Employee Assistance Provider Manual

BPA HEALTH

MAKING LIVES BETTER, ORGANIZATIONS MORE EFFECTIVE & COMMUNITIES STRONGER.

BPA Health's tailored behavioral health solutions and managed professional services help you meet your unique challenges.

Connect. Improve. Achieve.

BPA Health would like to welcome you to the BPA Health Provider Network. We look forward to supporting your successes as an EAP Provider in your local communities through the consistency and expertise of our Provider Network Management team of professionals. We believe personal contact maintains strong links to providers especially when dealing with sensitive matters. Our staff are trained and dedicated in the importance of positive and professional dealings with all clinicians and facilities in all areas of need. We look forward to working with you!

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I. Introduction

Company History

For over 40 years, BPA Health has pioneered behavioral health in Idaho & the Northwest. BPA Health connects people to services to improve lives and achieve positive outcomes. On the front lines of our work around the Northwest and nationally, we help people address problems that adversely impact their job performance, health and overall wellbeing. Our established regional roots help us understand and link communities and resources like no large national corporation can. And our deeply held belief that behavioral health is a critical part of overall health motivates our professionals to deliver services with all they have to offer – in mind, body and spirit.

Call 1-800-211-9477 or visit our website at www.bpahealth.com to learn more about our company.

Purpose of BPA Health Provider Manual

The purpose of this manual is to provide information about BPA Health service delivery system. The manual contains explicit statements regarding our mission, our managed care philosophy, and our commitment to total quality management. Our goal is to build a strategic partnership between BPA Health and the mental health/substance abuse providers who manage, provide, and coordinate behavioral treatment services for us. We will strive together to meet the objectives of our corporate mission.

We hope this manual provides you with a clear understanding of our treatment philosophy and of the policies and procedures that must be observed when providing treatment services to clients on behalf of BPA Health. We are committed to providing support to help assure your success in the behavioral health care environment. We look forward to working with you and hope that you find your relationship with BPA Health a satisfying and rewarding one.

II. EAP Services

Providing Healthcare Solutions, Living Healthier Lives

We offer a variety of products and services focusing on the physical and emotional well-being of employees and their families. Our customized healthcare solutions are backed with an extensive, nationwide provider network servicing all 50 states.

Employee Assistance Programs

The Employee Assistance Program (EAP) is an employer-sponsored program 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.

Total Absence Management Programs

BPA Health's Total Absence Management Programs help organizations cut costs and provide better care which allows employees to get back on the job quickly after an injury or illness.

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.

Consulting Services
BPA Health consulting offers products and services that help organizations develop leaders and increase organizational efficiencies through executive coaching, training, assessments and surveys.

Provider Network
BPA Health provides access to the credentialed provider network to other payers through BrightPath. By participating in the BPA Health Network, providers are able to serve clients through payers that utilize the BrightPath Network.

III. Credentialing and Contracting

BPA Health Credentialing Requirements
Credentialing and re-credentialing of BPA Health Network Providers is designed to ensure that providers within our networks meet BPA Health credentialing standards. The goal of this policy includes:

- Ensure each BPA Health provider is qualified by education, training, licensure and experience to deliver quality behavioral health services
- 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, physical and psychological health status and current clinical competence

As designated by the Quality Management Committee (QMC) the Credentialing Committee has responsibility and authority for credentialing and re-credentialing the BPA Health Provider Network. The Medical Director has been designated to review and approve credentialing and re-credentialing applications. The Medical Director may conduct additional review and investigations of credentialing applications where the credentialing process reveals factors that may impact the quality of care or services delivered to clients.

Membership or provisional status in the provider networks of BPA Health shall be extended only to professionally qualified practitioners who:

- demonstrate their current competence,
- continuously meet and satisfy the qualifications, standards and requirements set forth,
- practice in a geographic area determined by BPA Health to be advantageous to its clients and who possess the necessary physical and mental health to provide quality behavioral health services.

The credentialing and re-credentialing process shall be completed within 60 days of the receipt of the provider application and required documents. Prior to review, BPA Health will accept additional information from providers to correct incomplete, inaccurate, or conflicting credentialing information.

BPA Health will send written notification to the provider of the determination of the credentialing application within 60 days of the determination.

Qualifications and Criteria for Decision Making for EAP/BHP Network Membership

- Licensure, current/valid
  - Psychologist, Counselor, Social Worker, Marriage & Family Therapist, and Service Extenders
  - If not current/valid BPA Health will reject application
  - Professional Education & Training
- Psychologist – completed a one year pre-doctoral or post-doctoral internship in clinical or counseling psychology, and possess a PhD or PsyD
  - If not one year pre or post-doctoral BPA Health will reject application
- Counselor, Social Worker, Marriage and Family Therapist – five year post masters clinical experience
  - If not five years post masters BPA Health will reject application
- Service Extender – possess a service extender certificate from State Licensing Board, supervised by a BPA Health contracted psychologist
  - If no service extender certificate BPA Health will reject application
- Professional Liability Insurance
  - $1,000,000.00 per occurrence & $3,000,000.00 aggregate
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider, which disclose an instance of or pattern of behavior which may endanger client.
  - If there is an adverse professional liability claim Credentialing Committee will review
- No exclusion or sanctions from government programs
  - If there is an exclusion or sanction Credentialing Committee will review
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating client endangerment
  - If there is an adverse record Credentialing Committee will review
- General Requirements
  - Work history without gaps exceeding six months

Application Process

Unless otherwise specified applicants, must first complete a BPA Health application for participation in the network. The application may be submitted electronically or on paper.

Each application is reviewed upon receipt. The application must include the following minimum requirements to be considered:

- Complete, signed and dated BPA Health application;
- History of education;
- Work History for the past five years or since last credentialed by BPA Health;
- Current unrestricted license in the state where the practice is located as well as a history of licensure in all jurisdictions;
- Current liability insurance in compliance with minimum limits; Professional liability claims history including any pending professional liability actions;

- History of Medicare/Medicaid sanctions showing provider is currently in good standing;
- Listing of all sanctions or penalties imposed by hospitals, licensing boards and managed behavioral health organizations or managed care organizations within the past five years;
- Documentation of any voluntary or involuntary relinquishment of privileges to practice in a facility or jurisdiction;
- Hospital affiliations or privileges, as applicable;
- Attestation of history of loss of license and /or clinical privileges, disciplinary actions, and /or felony convictions;
- Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of clients;
- Attestation to the correctness/completeness of the application;

Applicants submitting incomplete applications or submitting the incorrect application will be contacted in writing and given the opportunity to complete the application process or re-file using the correct application. Upon identification of erroneous information, the applicant will be notified in writing and given the opportunity to correct the information.

Applications may not be signed and dated more than 180 days prior to the credentialing committee or contain primary or secondary source verification information collected more than 180 days prior to review.

BPA Health may conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may impact quality of care or services delivered to clients.

Credentialing Committee

As designated by the Quality Management Committee (QMC) the Credentialing Committee (CC) has responsibility and authority for credentialing and re-credentialing the BPA Health provider network. The Credentialing Program will be reviewed and modified as necessary, at least annually by the QMC.

The Credentialing Committee's primary responsibilities include:

- To apply established, nationally recognized criteria for both initial credentialing and re-credentialing.
- To ensure the ongoing use of quality review information in making credentialing and re-credentialing recommendations.
- To receive and integrate provider concerns and feedback on the Credentialing Program into ongoing credentialing activities.
- Discuss whether providers are meeting reasonable standards of care
- Accesses appropriate clinical peer input when discussing standards of care for a particular type of provider

The Credentialing Committee has overall responsibility for administering credentialing and re-credentialing decisions related to or affecting providers and organizations in a BPA Health

Provider Network. The Committee reviews credentialing and re-credentialing activities and makes recommendations concerning provider sanctions. Committee members include the Medical Director, Clinical Director, and Manager of Provider Network Management. The credentialing committee includes at least one participating provider who has no other role at BPA Health.

The Credentialing Committee is authorized to review the scope of clinical practice as well as the professional conduct and clinical performance of each provider. The Credentialing Committee must approve all credentialing applicants that are not "clean files" before a provider or facility is designated as a participating provider within the plan's network.

The Credentialing Committee has an exceptions process that can be used if it is necessary to credential a provider given the clients' needs. Providers also can be provisionally credentialed if necessary to make them available prior to completion of the full credentialing process. Provisional credentialing status is time-limited and can only be granted once for a given provider (See Provisional Credentialing below).

In addition to credentialing and re-credentialing providers, the Credentialing Committee also can terminate (e.g., due to lapsed licensure), restrict or limit a providers clinical privileges (e.g., based on quality of care and/or services issues). In these situations, the provider can enter into the Appeals Process as defined in the Provider Termination & Sanctioning policy.

Re-Credentialing

- BPA Health will re-credential providers and organizational providers at least every 36 months as required.
- Organizational providers are required to be in good standing with state and federal regulatory bodies and are reviewed and approved by an accrediting body. BPA Health will conduct a site visit if the provider has no accreditation status
- Providers and organizational providers that do not comply with re-credentialing standards will be terminated from the network.
- Information, criteria, and sources required are consistent with the credentialing procedures defined above.

Client concerns, complaints, on site review results, client record review results, quality of care issues, quality improvement activities and over/under utilization data are considered during the re-credentialing recommendation. During the re-credentialing cycle BPA Health conducts ongoing monitoring of provider sanctions, complaints and quality issues. When issues are identified, BPA Health adheres to the provisions as outlined in the Provider Termination and Sanctioning policy.

IV. Provider Rights and Responsibilities

Providers have specific rights and responsibilities as participants in the BPA Health Network.

Provider Rights

- Providers will be informed via initial application packet letter of:

    - their right to review the information obtained to evaluate their credentialing decision, attestation, or CV;
    - the process and provider's right to be informed of the credentialing decision;
    - provider's right to correct erroneous information (see below);
    - the appeal process for actions taken against providers (see below and Provider Termination and Sanction Policy).
- 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.
- Discrepancies of Information: for information obtained during verification from primary sources, providers have the right to correct discrepant or erroneous information by working directly with the reporting entity or listing agency.

If the credentials verification process reveals information that varies substantially with the information supplied by the provider on the (re)credentialing application the provider is notified by a staff member of BPA Health and given the opportunity to respond to inconsistent information on the (re)application. The provider will have ten calendar days to provide a response in writing. The provider's response and corrected information is documented in the credentialing file. It is the responsibility of the provider to contact the primary source if the provider feels that the primary source data is incorrect.

Status of Credentialing Application
Providers have the right to request the status of their application at any time

Appeals
Providers who have received an adverse determination from the Credentialing Committee are afforded an opportunity to appeal the decision. BPA Health will provide written notification within 10 business days when an adverse determination/action has been brought against a provider, the reasons for the action, and a summary of the appeal rights and process.

If the Credentialing Committee's recommendation is upheld to suspend or terminate a provider due to clinical concerns, BPA Health will report the decision to the National Practitioner Data Bank, state licensing board(s), and any other agencies as required if applicable. This process applies to both physicians and non-physicians, and only pertains to provider decisions affecting patient care and quality (versus breach of contract).

Once the executive team has made the decision to terminate a provider contract, the decision is final and not subject to an appeal process.

When appeals are identified, BPA Health adheres to the provisions as outlined in the Provider Termination and Sanctioning Policy and the Appeals Policy.

Provider Responsibilities
The behavioral health provider provides various modalities and comprehensive behavioral health and/or substance abuse services to all eligible clients. In order to receive BPA Health client referrals providers must contract and credential with BPA Health.

To comply with the BPA Health contract agreement BPA Health providers agree to the following:

- Provide to eligible clients covered services authorized by a BPA Health Representative. Such Covered Services shall be provided in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment.
- Maintain medical records on eligible clients, to whom services are rendered, using accepted medical record documentation and housing procedures. BPA Health shall have the right to access and copy the medical records of eligible clients at mutually convenient times. Provider shall provide BPA Health with reasonable access to medical records of eligible clients for a period of seven (7) years after termination of this Agreement.
- Participate in the quality assurance/utilization review programs and grievance procedures as established by BPA Health. This process may include both verbal and written communication of case-specific clinical and non-clinical information.
- Maintain all required licenses to practice in the state(s) in which services are rendered and operate in compliance therewith. Provider shall maintain all required licenses and be in compliance with federal laws and regulations.
- Provider shall not discriminate against eligible clients on the basis of source of payment, race, color, creed, sex, ethnicity, nationality, age, state of health, place or residence, disability or perceived disability, or any other basis prohibited by law.
- In cases of psychiatric emergency, provider agrees to make a reasonable effort to obtain pre-authorization for the eligible client's care prior to delivering services or hospitalization of the eligible client. If it is not possible to obtain pre-authorization, provider shall treat the psychiatric emergency or refer the client to a BPA Health-contracted hospital, and notify BPA Health. If provider fails to comply, BPA Health and eligible client shall be indemnified and held harmless by provider of any financial responsibility for any charges for such non authorized services. BPA Health will maintain a 24-hour Hotline to facilitate the approval process.
- Hold confidential all information concerning BPA Health, BPA Health providers and eligible clients.
- Provide covered services to individuals who participate in other managed care programs that BPA Health may offer and to accept payment for covered services as stipulated herein.
- Accept eligible clients upon referral from a BPA Health representative.
- Comply and cooperate with the BPA Health Quality Assurance Program including the Outcomes and Satisfaction Assessment process and the Credentialing process.
- Follow the Code of Ethics as adopted by the provider's as adopted by the provider's National Professional Association.

V. Clinical Practice Guidelines

Clinical practice guidelines offer research-based suggestions to treating a variety of disorders. Practice guidelines differ from treatment guidelines in that practice guidelines are more general suggestions for assistance rather than specific treatment requirements. The suggested practice guidelines include an assessment of the strength of the current scientific evidence for each recommendation.

The American Psychology Association has Clinical Guidelines for Practitioners ranging from record keeping, healthcare delivery systems, to Guidelines for Assessment of and Intervention with Persons with Disabilities. The purpose of these guidelines is to help educate clinicians and give recommendations about professional conduct. Furthermore, this offers a place for clinicians to maintain and develop competencies and/or stay current with new practice areas.

Client Records
Client records are the full, all-inclusive records including examinations, laboratory tests, results, encounters, referrals, mental health screenings and tests, contacts about the client, referrals, and any other clinical information that pertains to the care and treatment of the client. Records are to be prepared, maintained and stored as directed in Idaho state rules and regulations, and signed by the professional providing service.

Accurate and complete client records will assist providers in delivering the highest quality healthcare. They will also enable BPA Health to review the quality and suitability of services rendered. To ensure the clients privacy, client records should be kept in a secure location.

Client Records Release

Client's records shall be confidential and not released without written authorization of the covered person or a responsible covered person's legal guardian. When the release of client records is appropriate the extent of that release should be based upon client necessity or on a need to know basis. Each client record release needs to be documented in compliance with HIPPA regulations.

Client Record Audits
Client records may be audited to determine compliance with BPA Health standards for documentation and compliance with clinical practice guidelines. The coordination of care and services provided to clients including coordination with the primary care physician (PCP) may also be assessed during a client record audit.

Required Information
Providers must maintain complete client records for clients in accordance with the following standards:

- Clients name, and/or client record number on all chart pages
- Personal/biographical data is present (i.e. employer, home telephone number, spouse, etc.)
- All entries must be legible
- All entries must be dated and signed (can be electronic), or dictated by the provider rendering the care
- Significant illnesses or client conditions are documented on the problem list
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the client record. If no known allergies, NKA or NKDA is documented
- _Appropriate subjective and objective information pertinent to the clients presenting complaints is documented in the record

- Past treatment history (for clients seen three or more times) is easily identified and includes any psychiatric hospitalizations
- There is a DSM diagnosis
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Risk assessments at every session for suicidal and homicidal clients
- Confidentiality of clients information and records protected
- Progress note for each session
- Discharge Plan

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/client relationships. Clients have a right to appropriate and quality care. When cultural differences are disregarded clients are at risk for a poor quality of care. Clients are less likely to communicate their needs in an indifferent environment thus limiting effectiveness of the health care process.

Part of the credentialing and site visit process is to assess the cultural competency level of network providers and provide access to training to help develop culturally competent and proficient practices.

Network Providers must ensure:
- Clients knowledge of access to signers, client interpreters, and TTY services to facilitate communication without cost to them
- Consideration of the clients' language, ethnicity/race and its influence on the clients' health
- Culturally competent office staff that routinely come in contact with clients participate in ongoing cultural competency training and development
- Administrative staff attempts to collect race and language specific client information
- Treatment plans use consideration of race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process
- Office sites have posted and printed materials in the language spoken in English, Spanish, or other prevailing languages within the regions

Understanding the Need for Culturally Competent Services
Research shows that a person has better health outcomes when they experience culturally appropriate interactions with providers. Developing cultural competency begins with self-awareness and acceptance that cultural competency is ongoing. The experience of a client begins at the front door.
Failing in being culturally and linguistically competent practices could result in the following:

- Feelings of being insulted
- Client's reluctance and fear of making future contact with the office
- Misunderstanding and confusion
- Non-compliance
- Feelings of being uncared for, looked down on and devalued
- Parents' resisting to seek help for their children
- Missed appointments
- Provider's misdiagnosis
- Increased grievances or complaints

Preparing Cultural Competency Development
BPA Health encourages the recognition and acceptance of the value of meeting the needs of your clients.
Here are some questions to keep in mind as you provide care to BPA Health membership:

- How are cultural differences impacting your relationship with your client?
- What do you know about your client's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- What are your own cultural values and identity?

VI. General Billing

How to file a claim
BPA Health will accept claims for EAP services in either of two formats, the CMS 1500 or the BPA Health EAP Billing Form. The EAP Billing Form is available on the BPA Health website at www.bpahealth.com or you may contact Provider Relations at 800-688-4013 or 208-947-4377 to receive a hard copy.

The form may be faxed to: 208-344-7430 Attention: Claims

or mail to:
BPA Health, Claims Department
380 E. Parkcenter Blvd., Ste. 300
Boise, ID 83706.

All claims must have the required fields completed for processing purposes:

- Client Name and Address
- Client ID Number and Date of Birth
- Employer Group Name
- Authorization Number
- Date of Service and CPT Code
- ICD 10 or DSM Diagnosis Code
- Billed Amount

All claims must have the following information from the provider:

- Provider Name and Credentials

- Provider Physical Address and Billing Address (if applicable)
- Provider Phone Number and Tax ID Number

Claims must be submitted within 60 days of the date of service. Claims submitted with insufficient information will be returned and may be re-submitted after they have been corrected. All clean claims will be processed within 30 days.

Provider Reimbursement
Claims will be processed in accordance with contract and benefit guidelines. An EAP session is reimbursed at the provider contracted rate for EAP services. In accordance with contract guidelines, payment for EAP services is considered payment in full, and the provider may not balance bill the client for services rendered. No shows and late cancellations are not a reimbursable expense.

VII. Client and Provider Appeals and Complaints

Client and Provider Complaints
BPA Health will provide a copy of the Complaint Resolution policy to our clients, providers, stakeholders and the public, upon request. This policy is also available on our website at: www.bpahealth.com.

BPA Health believes that anyone has the right to make a complaint and express a concern about our programs and services. A client may designate a representative to file complaints 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 clients and customers. BPA Health will not retaliate or take any discriminatory action against any individual, facility or organization due to filing a complaint. BPA Health categorizes each complaint into one of the following categories:

- **Administrative Complaint**: dissatisfaction related to inadequate or poor performance and/or management of business operations
- **Quality of Care Complaint**: dissatisfaction related to an alleged violation of established clinical care guidelines
- **Regulatory Complaint**: dissatisfaction related to an alleged violation of contractual or regulatory standards

The following activities describe the complaints process:

Initiating a Complaint
The following are acceptable methods for submitting a complaint with BPA Health. However, any employee may take a complaint and forward it to the Appeals Coordinator for investigation:

a. Phone BPA Health at 1-800-726-0003 to speak directly to a Customer Support Specialist (CSS).
b. Mail written complaints directly to the attention of:

BPA Health
c/o Appeals Coordinator
380 E. Parkcenter Blvd, Suite 300
Boise, ID 83706

c. Fax to 1-208-344-7430

BPA Health will:

- Address complaints quickly and courteously, treating all complaints equally and seriously
- Record all complaints, keep clients and customers 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.

Appeals

BPA Health will ensure a timely, efficient, and fair appeals process is available to members, their authorized representatives, and providers to appeal decisions made by BPA Health. The following decisions are appealable:

1. Non-certification of requested care or services
2. Rejection and non-payment of claims
3. Adverse determinations by Credentialing Committee against a provider (See Provider Rights Section IV)

Non-Certification of Requested Care or Services

BPA Health is committed to providing our members with safe and timely access to medically necessary and clinically appropriate services. This commitment also includes service requests, which result in a non-certification determination. Any member, authorized representative, or provider rendering services has the right to appeal a non-certification decision.

For appeals of this type, BPA Health ensures the following appeal activities:

1. Notification of non-certifications sent to members, authorized representatives and/or providers will include instructions on how to appeal the non-certification decision.

2. The member, authorized representative and/or provider must submit an appeal request within 180 days of notice of non-certification or as designated by the health plan.

3. BPA Health will provide assistance to any member, authorized representative or provider needing assistance with an appeal request.

4. Standard appeal requests will be responded to or resolved in writing within 30 days of receipt.

5. Expedited appeals 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 72 hours of the request followed by a written

confirmation of the notification within 3 calendar days to the patient and attending physician or other ordering provider or facility rendering service.

6. Standard appeal requests should be submitted in writing. Expedited appeal requests can be submitted verbally or in writing.

7. A copy of our Appeals policy is available, upon request, to any member, authorized representative, or provider rendering services.

8. The member, authorized representative, or provider rendering service has the right to reasonable access to and copies of all documents, records, and other information that are relevant to the appeal.

9. The member, authorized representative and/or provider 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 may submit a second level appeal. Second level appeals are reviewed and determined by a BPA Health staff member that was not involved in the first level appeal decision and who holds hire qualifications or credentials. Should the appellant wish to subsequently challenge the second level appeal decision, the third level appeal will be reviewed and determined by a qualified party outside of the organization. For second and third level appeals, the member, authorized representative, or provider must submit additional information in their effort to overturn the original denial of certification. The appeal reviewer will take the submitted information, and all the information originally submitted, into account when rendering an appeal determination. All second and third levels are subject to the same timelines as first level appeals.

10. Each peer clinical reviewer, for each clinically reviewed appeal, must **attest** to meeting the following.
    a. The peer clinical reviewer is licensed or certified in a field that typically manages the clinical issue under review **and**
    b. The peer clinical reviewer has current and relevant knowledge and/or experience to render a determination for the services being reviewed

11. 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 health plan.

<u>Rejection and non-payment of claims</u>
BPA Health is committed to timely processing of claims that are submitted within the allowable billing period and are correct. Various factors may cause the denial of a claim. Any member, authorized representative, or provider rendering services has the right to appeal a claims non-processing or non-payment decision.

For appeals of this type, BPA Health ensures the following appeal activities:

1. Notification of non-processing or non-payment of a claim is sent to the provider.

2. The member, authorized representative and/or provider must submit an appeal request within 180 days of notice of non-processing or non-payment of the claim or as designated by the health plan.

3. BPA Health will provide assistance to any member, authorized representative or provider needing assistance with an appeal request.

4. All appeals concerning non-processing or non-payment of a claim are considered non-urgent appeals, and will therefore be processed as standard appeal requests and will be responded to or resolved in writing within 30 days of receipt.

5. Standard appeal requests should be submitted in writing.

6. A copy of our Appeals policy is available, upon request, to any member, authorized representative, or provider rendering services.

7. The member, authorized representative, or provider rendering service has the right to reasonable access to and copies of all documents, records, and other information that are relevant to the appeal.

8. The member, authorized representative and/or provider will have three (3) opportunities to have a non-processing or non-payment decision reviewed for reconsideration. Should the appellant wish to challenge the first level appeal decision made by BPA Health, they may submit a second level appeal. Second level appeals are reviewed and determined by a BPA Health staff member that was not involved in the first level appeal decision and who holds hire qualifications or credentials. Should the appellant wish to subsequently challenge the second level appeal decision, the third level appeal will be reviewed and determined by a qualified party outside of the organization. For second and third level appeals, the member, authorized representative, or provider must submit additional information in their effort to overturn the original denial of certification. The appeal reviewer will take the submitted information, and all the information originally submitted, into account when rendering an appeal determination. All second and third levels are subject to the same timelines as first level appeals.

9. 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 health plan.

Appeal Requests

The client or service provider must submit standard appeal requests in writing within 180 days from date of decision being appealed. Appeal requests must include the following client information:

- Client name
- Client date of birth
- Client ID

- Service type and dates of services being contested
- Explanation of why non-certification determination is being disputed
- Any additional documentation needed to support the appeal

BPA Health's Quality Department manages the appeals process. When an appeal is received by a BPA Health staff member, the appeal is immediately routed to an Appeals Coordinator.

VIII. Quality Assurance Program

BPA Health is committed to providing quality programs and services to our clients, families and customers and we place great emphasis on the quality of our provider networks. BPA Health's provider performance standards are assessed, monitored and maintained through the following quality monitoring activities:

- Provider Credentialing and Re-credentialing
- Quality of Care Concerns
- Site Visits
- Satisfaction Surveys
- Corrective Action Plan Compliance
- Terminations & Sanctions Monitoring

Structure
The Provider Quality Assurance Plan is governed by the Quality Management Committee (QMC) and overseen by the Provider Network Management department. All pertinent provider quality monitoring data is reported to the appropriate quality committee per BPA Health policies.

Primary Activities
The Director of Provider Networks oversees the daily operations of the Provider Quality Assurance activities. These activities include the following:

- Overseeing the monitoring functions
- Tracking and trending key indicators of:
    - Provider compliance with plan
    - Internal quality compliance to plan and adherence to nationally recognized criteria.
- Ensuring ongoing use of quality review information in making credentialing and re-credentialing decisions.

Primary Monitoring Activities
The BPA Health Provider Quality Assurance Plan includes the following primary monitoring activities:

- Provider Credentialing & Re-credentialing:
    - The Provider Quality Assurance Plan monitors and assesses provider credentialing and re-credentialing criteria and ensures BPA Health internal quality metrics comply with national standards.

    - BPA Health credentials providers within our networks who are licensed to practice independently according to rigorous criteria that reflect professional and community standards as well as applicable laws and regulations. All providers and/or agencies are required to participate in the credentialing process as the basis for ensuring BPA Health's providers meet our quality standards.
    - The re-credentialing process is a provider quality monitoring program that includes gathering pertinent data from client concerns, complaints on site review results, treatment record review results, quality of care issues, and quality improvement activities. In addition, BPA Health conducts ongoing monitoring of provider sanctions, complaints and quality issues. When issues are identified, BPA Health adheres to the provisions as outlined in the Provider Termination and Sanctioning Policy and Procedure.
- Quality of Care Concerns
    - The Provider Quality Assurance Plan monitors appeals, complaints and adverse incident data to ensure consistent quality of service to our clients. Pertinent data is reported to the appropriate quality committee per BPA Health policies.
- Site Visits
    - The Provider Quality Assurance Plan ensures BPA Health meets national quality accreditation standards for conducting on-site reviews of BPA Health's network providers. The site visits conducted are based upon accordance with BPA Health policy. Providers will be notified in advance if they are chosen for a site review. The visit will include a review of client charts, policies and practices.
- Satisfaction Surveys
    - Satisfaction surveys are utilized as a way to gather client and provider feedback regarding quality concerns. Data from the survey may trigger a complaint investigation.
- Corrective Action Plan Compliance
    - A Corrective Action Plan (CAP) is utilized as a mechanism to engage the provider in a performance improvement process as outlined in the Corrective Action Plan Policy
- Terminations & Sanctions Monitoring
    - A provider can be denied credentialing/re-credentialing, sanctioned, or terminated from providing services to BPA Health clients based upon accordance with the Provider Termination & Sanctioning Policy.