Substance Use Disorder
Provider Manual
2016

We are committed to providing real and human solutions that make lives better, organizations more effective and communities stronger.
BPA Health would like to welcome you to the Substance Use Disorder (SUD) Provider Network. BPA Health staff look forward to supporting your successes as a SUD 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. 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 1-800-922-3406 or visit the rest of our website at www.bpahealth.com today to learn more about our healthcare solutions.

Purpose of BPA Health Provider Manual

The purpose of this manual is to provide an overview of the state SUD System and specific information about BPA Health’s system designed to administer the state contract. This manual should be used in conjunction with the SUD IDAPA regulations as well as the provider contract. Both of these documents create the foundation for which providers serving state-funded clients look to for guidance.

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 and recovery support services to state-funded clients. 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.

Overview of the Substance Use Disorder Network

BPA Health administers the Substance Use Disorder System for three state agencies and the judiciary. The agencies are appropriated funding annually from the legislature to serve clients who have been assessed with a substance use disorder with the GAIN Assessment, state-approved assessment tool. The system utilizes a network of private providers managed by BPA Health. In addition, BPA Health operates an intake call center, care management department and billing/claims department. The Idaho Department of Health and Welfare and the Idaho Department of Correction utilize BPA Health’s call center, care management services and billing department to administer their funds. The judiciary and the Idaho Department of Juvenile Corrections utilize BPA Health’s provider network but manage intake and billing with their own staff.

Providers in the BPA Health Network must meet specific credentialing criteria, undergo annual audits, report Critical Incidents and cooperate with complaint investigations. The Provider Manual describes each of these areas in detail.
II. Provider Credentialing and Contracting

Credentialing and re-credentialing of BPA Health network providers is designed to ensure that providers within our networks meet state and BPA Health credentialing standards. The goal is to:

- 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 (CC) has responsibility and authority for credentialing and re-credentialing the BPA Health provider network. The Medical Director is 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 informing them of the determination of the credentialing application within 60 days of the determination.

Qualifications and Criteria for Decision Making for SUD Network Membership:

- Facility Approval
  - The treatment provider agency must have current State of Idaho Department of Health & Welfare Alcohol and Drug Abuse Treatment Program Certificate of Approval.
• If the treatment provider does not have an IDHW certificate of approval, BPA Health rejects the application. **Facility approval is not required for RSS providers.**

• Qualified Staff
  
  o The clinical staff at the provider agency must meet conditions of a Qualified SUD Professional, or Qualified SUD Trainee per IDAPA.
  
  o The provider agency must employ a Clinical Supervisor who meets qualifications as included in Section VIII of this manual.
  
  o Staff qualifications will be verified at time of application and time of any staff turnover. It is mandatory that change of staff be reported to BPA Health immediately on the staff update form located at [www.bpahealth.com](http://www.bpahealth.com).

• Professional Liability Insurance
  
  o SUD treatment providers - $1,000,000.00 per occurrence and $3,000,000.00 aggregate
  
  o SUD standalone case management providers - $1,000,000.00 per occurrence and $3,000,000.00 aggregate

• Commercial General Liability Insurance
  
  o SUD housing provider - $1,000,000.00 per occurrence and $2,000,000.00 aggregate
  
  o SUD alcohol and drug testing providers - $1,000,000.00 per occurrence and $1,000,000.00 aggregate

• Auto Insurance
  
  o SUD transportation providers - $1,000,000.00 per occurrence and $1,000,000.00 aggregate

• Training Requirements
  
  o Provider agency must complete WITS Training with the IDHW WITS Helpdesk and New Provider Orientation with a BPA Health Regional Coordinator prior to activation in the network(s) and any mandatory trainings that are scheduled.

**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 hard copy.

Each application is reviewed and must include the following minimum requirements:

• Complete, signed and dated BPA Health application;
• Current IDHW Certificate(s) of Approval; (treatment providers only)
- Listing of staff with licensure and background check documentation;
- Current liability insurance in compliance with minimum limits; professional liability claims history including any pending professional liability actions;
- Listing of all sanctions or penalties within the past five years;
- Documentation of any voluntary or involuntary relinquishment of privileges to practice in a facility or jurisdiction;
- 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 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 without reasonable accommodation;
- Attestation to the correctness/completeness of the application;
- Signed and dated Release of Information Form.

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

**Safe and Sober Housing providers will have an on-site visit to ensure all elements of IDAPA are being met.**

If any application is signed and dated by the provider more than 180 days prior to the credentialing committee review, it will be returned to the provider for updates.

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 consumers.

BPA Health will conduct primary source verifications of providers. Primary source is defined as the organization or entity that originally conferred or issued an element used in credentialing or the data bank(s) to which those organizations report.

**Credentialing Committee**

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 Provider Network Manager. 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.
In addition to credentialing and re-credentialing providers the Credentialing Committee can also terminate or restrict or limit a provider’s clinical privileges (e.g., based on quality of care and/or services issues). In these situations the provider can enter into the Provider Appeals process as defined in the Provider Termination & Sanctioning Policy.
III. 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: 1) their right to review the information obtained to evaluate their credentialing decision, attestation, or CV; 2) the process and provider’s right to be informed of the credentialing decision; 3) provider’s right to correct erroneous information (see below); 4) the appeal process for actions taken against providers (see below and Provider Termination & 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.

Adverse Action

Decisions made which are unfavorable to the provider will be reported to National Practitioner Data Bank and state licensing board(s) as required after the provider has exhausted the appeals process. If the provider does not agree with decisions or actions the provider is entitled to a review under the appeals process. 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.

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.
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.

Provider Responsibilities

The substance use disorder treatment provider must provide evidenced-based modalities in compliance with IDAPA and BPA Health requirements to state-funded clients. In order to receive BPA Health 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 covered services authorized by a BPA Health representative. Covered services shall be provided in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment and in accordance with Idaho Administrative Procedures Act (IDAPA) and applicable plan documents. Provider shall ensure that all personnel providing services to clients under this agreement provide such services in an ethical and professional manner, and in compliance with all applicable laws and regulations, including state licensure boards.
- Complete and maintain clinical records on eligible clients, to whom services are rendered, as required by the State of Idaho for providers as specified in IDAPA. BPA Health shall have the right to access and copy records of eligible clients for a period of five (5) years after termination of this Agreement.
- Maintain an active State Facility Certificate of Approval to receive SUD funding as defined by IDAPA.
- 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.
- Maintain professional liability insurance coverage in an amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate. Provider shall also (a) supply upon reasonable request a copy of the face sheet reflecting any changes in insurance coverage prior to their effective date; (b) supply copy of the face sheet for each annual renewal of the provider’s professional liability insurance. Provider shall immediately notify BPA Health in the event of termination or non-renewal of such insurance.
- Unless prohibited by law, promptly notify BPA Health of the initiation of litigation by any third party or the initiation of any state or federal investigation and of any facts or circumstances which indicate the possibility that a third party has a cause of action or will initiate litigation, with respect to any act or omission of provider or BPA Health, or any employees, agent, or contractor of provider or BPA Health.
- Consents to the listing of his/her name in BPA Health's directory or in the directory or other publications of any organization with which BPA Health has contracted.
to arrange for the provision of behavioral health care services or Idaho Department of Health & Welfare funded substance use disorder services.

- Not advertise or distribute material, which refers to BPA Health without BPA Health’s prior written consent.
- Comply with all reasonable administrative policies and procedures of BPA Health relating to the delivery of covered services including, but not limited to timeliness standards and procedures to request additional services beyond those initially authorized.
- Agree that during the course of this agreement and at all times thereafter, he/she shall hold confidential all information concerning BPA Health, BPA Health providers and eligible clients.
- Comply with all IDHW and BPA Health required standards as outlined in IDAPA and BPA Health Provider Manual.
- Agree to accept eligible clients upon referral from a BPA Health representative. If provider cannot meet the requirements of the referral, the provider must promptly notify BPA Health.
- Agree to allow appropriate BPA Health representatives, upon request, to inspect its facilities and its medical records of eligible clients.
- Agree to comply and cooperate with the BPA Health Quality Assurance Program including, but not limited to, Evidence Based Practice audits, outcomes and satisfaction assessment process, Continuous Quality Improvement (CQI), charitable choice requirements, co-occurring outcomes and the credentialing process. These elements will be pursuant to HIPAA and 42CFR privacy rules to ensure the limited purpose of evaluating for compliance, review competence and or qualifications of providers by evaluating their performance. These audits/reviews are not used for the purpose of any study or for direct client contact.
- Provider agrees to follow the Code of Ethics as adopted by the provider’s license and/or certificate related national professional association.
  - Notify BPA Health within ten (10) working days from receipt of notice to the agency or any personnel providing services pursuant to this agreement termination, non-renewal, or restriction of license, certificate, registration, or other legal authorization to provide any behavioral health services.
- Submit appeals and complaints using BPA Health’s Appeals Policy and Complaint Resolution Policy, available on the BPA Health website and in the Provider Manual.
- SUD Faith Based Providers must comply with Charitable Choice laws as outlined in the Federal Community Services Block Grant and Substance Abuse and Mental Health Services.
- Notify BPA Health thirty (30) days prior to any service site relocation or addition of new service site. Any new service sites must go through BPA Health’s established application and credentialing process.
- Comply with required provider trainings
- Report critical incidents as outlined in the Critical Incident Reporting Policy and Procedure and reporting form available on the BPA Health website.
- Maintain HIPAA compliance for electronic claims submission.
- Comply with the requirements of the GAIN/WITS interface as outlined by IDHW and BPA Health.
- Ensure that all personnel providing services to eligible clients under this agreement are properly trained and qualified per IDAPA and the BPA Health Provider Manual to
render the services they provide. Provider shall arrange for continuing education of personnel rendering services under this agreement as necessary to maintain such competence and satisfy all applicable licensing or other legal or regulatory requirements.

- Neither Provider nor any person providing services to eligible clients shall have been barred or excluded from participating in any federal health care program, including Medicaid.
IV. Referral Sources and Funding

Funding for Substance Use Disorder Services is appropriated from the Idaho State Legislature to four entities: Idaho Department of Health and Welfare, Idaho Department of Correction, Idaho Department of Juvenile Corrections and the Idaho Supreme Court.

BPA Health’s primary role is to credential and manage the performance of a Statewide Substance Use Disorder Network that can be used by the four entities. BPA Health manages clients, utilization and claims payment for only certain populations. Here is a summary of who conducts certain activities based on the state funding source:

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<th>Initial Authorization</th>
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V. Billable Services in the SUD System

Treatment and Recovery Support Services that are covered for eligible populations and allowable for state-funded reimbursement are described in IDAPA and detailed on each entity’s SUD Rate Matrix located on the BPA Health website.

Treatment Services

The following descriptions are based on ASAM Levels of Care. More detailed information on each level of care is included in the ASAM Manual.

Assessment

All approved programs must utilize the GAIN assessment tool as approved by the Idaho Department of Health and Welfare.

A qualified substance use disorders professional must develop a written assessment of each client to identify the effects of alcohol or substance use on the client's life. The qualified substance use disorders professional may be on staff or arranged for by the program.

Level I Outpatient Treatment

Called Outpatient Services for adolescents and adults, this level of care typically consists of less than 9 hours of service/week for adults, or less than 6 hours a week for adolescents for recovery or motivational enhancement therapies and strategies. Level 1 encompasses organized services that may be delivered in a wide variety of settings.

Level II.1 Intensive Outpatient / Partial Hospitalization

Called Intensive Outpatient Services for adolescents and adults, this level of care typically consists of 9 or more hours of service a week or 6 or more hours for adults and adolescents respectively to treat multidimensional instability. Level 2 encompasses services that are capable of meeting the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening, and/or on weekends.

Level III.1 Residential/Inpatient Treatment (Transitional/Halfway House)

Called Clinically Managed Low-Intensity Residential Services, this Adolescent and Adult level of care typically provides a 24 hour living support and structure with available trained personnel, and offers at least 5 hours of clinical service a week. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour living support setting.

Each alcohol and substance use disorders treatment program seeking approval as a Level III.1 - Clinically Managed Low Intensity Residential Treatment Facility (Level III.1) for Adolescents must meet these requirements:
a. A Child and Adolescent Residential Transitional Facility must meet the requirements in IDAPA 16.06.02, “Rules Governing Standards for Child Care Licensing,” and be licensed annually as a Children's Residential Care Facility.

b. Child and Adolescent Transitional Residential Treatment will be provided as a Level III.1 - Clinically Managed Low-Intensity Residential Service, which may include outpatient for clients who have completed Level III.5, and lack supportive recovery environments.

c. A Level III.1 facility provides living accommodations in a structured environment that encourages each child and adolescent client to assume responsibility for their own rehabilitation.

d. Treatment and adjunct services may be provided on-site or arranged for by the program.

e. A Level III.1 treatment facility must provide information regarding community resources to persons recovering from alcohol and substance use disorders.

f. Treatment under Level III.1 is directed toward applying recovery skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery, and reintegrating the individual into the worlds of school, work and family life.

g. Every Child and Adolescent Transitional Residential Treatment Facility must provide case management.

Each alcohol and substance use disorders treatment program seeking approval as a Level III.1 - Clinically Managed Low Intensity Residential Treatment Facility (Level III.1) for Adults must meet these requirements:

a. A Level III.1 treatment facility provides living accommodations in a structured environment that encourages each adult client to assume responsibility for their own rehabilitation.

b. Treatment and adjunct services may be provided on-site or arranged for by the program.

c. A Level III.1 treatment facility must encourage use of community resources by persons recovering from alcohol and substance use disorders.

d. There must be written provisions for medical screening, care of clients requiring minor treatment or first aid and handling of medical emergencies.

Supervision for Adults Level III.1. A Level III.1 treatment facility must be supervised by a qualified substance use disorders professional. A staff person must be available to residents twenty-four (24) hours per day, seven (7) days a week. The staff to client ratio must not exceed twelve (12) clients to one (1) staff person.
Level III.5 Residential/Inpatient Treatment

Called Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults, this level of care provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Patients in this level are able to tolerate and use full active milieu or therapeutic communities. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

Level 3.5 treatment facilities must provide individual and group counseling activities, family treatment services, and substance use disorders education. This Clinical Care must include at least twenty-one (21) hours a week of clinical treatment programing for adolescents. For adults, in addition to the requirements for therapeutic milieu, at least 30 hours of clinical treatment program hours are required. A minimum of 6 hours of structured non-clinical hours of recovery activities are required as part of this therapeutic milieu.

The therapeutic milieu and clinical involvement can be expected to encompass the entirety of each day for the resident/participant. The program will evidence the therapeutic milieu through its schedule of recreation and appropriate activities available to all clients during the day, evenings and on weekends. The activities must be planned to provide a consistent and well structured, flexible framework for daily living and practicing the skills being learned. Participants must be involved, whenever possible, in planning activities.

Recovery Support Services

Recovery Support Services (RSS) promote client engagement in the recovery process and provide services needed for support of a client’s continued recovery. Recovery support services are initiated with the client at the earliest possible point in the individual planning and service delivery process. Ideally, RSS are identified at the outset of treatment as part of the development of the individual treatment plan. It is expected that the client’s needs will change during course of treatment so recovery support is an ever-evolving plan. Organizations collaborating in order to provide RSS are expected to maintain linkages with the primary service provider in order to fully assess the effectiveness of on-going services and to determine if additional services are needed.

State-Funded Recovery Support Services include:

- Case Management – Basic and Intensive
- Safe & Sober Housing
- Alcohol & Drug Testing
- Transportation
- Life Skills
NOTE: ALL IDAPA applicable SUD standards for policies and procedures must be met.

Case Management

Case Management services are assessing, planning, linking, coordinating, monitoring, and advocating for clients and their families to ensure that multiple services, designed to ensure their needs for care, are delivered in a coordinated and therapeutic manner to meet the goals of treatment outcomes. For additional information please see RSS Resources:

Case Management to be provided by Qualified Substance Use Disorder Professional or ISAS trainee; a person with a - Bachelor’s Degree in Human Services or related field or higher from a nationally-accredited university or college or a Bachelor’s Degree and 2 years of experience working as a case manager in a related field. Supervision requirement is monthly unless currently clinically supervised on a different frequency.

The Case Manager is to complete a comprehensive service plan that addresses the needs of the client as identified through the assessment process. It is expected that the Case Manager will include information from the assessment and the treatment plan as they assess the client’s needs. A comprehensive plan is anticipated to include current medical needs, legal needs, financial, transportation concerns, mental health issues, housing status, job potentials, client strengths and limitations, family concerns that may impact the client and other areas that may influence the client’s success with completing treatment and being successful in the community. A written comprehensive case management service plan is to be completed within 30 days of the first client visit and to be updated at least every 90 days thereafter. To the maximum extent possible, this plan is to be a collaborative process involving the client and other support and service systems.

It is recognized that while assisting a client, phone calls or other contacts may be of short duration. Each day’s billable times may be included into one note for the total time, provided the note delineates the times for each activity.

Reimbursable services include: face-to-face contact with client, client’s family, legal representative, primary caregivers, service providers or others directly involved with the client’s recovery; telephone or email contact with the individuals listed above; paperwork completed to obtain services (client must be present); and documenting services for Idaho Department of Correction (IDOC) requirements.

Non-reimbursed services include missed appointments, attempted contacts, travel to provide service, leaving a message, transporting clients, documenting services (IDOC is the only exception), group case management, or mental health services provided by the Case Manager.

Life Skills

Life Skills programs are 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.

The goal of Life Skills services is that through advocacy, teaching, role modeling, educational, social service and groups, clients and consumers in recovery will find and adopt the various tools they will need to become productive members of society. Life Skills activities may include activities that are culturally, spiritually or gender specific.

Below is a list of approved subjects for (LS) programs. This list provides examples of possible topics that may be addressed as well as online resources for building a curriculum. This is only a guideline and providers may address additional topics as long as they are related to the list of approved curriculum subjects.

Any provider wanting to provide LS for any of these approved subjects must submit a basic curriculum outlining topics that will be addressed. IDHW may also request additional information and materials in addition to the curriculum.

Life Skills activities for recovering individuals may be provided on an individual basis or in a group setting and shall consist of one or more of the following objectives:

- Money Management - Budgeting and savings, balancing a checkbook/checking account, improving/fixing credit issues
- Employability Skills - Resume formats and content, filling out a job application, interviewing skills
- Healthy Relationships - Family relationships, marital/romantic relationships, friends/co-worker relationships, communication skills
- Nutrition and Cooking - Outline of a balanced diet, how to read and understand food labels, how unhealthy foods affect the body, meal planning, food shopping/creating a grocery list
- Stress and Anger Management - Relaxation techniques, coping skills, involvement in leisure activities
- Parenting Skills - Understanding basic child development, methods of disciplining children, how substance abuse affects parenting skills
- Adolescent Independent Living Skills - Apartment hunting, managing finances and paying bills, employability skills, applying for financial assistance/college loans, meal planning and food shopping
- Pastoral Counseling - Recognizing addiction, how substance abuse affects families and communities, the role of a “higher power” or religion in recovery, appropriate pastoral roles and interventions

Life Skills programs must have a written plan. This written plan must include the curriculum/outline to be used. The list of activities must include: i. A description of each activity; ii. The measurable goals of each activity; and iii. The staff person responsible for providing or supervising each activity.

Life Skills may be approved for clinical treatment providers on a case-by-case basis under the following conditions: i. The service is billable only as a recovery support service; and ii. The service is distinguishable from treatment services.

**Staffing in a Life Skills Program.** Each Life Skills program must ensure services are provided by qualified staff who meet the following requirements: a. Each staff person has completed
training to deliver the service or has a record of performance in the provision of service; b. Personnel file must contain documentation that each staff person is qualified; c. There must be one (1) qualified staff person for every thirty (30) clients in a group setting; and d. The total client caseload of any qualified staff person must not exceed forty-five (45) clients.

**Safe & Sober Housing**

Safe and Sober Housing (SSH) programs provide a safe, clean and sober environment for adults with substance use disorders who are transitioning back into the community.

Staffed Safe and Sober Housing facilities may include either or both of the following:

- Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living is typically provided for 3-6 months and can be offered in congregate settings that may be larger than residences typically found in the community.

- Long-term housing that provides stable, supported community living or assists the client in obtaining and maintaining safe, affordable, accessible, and stable housing.

Statutes regulating transitional housing can be found at 42 U.S. Code 11384 (b) and implemented at 24 CFR 583. Statutes for Safe and Sober Housing can be found in the federal Anti-Drug Abuse Act of 1988.

The Fair Housing Act prohibits discrimination in housing because of race, color, national origin, sex or familial status (families with children), or handicap.

Safe and Sober Housing programs afford the following community living components:

a) Regular meetings between the staff and clients.

b) Opportunities to participate in typical home activities.

c) Linkage to healthcare when these needs are identified.

d) Daily access to nutritious meals and snacks.

e) Opportunity of choice by the persons served as to room and housemates.

f) Opportunities to access community activities including but not limited to: cultural activities, social activities, recreational activities, spiritual activities, self-help groups, and necessary transportation.

Safe and Sober Housing programs shall not bill rent to clients receiving State Substance Use Disorder funding for housing but may impose a “program fee” to cover the following expenses:

- Basic Utilities—electricity, gas, water, sewer, trash, etc.
- Telephone Service
- Cable/Satellite T.V.
- Internet services (if available to client)
- Amenities Fund—Covers wear and tear on home living items such as furniture, bedding, curtains, washer and dryer, cookware, dishes, appliances, etc.
- Cleaning supplies (if supplied by provider)
Program fees must not exceed one hundred dollars ($100) per month. Program fees must be imposed equally on residents receiving state funding for housing and non-state funded residents. Adult Staffed Safe and Sober Housing facilities must assure that clients fully understand the purpose of an imposed program fee and what it includes. Adult Staffed Safe and Sober Housing facilities must disclose to the Department any program fees imposed and what is included in the fee.

**Termination of Housing from an Adult Staffed Safe and Sober Housing Facility.** The housing provider may discharge a client who violates house rules and requirements in accordance with the following: **a.** Client is informed verbally and in writing of reasons for discharge; **b.** A process is in place that recognizes the rights of the client to due process and allows the client to request a formal review of the decision; **c.** The reasons for discharge and any actions following are clearly documented in the client’s file.

**Drug Testing**

Alcohol and drug testing results are objective measures of treatment effectiveness, as well as a source of important information for periodic review of treatment progress. Alcohol and drug testing helps support positive treatment outcomes and provides accurate and reliable data supportive of other data collection efforts.

An accurate testing program is the most objective and efficient way to establish a framework for accountability and to gauge each client’s progress. Methods of testing may include the use of urine specimens or oral swabs.

In addition to the general requirements for RSS providers outlined in IDAPA, alcohol and drug testing programs must meet the following requirements:

- Alcohol and drug testing policies and procedures are based on established and tested guidelines. Licensed contracted laboratories analyzing urine or other samples are also to be held to established standards.

- Testing will be provided at the provider location and may be administrated randomly or at scheduled intervals.

- Frequency of testing will vary depending on a participant’s progress.

- The scope of testing is sufficiently broad to detect the participant’s primary drug of choice as well as other drugs of abuse, including alcohol.

- Elements contributing to the reliability and validity of a testing process include, but are not limited to:
  - Direct observation of sample collection;
  - Verification temperature and measurement of creatinine levels in urine samples to determine the extent of water loading;
  - Specific, detailed, written procedures regarding all aspects of sample collection, sample analysis, and result reporting;
A documented chain of custody for each sample collected;

- Quality control and quality assurance procedures for ensuring the integrity of the process, and;

- Procedures for verifying accuracy when drug test results are contested.

A RSS program can provide alcohol or drug testing under the following conditions:

- Train provider staff to administer alcohol and drug testing utilizing elements contributing to the reliability and validity of such testing.

- Onsite alcohol and drug testing utilizing elements contributing to the reliability and validity of such testing.

- All employees shall be instructed in the precautions to take when handling specimens and who has direct responsibility for supervising this activity.

- Employees responsible for collection and testing shall be provided with protective apparel.

- Provision shall be made for storage and disposal of samples and testing chemicals.

- A department, service or staff member shall be assigned responsibility for developing these policies and procedures and for documenting their implementation.

**Child Care Services**

Child Care programs provide care and supervision to a client’s child(ren) while the client is participating in clinical treatment and/or recovery support services. This includes care, control and supervision provided by an individual, other than a parent, during part of a twenty-four (24) hour day to a client’s child(ren), less than 13 years of age, while the client is attending a treatment appointment or recovery support service.

- Child care providers must be licensed and meet the Idaho Administrative Procedures Act (IDAPA) Rules 16.06.02 Rules Governing Standards for Child Care Licensing (Sect. 300).

- Child Care programs will be expected to provide the following services and perform the following tasks:
  - Provide services at a time and location that is suitable for the client to attend clinical treatment or recovery support services;
  - Provide a setting that promotes and ensures the health, well-being and safety of the child(ren) in care.

**Transportation Services**

Transportation services are provided to clients who are engaged in treatment and/or recovery support services and who have no other means of obtaining transportation. Reimbursement is not available for transportation services to and from employment.

Individual Transportation refers to any individual providing transportation who does not meet the definition of public or Agency Transportation and provides only transportation services to an eligible client.
Please Note—only Individual Transportation providers who are approved by the Bureau of Substance Use Disorders and have a Provider Agreement with the BPA Health can be reimbursed.

Public Transportation refers to any entity in the business of transportation that is organized to provide and actually provides transportation to the general public.

Please be advised that clients not funded by Medicaid may utilize transportation services for any SUD funded treatment and RSS that are defined in IDAPA. SUD clients may also use authorized transportation to any services/appointments that are directly related to any goals documented on the client's Comprehensive Case Management or RSS Service Plans.

This may include but is not limited to:

- Medical appointments
- Dental services
- Probation appointments
- Employment assistance services
- Idaho Division of Vocational Rehabilitation appointments/services
- Client case staffing
- Mental health services

Any transportation requests to recovery-oriented services not defined in IDAPA require documented confirmation of the appointment/service for which the client is receiving transportation services. Examples of documented confirmation could include a physician's note, appointment receipt, transport record, etc. Treatment providers and Case Managers should consider requirements regarding transportation services outlined in IDAPA and the transportation benefit limits when requesting client transportation.

VI. Services for Women with Dependent Children

These services for women with dependent children including women who are attempting to regain custody of their children apply to all approved treatment facilities and programs seeking specialty status to provide services to women with dependent children.

a. Primary Medical and Prenatal Care. Primary medical care, including prenatal care for women in treatment.

b. Primary Pediatric Care. Primary pediatric care for the children of women in treatment, including immunizations.

c. Gender Specific Treatment. Gender specific alcohol and substance use disorders treatment.

d. Therapeutic Interventions for Women. Therapeutic interventions for women addressing issues such as relationships, sexual and physical abuse, and parenting.
e. Therapeutic Interventions for Children. Therapeutic interventions for children in custody of women in treatment to address, among other things, developmental needs, sexual abuse, physical abuse, and neglect.
f. Child Care. Child care while the women are receiving services.
g. Treatment Provided as a Family Unit. Treating the family as a unit and therefore admit both women and their children into treatment, when appropriate.
h. Case Management. Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments, employment, and training programs.
i. Education and Special Education Programs. Education and special education programs.
j. Drug-free and Safe Housing. Drug-free and safe housing for women and their children.
k. Childhood Programs. Therapeutic day care, Head Start, and other early childhood programs for children.
l. Sexual Harassment Training. Curriculum that covers sexual harassment training for the clients.

VII. General Billing

SUD funding in the BPA Health provider network uses the electronic health record Web Infrastructure for Treatment Services (WITS). All billing is done through WITS however; BPA Health will manage billing appeals and use WITS to audit client files. WITS training is required for providers prior to being credentialed into the network.
VIII. Clinical Supervision

CLINICAL SUPERVISOR

The Clinical Supervisor must have a combination of education and experience as follows:

a. Master’s Degree from an accredited, approved, and recognized college or university in health and human services and the equivalent of three (3) paid full-time professional experience with two (2) years providing direct substance use disorders treatment and one (1) year paid full-time supervision experience in a substance use disorders treatment services state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority or have a Clinical Supervisor designation from the Idaho Board of Occupational Licensure. This experience must be relevant for child and adolescent treatment if supervising treatment in child and adolescent treatment programs; or

b. IBADCC Certified Clinical Supervisor;

c. Knowledge and experience demonstrating competence in alcohol and substance use disorders treatment including client evaluation, counseling techniques, relapse prevention, case management, and family therapy; and

d. For outpatient programs providing services to children and adolescents, the clinical supervisor must have two (2) years of experience working with families or children in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority. Working knowledge of child and adolescent growth and development, and the effects of alcohol and drugs on a child’s growth and development.

Approval of the agencies clinical supervisor will be determined at application or when completing the staff update in the case of change of clinical supervisor for the agency.

CLINICAL SUPERVISION

Agencies may choose to use the NWATTC Model as described in the Idaho “How To” Manual or choose their own model of clinical supervision to be approved by BPA Health.

Clinical Supervision centers on clinician knowledge, skills and attitudes and includes: evaluation of competencies, observation of skills, mentoring, planning and monitoring the work of another clinical staff person by a qualified Clinical Supervisor.

Clinical Supervision includes assuring the quality of treatment, creating a positive work environment and developing staff clinical skills.
The “How To” Manual is located on the BPA Health website at www.bpahealth.com.

**Supervision for Trainees**

For QSUDPTs clinical supervision is required at a minimum of once per month and is a combination of observation, AND individual supervision. A QP must be in the room while QSUDPT is providing services until trainee demonstrates competent practice in the particular competency and clinical supervisor documents proficiency in supervision file, at that point QP no longer has to be in same room but must be on-site during service delivery.

QSUDPT’s required supervision stays at a minimum of once per month until they meet the requirements as a QSUDP. (This is regardless of the fact they may rate high enough in some competencies to move to annual).

A QSUDPT must have a job description in their clinical supervision files that states they are a trainee and the fact that they are a trainee must be made clear to those receiving clinical services.

A QSUDP/Clinical Supervisor must co-sign all documentation done by the QSUDPT.
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.

Additional Resources:

- Institute of Behavioral Research, Texas Christian University [http://www.ibr.tcu.edu](http://www.ibr.tcu.edu)


Motivational Interviewing and Stages of Change: Integrating Best Practices for Substance Abuse Professional by Kathyleen M Tomlin and Helen Richardson.

Substance Abuse Treatment & the Stages of Change: Selecting & Planning Interventions by Connor, Donovan and DiClemente.

Client Records

Client records include results of examinations and laboratory tests, encounters, referrals, mental health screenings and tests, contacts about the client, 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 must be kept in a secure location.

Client Records Release

Client’s records shall be confidential and not released without the written authorization of the covered person or the 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 HIPAA and 42 CFR part 2 regulations.
Required Information

Providers must maintain complete client records in accordance with the following standards:

- 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 by the clinician (can be electronic)
- Significant illnesses or client conditions are documented
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the client record. If no known allergies exist, that must be documented
- Appropriate subjective and objective information pertinent to the client’s presenting complaints is documented in the record
- Past treatment history is easily identified and includes any psychiatric hospitalizations
- Working diagnosis is consistent with assessment
- **A Service plan that is appropriate for diagnosis and developed within 72 hours of admission to a residential facility; within 30 days of start of treatment in an outpatient program. The service plan must be updated every fourteen (14) days in a residential facility and at least ninety (90) days in an outpatient setting.**
- Risk assessments for suicidal and homicidal ideation
- Confidentiality of client’s information and records protected
- Progress note for each session
- The Service Plan should include discharge criteria
- **Discharge Summary which must be entered in the client record within 15 days following discharge or 30 days of inactivity.**

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. Clients have a right to appropriate and quality care. When cultural differences are disregarded clients are at risk for poor quality of care. Clients are less likely to communicate their needs in an indifferent environment, 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 cultural competent and culturally proficient practices.

Network Providers must ensure:

- Client 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 of the clients’ health
- Culturally competent office staff that routinely come in contact with clients participate in ongoing cultural competency training and development;

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• 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 English, Spanish, and 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 could cause the following results for clients:

• Feelings of being insulted
• 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 clients:

• How are cultural differences impacting your relationship with your clients?
• 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?

Cultural Competency Training

BPA Health encourages providers to continuously train their staff on cultural competency. Our trainers will also ensure that all trainings include cultural competency objectives to increase participants’ understanding, appreciation, acceptance, and respect for cultural differences and similarities. BPA Health is committed to the development, strengthening, and sustaining of healthy provider-client relationships that reflect cultural competence in the services provided by both the provider network and BPA Health staff. We believe that a client has a better outcome when they experience culturally appropriate interactions with treatment and RSS providers.
DDCAT for Provider Manual

BPA Health is contractually required to ensure all Treatment providers in the SUD Network are dual diagnosis capable. BPA Health utilizes the Capability in Addiction Treatment (DDCAT) developed by SAMSHA as a self-assessment tool. The agencies review and scoring of this tool is required documentation to be delivered to BPA Health within the first year of the agencies operation.

The DDCAT Index is used to assess addiction treatment agencies on their capacity to deliver services to people with co-occurring disorders

The DDCAT assesses seven areas:

1. Program Structure
2. Program Milieu
3. Clinical Practice: Assessment
4. Clinical Practice: Treatment
5. Continuity of Care
6. Staffing
7. Training

Each of these program areas or dimensions receives a score. Based on the program's overall score, the program or agency is categorized as:

- Addiction Only Services (AOS)
- Dual Diagnosis Capable (DDC)
- Dual Diagnosis Enhanced (DDE)

The tool is available on the BPA Health website at www.bpahealth.com. Providers should contact their Regional Coordinator to learn more about the required services and assessment process.

X. Utilization Management Program

Purpose

BPA Health's Utilization Management (UM) Program provides a structure and process by which clinical appropriateness and effectiveness of behavioral health 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 services, which focus on individualized treatment strategies that promote the principles of recovery and resiliency to consumers seeking substance use disorder treatment. The BPA Health UM program is designed to evaluate the quality, cost, and the coordination of services provided to our consumers. BPA Health strives to build strong, working relationships with our network and community-based providers to improve the delivery of services.
Goals

The purpose of utilization management is to create a system that facilitates necessary communication with the providers serving our consumers in order to produce efficiency in the authorization process and access to services. The UM program assures appropriate utilization, which includes evaluation of potential overutilization, underutilization and timely access to services, and identifies opportunities for improvement in utilization patterns. Review of services is based on medical necessity in accordance to BPA Health’s Clinical Review Criteria policies and standard operating procedures.

The following are the goals of the Utilization Management Program:

- 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 substance use disorder professionals.
- Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity according to the 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 behavioral health services in a timely manner based on turnaround of all UM decisions and timely notification about decisions to consumers and/or providers.
- Establish accountability structures and processes for communication and integration of a comprehensive plan of care 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 consumer and provider information and records.
- Explore opportunities to create and innovate in health care management, recovery oriented systems of care, and service delivery with consumers and providers.

Guiding Principles and Methodology

In order to solidify our commitment to quality healthcare, the BPA Health UM Program has received full URAC accreditation and adheres to both the Version 3.0 CORE and 7.0 Health Utilization Management (HUM) Accreditation Standards. Because BPA Health believes quality is an organizational value synonymous with performance, the UM Program is based
on a responsibility to consumer driven services, our provider network, and continuous quality improvement (CQI). UM is highly integrated with the Quality Management Program, which continuously monitors program data, evaluates clinical and consumer satisfaction results, and takes focused actions when opportunities for improvement are identified.

Clinical Review Criteria

BPA Health has approved the American Society of Addiction Medicine (ASAM) criteria for our UM Program clinical review criteria. The criteria facilitate the pairing of individuals living with substance use disorders with the services and tools they need for a successful and long-term recovery. ASAM empowers service providers to create client-centered service plans and to make objective decisions regarding level of care placement, movement throughout the care continuum, and co-occurring condition needs for a variety of populations in a wide range of care settings.

Clinical review criteria are used to ensure that all care management decisions (a) are made in a standardized and consistent manner, (b) will determine the most appropriate and medically necessary care available, (c) meet the needs for safety, health, and general wellbeing of the populations we serve, (d) are based in scientific literature pertaining to established clinical guidelines and organizational practices, both locally and nationally, and (e) will have regular oversight and reexamination by the BPA Health staff. These criteria are reviewed annually both internally and externally, to ensure that our assessment and determination tools are based on the latest scientific evidence and professional standards. The Care Management team is trained on the chosen clinical review criteria. During the course of day-to-day utilization management activities, UM staff will have readily available access to the appropriate criteria sets and clinical oversight for reference in clinical decision-making.

Staff Roles and Responsibilities

The Manager of Clinical Services and Frontline Team Supervisor oversee the day-to-day activities of the utilization management program. The UM Department utilizes non-clinical and clinical staff members. UM staff performs functions that ensure consumers get the right care at the right time based on the applicable benefit eligibility structure. These functions include care coordination activities that promote the consumer’s safe transition between providers and care settings.

Customer Support Specialists (CSS) are non-clinical staff and are not responsible for conducting any utilization management activities that require interpretation of clinical information. They are trained to review service requests for completeness of information, collection and transfer of non-clinical data, collection of structured clinical data, conducting initial screening to determine benefit eligibility, triage of crisis calls, processing documents from providers, consumers, and referral sources, placing initial assessment authorizations, and creating or modifying authorizations based on current processes. However, all collection of information and data entry processes they complete do not involve clinical decision-making. Licensed health professionals are available to non-clinical staff at all times. CSS are responsible for engaging and working with care management staff for oversight and follow up when there are questions of a clinical nature or when there is a crisis situation requiring immediate clinical intervention.
The Care Management team is comprised of health professionals with a minimum of a bachelor’s degree in an area related to behavioral health, an active license or certification (if applicable) and related experience. Care Managers perform initial and peer clinical reviews in the prospective, concurrent, and retrospective review processes. Care Managers that conduct initial clinical review possess an active, professional license or certificate to practice as a health professional in a state or territory of the United States and with a scope of practice that is relevant to the clinical area(s) addressed in the initial clinical review. Initial clinical reviewers have access to peer clinical review staff at or above the education/licensure level of themselves and/or the ordering provider, including access to the Clinical and Medical Directors. Medical necessity non-certifications are not issued upon initial clinical review, but initial reviewers can assist with notification of non-certifications.

Care Managers who conduct peer clinical reviews are clinical peers with a master’s degree in an area related to behavioral health, hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States and qualified as determined by the Clinical or Medical Director to render a clinical opinion about the procedures and treatment under review. Peer reviewers must hold a current and valid license/certification in the same licensure/certification category as the ordering provider; or as a doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.). M.D.’s and D.O.’s may review care recommended by any type of practitioner, but only M.D.’s and D.O.’s may review other M.D.’s and D.O.’s. Unless expressly allowed by state or federal law or regulation, peer reviewers are located in a state or territory of the United States when conducting a peer clinical review.

The Medical Director makes non-certification determinations based on medical necessity for services involving urgent care and residential treatment, in accordance with BPA Health policy. If initial clinical review indicates a potential medical necessity issue or quality of care concern, the care request will be referred to an appropriate clinical peer reviewer. Care Managers perform brief assessments and provide referral services for consumers who present in crisis.

**UM Decision-Making**

BPA Health will base review determinations for prospective and concurrent reviews 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. Retrospective reviews will be conducted when needed upon receipt of all pertinent clinical and claims information in writing and determinations are based on the clinical information available to the provider at the time the service was provided. When conducting a routine prospective, concurrent, or retrospective review BPA Health collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services. We do not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available, nor do we routinely request copies of all medical records on all patients reviewed, but rather only require portions of the record necessary to certify medical necessity or appropriateness of the admission, extension of stay, frequency or duration of service.
Additionally, BPA Health staff will use our electronic health record system as a means to share all clinical and demographic information on individual clients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from clients and providers. Information obtained during UM decision making process is confidential and will be managed in accordance with BPA Health policy.

BPA Health does not currently delegate the UM function.
Once providers have received facility approval from IDHW a BPA Health Regional Coordinator will conduct a new provider orientation. This orientation will familiarize providers with required documentation and BPA Health audit tools for Clinical Chart Audits, Clinical Supervision Audits, Recovery Support Services and Evidence Based Program Audits.

Within 90 days of this orientation, providers will undergo an initial review to establish a baseline understanding and application of network requirements. The results of this review are not reported to IDHW however, it will be used to determine the timeframe of the next scheduled Clinical Chart and Clinical Supervision Audits.

**Types of Audits**

1) Clinical Chart Audits are utilized to assess the quality of client records by reviewing documented client rights, client releases & collateral contacts, referrals for testing, and individualized service plans & discharge summaries. A random sample of clients for each population type are audited. At this time, billed services are reviewed and any incorrect billing will be recouped from the provider.

2) Clinical Supervision Audit review and evaluate documented supervision occurrences, activities, observations, and completion of professional development plans. The Idaho “How to Manual” is used as a guide when conducting the audit.

3) Evidence-based Programs & Practices Audits are utilized to evaluate the programs and practices used for substance abuse treatment by providers and ensure treatment provided is evidence-based which includes review of clinical charts, group observation and clinician and client interviews. The audit is conducted at a minimum of one time per year with the clinical chart portion integrated into the chart audit. Group observations and interviews will be conducted either stand alone or in conjunction with another visit.

4) Recovery Support Services Audits review and evaluate case management, drug and alcohol testing, life skills, transportation, child care and safe and sober housing services provided by treatment providers and RSS only providers. A random sample of clients for each RSS service provided are audited. At this time, billed services are reviewed and any incorrect billing will be recouped from the provider.

5) Facility Renewal Audits are conducted based on each treatment provider’s DHW facility certification expiration date. For each facility renewal treatment providers submit an application and their current policies & procedures. The application, policies & procedures are reviewed along with personnel files, clinical charts, and a facility walk thru performed. An approval summary is submitted to DHW summarizing the audit results and approval duration recommendation.

**Scheduled Audits**

A score of 80% or above on the Clinical Chart and Clinical Supervision audits places the provider on an annual audit schedule. Clinical Chart or Clinical Supervision Audit scores lower than 80% places the provider on a 90 day audit schedule for the next audit.

In the event of a score less than 80% the provider will be required to submit a Corrective Action Plan within 10 days upon receipt of the audit results. The Corrective Action Plan is then approved by the Regional Coordinator and the deadline for the next audit is set for approximately 90 days.
If the Regional Coordinator identifies a consistent deficiency and the score is above 80% a Performance Improvement Plan is requested and due for approval 10 days upon receipt of the request. The Performance Improvement Plan is then sent to the Regional Coordinator for approval and the provider remains on the annual timeline.

Providers that receive 90% or above on two consecutive audits will receive a 2 year approval and the next scheduled audit will be 24 months from that approval date. CARF accredited facilities will not be audited while CARF Accreditation is in good standing.

**For Cause Audits**

If BPA Health receives a complaint or identifies a problem or potential problem with any provider regardless of the schedule audit plan, BPA may determine an audit is necessary to ensure compliance.

**Audit Scheduling and Procedure**

Audits are scheduled the month prior to the deadline. Regional Coordinators will make every effort to schedule audits at the provider’s convenience prior to the deadline. To fulfill our contractual obligations to IDHW we cannot schedule audits past the deadline.

Once the audit is complete the Regional Coordinator is available to review the findings of the audit. In each region a Regional Coordinator is available to schedule technical assistance training.

Audits are an essential method to determine quality of a provider. Failing multiple audits without indication of sustainable improvement or in addition to other indicators such as complaints, Critical Incidents or inability to receive the quarterly incentive as described in the quality assurance section can threaten the active status of a provider in the SUD Network.
Client and Provider Appeals, Complaints and Critical Incident Reporting

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’s 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 higher 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.

Rejection and non-payment of claims

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 higher 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 WITS ID, if applicable
- 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.

**Critical Incident Reporting**

All Critical Incidents are required to be reported per IDAPA within 24 hours of when they occur or when notification of an event is received. Providers should report events to Provider Network Management by completing the Critical Incident Form and submitting it to providerrelations@bpahealth.com. The form can be found on the BPA Health website at [www.bpahealth.com](http://www.bpahealth.com). A Regional Coordinator will contact providers to follow-up on all Critical Incidents.

A Critical Incident is including, but not limited to, any event or events that threatens the safe and efficient operations of any provider or of the Contractor, or any event involving violence or serious injury at a provider site or during a provider sponsored activity, or any event involving a client who received services within the last thirty (30) days.

Critical Incidents may include, but are not be limited to the following:

1. Death that is related to client’s condition, such as a Motor Vehicle Accident, accidental overdose or medical condition that is related to Substance Use Disorder
2. Completed suicide
3. Suicide attempt while receiving treatment services
4. Actual, alleged or suspected cases of violence, abuse or neglect of a client
5. Any facility or provider related event that will substantially interfere with care
6. Any facility or provider related event requiring emergency services or law informant involvement
7. Any facility or provider break-in resulting in missing or stolen client files
8. Improper use or disclosure of patient records covered under CFR 42 and HIPAA
9. Major disaster or accidents affecting the location or well-being of clients
10. Employee criminal activity resulting in arrest, detention, or involvement with law enforcement
BPA Health is committed to providing quality programs and services to our clients, families, and customers. As such, we place great emphasis on the quality of our provider networks. BPA Health considers each network provider to be an integral part of the Quality Management Program and expects each provider to participate in BPA Health’s Provider Quality Assurance Plan. The Provider Quality Assurance Plan sets forth BPA Health’s provider network quality standards along all lines of business to ensure clients are receiving high quality care and providers’ treatment environment and operations.

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 and sanctions monitoring
- Incentive-based Performance Requirements

Primary Activities

The Provider Network Manager 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.
- Ensuring that appropriate training, resources and support are provided to providers and throughout the organization to achieve quality goals.

Primary Monitoring Activities

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

- Provider credentialing and 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 based on 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 & Sanctioning Policy.

- **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 all BPA Health’s network providers. The site visits conducted are conducted in accordance with BPA Health policy.

- **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 and 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.

- **Incentive-based Performance Requirements** include 1) entering of treatment notes for each client within 5 business days to ensure quality clinical record maintenance and 2) timely discharge of clients after 30 days of inactivity. Providers unable to maintain these elements or struggling with other clinical activities in WITS may be required to attend mandatory WITS trainings to bring their agency into long term compliance. In addition, these requirements will be integrated into a review of overall provider quality for Credentialing Committee consideration of administrative competence.
XIV. BPA Health Contact Information

For questions regarding contracts, facility service information, authorized levels of care and provider status and changes

**Provider Network Management**.............................................(800) 688-4013

Provider Network Email Contact..............................providerrelations@bpahealth.com

For questions regarding claims payment, denial, submissions etc., not for submission of claims

**Claims**..............................................................................(208) 947-1275

Claims Email Contact.............................................claims-dept@bpahealth.com

For questions regarding service vouchers, service authorization, and to speak to a Care Manager for clarification

**Care Management**...........................................................(800) 922-3406

For clients calling to complete eligibility screenings.

**Care Management Screenings**.............................................(800) 922-3406

Care Management Email Contact..............................sacare@bpahealth.com

**BPA Health Regional Coordinators**

Communication and education liaisons between the provider and BPA Health, a resource to providers and community stakeholders/referral sources for the State of Idaho Substance Abuse Treatment Delivery System.

**Nancy Irvin, Clinical Regional Coordinator Region 1**.........(208) 964-4868

Email: Nancyi@bpahealth.com

**Dean Allen, Clinical Regional Coordinator Region 2**..........(208) 305-4439

Email: Dean.Allen@bpahealth.com

**LaDessa Foster, Clinical Regional Coordinator Region 3 & 4**...(208) 284-4511

Email: LaDessa.Foster@bpahealth.com

**Sharon Burke, Regional Coordinator Contact Region 5**.......(208) 841-4944

Email: Sharon.Burke@bpahealth.com

**Doug Hulett, Clinical Regional Coordinator Region 6 & 7**.....(208) 921-8923

Email: Doug.Hulett@bpahealth.com
**XV. Definitions / Acronyms**

**42 CFR, Part 2:** Federal confidentiality rules that prohibit the disclosure of information concerning a client in alcohol or drug treatment unless further disclosure is expressly permitted by the written consent of the person who it pertains or otherwise permitted by 42 CFR, Part 2. Please note that to reduce stigma associated with substance abuse, this rule defines the required confidentiality and privacy for substance abuse treatment across the country. It is far more restrictive with regard to disclosure than HIPAA.

**Adverse or Critical Incident:** A Critical Incident is including, but not limited to, any event or events that threatens the safe and efficient operations of any provider or of the Contractor, or any event involving violence or serious injury at a provider site or during a provider sponsored activity, involving a client who received services within the last thirty (30) days. Such events are called “sentinel” because they signal the need for immediate investigation and response. Critical Incidents will include, but not be limited to the following:

1. Death that is related to client’s condition, such as a motor vehicle accident, accidental overdose or medical condition that is related to substance use disorder
2. Suicide
3. Serious suicide attempt while receiving treatment services in a residential or inpatient facility
4. Actual, alleged or suspected cases of violence, abuse or neglect of a patient/client
5. Any facility or provider related event that will substantially interfere with care
6. Any facility or provider break-in resulting in missing or stolen client files
7. Improper use or disclosure of patient records covered under CFR 42 and HIPAA
8. Major disaster or accidents affecting the location or well-being of clients
9. Employee criminal activity resulting in arrest, detention, or involvement with law enforcement

**American Society of Addiction Medicine Patient Placement Criteria (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. The third edition was released in 2013. Website: [http://www.asam.org/publications/patient-placement-criteria](http://www.asam.org/publications/patient-placement-criteria)

**Assessment:** The collection of data necessary to identify areas of concern and functioning and may be used to develop an individualized treatment and case management strategy aimed at eliminating or reducing alcohol/drug consumption utilizing a thorough evaluation of the person’s physical, psychological, and social status, a determination of the environmental forces that contribute to the alcohol/drug using behavior, and examination of the person’s support systems and resources.
NOTE: For clients receiving state-funded treatment, the required minimum assessment tool is the Global Assessment of Individual Needs-CORE (GAIN-CORE) or GAIN-I when court ordered. The GAIN-CORE must be administered by an individual trained and certified as a site administrator. Additional tests.measurements may be used to assist in defining the needs to be addressed (e.g., BECK depression scale, mental health screenings, ASI, SASI, and Socrates).

Assessment Building System (ABS): The GAIN Assessment Building System (ABS) is a HIPAA-compliant, web-based system hosted by Chestnut Health Systems that allows for computer-based and interactive administration of the GAIN instruments. Individuals utilizing this system must have authorization to access through WITS and be certified and approved by IDHW in GAIN administration. Website: http://www.gaincc.org/abs

Authorization Change Request (ACR): The documentation required to submit a utilization review in WITS including initial clinical reviews, concurrent reviews, change to service(s) request, request for a new service(s), updates to authorization span and units. Some ACRs require ASAM documentation accompany in order for a clinical determination to be made by the UM team. Some ACRs do not require ASAM documentation.

BPA Health (BPA): Managed Behavioral Health Organization that serves as the Management Services Contractor (see MSC definition) for the State of Idaho Substance Abuse Treatment System.

Website: http://www.bpahealth.com/

BPA Health Care Manager: Healthcare professional delivering utilization management (UM) services defined as: Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services. UM encompasses prospective, concurrent and retrospective review as well as any review of services where authorization is required in which clinical criteria are applied to a request. Care Managers are also responsible for care coordination activities.

BPA Health Recommended Forms: Refers to those Word documentation examples produced by BPA Health as having the required IDAPA and ASAM elements. Providers have the option to utilize these forms in their current format or reformat them to fit their respective agency or EHR needs. NOTE: The elements in the recommended forms must remain intact to meet IDAPA Standards.

BPA Health Required Forms: Refers to those PDF documentation examples produced by BPA Health that cannot be edited. These documents can be found on our website.

Bureau of Substance Use Disorders: A program within the IDHW Division of Behavioral Health that is responsible for the statewide delivery system of substance abuse clinical treatment and recovery support services.

Case management (CM): “Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.” Definition from Case Management Society of America (CMSA).

Charitable Choice: The general term for several laws that were enacted during the period
These laws are designed to give people in need of services choice among charities offering them services and apply to projects funded by seven Federal agencies including the Substance Abuse and Mental Health Services Administration. These laws clarify the rights and responsibilities of faith-based organizations that receive Federal Funds.

**Client:** A person/consumer/individual receiving services from the program for substance use disorders (SUD) services. This term may be used interchangeably with eligible recipient (see definition of eligible recipient).

**Client ID Number:** WITS generated identification number to identify clients within WITS. Can be used on hard copy clinical files.

**Clinical Chart Audit:** Review of client charts for compliance with IDAPA standards.

**Clinical Supervision Audit:** Review of staff supervision files for compliance with IDAPA and/or additional identified standards.

**Clinical Supervisor (CS):** A clinician having first met the requirements as a Qualified Professional (QP) and having met the qualifications of the supervisory staff which must be verified through written documentation of work experience, education, and classroom instruction.

**Comprehensive Case Management Service Plan:** A comprehensive service plan is based upon a current approved assessment that addresses the medical, social, psychosocial, legal, educational, and financial needs of the client for Case Management services. The Comprehensive Case Management Service Plan provides for the coordination of services across multiple need domains.

**Co-occurring Disorders (COD):** The occurrence of a mental health and substance 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.

**Customer Support Specialists:** Primary contact point for all BPA Health interactions with providers and clients. The Customer Support staff is responsible for conducting initial telephonic screenings and determining funding eligibility, answering questions regarding service vouchers, service authorization, and triaging calls to the correct department for resolution. Customer Support staff can be reached at 1-800-922-3406 (this number also provides 24 hour access to crisis counselors).

**Dual Diagnosis Capability in Addiction Treatment (DDCAT):** A fidelity instrument for measuring addiction treatment program services for persons with co-occurring (i.e., mental health and substance related) disorders. The DDCAT provides definition and standards to determine levels of structure and clinical quality to assist providers in developing treatment programs to meet the needs of the COD population.

Website: [http://www.samhsa.gov/co-occurring/ddcat/](http://www.samhsa.gov/co-occurring/ddcat/)

**Domains:** Specific bio-psycho-social assessment areas as defined by ASAM; six (6) dimensional criteria: acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and, recovery/living environment.
Diagnostic and Statistical Manual of Mental Disorders (DSM): The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults including Substance Abuse and Dependence. It is used to better understand illnesses and potential treatment.

Eligible Member: An individual who qualifies to receive SUD funded services through the contracted services of BPA Health. Also referred to as a client.

For-Cause Audit: Mandatory audit in suspected cases of abuse or other serious violations of state and federal regulations.


Health Insurance Portability and Accountability Act of 1996 (HIPAA): The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. The Security Rule 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. Website: http://www.hhs.gov/ocr/privacy/

Idaho Administrative Procedures Act. (IDAPA): IDAPA rules serve as the Administrative Rules for all state agencies. Administrative rules have the force and effect of law and as such are subject to a comprehensive process that includes review and approval by the Idaho Legislature to become final and enforceable. Website: http://adminrules.idaho.gov/

Intensive Outpatient (IOP): An organized 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: IDOC authorizations for IOP differ dependent upon Stages of Treatment Benefits plan– additional information on plan limitations are noted in the IDOC Rate Matrix.

Level of Care (LOC): A level or modality of care is a step in the client’s treatment process. A level of care includes clinical services, and may also include care coordination and recovery support services. Each time a client moves from one level of care to another, the clinician will be required to document the clinical observations justifying the change.

Life Skills (LS): Life Skills programs are 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.

Management Services Contractor (MSC): Organization that contracts with Idaho Department of Health and Welfare Bureau of Substance Use Disorders to manage the
statewide delivery system of substance abuse clinical treatment and recovery support services. Responsibilities of the MSC include: utilization review and care management services, quality management and outcome assessment, management reporting, account management, claims processing, data collection and managing the provider network.

**Not to exceed (NTE):** Not to exceed service limits (weekly/authorization) identified in the Rate Matrix.

**Outpatient (OP):** An organized nonresidential 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: IDOC authorizations for OP differ dependent upon Stages of Treatment Benefits plan– additional information on plan limitations are noted in the IDOC Rate Matrix.

**Pre-Treatment:** IDOC’s early intervention treatment modality to determine readiness and appropriateness for entering/engaging in treatment. Pre-Treatment period is not to exceed 60-days without clinical justification and coordination with Probation/Parole.

**NOTE:** Applies to IDOC populations only.

**Protected Health Information (PHI):** Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).

**Provider Notification:** BPA Health electronic notification process for the delivery of timely information to the SUD Provider Network.

**Provisional Voucher (PV):** An authorization (aka: voucher) entered by a provider to refer services to an agency other than themselves. This request is placed in a provisional status until reviewed by the MSC. If the request is approved then an authorization is created. If the request is denied then the authorization is never sent to referring agency. Some Provisional Voucher requests may be required to be accompanied by an ACR with ASAM documentation.

**Rate Matrix:** Reimbursement and CPT code schedule for all funding 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 in excess of authorized and appropriate payments have been made

**Recovery Support Services (RSS):** Approved non-clinical substance abuse 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
client at the earliest possible point in the individual planning and service delivery process. Website: [http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/RecoverySupportServices/tabid/381/Default.aspx](http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/RecoverySupportServices/tabid/381/Default.aspx)

**Regional Field Staff / Regional Coordinator (RC):** BPA Health clinical employees that mentor behavioral healthcare facilities, act as a liaison with BPA Health offices, provide training as developed, and assist in problem solving. Regional Coordinators monitor the requirements of the provider contracts with BPA Health and the State agencies contracting for the SUD services.

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

**Secure Email:** Email system that meets all HIPAA and 42 CFR, Part 2 Federal requirements for the secure transmission of PHI and/or related information to/from BPA Health and/or any other entity requesting such communication.

**Specialty Provider:** SUD Provider that has met additional specific requirements and is authorized to provide services to specific populations (e.g., Pregnant Women & Women with Children (PWWC)).

**Substance Abuse and Mental Health Services Administration (SAMHSA):** 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](http://www.samhsa.gov)

**Substance Use Disorder (SUD):** Substance use disorder is marked by a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. SUD is the new term for what previously included substance dependence and substance abuse.

**Service Plan:** Per IDAPA “All clients receiving services must have an individualized service plan. The development of a service plan must be a collaborative process involving the client and other support and service systems.” The Individualized Service Plan uses the IDHW approved comprehensive assessment (GAIN) for identified problem areas to develop goals, and treatment interventions specified for the client. IDAPA states that “The responsibility for the development and implementation of the service plan will be assigned to a qualified staff member.”

**Treatment Episode:** A treatment period that begins with admission to clinical treatment and ends with the last authorized service date.

**Treatment Provider:** Organization approved by the Idaho Department of Health & Welfare Bureau of Substance Use Disorders to provide clinical treatment services to individuals with substance abuse disorders.

**Authorization:** A voucher in WITS identifying funding source (contract), service, allowable units for reimbursement, and allowable time frame to use units. Vouchers are provided to eligible recipients to pay for clinical treatment and recovery support services from a network provider. Vouchers are provider and site specific and are sent to the provider chosen by the
eligible recipient.

**Web Infrastructure for Treatment Services (WITS):** 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.

**Additional acronyms not otherwise defined:**

- Adult Protection Services (APS)
- Child Protection Services (CPS)
- Idaho Department of Health & Welfare (IDHW)
- Evidenced Based Practices (EBP)
- Idaho Board of Alcohol/Drug Counselor Certification (IBADCC)
- Idaho Board of Occupational Licensing (IBOL)
- Idaho Dept. of Correction (IDOC)
- Idaho Dept. of Juvenile Corrections (IDJC)
- Idaho Supreme Court (ISC)