BPA HEALTH

EAP Provider Manual Supplement

May 29, 2020

BPA Health EAP Supplemental Manual

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Welcome to the BPA Health EAP Provider Network. This EAP Provider Manual Supplement is designed to augment the BPA Health Provider Manual in order to assist you in successfully implementing EAP services that are compliant with State, Federal and BPA Health standards. Documents mentioned in the manuals can be found in the Appendices or on our website at www.bpahealth.com.

Professional Licensure and Certification

EAP Network providers must hold a current valid license in one of the following:

- Counselor, Social Worker, or Marriage and Family Therapist
- Psychologist – PsyD or PhD, having completed a one year pre-doctoral or post-doctoral internship in clinical or counseling psychology

Office Updates

Providers must complete the appropriate form located on the BPA Health website as changes occur to address, phone, email, hours, EIN, etc.

Claims (EAP specific)

EAP claims must be submitted within 30 days of the date of service. Claims should be submitted on the BPA Health [EAP Billing Form]() (available on the BPA Health *website) or* the [*CMS 1500*]() (located *at [www.cms.gov/Medicare/CMS-Forms]()).* Claims with insufficient information will be returned for correction and resubmission. CMS 1500 Claims should be:

- Faxed to (208) 344-7430 Attention: Claims, OR
- Mailed to BPA Health, 8050 W. Rifleman, Ste. 100, Boise, ID 83704

Clinical Practice Guidelines (EAP specific)

Documentation Standards

There are a number of required documents that need to be completed or reviewed at time of intake. Some sample templates, can be found in the Appendices in this packet and on the BPA Health website.

- **Releases of Information (ROI)** for any other appropriate individuals to coordinate care (see [Appendix A]() for sample).
- **Informed consent**
- **Acknowledgement** that clients were provided a copy of:
    - Client Rights notification (see BPA Health website).
    - HIPAA and 42 CFR Part 2 confidentiality practices notification (this may be a part of Client Handbook.

- **Treatment Plans** - must be developed with the client, be client-centered and address client strengths and needs (see Appendix B for a sample form). Plans must include:
    - Measurable goals
    - Target dates for attainment
    - Discharge criteria
- **Discharge summary -** must be completed within 15 calendar days of successful discharge or known termination. If client stops coming to treatment the provider has 45 calendar days from last billed date of service to discharge.

Additional documentation standards for EAP providers can be found in Appendix C.

Quality Assurance and Compliance Plan (EAP specific)

The EAP Clinical Record review is based on BPA Health's Clinical Practice Guidelines.

Resources, Technical Assistance, and Training

BPA Health's website at **www.bpahealth.com** includes important resources including:

- BPA Health Provider Manuals
- Communications from BPA Health (these will also be emailed)
- Training information and some archived training webinars and materials
- Required and sample forms
- List of contracted BPA Health providers, including specialties, hours of operation, and EBPs being offered

What happens next?

We have activated you in our EAP Network and look forward to working with you. We do realize this is a lot of information. Please do not hesitate to contact us with any questions.

Welcome aboard!

Appendix

Appendix A – Release of Information Template (Sample)

Agency name, address, phone

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

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

_____ Release to: _____ Exchange with:

____
(Name of Agency or Individual) (Address)

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

(initial all that apply):

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

for the purpose of (initial all that apply):

_____ Care Coordination

_____ Other: ______________________________
(Be as specific as possible)

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

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

Client Signature: ______________________________ Date: __________

Parent/Guardian Signature: ______________________________ Date: __________

Agency Witness: ______________________________ Date: __________

SAMPLE

Appendix B – Treatment Plan (Sample)

Provider Name/Location
Treatment Plan

Client Name: ______________________________ **Date:** __________

Diagnoses: ________________________

Strengths:

1. ____
2. ____
3. ____

Directions: *Presenting and assessed problems must be addressed, referred, or deferred with justification.*

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

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

Discharge Criteria: **Projected Discharge Date:** __________
(Measurable indicators that client is ready for discharge from services):

1. ____
2. ____

SAMPLE

3. ____

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

I, ____________________________________, the client for whom this Treatment Plan was created, was involved with the development and agree with the Plan content.

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

____ ____________________
Client Signature Date

____ ____________________
Parent/Guardian (Required if under 16) Date

____ ____________________
Clinician (Name and credentials) Date

SAMPLE

Appendix C – EAP Documentation Standards

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

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