HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080
tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1
www.hpsm.org

Non-Specialty Behavioral Health Provider Network FAQ

This document is intended to support the Health Plan of San Mateo's (HPSM's) behavioral health provider network, contracted specifically for non-specialty mental health services. Please contact San Mateo County Behavioral Health and Recovery Services (BHRS) for information regarding specialty mental health and substance use disorder (SUD) treatment benefits.

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Getting Started

1) New Patients

(1) Prior to receiving behavioral health services, Medi-Cal beneficiaries must be screened by the ACCESS Call Center to determine the right system of care – either non-specialty (i.e., mild-to-moderate) services or specialty services.

The ACCESS Call Center (operated by San Mateo County BHRS) will:

- Screen members for emergency needs and refer to crisis support, then;
- Screen members based on specific criteria for specialty mental health care, non-specialty (mild-to-moderate) mental health care and/or substance use disorder treatment, then;
- Route members to the appropriate system of care:
    - Members who require mild-to-moderate services are routed to HPSM for matching with providers (see HPSM behavioral health matching program below).
    - Members who require specialty services are routed to San Mateo County BHRS.
    - Members who require substance use disorder services are routed to San Mateo County BHRS (please note members may receive SUD services and mild-to-moderate services in conjunction).

(2) Members whose level of care is identified to be mild-to-moderate services will be routed by the ACCESS Call Center to HPSM's behavioral health matching team.

HPSM operates a unique behavioral health matching program which receives member information from the ACCESS Call Center and matches these members to in-network behavioral health providers. After identifying a match, HPSM's matching team will outreach both the member and the provider.

- Member Outreach: Two attempts via phone or letter. The match information (i.e., provider's information) will be shared with the member either by letter or phone. Confidential voicemails will be left for members if allowed. If a member needs additional information from the matching team, they can call **650-616-2557** (member behavioral health matching line).
- Provider Outreach: The matching team will call the provider's office once. If the call goes to voicemail, the matching team will leave a voicemail and send a letter (with the name, date of birth, and phone number of the member from whom they should expect a call). Please note: the voicemail greeting must identify the provider's name and/or practice name to allow for confidential information to be provided. If providers need to reach the behavioral health matching team they may call **650-616-2580** (provider behavioral health matching line).

2) HPSM behavioral health matching program

HPSM relies on providers to let us know when they have capacity for new patients. To collect this information, we have a dedicated email and voicemail and encourage providers to let us know of changes in availability to see new clients. Some providers email weekly or bi-weekly to ensure their availability information is up-to-date.

The matching program's goals are to match members to in-network providers based on line of business (e.g. Medi-Cal, CareAdvantage, HealthWorx) or service type (therapy and medication support). The ability to meet additional preferences of members is determined largely by the level of information providers share with us.

Matching team contact Information:

- Member-dedicated phone number: **650-616-2557** (e.g., for members to receive linkage to NSMH services and/or to medication providers).
- Provider-dedicated phone number: **650-616-2580** (e.g., for NSMH providers to provide their ability for taking on new patients).
- Provider-dedicated email address: **HPSM_BH_Provider_Availability@hpsm.org**

When sending us your availability update, please include the following information:

- Your name or agency name.
- Your provider NPI (and / or your HPSM provider ID).
- How many openings you have for new members.
- What age groups you serve.
- Any changes to your practice's ability to offer services in additional languages.
  Please note: the matching program is not able to make matches based on provider preferences for diagnosis types, history of symptoms and presentation, appointment times, or other preferred criteria. In many cases, HPSM does not have this level of detail.

3) Guidance on sending HIPAA-compliant e-mails/Protected Health Information (PHI)

Providers must use secure, encrypted e-mails to send Protected Health Information (PHI). If you do not have access to encryption software, you may (1) call the matching team and use their confidential voicemail system to leave member details or (2) request an encrypted email from an HPSM to which you can reply and include PHI within the secured e-mail portal. You can also securely fax documents containing PHI to **650-616-0060**.

All PHI must be transmitted in accordance with HIPAA regulations, outlined here: **https://www.hhs.gov/hipaa/for-professionals/index.html**.

The following is a list of common PHI:

- Member demographics (e.g., name, date of birth, address, phone number).
- Member identifiers (e.g., Health Plan Beneficiary IDs, Social Security Number); and
- Combination of de-identified data that may allow identification of a member (e.g., combination of zip code, date of birth, and health status).

Common Transmission Methods: Transport Layer Security (TLS) is a cybersecurity protocol that enables secure end-to-end encryption for e-mail communications. Both Google/Gmail and Office365 offer Forced TLS, which must be set up manually by the user. Resources and guidance are available:

- **For Google/Gmail:** **https://support.google.com/a/answer/2520500?hl=en#zippy=%2Cunderstand-what-happens-to-messages-sent-to-or-from-servers-that-dont-use-tls**
- **Office365:** **https://learn.microsoft.com/en-us/exchange/mail-flow-best-practices/use-connectors-to-configure-mail-flow/set-up-connectors-for-secure-mail-flow-with-a-partner**

Frequently Asked Questions (FAQ)

1) How do I start treatment with a new member? Do I need a prior authorization?

Please make sure you receive a member match from HPSM for each member before you begin providing behavioral health services. Members who self-refer to your practice should be screened by the BHRS ACCESS Call Center to ensure they are being connected to the appropriate system of care (i.e., HPSM's non-specialty or BHRS's specialty). If the member is screened as having non-specialty needs, the member will be routed to the HPSM behavioral health matching team and matched to an available provider.

If you have seen a specific member previously through their HPSM benefit with in the last year, you may resume services without a new match.

HPSM does not require prior authorization for initial assessments and individual therapy. For family therapy, the first 12 visits in a calendar year do not require prior authorization. Please check the HPSM prior authorization list for the most up-to-date information on requirements, which are listed by specific code and service name: **https://www.hpsm.org/provider/authorizations**

2) I received a match from the HPSM matching team, but I don't have the member's phone number, and they didn't give me much information about this member (i.e., clinical information on the member). What do I do?

Members are given the contact information of the provider they are matched with. Members are guided to call the provider and schedule their initial assessment. Once that member contacts you, providers can ask for details directly from the member. Some basic member information is also available in the provider portal (phone number, primary language, HPSM member ID).

(3) I am a therapist: what if a member I am seeing will benefit from medications? How should I direct them to this care?

If you are recommending medication assessment for your client, it is important that you discuss any recommendations with the member directly before directing them to request a medication provider. There is no referral requirement to receive a medication assessment.

If a member is in non-specialty (mild-to-moderate) treatment with you and ready to receive a medication assessment, please direct the member to call HPSM's behavioral health matching team at

650-616-2557 to request a medication provider. Please note: The majority of HPSM's in-network medication providers are psychiatric nurse practitioners.

Some members may want to speak with their primary care physicians (PCP) before receiving a medication assessment from a new provider. Some PCPs can prescribe basic medications that support mental health symptoms. If this is the case for your client, and especially for youth clients, please reach out to PCP's directly to convey your clinical assessment and recommendations prior to the clients appointment with their PCP. Primary care contact information can be found in the member record in the provider portal.

(4) How do I check member eligibility and how often should I check?

It is important to check your patient's eligibility for health care benefits prior to each visit to ensure that the patient is covered for the services you intend to provide. Services are reimbursable only if the patient has active coverage on the date of service. A member match is not a guarantee of member eligibility on the date of service.

Medi-Cal eligibility is determined monthly. However, to reduce your risk of denied claims, we recommend checking member eligibility prior to each session. HPSM cannot reimburse for dates of service outside of a member's eligibility for health care benefits.

Member eligibility information is available:

- **On the provider portal.** Once logged in, member status (eligibility, claims, and authorizations) is located under the heading "Office Management": **https://www.hpsm.org/provider/portal**
- **HPSM's 24-hour Automated Telephone Eligibility Verification/Interactive Voice Recognition (ATEV/IVR) system.** Please have the member ID ready: **800-696-4776**
- Additional instructions on how providers can check member eligibility are available on our website: **https://www.hpsm.org/provider/resources/manual/customer-support**

(5) How do I know what behavioral health services are covered for each line of business (Medi-Cal, CareAdvantage, and HealthWorx)?

HPSM's member handbooks describe the benefits offered through the different lines of business and are available here: **https://www.hpsm.org/provider/resources/member-handbooks**

For more detail on procedure codes please check the Medi-Cal procedure code list to determine if the code is covered by Medi-Cal.

- If a code is covered by Medi-Cal, it will be covered for the following lines of business: Medi-Cal, CareAdvantage, and HealthWorx.
- If a code is not covered under Medi-Cal, the code will not be covered for Medi-Cal, CareAdvantage, or HealthWorx.

Covered procedure codes and rates are subject to change. Updated information can be found:

- **For Medi-Cal: https://files.medi-cal.ca.gov/rates/rateshome.aspx**
- **For Medicare: https://www.cms.gov/medicare/physician-fee-schedule/search/overview** (please note: Medicare does not cover LMFT services.)

(6) What determines how long you can see someone for individual therapy?

Members are eligible for covered services if they remain medically necessary. If you determine that treatment is not medically necessary, further services should not be rendered. Please check the HPSM prior authorization list for the most up-to-date policies (e.g., HPSM allows up to 12 family therapy visits per calendar year after which a prior authorization is required for payment).

HPSM's prior authorization list can be found here: **https://www.hpsm.org/provider/authorizations**

(7) How do I refer someone to substance use disorder (SUD) treatment?

HPSM members access substance use disorder services through BHRS as BHRS manages the drug Medi-Cal benefit for HPSM members. If you believe a member may need SUD services, it is important that you discuss any recommendations with the member directly before directing them to request substance use disorder treatment services. If the member is ready to receive SUD services, please refer them to the BHRS ACCESS Call Center to be screened and connected with an SUD provider. Some members may benefit from being encouraged to speak with their primary care physicians (PCP) about this as well.

Please note: a member may receive mild-to-moderate behavioral health services in conjunction with SUD services.

(8) What if a member's care needs are beyond the HPSM non-specialty benefit and needs to transition to the BHRS specialty system of care?

Please do not delay in referring the member to BHRS for assessment and potential transition to specialty services provided by BHRS (e.g., IOP, PHP, residential or case management to maintain or

improve their functioning). HPSM providers are expected to continue providing care until a new provider in the correct system of care has been identified and the member has started services. The referral forms can be found:

- **For members ages 18+: https://bit.ly/HPSMhigherleveladult**
- **For members ages 6-17: https://bit.ly/HPSMhigherlevelyouth**

A video tutorial for completing these forms is available here: **https://bit.ly/HPSMhigherlevelvideo**

(9) How often should I send my availability? What happens if I run out of availability to see additional members?

Please update HPSM's behavioral health matching team when you have availability to take on new members and when your availability changes. Some providers email weekly or bi-weekly to ensure their availability information is up-to-date. You can provide your availability to our matching team via email or by leaving a voicemail:

- **HPSM_BH_Provider_Availability@hpsm.org**
- **650-616-2580**

When updating your availability, please include the following information:

- Your name or agency name.
- Your provider NPI (and / or your HPSM provider ID).
- How many openings you have for new members.
- What age groups you serve.
- Any changes to your practice's ability to offer services in additional languages.
- Availability to provide in-person services.

The following are some resources for managing your patient load:

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

(10) I am not able to start or continue seeing this member, but they still need non-specialty mental health services. What should I do?

If the member requires non-specialty (mild-to-moderate) services and you are not able to provide care to the member, please let the member know and have them call the HPSM matching line at **650-616- 2557** to be matched with a new provider.

When ending care, please be sure you address all safety issues within clinical best practices and in consultation with your clinical supervisor before ending care.

(11) What if I completed treatment with a member who is no longer meeting medical necessity? Do I need to notify the HPSM with discharge summary?

HPSM does not require any discharge notification. When ending care, please be sure you address all safety issues within clinical best practices and in consultation with your clinical supervisor before ending care.

(12) My client is demonstrating [description of behavior/condition], what should I do?

HPSM is not able to provide clinical consultation. Please consult your clinical supervisor with the member's consent. You may want to connect with the member's care team (following appropriate consent protocols), which can include their primary care physician, family members, and/or other providers.

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

If you think the member needs a higher level of care, please do not delay in referring the member to BHRS for assessment and potential transition to specialty services provided by BHRS using the higher level of care forms. Providers are expected to continue providing care until a new provider in the correct system of Care has been identified and the member has started services.

(13) The matching team sent me a member that speaks a language me and/or my agency doesn't offer. What should I do?

Whenever possible the matching team will match members with providers that speak their language. When this is not available the team will match the member with an available provider.

All HPSM providers should make themselves familiar with HPSM's interpreter resources here: **https://www.hpsm.org/provider/resources/language-services**

Please let the behavioral health matching team know if your practice's language capabilities change:

- **HPSM_BH_Provider_Availability@hpsm.org**
- **650-616-2580** (voicemail only)

(14) I am a contracted provider and have hired a new clinician/provider on my team. Can they render services to members who have been matched to my practice?

Contact Provider Services to initiate the HPSM credentialing and contracting process for any new clinicians/providers prior to them rendering services to any HPSM members. Provide Services can be reached at **PSInquiries@hpsm.org**.

(15) Where do I direct questions about claims issues?

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