



Cenpatico Provider Manual

State of Florida



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Welcome To Cenpatico

Welcome to the Cenpatico Behavioral Health, LLC (Cenpatico) Provider Network. We look forward to a long and mutually rewarding partnership as we work together in the delivery of mental health and substance abuse services to our members in the state of Florida.

The Cenpatico Florida Provider Manual has been developed to answer your questions about Cenpatico's behavioral health program and to explain how we manage the delivery of mental health and substance abuse services to the members we serve. The Manual will also provide you with specific and detailed information about the Cenpatico service delivery system within the state of Florida.

This Manual provides a description of Cenpatico's treatment philosophy and the policies and procedures administered in support of this philosophy. It also describes the requirements established by Cenpatico and its clients, as well as the performance standards to be adhered to by Network Providers in the delivery of services to members. Cenpatico will provide bulletins, as needed; to incorporate any needed changes to this Manual online at www.cenpatico.com. Additionally, we offer a wealth of resources for our Florida providers on our website including this Manual, provider forms, etc.

We look forward to working with you and providing your group with support and assistance. We hope that you find your relationship with Cenpatico a satisfying and rewarding one.

About Cenpatico

MISSION

Together we inspire hope for a better life

VISION

Cenpatico will become the industry leader in recovery and resiliency based managed behavioral healthcare for the publicly funded consumer

GOAL

Demonstrate value to our customers in everything you do

History and Structure of Cenpatico

Cenpatico (www.cenpatico.com) is a wholly owned subsidiary of CenCorp Health Solutions, Inc. (CenCorp). CenCorp is a wholly-owned subsidiary of Centene Corporation (Centene) (www.centene.com). Sunshine State Health Plan of Florida, Inc. (Sunshine Health) has delegated the provision of covered behavioral health and substance abuse services to Cenpatico. Cenpatico will provide these covered services to Medicaid and other government services program members enrolled in Sunshine Health Medicaid program.

Cenpatico has provided comprehensive managed behavioral healthcare services for more than eleven (11) years, and currently operates in Arizona, Florida, Georgia, Indiana, Kansas, Ohio, South Carolina, Texas, Wisconsin and now Massachusetts. As an integral part of our core philosophy we believe that quality behavioral healthcare is best delivered locally. Cenpatico is a clinically driven organization that is committed to building collaborative partnerships with providers.

Cenpatico has defined “behavioral health” as both acute and chronic psychiatric and substance abuse disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems (ICD-9). Cenpatico provides quality, cost effective behavioral healthcare services for members of Sunshine Health. Cenpatico provides these services through a comprehensive provider network of qualified behavioral health clinicians, providers, and community mental health centers.

An experienced clinical and provider network is essential to provide consistent, superior services to our members. In order to achieve our goal, Cenpatico builds strong, long-term relationships with our provider network. This Provider Manual was designed to assist our provider network with the administrative and clinical activities required for participation in our system. Cenpatico prefers and encourages a partner relationship with our provider network. Member care is a collaborative effort that draws on the expertise and professionalism of all involved.

Cenpatico Managed Care Philosophy

Cenpatico is strongly committed to the philosophy of providing appropriate treatment at the least intensive level of care that meets the member’s needs.

Cenpatico believes that careful case-by-case consideration and evaluation of each member’s treatment needs are required for optimal medical necessity determinations.

Unless inpatient treatment is strongly indicated and meets Medical Necessity Criteria, outpatient treatment is generally considered the first choice treatment approach. Many factors support this position:

- Outpatient treatment allows the member to maximize existing social strengths and supports, while receiving treatment in the setting least disruptive to normal everyday life.
- Outpatient treatment maximizes the potential of influences that may contribute to treatment motivation, including family, social, and occupational networks.
- Allowing a member to continue in occupational, scholastic, and/or social activities increases the potential for confidentiality of treatment and its privacy. Friends and associates need not know of the member’s treatment unless the member chooses to tell them.
- Outpatient treatment encourages the member to work on current individual, family, and job-related issues while treatment is ongoing. Problems can be examined as they occur and immediate feedback can be provided. Successes can strengthen the member’s confidence so that incremental changes can occur in treatment.
- The use of appropriate outpatient treatment helps the member preserve available benefits for potential future use. Benefits are maximized for the member’s healthcare needs.

At Cenpatico, we take privacy and confidentiality seriously. We have processes, policies and procedures to comply with applicable federal and state regulatory requirements.

We appreciate your partnership with Cenpatico in maintaining the highest quality and most appropriate level of care for our members.

Florida Provider Quick Reference Guide

Important Phone Numbers

Prior-Authorization	866-796-0530
Claims Customer Service	877-730-2117
Network Development/Provider Relations	866-796-0530
Appeals/Grievances/Complaints	866-796-0530

Important Fax Numbers

Utilization Management (Submitting an OTR)	866-694-3649
Quality Management/Incident Reports	866-694-3649
Complaints	866-694-3649
Credentialing	866-694-3735

Verifying Member Eligibility

Cenpatico website	www.cenpatico.com
	(You must have a provider or practitioner log-in to access eligibility online)
Cenpatico	866-796-0530
Sunshine Health	866-796-0530
Electronic Data Systems (EDS) Website	http://mymedicaid-florida.com
	(Choose the "Secure Information for Providers" option under the "Providers" section on the homepage)

Cenpatico Website

www.cenpatico.com

Claims Address


Cenpatico
PO Box 6900
Farmington, MO 63640-3818

Claims must be received within 180 days from the date covered services were rendered.

Health Plan Contact Information

Sunshine State Health Plan, Inc.
866-796-0530
www.sunshinestatehealth.com

Sample Member ID Card

	Rx: US Script 1-800-460-8988 BIN:008019
Name:	Effective Date:
ID#:	DOB:
PCP Name :	PCP Phone #:
If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Sunshine Health for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Sunshine Health NurseWise® toll-free at 1-866-796-0530, option 7, or TDD/TTY 1-866-796-0524. NurseWise is open 24 hours a day.	

IMPORTANT CONTACT INFORMATION FOR MEMBERS		
Sunshine State Health Plan 400 Sawgrass Corporate Pkwy, Ste 100 Sunrise, FL 33325 www.sunshinestatehealth.com		
Call 1-866-796-0530 (TDD/TTY: 1-866-796-0524) for		
• 24/7 Member Services	• 24/7 NurseWise (option 7)	• Provider Services
• Prescription Drugs	• Vision Services	• Referrals
• Pre-Authorization	• Dental Services	• Eligibility (IVR)
• Behavioral Health		
For Medical Claims: Sunshine State Health Plan Attn: CLAIMS PO Box 3070 Farmington, MO 63640-3823	For Behavioral Health Claims: Cenpatico Behavioral Health Attn: CLAIMS PO Box 6900 Farmington, MO 63640-3818	

The Cenpatico Provider Network

Cenpatico Service Area

Cenpatico manages and reimburses claims for covered behavioral health benefits of Sunshine Health members throughout the State of Florida.

Network Provider Selection Process

Cenpatico contracts with behavioral health clinicians, providers and community mental health centers that consistently meet or exceed Cenpatico clinical quality standards, and are comfortable practicing within the managed care arena, including an understanding of Sunshine Health covered benefits and utilization. Network Practitioners/Providers should support a brief, solution-focused approach to treatment. Network Practitioners/Providers should be engaged with a collaborative approach to the treatment of Cenpatico members.

Cenpatico consistently monitors network adequacy. Network Providers are selected based on the following standards;

- Clinical expertise,
- Geographic location considering distance, travel time, means of transportation, and access for members with physical disabilities,
- Potential for high volume referrals,
- Specialties that best meet our members' needs; and
- Ability to accept new patients.

In addition to hospitals, behavioral health/substance abuse agencies, community mental health centers and emergency service providers, Cenpatico also contracts with clinically licensed behavioral health practitioners, including psychiatrists, psychologists, counselors/social workers, and nurse practitioners.

Cenpatico contracts its practitioner/provider network to support and meet the linguistic, cultural and other unique needs of every individual member, including the capacity to communicate with members in languages other than English and communicate with those members who are deaf or hearing impaired.

Practitioner Orientations and Ongoing Trainings

Cenpatico conducts an initial orientation within thirty (30) calendar days of practitioners, groups or facilities being placed on active status. Additional trainings are provided, upon request, to all practitioners and their staff regarding the requirements of their Contract and special needs of enrollees. Cenpatico shall also conduct ongoing trainings, as deemed necessary by the Health Plan or the Agency, in order to ensure compliance with program standards and their Contract.

Cenpatico will post information, updates, bulletins, and other pertinent practitioner information on its website.

The Network Practitioner/Provider's Office

Cenpatico reserves the right to conduct Network Practitioner/Provider site visit audits. Site visit audits are conducted as a result of member dissatisfaction or as part of a chart audit. The site visit auditor reviews the quality of the location where care is provided. The review assesses the accessibility and adequacy of the treatment and waiting areas.

General Network Practitioner Office Standards

Cenpatico requires the following:

- Office must be professional and secular.
- Signs identifying office must be visible.
- Office must be clean, and free of clutter with unobstructed passageways.
- Office must have a separate waiting area with adequate seating.
- Clean restrooms must be available.
- Office environment must be physically safe.
- Network Providers must have a professional and fully-confidential telephone line and 24 hour availability
- Member records & other confidential information must be locked up out of sight during the work day; and
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

The Network Practitioner's/Provider's office must have evidence of the following:

- Documents are posted in the Practitioner's/Provider's waiting room/reception area;
- The Agency's statewide consumer call center telephone number, including hours of operation and a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities, in accordance with Section 381.026, F.S., is posted;
- The Network Practitioner/Provider has a complete copy of the Florida Patient's Bill of Rights and Responsibilities, available upon request by a Member, at each office location; and
- The Network Practitioner's/Provider's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area in accordance with Section 641.511, F.S.

Credentialing

Credentialing Requirements

The Cenpatico provider network consists of licensed Psychiatrists (MD/DO), clinical Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Marriage & Family Therapists, Clinical Nurse Specialists or Psychiatric Nurse Practitioners, Community Mental Health Centers (CMHCs), and Providers.

Cenpatico Network Providers must adhere to the following requirements:

- In order to continue participation with our organization, all Network Practitioners/Providers must adhere to Cenpatico's Clinical Practice Guidelines and Medical Necessity Criteria which are located in this Manual.
- Network Practitioners/Providers must consistently meet our credentialing standards and Cenpatico guidelines on Primary Care Physician (PCP) notification.
- Failure to adhere to guidelines and standards at any time can lead to termination from our network.
- Notification is required immediately upon receipt of revocation or suspension of the Network Practitioner's/Provider's State License by the Division of Medical Quality Assurance, Department of Public Health.
- Cenpatico will conduct a background check with the Florida Department of Law Enforcement (FDLE) for all treating practitioners not currently enrolled in Medicaid program.
- If exempt for the criminal background screening requirements, a copy of the screen print of the Network Practitioner's current Department of Health licensure status and exemption reason must be included.
- Cenpatico shall not contract with any practitioner who has a record of illegal conduct; i.e. found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses

listed in Section 435.03, F.S.

- In order to be credentialed in the Cenpatico network, all individual Network Practitioners must be licensed to practice independently in the state of Florida.
- For MDs and DOs, Cenpatico will require proof of the Network Practitioners medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, as applicable.
- License must be current, active, and in good standing.
- All Network Practitioners' graduate degrees must be from an accredited institution.
- All Network Practitioners are subject to the completion of primary source verification of the Network Practitioner through our Credentialing Department located in Austin, Texas.
- The Network Practitioner agrees to complete and provide appropriate documentation for this primary source verification in a timely manner.
- The Network Practitioner further agrees to provide all documentation in a timely manner required for credentialing and/or re-credentialing.
- The Network Practitioner agrees to maintain adequate professional liability insurance as set forth in the Provider Agreement with Cenpatico.
- All credentialing applications are subject to consideration and review by the Cenpatico Credentialing Committee which meets monthly.

The credentialing and re-credentialing process will include verification of the following for MDs and DOs and will ensure compliance with 42 CFR 438.214:

- Valid Drug Enforcement Administration (DEA) certificates (where applicable); and
- Evidence that Cenpatico has evaluated the Network Practitioner's office using Cenpatico standards (as applicable).

Network Practitioners/Providers selected for participation must successfully complete the Cenpatico credentialing process. As part of that process, Network Practitioners/Providers must submit the following documentation:

- Review and assessment of properly completed, signed and dated Florida Credentialing Application and Attestations;
- Statement regarding history of loss or limitation or privileges or disciplinary activity as described in Section 456.039, F.S.;
- A statement from each Network Practitioner applicant regarding the following: any physical or mental health problems that may affect the Practitioner's ability to provide healthcare; any history or chemical dependency/substance abuse; any history of loss of license and/or felony conviction; and must eligible to become a Medicaid Practitioner;
- A copy of current Florida license(s) to practice pursuant to Section 641.495.F.S.;
- Malpractice fact sheet: Network Practitioners/Providers must carry \$1/\$3M in coverage, or such other amounts as required by State law;
- Copy of applicable diploma(s) and or certificates;
- MDs, DOs, and prescribing PAs and NPs are also asked to supply Drug Enforcement Administration (DEA) registration, and Board Certification(s);
- Current curriculum vitae, which includes at least five (5) years of work history with explanation in writing for a six (6) month, or more, gap; and
- Any sanction imposed on the Network Practitioner/Provider by Medicare or Medicaid.

Cenpatico will verify the following information submitted for Credentialing and/or Re-credentialing:

- Florida license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) and HIPDB claims
- Review five (5) years work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS- Excluded Parties Listing)

Once the application is completed, the Cenpatico Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

It is the Network Providers/Practitioners responsibility to notify Cenpatico of any of the following within ten (10) days of the occurrence:

- Any lawsuits related to professional role;
- Licensing board actions;
- Malpractice claims or arbitration;
- Disciplinary actions before a State agency and Medicaid/Medicare sanctions;
- Cancellation or material modification of professional liability insurance;
- Member complaints against practitioner/provider;
- Any situation that would impact a Network Practitioners/Providers ability to carry out the provisions of their Provider Agreement with Cenpatico, including the inability to meet member accessibility standards; and
- Changes or revocation with DEA certifications, hospital staff changes or NPDB or Medicare sanctions.

Network Practitioners/Providers may also have a site visit conducted by a Cenpatico representative as part of the credentialing or re-credentialing process. Failure to pass the site visit may result in a Corrective Action Plan (CAP) that must be satisfied before being considered for admission to the network. Network Practitioners/Providers are subject to an on-site visit at any time with or without cause.

Please notify Cenpatico immediately of any updates to your Tax Identification Number, service site address, phone/fax number, and ability to accept new referrals in a timely manner so that our systems are current and accurately reflect your practice. In addition, we ask that you please respond to any questionnaires or surveys submitted regarding your referral demographics, as may be requested from time to time.

Re-Credentialing Requirements

Florida Network Practitioners/Providers will be re-credentialed every three (3) years as required by the State of Florida. Cenpatico Network Practitioners/Providers will receive notice that they are due to be re-credentialed well in advance of their credentialing expiration date and, as such, are expected to submit their updated information in a timely fashion. Failure to provide updated information in a timely manner can result in suspension and/or termination from the network.

Quality indicators including but not limited to, complaints, appointment availability, critical incidents, and compliance with discharge appointment reporting will be taken into consideration during the re-credentialing process.

Council for Affordable Quality HealthCare (CAQH)

Cenpatico subscribes to the Council for Affordable Quality HealthCare (CAQH) to streamline the credentialing/re-credentialing process. If you are interested in having Cenpatico retrieve your credentialing/

re-credentialing application from CAQH, or if you are not enrolled with CAQH, Cenpatico can contact CAQH to obtain your credentialing items or assist you with setting up an account.

Once a CAQH Provider ID number is assigned, you can visit the CAQH website located at www.CAQH.org, or call the help desk at 888-599-1717, to complete the credentialing application. There is no cost for Network Practitioners/Providers to submit their credentialing applications and participate with CAQH.

Cenpatico Credentialing Policies and Procedures

Cenpatico credentialing and re-credentialing policies and procedures shall be in writing and include the following:

- Formal delegation and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of Network Practitioners/Providers who fall under its scope of authority;
- A process which provides for the verification of the credentialing and re-credentialing criteria;
- Approval of new Network Practitioners/Providers and imposition of sanctions, termination, suspension and restrictions on existing Network Practitioners/Providers;
- Identification of quality deficiencies which result in Sunshine Health's or Cenpatico's restriction, suspension, termination or sanctioning of a Network Practitioner/Provider; and
- A process to implement an appeal procedure for Network Practitioners/Providers whom Cenpatico has terminated.

Right to Review and Correct Information

All practitioners/providers participating with the Cenpatico Network have the right to review information obtained by Cenpatico to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Composite State Board of Medical Examiners and other state board agencies. This does not allow a practitioner/provider to review references, personal recommendations, or other information that is peer review protected.

Should a practitioner/provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner/provider, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to Cenpatico Credentialing Department. Upon receipt of this information, the practitioner/provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Cenpatico. Cenpatico Credentialing Committee will then include this information as part of the credentialing/recredentialing process.

Network Practitioner/Provider Demographic/Information Updates

Network Practitioners/Providers should advise Cenpatico with as much advance notice as possible for demographic/information updates. Network Practitioner/Provider information such as address, phone and office hours are used in our Provider Directory, and having the most current information accurately reflects our Florida Practitioner/Provider Network. Please use the Cenpatico Florida Provider Information Update Form. You may access this form on the Cenpatico website, www.cenpatico.com under Provider/Resources/Forms.

Completed Provider Information Update Forms should be sent to Cenpatico using one of the following methods;

- Fax: 866-694-3735
- Email: Provider_Change-cbh-tx@centene.com
- Mail: Cenpatico
Attn: IPR Unit- Florida
504 Lavaca St., Ste. 850
Austin, TX 78701

Network Practitioner/ Provider Request to Terminate

Network Practitioners/Providers requesting to terminate from the network must adhere to the Termination provisions set forth in their Provider Agreement with Cenpatico. This notice can be mailed or faxed to the Provider Relations Department. The notification will be acknowledged by Cenpatico in writing and the Network Practitioner/Provider will be advised on procedures for transitioning members if indicated.

Cenpatico fully recognizes that a change in a Network Practitioner's/Provider's participation status in Cenpatico's Practitioner/Provider Network is difficult for members. Cenpatico will work closely with the terminating Network Practitioner/Provider to address the member's needs and ensure a smooth transition as necessary. A Network Practitioner/Provider who terminates his/her contract with Cenpatico must notify all Cenpatico members who are currently in care at the time and who have been in care with that Network Practitioner/Provider during the previous six (6) months. Treatment with these members must be completed or transferred to another Cenpatico Network Practitioner/Provider within three (3) months of the notice of termination, unless otherwise mandated by State law. The Network Practitioner/Provider needs to work with the Cenpatico Care Management Department to determine which members might be transferred, and, which members meet Continuity of Care Guidelines to remain in treatment.

Cenpatico's Right to Terminate

Please refer to your Provider Agreement with Cenpatico for a full disclosure of causes for termination. As stated in your Provider Agreement, Cenpatico shall have the right to terminate the Provider Agreement by giving written notice to the Network Practitioner/Provider upon the occurrence of any of the following events:

- Termination of Cenpatico's obligation to provide or arrange mental health/substance abuse treatment services for members of Health Plans;
- Restriction, qualification, suspension or revocation of Network Practitioner's/Provider's license, certification or membership on the active medical staff of a hospital or Cenpatico participating practitioner group;
- Network Practitioner's/Provider's loss of liability insurance required under the Provider Agreement with Cenpatico;
- Network Practitioner's/Provider's exclusion from participation in Sunshine Health programs;
- Network Practitioner's/Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Practitioner's/Provider's insolvency or bankruptcy or Network Practitioner's/Provider's assignment for the benefit of creditors;
- Network Practitioner's/Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Network Practitioner's/Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Practitioner's/Provider's submission of false or misleading billing information;

- Network Practitioner's/Provider's failure or inability to meet and maintain full credentialing status with Cenpatico;
- Network Practitioner's/Provider's breach of any term or obligations of the Provider Agreement;
- Any occurrence of serious misconduct which brings Cenpatico to the reasonable interpretation that a Network Practitioner/Provider may be delivering clinically inappropriate care; or
- Network Practitioner's/Provider's breach of Cenpatico Policies and Procedures.

Network Practitioner/Provider Appeal of Suspension or Termination of Contract Privileges

If a Network Practitioner/Provider has been suspended or terminated by Cenpatico, he/she may contact the Cenpatico Florida Provider Relations department at 866-796-0530 to request further information or discuss how to appeal the decision.

For a formal appeal of the suspension or termination of contract privileges, the Network Practitioner/Provider should send a written reconsideration request to Cenpatico to the attention of the Quality Improvement Department:

Cenpatico
 Attn: Quality Improvement Department
 504 Lavaca St., Ste. 850
 Austin, TX 78701

Please note that the written request should describe the reason(s) for requesting reconsideration and include any supporting documents. This reconsideration request must be postmarked within thirty (30) days from the receipt of the suspension or termination letter to comply with the appeal process.

Cenpatico will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the Network Practitioner/Provider with the notification of suspension/termination. To request a copy of Cenpatico's Provider Dispute Policy, please contact the Quality Improvement Department at 866-796-0530.

Each Network Practitioner/Provider will be provided with a copy of their fully-executed Provider Agreement with Cenpatico. The Provider Agreement will indicate the Network Practitioner's/Provider's Effective Date in the network and the Initial Term and Renewal Term provisions in Cenpatico's Practitioner/Provider Network. The Provider Agreement will also indicate the cancellation/termination policies. There is no "right to appeal" when either party chooses not to renew the Provider Agreement.

Status Change Notification

Network Practitioners/Providers must notify Cenpatico immediately of any change in licensure and/or certifications that are required under federal, State, or local laws for the provision of covered behavioral health services to members, or a if there is a change in Network Practitioner's/Provider's hospital privileges. All changes in a Network Practitioner's/Provider's status will be considered in the re-credentialing process.

Network Practitioner/Provider Concerns

Network Practitioners/Providers who have concerns about Cenpatico should contact the Cenpatico Florida Provider Relations department at 866-796-0530 to register these complaints. All concerns are investigated, and written resolution is provided to the Network Practitioner/Provider on a timely basis.

Member Concerns about Network Practitioners/Providers

Members who have concerns about Cenpatico Network Practitioners/Providers should contact Cenpatico to register their concern. All concerns are investigated, and feedback is provided on a timely basis. It is the Network Practitioner's/Provider's responsibility to provide supporting documentation to Cenpatico if requested. Any validated concern will be taken into consideration when re-credentialing occurs, and can be cause for termination from Cenpatico's Practitioner/Provider Network. This process is referenced in your Provider Agreement with Cenpatico.

Critical Incident Reporting

A Critical Incident Report must be completed on any incident involving a Network Practitioner/Provider and any member(s)/ member advocate(s) seen on behalf of Cenpatico. Critical incidents are to be reported immediately but no more than 24 hours after the occurrence or knowledge of the occurrence.

A Critical Incident is defined as any occurrence which is not consistent with the routine operation of a Mental Health/Substance Abuse Network Practitioner/Provider. It includes, but is not limited to; injuries to members or member advocates, suicide/homicide attempt by a member while in treatment, death due to suicide/homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

The Critical Incident Report Form must be used to document all critical incidents and can be accessed on the Cenpatico website, www.cenpatico.com under Provider/Resources/Forms.

Submit completed Critical Incident Reports to the following address:

Cenpatico
Attn: Quality Improvement Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 866-796-0530
Fax: 866-694-3649

No Show Appointments

A "no show" is defined as a failure to appear for a scheduled appointment without notification to the practitioner/provider with at least twenty-four (24) hours advance notice. No show appointments must be recorded in the member record.

A "no show" appointment may never be applied against a member's benefit maximum.

Sunshine Health members may not be charged a fee for a "no show" appointment.

Cultural Competency

Cultural Competency within the Cenpatico Network is defined as, "a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members."

Cenpatico is committed to the development, strengthening, and sustaining of healthy practitioner/provider relationships with our members. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Cenpatico, as part of its credentialing process, will evaluate the cultural competency level of its Network Practitioners/Providers and will provide access to training and tool-kits to assist our Network Practitioners/Providers in developing culturally competent and culturally proficient practices.

Network Practitioners/Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them;
- Care is provided with consideration of the members' race/ ethnicity and language and its impact/ influence of the members' health or illness;
- Office staff that routinely come in contact with members have access to and participate in cultural competency training and development;
- The office staff responsible for data collection makes reasonable attempts to collect race and language specific member information;
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process; and
- Office sites have posted and printed materials in English, Spanish, or other prevailing languages within the region.

Understanding the Need for Culturally Competent Services

The Institute of Medicine's report entitled "Unequal Treatment," along with numerous research projects; reveal that when accessing the healthcare system people of color are treated differently. Research also indicates that a person has better health outcomes when they experience culturally appropriate interactions with medical practitioners/providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Network Practitioners/Providers should note that the experience of a member begins at the front door.

Failure to use culturally competent and linguistically competent practices could result in the following:

- Member's feelings of being insulted or treated rudely;
- Member's reluctance and fear of making future contact with the Network Practitioner's/Provider's office;
- Member's confusion and misunderstanding;
- Non-compliance by the member;
- Member's feelings of being uncared for, looked down on and devalued;
- Parents' resistance to seek help for their children;
- Unfilled prescriptions;
- Missed appointments;
- Network Practitioner's/Provider's misdiagnosis due to lack of information sharing;
- Wasted time for the member and Network Practitioner/Provider; and/or
- Increased grievances or complaints.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Sunshine Health and Cenpatico are committed to helping you reach this goal.

Take the following into consideration when you provide services to Sunshine Health/Cenpatico members;

- What are your own cultural values and identity?
- How do/can cultural differences impact your relationship with your patients?
- How much do you know about your patient’s culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?

Facts about Health Disparities

- Government-funded insurance consumers face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Consumers are more likely to experience long wait times to see healthcare providers.
- African American Medicaid consumers experience longer waits in emergency departments and are more likely to leave without being seen.
- Consumers are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Consumers that are children are less likely to receive childhood immunizations.
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.
- Health disparities come at a personal and societal price.

The entire Cenpatico Cultural Competency Plan can be accessed on line at www.cenpatico.com

Access and Coordination of Care

Provider Access Standards

Sunshine Health members may access behavioral health and substance abuse services through several mechanisms. Members do not need a referral from their Primary Care Physician (PCP) to access covered behavioral health and substance abuse services. Caregivers or medical consenters may self-refer members for behavioral health services. If assessment is required, Cenpatico must approve the assessment.

Cenpatico adheres to National Commission for Quality Assurance (NCQA) and State accessibility standards for member appointments. Network Practitioners/Providers must make every effort to assist Cenpatico in providing appointments within the following timeframes:

Type of Care	Appointment Availability	Provider Type
Routine – treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting.	Within fourteen (14) calendar days	Specialist

Urgent – is defined as a non life threatening situation, but should be treated within twenty-four (24) hours. Urgent care services are not subject to prior authorization or precertification	Within twenty-four (24) hours	Specialist
Emergent/Non-Life Threatening – defined as inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize a behavioral health condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care to result in injury to self or bodily harm to others; placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction to any bodily organ or part; serious harm to self or others due to an alcohol or drug abuse emergency; with respect to a pregnant woman having contractions – (i) that there is not adequate time to affect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child.	All non-life threatening emergencies are to be directed to the Emergency Room	Specialist, Hospital
Discharge (from hospital/acute care)	Within twenty four (24) hours of discharge	Specialist

If you cannot offer an appointment within these timeframes, please refer the member to the Cenpatico Service Center so the member may be rescheduled with an alternative provider who can meet the access standards and member’s needs. Adherence to these standards is monitored with telephone auditing through the quality program.

Network Practitioners/Providers shall ensure that services provided are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the member’s behavioral health condition dictates. Network Practitioners/Providers will offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees and shall ensure members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit members from accessing services.

Network Practitioners/Providers should call the Cenpatico Provider Relations department at 866-796-0530 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a Network Practitioner’s/Provider’s status will be considered in the re-credentialing process.

Access and Density Standards

Outpatient Behavioral Health Services:

Cenpatico will ensure that all Members have access to an outpatient behavioral health Network Practitioner within thirty (30) minutes average travel time from the Member’s residence for urban areas, or within sixty (60) minutes average travel time from the Member’s residence for rural areas.

Cenpatico shall ensure the outpatient behavioral health Practitioner/Provider Network comprises one (1) full-time behavioral health practitioner per 1,500 Members.

Psychiatrists:

Cenpatico will ensure our Florida Practitioner/Provider Network has at least one (1) psychiatrist and one (1) board certified child/adolescent psychiatrist (or one psychiatrist that meets all education and training criteria for Board Certification) within thirty (30) minutes average travel time from the Member's residence for urban areas, or within sixty (60) minutes average travel time from the Member's residence for rural areas.

Inpatient Psychiatric Services:

Cenpatico will ensure access to no less than one (1) psychiatric hospital bed per 2,000 Members.

No New Referral Periods

Network Practitioners/Providers are required to notify Cenpatico when they are not available for appointments. Network Practitioners/Providers may place themselves in a "no referral" hold status for a set period of time without jeopardizing their overall network status. "No referral" is set up for Network Practitioners/Providers for the following reasons:

- Vacation
- Full practice
- Personal leave
- Other personal reasons

Network Practitioners/Providers must call or write to the Cenpatico Provider Relations department to set up a "no referral" period. The Cenpatico Provider Relations department can be reached as follows:

Cenpatico
Attn: Florida Provider Relations
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 866-796-0530

Network Practitioners/Providers must have a start date and an end date indicating when they will be available again for referrals. A "no referral" period will end automatically on the set end date.

Coordination between Sunshine Health and Cenpatico

Sunshine Health and Cenpatico work together to assure quality behavioral health services are provided to all members. This coordination includes participation in Quality Improvement committees for both organizations, and planned focus studies conducted conjointly for physical and behavioral healthcare services.

In addition, Cenpatico works to educate and assist physical health and behavioral health practitioners in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Sunshine Health on a monthly basis, and is shared with Sunshine Health's QI committee quarterly. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency.

Quality Improvement

Cenpatico's Quality Improvement (QI) Program provides a structure and process by which quality of care and services are continually monitored, and improvements implemented and refined across time. The QI Program provides functional support for quality improvement activities in all departments across the organization. The principles of the QI Program are based on a belief that quality is synonymous with performance. For that reason, the QI Program is highly integrated with clinical services, access issues pertaining to Network Practitioners/Providers and services, credentialing, utilization, member satisfaction, Network Practitioner/Provider satisfaction, PCP communications, and administrative office operations, as well as Sunshine Health's Quality Improvement Program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

Cenpatico is committed to providing quality care and clinically appropriate services for our members. In order to meet our objectives, Network Practitioners/Providers must participate and adhere to our programs and guidelines.

Monitoring Clinical Quality

What does Cenpatico monitor?

Each year, and at various intervals throughout the year, Cenpatico audits and measures the following:

- Access standards for care;
- Adherence to Clinical Practice Guidelines;
- Treatment record compliance;
- Communication with PCPs and other behavioral health practitioners;
- Critical Incidents;
- Member safety;
- Member confidentiality;
- High-risk member identification, management and tracking;
- Discharge appointment timeliness and reporting;
- Re-admissions;
- Grievance procedures;
- Potential over- and under-utilization;
- Provider satisfaction; and
- Member satisfaction

How does Cenpatico monitor quality?

Cenpatico conducts surveys and conducts initiatives that monitor quality. These activities may include any of the following :

- Practitioner/Provider satisfaction surveys;
- Medical treatment record reviews;
- Grievance investigation and trending;
- Review of potential over- and under-utilization;
- Member Satisfaction Surveys;
- Outcome tracking of treatment evaluations;
- Access to care reviews;
- Appointment availability;
- Discharge follow-up after inpatient or partial hospitalization reporting;

- Crisis Response;
- Monitoring appropriate care and service;
- Practitioner/Provider quality profiling; and
- Outcome of FARS and CFARS functional assessments.

Findings are communicated to individual Network Practitioners/Providers and Network Practitioner groups for further discussion and analysis to reinforce the goal of continually improving the appropriateness and quality of care rendered. Cenpatico may request action plans from the Network Practitioner/Provider. Findings are considered during the re-credentialing process.

Network Provider Participation in the QI Process

Cenpatico's Network Providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided.

Network Providers are expected to meet Cenpatico's performance requirements and ensure member treatment is efficient and effective by:

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility;
- Cooperating with Cenpatico's complaint review process;
- Participating in Network Provider satisfaction surveys; and
- Cooperating with reviews of quality of care issues and critical incident reporting.

In addition, Network Providers are invited to participate in Cenpatico's QI Committees and in local focus groups.

Preventative Behavioral Health Programs

Cenpatico offers preventative behavioral health programs for our members. A brief description of the programs including who is eligible to participate is listed below. Cenpatico encourages you to refer your members to the programs directly when you see an unmet need. If you would like more information about the programs or if you have suggestions as to how we can improve our preventative behavioral health programs please contact the Quality Improvement department at 866-796-0530.

The Perinatal Depression Screening Program offers screening to members who are pregnant or have delivered to identify those who would benefit for treatment for depression. We send a copy of the Edinburgh Depression screening instrument to all pregnant women. Each member who completes the survey and returns it to Cenpatico receives a letter from Cenpatico informing them of their screening results and how to access help if appropriate. If a member screens positive for depression while pregnant or after delivery, our staff attempts outreach to assist the member in finding resources. Cenpatico outreaches to the medical practitioner/provider as well to assure the member has the care needed.

Cenpatico has a structured program for children who have been hospitalized for a mental health issue. These high risk children are especially vulnerable so Cenpatico's Care Coordinator and/or Case Management staff attempts outreach to the parents while the child is still hospitalized to educate them on firearm safety, medication safety and the need to give prescribed medications as ordered by their practitioner. Parents are also encouraged to keep their child's follow-up appointment within seven days of discharge. When they do, they receive a Build-a-Bear and a book called My Feelings.

Cenpatico appreciates your assistance in promoting these preventative behavioral health programs. If you have recommendations regarding other areas where we might make a difference, please contact us at 866-796-0530.

Confidentiality and Release of Member Information

Cenpatico abides by applicable federal and State laws which govern the use and disclosure of mental health information and alcohol/substance abuse treatment records.

Similarly, Cenpatico contracted providers are independently obligated to comply with applicable laws and shall hold confidential all member records and agree to release them only when permitted by law, including but not limited to 42 CFR 2.00 et seq., when applicable.

Communication With the Primary Care Physician

Sunshine Health encourages primary care physicians (PCPs) to consult with their members' mental health Network Practitioners/Providers. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

Network Practitioners/Providers should communicate not only with the member's PCP whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may also be providing service to the member. Examples of some of the items to be communicated include:

- Prescription medication;
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse); and
- The member's progress toward meeting the goals established in their treatment plan.

You may access the form to communicate with the PCP and other behavioral health practitioners on the Cenpatico website, www.cenpatico.com under Provider/Resources/Forms. Network Practitioners/Providers can identify the name and number for a member's PCP on the front-side of the Member ID Card.

Network Practitioners/Providers should screen for the existence of co-occurring mental health and substance abuse conditions and make appropriate referrals. Practitioners/Providers should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

Cenpatico requires that Network Practitioners/Providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the Network Practitioners/Providers responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests this information not be given to their PCP, the Network Practitioner/Provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP;

- A copy or summary of the intake assessment;
- Written notification of member's noncompliance with treatment plan (if applicable);
- Member's completion of treatment;
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
- The results of functional assessments.

Caution must be exercised in conveying information regarding substance abuse, which is protected under separate federal law.

Cenpatco monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Network Practitioner/Provider Treatment Requirements

Network Practitioners/Providers are required to:

- Refer members with known or suspected physical health problems or disorders to the member's PCP for examination and treatment;
- Only provide physical health services if such services are within the scope of the Network Practitioner's/Provider's clinical licensure;
- Network Providers (facilities and community mental health centers) must ensure Members that are discharging from an inpatient psychiatric or crisis stabilization unit (CSU) acute care, are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within twenty-four (24) hours from the date of discharge;
- Contact members who have missed appointments within twenty-four (24) hours to reschedule;
- Ensure all members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language;
- Make referrals or admissions of members for covered behavioral health services only to other Participating Healthcare Practitioners/Providers (those that participate in the Sunshine Health or Cenpatco Practitioner/Provider Network), except as the need for Emergency Care may require, or where Cenpatco specifically authorizes the referral, or as otherwise required by law;
- Comply with all State and federal requirements governing emergency, screening and post-stabilization services; and
- Provide member's clinical information to other practitioners/providers treating the member, as necessary to ensure proper coordination and treatment of members who express suicidal or homicidal ideation or intent, consistent with State law;

Monitoring Satisfaction

Satisfaction surveys are conducted periodically by Cenpatco. These surveys enable Cenpatco to gather useful information to identify areas for improvement.

Network Practitioners/Providers may be requested to participate in the annual survey process. The survey includes a variety of questions designed to address multiple facets of the Network Practitioners/Providers experience with our delivery system.

Network Practitioners/Providers should call the Cenpatco Provider Relations department at 866-796-0530 to address concerns as they arise. Feedback from Network Practitioners/Providers enables Cenpatco to continuously improve systems, policies and procedures.

Network Practitioner/Provider satisfaction is a key component to our overall success.

Network Provider Standards of Practice

Network Practitioners/Providers are requested to:

- Submit all documentation in a timely fashion;
- Comply with Cenpatico Care Management process;
- Cooperate with Cenpatico's QI Program (e.g., allow review of or submit requested charts, receive feedback);
- Support Cenpatico access standards;
- Use the concept of Medical Necessity and evidence-based Best Practices when formulating a treatment plan and requesting ongoing care;
- Coordinate care with other clinicians as appropriate, including consistent communication with the PCP as indicated in the Cenpatico QI Program;
- Assist members in identifying and utilizing community support groups and resources;
- Maintain confidentiality of records and treatment and obtain appropriate written consents from members when communicating with others regarding member treatment;
- Notify Cenpatico of any critical incidents;
- Notify Cenpatico of any changes in licensure, any malpractice allegations and any actions by your licensing board (including, but not limited to, probation, reprimand, suspension or revocation of license);
- Notify Cenpatico of any changes in malpractice insurance coverage;
- Complete credentialing and re-credentialing materials as requested by Cenpatico; and
- Maintain an office that meets all standards of professional practice.

Treatment Record Guidelines

Cenpatico requires treatment records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review. Treatment record standards are adopted that are consistent with the National Committee for Quality Assurance. The adopted standards facilitate communication, coordination and continuity of care and promote efficient, confidential and effective treatment. Medical records must be prepared in accordance with all applicable State and Federal rules and regulations and signed by the medical professional rendering the services.

Cenpatico requires the confidentiality of medical records in accordance with 42 CFR, Part 431, Subpart F. This includes confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease in accordance with s. 384.30(2), F.S.

Cenpatico requires compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Cenpatico's minimum standards for practitioners/provider medical record keeping practices include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information. The following 13 elements reflect a set of commonly accepted standards for behavioral health treatment record documentation.

1. Each page in the treatment record contains the patient's name or ID number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the treatment record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.

4. The record is legible to someone other than the writer.
5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status and the results of a mental status exam, are documented.
7. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
9. A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
10. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers and health care institutions are included, as appropriate.
12. Informed consent for medication and the patient's understanding of the treatment plan are documented.
13. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

Adherence to these guidelines is verified annually as part of the quality program.

Records and Documentation

Network Practitioners/Providers need to retain all books, records and documentation related to services rendered to members as required by law and in a manner that facilitates audits for regulatory and contractual reviews.

The Network Practitioner/Provider will provide Cenpatico, Sunshine Health, and other regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information. Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and or non-renewal of a Provider Agreement with Cenpatico.

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. You may access sample forms that Network Practitioners/Providers are encouraged to use for members on the Cenpatico website, www.cenpatico.com under Provider/Resources/Forms.

As part of our ongoing quality improvement program, clinical records may be audited to assure the quality and consistency of Network Practitioner/Provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the member must sign an authorization for release. You may access this form on the Cenpatico website, www.cenpatico.com under Provider/Resources/Forms. Chart Audits of member records will be evaluated in accordance with these criteria.

Clinical records require documentation of all contacts concerning the member, relevant financial and legal information, consents for release/disclosure of information, release of information to the member's PCP, documentation of member receipt of the Statement of Member's Rights and Responsibilities, the prescribed medications with refill dates and quantities, including clear evidence of the informed consent, and any other information from other professionals and agencies. If the Network Practitioner/Provider is able to dispense medication, the Network Practitioner/Provider must conform to drug dispensing guidelines set forth in Sunshine Health drug formulary.

Network Practitioners/Providers shall retain clinical records for members for as long as is required by applicable law. These records shall be maintained in a secure manner, but must be retrievable upon request.

Reporting Provider or Member Waste, Abuse or Fraud

Waste, Abuse and Fraud (WAF) System

Cenpatico is committed to the ongoing detection, investigation, and prosecution of waste, abuse and fraud (WAF).

- Waste – Use of healthcare benefits or dollars without real need. For example, prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.
- Abuse – Practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Health Plan program, including, but not limited to practices that result in unnecessary cost to the Health Plan program for services that are not Medically Necessary, or that fail to meet professionally recognized standards for healthcare. It also includes Enrollee practices that result in unnecessary cost to the Health Plan program.
- Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Health Plan program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or State healthcare fraud laws. Examples of practitioner/provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and practitioners/providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

Cenpatico, in conjunction with its management company, Centene Corporation, operates a WAF unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 866-685-8664. Cenpatico and Centene take reports of potential WAF seriously and investigate all reported issues.

Authority and Responsibility

The President/CEO and Vice President, Compliance of Cenpatico share overall responsibility and authority for carrying out the provisions of the compliance program.

Cenpatico, in conjunction with Sunshine Health, is committed to identifying, investigating, sanctioning and prosecuting suspected WAF.

The Cenpatico Practitioner/Provider Network shall cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations by Sunshine Health, at the practitioner/provider and/or subcontractor's own expense.

Cenpatico staff, its Practitioner/Provider Network and their personnel and/or subcontractor personnel, shall immediately refer any suspected WAF to the Medicaid Fraud Control Unit of Florida within the Office of the Attorney General at the following address:

Medicaid Fraud Control Unit of Florida
Office of the Attorney General
The Capitol
PL-01
Tallahassee, FL 32399-1050
Phone: (850) 414-3600
Fax: (850) 921-5194

Hotline Number - A toll-free hotline number has been established to report potential WAF issues. The hotline number is 1-866-685-8664. The number is available for use by any person, including Cenpatico employees and subcontractors. It is against corporate policy to retaliate against anyone who makes a referral. All callers have the option to remain anonymous.

Practitioners/Providers may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone at 1-866-796-0530.

Sunshine Health

Eligibility for Sunshine Health

The State of Florida has the sole responsibility for determining eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI.

Those eligible persons who are assigned to Sunshine Health currently include individuals in the following Medicaid categories:

- Low Income Families and Children;
- Sixth Omnibus Budget Reconciliation Act (SOBRA) - Pregnant women and children;
- Including presumptive eligibility;
- Supplemental Security Income (SSI) Medicaid Only;
- SSI Medicare, Part B only;
- SSI Medicare, Parts A and B;
- Medicaid Recipients who are residents of ALFs and are not enrolled in an ALF waiver program;
- Refugees;
- The Meds AD population;
- Individuals with Medicare coverage (e.g. dual eligible individuals) who are not enrolled in a Medicare Advantage Plan; and
- Title XXI MediKids.

Verifying Member Enrollment

Network Practitioners/Providers are responsible for verifying eligibility every time a Member schedules an appointment, and when they arrive for services.

Network Practitioners/Providers Should Use Any of the Following Options to Verify Member Enrollment:

- Contact Cenpatico Customer Service at 866-796-0530
- Access the Cenpatico Provider Website at www.cenpatico.com
- Verify online at State's fiscal agent (EDS) website at www.mymedicaid-florida.com


Sunshine Health has the capability to receive ANSI X12N 270 eligibility inquiries and generate an ANSI X12N 271 health plan eligibility response transaction through Sunshine Health.

For more information on conducting these transactions electronically, please contact our EDI department by phone or email:

Sunshine Health
c/o Centene EDI Department
Phone: 800-225-2573
Email: EDIBA@centene.com

Until the actual date of enrollment with Sunshine Health, Sunshine Health is not financially responsible for services the prospective Member receives. In addition, Sunshine Health is not financially responsible for services Members receive after their coverage has been terminated, however, Sunshine Health is responsible for those individuals who are Sunshine Health Members at the time of a hospital inpatient admission and change health plans during that confinement.

Sunshine Health Member ID Card

	Rx: US Script 1-800-460-8988 BIN:008019
Name:	Effective Date:
ID#:	DOB:
PCP Name :	PCP Phone #:
If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Sunshine Health for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Sunshine Health NurseWise® toll-free at 1-866-796-0530, option 7, or TDD/TTY 1-866-796-0524. NurseWise is open 24 hours a day.	

IMPORTANT CONTACT INFORMATION FOR MEMBERS		
Sunshine State Health Plan 400 Sawgrass Corporate Pkwy, Ste 100 Sunrise, FL 33325 www.sunshinestatehealth.com		
Call 1-866-796-0530 (TDD/TTY: 1-866-796-0524) for		
• 24/7 Member Services	• 24/7 NurseWise (option 7)	• Provider Services
• Prescription Drugs	• Vision Services	• Referrals
• Pre-Authorization	• Dental Services	• Eligibility (IVR)
• Behavioral Health		
For Medical Claims: Sunshine State Health Plan Attn: CLAIMS PO Box 3070 Farmington, MO 63640-3823	For Behavioral Health Claims: Cenpatico Behavioral Health Attn: CLAIMS PO Box 6900 Farmington, MO 63640-3818	

Community Outreach Guidelines for Network Practitioner/Provider's

Cenpatico's contract with Sunshine Health defines how Cenpatico and its Network Practitioners/Providers may market and advertise the Medicaid program. The Agency for Health Care Administration (AHCA) requires that our Network Practitioners/Providers submit samples of any community outreach materials they intend to distribute regarding Cenpatico, Sunshine Health or the Medicaid program to Cenpatico so that State approval can be granted prior to distribution or display. Cenpatico's Provider Relations staff will submit these materials to Sunshine Health who will forward to AHCA within two (2) business days of receipt. Cenpatico will send the Network Practitioner/Provider written notice of the State's approval or notification of any changes required by AHCA within two (2) business days of receiving notice from AHCA.

Member Rights and Responsibilities

Sunshine Health Member Rights and Responsibilities

1. A right to receive information about Sunshine Health, its benefits, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law.
3. A right to participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
4. A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
5. A right to receive healthcare services that are accessible are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
6. A right to receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
7. A right to receive assistance from both AHCA and Sunshine Health in understanding the requirements and benefits of the health plan.
8. A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
9. A right to receive information on the Grievance, Appeal and Fair Hearing procedures.
10. A right to voice grievances or file appeals about Sunshine Health decisions that affect their privacy, benefits or the care provided.
11. A right to request and receive a copy of your Medical Record.
12. A right to make recommendations regarding Sunshine Health's member rights and responsibilities policy.
13. A right to request that your medical record be changed or corrected.
14. A right to expect their medical records and care is kept confidential as required by law.
15. A right to receive Sunshine Health's policy on referrals for specialty care and other benefits not provided by the member's PCP.
16. A right to privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
17. A right to exercise these rights without adversely affecting the way Sunshine Health, its providers or AHCA treats the members.
18. A right to allow or refuse their personal information is sent to another party for other uses unless the release of information is required by law.
19. A right to choose a primary care practitioner (PCP) and to change to another PCP as frequently as they desire.
20. A right to receive timely access to care, including referrals to specialists when medically necessary without barriers.
21. A right to file for a State Hearing with AHCA.
22. A right to receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc. - in a manner and format that may be easily understood.
23. A right to make an advance directive, such as a living will.
24. A right to choose a person to represent them for the use of their information by Sunshine Health if they are unable to. To receive oral interpretation services free of charge for all non-English languages, not just

those identified as prevalent.

25. A right to make suggestions about their rights and responsibilities.
26. A right to get a second opinion from a qualified healthcare professional.
27. A right to information about your rights and responsibilities, as well as the Sunshine Health practitioners/providers and services.
28. A right to receive oral interpretation services free of charge for all non-English languages.
29. A right to be notified that oral interpretation is available and how to access those services.
30. A right to receive information about the basic features of managed care; which populations may or may not enroll in the program and Sunshine Health's responsibilities for coordination of care in a timely manner in order to make an informed choice.
31. A right to receive information on the following:
 - Benefits covered;
 - Procedures for obtaining benefits, including any authorization requirements;
 - Cost sharing requirements;
 - Service area;
 - Names, locations, telephone numbers of and non-English language spoken by current Sunshine Health practitioners/providers, including at a minimum, PCPs, specialists and hospitals;
 - Any restrictions on member's freedom of choice among Network Practitioners/Providers;
 - Practitioners/Providers not accepting new patients; and
 - Benefits not offered by Sunshine Health but available to members and how to obtain those benefits, including how transportation is provided.
32. A right to receive a complete description of disenrollment rights at least annually.
33. A right to receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
34. A right to receive detailed information on emergency and after-hours coverage, to include, but not limited to:
 - What constitutes an emergency medical condition, emergency services, and post-stabilization services;
 - That Emergency Services do not require prior authorization;
 - The process and procedures for obtaining Emergency services;
 - The locations of any emergency settings and other locations at which practitioners/providers furnish emergency services and post-stabilization services covered under the contract;
 - Member's right to use any hospital or other setting for emergency care; and
 - Post-stabilization care services rules in accordance with Federal guidelines.
35. A responsibility to inform Sunshine Health of the loss or theft of their ID card.
36. A responsibility to present their ID card when using healthcare services.
37. A responsibility to be familiar with Sunshine Health procedures to the best of their ability.
38. A responsibility to call or contact Sunshine Health to obtain information and have questions clarified.
39. A responsibility to provide information (to the extent possible) that Sunshine Health and its practitioners and providers need in order to provide care.
40. A responsibility to follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers.
41. A responsibility to inform your practitioner/provider on reasons you cannot follow the prescribed treatment of care recommended by your practitioner/provider.
42. A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
43. A responsibility to keep your medical appointments and follow-up appointments.

44. A responsibility to access preventive care services.
45. A responsibility to follow the policies and procedures of the AHCA Medicaid Plan.
46. A responsibility to be honest with practitioners/providers and treat them with respect and kindness.
47. A responsibility to get regular medical care from their PCP before seeing a specialist.
48. A responsibility to follow the steps of the appeal process.
49. A responsibility to notify AHCA and Sunshine Health and their practitioners/providers of any changes that may affect their membership, healthcare needs or access to benefits. Some examples may include:
 - If you have a baby;
 - If your address changes;
 - If your telephone number changes;
 - If you or one of your children is covered by another health plan;
 - If you have a special medical concern; and
 - If your family size changes.
50. A responsibility to keep all your scheduled appointments; be on time for those appointments, and cancel twenty-four (24) hours in advance if you cannot keep an appointment.

Cenpatico is committed to treating members in a manner that respects their rights and clearly states our expectations of member responsibilities. The various states in which we do business sometimes promulgate additional rights and responsibilities beyond those listed here. At a minimum, Cenpatico believes that all members have the following Rights and Responsibilities:

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and right to privacy.
3. A right to participate with practitioners/providers in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners/providers.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Civil Rights

Cenpatico provides covered services to all eligible members regardless of: Age, Race, Religion, Color, Disability, Sex, Sexual Orientation, National Origin, Marital Status, Arrest or Conviction Record, or Military Participation.

All Medically Necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with Cenpatico who refer or recommend members for services shall do so in the same manner for all members.

Customer Service

The Cenpatico Customer Service Department

Cenpatico operates a toll free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel, Monday through Friday 7:00 a.m. to 5:00 p.m. CST. After hours services are available during evenings, weekends and holidays. The after hours service known as NurseWise is staffed by customer service representatives with registered nurses and behavioral health clinicians available 24/7 for urgent and emergent calls.

The Cenpatico Customer Service department strives to support the mission statement in providing quality, cost-effective behavioral health services to our customers. We strive for customer satisfaction on every call by doing the right thing the first time and we show our integrity by being honest, reliable and fair.

The Customer Service department's primary focus is to facilitate the authorization of covered services for members for treatment with a specific clinician or clinicians. The Customer Service Department provides the member with information about Network Practitioners/Providers and assists the member in selecting a Network Practitioner/Provider who can meet their specific needs. Licensed clinicians on staff in the Clinical department are available to provide referrals for and assessment of the level of urgency of a caller presenting special needs.

In addition to working with members, the Cenpatico Customer Service department assists Network Practitioners/Providers with the following:

- Verifying member eligibility;
- Verifying member benefits;
- Obtaining authorization;
- Referrals; and
- Trouble-shooting any issues related to eligibility, authorizations, referrals, or researching prior services.
- Interpretation/Translation Services

Cenpatico is committed to ensuring that staff are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, Cenpatico provides or coordinates the following:

Customer Service is staffed with Spanish and English bilingual personnel.

Trained professional language interpreters, including American Sign Language, can be made available face-to-face at your office if necessary, or telephonic, to assist Practitioners/Providers with discussing technical, medical, or treatment information with Members as needed. Cenpatico requests a five-day prior notification for face-to-face services.

TDD access for members who are hearing impaired:

TTY: 800-955-8771

Voice: 800-955-8770

Key Information: To access interpreter services for Cenpatico members, contact Customer Service at 866-796-0530.

NurseWise

NurseWise is Cenpatico's after hour's nurse referral line through which callers can reach both customer service representatives and bilingual nursing staff. NurseWise provides nurse referrals and assessment and after-hours phone coverage seven (7) days per week including holidays for Cenpatico members.

The NurseWise referral service provides Members and Network Practitioners/Providers with the following:

- Provide referrals after hours;
- Verify member eligibility;
- Crisis Interventions;
- Emergency assessment for acute care services;
- After hours emergency refills;
- Documentation and notification of inpatient admissions that occur after hours; and
- Assistance with determining the appropriate level of care in accordance with clinical criteria, as applicable.

Non Emergency Transportation

Sunshine Health Members may need transportation to access care to a medically necessary Medicaid covered service.

Reform Members

Type of Care	Appointment Availability	Provider Type	Copay
Transportation	All emergency and (if needed) non-emergency transportation to and from your covered medical and dental appointments. Medicaid eligible non-emergency transportation services are given through TMS Transportation at 1-866-790-8817. Call them to make your appointment. Make your appointment 48 hours before you need to be picked up. If the transportation service is late to pick up, call 1-866-790-8817 to find out why it is late. Call 1-866-790-8817 if you need to cancel your transportation. If you have an emergency and need to be taken to the hospital, you must call 911.	No Limit	\$0

Non-Reform Members

SSH/Cenpatico Non-Emergency Transportation Services are Covered by FFS Medicaid please contact your local Medicaid Area office below.	
Medicaid Area Offices	
Area 1 Escambia, Okaloosa, Santa Rosa, Walton	800-303-2422
Area 2a Bay, Franklin, Gulf, Holmes, Jackson, and Washington Counties	800-699-7068
Area 2b Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties	800-248-2243
Area 3a Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee and Union	800-803-3245
Area 3b Citrus, Hernando, Lake, Marion and Sumter	877-724-2358

Area 4 Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia	800-273-5880
Area 5 Pasco, Pinellas	800-299-4844
Area 6 Hardee, Highlands, Hillsborough, Manatee, Polk	800-226-2316
Area 7 Orange, Osceola, Seminole, and Brevard Counties	877-254-1055
Area 8 Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota	800-226-6735
Area 9 Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	800-226-5082
Area 10 Broward	866-875-9131
Area 11 Dade, Monroe	800-953-0555

Complaints, Grievances and Appeals

Provider Complaints

What is a Complaint?

A complaint is defined as any dissatisfaction, expressed by a Network Practitioner/Provider orally or in writing, regarding any aspect of Cenpatico's operations, including but not limited to, dissatisfaction with Cenpatico's administrative policies.

Cenpatico has established and maintains an internal system for the identification and prompt resolution of Network Practitioner/Provider complaints. If a Network Practitioner/Provider is not satisfied with the resolution of a complaint, an appeal can be filed. Network Practitioners/Providers will not be discriminated against because he/she is making or has made a complaint.

To express a Complaint in writing please mail or fax to the following:

Cenpatico
 Attn: Quality Improvement Department
 504 Lavaca St., Ste. 850
 Austin, TX 78701
 Fax: 866-704-3063

To express a Complaint by phone, please call Cenpatico at:

866-796-0530

Cenpatico will acknowledge the Network Practitioner's/Provider's complaint within five (5) business days and will resolve the complaint within thirty (30) calendar days.

Member Complaints

What is a Complaint?

A Complaint is dissatisfaction about any matter other than an action. An action is defined as the denial or limited authorization of a requested service; the reduction, suspension or termination of a previously authorized service; or denial in whole or in part, of payment for a service. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a practitioner or employee, or failure to respect the member's rights.

Sunshine Health has established and maintains a Grievance system that complies with applicable Federal and State laws and regulations and affords our Network Practitioners/Providers and members the opportunity to initiate a Complaint. A Complaint can be filed by a member or any person acting on the member's behalf, including a non-participating or participating Network Practitioner/Provider with the member's signed consent. Sunshine Health's Member Services department is available to assist Network Practitioners/Providers, members, or member representatives with initiating a Complaint. Complaints can be filed in writing or by phone.

To express a Complaint in writing please mail or fax the Complaint to the following:

Sunshine Health
Appeal and Grievance Coordinator
400 Sawgrass Corporate Pkwy
Suite 100
Sunrise, FL 33325
Fax 1-866-796-0523

To express a Complaint by phone, please call Sunshine Health at:

1-866-796-0530
1-866-796-0524 (TDD/TTY)

Cenpatico Network Practitioners/Providers and members have one (1) year from the date of the action to file a Complaint. Sunshine Health has thirty (30) days to respond to and resolve the Complaint. It is one of Sunshine Health's goals to resolve all Complaints in a timely manner. When a decision is not wholly in the member's favor, the resolution letter must contain the Notice of the Right to a State Fair Hearing and the information necessary to file for a State Fair Hearing. No punitive action will be taken against a Network Practitioner/Provider who files a Complaint on behalf of a member.

Member Appeals

What is an Appeal?

An appeal is a written or oral request for review of an action/determination made by Cenpatico. An appeal can be filed for denial of payment or failure to act in a timely manner by the member or authorized representative acting on behalf of the member, with the member's written consent.

Cenpatico has developed and maintains an appeal system that complies with applicable Federal and State laws and regulations. An appeal must be filed with Cenpatico within thirty (30) calendar days from the date of the notice of Cenpatico's action/determination. Members may continue to seek covered services while the appeal is being resolved.

The timeframe for a grievance or appeal may be extended up to fourteen (14) calendar days if:

- The enrollee asks for an extension or the Health Plan documents that additional information is needed and the delay is in the enrollee's interest;
- If the timeframe is extended other than at the enrollee's request, the Health Plan must shall notify the enrollee within five (5) business days of the determination, in writing, of the reason for the delay.

A member or authorized representative has the right to file an appeal if Cenpatico denies or limits a request for a Covered Service. The Cenpatico Appeals Coordinator is available to assist a member in understanding and using the Cenpatico Appeals Process. Denials for non-covered benefits cannot be appealed.

If the member is still receiving the services that are under appeal review and the services are covered services, the services may continue until a decision is made on the appeal. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Cenpatico and were not terminated because benefit coverage for the service was exhausted. . If the original denial is upheld, the member may be financially responsible for the service. For continuation of services, the appeal must be requested within ten (10) working days of the notice of action.

Members have the opportunity to present their Appeal in person as well as in writing. Every oral Appeal received must be confirmed in writing by the member or his/her representative, unless an Expedited Appeal is requested.

To express an Appeal in writing please mail or fax the Appeal to the following:

Cenpatico
Attn: Appeals Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Fax: 866-714-7991

To express an Appeal by phone, please call Cenpatico at:

866-796-0530

Expedited Appeals

Members and authorized representatives also have the right to request that Cenpatico expedite an appeal, if

- A practitioner/provider certifies a delay in receiving the requested service would result in a substantial risk of serious or immediate harm to the member;
- The member is currently admitted as a patient in a hospital

For an Expedited Appeal in which the member is currently an inpatient in a hospital, a healthcare worker or hospital representative may act as the member's authorized representative without a signed written consent from the member.

To submit an Expedited Appeal in writing please fax the Expedited Appeal to the following:

Cenpatico
Attn: Appeals Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Fax: 866-714-7991

To initiate your Expedited Appeal by phone, please call Cenpatico at:

866-796-0530

If the Expedited Appeal relates to an ongoing emergency or denial to continue a hospital stay, Cenpatico will resolve the Expedited Appeal within seventy-two (72) hours after receipt of the request.

If Cenpatico determines that the Appeal does not qualify to be expedited, the member will be notified immediately and the resolution will be made within thirty (30) days calendar days.

The Cenpatico Appeals Coordinator can assist the member with their Expedited Appeal. The member may also have their Network Practitioner/Provider, a friend, a relative, legal counsel or another spokesperson assist them.

Medicaid Fair Hearing for Grievances

Members, or Network Practitioners/Providers acting as a representative with the Member's consent, may request a Medicaid Fair Hearing at any time during the Grievance or Appeals process if they so choose. A Medicaid Fair Hearing involves the termination, suspension, or reduction of a previously authorized course of treatment. Cenpatico personnel, the Member, the Member representative (or a representative of a deceased Member's estate) will participate in the Medicaid Fair Hearing.

Members, or their representatives, must request a Medicaid Fair Hearing within ninety (90) days of the date of the notice of resolution from Cenpatico. If a Medicaid Fair Hearing is requested and Members would like their benefits to continue, they must file the request within ten (10) days from the date Cenpatico sent the determination.

If the Medicaid Fair Hearing finds in favor of Cenpatico, the Member may be responsible for the cost of the continued benefits.

To request a Medicaid Fair Hearing, please write to:

The Office of Appeal Hearings
1317 Winewood Boulevard
Building 5, Room 203
Tallahassee, FL 32399-0700

Subscriber Assistance Program for Grievances & Appeals

Members, or their designated representatives, have the right to request a review with the Subscriber Assistance Program (SAP). Members must request this review with the SAP within one (1) year from the receipt of Cenpatico's final decision letter. Before Members and/or Network Practitioners/Providers can utilize the SAP, they must have completed Cenpatico's Appeals process.

The following information should be included in the SAP review request:

Your Name/Title;
Member Identification Number;
Your address; and
Reason for grievance/appeal review.

To request a Subscriber Assistance Program review, please write to:

Agency for Health Care Administration
Subscriber Assistance Program (SAP)
Building 1, MS #26
2727 Mahan Drive
Tallahassee, FL 32308

You can reach the Subscriber Assistance Program at 850-921-5458 or 888-419-3456.

The Subscriber Assistance Program will not consider reviewing a grievance or appeal that has been taken to a Medicaid Fair Hearing.

Benefit Overview

Non-reform/Reform Members age 21 and older:

- Up to 45 inpatient day's total (combined between medical and behavioral health) per fiscal year. (Fiscal year is from July 1st or initial date of enrollment through June 30th);
- Crisis Stabilization services are calculated at two (2) for one (1) inpatient days;
- Up to 28 inpatient days for substance abuse treatment per fiscal year for pregnant Members only. Fiscal year is from July 1st or initial date of enrollment through June 30th. Additional benefit can be approved for severe withdrawal cases meeting criteria;
- All inpatient provider services require prior-authorization, except in an emergency, and are subject to Medical Necessity;
- For practitioners/providers participating in Cenpatico's Florida Practitioner/Provider Network, covered outpatient traditional behavioral health therapy services do not require authorization; and
- Outpatient substance abuse services are not covered.

Non-reform/Reform Members under age 21:

- Unlimited behavioral health inpatient days;
- Crisis Stabilization services;
- Up to 28 inpatient days for substance abuse treatment per fiscal year for pregnant Members only. Fiscal year is from July 1st or initial date of enrollment through June 30th. Additional benefit can be approved for severe withdrawal cases meeting criteria;
- All inpatient services require prior-authorization, except in an emergency, and are subject to Medical Necessity;
- For practitioners/providers participating in Cenpatico's Florida Practitioner/Provider Network, covered outpatient traditional behavioral health therapy services do not require authorization; and
- Outpatient substance abuse services are not covered.

Provider or Service-Specific Benefits/Limitations:

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are limited to 26 behavioral health visits per calendar year;

Targeted Case Management - Limited to (344) units per month, procedure codes T1017 and T1017,HA;

Intensive Case Management - Limited to (48) units per day, per case management team, procedure code T1017,HK; and

Community Mental Health Services – multiple benefit limitations as identified in the Agency for Health Care Administration's (AHCA) "Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook" for the following procedure codes: H0031; H0031,HO; H0031,HN; H0031,TS; H0032; H0032,TS; H0046; H2000; H2000,HO; H2000,HP; H2010,HO H2010,HE; H2010,HQ; H2012; H2017; H2019; H2019,HM; H2019,HN; H2019,HO; H2019,HR; H2019,HQ; T1015; T1015,HE; T1023,HE.

For a listing of service codes and authorization requirements, please refer to the Florida Covered Professional Services & Authorization Guidelines located in this Manual. Network Practitioners/Providers should refer to their Provider Agreement with Cenpatico to identify which services they are contracted and eligible to provide.

Please note that all services performed must be medically necessary.

Covered Services & Authorization Grid

An asterisk (*) denotes a service that always requires prior-authorization. Please fax a completed Outpatient Treatment Request (OTR) form to 866-694-3649 to obtain prior-authorization or request additional sessions.

Acute Care & Step-Down Services		
Cenpatico covers the following acute care and step-down services;		
Inpatient Psych* Inpatient Detoxification* (detox is only covered for Members that are pregnant) Inpatient Eating Disorder treatment* Crisis Stabilization*, Observation* Electroconvulsive Therapy (ECT)* Partial Hospitalization Program-Psych (PHP)* Intensive Outpatient Program-Psych (IOP)*		
Please refer to your Agreement with Cenpatico to determine the services and respective billing codes you are contracted to provide.		
Inpatient Setting Professional Services		
Service Description	Billable Practitioner Types	Billing Codes
Diagnostic Interview:	MD, PA, ARNP, PHD, LMHC, LPC, LCSW & LMFT	90801, 90802
Insight Oriented/Behavior Modifying Therapy:	MD	90816, 90817, 90818, 90819, 90821, 90822 (No auth required if billed in conjunction with authorized Inpatient, Crisis Stabilization or Partial Hospitalization Program care)
Interactive Psychotherapy:	MD	90823, 90824, 90826, 90827, 90828, 90829 (No auth required if billed in conjunction with authorized Inpatient, Crisis Stabilization or Partial Hospitalization Program care)
Initial Hospital Care:	MD, PA, and ARNP	99221, 99222, 99223 (No auth required if billed in conjunction with authorized Inpatient, Crisis Stabilization, Observation or Partial Hospitalization Program care)

Subsequent Hospital Care:	MD, PA, and ARNP	99231, 99232 (No auth required if billed in conjunction with authorized Inpatient, Crisis Stabilization or Partial Hospitalization Program care)
	MD	99233 (No auth required if billed in conjunction with authorized Inpatient, Crisis Stabilization or Partial Hospitalization Program care)
Hospital Discharge:	MD, PA, and ARNP	99238, 99239 (No auth required if billed in conjunction with authorized Inpatient, Crisis Stabilization, Observation or Partial Hospitalization Program care)
Inpatient Consultation:	MD, PA, and ARNP	99251, 99252, 99253, 99254
	MD	99255
Initial Observation Care:	MD, PA, and ARNP	99218, 99219, 99234, 99235
	MD	99220, 99236
ECT Services:	MD	90870*

An asterisk (*) denotes a service that always requires prior-authorization. Please fax a completed Outpatient Treatment Request (OTR) form to 866-694-3649 to obtain prior-authorization or request additional sessions.

Outpatient Setting Professional Services		
Service Description	Billable Practitioner Types	Billing Codes
Diagnostic Interview:	MD, PA, ARNP, PHD, LMHC, LPC, LCSW & LMFT	90801, 90802
Insight Oriented/Behavior Modifying or Supportive Therapy:	MD, PA, ARNP, PHD, LMHC, LPC, LCSW & LMFT	90804, 90806, 90808, 90810, 90812, 90814
Insight Oriented/Behavior Modifying or Supportive Therapy With Med Management:	MD, PA, and ARNP	90805, 90807, 90809, 90811, 90813, 90815
Med Check:	MD, PA, and ARNP	90862
Other Psychotherapy:	MD, PA, ARNP, PHD, LMHC, LPC, LCSW, & LMFT	90846, 90847, 90853
	MD	90845
Psych Testing:	MD and PHD	96101*, 96102*, 96103*, 96105*
Neuropsych Testing:	MD and PHD (MD must be a licensed Psychiatrist)	96116*, 96118*, 96119*, 96120*
Office Consults:	MD, ARNP, and PHD	99241*, 99242*, 99243*, 99244*
	MD	99245*

Community Behavioral Health Services	
Service Description	Billing Codes
Assessment Services:	H0031 H0031, HN H0031, HO H0031, TS H2000 H2000, HO H2000, HP H2010, HO
Treatment Plan:	H0032 H0032, TS
Medical and Psychiatric Services:	H2010, HE H2010, HQ T1023, HE H0046 T1015 T1015, HE
Therapy Services:	H2019, HQ H2019, HR
Psych Testing:	H2019*
Day Services:	H2012*
Support Services:	H2017*
On-Site Services:	H2019, HM* H2019, HN* H2019, HO*

Targeted Case Management Services	
Service Description	Billing Codes
Targeted Case Management:	T1017* T1017, HA* T1017, HK*

Utilization Management

The Utilization Management Program

The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. Eastern Standard Time (EST). Additionally, clinical staff is available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number 1-866-796-0530. The Cenpatico Utilization Management team is comprised of qualified behavioral health professionals whose education, training and experience are commensurate with the Utilization Management reviews they conduct.

The Cenpatico Utilization Management Program strives to ensure that:

- Member care meets Cenpatico Medical Necessity Criteria;
- Treatment is specific to the member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided comply with Cenpatico quality improvement requirements; and, utilization management policies and procedures are systematically and consistently applied; and
- Focus for members and their families' centers on promoting resiliency and hope.

The purpose of Cenpatico's Utilization Management Program's procedures and Clinical Practice Guidelines is to ensure treatment is specific to the member's condition, effective, and provided at the least restrictive, most clinically appropriate level of care. In order to meet our objectives, Network Practitioners/Providers must participate and adhere to our programs and guidelines.

Cenpatico's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Cenpatico's Medical Necessity Criteria are used for the approval of medical necessity; plans of care that do not meet Medical Necessity guidelines are referred to a Florida licensed physician advisor or psychologist for review and peer to peer discussion.

Cenpatico conducts utilization management in a timely manner to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. Utilization Management files includes the date of receipt of information and the date and time of notification and resolution.

Cenpatico's Utilization Management Department is under the direction of our licensed Medical Director or physician designee(s). The Utilization Management Staff regularly confer with the Medical Director or physician designee on any cases where there are questions or concerns.

Member Eligibility

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. It is the responsibility of the Network Practitioner/Provider to monitor the member's ongoing eligibility during the course of treatment.

Network Providers should use any of the following methodologies to verify member eligibility;

- Contact Cenpatico Customer Service at 866-796-0530
- Access the Cenpatico Provider Website at www.cenpatico.com
- Verify online at State's fiscal agent (EDS) website at www.mymedicaid-florida.com

Inpatient Notification Process

Inpatient providers (including Crisis Stabilization Units) are required to notify Cenpatico of emergent and urgent admissions (Emergency Behavioral Health Care) no later than the next business day following the admission. Authorization is required to track inpatient utilization, enable care coordination, initiate discharge planning and ensure timely claim(s) payment.

Emergency Behavioral Healthcare requests indicate a condition in clinical practice that requires immediate intervention to prevent death or serious harm (to the member or others) or acute deterioration of the member's clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the member's safety. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavioral and is time limited in intensity and duration (usually occurs in seconds or minutes, rarely hours, rather than days or weeks). Thus, elements of both time and severity are inherent in the definition of an emergency.

All inpatient admissions require authorization. The number of initial days authorized is dependent on Medical Necessity and continued stay is approved or denied based on the findings in concurrent reviews. Members meeting criteria for inpatient treatment must be admitted to a contracted hospital or crisis stabilization unit. Members in need of emergency and/or after hours care should be referred to the nearest participating provider for evaluation and treatment, if necessary.

The following information must be readily available for the Cenpatico Utilization Manager when requesting initial authorization for inpatient care:

- Name, age, health plan and identification number of the member;
- Diagnosis, indicators, and nature of the immediate crisis;
- Alternative treatment provided or considered;
- Treatment goals, estimated length of stay, and discharge plans;
- Family or social support system; and
- Current mental status.

Outpatient Notification Process

Network Practitioners/Providers must adhere to the Covered Professional Services & Authorization Guidelines set forth in this Manual, when rendering services. Cenpatico does not retroactively authorize treatment.

For prior-authorizations during normal business hours, Network Providers should call:

866-796-0530

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

For those outpatient services that require authorization, the Network Practitioner/Provider must complete an Outpatient Treatment Request (OTR) form and fax the completed form to Cenpatico at 866-694-3649 for clinical review. Please refer to www.cenpatico.com under Provider/Resources/Forms to obtain the OTR form. Network Practitioners/Providers may call the Customer Service department at 866-796-0530 to check status of an OTR. Network Practitioners/Providers should allow up to 2 business days to process non-urgent requests.

IMPORTANT:

- The OTR must be completed in its entirety. The five (5) Axis diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
- Cenpatico will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Failure to submit a completed OTR can result in delayed authorization and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.
- Cenpatico's utilization management decisions are based on Medical Necessity and established Clinical Practice Guidelines. Cenpatico does not reimburse for unauthorized services and each Provider Agreement with Cenpatico precludes Network Practitioners/Providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Cenpatico's authorization of covered services is an indication of Medical Necessity, not a confirmation of member eligibility, and not a guarantee of payment.

Guidelines for Psychological Testing

Psychological testing must be prior-authorized for either inpatient or outpatient services. Testing, with prior-authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

It is important to note that;

- Testing will not be authorized by Cenpatico for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment (90801 and 90802) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with Cenpatico.
- Practitioners/Providers should submit a request for Psychological Testing that includes the specific tests to be performed. Practitioners/Providers may access Cenpatico's Psychological Testing Authorization Request Form on the Cenpatico website, www.cenpatico.com under Provider/Resources/Forms.

FARS/CFARS Requirements

Network Practitioners/Providers must comply with State regulations concerning Functional Assessment Rating Scale (FARS) for all Members over the age of eighteen (18) and Child Functional Assessment Rating Scale (CFARS) for all Members under age eighteen (18), and make the results of these assessments available to Cenpatico twice annually.

Each Member in care should receive a timely initial assessment as well as periodic reassessments to determine level of functioning and appropriate levels of service.

Reporting FARS/CFARS Scores

Results of the FARS/CFARS assessments should be maintained in the Member's medical record and include a chart trending the results of the functional assessments. Scores should be reported to Cenpatico twice annually (February and August) and should include the following information:

Data Element	Length	Description
Recipient ID	9	9-Digit Medicaid ID Number of member
Recipient DOB	10	Plan member's date of birth (MM/DD/CCYY)
Practitioner/Provider ID	9	9-Digit Medicaid HMO ID Number
Assessment Type	1	Designate the type of functional assessment that was done using "F" for FARS or "C" for CFARS
Initial Date	10	Date of initial assessment (MM/DD/CCYY)
Initial Score	2	Initial overall assessment score
6 Month Date	10	Date of 6 month assessment, if applicable (MM/DD/CCYY)
6 Month Score	2	6 month overall assessment score, if applicable
Discharge Date	10	Date of Discharge (MM/DD/CCYY)
Discharge Score	2	Overall assessment score at discharge

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when Medical Necessity Criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health practitioners providing treatment for the member. Network Practitioners/Providers are expected to work closely with Cenpatico's Utilization Management department in exercising judicious use of a member's benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Sunshine Health.

Cenpatico makes utilization decisions in a fair, impartial and consistent manner using a set of professionally validated clinical criteria that are based upon treatment efficacy and outcome research as well as input from professionals who provide mental health and chemical dependency treatment. These Criteria are reviewed on an annual basis by the Cenpatico Provider Advisory Committee that is comprised of Network Practitioners/Providers as well as Cenpatico clinical staff.

Cenpatico is committed to the delivery of appropriate service and coverage, and offers no organizational incentives, including compensation, to any employed or contracted Utilization Management staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and Utilization Management staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Determining Medical Necessity

Cenpatico Utilization Managers follow specific guidelines when evaluating whether treatment is medically necessary. These guidelines apply to all levels of care for both mental health and substance abuse services. Network Practitioners/Providers should use these guidelines in the formulation of treatment plans. Adequate treatment refers to clinical appropriateness, completeness and timeliness. The Cenpatico Medical Necessity Criteria is located within this manual and can also be found at www.Cenpatico.com

Concurrent Review

Cenpatico's Utilization Management Department will concurrently review the treatment and status of all members in inpatient (including crisis stabilization units) and partial hospitalization through contact with

the member's attending physician or the provider's Utilization and Discharge Planning departments. The frequency of review for all higher levels of care will be determined by the member's clinical condition and response to treatment. The review will include evaluation of the member's current status, proposed plan of care and discharge plans.

Discharge Planning

Follow-up after hospitalization is one of the most important markers monitored by Cenpatico in an effort to help members remain stable and to maintain treatment compliance after discharge. Follow-up after discharge is monitored closely by the National Committee for Quality Assurance (NCQA), which has developed and maintains the Health Plan Employer Data and Information Set (HEDIS). Even more importantly, increased compliance with this measure has been proven to decrease readmissions and helps minimize no-shows in outpatient treatment.

While a member is at an inpatient provider receiving acute care services, Cenpatico's Utilization Managers and Case Managers work with the provider's treatment team to make arrangements for continued care with outpatient Network Practitioners. Every effort is made to collaborate with the outpatient practitioner to assist with transition back to the community and a less restrictive environment as soon as the member is stable. Discharge planning should be initiated on admission.

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within twenty-four (24) hours after discharge. Cenpatico's Care Coordination Case Management staff follows up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, Cenpatico asks that Network Practitioner's please inform Cenpatico as soon as possible. Upon notification of a no-show, Cenpatico's Care Coordination staff will follow up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Psychotropic Medications

Cenpatico will monitor psychotropic medication usage in partnership with Sunshine Health to identify any medications for physical conditions prescribed by psychiatric practitioners as well as to review psychotropic medications prescribed by primary care physicians (PCP).

A comprehensive evaluation to include a thorough health history, psychosocial assessment, mental status exam, and physical exam should be performed before beginning treatment for a mental or behavioral disorder.

The role of non-pharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self injurious behavior, physical aggression that is acutely dangerous to others, or severe impulsivity endangering the member or others; or when there is marked disturbance of psycho-physiological functioning (such as profound sleep disturbance), marked anxiety, isolation, or withdrawal.

Florida Mental Health Act of 1971-The Baker Act

The Baker Act allows for involuntary examination (emergency or involuntary commitment). The Baker Act can be initiated by judges, law enforcement officials, or mental health professionals. There must be evidence that the person; (a) has a mental illness (as defined in the Baker Act) and (b) is a harm to self, harm to others, or self neglectful (as defined in the Baker Act). Examinations may last up to 72 hours and occur in 100+

Florida Department of Children and Families designated receiving facilities statewide.

Network Practitioners/Providers are encouraged to contact Cenpatico at the onset of administering court-ordered services (although such contact shall not be a prerequisite for payment). Cenpatico's Utilization Managers will obtain a copy of the court order from the practitioner/provider and will scan it into the Utilization Management System. If the court order is for a service that typically requires prior-authorization, Utilization Management will create an authorization and send a letter to the practitioner/provider notifying them of the approval.

Services that require authorization or notification per Cenpatico guidelines require authorization prior to claims submission. Cenpatico will make best efforts to authorize services from the court order/Baker Act.

To ensure accurate claims payment, the provider of care should call 866-796-0530 to verify court ordered services are authorized.

In the event that prior authorization is not secured and a Court Ordered/Baker Act service is denied, the claim can be resubmitted through the reconsideration process and will be reprocessed accordingly with the written clinical or court documentation.

Continuity of Care

When members are newly enrolled and have been previously receiving behavioral health services, Cenpatico will continue to authorize care as needed to minimize disruption and promote continuity of care. Cenpatico will work with non-participating practitioners/providers (those that are not contracted and credentialed in Cenpatico's Florida Practitioner/Provider Network) to continue treatment or create a transition plan to facilitate transfer to a participating Cenpatico practitioner/provider (Network Practitioner/Provider).

In addition, if Cenpatico determines that a member is in need of services that are not covered benefits, the member will be referred to an appropriate practitioner/provider and Cenpatico will continue to coordinate care including discharge planning.

Cenpatico will ensure appropriate post-discharge care when a member transitions from a State institution, and will ensure appropriate screening, assessment and crisis intervention services are available in support of members who are in the care and custody of the State.

Intensive Case Management (ICM)

The Case Management Department provides a unique function at Cenpatico. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance and facilitate positive treatment outcomes through the proactive identification of Members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. Cenpatico Case Managers are licensed behavioral health professionals with at least 3 years experience in the mental health field.

Cenpatico's ICM functions include:

- Early identification of Members who have special needs;
- Assessment of Member's risk factors and needs;

- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members are compliant with treatment;
- Active coordination of care linking Members to behavioral health practitioners and as needed medical services; including linkage with a physical health Case Manager for Members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed;
- Development of a case management plan of care;
- Referrals and assistance to community resources and/or behavioral health practitioners; and

For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, Cenpatico offers Care Coordination. Cenpatico's Care Coordinators are not licensed clinical staff and cannot make clinical decisions about what level of care is needed or assess members who are in crisis.

Cenpatico's Care Coordination functions include:

- Coordinate with Sunshine Health, member advocates or Network Providers for members who may need behavioral health services;
- Assist members with locating a Network Provider;
- Serve as a resource to inpatient discharge planners needing services for members;
- Coordinate requests for out-of-network providers by determining need/access issues involved; and
- Facilitate all requests for inpatient psychiatric consults for members in a medical bed.

Care Coordinators can also arrange a Single Case Agreement (SCA) when it becomes necessary to utilize out-of-network providers (providers not contracted with Cenpatico) to provide covered services. Cenpatico will utilize out-of-network providers, if necessary, to meet the member's clinical, accessibility or geographical needs when the network is inadequate for their specific situation. Before utilizing an out-of-network provider, Cenpatico makes every attempt to refer members to participating Network Providers who are contracted and credentialed with Cenpatico.

Single Case Agreements are required for the purposes of addressing the following:

- Insufficient network accessibility within the member's geographic area;
- Network Providers are not available with the appropriate clinical specialty, or are unable to meet special need(s) of the specific member;
- Network Providers do not have timely appointment availability;
- It is clinically indicated to maintain continuity of care; and
- Transition of care from an established out-of-network provider to a participating Cenpatico provider (Network Provider).

Notice of Action (Adverse Determination)

When Cenpatico determines that a specific service does not meet criteria and will therefore not be authorized, Cenpatico will submit a written notice of action (or, denial) notification to the treating network practitioner or provider rendering the service(s) and the member. The notification will include the following information/ instructions:

- a. The reason(s) for the proposed action in clearly understandable language.
- b. A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary.
- c. A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request.
- d. Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed

actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination.

- e. Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- f. For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal.
- g. The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Cenpatico ensures that only Florida clinically-licensed behavioral health clinicians review and make adverse determinations.

Peer Clinical Review Process

If the Utilization Manager is unable to certify the requested level of care based on the information provided, they will initiate the peer review process.

For both mental health and chemical dependency service continued stay requests, the physician or treating practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. When a determination is made where no peer-to-peer conversation has occurred, a practitioner can request to speak with the Clinical Consultant who made the determination within 1 business day. Practitioner should contact Cenpatico at 1-866-796-0530. The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare practitioner provides good cause in writing.

As a result of the Peer Clinical Review process, Cenpatico makes a decision to approve or deny authorization for services.

Treating practitioners may request a copy of the Medical Necessity Criteria used in any denial decision. Copies of the Cenpatico Medical Necessity Criteria are available on our website, www.cenpatico.com. If you would like a paper copy of the criteria, contact Customer Service at 1-866-796-0530.

The treating practitioner may request to speak with the Peer Reviewer who made the determination after any denial decision. If you would like to discuss a denial decision, contact Cenpatico at 1-866-796-0530.

Clinical Practice Guidelines

Cenpatico has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to: Treatment of Bipolar Disorder, Major Depressive Disorder, Schizophrenia, Post Traumatic Stress Disorder and Substance Use and Abuse. For children, Cenpatico has adopted guidelines for Depression in Children

and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/ Hyperactivity Disorder. Clinical Practice Guidelines may be accessed through our web site, www.cenpatico.com, or you may request a paper copy of the guidelines by contacting your Network Manager or by calling 866-796-0530. Copies of our evidence-based practices can be obtained in the same manner. Compliance with clinical practice guidelines is assessed annually as part of the quality process.

Claims

Cenpatico Claims Department Responsibilities

Cenpatico's claims processing responsibilities are as follows:

- To reimburse Clean Claims (see Clean Claim section below) within the timeframes outlined by the Agency for Health Care Administration (AHCA); and
- To reimburse interest on claims in accordance with the guidelines outlined in the Florida Prompt Pay Statute.

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through Sunshine Health) on the date of service;
- The service provided is a covered service (benefit of Sunshine Health) on the date of service; and
- Cenpatico's prior-authorization processes were followed.

Cenpatico's reimbursement is based on clinical licensure, covered service billing codes and modifiers, and the compensation schedule set forth in the Network Practitioner's/Provider's Agreement with Cenpatico. Reimbursement from Cenpatico will be accepted by the Network Practitioner/Provider as payment in full, not including any applicable copayments or deductibles.

It is the responsibility of the Network Practitioner/Provider to collect any applicable copayments or deductibles from the member.

Clean Claim

A clean claim is a claim submitted on an approved or identified claim format (CMS-1500 or CMS-1450 ("UB-04") or their successors) that contains all data fields required by Cenpatico and the State, for final adjudication of the claim. The required data fields must be complete and accurate. A Clean Claim must also include Cenpatico's published requirements for adjudication, such as: NPI Number, Tax Identification Number, or medical records, as appropriate.

Claims lacking complete information are returned to the Network Practitioner/Provider for completion before processing or information may be requested from the practitioner/provider on an Explanation of Benefit (EOB) form. This will cause a delay in payment.

Explanation of Payment (EOP)

An Explanation of Payment (EOP) is provided with each claim payment or denial. The EOP will detail each service being considered, the amount eligible for payment, copayments/deductibles deducted from eligible amounts, and the amount reimbursed.

If you have questions regarding your EOP, please contact Cenpatico's Claims Customer Service department at 877-730-2117.

Network Practitioner/Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within six (6) months, or 180 days, of the date the service(s) are rendered. Claims submitted after this period will be denied for payment.

Please submit a Clean Claim on a CMS-1500 Form or a CMS-1450 Form (“UB-04”) or their successors. A Clean Claim is one in which every line item is completed in its entirety.

Please ensure the billing practitioner’s/provider’s NPI number is listed in field 24J if you are billing with a CMS-1500 Form or field 56 if you are billing with a CMS-1450 (“UB-04”) Form.

Please use the correct mailing address.

Network Practitioners/Providers must submit claims to the following address for processing and reimbursement:

Cenpatico
PO Box 6900
Farmington, MO 63640-3818

Common Claims Processing Issues

It is the Network Provider’s responsibility to obtain complete information from Cenpatico and the member and then to carefully review the CMS-1500, or its successor claim form and/or CMS-1450 (“UB-04”), or its successor claim form, prior to submitting claims to Cenpatico for payment. This prevents delays in processing and reimbursement.

Some common problem areas are:

- Failure to obtain prior-authorization
- Federal Tax ID number not included
- Billing provider’s NPI number not included in field 24J (CMS-1500) or field 56 (CMS-1450)
- Insufficient Member ID Number. Network providers are encouraged to call Cenpatico to request the member’s Medicaid ID prior to submitting a claim
- Visits or days provided exceed the number of visits or days authorized
- Date of service is prior to or after the authorized treatment period
- Network Provider is billing for unauthorized services, such as the using the wrong CPT Code
- Insufficient or unidentifiable description of service performed
- Member exceeded benefits
- Claim form not signed by Network Provider
- Multiple dates of services billed on one claim form are not listed separately
- Diagnosis code is incomplete or not specified to the highest level available – be sure to use 4th and 5th digit when applicable
- Hand written claims are often illegible and require manual intervention, thereby increasing the risk of error and time delay in processing claims.

Services that are not pre-certified and require prior-authorization may be denied. Cenpatico reserves the right to deny payment for services provided that were/are not Medically Necessary.

Imaging Requirements For Paper Claims

Cenpatico uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do:

- Submit all claims in a 9" x 12" or larger envelope
- Complete forms correctly and accurately with black or blue ink only (or typewritten)
- Ensure typed print aligns properly within the designated boxes on the claim form
- Submit on a proper form; CMS-1500 or CMS-1450 ("UB04")
- Whenever possible refrain from submitting hand written claims

Do Not:

- Use red ink on claim forms
- Circle any data on claim forms
- Add extraneous information to any claim form field
- Use highlighter on any claim form field
- Submit carbon copied claim forms
- Submit claim forms via fax

Web Portal Claim Submission

Cenpatico's website provides an array of tools to help you manage your business needs and to access information of importance to you.

By visiting www.cenpatico.com, you can find information on:

- Provider Directory
- Preferred Drug List
- Frequently Used Forms
- EDI Companion Guides
- Billing Manual
- Secure Web Portal Manual
- Provider Office Manual
- Managing EFT

Cenpatico also offers our contracted providers and their office staff the opportunity to register for our Secure Web Portal. You may register by visiting www.cenpatico.com and creating a username and password. Once registered you may begin utilizing additional available services:

- Submit both Professional and Institutional claims
- Check claim status
- View and print member eligibility
- Request and view prior-authorizations
- Contact us securely and confidentially

We are continually updating our website with the latest news and information. Be sure to bookmark www.cenpatico.com to your favorites and check back often.

EDI Clearinghouses

Cenpatico's Network Providers may choose to submit their claims through a clearinghouse. Cenpatico accepts EDI transactions through the following vendors;

Trading Partner	Payer ID	Contact Number
Availity/THIN	68058	800-282-4548
Emdeon/WebMD/Envoy	68058	800-845-6592, #2
MedAvant/ProxyMed	68058	800-792-5256
The SSI Group	68058	800-880-3032

Cenpatico Billing Policies

Member Hold Harmless

Under no circumstances is a member to be balance billed for covered services or supplies. If the Network Practitioner/Provider uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for anything other than specified un-met deductible or copayments (if any).

Please Note:

- A Network Practitioner's/Provider's failure to authorize the service(s) does not qualify/allow the Network Practitioner/Provider to bill the member for service(s).
- Sunshine Health members may not be billed for missed sessions ("No-Show").

Network Practitioners/Providers can bill a Member only if they provide proof that they attempted to obtain Member insurance identification information within one hundred and eighty (180) days of service.

Non-Covered Services

If a Network Practitioner/Provider renders a non-covered service to a member, the Network Practitioner/Provider may bill the member only if the Network Practitioner/Provider has obtained written acknowledgement from the member, prior to rendering such non-covered service, that the specific service is not a covered benefit under Sunshine Health or Cenpatico and that the member understands they are responsible for reimbursing the Network Practitioner/Provider for such services.

Claims Payment and Member Eligibility

Cenpatico's Network Practitioners/Providers are responsible for verifying member eligibility for each referral and service provided on an ongoing basis.

When Cenpatico refers a member to a Network Practitioner/Provider, every effort has been made to obtain the correct eligibility information. If it is subsequently determined that the member was not eligible at the time of service (member was not covered under Sunshine Health or benefits were exhausted), a denial of payment will occur and the reason for denial will be indicated on the Explanation of Payment (EOP) accompanying the denial.

In this case, the Network Practitioner/Provider should bill the member directly for services rendered while the member was not eligible for benefits.

It is the member's responsibility to notify the Network Practitioner/Provider of any changes in his/her insurance coverage and/or benefits.

Claim Status

Please do not submit duplicate bills for authorized services. If your Clean Claim has not been adjudicated within forty-five (45) days, please call Cenpatico's Claims Customer Service department at 877-730-2117 to determine the status of the claim.

To expedite your call, please have the following information available when you contact Cenpatico's Claims Customer Service department:

- Member Name
- Member Date of Birth
- Member ID Number
- Date of Service
- Procedure Code Billed
- Amount Billed
- Cenpatico Authorization Number
- Network Provider's Name
- Network Provider's NPI Number
- Network Provider's Tax Identification Number

Retro Authorization

If your claim was denied because you did not have an authorization number, please send a request in writing for a Retroactive Authorization, explaining in detail the reason for providing services without an authorization.

Network Practitioners/Providers must submit their Retroactive Authorization request to:

Cenpatico
Attn: Appeals Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Fax: 866-714-7991

Retro Authorizations will only be granted in rare cases. Repeated requests for Retro Authorizations will result in termination from the Cenpatico Florida Practitioner/Provider Network due to inability to follow policies and procedures.

If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Customer Service department at 866-796-0530 and ask the representative to extend the end date on your authorization.

Resolving Claims Issues

Claim Reconsideration

If a claim discrepancy is discovered, in whole or in part, the following action may be taken:

1. Call the Cenpatico Claims Support Liaisons at 1-877-730-2117. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of our Claims Support Liaisons
2. When a practitioner/provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim should be submitted on a paper claim form. When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as

RESUBMISSION along with the original claim number written at the top of the claim. Failure to mark the claim may result in the claim being denied as a duplicate. Corrected resubmissions should be sent to the address below.

Cenpatico
Claims Resubmission
P. O. Box 6900
Farmington, MO 63640-3818

For issues that do not require a corrected resubmission the Adjustment Request Form can be utilized. The Claims Support Liaison can assist with determining when a corrected resubmission is necessary and when an Adjustment Request Form can be utilized.

3. For cases where authorization has been denied because the case does not meet the necessary criteria, the Appeals Process, described in your denial letter is the appropriate means of resolution. If your claim was denied because you did not have an authorization, please send a request in writing for a retro-active authorization, explaining in detail the reason for providing services without an authorization. Mail requests to the following address:

Cenpatico
Care Management
504 Lavaca St., Ste 850
Austin, TX 78701-2939

Retro authorizations will only be granted in rare cases. Repeated requests for retro authorizations will result in termination from the network due to inability to follow policies and procedures. If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Service Center and ask the representative to extend the end date on your authorization.

4. If a Resubmission has been processed and you are still dissatisfied with Cenpatico's response, you may file an appeal of this decision by writing to the address listed below. Note: Appeals must be filed in writing. Place APPEAL within your request. In order for Cenpatico to consider the appeal it must be received within 90 days of the date on the EOP which contains the denial of payment that is being appealed unless otherwise stated in your contract. If you do not receive a response to a written appeal within 45 days for Medicaid specific patients, or are not satisfied with the response you receive, you may appeal within 60 days of the HMO's final decision.

Cenpatico Appeals
PO Box 6000
Farmington, MO 63640-3809

5. If you are unable to resolve a specific claims issue through these avenues then you may initiate the Payment Dispute Process. Please contact your Cenpatico Provider Relations representative about your specific issue. Please provide detailed information about your efforts to resolve your payment issue. Making note of which Cenpatico staff you have already spoken with will help us assist you. Steps 1-4 should be followed prior to initiating the Payment Dispute Process. After contacting Provider Relations at the address below, your dispute will be investigated.

Cenpatico
Attention: Provider Relations
504 Lavaca St., Ste 850
Austin, TX 78701-2939
Phone: 866-796-0530

National Provider Identifier (NPI)

Cenpatico requires all claims be submitted with a Network Practitioner’s/Provider’s National Provider Identifier (NPI). This will be required on all electronic and paper claims. Network Practitioners/Providers must ensure Cenpatico has their correct NPI Number loaded in their system profile. Typically, each Network Practitioner’s/Provider’s NPI Number is captured through the credentialing process.

Applying for an NPI

Providers can apply for an NPI via the web or by mail:

To Register Online

- To register for an NPI using the web-based process, please visit the following website;
- <https://nppes.cms.hhs.gov/NPPES/>
- Click on the link that says “If you are a healthcare provider, the NPI is your unique identifier.” Then click on the link that says “Apply online for an NPI.” This should be the first link. Follow the instructions on the web page to complete the process.

To Register By Mail

- To obtain an NPI paper application, please call (800) 465-3203 (NPI Toll-Free).

Submitting Your NPI to Cenpatico

Please visit www.cenpatico.com to submit your NPI number. Network Providers may elect to contact the Cenpatico Provider Relations department by phone to share their NPI.

CMS 1500 (8/05) Claim Form Instructions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

CMS 1500 Claim Form

The diagram shows the CMS 1500 Claim Form with the following fields highlighted by blue circles:

- 1**: Insurance Program Identification (Medicare, Medicaid, Tricare, etc.)
- 1a**: Insured's I.D. Number
- 2**: Patient's Name (Last Name, First Name, Middle Initial)
- 3**: Patient's Birth Date (MM, DD)
- 4**: Insured's Name (Last Name, First Name, Middle Initial)
- 5**: Patient's Address (No., Street)
- 6**: Patient Relationship to Insured (Self, Spouse, Child, Other)
- 7**: Insured's Address (No., Street)
- 8**: Patient Status (Single, Married, Other, Employed, Student)

Field #	Field Description	Instructions or Comments	Required or Conditional
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other.	Not Required

1a	Insured I.D. Number	The 10-digit Medicaid identification number on the member's Cenpatico I.D. card.	R
2	Patient's Name (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Cenpatico I.D. card. Do not use nicknames.	R
3	Patient's Birth Date / Sex	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M=male, F=female	R
4	Insured's Name	Enter the patient's name as it appears on the member's Cenpatico I.D. card.	R
5	Patient's Address (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. <ul style="list-style-type: none"> • First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Second line – In the designated block, enter the city and state. • Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1. 	R
6	Patient's Relation to Insured	Always mark to indicate self.	C
7	Insured's Address (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. <ul style="list-style-type: none"> • First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Second line – In the designated block, enter the city and state. • Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1. 	Not Required
8	Patient Status		Not Required

CMS 1500 Claim Form

<input type="checkbox"/> PICA						PICA <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE 1 <input type="checkbox"/> (Medicare #)		MEDICAID 1 <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS 1 <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA 1 <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN 1 <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG 1 <input type="checkbox"/> (SSN)		OTHER 1 <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2						3. PATIENT'S BIRTH DATE 3 MM DD						SEX 3 M <input type="checkbox"/> F <input type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street) 5						6. PATIENT RELATIONSHIP TO INSURED 6 Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 7					
CITY				STATE		8. PATIENT STATUS 8 Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE			
ZIP CODE				TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE				TELEPHONE (Include Area Code) ()			

INFORMATION

Field #	Field Description	Instructions or Comments	Required or Conditional
9	Other Insured's Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured. NOTE: COB claims that require attached EOBs must be submitted on paper.	C
9a	*Other Insured's Policy or Group Number	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	Other Insured's Birth Date/ Sex	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate sex/gender. M=male, F=female for the person listed in box 9.	C
9c	Employer's Name or School Name	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	Insurance Plan Name or Program Name	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	Is Patient's Condition Related To	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	Reserved For Local Use		Not Required
11	Insured's Policy Group or Feca Number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C

11a	Insured's Date of Birth/ Sex	Same as field 3.	C
11b	Employer's Name or School Name	REQUIRED if Employment is marked Yes in box 10a.	C
11c	Insurance Plan Name or Program Name	Enter name of the insurance Health Plan or program.	C
11d	Is There Another Health Benefit Plan	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the Member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	Patient's or Authorized Person's Signature		Not Required.

CMS 1500 Claim Form

Field #	Field Description	Instructions or Comments	Required or Conditional
14	Date of Current : Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date reflecting the first date of onset for the: <ul style="list-style-type: none"> • Present Illness • Injury • LMP (last menstrual period) if pregnant 	C
15	If Patient Has Same or Similar Illness. Give First Date.		Not Required
16	Dates Patient Unable to Work in Current Occupation		Not Required
17	Name of Referring Physician or Other Source	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	C

17a	ID Number of Referring Physician	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI Number of Referring Physician	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization Dates Related to Current Services		Not Required
19	Reserved For Local Use		Not Required
20	Outside Lab/Charges		Not Required
21	Diagnosis or Nature of Illness or Injury. (Relate Items 1,2,3, OR 4 To Items 24E By Line)	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9-CM Volume 1 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes are NOT acceptable as a primary diagnosis. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	Medicaid Resubmission Code/ Original REF.NO.	For re-submissions or adjustments, enter the 12-character DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “RESUBMISSION” to avoid denials for duplicate submission. NOTE: Re-submissions may NOT currently be submitted via EDI.	C
23	Prior Authorization Number	Enter the Cenpatico authorization or referral number. Refer to the Cenpatico Provider Manual for information on services requiring referral and/or prior authorization.	Not Required

CMS 1500 Claim Form

PICA		PICA	
1. MEDICARE 1 MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNGS OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2		3. PATIENT'S BIRTH DATE 3 SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 5		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 4	
CITY STATE		7. INSURED'S ADDRESS (No., Street) 7	
ZIP CODE TELEPHONE (Include Area Code) ()		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 6	
8. PATIENT STATUS 8 Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY STATE	
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code) ()	

Field #	Field Description	Instructions or Comments	Required or Conditional
24A-J General Information	<p>Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24J. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.</p> <ul style="list-style-type: none"> • The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid Number qualifier, and Provider Medicaid Number. • Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below and in Appendix 4 for information on how to complete. • The un-shaded area of a claim line is for the entry of claim line item detail. 		
24A-G Shaded	Supplemental Information	<p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <ul style="list-style-type: none"> • NDC • Anesthesia Start/Stop time & duration • Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. • Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. • HIBCC or GTIN number/code. <p>For detailed instructions and qualifiers refer to Appendix 4 of this manual.</p>	C
24A Un-shaded	Date(s) of Service	<p>Enter the date the service listed in 24D was performed (MM/DD/YY). If there is only one date enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed within a date span, enter the date span in the "From" and "To" fields. The count listed in field 24G for the service must correspond with the date span entered.</p>	R
24B Un-shaded	Place of Service	<p>Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf</p>	R
24C Un-shaded	EMG	<p>Enter Y (Yes) or N (No) to indicate if the service was an emergency.</p>	R

24D Un-shaded	Procedures, Services or Supplies CPT/ HCPCS Modifier	<p>Enter the 5-digit CPT or HCPC code and 2-character modifier-- if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.</p> <p>Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.</p> <p>The following modifiers are recognized as modifiers that will impact the pricing of your claim. Modifiers that indicate licensure level must be placed in the first modifier position for correct pricing.</p> <table border="1" data-bbox="630 829 1079 1010"> <tr> <td>AH</td> <td>HN</td> <td>HO</td> <td>SA</td> <td>TD</td> </tr> <tr> <td>U2</td> <td>U3</td> <td>U4</td> <td>U6</td> <td>U7</td> </tr> <tr> <td>U8</td> <td>UB</td> <td>UC</td> <td>UD</td> <td></td> </tr> <tr> <td>HQ</td> <td>HR</td> <td>TF</td> <td>UA</td> <td>AJ</td> </tr> </table>	AH	HN	HO	SA	TD	U2	U3	U4	U6	U7	U8	UB	UC	UD		HQ	HR	TF	UA	AJ	R
AH	HN	HO	SA	TD																			
U2	U3	U4	U6	U7																			
U8	UB	UC	UD																				
HQ	HR	TF	UA	AJ																			
24E Un-shaded	Diagnosis Code	Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9 codes for the date of service or the claim will be rejected/denied.	R																				
24F Un-shaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R																				
24G Un-shaded	Days or Units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R																				
24H Shaded	EPSDT (CHCUP) Family Planning	Leave Blank	Not Required																				

24H Un-shaded	EPSDT (CHCUP) Family Planning	Enter the appropriate qualifier for EPSDT visit	C
24I Shaded	ID Qualifier	Use ZZ qualifier for Taxonomy	C
24Ja Shaded	Non-NPI Provider ID#	<p>Enter as designated below the Medicaid ID number or taxonomy code.</p> <ul style="list-style-type: none"> • Typical Providers: Enter the Provider taxonomy code or Medicaid Provider ID number that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. • Atypical Providers: Enter the 6-digit Medicaid Provider ID number. 	R
24Jb Un-shaded	NPI Provider ID	<ul style="list-style-type: none"> • Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a Member of a group, the rendering individual provider's 10-character NPI ID may be entered. 	R

CMS 1500 Claim Form

Field #	Field Description	Instructions or Comments	Required or Conditional
25	Federal Tax ID Number SSN/ EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	Patient's Account No.	Enter the provider's billing account number.	Not Required
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	R
28	Total Charges	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R

29	Amount Paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Cenpatico. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	Balance Due	REQUIRED when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	Signature of Physician or Supplier Including Degrees or Credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature. Note: does not exist in the electronic 837P.	Required
32	Service Facility Location Information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box #'s are not acceptable here.) <ul style="list-style-type: none"> • First line – Enter the business/facility/practice name. • Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Third line – In the designated block, enter the city and state. • Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. 	C
32a	NPI- Services Rendered	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	Other Provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. <ul style="list-style-type: none"> • Typical Providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). • Atypical Providers: Enter the 2-character qualifier 1D followed by the 6-character Medicaid Provider ID number (no spaces). 	C

33	Billing Provider Info and PH #	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. <ul style="list-style-type: none"> • First line – Enter the business/facility/practice name. • Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Third line – In the designated block, enter the city and state. • Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). 	R
33a	Group Billing NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	Group Billing Other ID	Enter as designated below the Billing Group Medicaid ID number or taxonomy code. <ul style="list-style-type: none"> • Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier. • Atypical Providers: Enter the 6-digit Medicaid Provider ID number. 	R

UB-04 Claim Form Instructions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

CMS 1500 Claim Form

Field #	Field Description	Instructions or Comments	Required or Conditional*
1	(Unlabeled Field)	<ul style="list-style-type: none"> • Line 1: Enter the complete provider name. • Line 2: Enter the complete mailing address. • Line 3: Enter the City, State, and zip+4 code (include hyphen) • Line 4: Enter the area code and phone number. 	R

2	(Unlabeled Field)	Enter the Pay-To Name and Address.	Not Required
3a	Patient Control No.	Enter the facility patient account/control number	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R
4	Type of Bill	Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero) . A leading "0" is not needed. Digits should be reflected as follows: <ul style="list-style-type: none"> • 1st digit - Indicating the type of facility. • 2nd digit - Indicating the type of care. • 3rd digit - Indicating the billing sequence. 	R
5	Fed. Tax No.	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	Statement Covers Period From/Through	Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service. (MMDDYY)	R
7	(Unlabeled Field)	Not Used	Not Required
8a	Patient Name	8a – Enter the patient's 10-digit Medicaid identification number on the member's Cenpatico I.D. card.	Not Required
8b	Patient Name	8b – Enter the patient's last name, first name, and middle initial as it appears on the Cenpatico I.D. card. Use a comma or space to separate the last and first names. <ul style="list-style-type: none"> • Titles (Mr., Mrs., etc.) should not be reported in this field. • Prefix: No space should be left after the prefix of a name e.g. McKendrick. H • Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). • Suffix: A space should separate a last name and suffix. 	R
9a-e	Patient Address	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (Not Required)	R (except line 9e)
10	Birthdate	Enter the patient's date of birth (MMDDYYYY)	R
11	Sex	Enter the patient's sex. Only M or F is accepted.	R

12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims.	R																								
13	Admission Hour	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.</p> <table border="1"> <tr> <td>00- 12:00 midnight to 12:59</td> <td>12- 12:00 noon to 12:59</td> </tr> <tr> <td>01- 01:00 to 01:59</td> <td>13- 01:00 to 01:59</td> </tr> <tr> <td>02- 02:00 to 02:59</td> <td>14- 02:00 to 02:59</td> </tr> <tr> <td>03- 03:00 to 03:39</td> <td>15- 03:00 to 03:59</td> </tr> <tr> <td>04- 04:00 to 04:59</td> <td>16- 04:00 to 04:59</td> </tr> <tr> <td>05- 05:00 to 05:59</td> <td>17- 05:00 to 05:59</td> </tr> <tr> <td>06- 06:00 to 06:59</td> <td>18- 06:00 to 06:59</td> </tr> <tr> <td>07- 07:00 to 07:59</td> <td>19- 07:00 to 07:59</td> </tr> <tr> <td>08- 08:00 to 08:59</td> <td>20- 08:00 to 08:59</td> </tr> <tr> <td>09- 09:00 to 09:59</td> <td>21- 09:00 to 09:59</td> </tr> <tr> <td>10- 10:00 to 10:59</td> <td>22- 10:00 to 10:59</td> </tr> <tr> <td>11- 11:00 to 11:59</td> <td>23- 11:00 to 11:59</td> </tr> </table>	00- 12:00 midnight to 12:59	12- 12:00 noon to 12:59	01- 01:00 to 01:59	13- 01:00 to 01:59	02- 02:00 to 02:59	14- 02:00 to 02:59	03- 03:00 to 03:39	15- 03:00 to 03:59	04- 04:00 to 04:59	16- 04:00 to 04:59	05- 05:00 to 05:59	17- 05:00 to 05:59	06- 06:00 to 06:59	18- 06:00 to 06:59	07- 07:00 to 07:59	19- 07:00 to 07:59	08- 08:00 to 08:59	20- 08:00 to 08:59	09- 09:00 to 09:59	21- 09:00 to 09:59	10- 10:00 to 10:59	22- 10:00 to 10:59	11- 11:00 to 11:59	23- 11:00 to 11:59	R
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03- 03:00 to 03:39	15- 03:00 to 03:59																										
04- 04:00 to 04:59	16- 04:00 to 04:59																										
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14	Admission Type	<p>REQUIRED for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes:</p> <ul style="list-style-type: none"> 1 Emergency 2 Urgent 3 Elective 4 Newborn 	C																								
15	Admission Source	<p>Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes:</p> <ul style="list-style-type: none"> 1 Physician Referral 2 Clinic Referral 4 Transfer from a Hospital 6 Transfer from another healthcare facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available 	R																								

16	Discharge Hour	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.</p> <table border="1" data-bbox="443 180 1243 720"> <tr> <td>00-12:00 midnight to 12:59</td> <td>12- 12:00 noon to 12:59</td> </tr> <tr> <td>01- 01:00 to 01:59</td> <td>13- 01:00 to 01:59</td> </tr> <tr> <td>02- 02:00 to 02:59</td> <td>14- 02:00 to 02:59</td> </tr> <tr> <td>03- 03:00 to 03:39</td> <td>15- 03:00 to 03:59</td> </tr> <tr> <td>04- 04:00 to 04:59</td> <td>16- 04:00 to 04:59</td> </tr> <tr> <td>05- 05:00 to 05:59</td> <td>17- 05:00 to 05:59</td> </tr> <tr> <td>06- 06:00 to 06:59</td> <td>18- 06:00 to 06:59</td> </tr> <tr> <td>07- 07:00 to 07:59</td> <td>19- 07:00 to 07:59</td> </tr> <tr> <td>08- 08:00 to 08:59</td> <td>20- 08:00 to 08:59</td> </tr> <tr> <td>09- 09:00 to 09:59</td> <td>21- 09:00 to 09:59</td> </tr> <tr> <td>10- 10:00 to 10:59</td> <td>22- 10:00 to 10:59</td> </tr> <tr> <td>11- 11:00 to 11:59</td> <td>23- 11:00 to 11:59</td> </tr> </table>	00-12:00 midnight to 12:59	12- 12:00 noon to 12:59	01- 01:00 to 01:59	13- 01:00 to 01:59	02- 02:00 to 02:59	14- 02:00 to 02:59	03- 03:00 to 03:39	15- 03:00 to 03:59	04- 04:00 to 04:59	16- 04:00 to 04:59	05- 05:00 to 05:59	17- 05:00 to 05:59	06- 06:00 to 06:59	18- 06:00 to 06:59	07- 07:00 to 07:59	19- 07:00 to 07:59	08- 08:00 to 08:59	20- 08:00 to 08:59	09- 09:00 to 09:59	21- 09:00 to 09:59	10- 10:00 to 10:59	22- 10:00 to 10:59	11- 11:00 to 11:59	23- 11:00 to 11:59	Not Required						
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17	Patient Status	<p>REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes:</p> <table border="1" data-bbox="443 856 1243 1682"> <thead> <tr> <th>Status</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Discharged to home or self care</td> </tr> <tr> <td>02</td> <td>Transferred to another short-term general hospital</td> </tr> <tr> <td>03</td> <td>Transferred to a SNF</td> </tr> <tr> <td>04</td> <td>Transferred to an ICF</td> </tr> <tr> <td>05</td> <td>Transferred to another type of institution</td> </tr> <tr> <td>06</td> <td>Discharged home to care of home health</td> </tr> <tr> <td>07</td> <td>Left against medical advice</td> </tr> <tr> <td>08</td> <td>Discharged home under the care of a Home IV provider</td> </tr> <tr> <td>20</td> <td>Expired</td> </tr> <tr> <td>30</td> <td>Still patient or expected to return for outpatient services</td> </tr> <tr> <td>31</td> <td>Still patient – SNF administrative days</td> </tr> <tr> <td>32</td> <td>Still patient – ICF administrative days</td> </tr> <tr> <td>62</td> <td>Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital</td> </tr> <tr> <td>65</td> <td>Discharged/Transferred to a psychiatric hospital or distinct psychiatric unit of a hospital</td> </tr> </tbody> </table>	Status	Description	01	Discharged to home or self care	02	Transferred to another short-term general hospital	03	Transferred to a SNF	04	Transferred to an ICF	05	Transferred to another type of institution	06	Discharged home to care of home health	07	Left against medical advice	08	Discharged home under the care of a Home IV provider	20	Expired	30	Still patient or expected to return for outpatient services	31	Still patient – SNF administrative days	32	Still patient – ICF administrative days	62	Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital	65	Discharged/Transferred to a psychiatric hospital or distinct psychiatric unit of a hospital	C
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18-28	Condition Codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	Accident State		Not Required
30	(Unlabeled Field)	Not Used	Not Required

CMS 1500 Claim Form

Field #	Field Description	Instructions or Comments	Required or Conditional*
31-34 a-b	Occurrence Code and Occurrence Date	<p>Occurrence Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.</p>	C

35-36 a-b	Occurrence Span Code and Occurrence Date	<p>Occurrence Span Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.</p>	C
37	(Unlabeled Field)	<p>REQUIRED for re-submissions or adjustments. Enter the 12-character DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "RESUBMISSION" to avoid denials for duplicate submission.</p> <p>NOTE: Re-submissions may NOT currently be submitted via EDI.</p>	C
38	Responsible Party Name and Address		Not Required
39-41 a-d	Value Codes Codes and Amounts	<p>Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields.</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual</p> <p>Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p>	C

CMS 1500 Claim Form

General Information Fields 42-47	Service Line Details	The following UB-04 fields – 42-47:																					
42 Line 1-22	Rev CD	<ul style="list-style-type: none"> Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23. 	R																				
42 Line 23	Rev CD	Enter 0001 for total charges.	R																				
43 Line 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R																				
43 Line 23	Page ___ of ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e. PAGE "1" OF "1").	R																				
44	HCPCS/Rates	<p>REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use a spaces, commas, dashes or the like between the CPT/HCPC and modifier(s)</p> <p>Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>The following revenue codes/revenue code ranges must always have an accompanying CPT/HCPC.</p> <table border="1" style="width: 100%; text-align: center;"> <tbody> <tr> <td>300-302</td> <td>329-330</td> <td>360-361</td> <td>610-612</td> </tr> <tr> <td>304-307</td> <td>333</td> <td>363-366</td> <td>615-616</td> </tr> <tr> <td>309-312</td> <td>340-342</td> <td>368-369</td> <td>618-619</td> </tr> <tr> <td>314</td> <td>349-352</td> <td>400-404</td> <td>634-636</td> </tr> <tr> <td>319-324</td> <td>359</td> <td>490-499</td> <td>923</td> </tr> </tbody> </table>	300-302	329-330	360-361	610-612	304-307	333	363-366	615-616	309-312	340-342	368-369	618-619	314	349-352	400-404	634-636	319-324	359	490-499	923	C
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45 Line 1-22	Service Date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY)	C
45 Line 23	Creation Date	Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)	R
46	Service Units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered.	R
47 Line 1-22	Total Charges	Enter the total charge for each service line.	R
47 Line 23	Totals	Enter the total charges for all service lines.	R
48 Line 1-22	Non-Covered Charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	Total	Enter the total non-covered charges for all service lines.	C
49	(Unlabeled Field)	Not Used	Not Required

CMS 1500 Claim Form

Field #	Field Description	Instructions or Comments	Required or Conditional*
50 A-C	Payer	Enter the name for each Payer reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	Health Plan Identification Number		Not Required
52			
A-C	Rel. Info	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y".	R
53	ASG. BEN.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R

54	Prior Payments	Enter the amount received from the primary payer on the appropriate line when Medicaid/ Cenpatico is listed as secondary or tertiary.	C
55	Est. Amout Due		Not Required
56	National Provider Identifier or Provider ID	REQUIRED: Enter provider's 10-character NPI ID.	R
57	Other Provider ID	Enter the qualifier "1D" followed by your 6-digit Medicaid Provider ID number.	Not Required
58	Insured's Name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	Patient Relationship		Not Required
60	Insured's Unique ID	REQUIRED: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance / Medicaid ID in the order of liability listed in field 50.	R
61	Group Name		Not Required
62	Insurance Group No.		Not Required
63	Treatment Authorization Codes		Not Required
64	Document Control Number	Enter the 12-character Document Control Number (DCN) of the paid Cenpatico claim when submitting a replacement or void on the corresponding A, B, C line reflecting Cenpatico from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim).	C
65	Employer Name		Not Required
66	DX		Not Required

CMS 1500 Claim Form

PICA						PICA											
1. MEDICARE 1		MEDICAID		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2						3. PATIENT'S BIRTH DATE 3			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) 4					
5. PATIENT'S ADDRESS (No., Street) 5						6. PATIENT RELATIONSHIP TO INSURED 6						7. INSURED'S ADDRESS (No., Street) 7					
CITY			STATE			8. PATIENT STATUS 8						CITY			STATE		
ZIP CODE		TELEPHONE (Include Area Code)				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE		TELEPHONE (Include Area Code)			

Field #	Field Description	Instructions or Comments	Required or Conditional*
67	Principal Diagnosis Code	<p>Enter the principal/primary diagnosis or condition (the condition established after study that is chiefly responsible for causing the visit) using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or “5”. “E” and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.</p>	R
67 A-Q	Other Diagnosis Code	<p>Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or “5”. “E” and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims with incomplete or invalid diagnosis codes will be denied for payment.</p>	C
68	(Unlabeled)	Not Used	Not Required
69	Admitting Diagnosis Code	<p>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes and most “V” are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.</p>	R
70 a,b,c	Patient Reason Code	<p>Enter the ICD-9-CM code that reflects the patient’s reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional.</p> <p>Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes and most “V” are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.</p>	R
71	PPS / DRG Code		Not Required
72 a,b,c	External Cause Code		Not Required

73	(Unlabeled)		Not Required
74	Principal Procedure Code /Date	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p> <p>REQUIRED for EDI Submissions.</p>	C
74 a-e	Other Procedure Code Date	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9 procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	C
75	(Unlabeled))		Not Required
76	Attending Physician	<p>Enter the NPI and Name of the physician in charge of the patient care:</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifier and ID number</p> <ul style="list-style-type: none"> • 0B – State License # • 1G – Provider UPIN • G2 – Provider Commercial # • ZZ – Taxonomy Code <p>LAST: Enter the attending physician’s last name</p> <p>FIRST: Enter the attending physician’s first name.</p>	R

77	Operating Physician	<p>REQUIRED when a surgical procedure is performed:</p> <p>NPI: Enter the operating physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifier and ID number</p> <ul style="list-style-type: none"> • 0B – State License # • 1G – Provider UPIN • G2 – Provider Commercial # • ZZ – Taxonomy Code <p>LAST: Enter the operating physician’s last name</p> <p>FIRST: Enter the operating physician’s first name.</p>	C
78 & 79	Other Physician	<p>Enter the Provider Type qualifier, NPI, and Name of the physician in charge of the patient care:</p> <p>(Blank Field): Enter one of the following Provider Type Qualifiers:</p> <ul style="list-style-type: none"> • DN – Referring Provider • ZZ – Other Operating MD • 82 – Rendering Provider <p>NPI: Enter the other physician 10-character NPI ID.</p> <p>QUAL: Enter one of the following qualifier and ID number</p> <ul style="list-style-type: none"> • 0B – State License # • 1G – Provider UPIN • G2 – Provider Commercial # <p>LAST: Enter the other physician’s last name.</p> <p>FIRST: Enter the other physician’s first name.</p>	C
80	Remarks		Not Required
81	CC	A: Taxonomy of billing provider. Use ZZ qualifier	R

Medical Necessity Criteria

Cenpatico created its Medical Necessity Criteria for use by the Cenpatico clinical staff and clinician consultants as well as Cenpatico’s network of practitioners/providers in making determinations regarding the appropriateness and the level of mental health and substance abuse care medically necessary for individuals whose benefits are managed by Cenpatico. These criteria are reviewed and revised annually and have been approved by the Cenpatico Quality Improvement Committee, the corporate oversight committee. Upon receipt of the necessary clinical information including the assessment of the individual’s biopsychosocial needs obtained from a face to face evaluation, Cenpatico clinical staff will make a medical necessity determination using these criteria.

For Chemical Dependency determinations, including ambulatory detoxification, Cenpatico utilizes the American Association of Addiction Medicine (ASAM) criteria. The medical necessity determinations will be consistent with Cenpatico's clinical practice guidelines and the prevailing standards of care. Cenpatico will then communicate the decision to the member, practitioner, and/or provider.

Cenpatico is dedicated to the principle that behavioral health and substance abuse services should be provided at the least restrictive level of care while ensuring safety, effectiveness, and a focus on recovery and resiliency.

Recovery is defined as the ability to live a fulfilling and productive life despite a history of behavioral health challenges, by reducing or eliminating the impact of the symptoms of mental illness, overcoming behavioral health challenges and developing compensatory life skills.

Resiliency is defined as the personal and community qualities that insulate us from trauma, adversity and stressors. Cenpatico is committed to careful consideration of the individual's biopsychosocial needs and to ensuring that quality cost-effective care is provided in a culturally competent manner.

Medical Necessity Definition

Cenpatico defines medical necessity as:

Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

- a. consistent with the diagnosis and treatment of a condition and standards of good medical practice and
- b. required for reasons other than convenience and
- c. the most appropriate supply or level of service

When applied to inpatient care, this means the needed services can only be safely given on an inpatient basis.

Cenpatico Medical Necessity is also available on our website at www.cenpatico.com

Hospitalization, Psychiatric Adult

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission – Severity of Need

Criteria A and either B, C or D must be met to satisfy the criteria for severity of need.

- D. Patient must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-IV).
- E. The patient demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
 1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.

2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
 3. An acute, severe decompensation in the ability to care adequately for own physical needs demonstrated through disordered, disorganized or bizarre behavior.
 4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. The patient demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
 2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
 3. Violent, unpredictable, or uncontrolled behavior that represents an imminently serious harm to the body or property of others.
 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission – Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face to face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

III. Continued Stay

Criteria A, B, C and D, and either E or F must be met to satisfy the criteria for continued stay.

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems consistent with the admission criteria and to the degree that would necessitate continued hospitalization.
- B. The current treatment plan should include documentation of diagnosis (DSM-IV-TR®, I V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24 hour basis.
- C. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and patient's response.
- E. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. This should be documented in daily progress notes by a physician.
- F. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

Hospitalization, Psychiatric, Child and Adolescent

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission - Severity of Need

Criteria A and either B, C or D must be met to satisfy the criteria for severity of need.

- A. Patient must have a diagnosed or suspected mental illness that can be expected to improve significantly. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I V).
- B. The patient demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
 1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.
 2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
 3. An imminently dangerous inability to care adequately for own physical needs through disordered, disorganized or bizarre behavior.
 4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
 1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
 2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
 3. Violent, unpredictable, or uncontrolled behaviors that represents an imminently serious harm to the body or property of others.
 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face to face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. Parents/ guardians/ other caretakers should be included in the evaluation process, unless there are specific clinical contraindications for their involvement.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.

- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

III. Continued Stay

Criteria A, B, C, D and E, and either F or G must be met to satisfy the criteria for continued stay.

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems consistent with the admission criteria and to the degree that would necessitate continued hospitalization.
- B. The current treatment plan should include documentation of diagnosis (DSM-IV-TR®, I V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24 hour basis.
- C. The patient's progress confirms that the presenting or newly defined problem will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and patient's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- G. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

Hospitalization, Psychiatric, Geriatric

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission – Severity of Need

Criteria A and either B, C or D must be met to satisfy the criteria for severity of need.

- A. Patient must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I V).
- B. The patient demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
 1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.
 2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
 3. An imminently dangerous inability to care adequately for own physical needs through disordered, disorganized or bizarre behavior.
 4. Other similarly clear and reasonable evidence of imminent serious harm to self.

- C. The patient demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
 - 1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
 - 2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
 - 3. Violent, unpredictable, or uncontrolled behavior that represents an imminently serious harm to the body or property of others.
 - 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face to face evaluation of the patient performed by an Attending Physician prior to, or within 24 hours following the admission.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. In addition to skilled nursing care for activities of daily living and supervision required for structure and redirection of behavior, the psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. For those patients whose co-morbid medical conditions may contribute to their mental status, there must be the availability of an appropriate initial medical assessment and ongoing medical management.
- D. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

III. Continued Stay

Criteria A, B, C, D and E, and either F or G must be met to satisfy the criteria for continued stay.

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems consistent with the admission criteria and to the degree that would necessitate continued hospitalization.
- B. The current treatment plan should include documentation of diagnosis (DSM-IV-TR®, axes I V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24 hour basis.
- C. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and patient's response.
- E. There should be evidence that disposition planning includes ongoing contact with facility of residence, personal caretakers and medical caretakers.
- F. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in

an inpatient setting. A physician should document this in daily progress notes.

- G. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

Hospitalization, Eating Disorders

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission – Severity of Need

Criteria A and one of criteria B, C, D, or E must be met to satisfy the criteria for severity of need.

- A. Patients must have a primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The illness can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Patients hospitalized because of another primary psychiatric disorder who have a coexisting Eating Disorder should be reviewed according to the criteria below only if the primary psychiatric disorder no longer requires hospitalization.
- B. Body weight less than 75% of Ideal Body Weight (IBW) or Body Mass Index (BMI) of 16 or below. If body weight is greater than 75% of IBW (or BMI > 16), this criterion can be met if there is evidence of weight loss of >15% in one month or weight loss associated with physiologic instability unexplained by any other medical condition. This criterion may be satisfied in children and adolescents who have a body weight between 75-85% of ideal, based upon height, during a period of rapid growth.
- C. Medical consequences of the eating disordered behavior that present the potential for imminent harm such that immediate medical and psychiatric stabilization is necessary before ambulatory or residential management can be considered safe or effective. Such medical consequences would include severe malnutrition, emaciation, significant electrolyte or fluid imbalance, cardiac arrhythmias, hypotension, impaired renal function, intestinal atony or obstruction, pancreatitis, gastric dilatation, esophagitis or esophageal tears, and colitis.
- D. In bulimia, immediate interruption of the binge/purge cycle is required to avoid imminent, serious harm, due to the presence of a co-morbid medical or psychiatric condition (e.g. pregnancy, uncontrolled diabetes, severe depression with suicidal ideation, etc.), with the need to ensure adequate nutrition and absorption of pharmaceuticals.
- E. Failure to respond to an adequate therapeutic trial of treatment in a less restrictive setting (partial hospital). An adequate therapeutic trial would, at a minimum, consist of treatment several times per week with twice weekly individual and/or family therapy, either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated.
- F. To meet this criterion, the patient must have significant weight loss (<85% IBW), significant impairment in social or occupational functioning, and be uncooperative with treatment (or cooperative only in a highly structured environment) despite having insight and motivation to recover. If patient has failed to improve in an acute program, there must be evidence to suggest that

necessary changes in the treatment plan cannot be implemented in an outpatient setting or that inpatient hospitalization is required due to medical co-morbidity or need for special feeding.

II. Admission – Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face to face evaluation of the patient performed by an Attending Physician prior to, or within 24 hours following the admission. For child and adolescents, parents/ guardians/ other caretakers should be included in the evaluation process, unless there are specific clinical contraindications for their involvement.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

III. Continued Stay

Criteria A, B, C, D and E, and either one of F, G, H, I or J, must be met to satisfy the criteria for continued stay.

- A. The admission criteria Severity of Need A and B, C, or D, and Intensity of Service A, B and C are continually met.
- B. The current treatment plan should include documentation of diagnosis (DSM-IV-TR®, axes I V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24 hour basis.
- C. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and patient's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. The patient's weight remains <85% of IBW and he/she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.
- G. Continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required. In order to satisfy this criterion, there must be evidence that patient is unable to participate in ambulatory treatment, lacks significant insight into the symptoms of his/her illness, and has regressed in response to progressive increases in privilege level.
- H. The patient continues to meet Admission Criteria, I-C with the need for ongoing medical monitoring of medical consequences of the eating disorder.
- I. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- J. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

Partial Hospitalization, Psychiatric, Adult

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission – Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. Patient must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. There is clinical evidence that a less intensive outpatient setting is not appropriate at this time and/or a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
 - 1. There is clinical evidence that the patient would be at risk to self or others if he were not in a partial hospitalization program; or
 - 2. As a result of the patient's mental disorder there is an inability to adequately care for one's physical needs, representing potential serious harm to self.
- D. Additionally, either:
 - 1. The patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or
 - 2. The patient is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

II. Admission – Intensity of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours, and the patient must be capable of seeking them as needed.
- B. The patient's condition must require a structured program with nursing and medical supervision, intervention and/or treatment for at least 4 hours per day.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.
- D. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-partial hospitalization needs.

III. Continued Stay

Criteria A, B, C, and D must be met to satisfy the criteria for continued stay.

- A. Despite treatment efforts, clinical evidence indicates the persistence of problems that necessitated the admission to the partial hospitalization program, or the emergence of additional problems consistent with the admission criteria.
- B. There are progress notes for each day that the patient is in a partial hospital/day treatment program documenting the provider's treatment, and the patient's response to treatment.

- C. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for partial hospitalization services.

Partial Hospitalization, Psychiatric, Child and Adolescent

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission – Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. Patient must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I V).
- B. There is clinical evidence that a less intensive outpatient setting is not appropriate at this time and/or a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
 - 1. There is clinical evidence that the patient would be at risk to self or others if he were not in a partial hospitalization program; or
 - 2. As a result of the patient's mental disorder there is an inability to adequately care for one's physical needs, representing potential serious harm to self.
- D. Additionally, either:
 - 1. The patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or
 - 2. The patient is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

II. Admission – Intensity of Need

Criteria A, B, C and D must be met to satisfy the criteria for intensity of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours, and the patient must be capable of seeking them as needed.
- B. The patient's condition must require a structured program with nursing and medical supervision, intervention, treatment, and/or family services for at least 4 hours per day.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.
- D. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-partial hospitalization needs.

III. Continued Stay

Criteria A, B, C, D, and E must be met to satisfy the criteria for continued stay.

- A. Despite treatment efforts, clinical evidence indicates the persistence of problems that necessitated the admission to the partial hospitalization program, or the emergence of additional problems consistent with the admission criteria.
- B. There are progress notes for each day that patient is in a partial hospital/day treatment program documenting the provider's treatment, and the patient's response to treatment.
- C. The patient's progress confirms that the presenting or newly defined problem will respond to the current treatment plan.
- D. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for partial hospitalization services.
- E. Patients must receive family therapy a minimum of once per week, unless a specific clinical reason is given as to why this is not needed and is documented in the medical record.

Intensive Outpatient Treatment, Psychiatric, Adult

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission – Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the individual has a primary DSM-IV-TR[®], IV diagnosis or severe emotional disturbance that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The individual's disorder can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. The individual is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
 - 1. A clear, current threat to the individual's ability to live in his/her customary setting for an individual who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient care.
 - 2. A clear, current threat to the individual's ability to be employed or attend school.
 - 3. An emerging/impending risk to the safety or property of the individual or of others.
- C. Either:
 - 1. For individuals with persistent or recurrent disorders, the individual's past history indicates that when the patient has experienced similar clinical circumstances, less intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others; or
 - 2. For individuals with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.

II. Admission – Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual, professional and/or social supports must be identified and available to the individual outside of program hours, and the individual must be capable of seeking them as needed when not attending the program.
- B. The individual's condition must require an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 2 hours/day or for 6 hours in a week.
- C. The individual treatment plan for intensive outpatient requires that a multidisciplinary team of professional and supervised support staff provide the services. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

- A. Despite treatment efforts, clinical evidence indicates the persistence of the problems that necessitated the admission to the intensive outpatient program, or the emergence of additional problems consistent with the admission criteria.
- B. There are progress notes for each day that patient is in intensive outpatient services documenting the provider's treatment, and the patient's response to treatment.
- C. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for intensive outpatient services.

Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the individual has a primary DSM-IV-TR®, IV diagnosis or severe emotional disturbance that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The individual's disorder can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. The individual is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
 - 1. A clear, current threat to the individual's ability to live in his/her customary setting for an individual who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient care.
 - 2. A clear, current threat to the individual's ability to be employed or attend school.
 - 3. An emerging/impending risk to the safety or property of the individual or of others.

C. Either:

1. For individuals with persistent or recurrent disorders, the individual's past history indicates that when the patient has experienced similar clinical circumstances, less intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others; or
2. For individuals with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.

II. Admission – Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual, professional and/or social supports must be identified and available to the individual outside of program hours, and the individual must be capable of seeking them as needed when not attending the program.
- B. The individual's condition must require an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 2 hours/day or for 6 hours in a week.
- C. The individual treatment plan for intensive outpatient requires that a multidisciplinary team of professional and supervised support staff provide the services. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

III. Continued Stay

Criteria A, B, C, and D must be met to satisfy the criteria for continued stay.

- A. Despite treatment efforts, clinical evidence indicates the persistence of the problems that necessitated the admission to the intensive outpatient program, or the emergence of additional problems consistent with the admission criteria.
- B. There are progress notes for each day that patient is in intensive outpatient services documenting the practitioner's treatment, and the patient's response to treatment.
- C. The patient's progress confirms that the presenting or newly defined problem will respond to the current treatment plan.
- D. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for intensive outpatient services.

Outpatient Treatment, Psychiatric

Quality of Care Standards

Criteria must apply for any requested service either at admission or during continued stay.

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

I. Initial Review - Severity of Need

Criteria A, B, C, and D must be met to satisfy the criteria for severity of need.

- A. A DSM-IV-TR® diagnosis on Axis I and/or Axis II.
- B. Completed assessments on Axes III, IV and V.

- C. A description of DSM-IV-TR®, IV psychiatric symptoms, intrapsychic conflict, behavioral and/or cognitive dysfunction consistent with the diagnoses on Axes I and II.
- D. Either 1, 2, or 3 below must be met to satisfy criteria D.
 - 1. At least mild symptomatic distress and/or impairment in functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I or Axis II disorder. This is evidenced by specific clinical description of the symptom(s) and/or impairment(s) consistent with a GAF (DSM-IV-TR®, Axis V) score of less than 71.
 - 2. The individual has a persistent DSM-IV illness for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
 - 3. There is clinical evidence that further therapy is required to support termination of therapy, although the individual no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. The therapist should be able to explain whether the treatment being utilized will change (and if not, why) when there has been sustained improvement as measured in part by a GAF score over 70.

II. Initial review - Intensity of Service

Criteria A and B must be met to satisfy the criteria for intensity of service.

- A. A medically necessary and appropriate treatment plan, or its update, specific to the patient's impairment in functioning and DSM-IV-TR®, IV psychiatric symptoms, behavior, cognitive dysfunctions, and/or psychodynamic conflicts. The treatment plan is expected to be effective in either:
 - 1. Alleviating the patient's distress and/or dysfunction, or
 - 2. Achieving appropriate maintenance goals for a persistent illness, or
 - 3. Supporting termination.
- B. The treatment plan must identify (1-6) to satisfy criteria B:
 - 1. The status of target-specific DSM-IV-TR®, IV psychiatric symptoms, behavior, and cognitive dysfunction being treated.
 - 2. The current or anticipated modifications in, biologic, behavioral, psychodynamic or psychosocial framework(s) of treatment for each psychiatric symptom/cluster and/or behavior.
 - 3. The status of specific and measurable goals for treatment specified in terms of symptom alleviation, behavioral change, cognitive alteration, psychodynamic change, or improvement in social, occupational, or scholastic functioning.
 - 4. The current, or anticipated modifications in, treatment methods in terms of:
 - 1. Treatment framework or orientation
 - 2. Treatment modality
 - 3. Treatment frequency
 - 4. Estimate of treatment duration
 - 5. Status of measurable, target criteria used to identify both interim treatment goals and end of treatment goals (unless this is a maintenance treatment) to substantiate that: a) treatment is progressing, and/or b) goals have been met and treatment is no longer needed.
 - 6. An alternative plan to be implemented if the patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are a second opinion or introduction of adjunctive or alternative therapies.

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued outpatient treatment.

- A. Intensity of Service Criteria for the Initial Treatment Review must be met.
- B. A DSM-IV-TR®, IV diagnosis on Axis I and/or a personality disorder diagnosis on Axis II.
- C. A description of -IV-TR®, IV psychiatric symptoms, intrapsychic conflict, cognitive dysfunction, or behavior consistent with the diagnoses given.
- D. Either 1, 2, or 3 must be met to satisfy criteria D.
 - 1. There is the persistence of, or recurrence of at least mild symptomatic distress and/or impairment in functioning due to these psychiatric symptoms and/or behavior.
 - 2. The individual has a persistent DSM-IV-TR®, IV illness for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.

Community Based Services (CBS)

H2012: Behavioral Health Day Services

I. Description of Services

Designed to enable individuals to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social and pre-vocational life management services. The context for this service is broader than that for group counseling, serving more members all at one time with greater variety and clinical objectives. The primary functions are stabilization of the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care; to provide transitional treatment after an acute episode; or to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

Individual and family therapy services must be provided by a master's level practitioner. Therapeutic care services must be provided, at a minimum, by a bachelor's level practitioner under the supervision of a master's level practitioner. Individual or group counseling services delivered as part of a substance abuse day treatment program must, at a minimum, be personally rendered by a substance abuse counselor or certified addictions professional. A licensed practitioner of the healing arts or master's prepared substance abuse professional must be available to provide clinical consultation for both mental health and substance abuse day treatment services during all hours of operation. Documentation must include at least a weekly summary progress note with exact dates and times of attendance; and a description of the clinical services and the member's response, with a focus on measurable outcomes and overall progress toward treatment goals.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

Criteria A-G must be met to satisfy criteria for admission.

- A. The member has received a psychological or psychiatric evaluation that includes a DSM-IV Axis I-V diagnosis that requires and will respond to therapeutic/supportive interventions and which documents the need for CBS.
- B. The service must be necessary to protect life, to prevent significant illness or significant disability, or

to alleviate severe pain.

- C. The service must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
- D. The service must be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- E. The service must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
- F. The service must be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
- G. The service must be provided to a member with an ICD-9-CM diagnosis in the following range: 290 through 298.9, 300 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.

IV. Continued Stay Criteria

Criteria A and B must be met to satisfy criteria for continued stay.

- A. There is adequate documentation from the provider that the Member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.
- B. The member is making adequate progress toward treatment goals as evidenced by a lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services provided by the CBS.

V. Discharge Criteria

Criterion A or B must be met to satisfy criteria for discharge.

- A. The member no longer meets continued stay criteria.
- B. The severity of illness requires a higher level of care.

H2012: Behavioral Health Day Services (Ages 24 Months – 5 Years)

I. Description of Services

Behavioral Health Day Services are appropriate early childhood therapeutic services for children age 24 months and older who are experiencing emotional problems and who meet the eligibility criteria described below. Services are designed to strengthen individual and family functioning, prevent more restrictive placement of children, and provide an integrated set of interventions to promote behavioral and emotional adjustment. Services must be provided in a therapeutic milieu that allows for a broad range of therapeutic activities designed for the treatment of specific social, emotional, and behavioral problems. Services may be authorized for less than six months.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

Criteria A-C must be met to satisfy criteria for admission.

- A. The member must be 24 months of age or older.
- B. There is an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, and 312.81 through 314.9.
- C. The member scores in at least the moderate impairment range on a behavior and functional rating scale developed for this age group.

IV. Continued Stay Criteria

Criteria A-C must be met to satisfy criteria for continued stay.

- A. Within at least six months of the original authorization and every six months thereafter, the members of the child's treatment team must provide written documentation that the child continues to meet the admission criteria stated above.
- B. There is adequate documentation from the provider that the Member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.
- C. Each member must, within 45 days of admission to behavioral health day services, have a written plan containing specific criteria for discharge from behavioral health day services.

V. Discharge Criteria

Criterion A or B must be met to satisfy criteria for discharge.

- A. The member no longer meets continued stay criteria.
- B. The severity of illness requires a higher level of care.

H2017: Psychosocial Rehabilitation Services

I. Description of Services

Combines daily medication use, independent living and social skills training, support to the clients and their families, housing, pre-vocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to diminish tendencies towards isolation and withdrawal and teaching of the member and family about symptom management, medication and treatment options. This service describes activities that are intended to restore a member's skills and abilities essential for independent living. Activities include development and maintenance of necessary daily living skills, food planning and preparation, money management, maintenance of the living environment and training in appropriate use of community services.

These services are designed to assist the member to compensate for or eliminate functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. Services differ from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. This service may also be used to facilitate cognitive and social skills necessary for functioning in a work environment focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the member, job matching, on the job training, and job support.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

Criteria A-H must be met to satisfy criteria for admission.

- A. The member has received a psychological or psychiatric evaluation that includes a DSM-IV Axis I-V diagnosis that requires and will respond to therapeutic/supportive interventions and which documents the need for CBS.
- B. The service must be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- C. The service must be individualized, specific, and consistent with symptoms or confirmed diagnosis of

the illness or injury under treatment, and not in excess of the patient's needs.

- D. The service must be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- E. The service must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
- F. The service must be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
- G. The service must be provided to a member with an ICD-9-CM diagnosis in the following range: 290 through 298.9, 300 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.
- H. The service must be provided to a member who currently exhibits psychiatric, behavioral or cognitive symptoms, addictive behavioral or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, pre-vocational and educational functioning (which is comparable to a GAF score of 50 or below).

IV. Continued Stay Criteria

Criteria A through D must be met to satisfy criteria for continued stay.

- A. Improvements in functioning will be lost if the member is discharged from this program and thus ongoing psychosocial rehabilitation is necessary to sustain such improvements in functioning.
- B. There is adequate documentation from the provider that the Member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.
- C. The member's treatment goals have not been met and this continued service is resulting in demonstrated improvement in the member's functioning.
- D. The member is making adequate progress toward treatment goals as evidenced by a lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services provided.

V. Discharge Criteria:

Criterion A or B must be met to satisfy criteria for discharge.

- A. The member no longer meets continued stay criteria.
- B. The severity of illness requires a higher level of care.

T1017: Targeted Case Management (Adult)

I. Description of Services

The purpose of Targeted Case Management services is to assist individuals in gaining access to needed medical, social, education, and other services. The primary goal of mental health targeted case management is to optimize the functioning of members who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each member.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

Criteria A-I must be met to satisfy criteria for admission.

- A. The member has received a psychological or psychiatric evaluation that includes a DSM-IV Axis I-V diagnosis that requires and will respond to therapeutic/supportive interventions and which documents the need for CBS.
- B. The member is enrolled in a Department of Children and Families (DCF) mental health target population (18 years and older).
- C. The member has a mental health disability (i.e., severe and persistent mental illness) that requires advocacy for and coordination of services to maintain or improve level of functioning.
- D. The member requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work and social environments of choice.
- E. The member lacks a natural support system for accessing needed medical, social, education, and other services.
- F. The member requires ongoing assistance to access or maintain needed care consistently within the service delivery system.
- G. The member has a mental health disability (i.e., severe and persistent mental illness) that, based upon professional judgment, will last for a minimum of one year.
- H. The member is not receiving duplicate case management services from another provider.
- I. The member meets at least one of the following requirements:
 - 1. is awaiting admission to, or has been discharged from, a state mental health treatment facility;
 - 2. has been discharged from a mental health residential treatment facility;
 - 3. has had more than one admission to a crisis stabilization unit (CSU), short- term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months;
 - 4. is at risk of institutionalization for mental health reasons or is experiencing long-term or acute episodes of mental impairment that may put the member at risk of requiring more intensive services.

Exception to Admission Criteria: The following members may receive mental health targeted case management for up to a maximum of 30 days without meeting the eligibility criteria for a specific target group:

- A. A member who has been referred by Cenpatico after a denied admission to or discharge from an inpatient psychiatric unit.
- B. A member who has been admitted to an inpatient psychiatric unit.
- C. A member who has been identified by Cenpatico as high-risk.
- D. A member who has relocated from a different DCF district or region and was already receiving mental health targeted case management services.

IV. Continued Stay Criteria

Criteria A-C must be met to satisfy criteria for continued stay.

- A. The member continues to meet admission criteria.
- B. The member is making adequate progress toward treatment goals as evidenced by lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services.
- C. There is adequate documentation from the provider that the Member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.

V. Discharge Criteria:

Criterion A or B must be met to satisfy criteria for discharge.

- A. The member no longer meets continued stay criteria.
- B. The severity of illness requires higher level of care.

T1017 HA: Targeted Case Management (Child)

I. Description of Services

The purpose of Targeted Case Management services is to assist individuals in gaining access to needed medical, social, education, and other services. The primary goal of mental health targeted case management is to optimize the functioning of members who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each member.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

Criteria A-H must be met to satisfy criteria for admission.

- A. The member is enrolled in a Department of Children and Families (DCF) children's mental health target population (birth through 17 years).
- B. The member has a mental health disability (i.e., severe and persistent mental illness) that requires advocacy for and coordination of services to maintain or improve level of functioning.
- C. The member requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work and social environments of choice.
- D. The member lacks a natural support system for accessing needed medical, social, education, and other services.
- E. The member requires ongoing assistance to access or maintain needed care consistently within the service delivery system.
- F. The member has a mental health disability (i.e., severe and persistent mental illness) that, based upon professional judgment, will last for a minimum of one year.
- G. The member is in out-of-home placement or at documented risk of out-of-home placement.
- H. The member is not receiving duplicate case management services from another provider.

Exception to Eligibility Criteria: The following members may receive mental health targeted case management for up to a maximum of 30 days without meeting the eligibility criteria for a specific target group:

- A. A member who has been referred by Cenpatico after a denied admission to or discharge from an inpatient psychiatric unit.
- B. A member who has been admitted to an inpatient psychiatric unit.
- C. A member who has been identified by Cenpatico as high risk.
- D. A member who has relocated from a different DCF district or region and was already receiving mental health targeted case management services.

IV. Continued Stay Criteria

Criteria A-C must be met to satisfy criteria for continued stay.

- A. The member continues to meet admission criteria.
- B. The member is making adequate progress toward treatment goals as evidenced by lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services.
- C. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.

V. Discharge Criteria:

Criterion A or B must be met to satisfy criteria for discharge.

- A. The member no longer meets continued stay criteria.
- B. The severity of illness requires a higher level of care.

H2019 HO/HM/HN: Therapeutic Behavioral Onsite Services (Ages 5 to 21 years)

I. Description of Services

Therapeutic Behavioral On-site Services are designed to assist complex-need members under the age of 21 and their families in an effort to prevent the need for a more intensive, restrictive behavioral health placement. The process must be driven by assessment of the individual needs and strengths of each child and family, and be developed and directed by a treatment team. It is recognized that involvement of the family in the treatment of the child or adolescent is necessary and appropriate. Provision of therapeutic behavioral on-site services with the family must clearly be directed toward meeting the identified treatment needs of the child or adolescent. Services must be provided where the child is living, working, or participating in education activities. These services may not be provided in a psychiatric hospital, a psychiatric unit of a general hospital, a crisis stabilization unit, or any other setting where the same services are already being paid for by another source. Services may include therapy, behavior management, and/or therapeutic support. Services may be authorized for less than six months.

Therapy includes: a strength-based, clinical assessment of the mental health, substance abuse, or behavioral disorders in order to evaluate, define, and delineate treatment needs; individual and family therapy as agreed to by the child and family; assessment and engagement of the child or adolescent and family's natural support system to assist in implementation of the treatment plan; and, development, implementation, and monitoring of behavior programming for the child or adolescent. Therapy services must be provided by a master's level practitioner supervised by a licensed practitioner of the healing arts and may not be billed for services provided to a group of members.

Behavior Management includes: an assessment of behavior problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the client's behaviors and the interactions that motivate, maintain or improve behavior; development of an individual behavior plan with measurable goals and objectives; training for caregivers and other involved persons in the implementation of the behavior plan; monitoring of the child and caregiver progress and revision as needed; and, coordination of services on the treatment plan with the treatment team. Behavior Management services must be provided by a certified behavior analyst or certified associate behavioral analyst and a minimum of eight units per month must be provided by a master's level practitioner. Behavior Management services may not be billed for services provided to a group of members.

Support Services must be related to the member's treatment goals and objectives and must include one or more of the following services: one-to-one supervision and intervention with the child or adolescent during therapeutic activities in accordance with the child's treatment plan; skill training of the child or adolescent for restoration of those basic living and social skills necessary to function in the child or adolescent's own environment; or, assistance to the child or adolescent and family in implementing the behavioral goals identified through family counseling and development of the treatment plan. Support Services must be provided, at a minimum, by a behavioral health technician supervised by a master's level practitioner and, although considered primarily a one-to-one interaction, may be provided in a group setting with a ratio not to exceed four group members to one staff person.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

Criterion A or B must be met to satisfy criteria for admission.

- A. The member must have an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 305.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, and 312.81 through 314.9 and
 - 1. be enrolled in a special education program for the seriously emotionally disturbed (SED) or the emotionally handicapped or have scored a 60 or below on the Axis V Children's Global Assessment of Functioning Scale within the last 6 months.
- B. The member must have an ICD-9-CM diagnosis of 295 through 298.9 (schizophrenia or other psychotic disorders, major depression or bipolar disorder) or 303.0 through 305.9 (substance abuse); and, prior to receipt of services, a licensed practitioner of the healing arts experienced in the diagnosis of behavioral health disorders must document that:
 - 1. the child or adolescent meets the criteria defined above.
 - 2. there is adequate evidence to indicate that the child or adolescent is at risk for a more intensive, restrictive and costly behavioral health placement.
 - 3. there is adequate evidence to indicate that the child's or adolescent's condition and functional level cannot be improved with a less intensive service such as individual, family, or group therapy.

IV. Continued Stay Criteria

Criteria A and B must be met to satisfy criteria for continued stay.

- A. Within six months of the original determination of eligibility for services and every six months thereafter, the members of the child's treatment team must document that the child continues to meet the eligibility criteria stated above.
- B. There is adequate documentation from the provider that the Member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.

V. Discharge Criteria

Within 45 days of admission to therapeutic behavioral on-site services, a plan must be developed with each child or adolescent and family, which contains specific discharge criteria. Discharge is appropriate if, at any time during the course of treatment, the member is found to no longer meet eligibility criteria.

VI. Clinical Exclusions

Criterion A or B must be met to preclude eligibility for the service.

- A. Members diagnosed with autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.
- B. Members with organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit from program services.

H2019 HO/HM/HN: Therapeutic Behavioral Onsite Services (Ages 0 – 5 Years)

I. Description of Services

Therapeutic Behavioral On-site Services are designed to assist complex-need members under the age of 21 and their families in an effort to prevent the need for a more intensive, restrictive behavioral health placement. The process must be driven by assessment of the individual needs and strengths of each child and family, and be developed and directed by a treatment team. It is recognized that involvement of the family in the treatment of the child or adolescent is necessary and appropriate. Provision of therapeutic behavioral on-site services with the family must clearly be directed toward meeting the identified treatment needs of the child or adolescent. Services must be provided where the child is living, working, or participating in education activities. These services may not be provided in a psychiatric hospital, a psychiatric unit of a general hospital, a crisis stabilization unit, or any other setting where the same services are already being paid for by another source. Services may include therapy, behavior management, and/or therapeutic support. Services may be authorized for less than six months.

Therapy includes: a strength-based, clinical assessment of the mental health, substance abuse, or behavioral disorders in order to evaluate, define, and delineate treatment needs; individual and family therapy as agreed to by the child and family; assessment and engagement of the child or adolescent and family's natural support system to assist in implementation of the treatment plan; and, development, implementation, and monitoring of behavior programming for the child or adolescent. Therapy services must be provided by a master's level practitioner supervised by a licensed practitioner of the healing arts and may not be billed for services provided to a group of members.

Behavior Management includes: an assessment of behavior problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the client's behaviors and the interactions that motivate, maintain or improve behavior; development of an individual behavior plan with measurable goals and objectives; training for caregivers and other involved persons in the implementation of the behavior plan; monitoring of the child and caregiver progress and revision as needed; and, coordination of services on the treatment plan with the treatment team. Behavior Management services must be provided by a certified behavior analyst or certified associate behavioral analyst and a minimum of eight units per month must be provided by a master's level practitioner. Behavior Management services may not be billed for services provided to a group of members.

Support Services must be related to the member's treatment goals and objectives and must include one or more of the following services: one-to-one supervision and intervention with the child or adolescent during therapeutic activities in accordance with the child's treatment plan, skill training of the child or adolescent for restoration of those basic living and social skills necessary to function in the child or adolescent's own environment or, assistance to the child or adolescent and family in implementing the

behavioral goals identified through family counseling and development of the treatment plan. Support Services must be provided, at a minimum, by a behavioral health technician supervised by a master's level practitioner and, although considered primarily a one-to-one interaction, may be provided in a group setting with a ratio not to exceed four group members to one staff person.

II. Intensity Guidelines

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

III. Admission Criteria

For children age 0 through 23 months, Criteria A-C must be met to satisfy criteria for admission.

- A. The member must have an ICD-9-CM diagnosis in one of the following categories: 294.8, 294.9, 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, or 312.81 through 314.9.
- B. The member must have experienced:
 - 1. trauma such as physical abuse, sexual abuse, severe neglect; witnessed life threatening violence; or death of the caretaker; or
 - 2. failure to thrive (due to emotional or psychosocial causes, not solely medical issues); or
 - 3. atypical development of temperament or behavior that interferes with social interaction and relationship development.
- C. Prior to receipt of services, a physician or other licensed practitioner of the healing arts experienced in the diagnosis of mental health disorders must provide written certification that:
 - 1. the child meets the criteria defined above.
 - 2. there is adequate evidence to indicate that the child is at risk for a more intensive, restrictive and costly mental health placement.
 - 3. there is adequate evidence to indicate the child's condition cannot be improved with less intensive services (e.g., individual/family therapy, group therapy).

For children age 24 months through 5 years, Criteria A-C must be met to satisfy criteria for admission.

- A. The member must have an ICD-9 diagnosis in the following range: 294.8, 294.9, 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, or 312.81 through 314.9.
- B. The member must score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.
- C. Prior to receipt of services, a physician or other licensed practitioner of the healing arts experienced in the diagnosis of mental health disorders must provide written certification that:
 - 1. the child meets the criteria defined above.
 - 2. there is adequate evidence to indicate that the child is at risk for a more intensive, restrictive and costly mental health placement.
 - 3. there is adequate evidence to indicate the child's condition cannot be improved with less intensive services (e.g., individual/family therapy, group therapy).

IV. Continued Stay Criteria

Criteria A and B must be met to satisfy criteria for continued stay.

- A. Within six months of the original determination of eligibility for services and every six months thereafter, the members of the child's treatment team must document that the child continues to meet the eligibility criteria stated above.
- B. There is adequate documentation from the provider that the Member is receiving the scope and

intensity of services required to meet the program goals stated in the Description of Services.

V. Discharge Criteria

Within 45 days of admission, each child must have specific, written discharge criteria. If a reassessment is done any time during the course of treatment and the member is found to no longer meet eligibility criteria, the member must be discharged from therapeutic behavioral on-site services.

Health Insurance and Accountability Act (HIPAA)

What is HIPAA?

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), which was signed into law in 1996, require the implementation of measures to standardize electronic transactions in the healthcare industry while protecting the security and privacy of health information used or disclosed in any medium, including oral communications.

As covered entities under these regulations, Cenpatico Practitioners/Providers are obligated to comply with them and any other applicable federal/state laws governing the use and disclosure of mental health information. For more information about HIPAA, please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov. From this CMS main page, select "Regulations and Guidance" and then "HIPAA – General Information"

Cenpatico takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable confidentiality/privacy laws.

Please contact the Cenpatico Privacy Officer at 512.406.7200 or in writing (refer to address below) with any questions about our privacy practices.

Cenpatico Compliance Department

504 Lavaca St., Suite 850
Austin, TX 78701

Please instruct any Member to contact Member Services with questions about our privacy practices using the contact information provide below:

Sunshine Health

400 Sawgrass Corporate Pkwy
Suite 100
Sunrise, FL 33325

For more information about HIPAA, please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov. From this CMS main page, select "Regulations and Guidance" and then "HIPAA – General Information".