

**OCTOBER 2022**  
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# BPA HEALTH PROVIDER MANUAL

*Connect. Improve. Achieve.*



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# BPA Health Provider Manual

Welcome to the BPA Health Provider Network. BPA Health's knowledgeable staff are dedicated to the importance of positive and professional interactions with all clinicians and facilities, regardless of network status.

## Manual Key

This manual uses a color-coded system of headers to assist readers in locating the information that is pertinent to them.

**Headings In Black** identify information for all providers.

**Headings In Gold** identify sections that are specific to behavioral health providers who have signed a Fee Schedule contract addendum for reimbursement by BPA Health. These providers serve a number of BPA Health managed programs including Employee Assistance Program (EAP), Student & Family Assistance Program (SFAP), and Student Wellness Program (SWP).

**Headings in Red** identify sections that are specific to Substance Use Disorder (SUD) program and service agencies who have signed a Rate Matrix contract addendum for reimbursement through the State of Idaho's Substance Use Disorder Funding program.

## About BPA Health

Over forty years ago, BPA Health was founded on the principles of compassion, trust and stewardship of the health and wellbeing of the individuals and organizations we serve. Today, BPA Health's footprint as well as range of services and solutions has grown, but the promise remains true. BPA Health views the world with empathy and expertise inspired by creative business thinking. As a result, BPA Health develops and delivers products and services to support specific, often overlooked aspects and outcomes of behavioral health. Whether working for a broader, more inclusive definition of healthcare or more efficient and effective business solutions, a strong spirit of service defines BPA Health.

The BPA Health Provider Manual and Appendices are the source for reference information about BPA Health procedures. It is intended to be used in conjunction with applicable state specific regulations, licensing and regulatory boards, as well as the BPA Health provider agreement and addenda. This manual includes general information applicable to all network providers, well as links to payor specific information.

A glossary section for this manual is located in [Appendix A](#). Forms referenced in this manual or in the provider agreement are available for download or printing through the provider's section of the website and within [Appendix E](#).

## Providing Healthcare Solutions, Living Healthier Lives

BPA Health focuses on offering a strong network of Behavioral Health, Substance Use Disorder, and Recovery Support Services. BPA Health's range of behavioral health services encompass employee assistance programs (EAP), student and family assistance programs (SFAP), and student wellness programs (SWP), all focusing on the member's physical and emotional well-being. These customized healthcare solutions are backed with an extensive, nationwide Provider Network servicing all 50 states.

## Public Sector Solutions

BPA Health's focus on healthy behavior extends to the public sector. We help public entities improve health delivery systems including substance abuse treatment and mental health services. BPA Health provides access to the credentialed roster of enrolled providers to other payers such as Speak Your Silence and We Vow. Our behavioral health focused network can be leased by larger medical insurances, or specific grant programs who need a more robust mental health roster. By participating in the BPA Health Network, providers can serve members through other benefit programs and may be invited to join other programs that serve specific demographic groups and populations.

## BPA Communications

BPA Health communicates with providers via phone, direct email and email campaign software, and USPS as needed. BPA Health staff are available by phone Monday through Friday 8am – 6pm MDT, with exceptions for holidays.

### Website

The BPA Health website can be found at [bpahealth.com](http://bpahealth.com). The site features searchable provider listing databases, as well as links to important provider resources. Please contact [ProviderRelations@bpahealth.com](mailto:ProviderRelations@bpahealth.com) for additional questions or assistance.

In the event of a disaster and during periods of prolonged network outages, BPA Health will communicate with the provider network any changes in how to contact us. During regular hours of operation BPA Health staff should be able to reach a provider office via phone, leave a voicemail, or send an email. When a provider's main contact phone number or email changes, the provider should report changes. BPA Health staff should receive a response to inquiries within three business days, or sooner in cases of emergency.

To contact BPA Health about specific questions or concerns, please reference the table below. Tenemos personas que hablan español disponibles para ayudarlo.

Intake Services	Call: (800) 726-0003 for- EAP Call: (833) 935-3816 for Student & Family Assistance (SFAP) and Student Wellness Program (SWP)
Clinical Care Managers	Call: (800) 922-3406 Email: <a href="mailto:CareManagers@bpahealth.com">CareManagers@bpahealth.com</a>
Provider Services	Call: (800) 688-4013 Email: <a href="mailto:providerrelations@bpahealth.com">providerrelations@bpahealth.com</a>
Claims	Call: (800) 922- 3406 Fax: (208)344-1430 Email: <a href="mailto:claims@bpahealth.com">claims@bpahealth.com</a>
WITS	Call: (208) 332-7316 Email: <a href="mailto:IDAutomationHelpDesk@dhw.idaho.gov">IDAutomationHelpDesk@dhw.idaho.gov</a> The Automation Help Desk is not a part of the BPA Health organization but is listed here for your convenience.

### Electronic Platforms

BPA Health uses several secure, HIPAA compliant electronic platforms to assist in reducing paper and increasing efficiencies. We use ZIX to encrypt our emails. Specific payor programs may require the use of specific tools and resources.

### Web Infrastructure of Treatment Services (WITS)

The State of Idaho payor SUD Program requires the use of the WITS Electronic Health Record (EHR). The State of Idaho's [WITS information page](#) includes valuable information in their e-manual, user guides and in their trainings. The Automation Helpdesk (AHD) is available to assist you with any WITS related questions.

In addition to the required New Provider Training additional WITS training and materials you should become familiar with include:

- Scheduler and Group Notes (treatment only)
- Consenting GAINs
- Authorization and clinical dashboards
- Submitting Authorization Change Requests and Notes to Authorizer

### Behavioral Health Programs

Enrollment in the BPA Health payor program allows referrals for members covered under Employee Assistance Program (EAP) and related services, Student and Family Assistance Program (SFAP), and Student Wellness Program (SWP). These

programs utilize short-term, solution-focused therapy and referrals. Differentiated from long term therapy, short term therapy has the following goals:

- Problem identification/assessment
- Solution-focused interventions
- Referral for additional services as needed (i.e., mental health counseling, substance use counseling, medication management)

BPA Health's program contracts with licensed counselors and behavioral health professionals who have two years post master's degree experience. Counselors who are not licensed to practice independently are required to report the name and licensure of their supervisor. Other licensed professionals who provide services listed on BPA Health fee schedule may apply to be in the network. Submission of application does not guarantee entry into BPA Health network. All applications are subject to review, verification and approval procedures.

### **Critical Incident Response (CIR)**

BPA Health provides reimbursement for Critical Incident Response facilitation, travel and mileage to providers who complete the BPA Health CIR training. This higher rate and service may also be available to providers completing other approved CIR trainings. More information can be found [here](#).

### **Employee Assistance Program - Management Referrals**

A Management Referral may be necessary when an employee's work performance becomes a concern. A supervisor may notice a gradual trend or pattern of deterioration in performance, an immediate change as the result of a dramatic work or personal issue, a single event/instance of policy violation, workplace violence, or sudden change in mental status leading to abnormal and potentially dangerous behavior. This process gives the employees an opportunity to improve their performance and retain their job. BPA Health assists with coordinating referrals and compliance reporting. Recommendations and compliance reports are forwarded to the supervisor when the employee chooses to release that information. When a potential Management Referral is identified in your area, our Intake Services Department may reach out to you regarding your availability. They will provide more information regarding Management Referral requirements, which include documentation of recommendations and reports of compliance. If you have experience in handling management referrals, please contact us.

### **Idaho Substance Use Disorder (SUD) Program**

All providers who render service to eligible Idaho Substance Use Disorder Funded members, are required to comply with IDAPA, ASAM, the BPA Health Provider Manual, and terms of signed contract and any applicable addendums. These

requirements cover administrative and clinical processes.

### **Oversight Functions**

BPA Health manages the network of SUD specialty providers for the following State of Idaho Partners: Idaho Department of Health and Welfare (IDHW), Idaho Department of Corrections (IDOC), Idaho Supreme Court (ISC) and Idaho Department of Juvenile Corrections (IDJC); and provides utilization management and oversight functions as described below.

<b>SUD SERVICES OVERSIGHT FUNCTIONS</b>					
	<b>Network Management</b>	<b>Eligibility Screening</b>	<b>Initial Authorization</b>	<b>Continued Stay Review</b>	<b>Claims</b>
<b>IDHW</b>	<b>BPA</b>	<b>BPA</b>	<b>BPA</b>	<b>BPA</b>	<b>BPA</b>
<b>IDOC</b>	<b>BPA</b>	<b>IDOC</b>	<b>IDOC</b>	<b>BPA</b>	<b>BPA</b>
<b>ISC</b>	<b>BPA</b>	<b>Courts</b>	<b>Courts</b>	<b>Courts</b>	<b>Courts</b>
<b>IDJC</b>	<b>BPA</b>	<b>IDJC</b>	<b>IDJC</b>	<b>IDJC</b>	<b>IDJC</b>

For questions related to utilization review, providers can contact BPA Health at 800-922-3406.

### **Potential Client Eligibility Screening**

All clients must first apply for and receive a denial from Medicaid in order to receive an authorization for SUD funding. It is important to note, Medicaid clients may be eligible for services, such as safe and sober housing, that are not covered under their Medicaid benefit plan. For eligibility screenings for IDHW funding, clients can contact BPA Health's intake team at 800-922-3406.

### **Payor Matrix Services**

The State of Idaho determines appropriate services and reimbursement rates for their SUD Program. Requirements, which may be reviewed during monitoring, are described below. Service listings are found on their Rate Matrices, which include the following:

#### **Partial Hospitalization Program (PHP)**

Partial Hospitalization Program (PHP) services are delivered a minimum of twenty (20) hours per week and should be billed daily as either ½ day (3-5 hours) or full day (6+ hours). (See ASAM manual for full description of PHP level of care). Services are expected to be maintained at a minimum of 20 hours of week throughout the client's participation in the PHP. PHP is a bundled service that includes:

- Assessment and Treatment planning
- At least three of the following:
  - Individual Therapy
  - Family Therapy
  - Group Therapy
  - Psychoeducation
- Additional services included in the bundled rate:
  - 24-hour Crisis Services
  - Skill-Building activities
  - Substance Use Screening and Monitoring
  - Drug Testing
  - Care Coordination/Transition Management/Discharge Planning

Providers may also request authorizations for RSS services on the SUD rate matrix that are not included in the bundles services listed above.

### **Safe and Sober Housing (SSH)**

Safe and Sober Housing organizations must adhere to the [Safe & Sober Housing Code of Ethics](#).

SSH providers may collect Program Fees from clients (see Rate Matrix for limits). The fees may be imposed to cover the following expenses:

- Basic utilities
- Telephone services
- Cable/satellite T.V.
- Internet services (if available to clients)
- Amenities fund to cover wear and tear on home living items (i.e., dishes, furniture, etc.)
- Cleaning supplies provided by provider

All houses are required to maintain records of clients entering and leaving the facility. At a minimum, there must be one entry per day for each billed date of service. This means that if a client does not leave the house for an entire day, they must still record that they were at the house to justify the billed service. These attendance logs must include a printed name or legible signature with the date. Initials will not be accepted. (The IDOC's program allows Parole Officers the option to grant up to a 3 day leave of absence for IDOC funded clients in extenuating circumstances like hospital, serving discretionary time. The leave of absence allows SSH provider to bill for those days and hold the room for the client. Provider is required to maintain paperwork verifying the Parole Officer has approved the leave).

- All sleeping rooms must meet applicable size and safety standards

for safe and sober houses

- Each house requires a house manager who is on-site a minimum of 20 hours per week, or a housing coordinator who is off-site that makes daily visits to the house to monitor house activities.
- A list of community resources must be posted in a visible location and available to clients 24/7
- House Rules must be posted and made available to all clients
- The facility and outdoor areas must be neat, clean, and welcoming
- The facility and any outdoor areas must be free from safety hazards

Inspections must be conducted weekly to determine if any hazards or potential safety issues exist. Inspection records must be maintained that includes the date and time of the inspection, problems encountered, and recommendations for improvement. Examples of hazards and safety issues include: broken pipes, malfunctioning heating or air conditioning, appliance or equipment failure (such as the microwave not working), door handles not functioning that impacts privacy, etc.

A fire drill must be conducted and documented at least once every 30 days at unexpected times, and under varying conditions to simulate unusual circumstances encountered in case of a fire. Documentation must include the date and time of the drill, and the recommendations for improvements if problems were encountered.

### **Enhanced Safe and Sober Housing (ESSH)**

Enhanced Safe and Sober Housing is available to eligible members with co-occurring diagnosis. This service is limited to the existing service providers as it is based on a finite grant. ESS houses are required to have 24/7 awake staff, and have an added requirement of weekly census and GPRA reporting.

### **Drug Testing**

Observed urinalysis (UA) testing is the preferred method. If provider is unable to conduct observed UA (i.e. no same-sex testers available) then provider may do an observed oral collection. Provider must follow industry collection standards.

Providers are required to have documentation that drug test results were sent to the appropriate party (e.g. to treatment providers, probation/parole, medical provider, open case workers, or outside

clinicians, as appropriate). These must be supported by the appropriate Releases of Information. If a Drug Testing provider is using a digital system to allow third party access to testing results, the provider must be able to show that the third party has been set up to access the results.

### **Childcare**

If a childcare provider allows client (parent/guardian) to leave premises while child(ren) is in childcare, the provider will need to obtain a childcare license and comply with State and local childcare guidelines.

Child care is billed per-child and in units. Therefore, the client may need to sign in and out more than once per day if the client is receiving multiple services during the day and there is a break in-between (such as counseling in the morning and group in the evening). We also encourage the logs to include the ages of the child(ren) and where or what service the parent is involved in (such as Matrix group, case management, etc.).

## **Idaho SUD Program Requirements**

### **Idaho's Health & Welfare "General Funding"**

This funding is comprised of State General Funds, and Federal grants including the Substance Abuse Treatment and Prevention Block Grant (SABG), and the State Targeted Response Grant for the treatment and prevention of Opiate Use Disorders - Idaho's Response to the Opioid Crisis (IROC). See Provider Manual, Contract and addendums for additional information. Rate Matrices on BPA Health website benefit coverage and limits. IDHW specific benefit program information and requirements include:

**Substance Abuse Block Grant (SABG)** –The SABG requires Providers to adhere to specific guidelines including: Prioritized Services for Persons Who Inject Drugs (PWID); education on the effects of IV drug use, HIV, and TB and the risk of needle sharing; and screening and treatment for tuberculosis (TB). See [Appendix SUD5](#) for details.

### **Idaho's State Opioid Response Grant (SOR)**

This grant provides funding for individuals with an opioid or stimulant disorder and requires treatment providers to:

- Utilize clinically appropriate evidence-based practices (EBP);
- Develop a partnership with a Data 2000 Waivered Prescriber who may provide Medication Assisted Treatment (MAT);

- Coordinate treatment and MAT services in close partnership with the client and prescriber;
- Facilitate payment to the MAT prescriber and payment for the medications within the approved limits on the Rate Matrix (providers must maintain copies of invoices);
- Agree not to require clients to taper off or stop the use of MAT inconsistent with prescriber's recommendations OR require clients to use MAT;
- Agree to work with pregnant women who identify as having an OUD to access appropriate care for themselves and their pregnancy;
- Agree not to purchase, prescribe, or provide directly or indirectly, marijuana or treatment using marijuana; and
- Provide clients with Naloxone training and encourage them to obtain Naloxone kits, and must collect all outcomes data, including GPRAs if required. Providers with Naloxone kits shall ensure staff receive training in administering Naloxone.

### **Idaho Department of Corrections Funding (IDOC)**

IDOC considers the following best practice services:

- Utilize cognitive-behavioral based programming that addresses SUD and criminogenic thinking
- Drug and Alcohol Tests up to two times per week (see Rate Matrix for limits)
- Utilization of Case Management
- Consideration of LSI-R score, found in the comment section of the initial referral, in establishing treatment plan
- Consistent and regular contact with Probation/Parole Officer (PPO), identified in the comment section of the initial referral. IDOC encourages providers to submit the IDOC Status Report Form monthly to keep the PO apprised of client progress. The form can be accessed [here](#).
- Providers may bill staffing units to complete and submit the form.
- POs may grant clients in SSH a leave of absence for up to 3 days, in unusual circumstances. Providers must maintain documentation from PO granting the leave of absence if they wish to continue billing for those three (3) days.

### **19-2524**

GAIN-I assessments must be completed within 10 days of referral unless otherwise specified in the comment section of the referral. If

the provider is unable to meet this deadline, they must contact the Pre-Sentence Investigator (PSI) or District Clinician to transfer the authorization to another provider. The PSI contact information should be included in the authorization. If unable to schedule, reach the client, or the client is no-showing/rescheduling appointments and the deadline will not be met, the Provider must communicate this to the PSI and District Clinician as it will impact sentencing dates with the court. Documentation of this communication must be in the client file. All PSI GAINs must be consented and referred in WITS to IDHW Behavioral Health. BPA Health screens all pre-sentence assessments, facilitates completion of indicated mental health assessments and provides any mental health treatment recommendations to the courts. Treatment Providers are NOT to make any mental health treatment recommendations for the 19-2524 population.

### **Re-entry**

The purpose of services for this benefit program is to focus on identification and intervention for issues related to motivation for change, relapse prevention and social support and environment during the community reintegration process.

- Authorizations bundle therapy and RSS services. See Rate Matrix for details.
- Provider shall engage client in treatment immediately (within 10 business days). IDOC has been granted a waiver from IDHW to not require these clients to complete a GAIN. Providers are encouraged to conduct an ASAM six dimensional assessment/clinical interview with clients to determine needs and to develop service plan based on that interview. Some clients may be engaged in aftercare groups at IDOC District offices. Collaboration with the PPO and required aftercare groups should be considered when developing the service plan with the client.
- An Authorization Change Request (ACR) may be submitted for review if client displays increased symptomology and meets admission criteria for a level of care or if client is not ready to commit/engage in services and could benefit from additional services.

Provider authorization requests that fall outside of the IDOC matrix are forwarded by BPA Health to IDOC for review and consideration.

### **Idaho Supreme Court Funding (ISC)**

ISC receives funding from the State General Fund. Populations Served include individuals that have pled guilty and agreed to participate in a problem-solving court. Offenders admitted to a problem-solving court receive SUD services as necessary.

### **Problem Solving Court Providers**

District courts may choose to contract with a specific provider(s) to provide treatment services to individuals enrolled in problem solving courts (e.g., Drug Court).

### **Idaho Department of Juvenile Correction (IDJC)**

IDJC receives funding from the State General Fund. The populations served include justice-involved juveniles requiring SUD services at ASAM Level 1.0 or higher who are not engaged in a problem-solving court.

- Providers must work collaboratively with referral sources, such as probation officers and others on the client's treatment team.
- Weekly, Providers must keep juvenile probation officer (JPO) informed of clients' progress, unless otherwise determined based on risk. Providers should communicate with JPO if a client needs additional or continued services.
- Providers must attempt to engage the client's family, with whom they have a close emotional connection, in treatment. If this is not clinically recommended, or if the client or family refuses this shall be clearly documented in WITS.
- The provider should work with JPO on appropriate discharges.

### **Credentialing, Recredentialing and Ongoing Monitoring**

BPA Health follows the National Committee for Quality Assurance (NCQA) 2021 Standards and Guidelines for the Accreditation of MBHOs (Managed Behavioral Healthcare Organizations). NCQA "works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation;" and is recognized as a leader in the industry. These standards provide us with an understanding of credentialing best practices, and guidelines for creating processes.

Credentialing and recredentialing of BPA Health Network Providers is designed to ensure that providers within our Network meet BPA Health credentialing standards. The goals are to:

- Ensure each BPA Health provider is qualified by education, training, licensure/certification and experience, to deliver quality behavioral health and support services
- Follow standards identified by NCQA, and industry best practices, to guide procedures and decision making.
- Maintain only competent and qualified providers through appropriate parameters of credentialing and application of performance standards without discrimination based on race, age, color, religion, national origin or sex
- Provide a means to address issues of professional conduct and current clinical competence

### **The Credentialing Committee**

The Credentialing Committee (CC) is comprised of a varied group of licensed behavioral health professionals, a psychologist, psychiatrist, licensed clinicians, as well as representatives of BPA Health including the Provider Services Manager, Director of Operations and Medical Director.

The Credentialing Committee (CC) reports to the Quality Management Committee (QMC) who reviews the committee Program Charter, meeting minutes and other credentialing activities. The CC reviews providers who have anomalies identified during initial credentialing, recredentialing, and ongoing monitoring.

The Credentialing Committee can recommend application approval or denial, suggest action plan sanctions, and endorse a provider's provision of specific services. The Credentialing Committee can require that providers obtain additional training or supervision, as well as recommend denial of providers who are requesting an initial credentialing and present a concern of any kind.

As a core consideration of all BPA Health decisions, CC further ensures credentialing decisions are not based on applicant's race, ethnicity, gender, age, sexual orientation, or patient type in which the provider specializes.

BPA Health will provide written notification to the provider when a professional review action has been brought against the provider. The reason for the action and a summary of the appeal rights and process will be provided. If the provider does not agree with decisions or actions, the provider is entitled to a review under the [Network Participation and Credentialing Committee Decision Appeals](#) as detailed on our website. When decisions are not overturned during appeal, and all appeals are exhausted, decisions will be reported to National Practitioner Data Bank, state licensing board(s), or other certification entities.

## **Application Processing**

BPA Health's standard is to complete the credentialing and re-credentialing process within 60 days of the receipt of a complete provider application and required documents. BPA Health may request and will accept additional information from applicants to correct incomplete, inaccurate, or conflicting credentialing information. Incomplete information or other extraneous factors may result in a delay in the credentialing process.

## **Credentialing**

Applicants must submit a completed application, along with all required supporting documentation for participation with one or more payor programs. Required documents can differ based on the payor programs the applicant is applying to join and the services they wish to provide. BPA Health must receive all required documents before an application is considered complete and ready for review. Provider Services staff will assist in determining if additional documents are needed. The application can be found on the BPA Health website. BPA Health will send written notification to the provider informing them of the determination of the credentialing application within 60 days of the decision.

**Please note: Submission of an application does not guarantee entry into the BPA Health Network.**

## **Recredentialing**

Recredentialing for all providers is required every three (3) years, and may occur more frequently if needed. BPA Health will notify providers approximately ninety days prior to the recredentialing due date reminding them to submit recredentialing information. BPA Health will only grant continued membership in the provider network to professionally qualified practitioners who:

- Demonstrate their current competence,
- Continuously meet and satisfy the qualifications, standards and requirements
- Offer provision of services required or requested by members, and reimbursed by applicable payors.
- Work collaboratively with members, payors, and service administrators. Stakeholder concerns, formal complaints, audit results, quality of care issues, quality improvement activities and over/under utilization data are considered during the re-credentialing process.

When recredentialing information is not received in a timely manner, BPA Health may terminate the provider's status in the network and require

provider to complete initial credentialing.

### **Sanction and Termination**

BPA Health strives to resolve quality of care and service concerns as well as contract compliance through technical assistance, consultation and education. In some situations (e.g., on-going professional competency or quality of care concerns, member complaints, etc.) sanctions may be necessary. BPA Health's Provider Services team may review situations with the Credentialing Committee in order to solicit their guidance and expertise.

BPA Health has the right to sanction, suspend, or terminate a provider/organization based upon, but not limited to the following criteria:

- The suspension, withdrawal, expiration, revocation, or non-renewal of any federal, state, or local license, certificate, or other legal credential
- Provider's indictment, arrest, or conviction of a felony or for any criminal charge related to or in any way impairing provider's ability to treat members
- The loss or material limitation of provider's insurance
- Determination by BPA Health that provider's continued participation in provider network could result in harm to members
- The exclusion, debarment, or suspension from participation in any government sponsored program, including, but not limited to: government programs, Medicare or the Medicaid program in any state
- Change of control of provider's practice to an entity not acceptable to BPA Health
- Any false statement or material omission in the participation application and/or confidential information forms and all other requested information
- The withdrawal, expiration or termination of a state contract
- Contractual noncompliance
- Failure of an audit
- Failure to provide and document care consistent with national standards and/or standards established by BPA Health Quality Management Committee
- Notifications of sanctions from state occupational licensing boards, Centers for Medicare/Medicaid (CMS), National Practitioner Databank (NPDB), or other sanctions monitoring methods
- Issues related to member complaints and grievances, quality of care, or member safety
- Any reported incident, which includes but is not limited to, adverse incidents, professional ethical issues, and/or complaints

BPA Health may impose a variety of appropriate sanctions, dependent upon the severity and nature of the violation. These include, but are not limited to:

- Agency or individual staff provisional status
- Corrective Action Plan, including but not limited to additional training and monitoring. See BPA Health Corrective Action Plan Policy
- Prepayment review, including payment suspension or non-payment of previously withheld funds
- Suspension of referrals/authorizations

Sanctions listed above may result in termination if a cure to the reason for sanction is not met.

### **Termination of Contract**

The above list is not progressive, and sanctions are not a required step in the disciplinary process. Based on the seriousness of the offense, the provider/organization may have their network status suspended or terminated immediately at the sole discretion of BPA Health. Sanctions listed above may result in termination if a cure to the reason for sanction is not met within the allotted timeframe.

A provider/organization that fails to comply with any applicable rule, term or provision of contractual agreement, or whose conduct is not in alignment with federal or state law may have their network status terminated in writing at the discretion of BPA Health.

### **Network Licensure/Certification Qualifications**

Payors may dictate that specific billable services are either overseen by, or provided by individuals holding a specific license, certification, education and/or training. Please note that in the following roles, supervisors cannot supervise their own supervisors, business partners, or family members.

### **SUD Professional Licensure and Certification**

State of Idaho payor SUD Program treatment providers must employ both a Qualified Substance Use Disorder Professional (QP/QSUDP) and a Clinical Supervisor.

**Qualified Professional(s)** are defined in State of Idaho Administrative Rule (IDAPA). Agencies may also choose to utilize the services of Qualified Substance Use Disorders Professional Trainees (QPT/QSUDPT)

**Clinical Supervisor** (see below) who meets one of the following criteria:

- Master's Degree from an accredited, approved, and recognized

- college or university in health and human services and the equivalent of three (3) years paid full-time professional experience with two (2) years providing direct substance use disorders treatment; **or**
- Clinical Supervisor designation from the Idaho Board of Occupational Licensure and professional experience in provision of substance use disorders treatment; **or**
  - Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) Certified Clinical Supervisor

When supervising individuals who provide services to children and adolescents, the clinical supervisor must have two (2) years of experience working with children and adolescents and knowledge of the effects of alcohol and drugs on child and adolescent growth and development.

**Case Management Agencies** must employ both a Case Management Supervisor, and qualified Case Manager(s).

#### **Case Managers**

- A QP or QPT per IDAPA; **or**
- A person with a bachelor's degree or higher in Human Services or related field from a nationally accredited university or college, **or**
- a person with a bachelor's degree plus 2 years of experience working as a case manager in a related field

#### **Case Management Supervisors**

- Have a master's degree in social services field (unless also providing supervision for clinical staff, this person is not required to be a clinical supervisor),
- Have documented knowledge of working with individuals with a SUD diagnosis, and
- Have knowledge of the role of case managers and of community resources.

#### **Recovery Coach Agencies**

- An IBADCC Certified Recovery Coach, Certified Provisional Recovery Coach, Certified Peer Recovery Coach, or Provisional Certified Peer Recovery Coach; **and an**
- IBADCC Certified Recovery Coach Supervisor

## **Staffing Policies, Roles and Job Descriptions**

(Revised March 2023)

All agencies must have policies and procedures related to the ensuring that their staff, employees and contractors are actively licensed or certified, and have no Medicaid/Medicare sanctions.

At a minimum such policies must:

- Ensure no staff, employees or contractors have been debarred, suspended or excluded as documented on Medicaid/Medicare debarment, exclusion or suspension lists.
- Ensure no staff, employees or contractors have had their professional certification or license suspended or revoked based on disciplinary action by the Idaho Board of Alcohol/Drug Counselor Certification, or the Idaho Board of Occupational Licenses due to an ethics violation.
- Document processes for ongoing monitoring of the above verification.

All staff must adhere to the guidelines and ethics of any licensure or certification board, and align service provision with their education and experience. Details of duties and scope of practice should be outlined in a written job description or comparable document. Providers must ensure they have the appropriate oversight per ASAM, State, and BPA Health regulations, and that all clinical staff are trained in utilized program EBPs.

### **State of Idaho Payor Program Enhanced Background Checks**

The State of Idaho's SUD Funding program requires that all agency staff have received an Enhanced Background Check Letter of Clearance from the [Idaho Criminal History Unit](#) (CHU) before working with eligible funded clients. This includes but may not be limited to anyone who provides face-to-face observed or non-observed services or has access to treatment notes and/or other Personally Identifiable Information (PII).

### **Office Procedures**

#### **Policies and Procedures**

Providers are required to create and maintain their own policies and procedures. The content of these documents may be dictated by several factors, including contracts, governing bodies and both formal and informal business agreements. Any policy or document required by BPA Health or its payors, is not required to be unique to BPA Health services or members. Any policies requiring BPA Health review must be submitted during application and/or as requested.

## **Member Rights and Responsibilities**

BPA Health's member rights and responsibilities can be found here: [Member Rights & Responsibilities](#). También esta disponible una versión en español de los [Derechos y Responsabilidades de los Miembros](#). Providers are encouraged to post rights and responsibilities in their offices and to provide copies during intake. Members may make recommendations to their provider's Rights and Responsibilities Policy.

## **Access to Treatment Records and Treatment Record Reviews/Audits**

Providers must maintain records on members, to whom services are rendered, using accepted medical documentation procedures. BPA Health has the right to access and copy records of members for a period of seven (7) years after the last date of service. Providers must maintain records of minor members until they reach the age of majority plus ten (10) years.

BPA Health may conduct record reviews as a part of credentialing and recredentialing activities, ongoing monitoring, or to follow-up on complaints or critical incidents. As outlined in the Provider Agreement, accommodation must be made to reasonable requests to access.

Providers must allow a member access to their personal clinical record upon written request and when clinically appropriate, following HIPAA policies and procedures, as well as Codes of Ethics.

## **Confidentiality, Privacy, & Security of Identifiable Health Information**

Providers are expected to comply with all applicable federal and state confidentiality, privacy and security laws, rules and/or regulations. This includes the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the associated promulgated rules and regulations, and 42 CFR Part 2. Providers are responsible for monitoring and implementing any changes that are made to these rules and regulations into their practice. See provider agreement for additional information.

Providers must take steps to ensure security and confidentiality of protected health information (PHI) and personally identifiable information (PII). This includes using HIPAA compliant software programs and email encryption. BPA Health uses email encryption and ensures software and forms with PHI or PII are HIPAA compliant.

If a provider learns of a potential breach, they are responsible to comply with notification requirements in a timely manner. If BPA Health receives a complaint or is made aware of a potential breach, BPA Health will follow complaint processes to investigate the allegation and implement correction action plan if

warranted.

### Appointment and Availability Standards

BPA Health has established timeliness standards for behavioral health appointments for all payor programs as follows:

Situation	Timeframe
Life-threatening emergency (severe symptom or incident requiring immediate attention for which a delay in care could be life threatening)	The individual should be seen in person immediately or referred to an appropriate emergency service provider
Non-life-threatening emergency (member is acute crisis needing to stabilize to prevent further deterioration)	As soon as possible, not to exceed 6 hours
Urgent (significant distress or severe situation, no presenting imminent risk of harm to self or others)	As soon as possible, not to exceed 48 hours
New member referrals	Within 10 business days
Routine care	Within 10 business days
IDHW payor program clients who transfer from residential level of care to OP or IOP	Within 5 business days of discharge from residential care

If a provider is unable to see an individual within these time frames, they must contact BPA Health for next steps including possible alternative referrals.

BPA Health's intake staff help connect members to appropriate counselors based on self-reported criteria. If a provider has upcoming openings or cancellations this can be reported using the form found [here](#). When a provider is within a member's requested criteria and service area, the member will be notified of availability.

### Out of Office Coverage

All providers must have a policy for coverage when they are out of office (e.g., ill, vacation, training).

### Notification of Changes

BPA Health Provider Services must be notified when a change in contact, management, service, or activity status occurs. Update forms can be found in [Appendix E](#).

Adding new locations take the same time to process as initial applications. Submissions should be planned for accordingly. Please note requests to add locations or services is not a guarantee of approval. Prior to processing these requests BPA Health may review current network capacity and census information to determine if adding the location or service is beneficial for both the provider and the network.

- | When to Notify BPA Health:  |
|---|
| <ul style="list-style-type: none"><li>• Changes to locations</li><li>• Office hours changing</li><li>• Updating/changing phone numbers or emails</li><li>• Adding or removing a service</li><li>• Changes to ownership</li><li>• Tax ID Change</li><li>• Billing information update or change</li><li>• NPI number change</li></ul> |

When providers are unable to add new individuals to their caseload, BPA Health can adjust their network listing to reflect that the provider is still in the network, but not accepting new patients. Additionally, providers should notify BPA Health when they are maintaining an active waitlist for services.

When providers are no longer interested in receiving service authorizations for a particular payor, they can choose to opt out of the payor referrals.

Permanent office closures should be reported as early as possible, in order to allow for member service transition.

Adding or removing a service site must be reported in advance, in order to allow the BPA Health Provider Services team adequate time to process the request.

### **Change of Ownership or Management**

Changes in ownership entity, Tax ID, or NPI, may require initial application into the network. These types of changes may require additional documentation, as identified by legal authority and/or BPA Health request.

### **Cultural Competency**

Within the BPA Health Network, cultural competency is defined as a set of congruent behaviors, attitudes, and policies that combine to work effectively in cross-cultural situations. BPA Health is devoted to the development and

strengthening of effective and healthy provider/member relationships. Members have a right to appropriate and quality care. When cultural differences are disregarded members are at risk for poor quality of care. Members are less likely to communicate their needs in an indifferent environment, limiting the effectiveness of the health care process. The U.S. Department of Health and Human Services developed and has posted to their website ([www.thinkculturalhealth.hhs.gov](http://www.thinkculturalhealth.hhs.gov)) the Culturally and Linguistically Appropriate Services (CLAS) Self-Assessment tool. All providers are encouraged to review CLAS and complete the Cultural Competence Self-Assessment. Specific payor programs may require completion of this self-assessment.

### **Hearing And Speech Impaired or Interpreter Services**

If needed, providers must provide interpretive services. There are a number of professional interpreter services available. Hearing and speech impaired members can use TTY or dial 711 from a telephone to be automatically connected to a TRS operator. Please see [additional information on 711](#). Payors may reimburse for services with, or provided by certified interpreters. These details will be located on the Fee Schedule or Rate Matrix.

### **Site Visits and Monitoring**

BPA Health may conduct a site visit of the provider's office(s) as a part of credentialing/recredentialing activities, ongoing monitoring, or to follow-up on complaints or adverse events. As outlined in the Provider Agreement, accommodation must be made to reasonable requests to access. If a site visit is to investigate significant member safety concerns, providers will be granted minimal or no advanced notice. Visits may include a walk-through of facility, review of policies and procedures and/or a review of member records/documentation.

### **Staff Updates**

Providers must complete the [SUD Staff Update Form](#) changes occur. The staff update form must be completed within 24 hours of a staff member being hired or terminating employment. Additionally, providers must notify the [WITS Helpdesk](#) within 24 hours of a staff member leaving to ensure WITS access is removed. Failure to comply may result in sanctions.

## **Provider Rights and Responsibilities**

### **Provider Rights**

BPA Health Network providers have specific rights and responsibilities.

- Providers have the right to review:
  - the information obtained to evaluate their credentialing decision, attestation, or Curriculum Vitae;

- the process and provider's right to be informed of the credentialing decision;
  - provider's right to correct erroneous information (see below); and
  - the appeal process for actions taken against providers.
- Providers have the right to review information obtained by BPA Health to evaluate their (re)credentialing applications except where disclosure is protected by peer review or prohibited by law.
  - Providers have the right to correct discrepant or erroneous information obtained by BPA Health during verification from primary sources by working directly with the reporting entity or listing agency.
  - Providers have the right to respond to inconsistencies discovered during credentials verification process as part of credentialing/recredentialing. It is the responsibility of the provider to contact the primary source if the provider feels that the primary source data is incorrect.
  - Providers have the right to request the status of their application at any time.
  - Providers have the right to appeal adverse determinations, as well as clinical and claims denials.

### **Provider Responsibilities**

Provider responsibilities are defined in contracts, addendums and in this manual. Requirements may vary depending on payor and benefit program

### **Regulatory Requirements**

Provider Agreement provisions include requiring compliance with all applicable state and federal rules, laws, and/or regulations. These include but are not limited to HIPAA, 42 CFR Part 2, licensure and certification regulations, child and elder abuse reporting, duty to warn, and Fraud, Waste and Abuse. It is the provider's responsibility to understand and comply with legal requirements for the states in which they are delivering services.

### **Adverse Events**

All providers are required to report to BPA Health within 24 hours any incident or event that threatens the safe and efficient operations of BPA Health or any contracted provider or involving a member who received authorized services within the last thirty (30) days. Reportable events include but are not limited to things such as completed suicide, stolen files, and employee criminal activity. BPA Health may follow-up on these for additional information. The BPA Health website includes forms and information here. for more information and link to reporting form. Failure to comply with reporting requirements may result in sanctions.

## **Fraud, Waste, and Abuse (FWA) Policy**

BPA Health is committed to preventing, detecting and correcting Fraud, Waste and Abuse. The purpose of BPA Health's Fraud, Waste, and Abuse Policy is to protect the operational, financial, and reputational interests of our organization as well as that of all stakeholders.

**"Fraud"** is 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.

**"Waste"** includes practices that, directly or indirectly, result in unnecessary costs to the healthcare system, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

**"Abuse"** includes actions that may, directly or indirectly, result in unnecessary costs to the healthcare system. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

**"Stakeholders"** are employees, partners, customers, providers, clients, members, and vendors.

Providers should report fraud, waste, and abuse, or suspicious activity such as inappropriate billing practices (e.g., billing for services not rendered or use of CPT codes not documented in the treatment record).

Concerns of FWA can be reported directly to BPA Health at (800)486-4372 or (208) 947-1290 or email [FWA@bpahealth.com](mailto:FWA@bpahealth.com). To report anonymously to a third party and confidential reporting service call (855)372-8345 or go to [www.FRAUDHL.com](http://www.FRAUDHL.com) and use company ID: BPAHealth.

BPA Health will investigate all FWA allegations.

## **Complaints**

BPA Health believes that anyone has the right to file a complaint and express a concern about our programs and services. A member may designate a representative to file a complaint on their behalf. There is no statute of limitations for the filing of a complaint. BPA Health welcomes complaints and considers them as valuable opportunities to learn, adapt, and improve the services we provide our members and customers. BPA Health will not retaliate nor take any discriminatory action against any individual, facility or organization due to filing a complaint.

Filing a complaint can be done over the phone, via fax, mail, email, or by completing the [Complaint Submission Form](#). BPA Health will provide a copy of the Complaint Policy to our members, providers, stakeholders and the public, upon request.

BPA Health will take the following steps when receiving a complaint:

- Address complaints quickly and courteously, treating all complaints equally and seriously.
- Record all complaints, keep complainants informed of the progress, and record the action taken to address the complaint.
- Respond to complaints within **five (5) days** from receipt and resolve them within **thirty (30) days** from receipt.
- Protect the identity of the complainant, or related members, whenever possible.

BPA Health collects and analyzes member and provider complaints for opportunities for process improvement at BPA Health and at provider offices.

## **Claims Procedures**

### **Preauthorization/Precertification**

Information regarding BPA Health's policies and procedures on authorizations is in the utilization management section of this manual. Providers may not bill, charge or seek reimbursement or a deposit from members for services determined not to be appropriate or covered.

### **Requests for Additional Information**

BPA Health may need additional information in order to process a claim. Providers must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in a denial of claims, a corrective action plan, or sanctions.

### **Payment Processing**

Clean claims will be processed within 30 days of receipt in accordance with contract, benefit guidelines, fee schedules and rate matrices. No shows and late cancellations are not a reimbursable expense.

### **Balance Billing**

In accordance with contractual agreements, payment for services is considered payment in full, and the provider may not balance bill the member for services rendered. Signed Rate and Fee Schedule agreements are considered Contractual Adjustments.

### **Claims Recoupment**

Providers should regularly review claims and payments to ensure they are coded and paid correctly. If BPA Health or provider determines a claim was paid in error, unsubstantiated, did not meet requirements or was overpaid BPA Health will pursue recoupment of the paid claim. If BPA Health initiates the recoupment the provider will be notified in writing. The recoupment may come from a withhold of future payments, or the provider may be asked to submit a check.

### **Claims Appeals**

Providers may appeal claims determinations by submitting the [Appeals Submission Form](#).

### **Claims Billing Audits**

BPA Health conducts random claims audits, looking at billing anomalies. Providers may be asked to submit additional information to help with review of billing concerns.

### **BPA Health Payor Behavioral Health Claims**

EAP claims must be submitted within 60 days of the date of service. Claims should be submitted on the [BPA Health Electronic Billing Form](#) or the CMS 1500 (located at [www.cms.gov/Medicare/CMS-Forms](http://www.cms.gov/Medicare/CMS-Forms)). Claims with insufficient information will be returned for correction and resubmission.

CMS 1500 Claims should be:

Faxed to: (208) 344-7430 *Attention: Claims,*

OR

Mailed to: BPA Health, 8050 W. Rifleman, Ste. 100, Boise, ID 83704

### **State of Idaho Payor Claims**

SUD claims are released to billing through WITS. They must be batched, billed, and received by BPA Health within 30 days of service. See WITS e-manual for more information. If at any time during treatment a client obtains Medicaid the provider must discharge the client from SUD funding and send in a Note to Authorizer (NTA). If it is determined that a provider did not discharge from SUD funding after client obtained Medicaid, BPA Health will recoup SUD claims that had been paid. Provider may be able to request Medicaid-braided funding for some services. See Rate Matrices on BPA Health website for more information.

Please note: BPA Health pays IDHW and IDOC claims. IDJC and ISC claims

are paid directly by IDJC and ISC.

Providers may collect all applicable co-payments directly from clients in accordance with BPA Health Provider agreements. Providers agree that applicable rate matrix reimbursement amounts are payment in full, minus applicable copays.

See also [Encounter Notes](#)

### **Claims Questions**

For questions regarding claims payment, denials and submissions, (not for submission of claims) call (800) 922- 3406, or email [claims-dept@bpahealth.com](mailto:claims-dept@bpahealth.com).

## **Clinical Practice Guidelines**

The [American Psychology Association](#) offers clinical guidelines for practitioners ranging from record keeping, healthcare delivery systems, to guidelines for assessment of intervention with persons with disabilities. The [Substance Abuse and Mental Health Services Administration](#) offers tips and information of effective evidence-based approaches for the treatment of SUD and mental health disorders. The purpose of these guidelines is to help educate clinicians and give recommendations about professional practices with specific populations.

Practice guidelines differ from treatment guidelines in that practice guidelines are more general suggestions for assistance rather than specific treatment requirements.

### **Supervision and Case Consultation Standards**

Supervision and case consultation help ensure quality and ethical care. Supervision additionally assists in the growth and development of behavioral health professionals. BPA Health expects all providers to participate in supervision and case consultation in accordance with their scope of practice and industry standards. Benefit programs may require specific supervision elements.

### **Release of Information (ROI)**

Member treatment and service records shall be kept confidential and not released without the written authorization (Release of Information or ROI) of the member or the member's legal guardian. When the release of member records is appropriate the extent of that release should be based upon necessity and must be documented in compliance with HIPAA and 42 CFR

Part 2 regulations. All treatment and RSS Service providers must obtain ROIs prior to releasing information.

### **State of Idaho Payor Supervision Requirements**

Supervision is an integral part of any quality assurance program. In order to bill for services, all clinicians, trainees, case managers, and recovery coaches providing billed services are required to meet qualification criteria and receive regular supervision as outlined below:

SUD clinicians, case managers and recovery coaches in the SUD program are required to participate in supervision with qualified supervisors as well as regular case consultation. Supervisors must use an evidence-based model of supervision.

**Supervision Documentation:** Supervision files must be maintained for a minimum of seven (7) years and should include:

- Demographic information (name, date of hire, credentials, certifications, frequency of supervision, job title and supervisor's name)
- Professional Development Plans (clinicians and case managers)
- Forms required by licensure/certification boards as applicable (i.e. Recovery Coach supervision form)
- Supervision notes must include date, time/length, method and content of supervision, and supervisor's signature.

**Clinical and Case Management supervision** must include a combination of observation, review of client records, assistance with and review of written professional development plan (including measurable and time specific goals), and case consultation. All Qualified Professional Trainees must have a minimum of monthly supervision until they become licensed/certified. Once licensed/certified, the frequency should be determined by the clinical supervisor, based on competencies, and occur no less than one (1) time per year.

**Recovery Coach Supervision** may include observation, role plays, individual meetings, and case consultation. Recovery Coach Supervisors must follow IBADCC guidelines on frequency, process, and forms.

### **Utilization of Evidence-based Programs (EBP)**

All SUD agencies are required to use evidence-based programs and are responsible for ensuring staff training and adherence to EBPs. Providers must submit an [Evidence-Based Programs and Practices Form](#) at time of

application and whenever EBPs are added or discontinued. BPA Health will post these EBPs in the provider profiles on our website.

### **Co-Occurring Capabilities Assessment**

All SUD agencies must be assessed as either “Co-occurring Capable” or “Co-occurring Enhanced.” This is determined by completing the [Co-Occurring Capability Assessment](#).

### **Documentation Standards**

Agencies must maintain administrative and treatment records. All providers must maintain records that align with industry and service best practices. This includes adherence to all applicable privacy rules, laws and regulations. Accurate and complete member records assist providers in delivering the highest quality healthcare. They also enable BPA Health to review the quality and suitability of services rendered. To ensure member privacy, electronic and written records should be kept in a secure manner and in compliance with HIPAA and 42 CFR Part 2 standards.

Releases of Information and Informed Consent forms are required. A sample [Release of Information](#) is in the appendices. Notification of both Client Rights, and HIPAA practices are required, and may be part of a handbook if provided. Charts should also include a Risk of Harm to Self or Others.

Notes should follow best practice guidelines, (i.e. SOAP or DAP notes), and be signed and dated. For more details see [Appendix D](#).

### **EAP/SWP/SFAP Program Documentation Standards**

Chart documentation must be legible and easy to follow. All client charts should include the following:

- Chart includes Member/Client Name, Address and contact phone number(s).
- Chart includes signed copy of Informed Consent (includes limits of confidentiality and, if applicable, telehealth).
- Chart includes acknowledgement of review of Notice of Privacy Practices.
- Chart includes signed release(s) of information, as applicable.
- Documentation/progress note for each billed session being reviewed that includes at a minimum the following:
  - date
  - client name

- intervention utilized
  - provider signature and credentials
- Documentation of presenting problem/reason for being seen (i.e., in assessment, initial progress note or treatment plan).
- Documentation of an assessment. This may be in the form of a biopsychosocial intake, or other clinical assessment tool.
- Assessment of risk of harm to self or others.
- If assessment indicated risk of harm, documentation of safety planning and other steps taken.
- If client has been seen more than once, documentation of plan with goals, objectives and interventions developed with and agreed to by client. Consider reasonable goal for the number of sessions authorized.
- Documentation of outcome of case following utilization of authorized sessions.
- If additional services needed, documentation of referrals provided and which the client chose.
- If client is a mandatory referral, documentation that reports were submitted on-time.

### **SUD Program Documentation Standards**

In order to bill for a service, the encounter note must be entered into WITS. In addition to intake documentation, all encounter notes, plans, discharge summaries must be clear, individualized, and reference evidence-based programs. Any documentation entered by an intern or trainee must include documentation that it was reviewed by and counter-signed by supervisor or (QP) as referenced above. Additionally, the following are required:

Fee determination completed by treatment provider in WITS (generally by person entering the authorization), updated by treatment provider as changes occur and minimally once per year. This is not required for IDJC or ISC funded clients.

IDHW General Release Form, required form for all treatment and RSS providers (see [Appendix A](#)).

Signed acknowledgement that client received or provider made available:

- Notification of use of any trainees, when applicable
- TB/HIV/Infectious Disease testing referrals

## Assessments

Assessments identify the clients' strengths and needs and serve as the basis of clients' treatment and case management plans. For IDOC clients, it is important to also consider LSI-R score.

IDHW – Comprehensive Diagnostic Assessment (CDA) addressing ASAM dimensions and completed by someone trained in ASAM. See [Idaho's Behavioral Health Standards](#) for specifics. CDA's should be submitted using the [Request for Service and Assessment Submission Form](#)

IDOC, IDJC and ISC – If authorized, a GAIN Assessment must be consented in WITS to funding partner. When a client transfers to another provider, their GAIN needs to be consented in WITS to the new provider as soon as written authorization is obtained. If a non-GAIN assessment was completed, that agency needs to send (e.g., fax or secure email) it to the new treatment agency.

All assessments (GAIN or CDAs) should be completed within 10 days of initial authorization. GAINs must be consented in WITS and CDAs must be submitted via a [Request for Service and Assessment Submission](#) form within 10 days of initial authorization. If unable to complete for any reason and the client is IDOC funded the delay should be communicated with IDOC and the PSI (if applicable).

## Other Assessments and Plans

Case Management (CM) assessments must be completed for all clients receiving case management services prior to developing case management plan. See sample CM assessment in [Appendix SUD1](#).

Service, Treatment and/or Case Management Plans must be developed with the client, be client centered and address all client strengths and needs that have been identified in assessments and clinical interviews. See [Appendix SUD2](#) for sample form that can be used for service, treatment and/or case management plans. Plans must include:

- Goals, objectives (SMART), and evidence-based interventions
- Frequency of each service/intervention being provided
- Target dates for goals and objectives
- Plan for family engagement and/or enhancing sober supports
- Treatment plans should include all Recovery Support Services (RSS) and

- o clearly identify who is providing each intervention (i.e. counselor, case manager, recovery coach)
- o Discharge criteria

### **Encounter Notes**

Encounter notes must be entered in WITS within five (5) business days of the date of service and released to billing within thirty (30) days. All notes should be individualized and meet applicable requirements and best-practice standards (i.e., DAP or SOAP). Treatment notes of trainees/interns must be reviewed and co-signed by a qualified professional prior to releasing to billing (see WITS e-manual for more information).

- o Group notes for all treatment services must also include documentation of the EBP facilitated in the group.
- o Case Management notes for CM services provided throughout one day may be bundled into a single note for the day (exception is CM family without client present which has a separate billing code). Within the note break document by time each service that was provided during the day (i.e., "1:00 – 1:30 met with client and discussed... 3:15 – 3:30 completed and submitted IDOC Status Update form"). If providing CM services, there must be a minimum of one face-to-face or telehealth CM appointment each month with either the client or the client's family.
- o Residential, Transitional, Partial Hospitalization Program, and SSH providers may bundle up to five (5) days of service in one encounter note. Documentation of clinical, professional and allied services such as group and individual sessions must be entered as Miscellaneous notes in WITS.

Additional documentation standards for treatment providers can be found in [Appendix SUD3](#)

### **Utilization Management**

BPA Health's Utilization Management (UM) Program provides a structure and process by which clinical appropriateness and effectiveness of services are defined, continuously monitored, and improved over time. The purpose of the UM program is to provide easy and equitable access to quality behavioral health and related support services. These services focus on individualized treatment strategies to promote the principles of recovery and resiliency of

members. The BPA Health UM program is designed to evaluate the quality, cost, and the coordination of services provided to our members. BPA Health strives to build strong, working relationships with our network and community-based providers to improve the delivery of services. BPA Health does not delegate the UM function. BPA Health uses the most current edition of the American Society of Addiction Medicine (The ASAM Criteria Third Edition, 2013) criteria for SUD utilization management.

BPA Health's utilization management program creates a system that facilitates communication with the providers in order to maintain efficient authorization and access to services. The UM program assures appropriate utilization, which includes evaluation of potential overutilization, underutilization and timely access to services. The program additionally identifies opportunities for improvement in utilization patterns. Review of services is based on medical necessity in accordance with BPA Health's Utilization Management policies and standard operating procedures.

The Utilization Management (UM) Program goals are:

- Assure services rendered are medically necessary and furnished in an amount, duration and scope that address the needs of the consumer using written, objective clinical review criteria based upon professionally recognized resources and established with input from clinical staff members and professionals.
- Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity according to the Utilization Management-Prospective, Concurrent and Retrospective Review Policy.
- Establish the process used to review and approve the provision of behavioral health services, including an appeal system for non-certifications including eligibility and service denials, reduction in services, or termination of services.
- Enable members to access approved behavioral health services in a timely manner.
- Notify members and/or providers of UM decisions in a timely manner.
- Establish accountability structures and processes for communication and integration of a comprehensive plan across providers, settings, and the continuum of care.
- Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and with applicable state and federal laws that govern the utilization management process.
- Protect the confidentiality of member and provider information and records.
- Explore opportunities to create and innovate in health care management, recovery-oriented systems of care, and service delivery with members and providers.

**Failure to follow authorization, certification, and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the member be held harmless from any financial responsibility for the provider's charges.**

### **Authorizations and Referrals**

To request an initial authorization for services and receive a referral to a network provider, individuals must call BPA Health to determine eligibility. This process may differ by benefit program.

Once eligibility has been determined, network providers offering appropriate services based on the members' needs will be made available for selection. BPA Health's website includes a searchable database of program and provider listings that allow members to search by location and service specialty.

When an individual is deemed ineligible for services, staff will provide them with information about available community support services and programs, including local or state-funded agencies, who might provide sliding scale discounts for treatment.

### **Prospective and Concurrent Review Process**

BPA Health bases UM determinations on the clinical information obtained at the time of the review and will accept information from any reasonably reliable source that will assist in the certification process. BPA Health collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services.

BPA Health may request clinical information at various points in treatment to ensure the ongoing need for care and treatment is appropriate and effective in improving health outcomes.

### **Retrospective Review**

Providers may request in writing a retrospective review if it is available under the member's benefit plan. Upon receipt of all required clinical and claims information BPA Health will have 30 calendar days to complete review. The provider and/or member will be notified in writing of any extensions and if any additional information needed.

### **Covered Services**

Covered services are determined by benefit program and authorized by BPA Health. The services must be provided in accordance with generally

accepted practices and standards prevailing in the professional community at the time-of-service provision. The provider shall ensure that all personnel providing covered services do so in an ethical and professional manner, and in compliance with all applicable laws and regulations, including those imposed by accreditation, licensure or certification board.

**Certification and Non-certification Determinations**

BPA Health does not issue non-certification based on initial clinical review. If initial clinical review indicates a potential medical necessity issue or quality of care concern, the request will be referred to an appropriate clinical peer reviewer at or above the education/licensure level of themselves and/or the provider, including access to the Clinical and Medical Directors. Requests of clinical nature will be peer reviewed prior to issuing a decision of non-certification for a clinical reason. Non-certification determinations for urgent care or residential treatment are reviewed by staff with Clinical endorsement (i.e., LCPC, LCSW) and if provider has higher licensure level, will be reviewed by the Medical Director. Notification of non-certifications sent to members, authorized representatives and/or providers will include instructions on how to appeal the non-certification decision. The provider requesting the authorization is responsible for notifying the member of non-certification and provide them information about available community support services and programs, such as local or state-funded agencies or facilities, who might provide sliding scale discounts for treatment. Written notification is available to the member upon request.

**SUD Program Response and Notification**

SUD providers must notify BPA Health prior to initiating any non-emergency treatment to verify client eligibility and authorization. Providers must contact BPA Health care managers telephonically during business hours if they are submitting a request in WITS for urgent care.

Utilization Review Type	BPA Health Response Time	Member/Provider Response Time for Additional
Prospective Review Involving Urgent Care	As soon as possible but no later than 72 clock hours from receipt of request	72 hours for clarification response
Prospective Non-urgent	As soon as possible, no longer than 7 calendar days	5 business days for clarification response

Once eligibility is determined under the client's SUD benefit program, BPA Health will review the clinical information submitted by the provider, to determine if client meets medical necessity criteria for the treatment services and/or level of care being requested. BPA Health may seek clarification or additional information from the provider prior to authorizing or certifying levels of care or services available under the client's benefit program (e.g., residential, intensive outpatient, or outpatient). RSS services are authorized in accordance with the listed limits in the Rate Matrix. Authorizations and certifications are for a specific number of units of services/days and for a specific period based on the client's clinical needs and limits in their benefit program.

Requests for additional SUD units or services and/or transferring to a different level of care will be reviewed by BPA Health as described above. The benefit program may, in limited instances, approve services that exceed limits allowed on the Rate Matrix.

### **Other Timelines**

Transfers from a residential level of care to another provider or a different level of care must be submitted within 3 calendar days of successful completion or known termination to allow for client to be authorized to enter another level of care. An ASAM update should be submitted with a Change to Service form in WITS if the client received billable residential services for at least 1 day.

Discharge summary and closing the authorization must be completed and entered by treatment provider in WITS within 15 calendar days of successful discharge or known termination. If client stops coming to treatment, the provider has 45 calendar days from last billed date of service to enter discharge in WITS. Treatment providers must notify RSS providers when they are discharging a client. Upon discharge, all treatment and RSS providers must close out authorizations by sending in a Note to Authorizer (NTA) to BPA Health for IDHW and IDOC clients. If client is IDOC, IDJC or ISC funded, providers must work collaboratively with their probation officers or designees regarding discharges.

### **SUD Program Authorization**

BPA Health will provide notification of certification by means of authorization to the provider requesting the authorization or the facility

rendering service within one (1) business day of the determination through the corresponding authorization in WITS. The provider requesting the authorization or facility rendering services is responsible for notifying the client of certification. Written notification is available to the client upon request. Notification of certification for services includes the number of extended days or units of service, the next anticipated review point (end date of current authorization), the new total number of days or services approved, and the date of admission or onset of services. BPA Health does not reverse a certification determination unless we receive new information relevant to the certification that was not available at the time of the original certification.

### **Adverse Clinical Determination/Peer Review**

Notifications of non-certifications include information on the appeal process. Any member, authorized representative, or provider rendering services has the right to appeal a non-certification decision.

The member, authorized representative and/or provider must submit an appeal request in writing within 180 calendar days of notice of non-certification or as designated by the payor plan or benefit program, by submitting the [Appeals Form](#).

BPA Health will provide assistance to any member, authorized representative or provider needing assistance with an appeal request. Standard appeal requests will be responded to or resolved in writing within thirty (30) calendar days of receipt. Expedited appeals can be submitted verbally or in writing and are available for non-certification of requests for authorizations involving urgent care only and will be completed with verbal notification of determination to the requesting party within seventy-two hours of the request followed by a written confirmation of the notification within three calendar days of notification of decision to the member and attending physician or other ordering provider or facility rendering service.

The appellant has the right to reasonable access to and copies of all documents, records, and other information that are relevant to the appeal. Appellant will have three (3) opportunities to have a non-certification decision reviewed for reconsideration. Should the appellant wish to challenge the first level appeal decision made by BPA Health, they must submit a second level appeal within sixty (60) calendar days of notice of the first level appeal denial.

BPA Health will support a decision by the appeal reviewer to overturn a previous denial of certification. BPA Health reserves the right to pay even if

the reviewer upholds the denial, as dictated by the benefit program.

### **Exhausted Benefits**

When a member's benefits have been exhausted or their benefit program does not include coverage for requested services, the provider must offer the member information about available community support services and programs, such as local or State-funded agencies or facilities, who might provide sliding fee scales for services.

## **Quality Management**

BPA Health is committed to providing quality programs and services to our members, and customers. As such, we place great emphasis on the quality of service delivered by our provider network. BPA Health considers each agency and provider to be an integral part of the network and expects each provider to participate in BPA Health's Provider Quality Assurance Plan. Further, any Clinical Record review is based on BPA Health's Clinical Practice Guidelines. These include For Cause reviews and audits.

The Provider Management Plan sets forth BPA Health's network specific quality standards along all lines of business to ensure members are receiving high quality care in safe treatment and service environments.

### **Quality Management Committee**

The Quality Management Committee (QMC) oversees the Quality Management program by providing an objective, systematic, and continuous process for assessing, monitoring, and improving the quality of all our functions, including the behavioral health services provided to members.

### **Scope of BPA Health Quality Management Committee**

- Providing guidance to staff on QM priorities and projects
- Maintaining the QM Program: annual review and making changes as needed
- Ensuring that appropriate training and resources are provided to the organization to achieve our quality aims
- Ensuring appropriate and effective credentialing function via oversight of Credentialing Committee
- Ensuring appropriate and effective utilization management via oversight of the Utilization Management Committee
- Ensuring appropriate and effective utilization and care management via advisory relationship with Clinical Leadership Council and Clinical Operations Team

- Working with Senior Leadership Team to identify and implement quality improvement projects based on issues related to Dimensions of Care and utilizing the Model of Continuous Improvement
- Reviewing critical incidents or critical quality of care concerns and development of action plans to address those as appropriate
- Developing and executing the QM Annual Work Plan
- Overseeing process for reporting adverse events, reportable quality issues (safety, ethics, appropriate clinical supervision, etc.) and suspension and termination from the BPA network to the appropriate agency such as state licensure boards, National Provider Data Bank, and any Accredited Organization

### **Record Reviews and Audits**

Network agreements require cooperation with record reviews and audits conducted by BPA Health.

Many BPA Health activities include the possibility or requirement of site and/or record reviews, including:

- Ongoing monitoring, including utilization management and claims reviews
- Quality of care concerns, including but not limited to professional competency and professional conduct concerns
- To verify compliance with shared contracts, addendums, fee schedules and rate matrices, or other contractually incorporated documents
- As required under a specific payor or program agreement.

Record reviews, visual inspections and/or audits may be conducted on-site in the provider's office, virtually, and through review of electronic or hard copy of documents supplied by the provider. Providers must supply copies of requested records to BPA Health within the specified timeframes. BPA Health utilizes HIPAA compliant software for providers to upload copies of records.

Clinical record reviews are conducted by BPA Health clinical staff. Other record reviews and/or audits are conducted by trained BPA Health staff. Tools used for routine audits are reviewed by BPA Health at least annually. BPA Health reserves the right to update, discontinue, implement, and/or replace tools at its discretion and without notice.

BPA Health will send the provider findings of record reviews and audits. If necessary, the findings will include notification of need for a corrective action plan to address deficiencies. Findings may include requirements of specific training topics and may specify if said trainings need to be live and/or interactive.

BPA Health can and will share records and findings with applicable payors as

required, or deemed appropriate by BPA Health leadership. Findings can include recommendations for trainings or corrective action plans.

## **Appendices**

### **Appendix A: Glossary**

The following terms used in the manual are defined as follows unless otherwise defined in the member's benefit program or coverage document. If a conflict exists between member's benefit program, the provider agreement and/or this manual, the conflict will be resolved as follows:

1. Member Benefit Program
2. The Provider Agreement
3. This Manual

#### **Terms and Acronyms:**

**42 CFR, Part 2:** The Federal confidentiality rules to protect the privacy of individuals who have received substance use disorder treatment by prohibiting unauthorized disclosures of records except under limited circumstances. 42 CFR, Part 2 is more restrictive with regards to disclosure than HIPAA.

**Access:** The ability to obtain available and medically necessary services when they are needed.

**Accreditation:** Process used by an accrediting entity or organization to recognize an individual or facility as meeting industry standards.

**Adverse Determination:** Determination by BPA Health that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet policy requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied or reduced

**Adverse Event:** An event, preventable or nonpreventable, that caused harm to a client. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death.

**American Society of Addiction Medicine (ASAM):** The ASAM criteria helps clinicians, counselors, and care managers develop patient-centered service plans and make objective decisions about patient admission, continuing care, and transfer/discharge for individuals with addictive, substance-related, and co-occurring conditions. Through their multidimensional assessment and the continuum of care, the criteria can improve patient outcomes. For more information go to: [asam.org](http://asam.org).

**Appeal:** A written or verbal request by a member, authorized representative or provider rendering services for further review of a decision made by BPA Health.

**Assessment:** The collection of data necessary to identify strengths and areas of concern. It should be used to develop an individualized treatment/service plan.

**Audit:** A review of member records, supervision and employee files, billing records, and overall facility safety to review the quality, effectiveness, and/or compliance with standards. May also be referred to as file review.

**Authorization/Authorized Services:** An authorization is an agreement that the service meets BPA Health clinical criteria. It is not a guarantee of payment. Payment is subject to member eligibility, provider licensure/certification, program provisions and benefit limits at the time that services are provided. Authorizations are provider and site specific.

**Authorization Change Request (ACR):** The documentation required to submit a utilization review for SUD funded services in WITS including initial clinical reviews, concurrent reviews, change to service request, request for a new service(s), and updates to an authorization span and/or units. Some ACRs require accompaniment of ASAM documentation in order for a clinical determination to be made by the UM team.

**Balance Billing:** The practice of billing a member the difference between the payment rates for authorized services agreed upon in the provider agreement and the provider's usual charge for the service(s).

**Basic Housing Essentials:** Basic housing essentials (bedding, towels, and hygiene items) are only available while a client is accessing Enhanced Safe and Sober Housing (ESSH). See rate matrix for additional limits. These can be requested by Mental Health Court, State Hospital, or the ESSH provider.

**Benefit Program:** Benefit Program shall mean (i) a managed care plan's written description of Covered Services and the conditions, limitations, and exclusions that apply including but not limited to the applicable utilization management and quality improvement requirements, and the financial incentives for Members to use Participating Providers, (ii) an Employee Assistance Program Services Contract defining eligibility requirements and scope of EAP services or (iii) an Administrative Services Agreement detailing the services provided to a group of individuals who qualify under certain demographic or clinical criteria.

**BPA Health Care Manager:** A healthcare professional delivering utilization management (UM) services defined as: evaluation of the medical necessity, appropriateness, and efficiency of use of health care services. Care Managers are also responsible for care coordination activities.

**Braided Funding:** SUD benefit program is available to qualifying member who also have Medicaid. See Rate Matrices for list of potential braided funding services.

**Case Management (CM):** Case management is a collaborative process that assesses, plans, links, coordinates, monitors, and advocates for options and services required to meet the member's health and human service needs.

**Case Management Plan:** Each member receiving case management services must have an individualized case management plan that includes strengths-based measurable SMART (Specific, Measurable, Attainable, Realistic, and Time specific) goals and treatment interventions to address, refer, or defer problems identified in the assessment(s). The case management plan can be combined with treatment plan into one service plan. The development of treatment, case management and service plans must be a collaborative process involving the member, qualified behavioral health professional(s), and other support and service systems.

**Certification (UM specific):** A determination that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit program.

**Change to Service (CTS):** Form in WITS utilized by SUD providers to attach ASAM clinical updates for BPA Care Managers to review.

**Charitable Choice:** Refers to United States government funding of faith-based organizations to provide social services. Per the Substance Abuse Block Grant (SABG), Substance Abuse and Mental Health Services Administration (SAMHSA) faith-based organizations that receive Federal funds must serve all eligible participants regardless of those persons' religious beliefs. In addition, recipients of services provided under Charitable Choice laws have the right to be provided with services from a non-religious provider.

**Client:** A user of services either managed or owned by BPA Health

**Clinical Supervisor (CS):** A clinician who meets BPA Health's qualifications for the licensure/certification, education, and work experience qualifications of clinical

supervisor.

**CMS-1500:** Billing form for EAP/SFAP/SWP providers. This may be uploaded and submitted to BPA Health using the [BPA Health claims form](#).

**Coinsurance:** The provision in some benefit programs requiring the member to pay a portion of the cost for covered services. This may be a fixed percentage or a set amount.

**Commission on Accreditation of Rehabilitation Facilities (CARF):** A private, not-for-profit organization that accredits health and human service programs across the continuum of care and across ages.

**Complaint:** Dissatisfaction communicated orally or in writing by a provider, member or his/her/its representative.

**Comprehensive Diagnostic Assessment (CDA):** An assessment completed by a clinician that meets all criteria in the [Idaho Behavioral Health Standards](#) on the IDHW website.

**Concurrent Review:** Utilization management conducted during a member's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review."

**Continued Stay Review:** Review of case to determine if the current level of care is still the most appropriate for the member.

**Continuous Quality Improvement (CQI):** The US Department of Health & Human Services defines as the systematic process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and improving program processes.

**Co-occurring Disorders (COD):** The occurrence of a mental health and substance use related disorder(s) as defined in the current DSM and diagnosed by someone with the licensed capacity to assess and diagnose. Also referred to as dual-diagnosis.

**Coordination of Care:** The process of coordinating care between behavioral health providers as well as with physical health care providers to improve quality of care and outcomes.

**Copayment:** The portion of a claim or expense that a member must pay out of

pocket.

**Corrective Action Plan (CAP):** A plan written by a provider to correct quality of care or contract compliance concerns. CAPs must be submitted to BPA Health for review and approval.

**Covered Services:** The services identified in the member's benefit program that have been authorized by a BPA Health. Such covered services shall be provided in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment. Covered services must be delivered in an ethical and professional manner, and in compliance with all applicable laws and regulation, including licensure and certification boards.

**CPT (Current Procedural Terminology):** Medical code set that is used to report medical and diagnostic procedures and services to entities such as health care professionals, insurance companies and accreditation organizations.

**Credentialing Committee:** The committee has the responsibility and authority for initial contracting and periodic review of the BPA Health provider network and determining if providers are meeting standards of care. The committee membership includes BPA Health staff and Medical Director, along with providers appointed by BPA Health.

**Critical Incident Response (CIR):** Requesting counselor to provide on-site services for members following a critical incident that impacts employer or student groups.

**Cultural Competence:** The capacity of the network to provide health services that are respectful and responsive to the health beliefs, practices, and needs of diverse patients. The U.S. Department of Health and Human Services provides information on [Culturally and Linguistically Appropriate Services \(CLAS\)](#) which can help close the gap in health inequities and improve care for all.

**Intake Specialists:** Intake Specialists are responsible for conducting initial telephonic screenings and determining eligibility for the substance use funding programs and counseling benefits, answering questions regarding service vouchers, service authorization, and triaging calls to the correct department for resolution.

**DSM (Diagnostic and Statistical Manual):** The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults including substance use disorders.

**DT:** Drug test

**Dual Diagnosis:** The occurrence of a mental health and substance use related disorder(s) as defined in the current DSM and diagnosed by someone with the licensed capacity to assess and diagnose. Also referred to as co-occurring disorder.

**EAP:** Employee Assistance Program

**EAP Management Referral:** Supervisor or HR requires an employee to seek assistance through the EAP for an assessment and possible treatment plan recommendations. Management Referrals may result from a positive drug-screen, serious policy violation, or if an employee exhibits unusual behavior in the workplace. BPA Health will need an Authorization for Use and Disclosure: Management Referral form signed by the employee prior to sending any requested reports of the employee's attendance or treatment plan compliance.

**Employee Assistance Program (EAP):** A benefit offered by some employers for a set number of free counseling appointments for employees and their family members. This program is designed to assist in the identification and resolution of issues at home and in the workplace such as stress, alcohol and drug use, legal and financial challenges and parenting issues. This is not a part of an employee's health insurance benefit.

**Enhanced Safe and Sober Housing (ESSH):** Temporary housing that enhances the therapeutic effect of the individual's substance use treatment and assists the individual in transitioning back into the community. ESSH Providers have staff onsite at all times, and employ QPs for clinical oversight and care coordination. The enrollment of additional network Enhanced Safe & Sober Houses is at the discretion of the State of Idaho applicable departments.

**Evidence-Based Programs or Practices (EBP):** Clinical programs and practices that research has shown to be effective in improving treatment outcomes.

**File Review:** A review of member charts to review the quality, effectiveness, and/or compliance with BPA Health and industry standards. May also be referred to as an audit.

**Fraud, Waste, and Abuse (FWA) Policy:** BPA Health's policy to protect the operational, financial and reputational interests of BPA Health, its employees, partners, customers, providers, members, and vendors.

**Global Assessment of Individual Needs (GAIN):** A SUD assessment tool. It is the

mandatory assessment for IDJC, IDOC and ISC funded members.

**HHS (U.S. Department of Health and Human Services):** The Department of Health and Human Services' mission is to enhance the health and well-being of all Americans by providing for effective health and human services and fostering sound, sustained advances in the sciences underlying medicine, public health and social services. <https://www.hhs.gov/>

**Health Insurance Portability and Accountability Act (HIPAA):** The HIPAA Privacy Act provides federal protections for individually identifiable health information held by covered entities and their business associates and gives members an array of rights with respect to that information. HIPAA permits the disclosure of health information needed for patient care and other important purposes. It specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

**IBADCC:** Idaho Board of Alcohol and Drug Counselor Certification

**ICD:** The international classification system which groups related diseases and procedures for the purpose of reporting statistical information. The current version is to be followed by providers.

**IDAPA:** The Idaho Administrative Procedures Act is a compilation of all final and temporary administrative rules affecting the citizens of Idaho that have been promulgated and adopted in accordance with the requirements of IDAPA.

**IDHW:** Idaho Department of Health & Welfare

**IDJC:** Idaho Department of Juvenile Corrections

**IDOC:** Idaho Department of Corrections

**IDOPL:** Idaho Division of Occupational and Professional Licenses. Previously referred to as IBOL, Idaho Bureau of Occupational Licenses.

**Intensive Out-Patient Program (IOP):** An organized non-residential service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a structured program, for a minimum of 9 hours of treatment per week for adults and 6 hours of treatment per week for adolescents (not including Recovery Support Services). **Note: See ASAM for more information on levels of care and Rate Matrix for any service limits.**

**IROC (Idaho's Response to the Opioid Crisis):** IROC is a funding opportunity provided by the SOR Grant, awarded to DBH by SAMHSA. It allows IDHW to dedicate funding to serving those who struggle with an OUD.

**ISC:** Idaho Supreme Court

**Legal and Financial Services:** Prepaid services offered to members with an EAP, SFAP, or SWP benefit. These services offer consultation at no charge to the member then a reduced fee if self-referred.

**Level of Care (LOC):** A level or modality of care is a step in the member's treatment process. A level of care includes clinical services, and may also include care coordination and recovery support services.

**Life Skills (LS):** Life Skills programs are non-clinical services designed to enhance personal and family skills for work and home, reduce marriage/family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community.

**LSI-R (Level of Service Inventory) Assessment:** A quantitative survey, used by IDOC, of offender attributes and offender situations relevant for making decisions about appropriate levels of supervision by IDOC and treatment.

**Management Services Contractor (MSC):** The organization (currently BPA Health) that contracts with IDHW's Division of Behavioral Health to manage the statewide delivery system of substance use clinical treatment and recovery support services.

**Manual:** This Provider Manual which describes the requirements and procedures applicable to providers in the BPA Health network and applicable payor programs.

**Medical Necessity:** Services justified as reasonable, necessary and/or appropriate, based on evidence-based clinical standards of care.

**Medication Assisted Treatment (MAT):** Prescribed medication for use in the treatment of addiction.

**Member:** Someone who is eligible for services managed or owned by BPA Health.

**National Practitioner Database (NPDB):** A web-based repository of reports containing information on medical malpractice payments and certain adverse

actions related to health care practitioners, providers, and suppliers.

**National Provider Identifier (NPI):** A unique 10-digit identification number for covered health care providers under HIPAA.

**Non-Certification:** A decision not to authorize care or services as requested based on the review of clinical and/or administrative information provided by the member or service provider, including service denials, reduction in service request, or termination of coverage.

**Note To Authorizer (NTA):** A type of Authorization Change Request that does not require clinical documentation.

**Not To Exceed (NTE):** Not to exceed service limits (within identified periods or per authorization) identified in the Rate Matrix.

**OM (out of matrix):** Under extenuating circumstances Partners may authorize services that fall outside of Rate Matrix. Providers must read authorization notes for details.

**Out-patient (OP):** An organized non-residential service, delivered in a variety of settings, in which addiction and mental health treatment personnel provide professionally directed evaluation and treatment for substance-related, addictive, and mental disorders. This also includes the services of an individual licensed practitioner (8 hours or less of treatment per week for adults and 5 hours or less of treatment per week for adolescents, not including RSS services). **Note: See ASAM for more information on levels of care and rate matrix for any service limits.**

**OUD:** Opioid Use Disorder

**Personally Identifiable Information (PII):** Any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means

**Partners:** An organization such as a state, department of a state, business, charity, etc. that BPA Health conducts business with or for on a contractual basis

**Peer Clinical Review:** A review conducted by an appropriate clinical health professional, after an initial request for care or services has resulted in a non-certification. Peer clinical review is also known as a "second level review."

**Pre-Authorization:** An approval process prior to provision of services. Authorizations are dependent upon eligibility and specifics of member's benefit

program.

**Program Fees:** SSH providers may collect approved program fees in accordance with rate matrix.

**Prospective Review:** Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). This is often called "pre-certification review" or "prior authorization."

**Protected Health Information (PHI):** A member's 'individual identifiable health information' as defined in 45 C.F.R. and 42 C.F.R. § 160.103 and/or applicable state law.

**Provider:** Anyone contracted to perform service with or for BPA Health. A hospital, facility, clinic, health care professional, or group of health or behavioral health professionals who provide a service to health plan or payor members

**Provider Agreement:** The contract between BPA Health and the provider which includes the terms, conditions, and responsibilities of both BPA Health and the provider.

**Provider Services (PS):** The Provider Services department at BPA Health. Manages credentialing and recredentialing activities. Contact this team to discuss contracts, compliance, and location service profiles.

**PWID:** Persons who inject drugs receiving block grant funded SUD services.

**QP:** Qualified Substance Use Disorder Professional as defined in IDAPA 16.07.17.

**Rate Matrix:** Reimbursement and CPT code schedule for all SUD benefit program streams including frequency, duration, and maximum allowable services.

**Recoupment:** Process of repaying claims for items of over payment, incomplete billing, unsubstantiated billing, or other concerns where payment(s) in excess of authorized and appropriate payments have been made.

**Recovery Coach (RC):** A personal guide and mentor for people seeking or in recovery. The Recovery Coach helps to remove barriers and obstacles, and links the recovering person to the recovery community. Recovery Coaches can act as a mentor, ally, role model, motivator, problem solver, resource broker, advocate, and/or community organizer.

**Recovery Support Service (RSS):** Approved non-clinical SUD services designed to engage and maximize the ability of eligible recipients to be successful in their recovery, and to live productively in the community. Recovery Support Services are initiated with the member at the earliest possible point in the individual planning and service delivery process.

**Release of Information (ROI):** Required documentation signed by the member and/or representative for the release of specifically identified information. Must include 42 CFR, Part 2 and HIPAA regulations.

**Retrospective Review:** Utilization management conducted following the provision of services. This includes outpatient procedures and services.

**SABG (Substance Abuse Block Grant):** Provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 pacific jurisdictions, and 1 tribal entity to prevent and treat substance abuse. See Appendix 2 for benefit program requirements.

**SAMHSA (Substance Abuse and Mental Health Services Administration):** The Federal agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Website: <http://www.samhsa.gov>.

**Separate Incident:** A separate and unrelated problem identified during the (EAP/SFAP/SWP) members Program Year will be considered a separate incident. Members may request additional sessions if there is a separate incident.

**Service Plan:** A combined treatment and case management plan.

**SOR (State Opioid Response):** Idaho's State Opioid Response grant

**SSH (Safe and Sober Housing):** Temporary housing that enhances the therapeutic effect of the individual's substance use treatment and assists the individual in transitioning back into the community.

**Staffing (planned facilitation):** Staffing (planned facilitation) is to be used by professional staff for collaboration with external collateral sources.

**Student and Family Assistance Program (SFAP):** A school district sponsored program designed to provide short-term solution focused therapy to students K-12 and their family to reduce absenteeism and other harmful behaviors, or work through any personal issue that is a barrier to the student's personal and

academic success.

**Student Wellness Program (SWP):** Available to enrolled students at the higher education levels (college universities, trade school, technical schools, etc.). Family and dependents are not eligible. These students also have access to legal, financial, and work/life services. This program is designed to provide short-term and solution-focused assistance for these students.

**SUD:** Substance Use Disorder(s) as defined in DSM

**Telehealth:** HealthIT.gov defines as the use of electronic information and telecommunications technology to support and promote long-distance clinical health care, member and professional health-related education, public health, and health administration. Telehealth platforms must be HIPAA compliant and providers must follow their state and federal telehealth guidelines.

**Treatment Plan:** Each member must have an individualized treatment plan that includes strengths-based measurable SMART (Specific, Measurable, Attainable, Realistic, and Time specific) goals and evidence-based treatment interventions (including frequency of interventions/services) to address, refer, or defer problems identified in the assessment(s). For members who are also receiving case management services their treatment plan can be combined with a case management plan into one service plan. The development of treatment, case management and service plans must be a collaborative process involving the member, qualified behavioral health professional(s), and other support and service systems.

**UCN (Unique Client Number):** WITS-generated unique identification number to identify clients (members) within WITS.

**Urgent:** A situation in which immediate care is not needed for stabilization, but if not addressed in a timely manner could escalate.

**Utilization Management:** Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. Utilization management encompasses prospective, concurrent and retrospective review; it does not include claims review, even if the organization chooses to conduct utilization review on a claims submission, unless a specific request from the claimant for retrospective review accompanies the claims submission.

**Utilization Review:** A formal evaluation of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

**Website:** BPA Health's website - <http://www.bpahealth.com>.

**Wellness Recovery Action Plan (WRAP):** a written plan created by the member, with the support of Recovery Coach, that can help guide the member through the process of identifying their personal wellness resources and how to use them as a guide in daily living, dealing with triggers, early warning signs of symptoms and indicators that things are breaking down, and developing advance directive and post crisis plans.

**WITS (Web Infrastructure for Treatment Services):** WITS is a web-based application and database that serves dual purposes, a management information system (MIS) and clinical documentation tool. As an MIS tool, the system allows the Division of Behavioral Health to meet current and emerging state and federal reporting requirements. As a clinical documentation tool, WITS provides an agency the ability to create a full electronic health record compliant with HIPAA and 42-CFR part II standards.

**Appendix B: Insurance Requirements for BPA Health Network Providers**

Provider Type	Type(s) and Coverage Limits
EAP	<b>Professional Liability/Malpractice:</b> \$1 mill per occurrence & \$3 mill per aggregate
SUD Treatment	<b>General Commercial Liability:</b> \$ 1 mil per occurrence & \$3 mill per aggregate <b>Professional Liability/Malpractice:</b> \$1 mill per occurrence & \$3 mill per aggregate
Case Management (SUD RSS)	<b>General Commercial Liability:</b> \$ 1 mil per occurrence & \$3 mill per aggregate <b>Professional Liability/Malpractice:</b> \$1 mill per occurrence & \$3 mill per aggregate
Recovery Coaching (SUD RSS)	<b>General Commercial Liability:</b> \$ 1 mil per occurrence & \$3 mill per aggregate <b>Professional Liability/Malpractice:</b> \$1 mill per occurrence & \$3 mill per aggregate
Life Skills (SUD RSS)	<b>General Commercial Liability:</b> \$1 mill per occurrence & \$3 mill per aggregate
Drug Testing (SUD RSS)	<b>General Commercial Liability:</b> \$1 mill per occurrence & \$1 mill per aggregate
SSH (SUD RSS)	<b>General Commercial Liability:</b> \$1 mill per occurrence & \$2 mill per aggregate
Child Care (SUD RSS)	<b>General Commercial Liability:</b> \$1 mill per occurrence & \$3 mill per aggregate
Transportation – company owned, commercial, or contracted vehicles (SUD RSS)	<b>Auto Liability:</b> \$500,000 per occurrence & \$500,000 per aggregate
Transportation – privately owned vehicles not used for sole purpose of transporting members (SUD RSS)	<b>Auto Liability:</b> Must show proof of minimum auto insurance coverage required by Idaho law for each vehicle used. When the program permits an employee to transport participants in an employee’s personal vehicle the program must ensure that employee(s) auto insurance coverage covers use for those services.

**Appendix C: Release of Information (Sample)**

**Agency name, address, phone**

**AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ authorize [enter Agency name] to:  
(Client Name or Parent/guardian of client)

\_\_\_\_ Release to: \_\_\_\_\_ Exchange with:

\_\_\_\_\_  
(Name of Agency or Individual) (Address)

the following information pertaining to \_\_\_\_\_  
(Client Name) (Date of Birth)

(initial all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Substance Abuse Records        | <input type="checkbox"/> Medication Records           |
| <input type="checkbox"/> Case Management Records        | <input type="checkbox"/> History & Physical Exam      |
| <input type="checkbox"/> Recovery Support Services      | <input type="checkbox"/> Medical Record               |
| <input type="checkbox"/> Substance Abuse Assessment     | <input type="checkbox"/> HIV/AIDS Related Information |
| <input type="checkbox"/> Treatment Plan                 | <input type="checkbox"/> Legal Services               |
| <input type="checkbox"/> Psychiatric Evaluation         | <input type="checkbox"/> Court Related Information    |
| <input type="checkbox"/> Mental Health Records          | <input type="checkbox"/> Admission/Discharge Summary  |
| <input type="checkbox"/> Progress Reports               | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Laboratory Data (Drug Testing) |   |

for the purpose of (initial all that apply):

- Care Coordination
- Other: \_\_\_\_\_  
(Be as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: \_\_\_\_\_  
(Date or event)

I also understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Appendix D: Behavioral Health Documentation Standards**

<b>STANDARD</b>	
<b>A. TREATMENT RECORD-KEEPING PRACTICES</b>	
1	Documentation is legible.
2	Client demographic information is documented (name, date of birth, address, telephone number, marital status and spouse's name, and guardianship if relevant)
3	Paper records include <i>client's</i> name or unique identifier on every page.
4	Informed consent
5	Individualized note for each billed service/session. Notes should include content of session, and <i>client's</i> progress towards goals.
6	All entries are signed and dated by author and include credentials. Electronic signatures are permitted in EHRs.
<b>B. ASSESSMENT (THIS INFORMATION CAN BE GATHERED USING ASSESSMENT TOOL(S), INTAKE PAPERWORK, OR DURING CLINICAL INTERVIEW)</b>	
7	Presenting problem including history, any current symptoms and behaviors.
8	Past behavioral health treatment history including any psychiatric hospitalizations and residential programs.
9	Medical history, including any significant illnesses or conditions, name of current physician(s), current medications, and any known allergies.
10	For children and adolescents, a developmental history that includes prenatal, and perinatal events, physical, psychological, social, intellectual, and educational history.
11	Risk assessment for suicidal and homicidal thoughts.
12	History of and risk assessment for victimization and/or trauma.
13	Additional assessments completed or updated if symptoms or presenting problems change.
14	Diagnosis consistent with assessment.
<b>C. TREATMENT AND DISCHARGE PLAN</b>	
15	Individualized treatment plan developed in collaboration with the client within the first five (5) sessions.
16	Dates and signatures of <i>client</i> , clinician, and when appropriate, significant others involved in client's care, and guardian on all plans and updates.

17	The discharge summary includes the client's status at the beginning and end of treatment, as well as summary of any referrals that may have been provided at discharge. This is to be completed by clinician within 15 days following known discharge or 45 days of inactivity.
----	---

## Appendix E: Important Resources

Name/Link	Type	Payor/Program	Purpose
<a href="#">Complaints Submission Form</a>	BPA Health Form	All	
<a href="#">Fraud Waste and Abuse Reporting</a>	Third Party Website	All	Use Company ID: BPAHealth
<a href="#">Member Rights and Responsibilities</a>	Sample Form	All	
<a href="#">Appeal Submission Form</a>	BPA Health Form	All	Non-certification or payment denial
<a href="#">Cultural Competence</a>	Self Assessment	All	
<a href="#">Provider Network and Credentialing Committee Decision Appeal</a>	BPA Health Form	All	Appeals submission
<a href="#">Availability Updates</a>	BPA Health Form	BPA Health	Advise BPA Health staff of availability
<a href="#">Claims Submission Form</a>	BPA Health Form	BPA Health	EAP Behavioral Health Billing Form
<a href="#">CMS Standard Claim Form</a>	Third Party Website	BPA Health	We accept the standard Medicare 1500 Claim Form
<a href="#">Service and Office Operations Updates</a>	BPA Health Form	BPA Health	Adjust specialty and hours of operation listings.
<a href="#">American Psychological Association</a>	Third Party Website	N/A - Informational	
<a href="#">Hearing and Speech Impaired Interpreter Services</a>	Third Party Website	N/A - Informational	
<a href="#">SAMHSA</a>	Third Party Website	N/A - Informational	
<a href="#">IDOC Status Report</a>	Third Party Website	State of Idaho SUD	Case communication with Probation & Parole
<a href="#">Idaho Behavioral Health Standards</a>	Third Party Website	State of Idaho SUD	
<a href="#">Idaho Criminal History Unit</a>	Third Party Website	State of Idaho SUD	Idaho Background Check Entity
<a href="#">Client Record Review Submission</a>	BPA Health Form	State of Idaho SUD	For information that can't be consented through WITS
<a href="#">Service and Office Operations Updates</a>	BPA Health Form	State of Idaho SUD	
<a href="#">SUD Staff Updates</a>	BPA Health Form	State of Idaho SUD	
<a href="#">Safe and Sober Housing Code of Ethics</a>	BPA Health Form	State of Idaho SUD	
<a href="#">WITS Website</a>	Third Party Website	State of Idaho SUD	Billing for State of Idaho payor program

# Appendix F: EAP/SFAP/SWP Audit Tool

## BPA HEALTH

### EAP/SFAP/SWP PROVIDER AUDIT

Provider Name:	<input type="text"/>	Review Date:	<input type="text"/>
Provider License:	<input type="text"/>	Reviewer Name:	<input type="text"/>
City:	<input type="text"/>	Reviewer License:	<input type="text"/>
State:	<input type="text"/>	Review Type*:	<input type="text"/>
*If review due to "other," describe: <input type="text"/>			

**SCORES**

	Score	Poss.
Facility Review	0	2
File 1 Review	0	20
File 2 Review	0	20
File 3 Review	0	20
Totals	0	62
Final Score:	0%	

Comments and any concerns not mentioned below

**Facility Review**

**Telehealth Services?**

Facility Requirements and Scoring (Provider attestation, complaints may require on-site visits for verification)		Evidence?	Points Scored	Total Possible
1	Attestation that HIPAA compliant telehealth software is being utilized (Scoring: Yes = 1, No/NA = 0)		0	
2	Accessible parking for individuals with physical disabilities. NA if exclusively telehealth. (Scoring: Yes = 1, No/NA = 0)		0	
3	Accessible entrance to office for individuals with physical disabilities. NA if exclusively telehealth. (Scoring: Yes = 1, No/NA = 0)		0	
4	Accessible restroom for individuals with physical disabilities. NA if exclusively telehealth. (Scoring: Yes = 1, No/NA = 0)		0	
5	Charged fire extinguisher in office. Verify date. (Scoring: Yes = 1, No = 0)		0	1
6	Member/client records are protected from public access in locked file cabinets, or if electronic, are encrypted/in HIPAA compliant program. (Scoring: Yes = 1, No = 0)		0	1

# BPA HEALTH

Comments and any concerns not mentioned above for Facility Review.

## BPA HEALTH

FILE 1 REVIEW		Member Name:	Dates of Service:	
Treatment Record Requirements and Scoring		Evidence ?	Points Scored	Total Possible
1	Chart includes Member/Client Name, Address and contact phone number(s). (Scoring: Yes = 2 points if record includes name, address AND phone, 0 if any missing)	0	0	2
2	Chart includes signed copy of Informed Consent (includes limits of confidentiality and, if applicable telehealth). (Scoring: Yes = 1 point, Missing/incomplete = 0)	0	0	1
3	Chart includes acknowledgement of review of Notice of Privacy Practices. (Scoring: Yes = 1, No = 0)	0	0	1
4	Chart includes signed release(s) of information, as applicable. (Scoring: Yes = 1, No/incomplete/NA = 0)	0	0	1
5	Documentation/progress note for each billed session being reviewed that includes at a minimum date, client name, intervention utilized, provider signature and credentials. (Scoring: Yes = 4 points per session note if contains all elements, Partial/3-4 elements = 2 points per note, No = 0 for each missing or incomplete note)	0	0	12
6	Documentation of presenting problem/reason for being seen (i.e. in assessment, initial progress note, or treatment plan). (Scoring: Yes = 1, No = 0)	0	0	1
7	Documentation of assessment. This may be in the form of a biopsychosocial intake, or other clinical assessment tool. (Scoring: Yes = 1, No = 0)	0	0	1
8	Assessment of risk of harm to self or others. (Scoring: Yes = 1, No = 0)	0	0	1
9	If assessment indicated risk of harm, documentation of safety planning and other steps taken. (Scoring: Yes = 1, No or NA = 0)	0	0	1
10	If client has been seen more than once, documentation of plan with goals, objectives and interventions developed with and agreed to by client (Scoring: Yes = 1, No or NA = 0)	0	0	1
11	Documentation of outcome of case following utilization of authorized sessions. (Scoring: Yes = 1, No or NA/not yet closed = 0)	0	0	1
12	If additional services needed, documentation of referrals provided and which the client chose. (Scoring: Yes = 1, No or NA = 0)	0	0	1
13	If client is a mandatory referral, documentation that reports were submitted on-time. (Scoring: Yes = 1, No or NA = 0)	0	0	1
14	Documentation legible and easy to follow? (Scoring: Yes = 1, No = 0)	0	0	1
<b>File 1 Total</b>			<b>0</b>	<b>20</b>

Comments and any concerns not mentioned above for File 1:

## BPA HEALTH



## BPA HEALTH

FILE 2 REVIEW		Member Name:	Dates of Service:		
Treatment Record Requirements and Scoring			Evidence?	Points Scored	Total Possible
1	Chart includes Member/Client Name, Address and contact phone number(s). (Scoring: Yes = 2 points if record includes name, address AND phone, 0 if any missing)		0	2	
2	Chart includes signed copy of Informed Consent (includes limits of confidentiality and, if applicable telehealth). (Scoring: Yes = 1 point, Missing/incomplete = 0)		0	1	
3	Chart includes acknowledgement of review of Notice of Privacy Practices. (Scoring: Yes = 1, No = 0)		0	1	
4	Chart includes signed release(s) of information, as applicable. (Scoring: Yes = 1, No/incomplete/NA = 0)		0		
5	Documentation/progress note for each billed session being reviewed that includes at a minimum date, client name, intervention utilized, provider signature and credentials. (Scoring: Yes = 4 points per session note if contains all elements, Partial/3-4 elements = 2 points per note, No = 0 for each missing or incomplete note)				12
6	Documentation of presenting problem/reason for being seen (i.e. in assessment, initial progress note, or treatment plan). (Scoring: Yes = 1, No = 0)		0	1	
7	Documentation of assessment. This may be in the form of a biopsychosocial intake, or other clinical assessment tool. (Scoring: Yes = 1, No = 0)		0	1	
8	Assessment of risk of harm to self or others. (Scoring: Yes = 1, No = 0)		0	1	
9	If assessment indicated risk of harm, documentation of safety planning and other steps taken. (Scoring: Yes = 1, No or NA= 0)		0		
10	If client has been seen more than once, documentation of plan with goals, objectives and interventions developed with and agreed to by client (Scoring: Yes = 1, No or NA = 0)		0		
11	Documentation of outcome of case following utilization of authorized sessions. (Scoring: Yes = 1, No or NA/not yet closed = 0)		0		
12	If additional services needed, documentation of referrals provided and which the client chose. (Scoring: Yes = 1, No or NA = 0)		0		
13	If client is a mandatory referral, documentation that reports were submitted on-time. (Scoring: Yes = 1, No or NA = 0)		0		
14	Documentation legible and easy to follow? (Scoring: Yes = 1, No = 0)		0	1	
<b>File 2 Total</b>				<b>0</b>	<b>20</b>

Comments and any concerns not mentioned above for File 2:

**BPA HEALTH**

[Empty rectangular box]





## BPA HEALTH

FILE 3 REVIEW		Member Name:	Dates of Service:		
Treatment Record Requirements and Scoring			Evidence?	Points Scored	Total Possible
1	Chart includes Member/Client Name, Address and contact phone number(s). (Scoring: Yes = 2 points if record includes name, address AND phone, 0 if any missing)			0	2
2	Chart includes signed copy of Informed Consent (includes limits of confidentiality and, if applicable telehealth). (Scoring: Yes = 1 point, Missing/incomplete = 0)			0	1
3	Chart includes acknowledgement of review of Notice of Privacy Practices. (Scoring: Yes = 1, No = 0)			0	1
4	Chart includes signed release(s) of information, as applicable. (Scoring: Yes = 1, No/incomplete/NA = 0)			0	
5	Documentation/progress note for each billed session being reviewed that includes at a minimum date, client name, intervention utilized, provider signature and credentials. (Scoring: Yes = 4 points per session note if contains all elements, Partial/3-4 elements = 2 points per note, No = 0 for each missing or incomplete note)				12
6	Documentation of presenting problem/reason for being seen (i.e. in assessment, initial progress note, or treatment plan). (Scoring: Yes = 1, No = 0)			0	1
7	Documentation of assessment. This may be in the form of a biopsychosocial intake, or other clinical assessment tool. (Scoring: Yes = 1, No = 0)			0	1
8	Assessment of risk of harm to self or others. (Scoring: Yes = 1, No = 0)			0	1
9	If assessment indicated risk of harm, documentation of safety planning and other steps taken. (Scoring: Yes = 1, No or NA = 0)			0	
10	If client has been seen more than once, documentation of plan with goals, objectives and interventions developed with and agreed to by client (Scoring: Yes = 1, No or NA = 0)			0	
11	Documentation of outcome of case following utilization of authorized sessions. (Scoring: Yes = 1, No or NA/not yet closed = 0)			0	
12	If additional services needed, documentation of referrals provided and which the client chose. (Scoring: Yes = 1, No or NA = 0)			0	
13	If client is a mandatory referral, documentation that reports were submitted on-time. (Scoring: Yes = 1, No or NA = 0)			0	
14	Documentation legible and easy to follow? (Scoring: Yes = 1, No = 0)			0	1
<b>File 3 Total</b>				<b>0</b>	<b>20</b>

Comments and any concerns not mentioned above for File 3:

# BPA HEALTH



# Appendix SUD1: Case Management Assessment (Sample)

## Case Management Assessment

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Who will help me with my sobriety?

Who will help me when I need a ride, financial help, or that I can turn to when feeling overwhelmed?

My skills and strengths I have learned throughout my lifetime thus far include:

Please check all the areas that have been identified as focus of possible assistance

### EDUCATION

GED     Vocational     College     Other \_\_\_\_\_

### EMPLOYMENT

Job Search     Applications     Cover Letters and Resume  
 Interviewing     Interview Clothing/Uniforms  
 Other \_\_\_\_\_

### HEALTH CARE

Medical Insurance/ Medicaid/Healthcare Exchange     Disability Application  
 Physician     Prescription assistance     Dental     Vision  
 Mental health counseling     Other \_\_\_\_\_

### FINANCIAL

Budgeting     Banking     Balance check book  
 TAFI     Consumer Credit Services

Other \_\_\_\_\_

**TRANSPORTATION**

Bus tokens       Driver's License       Insurance  
 Transportation providers       Other \_\_\_\_\_

**HOUSING**

Emergency / Temporary Housing       Adult Safe and Sober Housing  
 Subsidized Housing       Deposits       Utilities  
 Other \_\_\_\_\_

**BASIC NEEDS**

Food stamps       Food bank       WIC       Clothing  
 Other \_\_\_\_\_

**CHILDREN**

WIC       Formula       Diapers       Childcare       Immunizations  
 School supplies/fees       Clothing       Parenting  
 Other \_\_\_\_\_

**LEGAL**

Legal Aid       Other \_\_\_\_\_

**MISCELLANEOUS**

Time Management       Hobbies       Support Groups  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_

Client Signature/Date: \_\_\_\_\_

Case Manager Signature/Date: \_\_\_\_\_

## Appendix SUD2: Service, Treatment or Case Management Plan (Sample)

Provider Name/Location \_\_\_\_\_  
 Comprehensive Service, Treatment or Case Management Plan

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Strengths:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Directions:** All problems identified in assessment(s) must be addressed, referred, or deferred with justification. When appropriate, plans should include involvement of family and/or social supports. All plan should include building social support networks in dimension 6. Use the following grid for each of the six dimensions.

Dimension \_\_\_\_\_

Problem(s):	List all problems, needs and concerns identified for this dimension in assessment	Expected Completion Date	Review Date	Completion Date
Goal: <b>1</b>	SMART goal addressing problem. Include expected completion date.			
Objective(s): <b>1</b>	List all measurable objectives that will lead to goal attainment. Include frequency and expected completion dates for each objective.			
Intervention(s): <b>a</b>	List all interventions that provider will be offering to assist in goal attainment. Include frequency, expected completion date and when applicable, EBPs being provided for each intervention.			

**Updates:** include date of review, status of goals/objectives/and interventions, as well as any changes to plan if not attained by expected completion date.

**Discharge Criteria**

**Projected Discharge Date:** \_\_\_\_\_

(Measurable indicators that client is ready for discharge from services):

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Recovery Planning Team:**

(Who participated in the development of this service plan with the client: family, social supports, clinician, case manager, other service systems)

- 1.
- 2.
- 3.

These services have been agreed upon with the client and/or his/her/their Parent/Guardian and are deemed clinically necessary to facilitate this client's recovery.

I, \_\_\_\_\_, the client for whom this Service Plan was created, was involved with development and agree with the Plan content. I am aware that I have the freedom of choice among any qualified providers of services that I may receive as under the guidelines of this plan.

**By signing this document, I indicate that I was actively involved in its development and that I received a copy for my records.**

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (if required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician (Name and credentials)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Manager (Name and credentials)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinical Supervisor (Name and credentials)

\_\_\_\_\_  
Date

**Appendix SUD3: Additional Treatment Provider Documentation Standards**

<b>STANDARD</b>	
<b>A. TREATMENT RECORD-KEEPING PRACTICES</b>	
1	Documentation is legible.
2	Client demographic information is documented (name, date of birth, address, telephone number, marital status and spouse's name, and guardianship if relevant)
3	Paper records include client's name or unique identifier on every page.
4	Informed consent
5	Individualized encounter note for each billed service/session. Notes should include content of session, and client's progress towards goals. Group notes should include EBP utilized.
6	All entries are signed and dated by author and include credentials. Electronic signatures are permitted in EHRs.
<b>B. ASSESSMENT (THESE REQUIRED ELEMENTS MAY BE COMBINED IN ONE OR MORE ASSESSMENT TOOLS)</b>	
7	SUD providers are required to use these specific assessments: CDA including ASAM dimensions for IDHW SUD funded treatment, or GAIN for IDOC, IDJC, and ISC funded SUD treatment services.
8	Presenting problem including history, current symptoms and behaviors.
9	Past behavioral health treatment history including any psychiatric hospitalizations and residential programs.
10	Medical history, including any significant illnesses or conditions, name of current physician(s), current medications, and any known allergies.
11	Risk assessment for suicidal and homicidal thoughts.
12	History of and risk assessment for victimization and/or trauma.
13	Substance use assessment for those over the age of 12, including substance used, amount, frequency, route, and any prior treatment history.
14	For children and adolescents, a developmental history that includes prenatal, and perinatal events, physical, psychological, social, intellectual, and educational history.
15	Additional assessments completed or updated if symptoms or presenting problems change.

**C. TREATMENT/SERVICE PLANS**

16	Diagnosis consistent with assessment
17	Plans completed within the following time frames: 72 hours or 30 days outpatient and intensive outpatient.
18	Evidence that the treatment plan is individualized and was developed in collaboration with the client, and when appropriate, with significant others, family members and/or other service providers.
19	Plan is strengths based and addresses, refers, or defers all needs identified in the assessment(s). For IDOC and ISC funded clients SUD provider must also consider LSI-R assessment completed by IDOC.
20	SMART (specific, measurable, attainable, realistic and time limited) goals and objectives
21	Evidence-based interventions, including the frequency of each intervention/service
22	Reflects active involvement of the client, and when appropriate, significant others
23	Includes discharge planning from time of admission and measurable discharge criteria (for EAP providers this may mean ongoing assessment to determine if further treatment beyond EAP sessions are needed)
24	Plan is updated as changes occur and at a minimum of every 90 days for OP/IOP and every 14 days for residential levels of care. Updates should include documentation of progress and if lack of progress any necessary changes to improve outcomes.
25	Dates and signatures of client, clinician, and when appropriate, significant others involved in client's care, and guardian on all plans and updates.

**D. DISCHARGE SUMMARY**

26	The discharge summary includes the client's status at the beginning of treatment, the progress made in each dimension, the status at the end of treatment, and a summary of referrals or services to be provided after discharge. This is to be completed in WITS by clinician within 15 days following known discharge or 30 days of inactivity.
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**E. COORDINATION OF CARE**

27	ROIs for all persons and organizations that the clinician is collaborating with to ensure quality care (e.g., physician, RSS providers, POs, other service providers), as well as one for an emergency contact and the required IDHW General Release form. ROIs must meet HIPAA and 42 CFR Part 2 standards.
28	Documentation of all coordination of care activities that occurred, including dates, method and what was discussed.

**F. ADDITIONAL BENEFIT PROGRAM SPECIFIC REQUIREMENTS**

29	Education on the increased risk for HIV, TB, and other infectious diseases if using illicit substances and referrals for testing.
30	Random drug and alcohol testing.
31	Halfway House <u>(ASAM Level 3.1)</u> providers must maintain documentation that client was in the house on all dates billed. This
32	Maintain prescriber and pharmacy invoices for clients receiving SUD funded MAT services.

**Appendix SUD4: Additionnel RSS Provider Documentation**

<b>RSS PROVIDERS</b>	
<b>A. RECORD-KEEPING PRACTICES (ALL RSS PROVIDERS)</b>	
1	Documentation is legible.
2	Client demographic information is documented
3	Paper records include client's name or unique identifier on every page.
4	Individualized encounter note for each billed service/session. Notes should include content of session, and client's progress towards goals.
5	ROIs for all persons and organizations that the RSS provider is collaborating with to ensure quality care (e.g. physician, other RSS providers, POs, clinician, other service providers) as well as one for an emergency contact and the require IDHW General Release. ROIs must meet HIPAA and 42 CFR Part 2 standards.
6	Documentation of all coordination of care activities that occurred, including dates, method and what was discussed.
7	All entries are signed and dated by author and include any credentials. Electronic signatures are permitted in EHRs.
8	Discharge completed in WITS by within 15 days following known discharge or 30 days of inactivity.
<b>CASE MANAGEMENT PROVIDERS (IN ADDITION TO SECTION A)</b>	
1	Case Management Assessment completed within 30 days of first appointment.
2	Case Management Assessment includes at a minimum medical, social, psychosocial, legal, educational, housing and financial needs of the client as well as any barriers to accessing treatment.
3	Completed case management plan within 14 days of assessment. This plan may be incorporated with treatment plan.
4	Evidence that the case management plan is individualized and was developed in collaboration with the client, and when appropriate, with significant others, family members and/or other service providers.
5	Case management plan is strengths based and addresses, refers, or defers all needs identified in the assessment(s).

8	Case management plan includes SMART (specific, measurable, attainable, realistic and time limited) goals and objectives and Interventions and includes the frequency of each intervention/service and how it will be monitored
7	Case management plan reflects active involvement of the client, and when appropriate, significant others
8	Case management plan is updated as changes occur and at a minimum of every 90 days. Updates should include documentation of progress and if lack of progress any necessary changes to improve outcomes.
9	Dates and signatures of client, case manager, and when appropriate, significant others involved in client's care, and guardian should be on all plans and updates. If plan is combined with treatment plan, must also have clinician's signature.
<b>CHILD CARE PROVIDERS (IN ADDITION TO SECTION A)</b>	
1	Sign-in sheet for each billed service. The sheet must include date and time in and out, child(ren) name and ages, parent name, and where parent was during service. This does not need to be kept in individual client files. It does need to be maintained for seven (7) years.
<b>DRUG AND ALCOHOL TESTING PROVIDERS (IN ADDITION TO SECTION A)</b>	
1	Documentation that results of tests and no-shows are shared with clinician, SUD treatment provider and/or case manager.
<b>RECOVERY COACH PROVIDERS (IN ADDITION TO SECTION A)</b>	
1	Completed Wellness Recovery Action Plan (WRAP) within 30 days of first visit. The WRAP must be updated at least every ninety (90) days. Wellness Recovery Action Planning is a collaborative process that should be completed with the client, taking into consideration the client's strengths, needs, and culture.
2	Dates and signatures of client and Recovery Coach should be on all plans and updates.
<b>SAFE AND SOBER HOUSING PROVIDERS (IN ADDITION TO SECTION A)</b>	
1	Safe and Sober Housing providers must maintain documentation that client was in the house on all dates billed. Client file must be maintained for seven (7) years. (An exception is made for IDOC funded client's whose PO may grant up to a three day leave of absence. This must be documented in the client file).
<b>TRANSPORTATION PROVIDERS (IN ADDITION TO SECTION A)</b>	

1	Documentation of dates of pick-up and drop-off, miles driven. This does not need to be in individual client files. It does need to be maintained for seven (7) years.
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## **Appendix SUD5: SABG Requirements**

These regulations apply to substance abuse treatment funded services. In addition to the provider responsibilities below, BPA Health also has responsibilities including monitoring network for capacity and waitlist management (when needed) and referrals for interim services for those on waitlists.

Services for Individuals with Co-occurring Disorders [42 USC § 300x-66]

If the provider uses MHBG or SABG funds for treatment of individuals with co-occurring mental health and substance use disorders, it can demonstrate that such funds are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.

### **Tuberculosis Requirements and Definitions [42 U.S.C. §300x-24(a), 45 C.F.R. §96.121 and 45 C.F.R. §96.127]**

The provider directly or through arrangements with other public or nonprofit private entities, routinely make available the following TB services to each individual receiving treatment for substance use:

- Counseling the individual with respect to TB
- Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual
- Appropriate medical evaluation and treatment for individuals infected by mycobacterial TB

For clients denied admission to the program on the basis of lack of capacity, the program refers to such clients to other providers of TB services.

The provider has implemented infection control procedures that are consistent with those established by the District Health Department to prevent the transmission of TB and that address the following:

- Screening patients and identifying those individuals who are at high risk of becoming infected
- Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR Part 2
- Case management activities to ensure that individuals receive such services

The provider reports all individuals with active TB to the District Health Department as required by State law and in accordance with Federal and State confidentiality requirements, including 42 CFR Part 2.

**Capacity of Treatment for Intravenous Drug Users [42 U.S.C. §300x-23 and 45 C.F.R. §96.126]**

Within 7 days of reaching 90% of its treatment capacity, the provider notifies the BPA Health within 7 days of reaching 90% of its treatment capacity.

The provider admits each individual who requests and is in need of treatment for intravenous drug abuse up to its capacity:

- Not later than 14 calendar days after making the request, or
- Notifies BPA Health who may authorize services to another agency, or if necessary, offer immediate community resources and place client on wait list until they can be admitted into care.

The provider carries out activities to encourage individuals in need of treatment services for intravenous drug use to undergo such treatments by using scientifically sound outreach models such as those outlines below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:

- The standard intervention model as describe in the NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)
- The health education model as described in Rhodes, F., Humfleet, G.L. et al., AIDS Intervention Program for Injection Drug Users: Intervention Manual, (Feb. 1992)
- The indigenous leader model as described in Wiebel, W., Levin, L.B., The Indigenous Leader Model: Intervention Manual, (Feb. 1992)

**Treatment Services for Pregnant Women and Definitions [42 U.S.C. §300x-27, 45 C.F.R. §96.131, and 45 C.F.F §96.121]**

The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services.

The provider publicizes the availability of such services and that pregnant women receive admission preference.

If the provider receives funds to serve an injecting drug abusing population, the provider gives preference to treatment in the following order:

- Pregnant injecting drug users
- Other pregnant drug users
- Other injecting drug users
- All others

The provider refers pregnant women to BPA Health when the program has insufficient capacity to provide services to any such pregnant women who seek services of the program. BPA Health who may authorize services to another agency who can admit within 48 hours, or if necessary, will offer immediate community resources and place client on wait list until they can be admitted into care.

**Specialized Services for Pregnant Women and Women with Dependent Children (PWWDC) [42 USC §300x-22(b)(3) and 45 C.F.R. §96.124]**

If the provider receives SAPT Block Grant funds set aside for special services for pregnant women and women with dependent children (including women attempting to regain custody of their children), complete items in this section. The provider treats the family as a unit and therefore will admit both women and children into their treatment services, if appropriate. The provider must provide or arrange for the provision of the following services:

1. Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
2. Primary pediatric care, including immunization, for their children;
3. Gender specific substance abuse treatment and other therapeutic interventions for women which may
  - a. address issues of relationships,
  - b. sexual and physical abuse, and
  - c. parenting;
4. Child care while the women are receiving these services;
5. Therapeutic interventions for children in custody of women in treatment which may, among other things:
  - a. Address their developmental needs,
  - b. Their issues of sexual and physical abuse, and neglect;
6. Sufficient case management and transportation to ensure that women and their children have access to services provided above.

The program also provides to PWWDC directly or through community-based organizations, a comprehensive range of services that includes the following:

- Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments
- Employment and training programs
- Education and special education program
- Drug-free housing for women and their children
- Prenatal care and other health care service
- Therapeutic day care for children

- Head Start
- Other early childhood programs

**Coordination of services [42 USC §300x-1(b) (1)(A)(iii) and 42 USC §300x-28 (c) and §96.132(c)]**

The provider coordinates with the following to maximize the efficiency, effectiveness, quality and cost-effectiveness of services to produce the best possible outcomes:

- Health services
- Rehabilitation services
- Employment services
- Social services
- Correctional and criminal justice

**Training [42 USC §300c-28 and §96.132]**

Treatment and recovery personnel receive on-going training concerning:

- Recent trends in substance use disorders in the State
- Improved methods and evidence-based practices for providing substance use disorder treatment services
- Performance-based accountability
- Data Collection and reporting requirements
- Other matters related to further improve substance use disorder treatment

**The provider has in effect a system to protect patient records from inappropriate disclosure, and the system:**

- Complies with all applicable State and Federal laws and regulations, including 42 CFR Part 2
- Includes provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure

**Additional Requirements [42 USC §300x-53(a) and §96.132]**

The provider agrees to participate, if selected in the Independent Peer Review required of the State.

The provider agrees to permit and cooperate with federal investigations into the use of the MHBG and SABG.

The provider submits such data and reports as required by the State to meet block grant reporting requirements.

**Charitable Choice [42 USC §300x-65(c)]**

If the provider is a religious organization/faith-based program, agrees to the following:

The organization does not use SAPT Block Grant funds for activities involving worship, religious instruction, or proselytization. In delivering Block Grant-funded services, including outreach activities, the organization does not discriminate against current or prospective program participants based on:

- Religion
- Religious belief
- Refusal to hold a religious belief
- Refusal to actively participate in a religious practice

Otherwise eligible clients who object to the religious character of SAPT Block Grant-funded services are referred to alternative providers within a reasonable period of time of the objection.

The organization uses generally accepted auditing and accounting principles to account for SAPT Block Grant funds. The organization segregates Federal funds from non-Federal funds. The organization subjects Federal funds to an audit by the government.

**Non-Smoking [Public Law 103-227, Pro-Children Act of 1994]**

The provider demonstrates that it prohibits smoking in any facilities owned, leased or contracted for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by Federal programs.

**Prohibitions regarding receipt of funds [42 USC §300x-56 and Title 31, USC §1352]**

The provider requires that a person associated with the provider shall not knowingly and willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made from the MHBG or SABG. The provider requires that a person associated with the provider with knowledge of the occurrence of any event affecting the initial or continued right of the person to receive any payments from a grant made from the MHBG or SABG shall not conceal or fail to disclose any such event with an intent to fraudulently secure such payment either in a greater amount than is due or when no such amount is due.

The provider can demonstrate that it does not use federal funds to lobby the Executive or Legislative Branches of the State or Federal Government in connection with the MHBG or SABG.

If applicable, the provider can provide documentation that it a) receives federal funds in excess of \$100,000 and b) whether and how much it uses any non-federal funds for lobbying.

**Non-discrimination [42 USC §300x-57]**

The provider has and implements non-discrimination policies in hiring and service

provision using language consistent with the following:

Programs and activities receiving federal financial assistance, including programs funded in whole or in part by the MHBFR or the SABG, must have prohibitions against discrimination on the basis of the following: (1) age under the Age Discrimination Act of 1975 [42. USC §6101 et seq.]; (2) handicap under section 504 of the Rehabilitation Act of 1973 [29 USC §794]; (3) sex under title IX of the Education Amendments of 1972 [20 USC §1681 et seq.]; or (4) race, color, or national origin under title VI of the Civil Rights Act of 1964 [42 USC §2000d et seq.]

No person shall on the ground of sex (including, in the case of a woman, on the grounds that the woman is pregnant), or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available through the MHBG or SABG.

**Salary Limitations [HHS Acquisition Regulations 331.101-70]**

The provider demonstrates that it does not use the block grant funds to pay salaries in excess of Level II of the Federal Senior Executive pay scale.

**Government-Wide Debarment and Suspension [13 CFR 400.109]**

The provider agrees to participate in the government-wide exclusion of suspended or debarred personnel and has policies to that effect.