BPA HEALTH PROVIDER MANUAL

Rev. May 29, 2020

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BPA Health Provider Manual

BPA Health Overview

BPA Health would like to welcome you to our Provider Network. Our staff are trained and dedicated in the importance of positive and professional interactions with all clinicians and facilities in areas of need. We look forward to working with you!

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

Providing Healthcare Solutions, Living Healthier Lives
We offer a variety of products and services focusing on the physical and emotional well-being of employees and their families. Our customized healthcare solutions are backed with an extensive, nationwide Provider Network servicing all 50 states.

Employee Assistance Programs
The Employee Assistance Program (*EAP*) is an employer-sponsored program designed to assist in the identification and resolution of issues at home and in the workplace such as stress, alcohol and drug use, legal and financial challenges and parenting issues.

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

Public Sector Solutions
BPA Health's focus on healthy behavior extends to the public sector. We help public entities improve health delivery systems including substance abuse treatment and mental health services.

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

Provider Networks
BPA Health provides access to the credentialed *EAP Provider* Network to other *payers* such as Speak Your Silence and We Vow. Our behavioral health focused networks can be leased by larger medical insurances, or specific grant programs, who are in need of a more robust mental health roster. By participating in the BPA Health Network, *providers* are able to serve *clients* through other *benefit programs*, and may be requested to join other networks; which can provide distinct models, services, or treatment; to specific demographic groups.

Provider Manual
The BPA Health *Provider Manual* and Appendices are your reference for information about BPA Health policies and procedures. It is intended to be used in conjunction with applicable state specific regulations, licensing and regulatory boards, as well as the BPA Health provider agreement and addenda. It can also be used along with your *provider agreement,* and addenda to assist new employees in learning about the requirements of belonging to one or more of BPA Health's Networks. These documents create the foundation for which providers serving clients look to for guidance. The *manual* includes general information applicable to all Networks as well as links to Network specific information. This manual is reviewed and updated at least once a year. Any changes occurring between revisions will be communicated to *providers* through email and will be listed in Appendix 3.

Italicized terms are included in the Glossary section of this *manual* located in Appendix 1. Forms referenced in this *manual* or in the *provider agreement* are available for download or printing through the *provider's* section of the *website*.

Contact Information
BPA Health communicates with *providers* directly, through email, Constant Contact, and through USPS as needed. BPA Health staff are available by phone Monday through Friday 8am – 6pm MDT, with exceptions for holidays and other state approved events. BPA Health will notify *Network providers* in advance of any holiday or approved closures.

Appeals	To request an appeal, call (800) 922-3406 or email wecare@bpahelath.com

Change *Provider* Profile	To change or update your provider profile (e.g. address, hours, phone number), complete the appropriate form on the BPA Health *website*.
Claims	For questions regarding claims payment, denials and submissions, not for submission of claims call (800) 922-3406, fax (208)344-1430, or email claims-dept@bpahealth.com
Complaints	To report a complaint regarding an *EAP provider* or *EAP* services provided call (800) 726-0003. To report a complaint regarding a *SUD provider* or *SUD* services provided call (855)643-7233 or (208) 334-6870 or email DBHproviderquality@dhw.idaho.gov
Adverse Event	*Providers* in the must complete the *adverse event* form on the BPA Health *website*.
EAP Client Intake	Phone screenings for *EAP* referrals call (800) 726-0003 or (208)947-1308.
Fraud, Waste, and Abuse	To report *fraud, waste, or abuse* directly to BPA Heath call (800)486-4372 or (208) 947-1290 or email FWA@bpahealth.com. To report anonymously to a third party and confidential report service call (855)372-8345 or go on line to www.FRAUDHL.com and use company ID: BPAHealth.
Provider Relations	To obtain information regarding joining one of BPA Health's Networks, and credentialing and recredentialing processes please call (800)688-4013 or (208)947-4377 or email ProviderRelations@bpahealth.com To send supporting documentation such as malpractice insurance, please email ProviderRelations@bpahealth.com, or fax (208)344-7430. For questions regarding audit results call (800)688-4013 or email to ProviderRelations@bpahealth.com
Quality	For questions regarding surveys call (800)922-3406 or email to wecare@bpahealth.com
Substance Use Disorder (SUD) Care Management	For questions regarding Idaho state funded *SUD* service authorizations, and to speak with a *Care Manager* call (800)922-3406.

Substance Use Disorder (SUD) Client Intake	For screenings to determine eligibility for Idaho state *SUD* benefit program call (800)922-3406.
Training and Technical Assistance	For questions related to BPA Health sponsored trainings call (800)688-4013 or email BPATraining@bpahealth.com To request technical assistance please call (800)688-4013 or (208)947-4377 or email ProviderRelations@bpahealth.com

BPA Health routinely communicates with *providers* via encrypted email, constant contact, and telephone. In the event of a disaster and during periods of prolonged network outages, BPA Health will communicate any changes in how to contact us.

During regular hours of operation BPA Health staff should be able to reach a *provider* office via phone, leave voicemail, or send an email. When the main contact phone number or email changes, provider needs to email ProviderRelations@bpahealth.com . BPA Health staff should be able to contact *providers,* and when requesting information, receive a response within three (3) business days.

Electronic Resources

HIPAA Compliant Platforms

BPA Health uses a number of *HIPAA* and *42 CFR part 2* complaint electronic resources including but not limited to Quick Cap, *WITS*, Zoom, Docusign and Cognito forms to assist in reducing paper and increasing efficiencies.

Website

The BPA Health *website* can be found at bpahealth.com. You can search for a *provider* in one of our Networks, as well as find links to important *provider* resources. Please contact ProviderRelations@bpahealth.com if you are unable to find what you're needing.

Network Providers

Network *providers* are individuals or facilities who have signed a contract(s) to provide *covered services* to clients in one or more of the BPA Health Networks. They are contractors, not employees, of BPA Health.

Provider Identification Numbers
BPA Health assigns a unique number for each *provider* as well as a number for each *provider* office location. *Providers* should bill for the appropriate location of where services were delivered.

Before applying to join one of the BPA Health Networks, applicants must first have a *National Provider Identifier (NPI)*. The *NPI* is a unique ten digit identification number issued by the Centers for Medicare and Medicaid (CMS) for covered health care provider under *HIPAA*. Information on the *NPI* application process can be found at CMS.gov.

Policies and Procedures
Network providers must comply with the terms of their *provider agreement(s)* and any addendums, as well as the policies and procedures described in this *manual*. It is important to note that some policies and procedures are applicable only to some government sponsored contracts, EAP contracts, and/or *benefit programs*. Additionally, *providers* are required to maintain their own written policies and procedures. A list of situations that *providers* must address in policies and procedures can be found in Appendix 2.

Credentialing and Recredentialing

Credentialing and re-credentialing of BPA Health Network *Providers* is designed to ensure that *providers* within our Networks meet BPA Health credentialing standards. The goals are 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 and current clinical competence

The BPA Health Credentialing Committee (CC) has responsibility and authority for credentialing and re-credentialing the BPA Health provider Network. 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 before a provider or facility is designated as a provider within the program's Network. In an effort to expedite processing, the BPA Health's Medical Director may allow an Agency into the Network prior to review by the full Credentialing Committee. The Medical Director may conduct additional review and investigations of

credentialing applications where the credentialing process reveals factors that may affect the quality of care or services delivered to clients.

In addition to credentialing and re-credentialing *providers*, the *Credentialing Committee* can also terminate, restrict or limit a *provider's* clinical privileges (e.g., based on quality of care and/or services issues). In these situations, the *provider* may enter into the Adverse Action *Appeals* process (see BPA Health *website* for additional information). The *Credentialing Committee* can require that *providers* obtain additional trainings or supervision, or choose to deny *providers* who are requesting an initial credentialing and present a concern of any kind.

Decisions made which are unfavorable to the provider will be reported to National Practitioner Data Bank, state licensing board(s), or other certification entity, 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 Adverse Actions 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 will be provided.

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

BPA Health will send written notification to the provider informing them of the determination of the credentialing application.

Credentialing

Applicants must submit a completed application, along with required supporting documentation for participation in one or more of the BPA Health Networks. Required documents can differ based on the Network(s) the applicant is applying to join and the services they wish to provide. BPA Health must receive all required documents before an application is considered complete and ready for review. *Provider Network Management* staff can assist you in determining if additional documents are needed. The application can be found on the BPA Health *website*.

Please note: Submission of an application does not guarantee entry into a BPA Health Network. Prior to processing an application, BPA Health will review

current Network capacity and census information to determine if adding an agency is beneficial for both the agency and the Network.

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

- Demonstrate their current competence,
- Continuously meet and satisfy the qualifications, standards and requirements set forth.
- Practice in a geographic area determined by BPA Health to be advantageous to its clients

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

BPA Health will accept additional information from *providers* to correct incomplete, inaccurate, or conflicting credentialing information. Incomplete information or other extraneous factors may result in a delay of the credentialing process. BPA Health may terminate the *provider*'s status in the Network and require provider to go through initial credentialing process again if a completed application with all required supporting documentation is not received by the due date.

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

Insurance Standards

All BPA Health *providers must* carry appropriate insurance coverage. The requirements differ based on services provided. See Appendix 2 for specific insurance information and coverage requirements.

BPA Health Licensure/Certification Qualifications (Individual and Agency)
Licensure and certification qualifications for individuals and agencies differ based on *provider* networks and the services being offered. See links to SUD

Provider Manual Supplement in Appendix 3 and EAP Provider Manual Supplement in Appendix 4 for specific requirements.

Cultural Competency
Within the BPA Health Network, cultural competency is defined as a set of congruent behaviors, attitudes, and policies that combine to work effectively in cross-cultural situations. BPA Health is devoted to the development and strengthening of effective and healthy *provider/client* relationships. *Clients* have a right to appropriate and quality care. When cultural differences are disregarded *clients* are at risk for poor quality of care. *Clients* are less likely to communicate their needs in an indifferent environment, limiting effectiveness of the health care process. The *U.S. Department of Health and Human Services* developed and has posted to their website (www.thinkculturalhealth.hhs.gov) the *Culturally and Linguistically Appropriate Services (CLAS)* Self-Assessment tool. All *providers* are encouraged to review CLAS and complete the Cultural Competence Self-Assessment on the BPA Health *website*.

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

Change of Information
Please notify BPA Health *Provider Network Management (PNM)* if any of the following changes occur within your practice:

- Change of address
- Adding an additional location
- Office hours
- Phone number
- Contact email
- Staff leaving or new staff hired (*SUD providers* only)
- Adding or removing an evidence based practice (*SUD* treatment *providers* only)
- Adding or removing a service
- Ownership
- Tax ID number
- Billing address
- NPI number

- Leave of absence/suspension of new referrals and return and accepting new referrals
- No longer interested in belonging to one or more Networks
- Office closure

Change of information forms are available on the BPA Health *website*. Please note requests to add locations or services to one of the BPA Health Networks in not a guarantee of approval. Prior to processing these requests BPA Health will review current Network capacity and census information to determine if the adding the location or service is beneficial for both the *provider* and the Network.

Sanctions

BPA Health sanction process
BPA Health strives to resolve quality of care and service concerns as well as contract compliance through technical assistance, consultation and education. In some situations (e.g. on-going professional competency or quality of care concerns, *client complaints*, etc.) sanctions may be necessary. Those situations are referred to the *Credentialing Committee* for review.

The *Credentialing Committee* may require *providers* to obtain additional trainings or supervision, restrict or limit privileges, suspend referrals or terminate from the Network.

Appeals of Credentialing Committee Decisions
Providers who disagree with a Credentialing Committee decision may enter into the Adverse Action *Appeals* process (see BPA Health *website* for additional information on filing an appeal).

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

Provider Office Procedures

Client Rights and Responsibilities
BPA Health's minimum *client* rights and responsibilities can be found on BPA Health's *website*. *Providers* are encouraged to post *client* rights and

responsibilities in their offices and to provide copies to *clients* during intake. *Clients* may make recommendations to their provider's Rights and Responsibilities Policy.

Access to Treatment Records and Treatment Record Reviews/Audits
Providers must maintain records on *clients*, to whom services are rendered, using accepted medical documentation procedures. BPA Health as the right to access and copy records of *clients* for a period of seven (7) years after the last date of service. *Providers* must maintain records of minor *clients* until they reach the age of majority plus ten (10) years.

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

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

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

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

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

Appointment and Availability Standards
BPA Health has established the timeliness standards for behavioral health appointments for Network *providers* as follows:

Situation	Applicable Populations	Timeframe
Life-threatening emergency (severe symptom or incident requiring immediate attention for which a delay in care could be life threatening)	All populations	The *client* should be seen in person immediately or referred to appropriate emergency service provider.
Non-life-threatening emergency (*client* acute crisis who is needing to stabilize to prevent further deterioration)	All populations	As soon as possible, not to exceed 6 hours
Urgent (significant distress or severe situation, no presenting imminent risk of harm to self or others)	All populations All pregnant women seeking *SUD* treatment	As soon as possible, not to exceed 48 hours
Assessments	All populations	*SUD 19-2524 clients: GAIN I Core Assessment* complete and report submitted within 10 business days of referral. All others, within 30 days or during authorization period, whichever is shorter.
New *client* referrals for all populations	All populations	Within 10 business days
Transfer from residential level of care to *OP* or *IOP*	All populations	Within 5 business days of discharge from residential care
Routine care	All populations	Within 10 business days

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

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

Leave of Absence and Termination
If a *provider* is choosing to take a leave of absence, they must notify BPA Health so that referrals may be suspended. You can inform us of these changes by using the form HERE. When processing this form, staff may contact you do make special arrangements for your upcoming recredentialing.

Provider Rights and Responsibilities

Providers in one or more of the BPA Health Networks have specific rights and responsibilities.

Provider Rights:

1. *Providers* will be informed via initial application packet letter of:
    a. their right to review the information obtained to evaluate their *credentialing* decision, attestation, or CV;
    b. the process and *provider's* right to be informed of the credentialing decision;
    c. *provider's* right to correct erroneous information (see below); and
    d. the *appeal* process for actions taken against *providers* (see below and Provider Termination and Sanction Policy).
2. *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.
3. *Providers* have the right to correct discrepant or erroneous information obtained by BPA Health during verification from primary sources by working directly with the reporting entity or listing agency.
4. *Providers* have the right to respond to inconsistencies discovered during credentials verification process as part of credentialing/recredentialing. It is the responsibility of the *provider* to contact the primary source if the *provider* feels that the primary source data is incorrect.
5. *Providers* have the right to request the status of their application at any time.
6. Providers have to right to appeal adverse determinations from the Credentialing Committee, as well as clinical and claims denials.

Provider Responsibilities
Provider responsibilities are delineated in contracts, addendums and in this *manual.* Requirements may vary depending on what Network(s) and benefits programs a *provider* is contracted to serve.

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

An example of a federal regulation is the *Americans with Disabilities Act (ADA)* which includes requirements regarding provision of services to individuals covered under the *ADA*. *Providers* should adapt services and their offices to meet the needs of their *clients*.

Fraud, Waste, and Abuse Policy
BPA Health's policy to protect the operational, financial and reputational interests of BPA Health, it's employees, *partners*, customers, *providers, clients*, and vendors. BPA Health defines *fraud, waste and abuse* as follows:

- Fraud - the intentional, false representation or concealment of a material fact intended to result in financial or personal gain.
- Waste - An over-utilization of services or careless expenditure, consumption, mismanagement, or use of resources owned, managed, or operated by BPA Health to the detriment or potential detriment to BPA Health and/or BPA Health's *clients.*
- Abuse – the improper use of services or other resources owned, managed, or operated by BPA Health, contrary to the rightful or legal intended use. Can include excessive or improper use of one's position.

Providers should report *fraud, waste, and abuse*, or suspicious activity such as inappropriate billing practices (e.g., billing for services not rendered or use of *CPT* codes not documented in the treatment record). Concerns of *FWA* can be reported directly to BPA Health at (800)486-4372 or (208) 947-1290 or email FWA@bpahealth.com. To report anonymously to a third party and confidential report service call (855)372-8345 or go on line to www.FRAUDHL.com and use company ID: BPAHealth. BPA Health will investigate all *FWA* allegations.

Complaints

BPA Health believes that anyone has the right to file a *complaint* and express a concern about our programs and services. A *client* may designate a representative to file a *complaint* on their behalf. There is no statute of limitations for the filing of a *complaint*. BPA Health welcomes *complaints* and considers them as valuable opportunities to learn, adapt, and improve the services we provide our *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

To report a complaint to BPA Health regarding an *EAP provider* or *EAP* services provided call (800) 726-0003.

To report a complaint to the State of Idaho regarding a *SUD provider* or *SUD* services provided call (855)643-7233 or (208) 334-6870 or email DBHproviderquality@dhw.idaho.gov

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

1. Address complaints quickly and courteously, treating all complaints equally and seriously
2. Record all complaints, keep *clients* and customers informed of the progress, and record the action taken to address the complaint.
3. Respond to complaints within **five (5) days** from receipt and resolve them within **thirty (30) days** from receipt.
4. 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.
5. All *complaints* regarding *SUD providers* or services will be referred to IDHW. BPA Health reserves the right to investigate any *SUD* complaints it receives on a case-by-case basis.

Claims Procedures

Preauthorization

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

Claim Submission Guidelines

Claims submission requirements may vary by *benefit program* (see Appendix 3 SUD Provider Manual Supplement or Appendix 4 EAP Provider Manual Supplement for more details). All claims must be submitted within 30 days of date of service.

Requests for Additional Information

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

Payment Processing

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

Balance Billing

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

Claims Recoupment

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

Claims Appeals

Providers may appeal claims determinations. Appeals form can be found on the BPA Health website.

Claims Billing Audits

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

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

Supervision and Case Consultation Standards

Supervision and case consultation help ensure quality and ethical care. Supervision additionally assists in the growth and development of behavioral health professionals. BPA Health expects all providers to participate in supervision and case consultation in accordance with their scope of practice and industry standards. Some *Provider* Networks and *benefit programs* require specific supervision elements. If applicable, they will be documented in Manual Supplement.

Client Release of Information (ROI)

Client's treatment and service records shall be kept confidential and not released without the written authorization (*Release of Information or ROI*) of the *client* or the *client's* legal guardian. When the release of *client* records is appropriate the extent of that release should be based upon 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. All treatment and *RSS* Service providers must obtain ROIs prior to releasing information.

Documentation Standards

All *providers* must maintain *client* records (written and electronic) in compliance with BPA Health's documentation standards, policies and procedures, and all

applicable privacy rules, laws and regulations. Accurate and complete *client* records assist *providers* in delivering the highest quality healthcare. They also enable BPA Health to review the quality and suitability of services rendered. To ensure the *clients*' privacy, *client* records should be kept in a secure location and in compliance with *HIPAA* and *42 CFR Part 2* standards. See Appendix 3 SUD Provider Manual Supplement or Appendix 4 EAP Provider Manual Supplement for more details.

Utilization Management

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 treatment. The BPA Health *UM* program is designed to evaluate the quality, cost, and the coordination of services provided to our *clients.* BPA Health strives to build strong, working relationships with our Networks and community-based *providers* to improve the delivery of services. BPA Health does not delegate the *UM* function.

BPA Health's *utilization management* program creates a system that facilitates necessary communication with the *providers* serving our *clients* 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 (UM)* Program:

1. Assure services rendered are *medically necessary* and furnished in an amount, duration and scope that address the needs of the consumer using written, objective clinical review criteria based upon professionally recognized resources and established with input from clinical staff members and professionals.
2. Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity according to the Prospective, Concurrent, and Retrospective Review Policy.
3. 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.

4. Enable *clients* to access approved behavioral health services in a timely manner.
5. Notify *clients* and/or *providers* of *UM* decisions in a timely manner.
6. Establish accountability structures and processes for communication and integration of a comprehensive plan across providers, settings, and the continuum of care.
7. 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.
8. Protect the confidentiality of *client* and *provider* information and records.
9. Explore opportunities to create and innovate in health care management, recovery oriented systems of care, and service delivery with *clients* and *providers*.

Authorizations and Referrals

To request an initial *authorization* for services and receive a referral to a Network *provider*, individuals must call BPA to determine eligibility. The process may differ dependent upon *benefit program*.

If an individual is determined to meet eligibility they will be offered choice in selecting a Network *provider.* BPA Health's *website* includes a list of *providers* in each of the Networks. The list can be searched by addresses and specialties. If the individual does not meet eligibility for an *authorization* and referral, BPA Health will provide them with information about available community support services and programs, such as local or state-funded agencies or facilities, whom might provide sliding scale discounts for treatment.

Clinical Review Criteria

BPA Health utilizes current and explicit national guidelines and professional standards for making decisions regarding medical necessity of care. The BPA Health senior clinical staff is responsible to review and update all criteria and scripting documents annually. BPA Health staff and *providers* with current, unrestricted clinical licenses and knowledge relevant to the criteria will also be consulted for the development and review process. Clinical review criteria are used to ensure that all care management decisions:

1. Are made in a standardized and consistent manner.
2. Will determine the most appropriate and *medically necessary* care available.
3. Meet the needs for safety, health, and general wellbeing of the populations we serve.

4. Are based in scientific literature pertaining to established clinical guidelines and organizational practices, both locally and nationally, and
5. Will have regular oversight and reexamination by the BPA Health staff.

These criteria are reviewed annually by BPA Health, to ensure 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 and clinical oversight for reference in clinical decision-making.

Prospective and Concurrent Review Process

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

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

Response timelines for *prospective reviews*:

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

If a *client's* benefits have been exhausted or their *benefit program* does not include coverage for requested services, the *provider* must offer the *client* information about available community support services and programs, such as local or State-funded agencies or facilities, whom might provide sliding scale discounts for treatment.

Retrospective Review

Providers may request, in writing a *retrospective review*. If is determined that a *retrospective review* is available under the *client's benefit plan.* Upon receipt of all required clinical and claims information BPA Health will have 30 calendar

days to complete review. The *provider* and/or *client* will be notified in writing of any extensions and if any additional information needed.

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

Covered Services

Covered services, are determined by *benefit program* and authorized by a BPA Health. The services must be provided in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment. The *provider* shall ensure that all personnel providing *covered services* do so in an ethical and professional manner, and in compliance with all applicable laws and regulation, including licensure and certification boards.

***Certification* and Non-certification Determinations**

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

BPA Health does not issue *non-certification* based on initial 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 request will be referred to an appropriate clinical peer reviewer at or above the education/licensure level of themselves and/or the *provider*, including access to the Clinical and Medical Directors. Requests of clinical nature will be peer reviewed prior to issuing a decision of *non-certification* for a clinical reason. Notification of *non-certifications* sent to members, authorized representatives and/or *providers* will include instructions on how to *appeal* the *non-certification* decision. The *provider* requesting the *authorization* is responsible for notifying the *client* of *non-certification* and offer the *client* with information about available community support services and programs, such as local or state-funded agencies or

facilities, whom might provide sliding scale discounts for treatment. Written notification is available to the *client* upon request.

Adverse Clinical Determination/Peer Review

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

The *client*, authorized representative and/or *provider* must submit a first level *appeal* request in writing within 180 calendar days of notice of *non-certification* or as designated by the health plan or benefit program. BPA Health will provide assistance to any *client*, authorized representative or *provider* needing assistance with an *appeal* request. Standard *appeal* requests will be responded to or resolved in writing within thirty (30) calendar days of receipt. Expedited *appeals* can be submitted verbally or in writing and are available for *non-certification* of requests for *authorizations* involving urgent care only and will be completed with verbal notification of determination to the requesting party within seventy two hours of the request followed by a written confirmation of the notification within three calendar days of notification of decision to the *client* and attending physician or other ordering *provider* or facility rendering service.

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

BPA Health will support a decision by the *appeal* reviewer to overturn a previous denial of certification. BPA Health reserves the right to pay even if the reviewer upholds the denial, as dictated by the *benefit program*.

A copy of BPA Health's *appeals* policy is available upon request.

Appeals

Providers, clients, and their authorized representatives may *appeal* decisions made by BPA Health. Information on how to file an appeal can be found on the BPA Health *website*. The following are appealable:

- *Non-certification* of requested care or services
- Rejection and non-payment of claims
- Credentialing Committee decisions
- Adverse Determinations

Credentialing Committee Appeals

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

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

When *appeals* are identified, BPA Health adheres to the provisions as outlined in the Provider Termination and Sanctioning Policy and the Appeals Policy. See the BPA Health *website* for more information.

Quality Management

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, treatment and service environments, 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

Quality Management Committee

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

Subcommittees reporting up to QMC include:

- **Utilization Management Committee (UMC)** The Quality Management Committee has delegated oversight of the utilization management function to the UMC. The UMC has responsibility to:
  - recommend policies for development
  - Review and approve, and deny, or recommend revisions to policies related to UM activities
  - Review utilization issues (cases) as requested by the Medical Director
  - Review quarterly utilization reports and make recommendations for improvement
  - Review and approve studies, standards, clinical guidelines, trends in quality and utilization management measures and outcomes
- **Credentialing Committee (CC)** The Quality Management Committee has delegated decision-making authority to the *Credentialing Committee*. This committee, chaired by BPA Health's Medical Director with membership that includes *providers*, has responsibility to:
  - Credential and re-credential providers who deliver services to clients
  - Conduct professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of *clients*.
  - Receive and review, at a minimum, health practitioner/professional and *provider* credentials that do not meet BPA Health's credentialing criteria (that are not complete, "clean" as defined by BPA Health, and approved by BPA Health's medical director)
  - Conduct peer review evaluations
  - Make decisions regarding actions on the *credentialing* or *re-credentialing* information presented

Scope of BPA Health Quality Management Program
The Provider Network Management Department oversees the daily operations of the *provider* quality assurance activities. These activities include the following:

1. Overseeing the monitoring functions;
2. Tracking and trending key indicators of:
   a. *Provider* compliance with plan
   b. Internal quality compliance to plan and adherence to nationally recognized criteria.
3. Ensuring ongoing use of quality review information in making *credentialing* and *re-credentialing* decisions.
4. Ensuring that appropriate training, resources and support are provided to *providers* and throughout the organization to achieve quality goals.

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

1. *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.
2. 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.
3. 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.
4. Quality of Care Concerns:
    a. 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.
5. Site Visits:
    a. Ensures BPA Health includes standards for conducting on-site reviews of BPA Health's Network *providers.* The site visits are conducted in accordance with BPA Health standards that includes monitoring for contractual, health, and safety concerns.
6. Satisfaction Surveys:
    a. Satisfaction surveys are utilized as a way to gather *client* and *provider* feedback regarding quality concerns. Data from the survey may trigger a *complaint* or *fraud/waste/abuse investigation*.
7. Corrective Action Plan Compliance:
    a. 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.
8. Terminations and Sanctions Monitoring:
    a. A *provider* can be denied *credentialing/re-credentialing*, sanctioned, or terminated from providing services to BPA Health *clients* in accordance with the Provider Termination & Sanctioning Policy.

Coordination of Care
BPA Health monitors coordination of care between professionals involved in *client's* care, when transferring to a different *level of care* or new *provider*, and when terminating care with a *client*. Monitoring activities may include *utilization reviews* and *audits* of *client* records.

Record Reviews and Audits
BPA Health Network *providers* are required to cooperate with record reviews and *audits* conducted by BPA Health.

BPA Health may conduct record reviews and/or audits under any of the following circumstances:

- Routine quality and/or billing audit
- As a part of continuous quality improvement and/or monitoring activities
- Responding to a quality of care, professional competency, or professional conduct concern
- To verify compliance with *provider agreement*
- As required under a specific Network contract

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

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

BPA Health will provide *provider* with the findings of record reviews and *audits*. If necessary, the findings will include notification of need for a *corrective action plan* to address deficiencies.

Adverse Events
All *providers* are required to report to BPA Health within 24 hours any incident or event that threatens the safe and efficient operations of BPA Health or any contracted provider, involving a client who received authorized services within the last thirty (30) days. Reportable events include but are not limited to things such as completed suicide, stolen files, and employee criminal activity. BPA Health may follow-up on these for additional information. See BPA Health

website for more information and link to reporting form. Failure to comply with reporting requirements may result in sanctions.

Experience/Satisfaction Surveys
BPA Health sends out surveys to *Network providers* regarding their experiences with BPA Health; and services such as under State *SUD benefit program*; and to *clients* regarding their experiences with BPA Health and the *providers* they worked with. The results are used to identify opportunities for quality improvement. Data gathered from the survey may trigger a *complaint* or *fraud/waste/abuse* investigation.

Complaints
BPA Health collects and analyzes *client* and *provider* complaints for opportunities for process improvement at BPA Health and at *provider* offices. Quality committees review complaint data at least quarterly.

Appendices

Appendix 1: Glossary

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

1. Client's benefit program
2. The Provider Agreement
3. This Manual

Italicized words represent a defined term.

Terms and Acronyms:

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

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

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

Adverse Event or Critical Incident: An event that threatens the safe and efficient operations of BPA Health or any contracted provider, involving a client who received authorized services within the last thirty (30) days. Reportable events include but are not limited to things such as completed suicide, stolen files, and employee criminal activity. BPA Health may follow-up on these for additional information. See BPA Health *website* for more information.

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

Appeal: The process of a *provider* or a *client* or their legal representative requesting review or reconsideration of an adverse action.

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

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.

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

Authorization/Authorized Services: An authorization is an agreement that the service meets BPA Health clinical criteria. It is not a guarantee of payment. Payment is subject to *client* eligibility, *provider* licensure/certification and benefit limits at the time that services are provided. Authorizations for *EAP* services are emailed to *providers*. *SUD* funded treatment and Recovery Support services can be located in *WITS*. Authorizations are provider and site specific.

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

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

Basic Housing Essentials: Some clients in the *SUD benefit program* are eligible for *funding* for *basic housing essentials* (bedding, towels, and hygiene items). See rate matrix for limits. These can be requested by Adult Mental Health or State Hospital upon transfer to a *SSH* provider. Note: treatment or *RSS* providers can't request this service.

Benefit Program: shall mean (i) a managed care plan's written description of Covered Services and the conditions, limitations, and exclusions that apply including but not limited to the applicable utilization management and quality

improvement requirements, and the financial incentives for Members to use Participating Providers, (ii) an Employee Assistance Program Services Contract defining eligibility requirements and scope of EAP services or (iii) an Administrative Services Agreement detailing the services provided to a group of individuals who qualify under certain demographic or clinical criteria.

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

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

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

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

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

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

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

Client: A person/consumer/individual receiving services from a *provider*. This term may be used interchangeably with *member* and/or patient.

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

CMS-1500: Billing form for *EAP providers*.

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

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

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

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

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

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

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

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

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

Copayment: The portion of a claim or expense that a *client* must pay out of pocket.

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

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

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

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

Critical Incident Response (CIR): Employer requesting *EAP* counselor to provide on-site services for *clients* following a critical incident that impacts employees.

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

Customer Support Specialists: The Customer Support staff is responsible for conducting initial telephonic screenings and determining eligibility for the SUD *benefit program* or EAP referral, answering questions regarding service vouchers, service authorization, and triaging calls to the correct department for resolution.

DBH: Idaho Division of Behavioral Health. Responsible for Idaho Health and Welfare *SUD* benefit program. They also manage the state's SUD managed care contract with BPA Health.

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

DT: Drug test

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

Dx: Diagnosis

EAP: Employee Assistance Program

EAP Formal Management Referral: Management strongly recommends use of the *EAP* to remedy a performance-related concern (i.e. anger problems, poor working relationships, etc.) In order for the employer to receive reports of the employee's attendance or treatment plan recommendations (compliance or non-compliance) at *EAP* sessions BPA Health will need an Authorization for Use and Disclosure: Management Referral form signed by the employee.

EAP Informal Management Referral: A supervisor suggests to an employee that the *EAP* might be of assistance in addressing "whatever happens to be troubling" the employee (i.e. family/marriage issues, financial problems, etc.). The employer will not know if the employee utilizes the *EAP*.

EAP Mandatory Management Referral: Management requires an employee seek assistance through the *EAP* for an assessment and possible *treatment plan* recommendations. Mandatory referrals may result from a positive drug-screen in violation of a Drug-free Workplace Agreement or Department of Transportation (DOT) Regulations, serious policy violation or if employee exhibits unusual behavior in workplace. In order for the employer to receive reports of the employee's attendance or treatment plan recommendations (compliance or non-compliance) at *EAP* sessions BPA Health will need an Authorization for Use and Disclosure: Management Referral form signed by the employee.

Eligible Recipient: An individual who is eligible to receive Idaho *SUD funded* services at the time of service delivery. May also be referred to as *client*.

Employee Assistance Program (EAP): A benefit offered by some employers for a set number of free counseling appointments for employees and their family members. This is not a part of an employee's health insurance benefit. Some EAP benefits also include free legal and financial services.

Enhanced Safe and Sober Housing (ESSH): Temporary housing that enhances the therapeutic effect of the individual's substance use treatment and assists the individual in transitioning back into the community. ESSH *Providers* have awake staff onsite at all times and employ *QPs* for clinical oversite and care coordination.

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

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

Fraud, Waste, and Abuse (FWA) Policy: BPA Health's policy to protect the operational, financial and reputational interests of BPA Health, it's employees, *partners*, customers, *providers, clients*, and vendors. BPA Health defines fraud, waste and abuse as follows: Fraud - the intentional, false representation or concealment of a material fact intended to result in financial or personal gain. Waste - An over-utilization of services or careless expenditure, consumption, mismanagement, or use of resources owned, managed, or operated by BPA Health to the detriment or potential detriment to BPA Health and/or BPA Health's *clients.* Abuse – the improper use of services or other resources owned, managed, or operated by BPA Health, contrary to the rightful or legal intended use. Can include excessive or improper use of one's position.

Global Assessment of Individual Needs (GAIN): A *SUD assessment* tool. It is the mandatory *assessment* for *IDJC, IDOC* and ISC funded clients.

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

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

IBADCC: Idaho Board of Alcohol and Drug Counselor Certification

IBOL: Idaho Bureau of Occupational Licensing. Also referred to as the Idaho Division of Occupational Licensing.

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

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

IDHW: Idaho Department of Health & Welfare

IDJC: Idaho Department of Juvenile Corrections

IDOC: Idaho Department of Corrections

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

IROC: Idaho Response to the Opioid Crisis grant

ISC: Idaho Supreme Court

Legal and Financial Services: Prepaid services offered to *clients* with an *EAP* benefit. These services offer consultation at no charge to the *EAP client* then a reduced fee if self-referred.

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.

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

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

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

Manual: This Provider Manual which describes the requirements and procedures applicable to *providers* in the BPA Health network(s).

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

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

National Practitioner Database (NPDB): A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers and suppliers.

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

Non-Certification: A determination by BPA Health that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health *benefit program*.

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

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

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

Out-patient (OP): An organized non-residential service, delivered in a variety of settings, in which addiction and mental health treatment personnel provide professionally directed evaluation and treatment for substance-related,

addictive, and mental disorders. This also includes the services of an individual licensed practitioner (8 hours or less of treatment per week for adults and 5 hours or less of treatment per week for adolescents, not including RSS services). **Note**: See *ASAM* for more information on *levels of care* and *rate matrix* for any service limits.

OUD: Opioid Use Disorder

Partners: The term "Partners" applies to the four main State agencies who oversee the State SUD contract. Partners include Idaho Department of Health and Welfare (IDHW), Idaho Department of Corrections (IDOC), Idaho Department of Juvenile Corrections (IDJC), and Idaho Supreme Court (ISC).

Peer Reviewer: is licensed or certified in a field that typically manages the clinical issue under review and has current and relevant knowledge and/or experience to render a *UM* determination for the services being reviewed.

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

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

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

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

Provider: a network organization or individual that provides Substance Use Disorder, Behavioral Health, and/or Recovery Support Services. Applicable entity has entered into a contractual arrangement to provide *covered services* per their network application and reimbursement matrix or fee schedule.

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

Provider Network Management (PNM): The Provider Network Management department at BPA Health. Manages credentialing and recredentialing activities.

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

PWWC: Pregnant and Parenting Women/Women with Children receiving block grant funded *SUD* services.

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

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

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

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

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

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

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

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

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

Separate Incident: Request submitted for additional *EAP* sessions to address a different problem from prior authorization.

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

SOR: Idaho's State Opioid Response grant

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

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.

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

Telehealth: HealthIT.gov defines as the use of electronic information and telecommunications technology to support and promote long-distance clinical health care, client and professional health-related education, public health and health administration.

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

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

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

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

Utilization Review: The processes used by BPA Health to monitor the use of or evaluate the *medical necessity,* appropriateness, efficacy, or efficiency of behavioral health and *recovery support services*.

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

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

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

Appendix 2: Forms and Reference Documents

Regulations on Confidentiality, Privacy, & Security of PHI

1. *Provider* acknowledges that *Provider* is a "Covered Entity" as defined under *HIPAA* (45 C.F.R. § 160.102) and that as a Covered Entity, *Provider* is obligated, among other matters, to comply with the privacy and security provisions of *HIPAA* (45 C.F.R. § Part 164).
2. In order to provide satisfactory assurance to BPA Health that it will appropriately safeguard all "*Protected Health Information*" (as defined under *HIPAA* (45 C.F.R. §160.103)), provided to or obtained by the *Provider,* and that it will comply with applicable law regarding *Protected Health Information* with respect to any task or activity that it performs on behalf of BPA Health, to the extent that BPA Health would be required to comply with such law, the *Provider* hereby agrees that the *Provider* will not use or further disclose the *Protected Health Information* other than as permitted or required under the *Provider Agreement* or as required by law.
3. The permitted and required uses and disclosures of the *Protected Health Information* by the *Provider* are only those that are authorized by the *Provider Agreement* and are made to the *Provider's* employees, contractors, and agents, are directed to or required by BPA Health. The *Provider* will not use or further disclose the *Protected Health Information* other than as described previously, except that the *Provider* may use the *Protected Health Information* for its own proper management and administration and to fulfill any present or future legal responsibilities of the *Provider* that are permissible under applicable state and federal privacy laws, and may disclose such information if the disclosure is required by law as provided for in 45 C.F.R. §164.
4. The *Provider's* medical records pertinent to a *Client* shall be disclosed to BPA Health at its request in order that BPA Health can meet its obligations to perform quality *assessment* and *utilization* and *peer-review*.
5. The *Provider* will use appropriate safeguards to prevent the use or disclosure of *Protected Health Information* other than as provided for in the *Provider Agreement*.
6. The Provider will report to BPA Health any use or disclosure of the *Protected Health Information* not permitted by the *Provider Agreement* of which it becomes aware.
7. The *Provider* will ensure that it will enter *HIPAA* compliant Business Associate Agreements with any subcontractors or agents to whom it provides *Protected Health Information* received from BPA Health and require such contractors or agents to agree to the same restrictions and conditions that apply to the *Provider* with respect to such information. Any such disclosures of *Protected Health Information* to subcontractors,

agents, or other third parties shall be restricted to the minimum necessary to perform the function required.

8. The *Provider* will give individual *clients* the right of access, amendment, and accounting, regarding their *Protected Health Information* in accordance with applicable law.
9. The *Provider* will make its internal practices, books, and records relating to the use and disclosure of *Protected Health Information* received from BPA Health available to BPA Health and the Secretary of the Federal *Department of Health and Human Services* for purposes of determining BPA Health's compliance with applicable law, subject to attorney-client and other applicable privileges.
10. The *Provider* agrees to comply with the *HIPAA* breach notification rules found at 45 C.F.R. § 164.400 *et seq.* Provider shall also notify BPA Health of any breach as defined in 45 C.F.R. § 164.402 and notify BPA Health of all actions taken by Provider to comply with 45 C.F.R. §164.402.

Insurance Requirements for BPA Health Network Providers

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

Required Policies and Procedures

Policies and Procedures	EAP	SUD
Admissions		X
Screenings		X
Waitlist		X
Emergencies (client and provider/agency) 24/7	X	X
Reasonable accommodations (See ADA.gov for guidance)	X	X
Staff training		X
Participant Rights and Responsibilities	X	X
Quality Assurance plan	X	X
No show/late cancelation	X	X
Program Fees (*SSH providers* only)		X
Telehealth (only if providing telehealth)	X	X
HIPAA and 42 CFR Part 2	x	x
Disaster Recovery Plan	x	x
Access and Appointment Availability	x	X
Coverage when out of office	x	x
First Aid and CPR	X	x
Sentinel event reporting		x
Supervision/staffing		X
Cultural competency	X	X

Appendix 3: SUD Provider Manual Supplement

Link to the SUD Provider Manual Supplement which can be found here on BPA Health's website.

Appendix 4: EAP Provider Manual Supplement

Link to the EAP Provider Manual Supplement which can be found here on BPA Health's website.

Appendix 5: Provider Manual Update Log

BPA Health reviews the Provider Manual annually, at a minimum, incorporating changes since prior version. The following reflects the provider manual revision history, provides a general description of the changes, and last revised date. Consult the document, page and/or section indicated to review the change.

SECTION & CONTENT UPDATED	DATE OF CHANGE	REVISED IN MANUAL
EAP and SUD Provider Manual • Combined manuals with a full re-write. Changes include: • Adverse event report requirements for both SUD and EAP providers • Form updates for both SUD and EAP providers • Definition updates for both SUD and EAP providers • Documentation updates for both SUD and EAP providers • SUD Contract changes • Repeal of IDAPA 16.07.15 (SUD providers)		5/29/2020
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