste, or abuse with an HPSM member, service or provider, you must report it to HPSM and we'll investigate. Your actions can help to improve services and reduce costs for our members, customers, and plan partners.

To report suspected fraud, waste, or abuse, you can contact HPSM in one of these ways:

- **Phone:** 650-616-0050
- **Fax:** 650-829-2050
- **E-mail:** compliance@hpsm.org
- **Mail:** Health Plan of San Mateo
  Attn: Compliance Department
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080
- **Compliance Hotline:** 800-826-6762

You may remain anonymous if you prefer by calling the Compliance Hotline.

All information received or discovered by the HPSM's Compliance Department will be treated as confidential, and the results of investigations will be discussed only with persons having a

legitimate reason to receive the information (e.g., state and federal authorities, HPSM legal counsel, HPSM clinical reviewers and/or senior management).

You can also report FWA to the following agencies, depending on the program affected:

Medicare and Medi-Cal:

To report to the OIG:

- **Phone:** 800-HHS-TIPS (800-447-8477)
- **Online:** https://forms.oig.hhs.gov/hotlineoperations

Medi-Cal ONLY:

To report to the Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA)

- **Phone:** 800-722-0432
- **Online:** https://oag.ca.gov/bmfea/reporting

To report to the Department of Health Care Services (DHCS)

- **Phone:** 800-822-6222
- **Online:** http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

Resources

Fraud Waste and Abuse (FWA) Training

First tier, downstream and related entities (FDRs) may develop and provide their own FWA training so long as it meets CMS requirements. If an FDR does not provide FWA training that meets CMS requirements and related CMS guidance and has not been "deemed" compliant, SCAN requires that FDRs' employees take the CMS developed training which is accessible at the CMS Medicare Learning Network (MLN) at http://www.cms.gov/MLNProducts. For details on accessing the FWA training and education on the MLN website, select the link below or see the May 8, 2012, HPMS memo regarding Fraud, Waste and Abuse Training and Education Guidance

DHCS Helpful Hints & Resources

http://www.dhcs.ca.gov/individuals/Pages/ai_hints_res.aspx

Section 12

Privacy

Introduction

HPSM is committed to helping protect the privacy and integrity of our members' Protected Health Information or "PHI". As a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have an obligation and responsibility to protect your patient's and our member's PHI.

This section of the Provider Manual seeks to guide providers and other plan partners to secure HPSM's members PHI as well as identifying and reporting privacy incidents to HPSM.

Definitions

Privacy Incident is a situation where an individual or organization has suspicion or reason to believe protected health information (PHI) may have been lost, sent in an unencrypted format, or otherwise provided to an individual or organization that does not have a right to review or receive the PHI.

Incidents can affect one or more plan members.

Examples of Privacy Incidents

Privacy incidents may be unintentional and accidental or they may be intentional. The release of PHI in may be in a variety of formats: oral, written and electronic. The list below is not considered exhaustive. Potential incidents should always be reported to HPSM.

PHI sent to the wrong individual/organization

Examples include sending a fax to the wrong number or mailing PHI to the wrong address/individual.

PHI left unencrypted

Examples include PHI that is accessed electronically or sent to an unauthorized individual by email, and the PHI is not encrypted or otherwise unreadable.

Theft

Examples include PHI that is stolen due to the theft of an unencrypted or unprotected laptop or desktop; theft of hard drives or other media with PHI that is not encrypted, or theft of paper PHI.

Privacy and Security Safeguards

HPSM has adopted many safeguards to ensure our Members' PHI is properly used, disclosed, and safeguarded and we want to take this opportunity to remind you of some common areas of focus:

- Protect your computer passwords. Do not share passwords with your assistant, co-workers or family members. Do not let anyone else use your password. Do keep your passwords absolutely secret and confidential.
- Secure your laptop at all times. Sign off the laptop when you are not using it. Install encryption software on your laptops in case it is lost or stolen.
- Confirm that you are using the correct fax number before you fax any PHI.
- Protect your paper medical records and do not leave any PHI in publically accessible areas. Keep documents containing PHI in secured location such as locked file cabinets or rooms.
- Shred any PHI in appropriate receptacles and do not throw any PHI in the regular trashcans.
- Make sure any electronic media with PHI is disposed of properly including CDs, Thumb Drives, and Hard Drives in laptops, printers, and copier machines.
- The list of privacy and security practices are not exhaustive. If you have any questions or need more information, please contact HPSM's Privacy Officer at the number below.

Reporting Privacy Incidents

If you suspect or know about a privacy incident involving HPSM members PHI, you must report it to HPSM and we'll investigate. Your actions can help mitigate the potential negative impact of the incident on the member(s).

To report suspected privacy incidents, you can contact HPSM in one of these ways:

- **Phone:** 650-616-0050
- **Fax:** 650-829-2050
- **E-mail:** compliance@hpsm.org
- **Mail:** Health Plan of San Mateo

  Attn: Compliance Department

  801 Gateway Blvd., Suite 100

  South San Francisco, CA 94080
- **Compliance Hotline:** 800-826-6762

You may remain anonymous if you prefer by calling the Compliance Hotline.

All information received or discovered by the HPSM's Compliance Department is treated as confidential, and the results of investigations is shared only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, HPSM legal counsel, HPSM clinical reviewers and/or senior management).

You can also report potential breaches of PHI to the following agencies, depending on the program affected.

Resources

Office of Civil Rights Regional Office

http://www.hhs.gov/ocr/filing-with-ocr/index.html

Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Customer Response Center: (800) 368-1019

Fax: (202) 619-3818
TDD: (800) 537-7697

Email: ocrmail@hhs.gov

HIPAA FAQs for Professionals

http://www.hhs.gov/hipaa/for-professionals/faq

DHCS Office of HIPAA Compliance – Information Protection Unit

http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx