



Cenpatico Provider Manual

State of Georgia

Table of Contents

Welcome To Cenpatico	5
About Cenpatico	5
MISSION	5
VISION	5
OUR GOAL	5
History and Structure of Cenpatico	5
Cenpatico Managed Care Philosophy	6
The Cenpatico Provider Network	7
Cenpatico Service Area	7
Network Provider Selection Process	7
Contracting Conditions	7
The Network Practitioner's Office	7
General Network Practitioner Office Standards	8
Credentialing	8
Credentialing Requirements	8
Credentialing of Health Delivery Organizations	10
Re-Credentialing Requirements	11
Council for Affordable Quality HealthCare (CAQH)	11
Cenpatico Credentialing Policies and Procedures	11
Right to Review and Correct Information	11
Network Provider Demographic/Information Updates	12
Network Provider Termination	12
Network Practitioner/Provider Request to Terminate	12
Cenpatico's Right to Terminate	12
Network Provider Appeal of Suspension or Termination of Contract Privileges	13
Status Change Notification	14
No New Referral Periods	14
Network Provider Concerns	14
Member Concerns about Network Providers	14
Critical Incident Reporting	15
No Show Appointments	15
Cultural Competency	15
Understanding the Need for Culturally Competent Services	16
Facts about Health Disparities	16
Advanced Directives	17
Access and Coordination of Care	18
Provider Access Standards	18
Consent for Disclosure	19
Coordination between Peach State Health Plan and Cenpatico	20
Quality Improvement	20
Monitoring Clinical Quality	20
Network Provider Participation in the QI Process	21
Preventative Behavioral Health Programs	21
Confidentiality and Release of Member Information	22
Communication With the Primary Care Physician	22
Network Provider Treatment Requirements	23
Monitoring Satisfaction	24

Network Provider Standards of Practice	25
Records and Documentation	25
Record Keeping and Retention	25
Reporting Provider or Member Waste, Abuse or Fraud	26
Authority and Responsibility	26
Eligibility for the Peach State Program	27
Verifying Member Enrollment	27
Eligibility Payment Responsibility (72 Hour Rule)	28
Member Rights and Responsibilities	29
Peach State Health Plan Member Rights:	29
Peach State Health Plan Member Responsibilities	30
Civil Rights	31
Customer Service	31
The Cenpatico Customer Service Department	31
Interpretation/Translation Services	31
Transportation Services	32
NurseWise	32
Pharmacy	33
Preferred Drug List (PDL)	33
Pharmacy Lock-In Program	33
Complaints, Grievances and Appeals	34
Provider Complaints	34
Member Complaints	34
Administrative Review	35
Expedited Administrative Review Requests	36
Applicable Copayments	37
Benefit Overview	38
Covered Professional Services & Authorization Guidelines	39
Modifier Descriptions	40
Utilization Management	41
The Utilization Management Program	41
Member Eligibility	41
Inpatient Notification Process	42
Outpatient Notification Process	42
Outpatient Treatment Request (OTR)/ Requesting Additional Sessions	42
Guidelines for Psychological Testing	43
Medical Necessity	43
Concurrent Review	44
Discharge Planning	44
Psychotropic Medications	45
Continuity of Care	45
Intensive Case Management (ICM)	45
Notice of Action (Adverse Determination)	46
Peer Clinical Review Process	47
Clinical Practice Guidelines	47
Claims	47
Cenpatico Claims Department Responsibilities	47
Clean Claim	48
Claim Payment	48
Explanation of Payment (EOP)	48

Network Provider Billing Responsibilities	48
Timely Filing Requirements	49
Claims Filing Deadlines	49
Exceptions	49
Claim Resubmissions, Adjustments, and Disputes	50
Retro Authorization	50
Claim Reconsideration	51
Claims Appeal	51
Common Claims Processing Issues	53
Imaging Requirements For Paper Claims	54
Web Portal Claim Submission	54
EDI Clearinghouses	55
Cenpatico Billing Policies	55
Resolving Claims Issues	57
National Provider Identifier (NPI)	58
CMS 1500 (8/05) Claim Form Instructions	59
UB-04 Claim Form Instructions	67
Federal and States Laws Governing the Release of Information	78

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 Georgia.

The Cenpatico Georgia 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 Georgia.

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.cenpaticoga.com. Additionally, we offer a wealth of resources for our Georgia 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

OUR GOAL

Demonstrate value to our customers in everything you do

History and Structure of Cenpatico

Cenpatico (www.cenpaticoga.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). Peach State Health Plan of Georgia has contracted the provision of covered behavioral health and substance abuse services to Cenpatico.

Cenpatico has provided comprehensive managed behavioral healthcare services since 1994 and currently operates in Arizona, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Ohio, South Carolina, Texas, and Wisconsin. 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 Peach State Health Plan. Cenpatico provides these services through a comprehensive provider network of qualified behavioral health practitioners, providers, and community mental health centers.

An experienced clinical and facility 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.

The Cenpatico Provider Network

Cenpatico Service Area

Cenpatico manages and reimburses claims for the covered behavioral health and substance abuse benefits for consumers eligible for coverage and enrolled with Cenpatico in the State of Georgia. At present, Cenpatico covers lives in three Georgia Regions, Atlanta, Central and Southwest.

Network Provider Selection Process

Cenpatico contracts with behavioral health practitioners, 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 Cenpatico covered benefits and utilization. Network Providers should support a brief, solution-focused approach to treatment. Network 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 and behavioral health/substance abuse agencies, Cenpatico also contracts with clinically licensed behavioral health practitioners, including psychiatrists, psychologists, counselors/social workers, and nurse practitioners.

Cenpatico contracts its 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.

Contracting Conditions

Cenpatico does not require providers to sign exclusive agreements as a condition of contracting. Additionally, we have no stipulations in our agreements requiring providers to participate in multiple product lines. If you have questions or if you need additional clarification regarding this policy, please contact your local Network Manager:

Atlanta Region, Carla Menchion at 770-437-3001

Central and Southwest, Clinton Shedd at 478-951-7199

Provider Relations Specialist (all regions), Latisa Kidd at 770-437-3007

The Network Practitioner's Office

Cenpatico reserves the right to conduct Network Provider site visit audits. Site visits may be 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 Practitioners must have a professional and fully-confidential telephone line and twenty-four (24) hour availability.
- Member records and other confidential information must be locked up and out of sight during the work day.
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

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

- Child Abuse and HIPAA Privacy posters are posted in the Network Practitioner's waiting room/reception area;
- The Network Practitioner has a complete copy of the Patient's Bill of Rights and Responsibilities, available upon request by a member, at each office location; and
- The Network Practitioner's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area.

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 facilities.

Cenpatico Network Providers must adhere to the following requirements:

- In order to continue participation with our organization, all Network Providers must adhere to Cenpatico's Clinical Practice Guidelines and Medical Necessity Criteria which are located in this Manual.
- Network 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 Provider's State License by the Division of Medical Quality Assurance, Department of Public Health.
- In order to be credentialed in the Cenpatico network, all individual Network Providers must be licensed to practice independently in the State of Georgia.
- MDs and DOs must have hospital privileges and or a coverage plan. Hospital privileges must be current and active.
- Physician Assistants should have an independent relationship with a supervising physician or under direct personal supervision of the attending physician.
- Network Practitioners' graduate degrees must be from an accredited institution.
- All Network Providers are subject to the completion of primary source verification of the Network Provider through our Credentialing Department located in Austin, Texas.

- The Network Provider agrees to complete and provide appropriate documentation for this primary source verification in a timely manner.
- The Network Provider further agrees to provide all documentation in a timely manner required for credentialing and/or re-credentialing.
- The Network Provider agrees to maintain adequate professional liability insurance as set forth in the Practitioner Agreement with Cenpatico.
- All credentialing applications are subject to consideration and review by the Cenpatico Credentialing Committee which meets monthly.

Practitioners must submit at a minimum the following information when applying for participation with Cenpatico:

- Complete signed and dated Georgia Standardized Credentialing application or CAQH (Council for Affordable Quality Health Care) application.
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation.
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Georgia regulations regarding malpractice coverage.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate (if applicable).
- Copy of W-9.
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
- Copy of current unrestricted Medical License to practice in the state of Georgia.
- Current copy of specialty/board certification certificate, if applicable.
- Curriculum vitae listing, at minimum, a five-year work history.
- Signed and dated release of information form.
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training.
- Copy of Clinical Laboratory Improvement Amendments (CLIA) (if applicable).
- Copy of enumeration letter issued by NPPES (National Plan and Provider Enumeration System), depicting the providers' unique National Provider Identifier (NPI).

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

- Georgia 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 Provider's 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
- Any situation that would impact a Network Provider's ability to carry out the provisions of their Provider Agreement with Cenpatico, including the inability to meet member accessibility standards
- Changes or revocation with DEA certifications, hospital staff changes or NPDB or Medicare sanctions.

Network 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 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.

Credentialing of Health Delivery Organizations

Prior to contracting with Health Delivery Organizations (HDOs), Cenpatico verifies that the following organizations have been approved by a recognized accrediting body or meet Cenpatico standards for participation, and are in good standing with state and federal agencies.

HDO's are listed below:

- Hospital or Facility
- Community Service Board
- CMHC
- FQHC
- RHC

Cenpatico recognizes the following accrediting bodies:*

- CARF -Commission on Accreditation of Rehabilitation Facilities
- JCAHO -Joint Commission on Accreditation of Healthcare Organizations.
- NCQA - National Committee for Quality Assurance
- URAC - Utilization Review Accreditation Commission
- COA - Council on Accreditation

* This list may not be inclusive of all accrediting organizations

For those organizations that are not accredited and licensed, an on-site evaluation will be scheduled to review the scope of services available at the facility, physical plant safety, and the quality improvement program. A current Centers for Medicare and Medicaid Services (CMS) certificate will be accepted in lieu of a formal site visit, and can be utilized to augment the information required to assess compliance with Cenpatico standards.

HDO's are re-credentialed at least every three (3) years to assure that the organization is in good standing with state and federal regulatory bodies, has been reviewed and approved by an accrediting body (as applicable), and continues to meet Cenpatico participation and QI requirements. If HDO's are not accredited

prior to credentialing within the Cenpatico network, the HDO must be accredited within 18 months of being made an in-network provider.

Re-Credentialing Requirements

Cenpatico Network Providers will be re-credentialed every three (3) years as required by the State of Georgia. Cenpatico Network 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 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 to Network 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 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 Providers and imposition of sanctions, termination, suspension and restrictions on existing Network Providers;
- Identification of quality deficiencies which result in Cenpatico's restriction, suspension, termination or sanctioning of a Network Provider; and
- A process to implement an appeal procedure for Network Providers whom Cenpatico has terminated.

Right to Review and Correct Information

All 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 provider to review references, personal recommendations, or other information that is peer review protected.

Should a 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, 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 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/re-credentialing process.

Network Provider Demographic/Information Updates

Network Providers should advise Cenpatico with as much advance notice as possible for demographic/information updates. Network Provider information such as address, phone and office hours are used in our Provider Directory and having the most current information accurately reflects our Georgia provider network. Please use the Cenpatico Georgia Provider Information Update Form located on our website at www.cenpatico.com to provide your information to Cenpatico.

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

- Fax: 866-532-8837
- Mail: Cenpatico
Attn: IPR Unit - Georgia
504 Lavaca St., Ste. 850
Austin, TX 78701

Network Provider Termination

Network Practitioner/Provider Request to Terminate

Network 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 Provider will be advised on procedures for transitioning members if indicated.

Cenpatico fully recognizes that a change in a Network Provider's participation status in Cenpatico's provider network is difficult for members. Cenpatico will work closely with the terminating Network Provider to address the member's needs and ensure a smooth transition as necessary. A Network 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 Provider during the previous six (6) months. Treatment with these members must be completed or transferred to another Cenpatico Network Provider within three (3) months of the notice of termination, unless otherwise mandated by State law. The Network 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 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 Provider's license, certification or membership on the active medical staff of a hospital or Cenpatico participating provider group;
- Network Provider's loss of liability insurance required under the Provider Agreement with Cenpatico
- Network Provider's exclusion from participation in Cenpatico programs;
- Network Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's insolvency or bankruptcy or Network Provider's assignment for the benefit of creditors;
- Network Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Network Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Provider's submission of false or misleading billing information;
- Network Provider's failure or inability to meet and maintain full credentialing status with Cenpatico;
- Network 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 Provider may be delivering clinically inappropriate care; or
- Network Provider's breach of Cenpatico Policies and Procedures.

Network Provider Appeal of Suspension or Termination of Contract Privileges

New applicants who are declined participation in the Cenpatico Network have the right to request a reconsideration of the decision in writing within fourteen (14) days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two (2) weeks of the final decision

If a Network Provider has been suspended or terminated by Cenpatico, he/she may contact the Cenpatico Georgia Provider Relations department at 800-947-0633 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 Provider should send a written 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 and include any supporting documents. This 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 Provider with the notification of suspension/termination. To request a copy of Cenpatico's Provider Dispute Policy, please contact the Quality Improvement Department at 800-947-0633.

Each Network Provider will be provided with a copy of their fully-executed Provider Agreement with Cenpatico. The Provider Agreement will indicate the Network Provider's Effective Date in the network and the Initial Term and Renewal Term provisions in Cenpatico's 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 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 Provider's hospital privileges. All changes in a Network Provider's status will be considered in the re-credentialing process.

No New Referral Periods

Network Providers are required to notify Cenpatico when they are not available for appointments. Network 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 Providers for the following reasons:

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

Network 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: Georgia Provider Relations

3200 Highlands Parkway Suite 200

Smyrna, GA 30082

Phone: 800-947-0633

Network 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.

Network Provider Concerns

Network Providers who have concerns about Cenpatico should contact the Cenpatico Georgia Provider Relations department at 800-947-0633 or fax your concern to the Cenpatico Quality Improvement Department at 866-704-3063 to register these complaints. You may also use the on-line Provider Complaint form to register your concerns. All concerns are investigated, and written resolution is provided to the Network Provider on a timely basis.

Member Concerns about Network Providers

Members who have concerns about Cenpatico Network Providers should contact Peach State Health Plan to register their concern. Peach State Health Plan will coordinate a response assuring that all concerns are investigated, and feedback to the member is provided on a timely basis. It is the Network 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 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 Provider and any member(s)/ member advocate(s) seen on behalf of Cenpatico.

A critical incident is defined as any occurrence which is not consistent with the routine operation of a Mental Health/Substance Abuse Network 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 can be found in the forms section on Cenpatico's website at www.cenpatico.com. Submit completed Critical Incident Reports to the following address:

Cenpatico
Attn: Quality Improvement Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 800-947-0633
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 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.

Cenpatico 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 provider/ member relationships. 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 Providers and will provide access to training and tool-kits to assist our Network Providers in developing culturally competent and culturally proficient practices.

Network 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 or to the Provider. The Provider may contact Cenpatio to arrange a translator as needed.
- 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 make 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.
- 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 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 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 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 Provider's misdiagnosis due to lack of information sharing;
- Wasted time for the member and Network Provider; and/or
- Increased grievances or complaints.

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

Take the following into consideration when you provide services to Peach State Health Plan/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?

Advanced Directives

Cenpatico is committed to ensuring that its members know of, and are able to avail themselves of their rights to execute Advance Directives. Cenpatico is equally committed to ensuring that its Network Providers and office staff are aware of, and comply with their responsibilities under federal and State law regarding Advance Directives.

Network Providers must ensure adult members or member representatives over the age of eighteen (18) years receive information on Advance Directives and are informed of their right to execute Advance Directives. Network Providers must document such information in the permanent member medical record.

Cenpatico recommends:

- The first point of contact in the Network Provider office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the Network Provider's office and document this request.
- An Advance Directive should be included as a part of the member's medical record, including mental health Directives.
- If a Behavioral Health Advance Directive exists, the Network Provider should discuss potential emergencies with the member and/ or family members (if named in the Advance Directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives.
- If the member requests further information, member Advance Directive education/ information should be provided.

Cenpatico's Quality Improvement Department will monitor compliance with this provision during site visits and visits scheduled thereafter.

Access and Coordination of Care

Provider Access Standards

Cenpatico must ensure that provider accessibility is maintained so that there is a standard of coverage for members throughout the state. The following standards have been established by Cenpatico for the State of Georgia:

Provider	Access Standard
Outpatient Behavioral Health Practitioners	Urban/ Suburban: 1 provider within 30 miles Rural: 1 provider within 45 miles
Inpatient Providers	Urban/ Suburban: 1 provider within 30 miles Rural: 1 provider within 45 miles

Cenpatico 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 Providers must make every effort to assist Cenpatico in providing appointments within the following timeframes:

Appointment Requirements, Waiting Maximums & After-Hours Phone Response Times. Provider shall meet and maintain compliance with the State's waiting times for appointments with Medicaid Covered Persons as set forth herein, or as otherwise amended by the State.

The appointment waiting times are set forth below:

Type of Care	Appointment Availability
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
Urgent – is defined as a non life threatening situation that should be treated within twenty-four (24) hours. Urgent care services are not subject to prior authorization or precertification.	Within twenty-four (24) hours for services that are non-Emergent services or routine services
Emergent– 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. Urgent care services are not subject to prior authorization or pre-certification.	Immediately, on a twenty-four (24) hour basis, seven (7) days a week
Discharge (from hospital/acute care)	Within seven (7) days of discharge

Moreover, Provider shall provide adequate capacity for initial visits for pregnant women within fourteen (14) Calendar Days and visits for Health Check eligible children within ninety (90) Calendar Days of Medicaid Covered Person's enrollment in CMO. The Provider shall take corrective action and notify Cenpatico within three (3) days if there is a failure to comply with these waiting times. Cenpatico shall

also take whatever corrective action is necessary to ensure compliance with the State’s waiting time and capacity requirements. Cenpatico shall notify Provider in writing of any changes to the State’s appointment requirements and Provider shall comply in accordance with the Medicaid Contract.

Provider shall ensure that wait times in the Provider’s office do not exceed the following for pediatrics and adults:

Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Provider shall ensure that Provider’s response times for returning calls after-hours are as follows:

Urgent Calls	Shall not exceed twenty (20) minutes.
Other Calls	Shall not exceed one (1) hour.

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.

Network 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 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 Providers should call the Cenpatico Provider Relations department at 800-947-0633 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 Provider’s status will be considered in the re-credentialing process.

Consent for Disclosure

Cenpatico recognizes communication as the link that unites all the service components and a key element in any program’s success. To further this objective, Network Providers are required to obtain consent for disclosure of information from the member permitting exchange of clinical information among behavioral health providers and between the behavioral health provider and the member’s physical health provider.

If the member refuses to release the information, the Network Provider should document their refusal along with the reasons for declination in the medical record. Cenpatico monitors compliance of the behavioral health providers, to ensure consent for release of information form has been signed by the member, and for those agreeing to disclosure, that regular reports are being sent to the primary care provider (PCP) or other behavioral health providers.

Coordination between Peach State Health Plan and Cenpatico

Peach State Health Plan 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 jointly for physical and behavioral healthcare services.

In addition, Cenpatico works to educate and assist physical health and behavioral health providers in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Peach State Health on a monthly basis, and is shared with Peach State'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 Providers and services, credentialing, utilization, member satisfaction, Network Provider satisfaction, PCP communications, and administrative office operations, as well as Peach State Health Plan'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 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 providers;
- 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 :

- 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; and
- Provider quality profiling

Findings are communicated to individual Network Providers and Network Provider 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 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. You can 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 Peri-natal Depression Screening Program offers screening to members who are pregnant in an effort to identify them and to follow-up. Each member who participates receives a letter from Cenpatico. 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, and the parents receive a gift card for Wal-Mart.

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 Network 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

Cenpatico encourages primary care physicians (PCPs) to consult with their members' mental health Network 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 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).
- The member's progress toward meeting the goals established in their treatment plan.

A form to be used in communicating with the PCP and other behavioral health providers can be found in the forms section on Cenpatico's website at www.cenpatico.com. Network Providers can identify the name and number for a member's PCP on the front-side of the Member ID Card.

Network providers should screen for the existence of co-occurring mental health and substance abuse conditions and make appropriate referrals. 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 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 Provider's 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 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 Provider Treatment Requirements

Network 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 Provider's clinical licensure;
- Network Providers (facilities and community mental health centers) must ensure members that are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. The outpatient treatment must occur within seven (7) days 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 Providers (those that participate in the Peach State Health Plan or Cenpatco 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;
- Provide member's clinical information to other 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;
- Network Providers that are psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 agree to comply with all applicable legal requirements relating to restraint and seclusion.

Cenpatico has adopted the National Committee for Quality Assurance guidelines for Treatment Records. The standards are listed below:

Consistent, current and complete documentation in the treatment record is an essential component of quality patient care. 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, practitioner 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.

Monitoring Satisfaction

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

Network 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 Provider's experience with our delivery system.

Network Providers should call the Cenpatico Provider Relations department at 866-896-5053 to address concerns as they arise. Feedback from Network Providers enables Cenpatico to continuously improve systems, policies and procedures.

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

Network Provider Standards of Practice

Network 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.

Records and Documentation

Network 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 Provider will provide Cenpatico 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.

As part of our ongoing quality improvement program, clinical records may be audited to assure the quality and consistency of Network 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. 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 Provider is able to dispense medication, the Network Provider must conform to drug dispensing guidelines set forth in Cenpatico drug formulary.

Network 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 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 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 Peach State Health Plan, is committed to identifying, investigating, sanctioning and prosecuting suspected WAF.

The Cenpatico 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 Peach State Health Plan, at the provider and/or subcontractor's own expense.

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

Medicaid Fraud Control Unit of Georgia
Office of the Attorney General
2100 East Exchange Place
Building One, Suite 200
Tucker, GA 30084
Phone: (770) 414-3655
Fax: (770) 414-2718

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.

Providers may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone at 1-800-947-0633.

Eligibility for the Peach State Program

Cenpatico manages the Behavioral Health benefits for the Peach State Health Plan. You may have patients who request information about their benefits or eligibility with this plan. The local office of the Georgia Department of Community Health (DCH) is responsible for determining eligibility of persons applying for the Peach State Program. Persons interested in applying for the Peach State Program should be referred to the local county office of the DCH in the county in which the individual lives.

Applicants enroll in Peach State by contacting the Enrollment Broker during the application process. The member has an opportunity to select a primary care provider (PCP) with the assistance of a Selection Counselor. Individuals who do not make a voluntary PCP selection are assigned to a PCP via an automated assignment process that links the member with an appropriate PCP.

Member eligibility in Peach State is effective on the first calendar day of a month, and may be confirmed by any of the Eligibility Verification systems described below.

Verifying Member Enrollment

Network Providers are responsible for verifying eligibility every time a member schedules an appointment and when they arrive for services. Cenpatico Customer Service will assist you with determining member eligibility. Customer Service Representatives, available during regular business hours at 1-800-947-0633, have access to current member eligibility information.

Network Providers should use any of the following options to verify member enrollment:

- Verify online via the GHP web portal at www.mmis.georgia.gov
- Contact Cenpatico Customer Service at 800-947-0633

- Access the Cenpatigo Provider Website at www.cenpatigo.com
- Verify through the Peach State's website at www.pshpgeorgia.com.

When you call to check eligibility, please have available as much of the following information as possible:

- Member's full name (including correct spelling)
- Any other names such as maiden names, aliases, etc
- Medicaid Number
- Social Security Number
- Address
- Telephone

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

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

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

Eligibility Payment Responsibility (72 Hour Rule)

Providers will be required to verify member eligibility via the GHP web portal prior to providing services to Peach State members. Providers that verify eligibility and submit claims for services within 72 hours after the verification process will have their claims honored and will not be subjected to recoupments related retrospective eligibility terminations. Listed below are instructions and procedures that must be followed in order to comply with this policy:

72 Hour Eligibility Requirements: This policy only applies if the steps identified below are followed. As a reminder, Medicaid is the payor of last resort; therefore this policy does not supersede the CMS guidelines related to Coordination of Benefits.

- Eligibility verification must be completed via the GHP web portal at <https://www.mmis.georgia.gov/wps/portal>.
- Providers must print and maintain a valid copy of the eligibility screen shot and provide the information to the plan in the event that a claim is denied for eligibility.
- Reconsideration or appeal is required to process the claim. The screen shot must contain a date/time stamp in order to be considered valid.
- In order to be reimbursed for these services, an appeal needs to be initiated and proof supplied to the plan that verification was obtained via the GHP web portal within the 72 hour time frame.
- Appeals should be submitted to:

Cenpatigo
Attn: Appeals
PO Box 6000
Farmington, MO 63640-3812

Member Rights and Responsibilities

Peach State Health Plan Member Rights:

1. A right to have all your personal information including your medical record kept private.
2. A right to be given choices about your healthcare. To know all of your options.
3. A right to never worry about someone forcing you to do something because it makes his or her job easier.
4. A right to ask for and receive a copy of your medical record.
5. A right to request your medical records.
6. A right to get services in agreement with Quality Assessment and Performance Improvement Access Standards.
7. A right to be free from any form of restraint or seclusion as a means of force, discipline, convenience or revenge.
8. A right to exercise these rights. Also, to know if you do, it will not change how you are treated by the plan, its doctors and providers.
9. A right to file a complaint against a doctor, hospital or Peach State. If you file a complaint, no one can stop you from continuing to get services.
10. A right to not pay if Peach State runs out of money to pay their bills.
11. A right to not pay for healthcare even if Medicaid or PeachCare for Kids and Peach State does not pay the doctor who treated you.
12. A right to never pay more than what Peach State would charge, if Peach State has to have someone else manage your care.
13. A right to only have a small co-payment and/or deductible, as allowed by state laws and DCH regulations.
14. A right to be treated with dignity, respect and privacy from Peach State staff, providers, physicians and their office staff.
15. A right to choose a Peach State doctor (PCP) and be told which hospitals to use.
16. A right to change your doctor without a reason.
17. A right to know about other doctors who can help you with treatment.
18. A right to know your rights and responsibilities with Peach State and to call if you have questions or comments or want to make changes to them.
19. A right to get information about Peach State's organization and services, providers, physicians, and hospitals and your rights and responsibilities.
20. A right to get a second opinion.
21. A right to know about all the services you will get. This includes:
 - Hours of operation.
 - How to get emergency care after hours.
 - How to get services if you are out of town.
 - What may not be covered?
 - What has limited coverage?
21. A right to be told if your services change. To be told if we cancel a service.
22. A right to be told if your doctor is no longer available.
23. A right to tell us and your doctor if you need help talking to your doctor. You will not have to pay if you are hearing impaired or if you do not speak English.
24. A right to know all information about your doctor(s) so they can care for you.
25. A right to tell your doctor what you like and don't like about your care.
26. A right to speak with your physician about decisions related to your health care.

27. A right to help set treatment plans with your physician, talk to your physician openly and understand your health care options: regardless of cost or benefit coverage.
28. A right to understand your health problems and to speak with your physician about your treatment plans which you and your doctor agree.

Peach State Health Plan Member Responsibilities

1. A responsibility to give information about yourself to the Peach State organization, providers, physicians, and hospitals in order to help set treatment goals.
2. A responsibility to give info about you and your health to your PCP.
3. A responsibility to know how to take your medicines the right way.
4. A responsibility to ask questions about your health care.
5. A responsibility to follow your instructions for care agreed upon by which you and your physician or hospital.
6. A responsibility to help set treatment goals with your PCP.
7. A responsibility to read the Member Handbook to understand how Peach State works.
8. A responsibility to call Peach State and ask questions when you don't understand.
9. A responsibility to always carry your Peach State Member ID card.
10. A responsibility to always carry your Medicaid or PeachCare for Kids Member ID card.
11. A responsibility to show your ID cards to each provider.
12. A responsibility to schedule appointments for care with your doctor.
13. A responsibility to go to the emergency room when you have an emergency.
14. A responsibility to notify Peach State as soon as possible if you go to the emergency room.
15. A responsibility to get a referral from your PCP for specialty care.
16. A responsibility to cooperate with people providing your health care.
17. A responsibility to be on time for appointments.
18. A responsibility to notify the doctor's office if you need to cancel an appointment.
19. A responsibility to notify the doctor's office if you need to change your appointment time.
20. A responsibility to respect the rights of all providers.
21. A responsibility to respect the property of all providers.
22. A responsibility to respect the rights of other patients.
23. A responsibility to not be disruptive in your doctor's office.
24. A responsibility to keep all your appointments. To be on time and cancel within twenty-four (24) hours if you cannot make it.
25. A responsibility to treat your provider with dignity and respect.

In addition to the Member Rights and Responsibilities provided by Peach State Health Plan, Cenpatico believes that members also 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 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.
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 7:30 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 Providers and assists the member in selecting a Network 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 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 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: 800-255-0056

Voice: 800-255-0135

Key Information: To access interpreter services for Cenpatico members, contact Customer Service at 800-947-0633.

Transportation Services

For non-emergent transportation, contact the service provider in your area as below. In situations where urgent transportation is needed and cannot be coordinated with out transportation services, Peach State Member Services Representatives will coordinate transportation arrangements. To contact Peach State Member Services, call 1-800-704-1484.

North: Southeastrans, Inc. Toll free 866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta: Southeastrans, Inc. 404-209-4000	Fulton and DeKalb
Central: Southeastrans Toll free 866-991-6701 Local 404-305-3535	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox and Wilkinson
East: LogistiCare Toll free 888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne and Wilkes
Southwest: Southwest Georgia Regional Development Center Toll free 1-866-443-0761	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster and Worth

NurseWise

NurseWise is Cenpatico's after hours 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.

NurseWise after hours service provides Members and Network Providers with the following:

- Provider referrals;
- Verification of member eligibility;
- Crisis Interventions
- Emergency assessment for acute care services;
- Emergency prescription 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.

Pharmacy

Preferred Drug List (PDL)

Peach State is responsible for maintaining a Preferred Drug List (PDL) of medications that provides a comprehensive range of psychotropic medications that are reviewed for efficacy, safety, evidence-based support for therapeutic benefit, and cost-effectiveness.

The Peach State PDL is not intended to be a substitute for sound clinical knowledge and judgment. Each Physician, Nurse Practitioner, and Physician's Assistant is expected to select appropriate drug therapy individualized for each member and that provides the highest quality of care. The updated Peach State PDL can be found on the Peach State website at: www.pshpgeorgia.com.

For Prior Authorization, please contact:

US Scripts

Customer Service Phone: 800-460-8988

Customer Service Fax: 559-244-3710

Prior Authorization Phone: 866-399-0928

Prior Authorization Fax: 866-399-0929

Pharmacy Lock-In Program

The purpose of the Pharmacy Lock-In Program is to detect and prevent continued abuse of the pharmacy benefit by restricting the members to only one pharmacy for a defined period. Peach State will monitor and control alleged abuse of the prescription benefit, by Peach State members, as determined through analysis and audit, when one or more of the following criteria are met:

- Prescriptions written on stolen, forged or altered prescription blank;
- Two or more episodes of over-utilization, which involve the Member receiving prescriptions in excess of what the prescriber intended;
- Medication prescribed is inappropriate for age or gender of patient;
- Prescribed medications do not correlate with the Member's medical condition, as identified by his/her PCP, or ICD-9 code from encounter data;
- Prescription written by Out-of-Network Providers;
- Member tends to have prescriptions filled at multiple pharmacies, and/or pharmacies out of the Member or Provider's local area; or
- Member receives more than five therapeutic agents per month;
- Members receives more than three Controlled Substances per month;
- Member receives duplicative therapy from different prescribers.

Providers who suspect a member is meeting the above criteria should contact the department below to report such cases.

Complaints, Grievances and Appeals

Provider Complaints

What is a Complaint?

A complaint is defined as any dissatisfaction, expressed by a Network 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 Provider complaints. If a Network Provider is not satisfied with the resolution of a complaint, an appeal can be filed. Network 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:
800-947-0633

Cenpatico will acknowledge the Network 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 provider or employee, or failure to respect the member's rights.

Cenpatico has established and maintains a Grievance system that complies with applicable Federal and State laws and regulations and affords our Network 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 Provider with the member's signed consent. Cenpatico's Customer Services department is available to assist Network 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:

Cenpatico
Complaints
504 Lavaca, Suite 850
Austin, TX, 78740

To express a Complaint by phone, please call Cenpatico at:
800-947-0633

Members or persons authorized to initiate a complaint on behalf of a member may submit their complaint directly to Peach State Health Plan at:

Peach State Health Plan
Attn: Quality Department
3200 Highlands Parkway SE, Suite 300
Smyrna, Georgia 30082

Cenpatico Network Providers and members have one (1) year from the date of the action to file a Complaint. Cenpatico has thirty (30) days to respond to and resolve the Complaint. It is one of Cenpatico'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 Provider who files a Complaint on behalf of a member.

Administrative Review

What is an Administrative Review?

An administrative review is a written request for review of an action/determination made by Cenpatico. An administrative review can be filed by the member or authorized representative acting on behalf of the member, with the member's written consent.

Cenpatico has developed and maintains an administrative review system that complies with applicable Federal and State laws and regulations. An administrative review 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 administrative review is being resolved.

If the member is still receiving the services that are under administrative review and the services are covered services, the services may continue until a decision is made on the administrative review. If it is determined that the services were not medically necessary or appropriate, the member will be responsible for paying for the service(s). 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.

A member or authorized representative has the right to request an administrative review 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 Administrative Review Process.

Every oral request for administrative review received must be confirmed in writing by the member or his/her representative, unless an expedited administrative review is requested.

To request an administrative review in writing please mail or fax the request to the following:

Cenpatico

Attn: Appeals Department

504 Lavaca St., Ste. 850

Austin, TX 78701

Fax: 866-714-7991

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

800-947-0633

Expedited Administrative Review Requests

Members and authorized representatives also have the right to request that Cenpatico expedite an administrative review, if the timeframe of a standard administrative review would seriously jeopardize the individual's health or life. Expedited administrative reviews are not offered retrospectively.

For an expedited administrative review in which the member is currently an inpatient in a hospital, the attending physician may act as the member's authorized representative without a signed written consent from the member.

To submit an expedited administrative review in writing, please fax the request to the following:

Cenpatico

Attn: Appeals Department

504 Lavaca St., Ste. 850

Austin, TX 78701

Fax: 866-714-7991

To initiate your expedited administrative review by phone, please call Cenpatico at:

800-947-0633

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

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

The Cenpatico Appeals Coordinator can assist the member with their expedited administrative review. The member may also have their Network Provider, a friend, a relative, legal counsel or another spokesperson assist them.

If Cenpatico extends the timeframe for the decision and issuance of notice of Proposed Action, **Cenpatico shall give the Member written notice of the reasons for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.** Cenpatico shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires

Administrative Law Hearing at the Department of Community Health

The State will maintain an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (O.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 431.200 et

seq. The Administrative Law Hearing process shall provide Medicaid Members an opportunity for a hearing before an Administrative Law Judge.

A member or member's authorized representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by Cenpatico. The parties to the Administrative Law Hearing shall include Cenpatico as well as the Member, Member's Authorized Representative, or representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member. The request for the Administrative Law Hearing should be mailed to:

Department of Community Health
Legal Services Section
Division of Medical Assistance
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

PeachCare members do not have access to the Medicaid Administrative Law Hearing process. If a PeachCare member is dissatisfied with a Notice of Adverse Action issued through a Cenpatico Administrative Review, the member can request a review of the decision by the State Management Review Committee (level two) in writing to:

Department of Community Health
PeachCare for Kids
2 Peachtree Street, NW
Atlanta, GA 30303-3159

Second level review by Peach State Health Plan following grievance disposition or administrative review by

Cenpatico Members who:

- Submit a grievance or a request for administrative review to Cenpatico, and
 - Are not satisfied with Cenpatico's disposition of the grievance or administrative review
- may request a second level review by Peach State Health Plan of Cenpatico's disposition of the grievance or administrative review. Peach State's second level review of an administrative review determination by Cenpatico has no impact on the member's concurrent right to request a fair hearing from the state. Members may file second level review requests in writing with Peach State within 30 days of the date of Cenpatico's determination on a grievance or Notice of Adverse Action, by mailing the request to:

Peach State Health Plan
Appeals/Grievance Coordinator
3200 Highlands Parkway SE
Suite 300
Smyrna, GA 30082

Applicable Copayments

Children under age 21, pregnant women, nursing facility residents and Hospice care members are exempted from co-payments.

There are no co-payments for family planning services and for emergency services except as defined below.

Services cannot be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount										
FQHC/RHCs		A \$2 co-payment on all FQHC and RHC.										
Outpatient		A \$3 member co-payment is required on all non-emergency outpatient hospital visits										
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility is exempted from the inpatient co-payment.	A co-payment of \$12.50 will be imposed on hospital inpatient services										
Emergency Department		A \$6 co-payment will be imposed if the Condition is not an Emergency Medical Condition										
Prescription Drugs		<table> <tr> <td>Drug Cost:</td> <td>Co-pay Amount:</td> </tr> <tr> <td><\$10.01</td> <td>\$.50</td> </tr> <tr> <td>\$10.01 - \$25.00</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 - \$50.00</td> <td>\$2.00</td> </tr> <tr> <td>>\$50.01</td> <td>\$3.00</td> </tr> </table>	Drug Cost:	Co-pay Amount:	<\$10.01	\$.50	\$10.01 - \$25.00	\$1.00	\$25.01 - \$50.00	\$2.00	>\$50.01	\$3.00
Drug Cost:	Co-pay Amount:											
<\$10.01	\$.50											
\$10.01 - \$25.00	\$1.00											
\$25.01 - \$50.00	\$2.00											
>\$50.01	\$3.00											

Benefit Overview

Cenpatico covers a comprehensive array of behavioral health and substance abuse services in Georgia. Services for Cenpatico members include, but are not limited to the following;

- Inpatient hospitalization
- Community Based Acute Residential Treatment
- Crisis Intervention Services
- Partial Hospitalization
- Day Treatment
- Intensive Outpatient Treatment
- Outpatient Therapy (Individual, Family and Group)
- Medication Management
- Psychological Testing
- Electroconvulsive Therapy (ECT)
- Community Support Services
- Telemedicine (90801, 90862 and H0039 only)

For a listing of service codes and authorization requirements, please refer to the Georgia Covered Professional Services & Authorization Guidelines located in this Manual. Network 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 must be medically necessary.

Covered Professional Services & Authorization Guidelines

Please note that the listing below does not fully comprise all Cenpatico Georgia covered services. Please refer to your Provider Agreement with Cenpatico to identify additional services you are contracted and eligible to provide.

Service Description	Billable Provider Type(s)	Billing Codes	Auth Required
Initial Hospital Care:	MD	99221, 99222, 99223	No
Subsequent Hospital Care:	MD	99231, 99232, 99233	No
Initial Inpatient Consultation:	MD	99251, 99252, 99253, 99254, 99255	Yes
Hospital Discharge:	MD	99238, 99239	No
Individual Inpatient Psychotherapy	MD, APNP	90816, 90818	Yes
Individual Inpatient Psychotherapy with Medication Management	MD, APNP	90817, 90819	No
ECT	MD	90870	Yes
Diagnostic Interview:	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP	90801, 90802	*Yes- See note below
Individual Psychotherapy:	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP	90804, 90806, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90875, 90876	*Yes- See note below
Individual Psychotherapy with Medication Management:	MD, APNP	90805, 90807, 90811, 90813, 90815, 90817, 90819, 90822, 90824	No
Med Check:	MD, APNP	90862	No
Family Psychotherapy with Patient Present:	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP	90846, 90847	*Yes- see note below
Group Therapy	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP	90853, 90857	*Yes- see note below
Psych Testing:	MD and PhD	96101, 96110	Yes
Neuropsych Testing:	MD and PhD (MD must be a licensed Psychiatrist)	96116, 96118	Yes

*Note: One 90801 or 90802 is allowed without auth within six (6) month. One 90801 or 90802 and a mix of twenty-nine (29) of the following services may be provided to a member without authorization from Cenpatico, however authorization must be obtained from Cenpatico for sessions provided after the 30th

visit has been used; 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90846, 90847, 90853, 90857, 90875, 90876.

Modifier Descriptions

For use with HCPCS Codes

- HA – Child/Adolescent Program
- HB – Adult Program, non geriatric
- HE – Mental health program
- HF – Substance abuse program
- HQ – Group setting
- HR – Family/couple with client present
- HS – Family/couple without client present
- HT – Multi disciplinary team
- GT-Telemedicine
- TF – Intermediate Intensity
- TG – High Intensity
- U1 – MD
- U2 – PhD (Psychologist)
- U3- LCSW, LMFT, LPC, NP, CNS, PA
- U4- LAPC, LMSW and other degreed behavioral health professionals
- U5- non-degreed behavioral health paraprofessionals
- UK – Services provided on behalf of the client to someone other than the client (collateral relationship)

Utilization Management

The Utilization Management Program

The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 7:30 a.m. to 5:00 p.m. Central Standard Time (CST). Additionally, clinical staff is available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number - 1-800-947-0633. 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 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 Clinical 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.

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. Medical Necessity Criteria are used for the approval of services requiring prior authorization; plans of care that do not meet medical necessity guidelines are referred to a 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 Clinical 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 Provider to monitor the member's ongoing eligibility during the course of treatment.

Network Providers should use any of the following options to verify member enrollment:

- Contact Cenpatico Customer Service at 800-947-0633
- Access the Cenpatico Provider Website at www.cenpatico.com
- Verify online GHP web portal at www.mmis.georgia.gov

Inpatient Notification Process

Inpatient providers (including Crisis Stabilization Units) are required to notify Cenpatigo of emergent and urgent admissions (Emergency Behavioral Healthcare) 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 facility for evaluation and treatment, if necessary.

The following information must be readily available for the Cenpatigo 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.

For prior-authorizations during normal business hours, Network Providers should call: 1-800-947-0633

Outpatient Notification Process

Network Providers must adhere to the Covered Professional Services & Authorization Guidelines set forth in this Manual, when rendering services. Please refer the Covered Professional Services & Authorization Guidelines to identify which services require prior authorization. Cenpatigo does not retroactively authorize treatment.

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

For those outpatient services that require authorization, the Network Practitioner must complete an Outpatient Treatment Request (OTR) form and fax the completed form to Cenpatigo at 800-694-3649 for clinical review. Please refer to www.cenpatigoga.com under Provider/Resources/Forms to obtain a copy of the OTR. Network Providers may call the Customer Service department at 800-947-0633 to check status of an OTR. Network Providers should allow up to fourteen (14) calendar 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 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 provider is contracted and credentialed with Cenpatico.
- Providers should submit a request for Psychological Testing that includes the specific tests to be performed. Cenpatico's Psychological Testing Authorization Request form can be found at www.cenpatico.com under the Provider/Resources/Forms section.

Medical Necessity

As of February 1, 2011, Cenpatico will be using InterQual Criteria for mental health for both adult and pediatric guidelines. There will be no changes to the Community-Based Services criteria and Cenpatico will continue to utilize the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance abuse MNC (KCPC in Kansas). InterQual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes.

InterQual Criteria, used by over 3000 organizations and agencies, are developed by physicians and other healthcare professionals who review medical research and incorporate the expertise of a national panel of over 700 clinicians and medical experts representing community and academic practice settings throughout the U.S. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from practitioners.

ASAM and the McKesson InterQual criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Community-Based Services criteria can be found in this manual and on the Cenpatico website at: www.Cenpatico.com

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 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 Cenpatico.

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 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.

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 facility'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 in an inpatient facility receiving acute care services, Cenpatico's Utilization and Case Managers work with the facility's treatment team to make arrangements for continued care with outpatient Network Providers. Every effort is made to collaborate with the outpatient practitioners 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 seven (7) days after discharge. Cenpatico's Care Coordination/Case Management staff follow-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 Providers 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 Peach State Health Plan to identify any medications for physical conditions prescribed 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.

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 providers (those that are not contracted and credentialed in Cenpatico's provider network) to continue treatment or create a transition plan to facilitate transfer to a participating Network 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 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 providers 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 providers

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 Peach State Health Plan, 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 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, providers 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 a grievance (Level 1 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.

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 provider 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. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available. When a determination is made where no peer-to-peer conversation has occurred, a provider can request to speak with the Clinical Advisor who made the determination within one (1) business day. Providers should contact Cenpatico at 1-800-947-0633 to discuss UM denial decisions.

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 provider 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.

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 sources. Clinical practice guidelines adopted include but are not limited to: Treatment of Bipolar Disorder, Treatment of Major Depressive Disorder, Treatment of Schizophrenia and Substance Use and Abuse. Evidence-based practice guidelines have been adopted from a wide variety of recent publications. They are on topics such as, ADHD, Adjustment Disorder, Anxiety Disorder, and Post Traumatic Stress 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 representative or by calling 800-947-0633. Copies of our evidence based practices can be obtained in the same manner.

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 State of Georgia (HB1234)..
- To reimburse interest on claims in accordance with the guidelines outlined by the State of Georgia..

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through Cenpatico) on the date of service;
- The service provided is a covered service (benefit of Cenpatico) 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 Provider's Agreement with Cenpatico. Reimbursement from Cenpatico will be accepted by the Network Provider as payment in full, not including any applicable copayments or deductibles.

It is the responsibility of the Network 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 Provider for completion before processing or information may be requested from the provider on an Explanation of Benefit (EOB) form. This will cause a delay in payment.

Claim Payment

A Clean Claim will be processed with 15 business days of receipt of the claim. A non-clean claim. Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) days of receipt of the electronic claim

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 866-324-3632.

Network Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within one hundred eighty (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 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 Providers must submit claims to the following address for processing and reimbursement:

Cenpatico
Attn: Claims
PO Box 6700
Farmington, MO 63640

Timely Filing Requirements

All claims must be submitted within 180 days from the date the service was provided in order to be considered for payment. Claims received after this time frame will be denied for failure to file timely.

Claims Mailing Instructions

Submit paper claims to Cenpatico at the following address:

Cenpatico
Claim Processing Department
P.O. Box 6700
Farmington, MO 63640-3816

Administrative claim appeals must be submitted in writing to:

Cenpatico
Attn: Appeals
P. O. Box 6000
Farmington, MO 63640-3816

Cenpatico encourages all providers to submit claims electronically.

Claims Filing Deadlines

Original claims must be submitted to Cenpatico within 180 calendar days from the date services were rendered or compensable items were provided. Claims received outside of this timeframe will be denied for untimely submission. Clean Claims will be process within 15 business days. Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) days of receipt of the electronic claim.

Resubmission- All requests for claim reconsideration or adjustment must be received within 90 calendar days from the original date of submission. Please include the word “resubmission or reconsideration” and the claim number on the claim form to help us identify that this is a resubmission of an existing claim. Claims submitted after the ninety (90) day time frame will be denied for failure to resubmit timely

Appeals- All appeals of a denied claim must be submitted in writing and filed within thirty (30) days of the date of denial (date of EOP) in order to be considered. The written correspondence must clearly indicated that you are appealing a denial of a claim. Claim appeals submitted after the thirty (30) day time frame will not be denied for failure to request the appeal timely. Cenpatico shall process, and finalize, all appealed claims to a paid or denied status within thirty, (30) days from the date of denial of claim payment.

Exceptions

Coordination of Benefits (COB) – Claims must be submitted to Cenpatico with a copy of the EOP from the primary payor within 180 days of the date on the primary payor’s EOP, but never more than twelve (12) months from the month of service to:

Cenpatico
P.O. Box 6700
Farmington, MO 63640-3812

When submitting a paper claim that has been denied, and is more than **six (6) months** after the month of service, you will be required to provide a copy of the primary Payor Remittance Advice with the denial to demonstrate that the original claim was submitted timely.

Claim Resubmissions, Adjustments, and Disputes

Claims-Specific Processes

Providers should exhaust each level of the claims inquiry and resolution process before initiating the next level.

Status inquiries

To check the status of previously submitted claim(s), providers may use the Cenpatico web portal or contact the Provider Services Department at 1-800-947-0633, Monday through Friday 7:00 a.m. to 7:00 p.m. Callers should have the servicing provider's name, member name, member ID number, date of birth, date of service and claim number, if applicable.

Informal Claim Payment Adjustment

Informal adjustment requests normally are filed after the (maximum) ninety (90) day period that follows initial filing of a claim (in other words, after the claim is either paid in part or denied within ninety (90) days following initial filing of the claim).

A reconsideration/adjustment request for a single claim may initially be handled through a telephone call to Provider Services by calling 1-866-974-0633 Monday - Friday from 7:00 AM - 7:00 PM. Provider Services will create a contact service form (CSF) and submit the single claim adjustment request for review. Providers should follow-up within 10-14 business days of submitting the request or monitor the next few remittance advices for claim payment/denial.

If more than one claim requires an adjustment, a Provider Adjustment Form must be completed and submitted with the supporting documentation.

Requests for reconsideration/adjustment that involve like or similar issues may be batched together using one Provider Adjustment Request Form that is attached to the packet. The form should clearly describe the issue with all supporting documentation attached.

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 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 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 800-947-0633 and ask the representative to extend the end date on your authorization.

Claim Reconsideration

If a claim discrepancy is discovered, in whole or in part, contact Cenpatico's Claims Customer Service department at 866-324-3632 to speak with a Claims Support Liaison. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of a Claims Support Liaison.

All reconsideration requests must be submitted within ninety (90) days from the original date submitted in order to be considered for payment. Please include the word "reconsideration" and the claim number on the claim form to help us identify that this is a resubmission of an existing claim. Claims submitted after the ninety (90) day time frame will be denied for failure to resubmit timely.

Providers may resubmit claims, clearly marking them with the word "resubmission" and the claim number, usually to correct simple or basic errors in the original submission and to qualify the claim as a clean claim. Resubmissions must be received by Cenpatico within the first 90 days following initial filing of a non-clean claim.

No payment received within 30 days of initial filing of claim. Providers must wait at least 30 days from the initial submission before resubmitting the claim. The claim must be clearly marked as a resubmission and have the claim number on it. This will help to ensure that the claim is not denied as a duplicate.

Cenpatico
ATTN; Claims resubmission
PO BOX 6700
Farmington, MO 63640-3812

Claims Appeal

Claim complaints also are filed after the thirty (30) day (maximum) period that follows the claim denial. A decision will be rendered within thirty (30) days of receipt of the appeal and you will receive notification of the decision via the EOP notice or written correspondence. If you are still not satisfied with the decision of the committee, you have the option of choosing an Administrative Review or Binding Arbitration. The request for Administrative Review or Binding Arbitration must be submitted within thirty (30) days of receipt of the plan's decision. Request received after this time frame will not be considered. All arbitration costs will be shared by the Plan and provider.

Cenpatico
ATTN; Provider Appeal
PO BOX 6000
Farmington, MO 63640-3812

Administrative Review/Binding Arbitration

A request for administrative review or Binding Arbitration is a request for review of a Proposed Action, which includes certain adverse decisions made by the plan Medical Management Department. Providers may request an administrative review or Binding Arbitration on behalf of a member so long as they submit to Cenpatico within 30 days of the date of the Proposed Action written member consent for the provider to act on the member's behalf.

Providers may request on behalf of a member an Administrative Review or Binding Arbitration of a Proposed Action, in particular, when a decision is made by Medical Management to deny a service, in whole or in part (including type or level), or to reduce, suspend or terminate a service previously authorized for a member. The provider must obtain and provide to Cenpatico the written consent of the member to file an Administrative Review or request Binding Arbitration on behalf of the member. Requests should be clearly marked as requests for "Administrative Review" or "Binding Arbitration" Provider requests which are not accompanied by written member consent or for which such consent is not provided within 30 days of receipt of the Notice of Proposed Action, will be processed as provider complaints.

Standard requests for Administrative Review or Binding Arbitration must be received by Cenpatico within 30 days of the date of the Proposed Action that they concern. Written requests should be submitted to:

Cenpatico
Administrative Review
P.O. BOX 6000
Farmington, MO
63640-3816

Claims audits

Cenpatico uses claims audits to ensure accuracy of the claims payment process. Cenpatico audit review nurses will perform retrospective review of claims paid to providers to ensure accuracy of the payment process. If a claim is found to be overpaid, the amount will be recouped against future claim payments. A letter will be sent to the provider notifying them of the reason for the recoupment and the amount.

Provider complaints

Cenpatico's provider complaint system permits providers to dispute Cenpatico's policies, procedures, or any aspect of Cenpatico administrative functions (including the process by which Cenpatico handles Proposed Actions and EOPs), other than the specific claims and administrative review matters described above.

Provider complaints must be submitted in writing (or via the Cenpatico website) to the Cenpatico Provider Complaint Coordinator at:

Cenpatico
ATTN: Complaint Coordinator
504 Lavaca, Suite 850
Austin, TX 78701

Provider complaints must be filed within 30 days of the date of the event or occurrence addressed in the complaint. Within 30 business days of receipt of each timely filed provider complaint, the Provider Complaint Coordinator mails or electronically transmits to the provider written notice of Cenpatico's resolution of the complaint. Providers with questions regarding provider complaints should call the Provider Services Department at 1-800-947-0633.

Denied Claims- Provider Appeals/Consolidated Complaints

Effective July 1st, 2008, a provider may batch multiple claim appeals that are similar in nature using the revised Provider Adjustment Form. The adjustment form must be marked to indicate the nature of the complaint and the number of items attached.

- Providers have thirty (30) days from the date of the EOP to initiate a written request for an appeal of a denied claim. The written correspondence must clearly indicated that you are appealing a denial of a claim

- Appeals received after the thirty (30) day time frame will be denied for failure to request the appeal in a timely manner. Appeals should be submitted to:
- A decision will be rendered within 30 days of receipt of the appeal and the provider will receive notification of the decision via the EOP notice or written correspondence. If a provider is not satisfied with the decision of the committee, the provider has the option of choosing an Administrative Review or Binding Arbitration. The request for Administrative Review or Binding Arbitration must be submitted within thirty (30) days of receipt of the plan's decision. Request received after this time frame will not be considered.
- If the claim was denied or underpaid, but subsequently overturned on appeal, an adjustment will be made to pay the additional amount owed. In addition to the amount paid, twenty (20%) percent interest will be applied to the claim(s) and calculated starting 15 days after the claims was **received/submitted**. The interest payment will appear on the EOP.

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.

PAPER CLAIMS

All paper claims sent to the Claims Office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. You will NOT receive an EOP for claims rejected in the first-pass edits. You will receive a letter explaining why the claim was rejected

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's:

- 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

Don'ts:

- 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 has a specific list of EDI clearinghouse vendors that submit claims directly to Cenpatico. In addition, your existing EDI vendor may also submit claims to Emdeon or Payer Path to Cenpatico.

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
Emdeon	68050	800-845-6592
Relay Health/McKesson	68050	800-527-8133
Capario/Proxy Med	68050	800-792-5256

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs. Please contact the Cenpatico EDI Department for specific billing EDI edits and requirements. You may contact them at 1-800-225-2573 Ext. 25525 or email the department at EDIBA@centene.com

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

Cenpatico Billing Policies

Member Hold Harmless

Under no circumstances is a member to be balance billed for covered services or supplies. If the Network 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 Provider's failure to authorize the service(s) does not qualify/allow the Network Provider to bill the member for service(s).
- Cenpatico members may not be billed for missed sessions ("No-Show").

Recoupments

Prior to recoupment or offsets for overpayments or billing errors;

Cenpatico shall send written notification to the Provider indicating the reason for the overpayment with a list of the affected patients; and

Cenpatico shall allow 30 days for a written response from the Provider.

If the Provider does not respond by letter to dispute the recoupment within thirty (30) days, Cenpatico will auto recoup the payments. Cenpatico will limit recoupments to twelve (12) months from the date of service.

Non-Covered Services

If a Network Provider renders a non-covered service to a member, the Network Provider may bill the member only if the Network 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 Peach State Health Plan or Cenpatico and that the member understands they are responsible for reimbursing the Network Provider for such services.

Claims Payment and Member Eligibility

Cenpatico's Network 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 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 Peach State Health Plan 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 Provider should provide a screen shot showing eligibility for the member, including date and time of verification, from the GHP web portal so the claim may be reconsidered according to State Law.

It is the member's responsibility to notify the Network 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 fifteen (15) days, please call Cenpatico's Claims Customer Service department at 866-324-3632 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 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 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 800-947-0633 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, contact Cenpatico's Claims Customer Service department at 866-324-3632 to speak with a Claims Support Liaison. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of a Claims Support Liaison.

Claim Resubmission

When a Network Provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim may be submitted. 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.

Network Providers must submit their claims resubmission request and corrected claims to:

Cenpatico
Attn: Claims Resubmission
PO Box 7200
Farmington, MO 63640-3818

For issues that do not require a corrected resubmission, an 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.

Claims Appeal

If a Claim Resubmission has been processed and you are still dissatisfied with Cenpatico's response, you may file a Claims Appeal of this decision by writing to the address listed below.

Please Note: Claims Appeals must be filed in writing. Ensure your written request makes evident that you are submitting an APPEAL. You will be notified in writing of resolution of your dispute within thirty (30) calendar days of Cenpatico's receipt of your Appeal.

Network Providers must submit their claims Appeal to:

Cenpatico
Attn: Appeals
PO Box 6000
Farmington, MO 63640

Payment Dispute Process

If you are unable to resolve a specific claim(s) issue through these avenues then you may initiate the Payment Dispute Process. Please contact your Cenpatico Provider Relations Department representative about your specific issue. Please provide detailed information about your efforts to resolve your payment issue; the ability to provide information regarding which Cenpatico staff/departments you have already spoken with, will assist us with your request.

Please Note: Network Providers should complete the steps/processes described above to resolve the difficulty with their claim prior to initiating the Payment Dispute Process. After contacting Provider Relations at the address below, your dispute will be investigated. You will be notified by telephone, fax or letter of the result within ten (10) business days.

Network Providers can contact their Cenpatico Provider Relations Specialist as follows:

Cenpatico
Attention: Georgia Provider Relations
3200 Highlands Parkway Suite 200
Smyrna, Ga 30082
Phone: 800-947-0633

National Provider Identifier (NPI)

Cenpatico requires all claims be submitted with a Network Provider's National Provider Identifier (NPI). This will be required on all electronic and paper claims. Network Providers must ensure Cenpatico has their correct NPI Number loaded in their system profile. Typically, each Network 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 Cenpatigo

Please visit www.cenpatigoga.com to submit your NPI number. Network Providers may elect to contact the Cenpatigo 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.

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 Cenpatigo 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 Cenpatigo 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 Cenpatigo 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

Field #	Field Description	Instructions or Comments	Required or Conditional
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
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

Field #	Field Description	Instructions or Comments	Required or Conditional
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.
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

Field #	Field Description	Instructions or Comments	Required or Conditional
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

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

<p>24D Un-shaded</p>	<p>Procedures, Services or Supplies CPT/ HCPCS Modifier</p>	<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	<p>R</p>
AH	HN	HO	SA	TD																			
U2	U3	U4	U6	U7																			
U8	UB	UC	UD																				
HQ	HR	TF	UA	AJ																			
<p>24E Un-shaded</p>	<p>Diagnosis Code</p>	<p>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.</p>	<p>R</p>																				
<p>24F Un-shaded</p>	<p>Charges</p>	<p>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.</p>	<p>R</p>																				
<p>24G Un-shaded</p>	<p>Days or Units</p>	<p>Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.</p>	<p>R</p>																				

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

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

Field #	Field Description	Instructions or Comments	Required or Conditional
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

Field #	Field Description	Instructions or Comments	Required or Conditional
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.

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

Field #	Field Description	Instructions or Comments	Required or Conditional*
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

Field #	Field Description	Instructions or Comments	Required or Conditional*																								
13	Admission Hour	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services . <table border="1" data-bbox="443 302 1252 842"> <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
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																										
14	Admission Type	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: 1 Emergency 2 Urgent 3 Elective 4 Newborn	C																								
15	Admission Source	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: 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																								

Field #	Field Description	Instructions or Comments	Required or Conditional*																														
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"> <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						
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																																
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"> <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
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																																

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

Field #	Field Description	Instructions or Comments	Required or Conditional*
31-34 a-b	Occurrence Code and Occurrence Date	Occurrence Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) 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. 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.	C
35-36 a-b	Occurrence Span Code and Occurrence Date	Occurrence Span Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) 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. 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.	C

Field #	Field Description	Instructions or Comments	Required or Conditional*
37	(Unlabeled Field)	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. NOTE: Re-submissions may NOT currently be submitted via EDI.	C
38	Responsible Party Name and Address		Not Required
39-41 a-d	Value Codes Codes and Amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). 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. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual 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.	C

General Information Fields 42-47	Service Line Details	The following UB-04 fields – 42-47:	
		<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. 	
42 Line 1-22	Rev CD	Enter the appropriate 4 digit revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	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

General Information Fields 42-47	Service Line Details	The following UB-04 fields – 42-47: <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. 																					
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").																					
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/HCPCS 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/HCPCS 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/HCPCS.</p> <table border="1" data-bbox="558 852 1317 1079"> <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
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																				
45 Line 1-22	Service Date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY)																					
45 Line 23	Creation Date	Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)																					
46	Service Units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered.																					
47 Line 1-22	Total Charges	Enter the total charge for each service line.																					
47 Line 23	Totals	Enter the total charges for all service lines.																					
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.																					
48 Line 23	Total	Enter the total non-covered charges for all service lines.																					
49	(Unlabeled Field)	Not Used																					

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

Field #	Field Description	Instructions or Comments	Required or Conditional*
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
67	Principal Diagnosis Code	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. 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. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R
67 A-Q	Other Diagnosis Code	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. 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. NOTE: Claims with incomplete or invalid diagnosis codes will be denied for payment.	C
68	(Unlabeled)	Not Used	Not Required
69	Admitting Diagnosis Code	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. 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. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R

Field #	Field Description	Instructions or Comments	Required or Conditional*
70 a,b,c	Patient Reason Code	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. 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. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	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	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. 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. DATE: Enter the date the principal procedure was performed (MMDDYY). REQUIRED for EDI Submissions.	C
74 a-e	Other Procedure Code Date	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. 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. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	(Unlabeled))		Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional*
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

Federal and States Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov and then select "Regulations and Guidance" and "HIPAA – General Information";
- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: <http://www.samhsa.gov/>
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Cenpatico network are independently obligated to know, understand and comply with these laws.

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

Peach State Health Plan
3200 Highlands Parkway Suite 3000
Smyrna, GA 30082