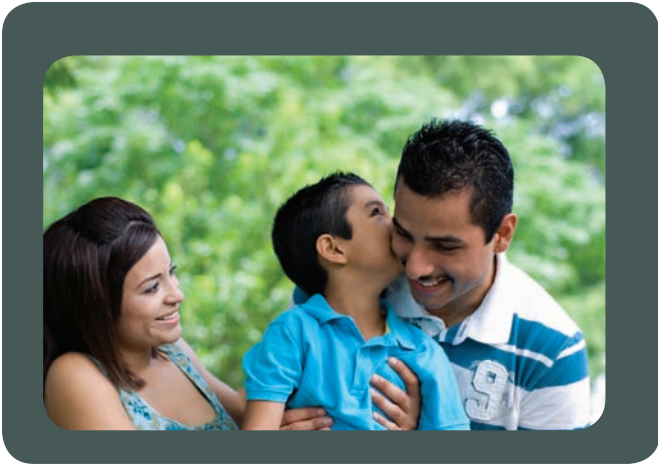


Cenpatico Provider Manual

State of Indiana



(877) 647-4848

www.cenpatico.com



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Welcome To Cenpatico

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

The Cenpatico Indiana 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 Indiana.

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

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

About Cenpatico

MISSION

Together we inspire hope for a better life

VISION

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

GOAL

Demonstrate value to our customers in everything you do

History and Structure of Cenpatico

Cenpatico (www.cenpatico.com) is a wholly-owned subsidiary of CenCorp Health Solutions, Inc. (CenCorp). CenCorp is a wholly-owned subsidiary of Centene Corporation (www.centene.com). Managed Health Services (MHS) of Indiana has delegated the provision of covered behavioral health and substance abuse services to Cenpatico.

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

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

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

Cenpatico Managed Care Philosophy

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

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

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

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

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

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

Indiana Provider Quick Reference Guide

Important Phone Numbers

Prior Authorization	877-647-4848
Claims Customer Service	866-324-3632
Network Development/Provider Relations	877-647-4848
Appeals/Grievances/Complaints	877-647-4848

Important Fax Numbers

Utilization Management (Submitting an OTR)	866-694-3649
Quality Management/Incident Reports	866-694-3649
Complaints	866-704-3063
Credentialing and Internal Relations Departments	866-694-3735

Verifying Member Eligibility

Cenpatico	877-647-4848
Cenpatico Website	www.cenpatico.com
	(You must have a provider log-in to access eligibility online)
Managed Health Services (MHS)	877-647-4848

Network Providers who are registered Indiana providers may also check eligibility through the EDS Web Interchange:

<https://interchange.indianamedicaid.com/Administrative/logon.aspx>

Cenpatico Website

www.cenpatico.com

All forms are accessible on the Cenpatico website..

Claims Address

Cenpatico
PO Box 6800
Farmington, MO 63640-3818

Health Plan Contact Information

Managed Health Services
877-647-4848

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 Hoosier Healthwise and Healthy Indiana Plan (HIP) coverage and enrolled with MHS throughout the State of Indiana. At present, MHS covers lives in all counties of the state of Indiana.

Network Provider Selection Process

Cenpatico contracts with behavioral health clinicians, facilities 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 MHS 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
- 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.

The Network Practitioner's Office

Cenpatico reserves the right to conduct Network Practitioner site visit audits. Site visit audits will 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 Providers must have a professional and fully-confidential telephone line and 24 hour availability

- Member records & other confidential information must be locked up out of sight during the work day; and
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

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

- The Network Practitioner has a complete copy of the Member's Bill of Rights and Responsibilities, available upon request by a member, at each office location
- The Network Practitioner's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area
- Office must be compliant with all American Disabilities Act (ADA) rules and regulations

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. Bachelor level practitioners will not be eligible to be credentialed as a participating practitioner.

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.
- Network Practitioners must consistently meet our credentialing standards and Cenpatico guidelines on Primary Medical Provider (PMP) notification and all behavioral health practitioners participating in the member's care.
- 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 Practitioners must be licensed to practice independently in the State of Indiana, or minimum of a Masters Level under the supervision of an MD or HSPP.
- Licensed psychologists must obtain endorsement as a Health Services Provider in Psychology (HSPP) in order to engage in the diagnosis and treatment of mental and behavioral disorders. If a psychologist is not endorsed as an HSPP, they must practice under the supervision of a health service provider in psychology for the purpose of qualifying for endorsement.
- For MDs and DOs, Cenpatico will require proof of the Network Practitioner's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, as applicable.
- License must be current, active, and in good standing.
- MDs and DOs must have hospital privileges and/or a coverage plan. Hospital privileges must be current and active.
- All Network Practitioners' graduate degrees must be from an accredited institution.
- All Network Practitioners are subject to the completion of primary source verification of the Network Practitioner through our Credentialing Department located in Austin, Texas.
- The Network 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.

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

- Complete signed and dated Indiana 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 practitioner's name, or evidence of compliance with Indiana 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 Indiana
- 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 provider's unique National Provider Identifier (NPI)
- All mid level practitioners must be supervised by a Health Services Provider of Psychiatry aka HSPP or M.D. Psychiatrist
- All mid level practitioners must provide a signed Supervising Attestation Form indicating that appropriate supervision is in place

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

- Indiana 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 responsibility of each Network Provider 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 Practitioner's ability to carry out the provisions of their Practitioner 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.

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

Re-Credentialing Requirements

Cenpatico Network Providers will be re-credentialed every three (3) years as required by the State of Indiana. 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 CAQH to streamline the credentialing and re-credentialing process. If you are interested in having Cenpatico retrieve your credentialing and re-credentialing application from CAQH, or if you wish to enroll 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
- 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 practitioner to review references, personal recommendations, or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing or 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 practitioner 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 or re-credentialing process.

Network Provider Demographic/Information Updates

Network Providers should advise Cenpatico with as much advance notice as possible for demographic and/or 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 Indiana provider network. Network Providers are encouraged to use the Provider Change Form located on our website to submit demographic changes. You may access this form on the Cenpatico website, www.cenpatico.com.

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

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

Network Provider Termination

Network Provider Request to Terminate

Network Providers requesting to terminate from the network must adhere to the termination provisions set forth in their Practitioner Agreement with Cenpatico. This notice can be either mailed or faxed to:

Cenpatico
Attn: Provider Relations
1099 N Meridian St, Ste 400
Indianapolis, IN 46204
Fax: 866-912-4249

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 Practitioner Agreement with Cenpatico for a full disclosure of causes for termination. As stated in your Practitioner Agreement, Cenpatico shall have the right to terminate the Practitioner 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 Practitioner's license, certification or membership on the active medical staff of a hospital or Cenpatico participating practitioner group
- Network Practitioner's loss of liability insurance required under the Practitioner Agreement with Cenpatico
- 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 Practitioner Agreement
- Any occurrence of serious misconduct which brings Cenpatico to the reasonable interpretation that a Network Provider may be delivering clinically inappropriate care
- 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. Requests for reconsideration will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than sixty (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 or she may contact the Cenpatico Indiana Provider Relations Department at 877-647-4848 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 reconsideration request to:

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

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

Cenpatico will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the Network Provider with the notification of suspension/termination. Please contact the Quality Improvement Department at 877-647-4848 to request a copy of Cenpatico's Provider Dispute Policy. Each Network Provider will be provided with a copy of their fully-executed Practitioner Agreement with Cenpatico. The Practitioner 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 Practitioner Agreement will also indicate the cancellation and/ or termination policies. There is no "right to appeal" when either party chooses not to renew the Practitioner 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 Practitioner's hospital privileges. All changes in a Network Provider's status will be considered in the re-credentialing process.

No New Referral Periods

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

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

Network Practitioners 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: Indiana Provider Relations
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 877-647-4848

Network Practitioners 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 Cenpatico Indiana Network Manager at 877-647-4848 to register these complaints. 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 Cenpatico to register their concern. All concerns are investigated, and feedback 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 Practitioner 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 Incident Report Form must be used to document critical incidents. You may access this form on the Cenpatico website, www.cenpatico.com.

Submit completed Incident Report Forms to the following address:

Cenpatico
Attn: Quality Improvement Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 877-647-4848
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.

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

Cultural Competency

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

Cenpatico is committed to the development, strengthening, and sustaining of healthy practitioner 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. Providers may contact the Customer Service Department at 877-647-4848 to coordinate interpreter services for members.
- Care is provided with consideration of the members’ race/ ethnicity and language and its impact/ influence of the members’ health or illness.
- Office staff who routinely come into 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/Provider’s office
- Member’s confusion and misunderstanding

- Non-compliance by the member
- Member's feelings of being uncared for, looked down on and devalued
- Parents' resistance to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Network Practitioner's/Provider's misdiagnosis due to lack of information sharing
- Wasted time for the member and Network Practitioner/Provider
- Increased grievances or complaints

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

Take the following into consideration when you provide services to MHS/Cenpatico members:

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

Facts about Health Disparities

- Government-funded insurance consumers face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Consumers are more likely to experience long wait times to see healthcare providers.
- African American Medicaid consumers experience longer waits in emergency departments and are more likely to leave without being seen.
- Consumers are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Consumers who 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.

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 Practitioners 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 Practitioner 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 Practitioner'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 performed as a part of a Member complaint and visits scheduled thereafter on an as needed basis.

Access and Coordination of Care

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 the Office of Medicaid Policy and Planning for provider coverage for the state of Indiana:

Provider	Accessibility Standard
Psychiatrists	2 Practitioners Within 60 Miles Of A Member
Inpatient Acute Care Provider for Urban and Suburban Areas	1 Provider Within 30 Miles Of A Member
Inpatient Acute Care Provider for Rural Areas	1 Provider Within 45 Miles Of A Member
Outpatient Behavioral Clinician for Urban and Suburban Areas	1 Practitioner Within 30 Miles Of A Member
Outpatient Behavioral Clinician for Rural Areas	1 Practitioner Within 45 Miles Of A Member

Practitioner Availability Standards

MHS members may access behavioral health and substance abuse services through several mechanisms. Members do not need a referral from their PMP 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 State accessibility standards for member appointments. Network Practitioners must make every effort to assist Cenpatico in providing appointments within the following timeframes:

Type of Care	Appointment Availability
Routine – treatment of a condition that would have no adverse effects if not treated within ten business days	Within ten (10) business 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 urgent services

Emergent/Non-Life Threatening – defined as inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize a behavioral health condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care to result in injury to self or bodily harm to others; placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction to any bodily organ or part; serious harm to self or others due to an alcohol or drug abuse emergency; with respect to a pregnant woman having contractions – (i) that there is not adequate time to affect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or unborn child.	All non-life threatening emergencies are to be directed to the Emergency Room.
Wait times – wait times in practitioner waiting rooms	Should not exceed one (1) hour
Discharge (from hospital/acute care)	Within seven (7) days of discharge

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 practitioner who can meet the access standards and member’s needs. Adherence to these standards is monitored with telephone auditing through the quality program.

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 877-647-4848 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 is 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 practitioners and between the behavioral health practitioner 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 practitioners, to ensure a 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 PMP or other behavioral health practitioners.

Coordination between MHS and Cenpatico

MHS and Cenpatico work together to assure quality behavioral health services are provided to all members. This coordination includes participation in Quality Improvement (QI) 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 practitioners in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to MHS on a monthly basis, and is shared with MHS'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, PMP communications, and administrative office operations, as well as MHS' QI 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 PMPs and other behavioral health practitioners
- Critical Incidents
- Member safety
- Member confidentiality
- High-risk member identification, management and tracking
- Discharge appointment timeliness and reporting
- Re-admissions
- Grievance procedures
- Potential over- and under-utilization
- Provider satisfaction
- 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
- Provider quality profiling

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

Network Provider Participation in the QI Process

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

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

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility
- Cooperating with Cenpatico's complaint review process
- Participating in Network Provider satisfaction surveys
- 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.

Preventive Behavioral Health Programs

Cenpatico offers preventive 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 preventive behavioral health programs please contact the QI Department at 512-406-7200.

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 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 physician. Parents are also encouraged to keep their child's follow-up appointment within seven (7) 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 preventive behavioral health programs. If you have recommendations regarding other areas where we might make a difference, please contact us at 512-406-7200.

Confidentiality and Release of Member Information

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

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

Communication with the Primary Medical Providers

MHS encourages PMPs to consult with their members' mental health Network Practitioners. In many cases the PMP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

Network Practitioners should communicate not only with the member's PMP 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 PMP, 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

The Behavioral/ Physical Health Coordination Form to be used in communicating with the PMP and other behavioral health practitioners is located on the Cenpatico website, www.cenpatico.com. Network Practitioners can identify the name and number for a member's PMP through the EDS Web Interchange.

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

Cenpatico requires that Network Practitioners report specific clinical information to the member's PMP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the Network Practitioner's responsibility to keep the member's PMP 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 PMP, the Network Practitioner 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 PMP:

- A copy or summary of the intake assessment within 5 days of the initial visit
- 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
- The results of functional assessments

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

Cenpatico monitors communication with the PMP 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 PMP 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 MHS or Cenpatico practitioner network), except as the need for Emergency Care may require, or where Cenpatico 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 practitioners 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
- Maintain adequate appointment availability access, per the Practitioner Access Standards guidelines

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 877-647-4848 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 Utilization 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 to include SMART goals and time-limited treatment
- Coordinate care with other clinicians as appropriate, including consistent communication with the PMP 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
- 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, MHS, 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 Practitioner 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 Practitioner 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 and disclosure of information, release of information to the member's PMP, documentation of member receipt of the Statement of Member's Rights and Responsibilities, the prescribed medications with refill dates and quantities, including clear evidence of the informed consent, and any other information from other professionals and agencies. If the Network Practitioner is able to dispense medication, the Network Practitioner must conform to drug dispensing guidelines set forth in the State of Indiana's 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 practitioner/provider fraud include: lack of referrals by PMPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and practitioners/providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

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

Authority and Responsibility

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

Cenpatico, in conjunction with MHS, 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 MHS, 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 Indiana within the Office of the Attorney General at the following address:

Medicaid Fraud Control Unit of Indiana
Office of the Attorney General
8005 Castleway Drive
Indianapolis, IN 46250-1946
Phone: (317) 915-5303
Fax: (317) 232-6523

Hotline Number - A toll-free hotline number has been established to report potential WAF issues. The hotline number is 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 877-647-4848.

Verifying Member Enrollment

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

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

- Contact Cenpatico Customer Service at 877-647-4848
- Access the Cenpatico Provider website at www.cenpatico.com
- Access the state EDS Web Interchange Eligibility Verification System (EVS) at <https://interchange.indianamedicaid.com/Administrative/logon.aspx>

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

Member Rights and Responsibilities

Managed Health Services Member Rights

1. A right to courteous and considerate treatment from Managed Health Services (MHS) staff, providers, physicians and their office staff.
2. A right to be treated with respect and dignity, including recognition of your need for privacy.
3. A right to choose an MHS Primary Medical Provider (PMP) and be told which hospitals to use/have access to.
4. A right to change your health plan (1) anytime during your first 90 days with the plan (HHW Members), before making your first payment and are fully eligible (HIP members); (2) annually during open enrollment (except HIP Members); and (3) any time during the year if you have a "just cause" or "for cause" reason (HIP).

5. A right to know how to receive referrals for specialty care and other services.
6. A right to review our practice guidelines which are the criteria used to approve or deny medical requests such as authorizations for specialist care.
7. A right to information about your rights and responsibilities, about MHS and about MHS practitioners, providers and services. We will send you a Member Handbook when you join MHS and a member newsletter four times a year. In addition, detailed information on MHS is located at www.mhsindiana.com or you may also call our Member Services Department at 877-MHS-4U4U (647-4848).
8. A right to confidentiality regarding your medical records and all other personal information and to be given the opportunity to approve or refuse the release of personal information except when the release is required by law.
9. A right to be involved in decisions about your health care with your practitioners and be given information about alternative treatment options, and the option to refuse treatment.
10. A right to make choices about the medical care you would want if you are too ill or hurt to state your decisions, such as letting your doctor know if you would or would not like to use life support machines if something serious happens, letting your doctor know if you would like to be an organ donor, deciding right now the medical care you want or don't want if you become too sick to decide at some future date, and giving someone the power to say "yes" or "no" to your medical treatments if you are no longer able to make those decisions.
11. A right to personalized help from MHS staff so you can ensure that you are getting the care needed, especially in cases where you or your child have "special health care needs" such as dealing with a long-term disease or severe medical condition. We make sure that you get easy access to all the care that is needed and will help coordinate the care with the multiple doctors and case managers involved to make things easier for you.
12. A right to a discussion regarding appropriate or medically necessary treatment options and alternatives, regardless of cost or benefit coverage in a manner that is understandable.
13. A right to be free from any actions used to punish, isolate, convince or persuade you for any reason.
14. A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
15. A right to use your rights and be free of discrimination or other adverse actions by MHS as a consequence.
16. A right to get a second opinion from a qualified healthcare professional.
17. A right to access to family planning and OB services for annual women's tests freely without approval by MHS or your MHS doctor. This includes birth control, HPV tests, Chlamydia tests and annual PAP smears.
18. A right to be informed of any denied authorizations and be assured that you will receive this information as quickly as needed so that your medical needs are met and treatment not delayed. We will not jeopardize your medical condition waiting for approval of services. Authorizations are reviewed based on your medical needs and made in compliance with state timeframes.
19. A right to receive written notice of denied authorizations, partial denial or limitation of a service. This includes any decision to limit the number of visits, date range or decisions that other treatment options would be better.
20. A right to request and receive a copy of your medical records and to request that these records be changed. This request will not affect how the plan, providers or the State treats you.
21. A right to be given a full range of advice and counseling from your healthcare providers as appropriate for your condition.
22. A right to voice complaints or appeals about the organization or the care it provides
23. A right to know how to file a complaint, how to use the grievance procedure, and how to be protected from any negative actions resulting from use of the complaint or grievance procedure.

24. A right to file an appeal with the Family and Social Services Administration (FSSA) Office of Hearing and Appeals if you are not satisfied with the final decision after using the grievance procedure.
25. A right to file an appeal with the Family and Social Services Administration (FSSA) Office of Hearing and Appeals if you are not satisfied with the final decision after using the grievance procedure.
26. A right to not have your enrollment terminated or be encouraged to disenroll from MHS because of healthcare needs or changes in health status.
27. A right to be given complete information so that you can give informed, voluntary permission to participate in any medical research even though experimental/investigational procedures are not covered services.
28. A right to complete benefit information, including how to get services during regular hours of operation, how to get emergency care after hours, how to get out-of-area care, and what exclusions and limits are present on covered services.
29. A right to be told about a change in any benefit, termination of services, and availability of any provider. You will receive notification from the state if your doctor is no longer available through the Hoosier Healthwise Program. You should be given at least 30 days to choose another doctor before being assigned a doctor.
30. A right to have Managed Health Services (MHS) or contracted providers arrange for interpreter services at no charge to you if you are hearing impaired or have trouble understanding English.
31. A right to make recommendations about our Member Rights and Responsibilities policy.
32. A right to free medical care for covered services unless co-payments are required. This includes the right to:
 - Free covered services you have already received, even if MHS closes.
 - Free covered services you have already received, even if the state does not pay MHS.
 - Free covered services you have already received, even if MHS does not pay for it under our contract, but services are covered through your Hoosier Healthwise State coverage.
 - Not have to pay extra payments for covered services you got even if MHS could have provided the service for less.

Managed Health Services Member Responsibilities

1. A responsibility to establish a relationship with your new MHS doctor (Primary Medical Provider) within the first 90 days.
2. A responsibility to read the notices MHS sends to you about your health plan benefits.
3. A responsibility to update your case worker, MHS, and your Primary Medical Provider when you change your address or telephone number so we can continue to get benefit updates to you.
4. A responsibility to provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly care for you.
5. A responsibility to keep all scheduled appointments; be on time for those appointments, and to cancel 24 hours in advance if you cannot make an appointment.
6. A responsibility to understand your health problems to the best of your ability and work with your doctors to develop treatment goals you both agree on to the degree possible.
7. A responsibility to follow plans and instructions for care that you have agreed to with your MHS doctors, and to get all care from your Primary Medical Provider, except for referrals made by your Primary Medical Provider and self-referral services.
8. A responsibility to show your HHW, CHIP, or HIP card every time you get care.
9. Pay any required monthly premiums on time to avoid losing your health benefits.
10. Notify the State of any changes in your income, address, telephone numbers, e-mail address or family.

In addition to the Member Rights and Responsibilities provided by the MHS, 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.

The information above is available in other languages or formats, including Spanish, large print or Braille. Please contact Customer Service at 1-877-MHS-4U4U (1-877-647-4848) if you need this information in another format

Civil Rights

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

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

Customer Service

The Cenpatico Customer Service Department

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

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

The Customer Service Department's primary focus is to facilitate the authorization of covered services for members for treatment with a specific clinician or clinicians. The Customer Service Department provides the member with information about Network Providers and assists the member in selecting a Network Provider who can meet their specific needs. Licensed clinicians on staff in the Utilization Management department are available to manage calls requiring an assessment for 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

Trouble-shooting any issues related to eligibility, authorizations, referrals, or researching prior services

Interpretation/Translation Services

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

Customer Service is staffed with Spanish and English bilingual personnel.

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

TDD access for members who are hearing impaired

TTY: 800-743-3333

Voice: 800-743-3333

Key Information: To access interpreter services for Cenpatico members, contact Customer Service at 877-MHS-4U4U (647-4848).

NurseWise

NurseWise is Cenpatico's after hour's nurse referral line through which callers can reach both customer service representatives and bilingual nursing staff.

The NurseWise triage service provides Members and Network Providers with the following:

Provide referrals after hours

Verify member eligibility

Crisis Interventions

Emergency assessment for acute care services

After hours emergency refills

Documentation and notification of inpatient admissions that occur after hours

Assistance with determining the appropriate level of care in accordance with clinical criteria, as applicable
NurseWise provides after-hours phone coverage seven (7) days per week including holidays for Cenpatico members.

Complaints, Grievances and Appeals

Provider Complaints

What is a Complaint?

A complaint is defined as any dissatisfaction, expressed by a Network Provider verbally 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:
877-647-4848

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

If a Network Practitioner's clinical privileges are altered by Cenpatico, the Practitioner can file a dispute. A Practitioner Dispute must be requested in writing within thirty (30) days of notification of the change in clinical privileges. Details of how to file a Practitioner Dispute are mailed with the notification letter.

Member Complaints

What is a Complaint?

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

MHS 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 provider with the member's signed consent. MHS Member 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:

Managed Health Services
1099 N Meridian St, Suite 400
Indianapolis, IN 46204

To express a Complaint by phone, please call MHS at:
877-647-4848

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

Member Appeal

What is an Appeal?

An appeal is a written or verbal request for review of an action/determination made by Cenpatico. An appeal 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 appeal system that complies with applicable Federal and State laws and regulations. An appeal must be filed with Cenpatico within thirty (30) calendar days from the date of the notice of Cenpatico's action/determination. Members may continue to seek covered services while the appeal is being resolved. Cenpatico will make its determination within twenty (20) business days of receipt of the appeal and written notification will be sent to the member or designated representative.

If the member is still receiving the services that are under appeal review and the services are covered services, the services may continue until a decision is made on the appeal. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Cenpatico and were not terminated because benefit coverage for the service was exhausted.

A member or authorized representative has the right to file an appeal if Cenpatico denies or limits a request for a Covered Service. The Cenpatico Appeals Coordinator is available to assist a member in understanding and using the Cenpatico Appeal Process. Denials for non-covered benefits cannot be appealed. Members have the opportunity to present their appeal in person as well as in writing. Every oral appeal received must be confirmed in writing by the member or his/her representative, unless an Expedited Appeal is requested.

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

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

To express an appeal by phone, please call Cenpatico at 877-647-4848.

Members who are not satisfied with Cenpatico's disposition of an appeal may request an Independent Review. Members must file independent review requests with Cenpatico within 45 days of the date of Cenpatico's Notice of Adverse Action, by calling or mailing the request to:

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

Cenpatico completes independent reviews within 15 business days of receipt of the request for a standard independent review or within 72 hours of receipt of request of an expedited review. Notification is sent within 3 business days of the decision. Members also have the option of requesting a State Fair Hearing at the Indiana Family and Social Services Administration (FSSA) after exhausting all internal appeal options.

A state fair hearing request must be made within thirty (30) calendar days from the last notification letter. The member may call MHS to set up the hearing, or may write to the FSSA directly at this address to ask for a hearing:

Hearings and Appeals Section, MS-04
Indiana Family and Social Services Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204-2773

Expedited Appeals

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

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

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

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

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

877-647-4848

Expedited Appeals will be resolved within forty-eight (48) hours and the provider will be notified telephonically. Written notification is sent out within one (1) business day of providing or attempting to provide oral notification.

If Cenpatico determines that the Appeal does not qualify to be expedited, the member will be notified immediately and the resolution will be made within twenty (20) calendar days.

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

Benefit Overview

Cenpatico covers a comprehensive array of behavioral health and substance abuse services in Indiana. Services for Hoosier Healthwise and Healthy Indiana Plan (HIP) members include, but are not limited to the following;

Inpatient hospitalization

Observation/23-hour stay

Partial Hospitalization

Intensive Outpatient Treatment

Outpatient Therapy (Individual, Family and Group)

Medication Management

Psychological Testing and Neuropsychological Testing

Electroconvulsive Therapy (ECT)

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

Please note that all services must be medically necessary.

The following services are carved out of Cenpatico benefits for Hoosier Healthwise and HIP members. These services are covered through FFS Medicaid:

- MRO Services
- Inpatient care at a State Psychiatric Hospital
- Care provided at a Psychiatric Residential Treatment Facility

Covered Professional Services & Authorization Grid

Please note that the listing below does not fully comprise all Cenpatico covered services. Please refer to your Practitioner Agreement with Cenpatico to identify additional services you are contracted for and eligible to provide. Services must be submitted/ billed under the supervising Psychiatrist or Health Services Provider in Psychology's (HSPP) National Provider Identifier (NPI). Modifiers AF and Q6 can also be accepted for MDs.

Provider Type abbreviations: MD = Psychiatrist; PhD = HSPP or Psychologist; NP = Clinical Nurse Specialist, Advanced Practice Nurse, Nurse Practitioner, etc.; MLC = Master's Level Clinician such as Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), etc.

Services performed by behavioral health licensed clinicians at CMHCs, FQHCs, and RHCs, are covered by Cenpatico

Authorization (Auth) requirements listed below assume provider is a participating provider with Cenpatico.

Service Description	Rendering Provider Type(s)	Billing Codes	Modifiers	Auth Required
Initial Hospital Care	MD, NP	99221, 99222, 99223	None for MD, SA in first position with HE in second position for NP	No auth required if inpatient stay is authorized
Subsequent Hospital Care	MD, NP	99231, 99232, 99233,	None for MD, SA in first position with HE in second position for NP	No auth required if inpatient stay is authorized
Initial Inpatient Consultation (Codes covered for HHW only)	MD, NP	99251, 99252, 99253, 99254, 99255	None for MD, SA in first position with HE in second position for NP	No auth required if inpatient stay is authorized
Hospital Discharge	MD, NP	99238, 99239	None for MD, SA in first position with HE in second position for NP	No auth required if inpatient stay is authorized
Initial Observation Care (< 24 hour stay):	MD, NP	99234, 99235, 99236	None for MD, SA in first position with HE in second position for NP	No auth required if observation/<24 hour stay is authorized
Initial & Established Patient, Outpatient Consultation	MD, NP	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	None for MD, SA in first position with HE in second position for NP	Yes

Individual Inpatient Psychotherapy	MD, PhD, NP, MLC	90816, 90818, 90821, 90823, 90826, 90828	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	Yes
Individual Inpatient Psychotherapy with Medication Management	MD, NP	90817, 90819, 90822, 90824, 90827, 90829	None for MD, SA in first position with HE in second position for NP ²	No
ECT	MD	90870		Yes
Diagnostic Interview	MD, PhD, NP, MLC	90801, 90802	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	2 (1 for supervisor and 1 for midlevel) without auth every 12 months
Individual Psychotherapy	MD, PhD, NP, MLC	90804, 90806, 90808, 90810, 90812, 90814	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	Yes, after initial visit option ¹
Individual Psychotherapy with Medication Management	MD, NP	90805, 90807, 90811, 90813	None for MD, SA in first position with HE in second position for NP ²	No
Extended Individual Psychotherapy with Medication Management:	MD, NP	90809, 90815	None for MD, SA in first position with HE in second position for NP ²	Yes
Med Check	MD, NP	90862	None for MD, SA in first position with HE in second position for NP ²	No
Family Psychotherapy with and without Patient Present	MD, PhD, NP, MLC	90846, 90847, 90849	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	Yes, after initial visit option ¹

Group Therapy	MD, PhD, NP, MLC	90853	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	Yes, after initial visit option ¹
Interactive Group Therapy	MD, PhD, NP, MLC	90857	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	Yes, after initial visit option ¹
Psych Testing	MD and PhD	96101, 96103, 96105, 96110, 96111	AH or HP for non-HSPP Psychologist and none for MD or HSPP	Yes
Neuropsych Testing	MD and PhD (MD must be a licensed Psychiatrist)	96116, 96118	AH or HP for non-HSPP Psychologist and none for MD or HSPP	Yes
Bio-psychosocial Assessment or Intervention	MD, PhD, NP, MLC In FQHC or RHC only	96150, 96151, 96152, 96153, 96154, 96155	Service must be performed by licensed behavioral health clinician utilizing modifier to indicate type of rendering provider	No
Alcohol/SA structured screening	MD, PhD, NP, MLC	99408, 99409	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	No
Smoking Cessation	MD, PhD, NP, MLC	S9075	Service must be performed by licensed behavioral health clinician utilizing modifier to indicate type of rendering provider	No
Emergency Office Service	MD, PhD, NP, MLC	99058	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for MLC, HO for master's level clinician or AJ for Social Workers	Yes
Telemedicine Facility Fee		Q3014	Billable under supervisor for facility	No

Injections	MD, NP	96372	None for MD, SA in first position with HE in second position for NP ²	No
Methadone Treatment (code subject to approval by OMPP)	MD, PhD, NP, MLC (performed at a clinic only)	H0020	No modifier needed for MD or HSPP, AH or HP for non-HSPP Psychologist, SA/HE for NP, HO for master's level clinician or AJ for Social Workers	Yes

¹Participating providers receive 5 initial visits without authorization after the first assessment (codes 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853 and 90857). After these visits are used, an authorization is required. This privilege counts against the billing (supervising) provider not the rendering provider. Therefore if services for multiple rendering providers are billed under the same supervisor, only one set of 5 visits without auth will be allowed for that member rather than 5 visits without auth for each rendering midlevel provider.

²Nurse Practitioners not registered with IHCP to bill independently must bill medication management services under a supervisor with a DEA license.

³Professional Services billed in conjunction with a clinic service (REV 510) may be subject to a payment reduction.

Partial Hospitalization Benefit

Partial hospitalization services, previously a value-added service by Cenpatico, are now part of the Covered Benefits offered for Hoosier Healthwise and Healthy Indiana Plan members. **Due to switching to the newly defined benefit, Cenpatico's coding instructions have changed.** Previously, Cenpatico contracted with facilities offering partial hospitalization using a per diem Revenue Code. Starting January 1, 2011, partial hospitalization will be offered through community mental health centers. Hospitals will only be contracted for partial hospitalization when they fulfill an access need and are not associated with a community mental health center. Hospitals previously contracted for partial hospitalization that have an associated community mental health center will now need to utilize the community mental health center for partial hospitalization.

When partial hospitalization is offered through the community mental health center, physician services shall be reimbursed separately. Services performed by other clinicians will be included in the partial hospitalization rate. Partial hospitalization offered by a hospital and billed using a Revenue Code is inclusive of all professional services.

Partial hospitalization services must be authorized and must be offered a minimum of 4 days a week, 4-6 hours per day. Cenpatico may request copies of medical records periodically to validate treatment length and rendering providers utilized to compare to services billed.

Service Description	Rendering Provider Type(s)	Billing Codes	Modifiers	Auth Required
Partial Hospitalization		S0201	Billable under supervisor for facility	Yes

Utilization Management

The Utilization Management Program

The Cenpatico Utilization Management (UM) department's hours of operation are Monday through Friday (excluding holidays) from 7:00 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 1-877-647-4848. The Cenpatico UM team is comprised of qualified behavioral health professionals whose education, training and experience are commensurate with the UM reviews they conduct.

The Cenpatico UM 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 family's centers on promoting resiliency and hope.

The purpose of Cenpatico's UM 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; 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 UM 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. UM files includes the date of receipt of information and the date and time of notification and resolution.

Cenpatico's UM Department is under the direction of our licensed Medical Director or physician designee(s). The UM 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 methodologies to verify member eligibility;

- Contact Cenpatico Customer Service at 877-647-4848
- Access the Cenpatico Provider Website at www.cenpatico.com
- Access the state EDS Web Interchange Eligibility Verification System (EVS)
<https://interchange.indianamedicaid.com/Administrative/logon.aspx>

Inpatient Notification Process

Inpatient facilities are required to notify Cenpatico of emergent and urgent admissions (Emergency Behavioral Healthcare) no later than forty eight (48) hours 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. 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 Cenpatico Utilization Manager when requesting initial authorization for inpatient care:

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

Outpatient Notification Process

Network Practitioners must adhere to the Covered Professional Services & Authorization Guidelines set forth in this Manual when rendering services. Network Practitioners may provide a covered evaluation/assessment and up to five (5) outpatient/office location follow-up sessions per participating practitioner per member without seeking authorization from Cenpatico. Please refer the Covered Professional Services & Authorization Guidelines to identify which services apply to this requirement. Once the evaluation/assessment and five (5) outpatient/office location follow-up sessions per participating practitioner per member are utilized, Network Practitioners must contact Cenpatico to obtain authorized sessions for continued services. **Cenpatico does not retroactively authorize treatment.**

**For prior authorizations during normal business hours, Network Practitioners should call:
877-647-4848**

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

When requesting additional sessions for those outpatient services that require authorization, the Network Practitioner must complete an Outpatient Treatment Request (OTR) form and fax to the completed form to Cenpatico at 866-694-3649 for clinical review. You may access this form on the Cenpatico website, www.cenpatico.com.

Network Practitioners may call the Customer Service department at 877-647-4848 to check status of an OTR.
Network Practitioners should allow up to 5 business days to process non-urgent requests.

IMPORTANT:

- **The OTR must be completed in its entirety.** The five (5) Axis diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
- **Cenpatico will not retroactively certify routine sessions.** The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- **Failure to submit a completed OTR can result in delayed authorization** and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.
- **Cenpatico's UM decisions are based on Medical Necessity and established Clinical Practice Guidelines.** Cenpatico does not reimburse for unauthorized services and each Practitioner 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;

- All Psychological and Neuropsychological Testing for both medical conditions and behavioral health conditions will be reviewed by Cenpatico for authorization.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment (90801 and 90802) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the Practitioner is contracted and credentialed with Cenpatico.
- Practitioners should submit a request for Psychological Testing and Neuropsychological Testing that includes the specific tests to be performed. Cenpatico's Testing Authorization Request forms can be found online at www.cenpatico.com.

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when medical necessity criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health practitioners providing treatment for the member. Network Providers are expected to work closely with Cenpatico's UM 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 MHS.

As of February 1, 2011, Cenpatico will be using InterQual Criteria for mental health for both adult and pediatric guidelines. Cenpatico will continue to utilize the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance abuse MNC. 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.

Both ASAM and InterQual 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 UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Concurrent Review

Cenpatico's UM Department will concurrently review the treatment and status of all members in inpatient through contact with the member's attending physician or the facility's Utilization and Discharge Planning departments. The frequency of review for 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 Practitioners. Every effort is made to collaborate with the outpatient practitioner to assist with transition back to the community and a less restrictive environment as soon as the member is stable. Discharge planning should be initiated on admission.

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within 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 Practitioners 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 MHS to identify any medications for physical conditions prescribed by psychiatric practitioners as well as to review psychotropic medications prescribed by the PMP.

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 Indiana provider network) to continue treatment or create a transition plan to facilitate transfer to a participating Cenpatico provider (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.

Disease Management

Cenpatico offers disease management programs to MHS Indiana members with Depression, Bipolar Disorder and ADHD to provide a coordinated approach in managing the disease and improve the health status of the member. This is accomplished by identifying and providing the most effective and efficient resources, enhancing collaboration between medical and behavioral health providers and ongoing monitoring of outcomes of treatment. Each of Cenpatico's disease management programs are based on clinical practice guidelines and include research evidence-based practices. Multiple communication strategies are used in disease management programs to include written materials, telephonic outreach, web-based information, in person outreach through MemberConnections program and case managers, and participation in community events.

All members enrolled in a disease management program are stratified based on acuity to determine the appropriate level of intervention.

- Low Risk (Population Based) – All members of target population
- Moderate Risk (Case Management)– member with identified diagnosis and defined predictive modeling criteria
- High (Care Management) – Members with eligible diagnosis and inpatient behavioral health admission within past 6 months

Cenpatico Care Managers are licensed behavioral health professionals with at least 3 years experience in the mental health field. In Indiana, all members discharged from an inpatient psychiatric or substance abuse hospital will be admitted and followed by care management for no fewer than 180 days.

Single Case Agreements

Cenpatico arranges Single Case Agreements (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 Practitioners do not have timely appointment availability
- It is clinically indicated to maintain continuity of care
- 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, facilities 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 practitioner 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 practitioner to discuss the determination.
- e. Instructions for requesting an appeal, including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- f. For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal.
- g. The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Peer Clinical Review Process

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

For both mental health and chemical dependency service continued stay requests, the physician or treating practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the UM 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 practitioner can request to speak with the Peer Reviewer who made the determination within one (1) business day. Practitioners should contact Cenpatico at 877-647-4848 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 practitioner provides good cause in writing.

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

Clinical Practice Guidelines

Cenpatico has adopted many of the clinical practice guidelines published by the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry as well as evidence based practices for a variety of sources. Clinical practice guidelines adopted for adults include but are not limited to: Treatment of Bipolar Disorder, Treatment of Major Depressive Disorder, Treatment of Schizophrenia and Substance Use and Abuse. For children, Cenpatico has adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/ Hyperactivity Disorder. 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 877-647-4848. Copies of our evidence based practices can be obtained in the same manner. Compliance with Clinical Practice Guidelines is assessed annually as part of the quality process.

Claims

Cenpatico Claims Department Responsibilities

Cenpatico's claims processing responsibilities are as follows:

- To reimburse Clean Claims (see Clean Claim section below) within the timeframes outlined by the Prompt Payment Statute
- To reimburse interest on claims in accordance with the guidelines outlined in the Prompt Pay Statute

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through MHS) on the date of service
- The service provided is a covered service (benefit of MHS) on the date of service
- Cenpatico's prior authorization processes were followed
- Provider's billing information is registered and active with IHCP
- Claim information follows National Correct Coding Initiatives (NCCI)

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. The Network Provider or their Supervisor must be on file with the Indiana Health Coverage Program (IHCP) as participating in Indiana Medicaid for claims to be accepted and adjudicated by Cenpatico.

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.

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.

Electronic Funds Transfer (EFT)

Cenpatico offers claims payment via electronic funds transfer. To sign up, please visit the website www.cenpatico.com and complete the Electronic Funds Transfer Agreement.

Network Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within **ninety (90)** days of the date the service(s) are rendered. Claims submitted after this period will be denied for payment. The Network Provider or their Supervisor must be on file with IHCP as participating in Indiana Medicaid for claims to be accepted and adjudicated by Cenpatico.

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/supervising 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 paper claims to the following address for processing and reimbursement:

Cenpatico
PO Box 6800
Farmington, MO 63640-3818

Electronic claims submission can be done via Cenpatico's web portal or through a clearinghouse. Please see section titled EDI Clearinghouses for more information about EDI submission or visit www.cenpatico.com for access to the web portal.

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 as follows:

- 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.

Primary Diagnosis

Cenpatico adjudicates claims for behavioral health and substance abuse. Claims with a primary diagnosis not related to behavioral health or substance abuse may be denied. If Network Provider receives such a denial, please evaluate the service performed. If the service is a behavioral health/substance abuse service performed by a licensed behavioral health provider, please resubmit to Cenpatico with an appropriate primary diagnosis. Claims for medical conditions or services should be submitted to Managed Health Services.

Imaging Requirements For Paper Claims

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

Do:

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

Do Not:

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

Web Portal Claim Submission

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

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

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

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

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

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

EDI Clearinghouses

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

Trading Partner	Payor ID	Contact Number
Emdeon	68052	800-845-6592
Capario	68052	800-792-5256, x812

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).
- MHS members may not be billed for missed sessions ("No-Show").

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 MHS 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 MHS 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 bill the member directly for services rendered while the member was not eligible for benefits.

It is the member's responsibility to notify the Network 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 thirty (30) 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 Indiana provider network due to inability to follow policies and procedures.

If the authorization contains unused visits and the end date has not expired, please call the Cenpatico Customer Service department at 877-647-4848 and ask the representative to extend the end date on your authorization to allow the utilization of the unused visits.

Resolving Claims Issues

Claim Reconsideration

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

1. Call the Cenpatico Claims Support Liaisons at 866-324-3632. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of our Claims Support Liaisons.
2. When a provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim should be submitted on a paper claim form. When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as **RESUBMISSION** along with the original claim number written at the top of the claim. Failure to mark the claim may result in the claim being denied as a duplicate. Corrected resubmissions should be sent to the address below.

Cenpatico
Claims Resubmission
P. O. Box 6800
Farmington, MO 63640-3818

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

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

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

Retro authorizations will only be granted in rare cases. Repeated requests for retro authorizations will result in termination from the network due to inability to follow policies and procedures. If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Service Center at 877-647-4848 and ask the representative to extend the end date on your authorization.

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

Cenpatico Appeals
PO Box 6000
Farmington, MO 63640-3809

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

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

National Provider Identifier (NPI)

Cenpatico requires all claims be submitted with a Network Provider's National Provider Identifier (NPI). This will be required on all electronic and paper claims. Network Providers/ Supervisors must ensure Cenpatico has their correct NPI Number loaded in their system profile. Typically, each Network Practitioner's NPI Number is captured through the credentialing process. The Network Provider or their Supervisor must be on file with the IHCP as participating in Indiana Medicaid for claims to be accepted and adjudicated by Cenpatico. 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 NPI toll-free at 800-465-3203.

Submitting Your NPI to Cenpatico

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

CMS 1500 (8/05) Claim Form Instructions

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

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

CMS 1500 Claim Form

The image shows a scan of the CMS 1500 Claim Form. Blue circles are placed over the following fields: 1 (Insurance Program Identification), 1a (Insured's I.D. Number), 2 (Patient's Name), 3 (Patient's Birth Date and Sex), 4 (Insured's Name), 5 (Patient's Address), 6 (Patient Relationship to Insured), 7 (Insured's Address), and 8 (Patient Status). The form is divided into several sections: Insurance Program Identification (1), Insured's I.D. Number (1a), Patient's Name (2), Patient's Birth Date and Sex (3), Insured's Name (4), Patient's Address (5), Patient Relationship to Insured (6), Insured's Address (7), and Patient Status (8). There are also checkboxes for various insurance programs like Medicare, Medicaid, Tricare, etc.

Field #	Field Description	Instructions or Comments	Required or Conditional
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other.	Not Required
1a	Insured I.D. Number	The 10-digit Medicaid identification number on the member's Cenpatico I.D. card.	R
2	Patient's Name (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Cenpatico I.D. card. Do not use nicknames.	R
3	Patient's Birth Date / Sex	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M=male, F=female	R
4	Insured's Name	Enter the patient's name as it appears on the member's Cenpatico I.D. card.	R

5	Patient's Address (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. <ul style="list-style-type: none"> • First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Second line – In the designated block, enter the city and state. • Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1. 	R
6	Patient's Relation to Insured	Always mark to indicate self.	C
7	Insured's Address (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. <ul style="list-style-type: none"> • First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Second line – In the designated block, enter the city and state. • Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1. 	Not Required
8	Patient Status		Not Required

CMS 1500 Claim Form

PICA		PICA	
1. MEDICARE 1 MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER		1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2		3. PATIENT'S BIRTH DATE SEX 3	
5. PATIENT'S ADDRESS (No., Street) 5		6. PATIENT RELATIONSHIP TO INSURED 6	
CITY STATE 8		7. INSURED'S ADDRESS (No., Street) 7	
ZIP CODE TELEPHONE (Include Area Code) 8		CITY STATE	
		ZIP CODE TELEPHONE (Include Area Code)	
		Employed Full-Time Student Part-Time Student	

Field #	Field Description	Instructions or Comments	Required or Conditional
9	Other Insured's Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured. NOTE: COB claims that require attached EOBs must be submitted on paper.	C
9a	*Other Insured's Policy or Group Number	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	Other Insured's Birth Date/ Sex	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate sex/gender. M=male, F=female for the person listed in box 9.	C
9c	Employer's Name or School Name	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	Insurance Plan Name or Program Name	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	Is Patient's Condition Related To	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	Reserved For Local Use		Not Required
11	Insured's Policy Group or Feca Number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	Insured's Date of Birth/ Sex	Same as field 3.	C
11b	Employer's Name or School Name	REQUIRED if Employment is marked Yes in box 10a.	C
11c	Insurance Plan Name or Program Name	Enter name of the insurance Health Plan or program.	C
11d	Is There Another Health Benefit Plan	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the Member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required

13	Patient's or Authorized Person's Signature		Not Required.
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CMS 1500 Claim Form

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

Field #	Field Description	Instructions or Comments	Required or Conditional
14	Date of Current : Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date reflecting the first date of onset for the: <ul style="list-style-type: none"> • Present Illness • Injury • LMP (last menstrual period) if pregnant 	C
15	If Patient Has Same or Similar Illness. Give First Date.		Not Required
16	Dates Patient Unable to Work in Current Occupation		Not Required
17	Name of Referring Physician or Other Source	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	C
17a	ID Number of Referring Physician	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI Number of Referring Physician	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization Dates Related to Current Services		Not Required
19	Reserved For Local Use		Not Required
20	Outside Lab/Charges		Not Required

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

CMS 1500 Claim Form

Field #	Field Description	Instructions or Comments	Required or Conditional
24A-J General Information	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.	<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	The shaded top portion of each service claim line is used to report supplemental information for: <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. For detailed instructions and qualifiers refer to Appendix 4 of this manual.	C
24A Un-shaded	Date(s) of Service	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.	R
24B Un-shaded	Place of Service	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	R
24C Un-shaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	R

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

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

CMS 1500 Claim Form

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

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

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

UB-04 Claim Form Instructions

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

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

CMS 1500 Claim Form

The diagram shows the CMS 1500 Claim Form with numbered callouts:

- 1**: Points to the insurance type selection area (Medicare, Medicaid, Tricare, etc.).
- 2**: Points to the Patient's Name field.
- 3**: Points to the Patient's Birth Date field.
- 4**: Points to the Insured's Name field.
- 5**: Points to the Patient's Address field.
- 6**: Points to the Patient Relationship to Insured field.
- 7**: Points to the Insured's Address field.
- 8**: Points to the Patient Status field.

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

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

12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims.	R																								
13	Admission Hour	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.</p> <table border="1"> <tr> <td>00- 12:00 midnight to 12:59</td> <td>12- 12:00 noon to 12:59</td> </tr> <tr> <td>01- 01:00 to 01:59</td> <td>13- 01:00 to 01:59</td> </tr> <tr> <td>02- 02:00 to 02:59</td> <td>14- 02:00 to 02:59</td> </tr> <tr> <td>03- 03:00 to 03:39</td> <td>15- 03:00 to 03:59</td> </tr> <tr> <td>04- 04:00 to 04:59</td> <td>16- 04:00 to 04:59</td> </tr> <tr> <td>05- 05:00 to 05:59</td> <td>17- 05:00 to 05:59</td> </tr> <tr> <td>06- 06:00 to 06:59</td> <td>18- 06:00 to 06:59</td> </tr> <tr> <td>07- 07:00 to 07:59</td> <td>19- 07:00 to 07:59</td> </tr> <tr> <td>08- 08:00 to 08:59</td> <td>20- 08:00 to 08:59</td> </tr> <tr> <td>09- 09:00 to 09:59</td> <td>21- 09:00 to 09:59</td> </tr> <tr> <td>10- 10:00 to 10:59</td> <td>22- 10:00 to 10:59</td> </tr> <tr> <td>11- 11:00 to 11:59</td> <td>23- 11:00 to 11:59</td> </tr> </table>	00- 12:00 midnight to 12:59	12- 12:00 noon to 12:59	01- 01:00 to 01:59	13- 01:00 to 01:59	02- 02:00 to 02:59	14- 02:00 to 02:59	03- 03:00 to 03:39	15- 03:00 to 03:59	04- 04:00 to 04:59	16- 04:00 to 04:59	05- 05:00 to 05:59	17- 05:00 to 05:59	06- 06:00 to 06:59	18- 06:00 to 06:59	07- 07:00 to 07:59	19- 07:00 to 07:59	08- 08:00 to 08:59	20- 08:00 to 08:59	09- 09:00 to 09:59	21- 09:00 to 09:59	10- 10:00 to 10:59	22- 10:00 to 10:59	11- 11:00 to 11:59	23- 11:00 to 11:59	R
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14	Admission Type	<p>REQUIRED for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes:</p> <p>1 Emergency 2 Urgent 3 Elective 4 Newborn</p>	C																								
15	Admission Source	<p>Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes:</p> <p>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</p>	R																								

16	Discharge Hour	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.</p> <table border="1" data-bbox="443 178 1247 720"> <tr> <td>00-12:00 midnight to 12:59</td> <td>12- 12:00 noon to 12:59</td> </tr> <tr> <td>01- 01:00 to 01:59</td> <td>13- 01:00 to 01:59</td> </tr> <tr> <td>02- 02:00 to 02:59</td> <td>14- 02:00 to 02:59</td> </tr> <tr> <td>03- 03:00 to 03:39</td> <td>15- 03:00 to 03:59</td> </tr> <tr> <td>04- 04:00 to 04:59</td> <td>16- 04:00 to 04:59</td> </tr> <tr> <td>05- 05:00 to 05:59</td> <td>17- 05:00 to 05:59</td> </tr> <tr> <td>06- 06:00 to 06:59</td> <td>18- 06:00 to 06:59</td> </tr> <tr> <td>07- 07:00 to 07:59</td> <td>19- 07:00 to 07:59</td> </tr> <tr> <td>08- 08:00 to 08:59</td> <td>20- 08:00 to 08:59</td> </tr> <tr> <td>09- 09:00 to 09:59</td> <td>21- 09:00 to 09:59</td> </tr> <tr> <td>10- 10:00 to 10:59</td> <td>22- 10:00 to 10:59</td> </tr> <tr> <td>11- 11:00 to 11:59</td> <td>23- 11:00 to 11:59</td> </tr> </table>	00-12:00 midnight to 12:59	12- 12:00 noon to 12:59	01- 01:00 to 01:59	13- 01:00 to 01:59	02- 02:00 to 02:59	14- 02:00 to 02:59	03- 03:00 to 03:39	15- 03:00 to 03:59	04- 04:00 to 04:59	16- 04:00 to 04:59	05- 05:00 to 05:59	17- 05:00 to 05:59	06- 06:00 to 06:59	18- 06:00 to 06:59	07- 07:00 to 07:59	19- 07:00 to 07:59	08- 08:00 to 08:59	20- 08:00 to 08:59	09- 09:00 to 09:59	21- 09:00 to 09:59	10- 10:00 to 10:59	22- 10:00 to 10:59	11- 11:00 to 11:59	23- 11:00 to 11:59	Not Required						
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17	Patient Status	<p>REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes:</p> <table border="1" data-bbox="443 856 1252 1682"> <thead> <tr> <th>Status</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Discharged to home or self care</td> </tr> <tr> <td>02</td> <td>Transferred to another short-term general hospital</td> </tr> <tr> <td>03</td> <td>Transferred to a SNF</td> </tr> <tr> <td>04</td> <td>Transferred to an ICF</td> </tr> <tr> <td>05</td> <td>Transferred to another type of institution</td> </tr> <tr> <td>06</td> <td>Discharged home to care of home health</td> </tr> <tr> <td>07</td> <td>Left against medical advice</td> </tr> <tr> <td>08</td> <td>Discharged home under the care of a Home IV provider</td> </tr> <tr> <td>20</td> <td>Expired</td> </tr> <tr> <td>30</td> <td>Still patient or expected to return for outpatient services</td> </tr> <tr> <td>31</td> <td>Still patient – SNF administrative days</td> </tr> <tr> <td>32</td> <td>Still patient – ICF administrative days</td> </tr> <tr> <td>62</td> <td>Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital</td> </tr> <tr> <td>65</td> <td>Discharged/Transferred to a psychiatric hospital or distinct psychiatric unit of a hospital</td> </tr> </tbody> </table>	Status	Description	01	Discharged to home or self care	02	Transferred to another short-term general hospital	03	Transferred to a SNF	04	Transferred to an ICF	05	Transferred to another type of institution	06	Discharged home to care of home health	07	Left against medical advice	08	Discharged home under the care of a Home IV provider	20	Expired	30	Still patient or expected to return for outpatient services	31	Still patient – SNF administrative days	32	Still patient – ICF administrative days	62	Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital	65	Discharged/Transferred to a psychiatric hospital or distinct psychiatric unit of a hospital	C
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18-28	Condition Codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	Accident State		Not Required
30	(Unlabeled Field)	Not Used	Not Required

CMS 1500 Claim Form

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

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

CMS 1500 Claim Form

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

CMS 1500 Claim Form

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

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

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

CMS 1500 Claim Form

PICA		PICA	
1. MEDICARE 1 <input type="checkbox"/> (Medicare #)		MEDICAID 1 <input type="checkbox"/> (Medicaid #)	
TRICARE 1 CHAMPVA 1 GROUP HEALTH PLAN 1 FECA 1 BULKING 1 OTHER 1		1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2		3. PATIENT'S BIRTH DATE 3 MM DD	
5. PATIENT'S ADDRESS (No., Street) 5		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 4	
CITY 5		6. PATIENT RELATIONSHIP TO INSURED 6 Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
STATE 5		7. INSURED'S ADDRESS (No., Street) 7	
8. PATIENT STATUS 8 Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY 7	
ZIP CODE 8		STATE 7	
TELEPHONE (Include Area Code) 8 ()		TELEPHONE (Include Area Code) 7 ()	

Field #	Field Description	Instructions or Comments	Required or Conditional*
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

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

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:

Managed Health Services
1099 N Meridian St, Ste 400
Indianapolis, IN 46204
877-647-4848