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January 1, 2025

REMINDER: Summary of Changes for 2025 HPSM Provider Manual

Dear providers,

Here is a summary of changes by section to the Health Plan of San Mateo's (HPSM's) Provider Manual. These changes are effective January 1, 2025. Review the digital Provider Manual or download the PDF here: **https://www.hpsm.org/provider/resources/manual**

Section 1: About the Health Plan of San Mateo (HPSM)

- Pharmacy Services information updated in "Who to Contact."
- Automated Telephone Eligibility Verification (ATEV) removed throughout Provider Manual.

Section 2: Customer Support

- For copies of materials related to Medi-Cal Rx, members can visit **https://www.medi-calrx.dhcs.ca.gov/home/.**
- All HPSM members have rights and responsibilities which can be found in this section. If you'd like a hard copy of member rights and responsibilities, contact **800-750-4776**.

Section 3: Members Complaints

- CareAdvantage members have 65 days to file Part C and Part D Appeals. Previously, members had 60 days to file.
- Members have 180 days to file pharmacy (through Medi-Cal Rx) appeals. Previously, members had 60 days to file.
- Processing for all pharmacy appeals (through Medi-Cal Rx) has a timeframe of 60 calendar days. Previously, members had, 90 calendar days.
- Processing for all pharmacy grievances (through Medi-Cal Rx) has a timeframe of 30 calendar days. Previously, members had 30 business days.

- CareAdvantage members must file an appeal within 65 calendar days from the date of HPSM's Notice of Denial. Previously, members had 60 calendar days.
- To submit grievances online, members can visit **https://www.hpsm.org/member/file-a-complaint**.
- All grievances related to Medi-Cal outpatient pharmacy services should be submitted to Medi-Cal Rx. Previously, submitted to DMHC.
- To submit requests for state hearings through phone, Medi-Cal members or/and their authorized representative(s) can contact the following number: **1-800-743-8525 (TTY: 1-800-952-8349).**
- To submit state hearing requests through fax, Medi-Cal members and their authorized representative(s) can submit to the following fax number: **916-309-3487 or toll-free at 1-833-281-0903.**
- To submit requests for state hearings by mail, Medi-Cal members and their authorized representative(s) can submit to the following address:
  California Department of Social Services
  Attn: State Hearing Division
  Post Office Box 944243, Mail Station 9-17-433
  Sacramento, California 94244-2430
- To submit requests for state hearings online, Medi-Cal members and their authorized representative(s) can visit **https://www.hpsm.org/member/file-a-complaint/**.
- Members can submit requests for state hearings online, request forms in different languages or in large print: **https://www.hpsm.org/member/file-a-complaint/https://www.hpsm.org/member/file-a-complaint/**.
- Providers who wish to appeal a denied decision related to Medi-Cal outpatient pharmacy services must submit an appeal to Medi-Cal Rx. Previously, it was submitted to Magallan.
- When filing pharmacy appeals, provider prior authorization appeals are accepted via the Medi-Cal Rx Provider Portal, via fax, or by mail.
- Providers have 180 days from the date of the initial denial to submit a prior authorization appeal.
- For pharmacy appeals, Medi-Cal Rx will ensure prior authorization appeal requests are reviewed within 60 calendar days and the prior authorization submitter receives notification of determination of the prior authorization appeal request.
- Medi-Cal Provider Claims Appeal Unit address line removed from the Provider Manual.
- The toll-free number **1-800-750-4776** for HealthWorx and ACE to file pharmacy appeals has been added to the Provider Manual.

Section 4: Claims

- Long term care paper claims must be submitted to HPSM using the National Uniform Billing Committee UB-04 form. Previously, HPSM accepted the Payment Request for Long Term Care 25-1 claim form.
- LTC 24-1 field description and requirements section removed from the Provider Manual.
- HPSM partners with three different clearinghouses, Office Ally (HPSM1), Change Healthcare (Payer ID SX174 for 837 Professional and 12X74 for 837 Institutional) and WayStar (HPSM1). Previously, HPSM partnered with only two clearinghouses.
- The clearinghouse for dental claims is Change Healthcare, the payer ID is: HPSM1.
- Intermediate Care Facilities (ICF) payment accommodation codes list removed.
- Payment for inpatient services for Nursing Facility Level A list removed from the Provider Manual.

Section 5: Provider Disputes

- Provider disputes should be sent 365 days from the initial remittance advice date. Previously, it was 365 days from the date when a claim was denied.
- A provider can submit an amended dispute within 30 working days of receiving a returned dispute requesting additional information and still comply with the 365-day limit.

Section 6: Ancillary Services

- Pharmacy claims should be billed to Medi-Cal Rx. This includes medications, some diabetic testing supplies, and medically necessary enteral formulas.
- All prior authorization requests are reviewed and processed by Medi-Cal Rx's pharmacy staff. Previously, prior authorizations were reviewed by Magellan.
- A subsection for Transportation Ride Benefits has been added to the Provider Manual. This subsection includes detailed information about how Medi-Cal and CareAdvantage members who have no means of transportation to approved health care visits can use HPSM's Ride Benefit at no cost.

Section 7: Utilization Management

- For physician administered drugs (PADs), Pharmacy Services staff are available by telephone between 8:00 am and 5:00 pm, Monday through Friday at **650-616-2088.**
- The HPSM Health Services Division's Integrated Care Management (ICM) unit administers care coordination benefits and collaborates with providers on HPSM members' care plans.
- In addition to HPSM's Director of Pharmacy overseeing outpatient pharmacy benefits operations activities for HealthWorx and CareAdvantage, they also oversee management of physician administered drugs for HealthWorx, CareAdvantage, Medi-Cal, and ACE.
- The Director of Pharmacy oversees pharmacy staff and daily operations of pharmacy benefit

management, except for outpatient pharmacy benefits for Medi-Cal members managed by the Department of Health Care Services (DHCS).

- The Pharmacy Services department, comprised of pharmacists and technicians, uses standard criteria and resources to determine the medical necessity of physician-administered drugs (PADs) and reviews its policies annually at the Pharmacy and Therapeutics Committee.
- Information about the role and responsibility of HPSM Utilization Management Workgroup is removed from the Provider Manual.
- Primary and specialty dental providers can complete covered treatments without prior authorization. For questions on member dental history or for services not covered, prior authorization with supporting information can be submitted to determine medical necessity for benefit exceptions.
- Orthodontists in network do not need to send prior authorization for members aged 7-21 that have met Handicapping Labio-lingual Deviation (HLD) score of 21+ or an automatic qualifying option.
- For members 21 and under with HLD auto qualifier or a score of 21 and up, the HLD score sheet should be noted on the billing form or attached to the claim. Providers should retain HLD scoresheets and all related clinical records.
- Orthodontists should submit prior authorization for members who do not meet the HLD score and/or qualify for an Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) exception.
- Prior authorization requests denied for medical necessity must be reviewed by the Medical Director or Clinical Pharmacist for physician administered drugs. Previously, review was for medical injectable drugs only.
- Care Coordination Unit removed from the Integrated Care Management Program section of the Provider Manual.
- Members may receive immunizations through their primary care provider, at an in-network pharmacy, or self-refer to public health clinics.
- HPSM staff and network providers are responsible for coordinating services with San Mateo County Behavioral Health and Recovery Services to ensure that individual members with coexisting medical and behavioral disorders receive appropriate treatment in the appropriate ambulatory and/or inpatient setting.
- Long Term Services and Supports (LTSS) liaisons for the Developmentally Disabled (ICF/DD) are trained to identify and understand the full spectrum of Medi-Cal long-term institutional care, including payment and coverage rules. LTSS liaisons serve as a single point of contact for service providers in both a provider representative role and to support care transitions as needed.
- LTSS liaisons assist in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support member needs. Questions for our LTSS liaison can be directed at **PSInquiries@hpsm.org**.
- Members transitioning from home to acute care or skilled nursing facilities are supported by a care

manager (previously nurse case manager) and a care transitions coach throughout their care journey. The care manager serves as the main contact for the member and their healthcare team and initiates communication with the member's primary care physician during each care transition.

- HPSM contracts with MedWatchers to administer Medication Therapy Management (MTM) services. Previously, it was SinfoniaRx.
- For pharmacy benefits, the Director of Pharmacy continuously monitors how Clinical Pharmacist reviewers apply criteria and guidelines.
- Micromedex DrugDex Compendia (for pharmaceuticals) was added to the criteria and guidelines HPSM uses for all medical necessity determinations.

Section 8: Provider Services

- The Chief Executive Officer or Chief Finance Officer countersigns the contract after approval of the initial credentialing application.
- The Primary Care Physician must submit all patient vaccination records to local health departments and appropriate immunization registries. All immunization records must be reported within 14 days of vaccine administration.
- HPSM contracted providers must complete the HPSM Regulatory Provider Training at the time of re-credentialing with HPSM.

Section 9: Quality Improvement

- Providers must report any Provider Preventable Conditions (PPCs) in Medi-Cal patients using the PPC Reporting Form within five days of discovery, regardless of seeking reimbursement. HPSM reviews encounter data and reports PPCs to DHCS.
- Online reporting guidance for PPCs, including the definitions of recognized PPCs, can be found by visiting **http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx**.

Section 10: Health Promotion/Education

- The Diabetes Prevention Program (DPP) includes weekly one-hour sessions led by trained Lifestyle Coaches for six months, followed by monthly sessions for the next six months. Coaches help participants with healthy eating, exercise plans, weight loss goals, and provide handouts. Participants also receive group support.
- Members who enroll in the Baby + Me program can get up to $100 in Target gift cards for going to two appointments during pregnancy and after having their baby.

- The following resources were added to the list of resources and services the Baby + Me program connect members to: breast pump vendors, local programs for parents and families, doula services, information about quitting tobacco, and perinatal depression support groups.
- Through the Cancer Screening Rewards Program, HPSM CareAdvantage members due for breast or colorectal cancer screening can receive a Cinemark Prepaid Movie Ticket. The ticket will be shipped within 90 days of screening to the address on file. For more information, contact the Health Promotion Unit at **650-616-2165**.
- For more information on physical activity resources, contact HPSM's Health Promotion Unit at **650-616-2165**.
- A YMCA membership is available to HPSM CareAdvantage members at no cost. For more information, members can visit **https://www.hpsm.org/fitness**.
- Telephonic interpreter services are provided through Certified Languages International (CLI) at no cost to the member or provider.
- In-person interpreter services for spoken language and sign language can be scheduled through HPSM no less than 5 business days in advance of the appointment.

Section 11: Fraud, Waste, and Abuse

- Information on HPSM's next course of action for monitoring potential fraud waste and abuse has been updated.
- HPSM reviews system-identified providers and determines actions, which may include provider education on billing, medical record requests for clinical justification, and overpayment reimbursement requests.

Section 12: Privacy

- No changes.

Network providers can request a hard copy or submit questions about this notification to **PSInquiries@hpsm.org**.

Thank you,

The Health Plan of San Mateo