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Healthy is for everyone

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Behavioral Health Treatment (BHT) Provider FAQ – Magellan Transition

As of October 1, 2024, HPSM will resume direct management of the Behavioral Health Treatment (BHT) benefit for the Health Plan of San Mateo (HPSM) Medi-Cal members from Magellan Health. This document provides responses to providers' frequently asked questions on this transition. For additional questions, please contact Molly Carter, Provider Network Liaison, at molly.carter@hpsm.org.

Topics include:

- **Basics/Getting Started**
- **Credentialing/Contracting**
- **Referrals**
- **Eligibility**
- **Authorizations**
- **Claims**
- **Other**

Basics/Getting Started

How do I access HPSM's provider portal? What can I do on the portal?

You can register for HPSM's provider portal after October 1, 2024, by visiting this link or calling **650-616-2106**. Please allow up to 30 days for your contract information to be updated in HPSM's system which is required for portal registration.

You can use the portal to:

- Verify member eligibility
- Check other health coverage (OHC) status
- Check authorization status
- Sign up for Electronic Funds Transfer & Electronic Remittance Advice (EFT/ERA)

Who should register for the portal?

Anyone who needs to check member eligibility, authorization status, or submit an EFT/ERA request can register for the portal. Each staff person should have their own portal login credentials for security purposes.
For EFT/ERA sign up, HPSM can only accept and process requests at the contracted group level along with the group billing NPI and group billing Tax ID.

Credentialing/Contracting

What are HPSM's rates? What codes does HPSM cover?

Please see your contract for HPSM's fee schedule.

I have questions about my credentialing application, whom do I contact?

Please contact your direct credentialing contact person if you have already connected with one, and if not email: **hpsmcredentialing@hpsm.org**.

What do I need to do if providers leave my group or new providers join?

When providers leave your group, please notify HPSM via email at **hpsmcredentialing@hpsm.org**.

When a new provider joins your group, if they are a HO level provider (BCBA or Licensed Provider), they will need to be credentialed by HPSM to begin seeing members. Currently, HPSM is only credentialing HO level providers (BCBA or Licensed Practitioner). Other provider's information does not need to be submitted to HPSM at this time.

Please complete HPSM's Provider Intake form: **https://providers.hpsm.org/ProviderIntake/**. Select the option for "Joining as rendering provider(s) to an existing Provider Group." If there is more than one new provider joining your group, there will be an option in the Provider Intake form to download the HPSM provider roster template, complete and upload it.

What is HPSM's credentialing approval timeframe?

HPSM's credentialing timeframe primarily hinges on the completeness of submitted applications. HPSM will prioritize providers with 100% completed applications along with required paperwork, as well as clean files for our Medical Director's review and approval (typically within four to eight weeks). Following approval, HPSM will send out a credentialing approval letter within 60 days. HPSM normally sends out a credentialing approval decision to inform the provider of HPSM's credentialing decision quickly.

Is HPSM following the 3-tier model? What are HPSM's requirements for each provider level?

HPSM will follow the guidelines in the California State Plan amendment for the qualifications required for each provider type. Please see SPA 14-026 for guidance, "BHT Services Chart":
https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA14-026.pdf

Referrals

Where do I send my group's availability?

Please send availability information to **ABA_Provider_Availability@hpsm.org**.

Do members need a referral for ABA and CDE services or can they self-refer?

Per Department of Health Care Services (DHCS) APL 23-010 , a licensed physician, surgeon or psychologist must have determined ABA services to be medically necessary in order for a Medi-Cal member to be eligible for BHT services. Based on this requirement, HPSM members cannot self-refer for BHT services.

Please ensure that you have a provider referral on file for every HPSM member that you serve. If a member contacts your group to inquire about services and you have not received a copy of the provider referral for services from HPSM or directly from a provider, the member can be directed to HPSM for coordination support and may need to be directed to discuss a referral with their physician.

If a member reaches out to a BHT provider directly and states they've been referred for services at some point in the past, direct member to HPSM BHT team at **650-616-2557** who can support in identifying if a referral is on file.

What is the referral process for a CDE?

- A provider must have had some indication of developmental issues and recommend a referral for a CDE for an HPSM Medi-Cal member to be eligible for a CDE.
- When a member contacts HPSM requesting a CDE, HPSM will verify that they have the appropriate provider referral in place.
- HPSM will contact its in-network CDE providers to verify their availability and ability to accept the member.
- Once a group agrees to see the member, HPSM will fax the member's information (include the referring provider's referral form) to the group and provide the member with the group's contact information.
- Please update HPSM once the appointment is scheduled. HPSM will be following up to confirm that the member is engaged in services.

What is the timely access standard to see members in?

Providers are required to meet the timely access standard of an appointment within 10 business days for a non-urgent routine or follow-up need.

Eligibility

How do I confirm that a member has active HPSM coverage?

This can be checked via HPSM's provider portal, or via one of the sources below:

- Medi-Cal Automated Eligibility Verification System (AEVS) line: 800-456-2387
- Medi-Cal Website: **https://secure.medi-cal.ca.gov/mcwebpub/login.aspx**
- Call (650) 616-2106

It is recommended that providers verify eligibility for each date of service. Please keep in mind that a member may add new primary coverage under another benefit.

Is a CDE required for a member to receive ABA services?

No, Medi-Cal does not require a CDE for a member to receive ABA services.

Is an Autism diagnosis required for a member to receive ABA services?

Medi-Cal does not require an *Autism diagnosis* to receive ABA services. Please note, however, that prior authorization requests require *a diagnosis* to determine medical necessity. HPSM claims also require a diagnosis.

What is required for a member to be eligible for ABA services?

CA DHCS (Department of Health Care Services) APL 23-010 states the following as the eligibility criteria for ABA services:

- Member must have active HPSM coverage
- Be under 21 years of age
- A licensed physician, surgeon or psychologist has determined BHT services to be medically necessary
- Member must be medically stable with no need for 24-hour nursing/monitoring

Read APL 23-010 here:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-010.pdf

Authorizations

Will HPSM be honoring current authorizations Magellan provided for HPSM members that have end dates after the 10/1/2024 transition, or will new authorizations be needed?

HPSM will be honoring Magellan's authorizations for services that were decided prior to October 1. For any dates of service on or after October 1, 2024, claims should be submitted to HPSM instead of Magellan. When a re-authorization is needed, it should be submitted to HPSM.

What BHT services require prior authorization as of 10/1/2024?

At this time, the below CDE and FBA codes will not require authorization:

- CDE: 96112, 96113
- FBA: 97151

ABA services will require Prior Authorization. Please check HPSM's Prior Authorization Required List on and after October 1 to regularly to confirm which codes do and do not require authorization. Please note this list will not be updated to reflect BHT codes until October 1, 2024:
https://www.hpsm.org/provider/authorizations

How do I request prior authorization from HPSM?

After October 1, 2024, please submit HPSM's Prior Authorization Request Form via fax to **650-829-2079.** You can find the form here: **https://www.hpsm.org/docs/default-source/provider-forms/prior_authorization_request_form.pdf**

Please list the group name and billing NPI as requesting provider, and do not include modifiers on the authorization request. If you need to make a retro authorization request after October 1 for Dates of Service prior to October 1, please submit the prior authorization request to Magellan.

What is the authorization decision turnaround time?

Please see HPSM's Prior Authorizations webpage for the most up-to-date turnaround times:
https://www.hpsm.org/provider/authorizations

What documents should I include with the prior authorization request?

Please include any relevant clinical information pertaining to your request. Ensure you've reviewed HPSM's webpage on prior authorizations here: **https://www.hpsm.org/provider/authorizations**

ABA requests should include treatment plans in order to demonstrate medical necessity.

What should be included in the treatment plan?

HPSM utilizes Milliman Care Guidelines for medical necessity determinations. Treatment plans must include all DHCS required Care plan elements listed in APL 23-010 .

Are authorizations issued to the group or individual provider? What if a clinician changes?

When completing the prior authorization form, please list the contracted group, including the groups' billing NPI, as the requesting provider. If this is done, the authorization will be issued to the group and a clinician change should not necessitate a change in authorization.

How many hours are approved for FBA?

HPSM will not require prior authorization for FBA (code 97151) at this time. Please see your contract for any billing frequency limitations based on codes.

Will HPSM have specific guidance for medical necessity?

HPSM will follow Medi-Cal guidance for coverage and medical necessity of BHT services and will not impose any additional requirements beyond DHCS (Department of Health Care Services) requirements. HPSM uses Milliman Care Guidelines for prior authorization criteria.

Members who are eligible for BHT are under 21 for whom a licensed physician, surgeon, or psychologist determines that BHT services are Medically Necessary, regardless of diagnosis. They must be medically stable and not have a need for 24-hour medical/nursing monitoring.

Please see these documents for state guidance on medical necessity:

- SPA 14-026: **https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA14-026.pdf**
- SPA 18-011: **https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA_SPA_18-011package.pdf**
- APL 23-010: **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-010.pdf**

Providers will receive a match (not authorization) from HPSM BHT team. HPSM will be tracking whether member has an active referral on file. Prior authorization requests are submitted by providers and HPSM will review and decision.

Is an authorization required when HPSM is a member's secondary coverage?

HPSM authorization is not required if the benefit is approved by the member's primary insurance. Authorization is required if the benefit is denied by the member's primary insurance.

What is the processes to send an addendum or change an authorization?

Please complete an Authorization Correction Form: **https://www.hpsm.org/docs/default-source/provider-forms/authorization_correction_form.pdf**

A new prior authorization request is required for changes in procedure codes.

Will retro authorizations be allowed, and under what criteria?

Yes. Please refer to HPSM's Prior Authorization webpage under "What is HPSM's policy on retroactive authorization requests?": **https://www.hpsm.org/provider/authorizations**

Claims

How can I submit claims to HPSM?

Please visit HPSM's claims page for claims submission information:
https://www.hpsm.org/provider/claims/submit-claims

What is the claims payment timeframe for HPSM?

HPSM will pay claims within 45 business days. HPSM's average claims payment timeframe is shorter.

What is the timely filing requirement for HPSM?

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 below.

Medi-Cal Claims	
Claims Submission from Date of Service	**Reimbursement Policy**
0-6 months	100% of approved payment
7-9 months	75%
10-12 months	50%
More than one year	0% (without written justification)

If we work with a clearinghouse not listed, can we still submit claims electronically?

Yes. Providers can submit the CMS 1500 form electronically using HPSM's online claims portal, eHealthSuite: **https://hpsmprd3.hpsm.org/eHEALTHsuiteWeb/**

To set up an eHealthSuite account, call 650-616-2106.

How do we sign up for EFT/ERA?

Providers can sign up for EFT/ERA via the provider portal. Call 650-616-2106 or register at this address after October 1:
https://hpsm.healthtrioconnect.com/register/nonmember/userinfo/UserInformation?payor=1060&portal=Provider&referringUrl=https://www.hpsm.org/provider-portal-login.

What if a member has Other Health Coverage (OHC) as primary coverage?

By law, if a member has both Medi-Cal and Other Health Coverage, claims must be submitted to the primary coverage for consideration before Medi-Cal will evaluate a claim. First, you should submit a claim to the member's primary coverage. If after receiving an EOB from the primary coverage, you would like to submit a secondary claim to HPSM, you may do so along with a copy of the EOB from the primary plan. HPSM will process the claim for any additional payment the claim is eligible for under Medi-Cal. Members must abide by the network rules enforced by the primary insurer for HPSM to consider the claim as the secondary.

How can we submit secondary claims to HPSM?

After review by the primary insurance, you may submit the claim to HPSM as secondary. HPSM will review the claim for possible additional payment under Medi-Cal. Additional payment is not guaranteed.

To do so, submit the claim by mail to HPSM. You must include the EOB from the primary insurance. Send the claim to:

The Health Plan of San Mateo
Attn: Claims Processing
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

How should claims be submitted for the HN and HM provider level?

All claims for HN and HM level providers should be submitted under their supervising BCBA or Licensed Provider's NPI number as rendering provider on the claim. Use the modifier HO, HN, or HM to indicate which level of provider provided the service to the HPSM member to receive the correct rate.

Which modifiers should be used for telehealth services?

- Synchronous, interactive audio and visual telecommunications systems: modifier 95.
- Asynchronous store and forward telecommunications systems: modifier GQ.
- Synchronous telephone or other real-time interactive audio-only telecommunications systems: modifier 93.

How can I dispute or correct a claim?

There are several ways to dispute or correct a claim. When in doubt, call **650-616-2106** or email **claimsinquiries@hpsm.org** for guidance.

A claim should be rebilled when HPSM denies a claim because of incorrect information supplied on the claim form. You can update claims using the Claims Correction Request Form when you want to modify a previously submitted claim line that has already been paid. See HPSM's website for further guidance on these two processes: **https://www.hpsm.org/provider/claims/update-claims**

HPSM offers 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. For more information on PDR, see HPSM's Provider Manual:

https://www.hpsm.org/provider/resources/manual/provider-disputes

Other

Does HPSM have a provider training requirement?

As part of HPSM's initial credentialing process, providers attest to reviewing HPSM's provider training slide document. HPSM may request additional review and attestation of training materials on an annual or periodic basis, depending on what's required by regulatory agencies.

Does HPSM offer Interpreter Services?

Yes, HPSM offers Language Assistance services at no cost for members and providers. Providers are responsible for scheduling in person interpreters in advance of appointments. Phone and video interpreters are available on demand. For more information visit our Language Services page on HPSM's website: **https://www.hpsm.org/provider/resources/language-services**