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Health Plan of San Mateo (HPSM) Behavioral Health Treatment (BHT) Report Process Expectations

This document is intended to provide HPSM BHT providers with guidance on HPSM's expectations regarding report process (including CDE, FBA, Care Plan and discharge reports). Please note: All contracted providers are required to provide linguistically appropriate services to members with limited English proficiency or with a hearing impairment. All services, including discussion of reports, should be delivered in the member's primary language. Ensure **language assistance services** are utilized when appropriate.

Questions? Please contact HPSM's BHT team at **bht_referral_support@hpsm.org**.

Contents

Comprehensive Diagnostic Evaluation (CDE) reports

This is only applicable to CDE providers.

1. Discuss the CDE process with the member's family (necessary intake documents, what to expect for evaluation and time required for evaluation, how family will receive report e.g. via email in 4-6 weeks).
2. Please ensure you discuss CDE findings and recommendations with the family, including why specific services may be recommended as these services may be new to the family.
3. Upon completion of the report, ensure the family receives the report.
4. Within a timely manner and in keeping with clinical best practices, share the CDE report with the **HPSM BHT team** via secure email or HPSM BHT fax **650-829-2006**. Our team will

follow up on recommendations for ABA and BHT-related services such as speech therapy, occupational therapy, etc.

5. If there is a delay in completing the report, update **HPSM BHT team** via secure email.
6. Fax the CDE report to the referring physician; their information is included in the referral we share with you at the time of match. Release of Information is not required to share CDE report with referring physician (see below).
    a. *A CDE provider can share results with a referring physician without a Release of Information (ROI) per:*
        i. *U.S. Department of Health and Human Services, "HIPAA Privacy Rule," 45 CFR § 164.506(c), "Uses and disclosures for treatment, payment, and health care operations." California Health and Safety Code, Section 123145, "Confidentiality of medical information."*
        ii. *Title 22, California Code of Regulations, Section 50030, which governs the use of patient medical records and confidentiality within California healthcare programs.*
        iii. *The sharing of patient information between healthcare providers involved in a patient's care is typically permitted under the Health Insurance Portability and Accountability Act (HIPAA), which allows for the exchange of health information for treatment purposes without the need for a formal release of information. Since the referring physician is considered part of the care team, it is generally understood that communication regarding the patient's care (such as the results etc.) is part of the treatment process.*

Functional Behavior Assessment (FBA) reports

This is only applicable to FBA/Applied Behavior Analysis (ABA) providers.

1. After completing the FBA, please ensure you've discussed and shared the report with the family.
    a. Discuss potential timeline of services (how long it takes to complete the FBA report and submit it to HPSM, when to expect to hear from the provider, anticipated start date for ABA services, etc.)
    b. Ensure the clinical assessor's contact information and/or provider point of contact is provided if the parent has any questions after the last FBA appointment.
2. If ABA is recommended and the family agrees with ongoing services, please submit a prior authorization (PA) to HPSM including the FBA report.

   a. Please follow **HPSM prior authorization guidance here**.

   b. Review the **BHT prior authorization guide here**.

3. If ABA is not recommended, please notify HPSM BHT team via secure email along with any recommendations.

Care Plans

Also referred to as "progress reports" or "treatment plans" and only applicable to ABA providers.

1. Please ensure you've discussed the member's individualized care plan, including clinical recommendations, with the member's family.
   a. In discussion with the family and within the care plan, include a fade out plan and transition plan if level of services are decreasing. Explain why level of services are decreasing/increasing (e.g. decreasing due to graduation).
   b. Confirm with the family that they understand the plan.
   c. Ensure continuous review of care plan with your team and the family per clinical best practice guidelines.
2. Care plan elements should include all elements within **APL 23-010**. See section III in the APL for details. Care plan elements also outlined here:
   a. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence based BHT services.
   b. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
   c. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
   d. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
   e. Include the member's current level of need (baseline, expected behaviors the guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery,

specify plan for generalization and report goal as met, not met, or modified (include explanation).

f. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
g. Clearly identify the service type, number of hours of direct service(s), observation and direction, guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
h. Include care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable.
i. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision. However, do not reduce the number of medically necessary BHT hours that a member is determined to need by the hours the member spends at school or participating in other activities.
j. Deliver BHT services in a home or community-based setting, including clinics. BHT intervention services provided in schools, in the home, or other community settings, must be clinically indicated, medically necessary and delivered in the most appropriate setting for the direct benefit of the member. BHT service hours delivered across settings, including during school, must be proportionate to the member's medical need for BHT services in each setting.
k. Include an exit plan/criteria. However, only a determination that services are no longer medically necessary under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard can be used to reduce or eliminate services.

3. Once completed, ensure the member's family receives a copy of the care plan.
4. Care plans are included in every prior authorization request following the initial request.

Discharge Initiated by Family

1. In the discharge report, include the reason for discharge (the family was dissatisfied with ABA services, family prefers different treatment setting, etc.). Include the most updated care plan and clinical recommendations.
2. Ensure discharge report includes last date of services.

3. Review with the member's family and provide a copy of report.
4. Include the current authorization number for this member. Current PA will be end dated to align with your reported discharge date.
5. Ensure discharge report is shared with the **HPSM BHT team** including any request for support.

Discharge Initiated by Provider

ABA providers can initiate the discharge of a member, however providers have the responsibility of working with HPSM to ensure that the member is matched with a new provider for ABA services moving forward. Prior to deciding to discharge a member, please communicate any ongoing issues to the family and work toward resolution. If unable to resolve issues prompting discharge, proceed to next steps.

1. If you as the current provider are requesting that a member be reassigned to a new ABA provider, please ensure you've completed the **Request for Reassignment form** and submitted it to **HPSM Provider Services** at least 30 days prior to discharging the member This requires HPSM approval before discharging a member from your services. If HPSM approves your request, then submit the discharge report to HPSM. If discharging due to graduation or some other event where rematch is not needed, do not submit 'Request for Reassignment' form. In discharge report, include reason for discharge e.g. graduation from services
2. Include most updated care plan and clinical recommendations
3. Ensure discharge report includes the last date of services.
    a. Review with the member's parents and provide a copy of report.
    b. Include the current authorization number for this member. Current prior authorization will be end dated to align with your reported discharge date.
    c. Ensure discharge report is shared with **HPSM's BHT team** or faxed to the BHT team at **650-829-2006**. Indicate whether support is required from HPSM BHT team to re-match member.