

Cenpatico Provider Manual

State of Texas



**Lubbock Service Area
El Paso Service Area
Travis Service Area**

**Bexar Service Area
Nueces Service Area**

**STAR Program
CHIP Program
CHIP RSA Program
STAR+PLUS Program**

**800-716-5650
888-471-4357
800-213-9927
800-466-4089**

www.cenpatico.com

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Welcome To Cenpatico

Welcome to the 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 Texas.

The Cenpatico 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 Texas.

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/Practitioners 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 Texas Providers/Practitioners on our website including this Manual, provider forms, etc.

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

About Cenpatico

Our Mission

We will be the market leader promoting innovative care delivered by passionate people to enhance the quality of life in our communities, one person at a time.

Our Vision

Cenpatico provides quality, cost-effective behavioral health services and products to members, employers, schools, health plans and medical groups. We earn our customers' trust by ensuring satisfaction with the outcome of every contact with Cenpatico: our products, services and people.

Our Values

QUALITY – We provide quality services, in all aspects of our business. We value doing the right thing at the right time, the first time.

INTEGRITY – We work with our members, customers, vendors and employees honestly, reliably and fairly.

CUSTOMER SERVICE – We take pride in satisfying and exceeding our customers' expectations.

History and Structure of Cenpatico

Since 2003, we have been doing business in all of our markets through our Cenpatico entity.

However, our members in Texas have only known us as IMHS, which is our legal name.

IMHS was incorporated in Texas in 1996 as a not-for-profit corporation and licensed as a Utilization Review Agent. IMHS is a membership-run organization whose sole member is Integrated Mental Health Management, LLC (IMHM). The sole member of IMHM, LLC is Cenpatico Behavioral Health, LLC. In 2011, we began doing business as Cenpatico in all markets, including Texas. We encourage our provider network to access www.cenpatico.com frequently to obtain important and helpful information about Cenpatico and the procedures pertinent to our provider network.

An integral part of the Cenpatico core philosophy is our belief that quality behavioral healthcare is best delivered locally. Cenpatico is a clinically driven organization that is committed to building collaborative partnerships with providers/practitioners.

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 STAR Health. Cenpatico provides these services through a comprehensive provider network of qualified behavioral health clinicians, facilities, and community mental health centers.

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

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.

Providing the highest quality and most appropriate level of care for our members often involves the use and disclosure of private and confidential information. At Cenpatico, we take privacy and confidentiality seriously. We have processes, policies and procedures to comply with applicable federal and state regulatory privacy and confidentiality requirements.

We appreciate your partnership with Cenpatico in complying not only with the privacy and confidentiality requirements but with all applicable federal and state regulatory requirements and standards and in constantly maintaining the highest quality and most appropriate level of care for our members.

Superior contracts with the Texas Health and Human Services Commission (HHSC) to provide services to STAR, STAR+PLUS and CHIP members. Superior Health Plan (SHP) provides and coordinates services to members in designated service delivery areas (defined on page 9). SHP is designed to provide four main objectives. The objectives are:

- Improved access to care
- Improved quality of care
- Improved Member health status
- Improved Member and Provider satisfaction



Cenpatico Provider Quick Reference Guide

Cenpatico Important Phone Numbers

Prior-Authorization:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927
Claims Customer Service	877-730-2117
Network Development/Provider Relations	877-264-6550
Appeals/ Complaints	800-716-5650

Cenpatico Important Fax Numbers

Utilization Management (Submitting an OTR)	866-694-3649
Quality Management/Critical Incident Reports	866-694-3649
Complaints	866-704-3063
Network Management	866-739-3424
Credentialing	866-694-3735

Verifying Member Eligibility

Cenpatico Website.....www.cenpatico.com
(You must have a provider log-in to access eligibility online)

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

Cenpatico Website

www.cenpatico.com

Claims Address (STAR & CHIP)

Cenpatico Claims
PO Box 6300
Farmington, MO 63640-3818

HealthPlan Contact Information
Superior Health Plan
800-218-7453

The Cenpatico Provider Network

Cenpatico Service Area

Cenpatico manages STAR and CHIP behavioral health benefits for Members in the following Texas service delivery areas: Bexar, El Paso, Lubbock, Nueces, and Travis. Cenpatico also manages the Medicaid STAR+PLUS behavioral health benefits for Members in the Bexar and Nueces service delivery areas.

RSA Behavioral Health Services

Superior HealthPlan Network is contracted with the Texas Health and Human Services Commission to administer the CHIP Rural Service Area (RSA) throughout the State, in 170 predominantly rural counties in Texas. Superior HealthPlan Network contracts with Cenpatico to provide behavioral health utilization management services for Superior CHIP RSA Members. CHIP RSA benefits are identical to that of CHIP HMO Members. All services including pre-authorization related to behavioral health must be coordinated through Cenpatico.

FOR CHIP RSA PRE-AUTHORIZATION REQUESTS, PLEASE CALL 800.213.9927.

Network Provider/Practitioner 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 HMO covered benefits and utilization. Network Practitioners should support a brief, solution-focused approach to treatment. Network Practitioners should be engaged with a collaborative approach to the treatment of Cenpatico members.

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

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

In addition to hospitals and behavioral health/substance abuse agencies, Cenpatico also contracts with clinically licensed behavioral health practitioners, including psychiatrists, psychologists, licensed psychological associates (LPA), 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.

Cenpatico provides a network of behavioral health and substance abuse treatment providers. As times, the Cenpatico network is limited where providers are affiliated with an established physician group associated with a hospital. Certain mid-level clinicians, associated with a Residential Treatment Center (RTC) may be limited to providing services only within the RTC facility.

Cenpatico maintains an open network; however, at the point Cenpatico determines that accessibility standards in a service area have been met or exceeded the network will be closed until such time that a need to enhance the network is identified.

The Network Practitioner's Office

Cenpatico reserves the right to conduct Network Provider/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 the office must be visible.
- Office must be clean, and free of clutter with unobstructed passageways.
- Office must have a separate waiting area with adequate seating.
- Clean restrooms must be available.
- Office environment must be physically safe.
- Network Practitioners must have a professional and fully-confidential telephone line and twenty-four (24) hour availability.
- Member records and other confidential information must be locked up and out of sight during the work day.
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

Credentialing

Credentialing Requirements

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

Cenpatico Network Providers/Practitioners must adhere to the following requirements;

- In order to continue participation with our organization, all Network Providers/Practitioners must adhere to Cenpatico's Clinical Practice Guidelines and Medical Necessity Criteria which are located in this Manual.
- Network Providers/Practitioners must consistently meet our credentialing standards and Cenpatico guidelines on Primary Care Physician (PCP) notification.
- Failure to adhere to guidelines and standards at any time can lead to termination from our network.
- Notification is required immediately upon receipt of revocation or suspension of the Network Provider's/Practitioner'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 Texas.
- 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.
- Physician Assistants and Nurse Practitioners should have an independent relationship with a supervising physician or under direct personal supervision of the attending physician.
- Network Practitioner's graduate degrees must be from an accredited institution.
- All Network Practitioners are subject to the completion of primary source verification through our Credentialing Department located in Austin, Texas.
- The Network Practitioner agrees to complete and provide appropriate documentation for this primary source verification in a timely manner.
- The Network Provider/Practitioner further agrees to provide all documentation in a timely manner required for credentialing and/or re-credentialing.
- The Network Provider/Practitioner agrees to maintain adequate professional liability insurance as set forth in the Facility/Practitioner Agreement with Cenpatico.

- All credentialing applications are subject to consideration and review by the Cenpatico Credentialing Committee which meets monthly.

Texas Legislative Bill No. 1594

Applies only to a practitioner who joins an established medical group that has a current contract in force with Cenpatico

ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under bill 1594, an applicant physician must:

- (1) be licensed in the state of Texas, and in good standing with, the Texas Medical Board; and
- (2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a physician in the issuer's health benefit plan network.

All practitioners, including physicians, must submit at a minimum the following information when applying for participation with Cenpatico:

- Complete signed and dated Texas 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 Texas regulations regarding malpractice coverage.
- Copy of current Texas Controlled Substance registration certificate (if applicable).
- 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 Texas.
- 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 practitioners' unique National Provider Identifier (NPI).

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

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

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

It is the Network Provider's/Practitioner's responsibility to notify Cenpatico of any of the following within ten (10) days of the occurrence:

- Any lawsuits related to professional role
- Licensing board actions
- Malpractice claims or arbitration
- Disciplinary actions before a State agency and Medicaid/Medicare sanctions
- Cancellation or material modification of professional liability insurance
- Member complaints against practitioner
- Any situation that would impact a Network 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.

Network Providers/Practitioners are subject to an on-site visit at any time with or without cause.

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

Re-Credentialing Requirements

Cenpatico Network Providers/Practitioners will be re-credentialed every three (3) years as required by the State of Texas. Cenpatico Network Providers/Practitioners 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 are included in the re-credentialing process. Examples of quality indicators are: complaints, appointment availability, critical incidents, and compliance with discharge appointment reporting.

Cenpatico Credentialing Policies and Procedures

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

- Formal delegation and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of Network Practitioners 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/Practitioners and imposition of sanctions, termination, suspension and restrictions on existing Network Providers/Practitioners;
- Identification of quality deficiencies which result in Cenpatico'ss restriction, suspension, termination or sanctioning of a Network Provider/Practitioner; and
- A process to implement an appeal procedure for Network Providers/Practitioners whom Cenpatico has terminated.

Right to Review and Correct Information

All practitioners 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 Texas 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/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 the 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/re-credentialing process.

Network Practitioner Demographic/Information Updates

Network Providers/Practitioners should advise Cenpatico with as much advance notice as possible for demographic/information updates. Network Providers/Practitioners information

such as address, phone and office hours are used in our Provider Directory and having the most current information accurately reflects our Texas provider network. Please use the Cenpatico Provider Information Update Form located on line at www.cenpatico.com to provide your information to Cenpatico.

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

Fax: (866) 694-3735

Email: Provider_Change-cbh-tx@centene.com

Mail: Cenpatico

Attn: IPR Unit- Texas

504 Lavaca St., Ste. 850

Austin, TX 78701

Network Provider/Practitioner Termination

Network Provider/Practitioner Request to Terminate

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

Cenpatico fully recognizes that a change in a Network Provider's/Practitioner's participation status in Cenpatico's provider network is difficult for members. Cenpatico will work closely with the terminating Network Provider/Practitioner to address the member's needs and ensure a smooth transition as necessary. A Network Provider/Practitioner who terminates his/her contract with Cenpatico must notify all Superior HealthPlan members who are currently in care at the time and who have been in care with that Network Provider/Practitioner during the previous six (6) months. Treatment with these members must be completed or transferred to another Cenpatico Network Provider/Practitioner within three (3) months of the notice of termination, unless otherwise mandated by State law. The Network Provider/Practitioner 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/Practitioner upon the occurrence of any of the following events:

- Termination of Cenpatico's obligation to provide or arrange mental health/substance abuse treatment services for members of health plans;
- Restriction, qualification, suspension or revocation of Network Provider's/Practitioner's license, certification or membership on the active medical staff of a hospital or Cenpatico participating practitioner group;
- Network Provider's/Practitioner's loss of liability insurance required under the Practitioner Agreement with Cenpatico
- Network Provider's/Practitioner's exclusion from participation in Cenpatico programs;
- Network Provider's/Practitioner's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's/Practitioner's insolvency or bankruptcy or Provider's and/or Practitioner's assignment for the benefit of creditors;
- Network Provider's/Practitioner's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;

- Network Provider's/Practitioner's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Provider's/Practitioner's submission of false or misleading billing information;
- Network Provider's/Practitioner's failure or inability to meet and maintain full credentialing status with Cenpatico;
- Network Provider's/Practitioner'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 Provider's/Practitioner's may be delivering clinically inappropriate care; or
- Network Provider's/Practitioner's breach of Cenpatico Policies and Procedures.

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

Right to Appeal Adverse Credentialing Determinations

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

If a participating Network Provider/Practitioner has been suspended or terminated by Cenpatico, he/she may contact the Cenpatico Provider Relations department at 800-716-5650 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/Practitioner should send a written reconsideration request to Cenpatico to the attention of the Credentialing Department:

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 related to clinical issues. Details of the Provider Dispute Policy will be provided to the Network Provider/Practitioner with the notification of suspension/termination of clinical privileges. To request a copy of

Cenpatico's Provider Dispute Policy, please contact the Quality Improvement Department at 800-716-5650.

Each Network Provider/Practitioner will be provided with a copy of their fully-executed Practitioner Agreement with Cenpatico. The Practitioner Agreement will indicate the Network Provider's/Practitioner'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/termination policies. There is no "right to appeal" when either party chooses not to renew the Practitioner Agreement.

Status Change Notification

Network Provider/Practitioner 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/Practitioner'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: Cenpatico Provider Relations
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 800-716-5650

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.

Texas Health Steps Services

Texas Health Steps is a comprehensive preventive care program that combines diagnostic screenings, communication and outreach, and medically necessary follow-up care, including dental, vision and hearing examinations, for Medicaid-eligible children under the age of 21. Superior is committed to the wellness of each Member and encourages Practitioners to follow the steps outlined in this section when providing preventive health services to Superior Members.

Superior is responsible for facilitating all covered services as described in the Texas Medicaid Provider Procedures Manual, per the terms of the Superior contract with the Texas Health and Human Services Commission. Texas Health Steps Practitioners should also refer to the Texas Medicaid Provider Procedures Manual and the Texas Medicaid Service Delivery Guide for a description of all components of the medical exam. Refer to bi-monthly Medicaid Bulletins for up to date information on Texas Health Steps.

Children of Migrant Farm workers

Children of Migrant Farmworkers due for a Texas Health Steps medical check up can receive their periodic check up on an accelerated basis prior to leaving the area. A check up performed under this circumstance is considered an exception to periodicity.

Performing a make-up exam for a late Texas Health Steps medical check up previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late check up.

Network Provider/Practitioner Concerns

Network Providers/Practitioners who have concerns about Cenpatico should contact the Cenpatico Provider Relations Department at 800-716-5650 to register these complaints. All concerns are investigated, and written resolution is provided to the Network Providers/Practitioners on a timely basis.

Member Concerns about Network Providers/Practitioners

Members who have concerns about Cenpatico Network Providers/Practitioners 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/Practitioner'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/Practitioner 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/Practitioner. It includes, but is not limited to; injuries to members or member advocates, suicide/homicide attempt by a member while in treatment, death due to suicide/homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

The Critical Incident Report is located on line at www.cenpatico.com and must be used to document critical incidents. Submit completed Critical Incident Reports to the following address:
Cenpatico

Attn: Quality Improvement Department
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 800-716-5650
Fax: 866-704-3063

No Show Appointments

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

Session Debits for No Show Appointments

A no show appointment may never be applied against a benefit maximum.

Fees for No Show Appointments – HMO Members

- STAR, STAR+PLUS, and CHIP 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/Practitioners and will provide access to training and tool-kits to assist our Network Providers/Practitioners in developing culturally competent and culturally proficient practices.

Network Providers/Practitioners must ensure the following:

- Members understand that they have access to medical interpreters, signers, and Relay services to facilitate communication without cost to them.
- Care is provided with consideration of the members’ race/ ethnicity and language and its impact/ influence of the members’ health or illness.
- Office staff that routinely come in contact with members have access to and participate in cultural competency training and development.
- 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 minorities are treated differently. Research also indicates that a person has better health outcomes when they experience culturally appropriate interactions with medical practitioners. 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/Practitioners should note that the experience of a member begins at the front door.

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

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

Preparing Cultural Competency Development

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

Take the following into consideration when you provide services to 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 members face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Members are more likely to experience long wait times to see healthcare practitioners.
- Members are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.
- Health disparities come at a personal and societal price.

Advance Directives

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

Network Providers/Practitioners 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/Practitioners 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/Practitioner should discuss potential emergencies with the member and/ or family members (if named in the Advance Directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives.

- If the member requests further information, member Advance Directive education/information should be provided.

Cenpatico's Quality Improvement Department will monitor compliance with this provision during site visits and when assessing compliance with Medical Record Guidelines.

Access and Coordination of Care

Provider/Practitioner Access Standards

All Superior HealthPlan members may access behavioral health and substance abuse services through several mechanisms. Members do not need a referral from their Primary Care Physician (PCP) to access covered behavioral health and substance abuse services; however, if the PCP thinks a referral to behavioral health or substance abuse services is indicated one should be made. Caregivers or medical consenters may self-refer members for behavioral health services. If assessment is required, Cenpatico must approve the assessment.

Cenpatico adheres to National Commission for Quality Assurance (NCQA) and State accessibility standards for member appointments. Network Providers/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 twenty-four (24) hours or could be treated in a less acute setting	Within ten (10) business days, unless requested earlier by DFPS
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 pre-certification.	Within twenty-four (24) hours for services that are urgent
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.
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/Practitioners 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/Practitioners 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/Practitioners should call the Cenpatico Provider Relations department at 800-716-5650 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/Practitioner's status will be considered in the re-credentialing process.

Outpatient Behavioral Health Service Provider/Practitioner Access

At a minimum, Cenpatico ensures that members with behavioral health coverage have access to an outpatient Behavioral Health Service Practitioner in the Network within 75 miles of the Member's residence. Outpatient Behavioral Health Service Practitioners must include Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient hospital departments. A Qualified Mental Health Provider (QMHP), as defined and credentialed by the Texas Department of State Health Services standards (T.A.C Title 25, Part I, Chapter 412), is an acceptable outpatient practitioner as long as the QMHP is working under the authority of an MHMR entity and is supervised by a licensed mental health professional or physician.

Hospital Access

Cenpatico ensures that all Members have access to an Acute Psychiatric Care Hospital in the Provider Network within 30 miles of the Member's residence.

Consent for Disclosure

Cenpatico recognizes communication as the link that unites all the service components and a key element in any program's success. To further this objective, Network Providers/Practitioners 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 practitioner.

If the member refuses to release the information, the Network Practitioner 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 form for release of information has been signed by the member, and for those agreeing to disclosure, that regular reports are being sent to the primary care practitioner (PCP) or other behavioral health practitioners.

Coordination between Superior HealthPlan and Cenpatico

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

In addition, Cenpatico works to educate and assist physical health and behavioral health practitioners in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Superior HealthPlan on a monthly basis, and is shared with Superior'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.

Coordination between Cenpatico and the Local Mental Health Authority

The delivery of high quality care involves the ability to provide care that coincides with the needs of the Member. Cenpatico has formal coordination arrangements with Local Mental Health Authorities (LMHA) to ensure coordination of care for all Members and the delivery of quality services to Superior Members.

Coordination for Services Not Directly Provided through Superior or Cenpatico

There are several services that are available to Superior Members based on their STAR/STAR+PLUS or CHIP eligibility. The services listed in the following are accessed outside of the Superior or Cenpatico network, and are not part of the STAR/STAR+PLUS or CHIP managed care programs.

- Mental Health Rehabilitation
- Texas Health Steps Dental (STAR)
- Early Childhood Intervention (ECI) Case Management/Service Coordination
- MHMR Targeted Case Management
- Pregnant Women and Infants Case Management (PWI)
- Texas Health Steps Medical Case Management
- Texas School Health and Related Services (SHARS)
- Texas Commission for the Blind (TCB) Case Management
- Tuberculosis (TB) Services Provided by DSHS-Approved Providers (Directly Observed Therapy and Contact Investigation)
- Women, Infants and Children nutrition program (WIC)
- Texas Agency Administered Programs and Case Management Services
- Vendor Drug Program (for prescription drugs not supplied in the practitioner's office or hospital setting)
- Medical Transportation Program (MTP) through the Texas Department of Transportation
- DADS Hospice Services
- Essential Public Health Services
- Day Activity and Health Services
- Personal Assistance Services

- 1915 (c) Nursing Facility Waiver Services

All network practitioners are encouraged to refer to and coordinate services with the above agencies. Please refer to the current DADS Provider Manuals for a more inclusive listing of limitations and exclusions that apply to each benefit category. If more information or assistance is required, contact Superior's Member Services at 1-800-783-5386.

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/Practitioners and services, credentialing, utilization, member satisfaction, Network Provider/Practitioner satisfaction, PCP communications, and administrative office operations, as well as Superior's Quality Improvement Program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

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

Monitoring Clinical Quality

What does Cenpatico monitor?

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

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

How does Cenpatico monitor quality?

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

- Provider satisfaction surveys;
- Medical treatment record reviews;
- Complaint investigation and trending;
- Review of potential over- and under-utilization;

- Member Satisfaction Surveys;
- Outcome tracking of treatment evaluations;
- Access to care reviews;
- Appointment availability;
- Discharge follow-up after inpatient or partial hospitalization reporting;
- Crisis Response;
- Monitoring appropriate care and service; and
- Provider/Practitioner quality profiling

Findings are communicated to individual Network Practitioners 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. Findings are considered during the re-credentialing process.

Network Provider/Practitioner Participation in the QI Process

Cenpatico's Network Providers/Practitioners are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided. Network Providers/Practitioners are expected to meet Cenpatico's performance requirements and ensure member treatment is efficient and effective by:

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

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

Preventative Behavioral Health Programs

Cenpatico offers preventative behavioral health programs for our members. A brief description of the programs including who is eligible to participate is listed below. You can refer your members to the programs directly when you see an unmet need. If you would like more information about the programs or if you have suggestions as to how we can improve our preventative behavioral health programs please contact the Quality Improvement department at 512-406-7200.

The Perinatal 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 days of discharge. When they do, they receive a Build-a-Bear and a book called My Feelings and the parents receive a gift card for Wal-Mart.

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

Primary Care Provider (PCP)

The PCP is the cornerstone of Superior HealthPlan. The PCP serves as the “medical home” for the patient. The “medical home” concept should assist in establishing a Member/Provider relationship and ultimately better health outcomes. The PCP is responsible for the provision of all primary care services for Superior's Members. In addition, the PCPs are responsible for calling in needed referrals and/or authorization for specialty services to Superior network Providers.

Coordination between Behavioral Health and Physical Health Services

Superior HealthPlan and Cenpatico encourage primary care physicians (PCPs) to consult with their members' mental health Network Practitioners. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Facilities and Practitioners should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required. Behavioral Health Services are covered services for the treatment of mental or emotional disorders and for the treatment of chemical dependency disorders.

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

- Prescription medication
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.

- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse).
- The member's progress toward meeting the goals established in their treatment plan.

A form to be used in communicating with the PCP and other behavioral health practitioners is included for your review on line at www.cenpatico.com. Network Practitioners can identify the name and number for a member's PCP on the front-side of the Member ID Card.

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 PCP for examination and treatment.

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

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

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

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

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

PCPs may provide behavioral health related services within the scope of their practice. PCPs can also reference Cenpatico's behavioral health assessment tool online at www.cenpatico.com to assist in making appropriate referrals. Members have a right to select and have access to, without a PCP referral, an in-Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery.

Superior HealthPlan allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not.

ATTENTION FEMALE MEMBERS

You have a right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

- One well-woman check-up per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to Specialist within the network

Long Term Services and Support (LTSS) Provider Responsibilities

Eligible populations for the STAR+PLUS Program

Mandatory

- SSI-eligibles over age 20
- Individuals over age 20 who are Medicaid eligible because they are in a Social Security
- Exclusion Program. Note: These individuals are considered MAO for purposes of 1915 (c) waiver eligibility.
- Dual Eligibles are those individuals who are covered by both Medicare and Medicaid. Federal and State Law require Medicaid (STAR, STAR+PLUS) be the payor of last resort. Any other insurance, including Medicare, is always primary to Medicaid coverage.

Voluntary

1. SSI-eligible children (under age 21)
2. Children (under age 21) who are Medicaid eligible because they are in a Social Security Exclusion Program.

Excluded

The following types of Medicaid-eligible individuals are excluded from participation in the STAR+PLUS program:

1. Persons in institutional settings
 - a. Eligibles residing in a nursing facility
 - b. Residents of Intermediate Care Facilities for the Mentally Retarded (ICFMH)
 - c. Residents of Institutions of Mental Disease or State Hospitals
2. Persons enrolled in a waiver program other than the 1915 (c) Nursing Facility Waiver program:
 - a. Community Living Assistance and Support Services
 - b. Medically Dependent Children's Waiver
 - c. Home and Community Services Waiver
 - d. Deaf Blind Multiple Disability Waiver
 - e. Consolidated Waiver Program
 - f. Individuals not eligible for full Medicaid benefits (e.g., Frail Elderly program, QMB, SLMB, QDWI, undocumented immigrants);
 - g. Individuals receiving long term care services through non-Medicaid funded programs;
 - h. Individuals who are diagnosed with End Stage Renal Disease (ESRD) (except those in the STAR+PLUS 1915 (c) Waiver);

- i. Individuals who are ventilator dependent (except those in the STAR+PLUS 1915 (c) Waiver)

Members will be provided a Superior HealthPlan Member ID card (Attachment 4-D). The Primary Care Physician name and telephone will be listed on the card along with the effective date (excluding dual eligibles that are not required to select a primary care practitioner).

Long Term Services and Support (LTSS) Providers for STAR+PLUS Members

The Long Term Services and Support Providers partner with Superior HealthPlan to deliver care to members. A key component of the LTSS Provider's responsibility is to maintain ongoing communication with the member's PCP.

Key Information

- Verify member eligibility before performing services.
- Ensure necessary Referral/Authorizations have been obtained prior to provision of services.
- Use the HHSC-issued API when filing claims for LTSS services to members.
- Bill and report long term services and support (LTSS) in compliance with the LTSS HCPC Codes and STAR+PLUS Modifiers Matrix.
- Notify the plan whenever there is a change in the member's physical or mental condition and a change in their eligibility.
- Ensure that there is ongoing continuity of care between the member's SHP Service Coordinator and their PCP.
- Ensure that for Members who are eligible for both Medicare and Medicaid, Medicare services are accessed first prior to Medicaid or 1915(c) waiver services
- Refer to the LTSS Bulletin posted on the Texas Medicaid Healthcare Partnership (TMHP) website (www.tmhp.com) for additional information and updates.

Who can serve as a Long Term Services and Support Provider?

- Personal Assistant Services (PAS)
- Day Activity and Health Services (DAHS)
- Adaptive aids and Medical Suppliers
- Assisted Living and Residential Care (ALRC) services
- Adult Foster Care (AFC) Providers
- Emergency Response Services
- Home Meal Delivery Providers
- In-Home Skilled Nursing Providers
- Minor Home Modification Providers
- Respite Care Service Providers
- Occupational, Physical and Speech Therapy Providers
- Transitional Assistance Service Providers
- Medical Supplies

Texas Department of Family and Protective Services

Behavioral health practitioners and/or physical health practitioners, who are treating a behavioral health condition, are responsible for appropriate referrals to the Texas Department of Family and Protective Services (TDFPS) for suspected or confirmed cases of abuse.

Cenpatico works with TDFPS to ensure that the at-risk members receive needed services. Children who are served by TDFPS may transition in and out of an Cenpatico Service Area rapidly, experiencing placements or reunification inside and out of the Service Area.

During the transition period for a child moving between custodians and beyond, practitioners must:

- Provide periodic written updates on treatment status of Members to TDFPS as required by TDFPS
- Participate, when requested by TDFPS, in planning to establish permanent homes for Members
- Refer suspected cases of abuse or neglect to TDFPS
- Participate in Superior’s training activities regarding TDFPS coordination
- Scheduling behavioral health appointments within 14 days unless requested earlier by TDFPS

For assistance with Members and TDFPS, practitioners should call Cenpatico at:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089

Case Management Services for Children with Special Health Care Needs (CSHCN)

- Covered Services are above and beyond those normally provided to all Members and include, but are not limited to:
- Outreach and informing--Includes discussion of Covered Services (including specialty services) with the family, the possibility of the family's right to select an in-network Specialist Physician as a PCP, out-of-network services applicable to the child’s condition if not available in-network, the availability of enhanced care coordination and community referrals
- Enhanced care coordination-- Includes responding to a family’s request for coordination activities or suggesting this service to the family where appropriate. Services are delivered at an administrative level and to facilitate overall care.
- Intensive case management--Trained case managers (nurses or social workers) who provide case management activities such as intake, assessment of services needed, and written documentation of individual plan specifying assistance with accessing services and periodic re-assessment.
- Community referral—Cenpatico and the Superior work to enlist and establish relationships with community organizations to promote improved referrals and service delivery to increase the health and well being of CHIP Members.

Emergency Transportation

Emergency Transportation by Ambulance is reimbursable with limitation to basic life support (BLS) ambulance services provided to Members in two situations:

- Emergency
- Non-emergency for the severely disabled.

EMERGENCY TRANSPORTATION DOES NOT REQUIRE PRIOR AUTHORIZATION

All out of State (air and ground) and non-emergent transports require prior authorization.

Request for transport for non-emergent transports must be made prior to provision of service. For prior authorization, contact Superior at:

Superior Medical Management/Care Management
1 (800) 218-7508

Medical Transportation Program (MTP) – STAR and STAR+PLUS Non-Emergency Transportation

The Texas Department of Health Medical Transportation Program (MTP) is designed to serve STAR/ STAR+PLUS patients that have no other means of transportation for medical and dental appointments. MTP will utilize the most cost-effective method of transportation that does not endanger a patient's health, to include an ambulance or wheelchair van.

To request medical transportation services, a Member should contact MTP at: 1-877-633-8747.

MTP's Intake Specialists are available to take requests by telephone on weekdays from 8:00 a.m. to 5:00 p.m. MTP requires at least two work days' advance notice for most requests but will attempt to accommodate urgent ones. Patients should call in their request as far in advance as possible.

Network Facility/Practitioner Treatment Requirements

Network Providers/Practitioners are required to:

- Refer members with known or suspected physical health problems or disorders to the member's PCP for examination and treatment;
- Only provide physical health services if such services are within the scope of the Network practitioner's clinical licensure;
- Network 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 Practitioners (those that participate in Superior

- HealthPlan or the Cenpatico provider networks), 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;
 - Network providers that are psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 agree to comply with all applicable legal requirements relating to restraint and seclusion.

Treatment Record 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 Multi-Axial 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 practitioners 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 practitioners 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 practitioner's experience with our delivery system.

Network Providers/Practitioners should call the Cenpatico Provider Relations department at 800-716-5650 to address concerns as they arise. Feedback from Network Providers/Practitioners enables Cenpatico to continuously improve systems, policies and procedures.

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

Network Provider/Practitioner Standards of Practice

Network Providers/Practitioners are requested to:

- Submit all documentation in a timely fashion;
- Comply with Cenpatico Care Management process;

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

Medical Records and Documentation

Medical records means the complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory test, results, examinations and notes, accessible at the site of the Member’s participating primary care physician or practitioner, that document all medical services perceived by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable rules and regulations, and signed by the medical professional rendering the services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Practitioners must keep accurate and complete medical records including documentation using the DMS-IV multi-axial classifications. Such records will enable practitioners to render the highest quality health care service to Members. They will also enable Cenpatico to review the quality and appropriateness of the services rendered. To ensure the Member’s privacy, medical records should be kept in a secure location. Cenpatico requires practitioners to maintain all records in compliance with state and federal laws, as they pertain to mental health records.

REQUIRED INFORMATION

Practitioners must maintain complete medical records for Members in accordance with the following standards:

1. Member’s name, and/ or medical record number on all chart pages

2. Personal/ biographical data is present (i.e. employer, home telephone number, spouse, etc.)
3. All entries must be legible
4. All entries must be dated and signed, or dictated by the practitioner rendering the care
5. Significant illnesses and/ or medical conditions are documented on the problem list
6. Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA is documented
7. Evidence that preventive screening and services are offered in accordance with Cenpatico practice guidelines.
8. Appropriate subjective and objective information pertinent to the Member's presenting complaints is documented in the record
9. Past treatment history (for Members seen three or more times) is easily identified and includes any psychiatric hospitalizations
10. Working diagnosis is consistent with findings
11. Treatment plan is appropriate for diagnosis
12. Unresolved problems from previous visits are addressed in subsequent visits
13. Laboratory and other studies ordered as appropriate
14. Referrals to specialists and ancillary practitioners are documented including follow up of outcomes and summaries of treatment rendered elsewhere
15. For Members 10 years and over, appropriate notations concerning use of tobacco, alcohol and an assessment of substance use
16. Documentation of failure to keep an appointment
17. Evidence that the Member is not placed at inappropriate risk by a diagnostic or therapeutic problem
18. Confidentiality of Member information and records protected
19. Evidence that an Advance Directive has been offered to adult Members

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. The website at www.cenpatico.com gives sample forms that Network Practitioners are encouraged to use for members.

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

Network Practitioner 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.

Medical Records Release

All medical records of covered persons shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Each medical record release needs to be documented in compliance with HIPAA regulations.

Written authorization is required for the transmission of the medical record information of a current Superior Member or former Superior Member to any other Practitioner.

Medical Records Transfer for New Patients

All practitioners are required to document, in the Member's medical record, attempts to obtain records from prior treating practitioners for all new Superior Members. If the Member or Member's guardian is unable to remember where they obtained behavioral health care, or are unable to provide an appropriate address, then this should also be noted in the record.

Medical Records Audits

Medical records may be audited to determine compliance with Cenpatico standards for documentation and compliance with clinical practice guidelines. The coordination of care and services provided to Members, including coordination with PCP may also be assessed during a medical record audit.

Reporting Facility, Practitioner 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 a 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 Care 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 Care program.

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the health plan program to himself, the corporation, or some other person. It also includes any act that

constitutes fraud under applicable Federal or State healthcare fraud laws. Examples of Provider/Practitioner fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and Provider/Practitioners 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 Management Company, LLP, operates a WAF unit. If you suspect or witness a Provider/Practitioner 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 Superior HealthPlan, 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 Superior HealthPlan, at the Provider/Practitioner 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 Texas within the Office of the Inspector General at the following address:

Office of Inspector General
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

Hotline Number - A toll-free hotline number has been established to report potential WAF issues. The hotline number is 1-800-436-6184. 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/Practitioners may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone at 1-888-471-4357.

Fraud Information

Reporting Waste, Abuse or Fraud by a Provider or Client

Medicaid Managed Care and CHIP

If you suspect a person who receives benefits or a provider/practitioner (a doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.

Reporting Provider/Practitioner/Client Waste, Abuse and Fraud

You can report directly to your health plan any providers/practitioners or clients at you suspect of waste, abuse, or fraud:

Superior HealthPlan
Fraud and Abuse Unit
7711 Carondelet Avenue
St. Louis, MO 63105

Or if you can get on the Internet go to www.hhsc.state.tx.us and select “Reporting Waste, Abuse and Fraud” tab on the left side of the screen. The site tells you about the types of waste, abuse and fraud to report. If you cannot get on the Internet and would rather talk to a person, call the HHSC Office of Inspector General (OIG) Fraud Hotline at 1-800-436-6184. You also can send a note or letter to the following addresses:

To report providers/practitioners, use this address:

Office of Inspector General
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

To report clients, use this address:

Office of Inspector General
General Investigations/Mail Code 1362
P.O. Box 85200
Austin, TX 78708-5200

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider/practitioner (a doctor, dentist, counselor, etc.) include:
 - Name, address, and phone number of provider/practitioner
 - Name and address of facility (hospital, nursing home, home health agency, etc.)
 - Medicaid number of the provider/practitioner and facility, if you have it
 - Type of provider/practitioner (doctor, dentist, therapist, pharmacist, etc.)
 - Names and phone numbers of other witnesses who can help in the investigation
 - Dates of events
 - Summary of what happened
- When reporting about someone who receives benefits, include:
 - The person’s name
 - The person’s date of birth, Social Security number, or case number if you have it
 - The city where the person lives
 - Specific details about the waste, abuse or fraud

Health Insurance and Accountability Act (HIPAA)

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

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

Please contact the Cenpatico Privacy Officer at 512.406.7200 or in writing (refer to address at the top of the next page) 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:

STAR and CHIP HMO.....1-800-783-5386
CHIP RSA.....1-800-820-5685
STAR+PLUS.....1-866-516-4501

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

Verifying Member Enrollment

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

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

- Contacting Cenpatico Customer Service at:
 - STAR 800-716-5650
 - STAR+PLUS 800-466-4089
 - CHIP 888-471-4357
 - CHIP RSA 800-213-9927
- Accessing the Cenpatico Provider Website at www.cenpatico.com
- State Automated Inquiry System (AIS) 800-925-9126 (STAR and STAR+PLUS)
- CHIP Inquiry System 800-645-7164

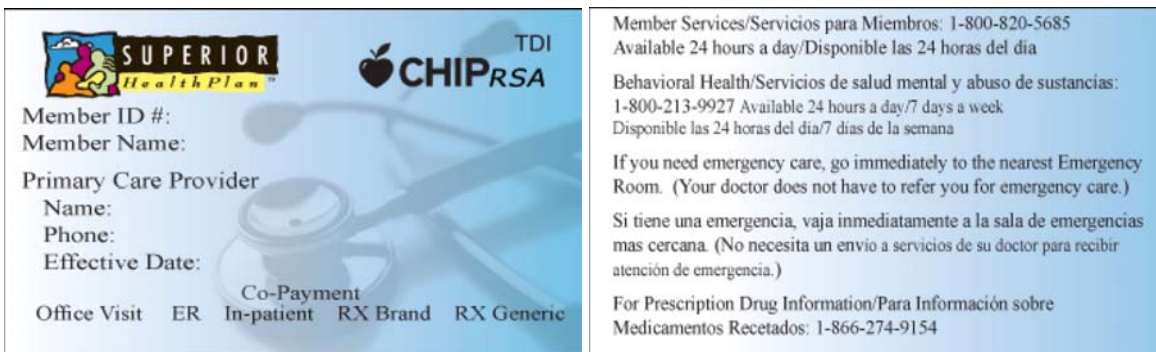
STAR/STAR+PLUS members receive a monthly Medicaid Form 3087 from the State, confirming eligibility on a month-to-month basis. The eligibility form includes information of which health plan the Member is enrolled. The State may also issue a Temporary Medicaid Form 1027A, which can be used to verify Medicaid eligibility. A copy of the monthly Medicaid 3087 is included on the next page.

Superior distributes a Member ID Card to all eligible CHIP Members, within five days of receipt of the Member’s enrollment in Superior. A copy of Superior’s CHIP Member ID Card is included at the top of the next page.



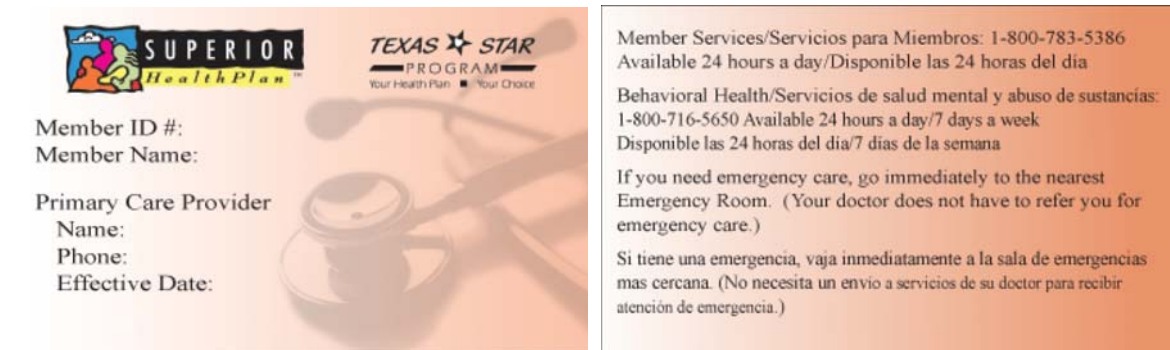
Superior CHIP ID Card

Superior distributes a Member ID Card to all eligible CHIP Members, within five days of receipt of the Member’s enrollment in Superior. A copy of Superior’s CHIP Member ID Card is included below.



Superior CHIP RSA ID Card

Superior distributes a Member ID Card to all eligible STAR/ STAR+PLUS Members, within five days of receipt of the Member’s enrollment in Superior. A copy of Superior’s STAR and STAR+PLUS ID Cards are included below.



Superior STAR ID Card



Superior STAR+PLUS ID Card

Member Rights and Responsibilities

Cenpatico Members are given Rights & Responsibilities as outlined in the Texas Administrative Code (TAC) 353.201 – 353.203. Providers/Practitioners should be aware of what information is being conveyed to their patients. *The Member Rights & Responsibilities* detailed below are outlined in the Member Handbooks for STAR and STAR+PLUS (Medicaid) and CHIP & CHIP RSA. The programs are different, therefore, the Rights and Responsibilities read differently.

STAR and STAR+PLUS Member Rights and Responsibilities

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
 - a) Be treated fairly and with respect; and
 - b) Know that your medical records and discussions with your practitioners will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a healthcare plan and primary care provider. This is the doctor or health care practitioner you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider/practitioner in a reasonably easy manner. That includes the right to:
 - a) Be told how to choose and change your health plan and your primary care practitioner;
 - b) Choose any health plan you want that is available in your area and choose your primary care practitioner for that plan;
 - c) Change your primary care practitioner;
 - d) Change your health plan without penalty; and
 - e) Be told how to change your health plan or your primary care practitioner.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a) Have your practitioner explain your healthcare needs to you and talk to you about the different ways your healthcare problems can be treated; and
 - b) Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

- a) Work as part of a team with your practitioner in deciding what healthcare is best for you.
 - b) Say yes or no to the care recommended by your practitioner.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
 - a) Make a complaint to your health plan or to the state Medicaid program about your health care, practitioner or health plan.
 - b) Get a timely answer to your complaint.
 - c) Use the plan's appeal process and be told how to use it.
 - d) Ask for a fair hearing from the state Medicaid program and request information about how that process works.
 6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a) Have telephone access to a medical professional 24 hours a day, 7 days a week in order to get any needed emergency or urgent care.
 - b) Get medical care in a timely manner.
 - c) Be able to get in and out of a healthcare practitioner's office. This includes barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
 - d) Have interpreters, if needed, during appointments with your practitioners and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
 - e) Be given an explanation you can understand about your health plan rules, including the health care services you can get and how to get them.
 7. You have the right not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or to punish you.
 8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
 9. You have a right to know that you are not responsible for paying covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid Program. That includes the responsibility to:
 - a) Learn and understand your rights under the Medicaid program.
 - b) Ask questions if you don't understand your rights.
 - c) Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
 - a) Learn and follow your health plan's rules and Medicaid's rules.
 - b) Choose your health plan and primary care provider quickly.
 - c) Make any changes in your health plan and primary care practitioner in the ways established by Medicaid and by the health plan.

- d) Keep your scheduled appointments.
 - e) Cancel appointments in advance when you cannot keep them.
 - f) Always contact your primary care provider first for your non-emergency medical needs.
 - g) Be sure to have approval from your primary care provider before going to a specialist.
 - h) Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
 - a) Tell your primary care provider about your health.
 - b) Talk to your practitioners about your healthcare needs and ask questions about the different ways your healthcare problems can be treated; and
 - c) Help your practitioners get your medical records.
 4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
 - a) Work as a team with your practitioner in deciding what healthcare is best for you.
 - b) Understand how the things you do can affect your health.
 - c) Do the best you can to stay healthy.
 - d) Treat practitioners and staff with respect.

CHIP and CHIP RSA Member Rights and Responsibilities

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers/practitioners.
2. Your health plan must tell you if they use a "limited practitioner network." This is a group of doctors and other providers/practitioners who only refer patients to other doctors who are in the same group. "Limited practitioner network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers/practitioners in your health plan and their addresses.
6. You have a right to pick from a list of health care practitioners that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how that works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to the CHIP Perinatal Program.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have a right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals and other practitioners.
16. You have the right to talk to your child's doctors and other practitioners in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES:

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other practitioners to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other practitioners co-payments that you owe them. If your child is getting CHIP Perinatal Programs services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal Program services by health care practitioners, other members, or health plans.

Perinate Member Rights and Responsibilities

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals and other practitioners.
2. You have a right to know how the perinatal practitioners are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.

3. You have a right to know how the health plan decides whether a perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decides those things.
4. You have a right to know the names of the hospitals and the other perinatal practitioners in the health plan and their addresses.
5. You have a right to pick from a list of health care practitioners that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services when your unborn child needs them if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other practitioners.
10. You have the right to talk to a Perinatal practitioner in private and to have your medical records kept private. You have the right to look over and copy medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan is right.

MEMBER RESPONSIBILITIES:

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.

5. You must try to get the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of the CHIP Perinatal Program by the health care Practitioner, other members, or health plans.

In addition to the Member Rights and Responsibilities provided by Superior HealthPlan, Cenpatico believes that members also have the following Rights and Responsibilities:

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

Civil Rights

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

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

Second Opinions

Cenpatico will allow Members' access to a second opinion from a network practitioner, applicable to the specialty service that is requested. Cenpatico will also facilitate a second

opinion from an out-of-network practitioner if a network practitioner is not available, at no additional cost to the Member.

Cultural Sensitivity

Superior places great emphasis on the wellness of its Members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a Practitioner's relationship with patients and in the long run the health and wellness of the patients themselves.

Following is a list of principles for health care Practitioners, to include knowledge, skills and attitudes, related to cultural competency in the delivery of health care services to Superior Members:

Knowledge

- Practitioner's self understanding of race, ethnicity and influence
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns
- Understanding of the particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress, socioeconomic status
- Understanding of the cultural differences within minority groups
- Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network
- Understanding of the differences between "culturally acceptable" behavior of psychopathological characteristics of different minority groups
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients
- Understanding of the cultural beliefs of health and help seeking patterns of minority patients
- Understanding of the health service resources for minority patients
- Understanding of the public health policies and its impact on minority patients and communities

Skills

- Ability to interview and assess minority patients based on a psychological/social/biological/ cultural/ political/ spiritual model
- Ability to communicate effectively with the use of cross cultural interpreters
- Ability to diagnose minority patients with an understanding of cultural differences in pathology
- Ability to avoid under diagnosis or over diagnosis
- Ability to formulate treatment plans that are culturally sensitive to the patient and family's concept of health and illness
- Ability to utilize community resources (church, CBOs, self-help groups)
- Ability to provide therapeutic and pharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication
- Ability to ask for consultation

Attitudes

- Respect the "survival merits" of immigrants and refugees
- Respect the importance of cultural forces
- Respect the holistic view of health and illness
- Respect the importance of spiritual beliefs
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines
- Be aware of transference and counter transference issues

Cenpatico encourages and advocates for providers/practitioners to provide culturally competent care for its Members. Providers/Practitioners are also encouraged to participate in training provided by other organizations. You can visit www.hrsa.gov/healthliteracy/training.htm for an online training course developed by the Health Resources and Services Administration (HRSA) and earn CEU and/or CME credits.

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 8:00 a.m. to 6:00 p.m. CST. After hours services are available during evenings, weekends and holidays. The after hours service 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/Practitioners and assists the member in selecting a Network Provider/Practitioner 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/Practitioners 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:

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

Behavioral Health Education materials are provided in Spanish and/or English at the appropriate 4th to 6th grade reading level.

The following TDD access is available for members who are hearing impaired:
TTY: 877-826-9348

- Voice: 877-826-6607

Key Information: To access interpreter services for Cenpatico members, contact Customer Service at:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

NurseWise

NurseWise is Superior HealthPlan’s after hours 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/Practitioners with the following:

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

NurseWise provides after-hours phone coverage seven (7) days per week including holidays for Superior HealthPlan members. Referral and assessment decisions are made according to established Medical Necessity Criteria that define the level of urgency, intensity, and appropriate level/setting of care. The Cenpatico Medical Necessity Criteria are located within this Manual and can also be found at www.cenpatico.com.

Complaints and Appeals

Provider Complaints

What is a Complaint?

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

Cenpatico has established and maintains an internal system for the identification and prompt resolution of Network Provider complaints. If a Network Provider/Practitioner is not satisfied with the resolution of a complaint, an appeal can be filed. Network Providers/Practitioners 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:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

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

CHIP Providers/Practitioners also have the right to appeal to the Texas Department of Insurance after exhausting the Plan's appeal proceedings, by contacting the Department at:

Texas Department of Insurance
Consumer Protection Mail Code 111-1A
PO Box 149091
Austin TX 78714-9091
Phone 1.800.252.3439

STAR/ STAR+PLUS Providers/Practitioners have the right to file a complaint with HHSC after exhausting the Plan's complaint appeals process, by contacting the Department at:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
Attn: Resolution Services
1-800-252-8263

Under the complaint/ appeal process, HHSC works with Cenpatico and providers/practitioners to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and complaints, and addresses other program/ contract issues.

Member Complaints

What is a Complaint?

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

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

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

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:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

Cenpatico Network Providers/Practitioners and members have a right to file a Complaint.

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

Members may at any time file a complaint directly to Superior **HealthPlan**

Superior HealthPlan
ATTN: Complaint Department
2100 S. IH-35 Ste 202
Austin, TX 78704
Fax: 1-866-683-5369

or Texas Health and Human Services Commission by contacting the Health and Human Services Commission (HHSC) at 1-800-252-8263 or by mailing to:

Texas Health and Human Services Commission
Health Plan Operations – H320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

State Fair Hearing Information

Can I ask for a State Fair Hearing?

If a Member of the health plan disagrees with the health plan's decision, the Member has the right to ask for a fair hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling them the name of the person the member wants to represent. A provider/practitioner may be the Member's representative. The Member or Member representative must ask for the fair hearing within 90 days of the date on the health plan's letter that tells of the decision the Member is challenging. If the Member does not ask for the fair hearing within 90 days, the Member may lose his/her right to a fair hearing. To ask for a fair hearing, the Member or Member representative should either send a letter to the health plan:

Cenpatico
Attn: Appeals Coordinator
504 Lavaca, Suite 850
Austin, Texas 78701
Fax: (512) 406-7217

Or call: 800-716-5650.

If the Member asks for a fair hearing within 10 days from the time you get the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a fair hearing, the Member will get a packet of information letting him/her know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, the Member or the Member's representative can tell why he/she needed the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

CHIP Complaint Appeals to the State – Texas Department of Insurance

CHIP Members may appeal to the Texas Department of Insurance if not satisfied with the resolution of a complaint or complaint-appeal. Members can contact:

Texas Department of Insurance
Consumer Protection Mail Code 111-1A
P.O. Box 149091
Austin, Texas 78714-9091
Phone: 1-800-252-3439

Notice of Action (Adverse Determination)

At times Cenpatico will not authorize a service requested by a provider/practitioner. When Cenpatico determines that a specific service does not meet criteria, Cenpatico completes and sends a written notice of action which includes:

The reason(s) for the denial in clearly understandable language

- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary.
- Information on how the provider/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 business day of a request by the treating practitioner to discuss the determination.
- 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.
- The Member’s right to request review by an independent review organization (CHIP) or state fair hearing (STAR/ STAR+PLUS) and instructions for submitting this request
- For all urgent pre-certification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal.

Appeal of Adverse Determination

A Member or Provider/Practitioner has the right to appeal if Cenpatico denies or limits a request for a covered service; which includes an option for the request of an Appeal for denial of payment for services in whole or in part. Cenpatico’s Appeals Coordinator is available to assist a Member in understanding and using the Cenpatico appeal process. Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested. Denials for non-covered benefits cannot be appealed. A member has the option of requesting a State Fair Hearing at any time during or after the Appeal process.

STAR/ STAR+PLUS Members have thirty (30) days from the date of the adverse determination denial letter to appeal the denial or limitation. CHIP Members may file an appeal at anytime after receiving the notification of adverse determination. Cenpatico will acknowledge the appeal within 5 days of receipt, and complete the appeal process within 30 days.

Written appeals should be sent to:

Cenpatico
 Attn: Appeals Coordinator
 504 Lavaca, Suite 850
 Austin, Texas 78701
 Fax: (512) 406-7217

To express an Appeal by phone, please call Cenpatico at:
 CHIP Program.....888-471-4357
 STAR Program.....800-716-5650

STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

In addition a STAR/ STAR+PLUS Member may be granted an additional 14 days to have the appeal resolved if more information is needed to benefit the Member that will take additional time or if the Member requests such extension. Cenpatico will provide written notice of the reason for delay if the Member has not requested the delay.

Appeal of Adverse Determination for continuation of services

If the Member is currently receiving a service that is being denied or limited, the appeal must be filed within 10 days of the adverse determination letter or the date that services will be discontinued or limited, to facilitate review for continuation of the receipt of the services currently being provided.

Cenpatico will continue to provide benefits that are currently being provided while the appeal is being reviewed, if:

1. The appeal is sent in the required time frame
2. The appeal is for a service that has been previously approved, and is currently being provided
3. The appeal is for a service ordered by an Cenpatico approved Provider/Practitioner

However, it is important to note that if the appeal is not approved, the Member may be financially responsible for the cost of the benefits received while your appeal was being reviewed.

Expedited Adverse Determination 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 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. Expedited Appeals can be submitted orally or in writing.

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:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

Expedited Appeals will be resolved within twenty four (24) hours and the provider/practitioner will be notified telephonically. Written notification is sent out within three (3) business days 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 thirty (30) days calendar days. The Cenpatico Appeals Coordinator can assist the member with their Expedited Appeal. The member may also have their Network Provider/Practitioner, a friend, a relative, legal counsel or another spokesperson assist them.

External Review

STAR and STAR+PLUS members have a right to request a State Fair Hearing if a specific service has been denied, reduced, or modified. A Fair Hearing can be requested by calling 1-800-252-8263 or writing to:

Superior HealthPlan
Attn: Fair Hearing Coordinator
2100 S. IH 35, Suite 202
Austin, TX 78704
Fax

CHIP/CHIP RSA members have the right to an immediate review by an independent review organization (IRO) in cases of a life-threatening condition. An IRO is requested by completing the IRO form (included in adverse determination notice) and sending to the following address:

Superior HealthPlan, Inc.
Attn: IRO Request
2100 S. I.H.-35, Suite 202
Austin, Texas 78704
Fax: 1-866-918-2266

If a CHIP Member has a life-threatening condition, the Member has the right to have the adverse determination reviewed by someone who is independent from Cenpatico HealthPlan. "Life-threatening" is defined as a disease or condition, for which the likelihood of death is probable, unless the course of the disease or condition is interrupted. The Member, a person acting on behalf of the Member, or the Member's Practitioner of record may determine whether a life-threatening condition exists.

In addition, CHIP Members have the right to request an IRO review for non-life threatening conditions, if Cenpatico's adverse determination is upheld upon appeal through the Plan's internal appeal process.

An Independent Review Organization (IRO) is an outside organization that the Texas Department of Insurance (TDI) randomly chooses to review the health plan's denial of a service the Member and Provider/Practitioner feel is medically necessary. This organization is not associated with the health plan or provider/practitioner. There is no cost to the Member for this independent review.

To request an IRO, Member can use the “Request for a Review by an Independent Review Organization” form that is sent along with the denial letter. This form needs to be completed and forwarded to Superior. Superior will send Member’s request immediately to TDI. TDI will assign a random IRO within one working day. TDI will let the Member and Cenpatico know who the IRO is. Cenpatico will then send all of the records related to the case to the IRO no later than the third working day from the date of the Member’s request for an IRO. The IRO will make a decision in no more than 15 days from the date they receive all of the information from Cenpatico about the case. The IRO will send the Member a letter that will let them know what they decide. Cenpatico is bound to comply with the decision of the IRO.

If Member’s case is a life-threatening condition, the IRO’s decision should not take longer than eight calendar days.

To request an IRO review of an adverse determination, the “Request for a Review by an Independent Review Organization” form (See Attachment 15-A) should be completed and forwarded to Cenpatico, who will take immediate action to have all of the records related to the case forwarded to the IRO to facilitate their review and decision on the case.

Benefit Overview

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

- Inpatient hospitalization
- Crisis Stabilization Services
- Partial Hospitalization
- Intensive Outpatient Treatment
- Outpatient Therapy (Individual, Family and Group)
- Medication Management
- Psychological Testing
- Electroconvulsive Therapy (ECT)

For a listing of service codes and authorization requirements for the STAR, STAR+PLUS and CHIP/CHIP Perinate, please refer to the Texas Covered Professional Services & Authorization Guidelines located in this Manual and the Texas Medicaid Provider Procedures Manual for listing of limitations and exclusions. Network Providers/Practitioners should also reference their Facility or Practitioner Agreement with Cenpatico to identify which services they are contracted and eligible to provide.

Please note that all services must be medically necessary.

For members receiving behavioral health services in the Dallas area, please refer to ValueOptions NorthSTAR manual for information, as Cenpatico is not a contracted vendor for STAR, STAR+PLUS and CHIP in that region. Provider Contact Information:

ValueOptions NorthSTAR
1199 South Beltline Rd., Ste. 100
Coppell, TX 75019
(888) 800-6799

Adults receiving behavioral health/substance abuse services at Institutes for Mental Diseases

Pursuant to Title 25 of the Texas Administrative Code (Section 419.465 - subsection (b)(1)(B)[1]) and the 2008 Texas Medicaid Provider Procedures Manual (Chapter 32 / Section 32.3.1 and Chapter 32.3.2.1), the Texas Medicaid program does not pay for any behavioral health/substance abuse services for a person 22 to 64 years of age who resides in an Institute for Mental Disease (IMD).

Spell of Illness Removed

In the traditional Medicaid program, the Spell of Illness Limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for 60 consecutive days. This limitation does NOT apply to STAR or CHIP Members.

Inpatient hospital services for a medical-related diagnosis are carved out of the STAR+PLUS covered benefits. The STAR+PLUS HMO is responsible for authorization and management of the inpatient hospital stay until the time of discharge, or until such time that there is a loss of Medicaid eligibility. As a result, the 30-day spell of illness limitation applicable to fee-for-service Medicaid also applies to STAR+PLUS Members who are not Dually Eligible. The Texas Medicaid Program provides 30 inpatient benefit days per spell of illness. STAR+PLUS HMOs are responsible for professional charges during every month for which the HMO receives a full capitation for a Member.

Prescriptions

All STAR Medicaid Members receive unlimited prescriptions as part of the Medicaid Managed Care Program. STAR+PLUS Medicaid Members who are not Dual Eligible (covered by both Medicare and Medicaid) also receive unlimited prescriptions.

The Texas Vendor Drug Program is responsible for administering the prescription program. The Medicaid product formulary listing is included on the Vendor Drug Program's website, at <http://www.hhsc.State.tx.us/HCF/vdp/vdpstart.html>. For questions related to prescriptions for Superior Members, contact the Texas Medicaid and CHIP Prescription Help Desk at 1-800-435-4165

Adult Well Check

This annual adult physical exam is an additional benefit for STAR and STAR+PLUS non-dual Members 21 years and older. The annual adult well exam may be received in addition to the Member's annual OB/GYN visit for females.

CHIP Perinate Providers/Practitioners (care for the unborn child)

CHIP Perinate members (pregnant women) are not required to select a Primary Care Provider (PCP). CHIP Perinate members (pregnant women) can go to any CHIP Perinatal provider/practitioner listed in the CHIP Perinate section of the Superior HealthPlan CHIP and CHIP RSA Provider Directories for prenatal and post partum care. Newborn Services would be covered under the medical plan.

Covered Professional Services & Authorization Guidelines for CHIP/CHIP Perinate

Please note that the listing below does not fully comprise all Cenpatico covered services. Please refer to your Practitioner Agreement with Cenpatico to identify the specific services you are contracted and eligible to provide. Newborn Services would be covered under the medical plan.

SERVICE TYPE	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Acute Inpatient Hospitalization Mental Health Diagnosis only	Yes	Yes	Limited to 45 days per 12-month period. 20 days must be reserved for IP care; 25 days may be converted to RTC/PHP/IOP. Requires Prior Authorization.
Acute Inpatient Detoxification	Yes	Yes	Medically necessary detox-stabilization services limited to 14 days per 12-month period (this is separate from 60 days allowable for residential programs). Requires Prior Authorization.
Residential Treatment Mental Health Diagnosis only	Yes	Yes	25 days of the inpatient benefit can be converted to residential treatment. Conversion rate 1:1. Requires Prior Authorization
Residential Treatment - Chemical Dependency Diagnosis only	Yes	Yes	60 days per 12-month period (30 days may be converted to PHP) Requires Prior Authorization
Partial Hospitalization - Mental Health/Chemical Dependency	Yes	Yes	PHP converts the 25 IP days or the 30 residential CD days to PHP 2:1. Requires Prior Authorization
Intensive Outpatient - Mental Health	Yes	Yes	Inpatient days converted to IOP are in addition to the outpatient limits and do not count towards these limits. Conversion rate is 3:1 Requires Prior Authorization
Intensive Outpatient - Chemical Dependency	Yes	Yes	Limit set to 60 may have up to 12 weeks/yr Requires Prior Authorization
OUTPATIENT SERVICES-Not Including Medication Management	Yes	Yes, following initial 6 sessions (only applies to specific codes)	For both MH and CD: Up to 60 visits per 12-month rolling calendar period. Par Practitioners Require Prior Auth after 1 initial and 5 follow up visits. Non-par Providers always Require Prior Authorization
HOME VISITS Mental Health/Chemical Dependency	Yes	Yes	For both MH and CD: Up to 60 (including OP) visits per 12-month period. Based on medical necessity criteria. Requires Prior Authorization

SERVICE TYPE	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Medication Management	Yes	Non Par - Yes Par - No	Unlimited Non-Par Practitioners Require Prior Authorization
Psychological Testing	Yes	Yes	Limited to 8 hrs/ rolling 12 months. Units approved based on medical necessity criteria. Requires Prior Authorization
NeuroPsych Testing	No	N/A	Not a covered benefit.
Psychosocial Rehabilitation Services	Yes	Yes	Only H2014 and H2017 covered Requires Prior Authorization Unlimited
Court Ordered Treatment and involuntary commitments	Yes	Yes	
Community Support Services	No	N/A	Not a covered benefit. (only H2014 and H2017-see above psychosocial rehabilitation services)

Superior STAR/STAR+PLUS Value Added Services

Superior STAR/ STAR+PLUS Members have access to specific value added services, in addition to the Members’ access to basic Medicaid benefits and services. A Value Added Services Chart is included in the following Table:

Behavioral Health Value-Added Services for STAR and STAR+PLUS (all ages)		
Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Health Psychology Interventions provided by a behavioral health practitioner in a medical setting that focuses on the effective management of chronic medical conditions. This might include psycho-educational groups for chronic conditions, individual coaching for patients with chronic disease states, or skills training activities.	Limited to non-dual Members only. Services must be authorized and is based on medical necessity.	Network Federally Qualified Health Centers (FQHCs), PCP Offices, etc.
Intensive Outpatient Treatment/Day Treatment (IOP) Used as an alternative to step down from more restrictive levels of care.	Limited to non-dual Members only. Services must be authorized and is based on medical necessity. Services will be authorized for greater than one and one half hours, but less than five hours per day.	MHMRs and Contracted Providers who offer this level of care.
Partial Hospitalization/Extended Day Treatment- An alternative to or a step down from, inpatient care.	Limited to non-dual Members only. Services must be authorized and is based on medical necessity. Services will be authorized for a minimum of five hours, but for less than 24-hours per day.	MHMRs and Contracted providers who offer this level of care.

For Long Term Service and Support Covered Services and Service Coordination Services please contact Superior HealthPlan at (866) 516-4501.

Covered Professional Services & Authorization Guidelines for STAR

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

SERVICE TYPE	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Acute Inpatient Hospitalization	Yes	Yes	Requires Prior Auth. Unlimited Days.
Acute Inpatient Detoxification	Yes	Yes	Requires Prior Auth. Based on medical necessity criterion for detox-stabilization services. Unlimited Days.
Residential Treatment Mental Health/Chemical Dependency	No	N/A	Not a covered benefit.
Partial Hospitalization Mental Health/Chemical Dependency	Yes	Yes	Requires Prior Authorization. Unlimited Days.
Intensive Outpatient - Mental Health/Chemical Dependency	Yes	Yes	Requires Prior Authorization. Unlimited Days.
OUTPATIENT SERVICES - Not Including Medication Management	Yes	Yes, following initial 6 sessions (only applies to specific codes)	For both MH and CD: Unlimited visits for members up to age 21. Over age 21 – No therapy benefit for substance abuse services Par Practitioners Require Prior Auth after 1 initial and 5 follow up visits. Non-par Practitioners always Require Prior Authorization
HOME VISITS - Mental Health/Chemical Dependency	No		For both MH and CD: Unlimited visits for members up to age 21. Over age 21 – No therapy benefit for substance abuse services Requires Prior Authorization
Medication Management	Yes	Non Par - Yes Par - No	Unlimited Non-Par Practitioners Require Prior Authorization
Psychological Testing	Yes	Yes	Limited to 8 hrs/day and 16 hrs/year. Units approved based on medical necessity criteria. Requires Prior Authorization
NeuroPsych Testing	Yes	Yes	Limited to 8 hrs/day and 16 hrs/year. Units approved based on medical necessity criteria. Requires Prior Authorization

SERVICE TYPE	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Psychosocial Rehabilitation Services	No	N/A	Not a covered benefit.
Court Ordered Treatment and involuntary commitments	Yes	Yes	
Community Support Services	No	N/A	Not a covered benefit.
Alcohol and/or Drug Assessment (H0001)	Yes	No	Authorization is not required Limited to once per episode of care per provider, per member, per rolling 6 months without an authorization Cannot bill same day as H0014
Alcohol and/or Drug Abuse Services – Detoxification (Outpatient) (H0014)	Yes	Yes	Authorization is required Limited to 21 days per episode of care Cannot bill same date of service as H0001, H2010 Must bill same day as H0004 or H0005
Alcohol and/or Drug Abuse Services Not Otherwise Specified- Residential Treatment (H0047)	Yes	Yes	Authorization is required Maximum of 35 days per episode. Limited to 2 episodes of care per 6 months and 4 per rolling year Specialized female (including: pregnant women and women with children) coverage maximum of 90 days per episode of care
Medication Assisted Therapy (MAT)- Alcohol and/or Drug Services (H0020)	Yes	No	Authorization is not required MAT is limited to one count per date of service Limited to a maximum of one hour (four units) per date of service
Medication Assisted Therapy - Opioid Addiction (Per 15 minutes) (H2010 HG)	Yes	No	Authorization is not required Limited to one count per date of service Cannot bill same day as H0014
Medication Assisted Therapy-Non-Opioid Addiction (SA) (Per 15 minutes) (H2010 HF)	Yes	No	Authorization is not required Limited to one count per date of service Cannot bill same day as H0014
Behavioral Health Counseling and Therapy (Per 15 minutes) (H0004 HF)	Yes	Yes	Authorization is required Limited to a combined total of 135 hours of group services and 26 hours of individual services per year
Alcohol and/or Drug Services Group Counseling (Per Hour) (H0005)	Yes	Yes	Authorization is required Limited to a combined total of 135 hours of group services and 26 hours of individual services per year

SERVICE TYPE	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Alcohol and/or drug services medical/somatic medical intervention in ambulatory setting (H0016 HF)	Yes	Yes	Limited to once per day per member Not a stand alone service. Must be provided in conjunction with other ambulatory treatment services (H0050 or S9445)
Alcohol and/or Drug Brief Intervention (H0050 HF)	Yes	No	Limited to once a day regardless of time spent with member. Must bill with H0016 or it will deny
Education Not Otherwise Classified (S9445 HF)	Yes	No	Limited to once per day per member Non-physician Must bill with H0016 or it will deny
Psychosocial Rehab Svc (H2017 HF)	Yes	Yes	Limited to once a day regardless of time spent with member
Mental Health Assessment (H0031 HF)	Yes	No	Limited to once per day per member Non Physician Must bill with H2017 or it will deny
Mental Health Service Plan Development (H0032 HF)	Yes	No	Limited to once per day per member Non Physician Must bill with H2017 or it will deny
Alcohol and/or Drug Treatment Program, per hour (H2035 HF)	Yes	Yes	Limited to once per day per member May not exceed 70 days per rolling six months
Alcohol and/or Drug Abuse Services Not Otherwise Specified R&B (H0047 HF)	Yes	No	Limited to once per day per member Must bill with H2035 or H2017 or it will deny

Covered Professional Services & Authorization Guidelines for STAR+PLUS

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

Services type	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Acute Inpatient Hospitalization	Yes	Yes	Requires Prior Authorization. Unlimited
Acute Inpatient Detoxification	No	N/A	Refer to Superior (not a covered benefit by Cenpatico)
Residential Treatment Mental Health/Chemical Dependency	No	N/A	Not a covered benefit.
Partial Hospitalization Mental Health/Chemical Dependency	Yes	Yes	Unlimited for Non-dual Members Only. (Not covered for Dual Members) Requires Prior Auth.
Intensive Outpatient - Mental Health/Chemical Dependency	Yes	Yes	Unlimited for Non-dual Members Only. (Not covered for Dual Members) Requires Prior Authorization
OUTPATIENT SERVICES - Not Including Medication Management	Yes	Yes, following initial 6 sessions (only applies to specific codes)	Par Practitioners Require Prior Auth after 1 initial and 5 follow up visits. Non-par Practitioners always Require Prior Authorization Unlimited
HOME VISITS - Mental Health/Chemical Dependency	Yes	Yes	Requires prior auth, approved units based on medical necessity criteria. Unlimited
Medication Management	Yes	Non Par - Yes Par - No	Non-Par Practitioners Require Prior Authorization. Unlimited
Psychological Testing	Yes	Yes	Psych Testing requires prior auth. 8 hrs/rolling 12 months. Units approved based on medical necessity criteria.
NeuroPsych Testing	No	N/A	Covered by health plan.
Psychosocial Rehab Services	Yes	Yes	Not a covered benefit.
Court Ordered Treatment and involuntary commitments	Yes	Yes	
Community Support Services	Yes	Yes	Not a covered benefit.

Services type	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Alcohol and/or Drug Assessment (H0001)	Yes	No	Authorization is not required Limited to once per episode of care per provider, per member, per rolling 6 months without an authorization Cannot bill same day as H0014
Alcohol and/or Drug Abuse Services – Detoxification (Outpatient) (H0014)	Yes	Yes	Authorization is required Limited to 21 days per episode of care Cannot bill same date of service as H0001, H2010 Must bill same day as H0004 or H0005
Alcohol and/or Drug Abuse Services Not Otherwise Specified- Residential Treatment (H0047)	Yes	Yes	Authorization is required Maximum of 35 days per episode. Limited to 2 episodes of care per 6 months and 4 per rolling year Specialized female (including: pregnant women and women with children) coverage maximum of 90 days per episode of care
Medication Assisted Therapy (MAT)- Alcohol and/or Drug Services (H0020)	Yes	No	Authorization is not required MAT is limited to one count per date of service Limited to a maximum of one hour (four units) per date of service
Medication Assisted Therapy - Opioid Addiction (Per 15 minutes) (H2010 HG)	Yes	No	Authorization is not required Limited to one count per date of service Cannot bill same day as H0014
Medication Assisted Therapy-Non-Opioid Addiction (SA) (Per 15 minutes) (H2010 HF)	Yes	No	Authorization is not required Limited to one count per date of service Cannot bill same day as H0014
Behavioral Health Counseling and Therapy (Per 15 minutes) (H0004 HF)	Yes	Yes	Authorization is required Limited to a combined total of 135 hours of group services and 26 hours of individual services per year
Alcohol and/or Drug Services Group Counseling (Per Hour) (H0005)	Yes	Yes	Authorization is required Limited to a combined total of 135 hours of group services and 26 hours of individual services per year
Alcohol and/or drug services medical/somatic medical intervention in ambulatory setting (H0016 HF)	Yes	Yes	Limited to once per day per member Not a stand alone service. Must be provided in conjunction with other ambulatory treatment services (H0050 or S9445)

Services type	Covered? Yes/No	Authorization Required?	Ages, Limits, Co-Pays, Deductible
Alcohol and/or Drug Brief Intervention (H0050 HF)	Yes	No	Limited to once a day regardless of time spent with member. Must bill with H0016 or it will deny
Education Not Otherwise Classified (S9445 HF)	Yes	No	Limited to once per day per member Non-physician Must bill with H0016 or it will deny
Psychosocial Rehab Svc (H2017 HF)	Yes	Yes	Limited to once a day regardless of time spent with member
Mental Health Assessment (H0031 HF)	Yes	No	Limited to once per day per member Non Physician Must bill with H2017 or it will deny
Mental Health Service Plan Development (H0032 HF)	Yes	No	Limited to once per day per member Non Physician Must bill with H2017 or it will deny
Alcohol and/or Drug Treatment Program, per hour (H2035 HF)	Yes	Yes	Limited to once per day per member May not exceed 70 days per rolling six months
Alcohol and/or Drug Abuse Services Not Otherwise Specified R&B (H0047 HF)	Yes	No	Limited to once per day per member Must bill with H2035 or H2017 or it will deny

Utilization Management

The Utilization Management Program

The Cenpatico Utilization Management (UM) department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 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 – 800-716-5650. The Cenpatico Utilization Management team is comprised of qualified behavioral health professionals whose education, training and experience are commensurate with the Utilization Management reviews they conduct.

The Cenpatico Utilization Management Program strives to ensure that:

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

The purpose of Cenpatico's Utilization Management Program's procedures and Clinical Practice Guidelines is to ensure treatment is specific to the member's condition, effective, and provided at the least restrictive, most clinically appropriate level of care.

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

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

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

Member Eligibility

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. The Texas Health and Human Services Commission (HHSC) is responsible for determining Medicaid (STAR/ STAR+PLUS) eligibility. It is the responsibility of the Network Provider/Practitioner to monitor the member's ongoing eligibility during the course of treatment.

Eligibility for the CHIP Program

CHIP eligibility and enrollment is facilitated by Maximus/CHIP, the State's contracted administrator (Administrative Services Contractor) for the CHIP program. CHIP Customer Service at: 888-471-4357 can verify CHIP eligibility for any CHIP patient. Or, you can utilize the CHIP Automated Inquiry Eligibility line at 1-800-645-7164 to verify CHIP eligibility. Children under age 19 and whose family's income is below 200% of the federal poverty level (FPL) are eligible to enroll in the CHIP program if they do not qualify for Medicaid coverage. The four CHIP eligibility categories are:

- At or below 100% of FPL
- 101% to 150% of FPL
- 151% to 185% of FPL
- 186% to 200% of FPL

Children of families with group health insurance or Medicaid coverage are NOT eligible for the CHIP program.

Superior Member Enrollment, Re-enrollment, Disenrollment, and Plan Changes

Once enrolled with Superior, a Member is enrolled for a period of twelve (12) months. Members must reenroll every twelve (12) months. Members are only allowed to make plan changes once a year. Members may request to change plans for exceptional reasons or good cause. HHSC will make the final decision.

Re-enrollment

- At the beginning of the 10th month, CHIP will send a notice to the family outlining the next steps for renewal or continuation of coverage.
- Failure of the Member to respond to the renewal notice will result in the Member's disenrollment from the Plan at the end of the 12 month enrollment period.

Disenrollment may occur due to:

- Change in family income
- "Aging out" when a child turns nineteen
- Failure to re-enroll at the conclusion of the 12 month eligibility period
- Change in health insurance status, such as a child enrolling in an employer-sponsored insurance plan
- Member's failure to meet monthly cost-sharing obligations
- Permanent move out of the State
- Enrollment in Medicaid
- Death of a child

Plan Changes

Members are allowed to make health plan changes under the following circumstances

- For any reason within 90 days of enrollment in CHIP
- For cause at any time; and
- During the annual re-enrollment period

Under no circumstances can a Provider/Practitioner take retaliatory action against a Member due to dis-enrollment from either the Provider/Practitioner or a plan.

Pregnant CHIP Members

Because of other CHIP program eligibility changes, most pregnant CHIP teenagers and their newborns, up to one year of age, may qualify for Medicaid. Since the Medicaid Program provides a much more comprehensive scope of services for both the pregnant teen and their newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. For this reason, it is critical that Providers/Practitioners notify Superior HealthPlan immediately upon learning about a CHIP teen's pregnancy. Superior HealthPlan will refer the family to CHIP to determine if the teen is Medicaid eligible. Pregnant CHIP teens who are Medicaid eligible will be transferred from CHIP to Medicaid as soon as possible.

CHIP Perinate Enrollment

The goal is to enroll the unborn child in CHIP as soon as possible for the greatest prenatal benefit. Enrollment will be expedited. When multiple health plans offer coverage in an area, the welcome letter will include a statement indicating the woman can call in and select her health plan over the telephone. If only one health plan is offered in the area, the woman will be defaulted into that plan.

Key Information: At any time after the child is born, the family may submit an application for Medicaid. If eligible, the child will be disenrolled from CHIP and subsequently enrolled in Medicaid the month following CHIP disenrollment.

CHIP Perinate Eligibility Definitions:

- CHIP Perinate means a CHIP Perinatal Program member identified prior to birth.
- CHIP Perinate Newborn means a CHIP Perinate who has been born alive.

The mother of the CHIP Perinate has 15 calendar days from the time the enrollment packet is sent by the vendor to enroll in an MCO (where a choice is available). CHIP Perinate Newborns are eligible for 12 months continuous enrollment beginning with the month of enrollment as a CHIP Perinate (month of enrollment + 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

CHIP Perinate Eligibility

- A CHIP Perinate (unborn child) who is born on or after September 1, 2010, and who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (beginning on the date of birth).
- A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" if: (1) born before September 1, 2010, or (2) if born on or after September 1, 2010, to a family with an income above 185% to 200% FPL.
- A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an

unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

Eligibility determination is made by the Administrative Services Coordinator

CHIP Perinate Plan Changes

- A CHIP Perinate (unborn child) who is born on or after September 1, 2010, and who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (beginning on the date of birth).
- A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" if: (1) born before September 1, 2010, or (2) if born on or after September 1, 2010, to a family with an income above 185% to 200% FPL.
- A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal Health plan.
- If the mother of the CHIP Perinate lives in an area with more than one CHIP perinatal Program MCO, and ***does not*** select an MCO within 15 calendar days of receiving the enrollment packet, the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.
- When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP Program members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Program member's health plan. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal Program member's enrollment period, or (2) the end of the traditional CHIP Program member's enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program member's information. Once the child's CHIP Perinatal Program coverage expires the child will be added to his or her siblings' existing CHIP Program case.
- CHIP Perinatal Program Members may request to change health plans under the following circumstances:
 - for any reason within 90 days of enrollment in the CHIP Perinatal Program; and
 - for cause at any time.

CHIP Perinate Newborn Renewal

All CHIP Program and CHIP Perinatal Program Members in a household must be enrolled in the same MCO. Upon certification of CHIP Perinatal Program eligibility, children in the household enrolled in the CHIP Program must be prospectively enrolled in the MCO providing the CHIP Perinatal Program coverage and disenrolled from their current MCO the first possible month. Co-payments, cost-sharing, and enrollment fees still apply to children enrolled in the CHIP Program.

In order to synchronize all CHIP Program and CHIP Perinatal Program Members in a household, all Members will remain in the MCO providing CHIP Perinatal Program coverage until the CHIP Perinate Newborn completes its 12-month eligibility. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Member's information. Once the child's CHIP Perinatal Program coverage expires, the child will be added to his or her siblings' existing CHIP program case. The coverage period for the newly enrolled child will be the remaining period of coverage of the siblings already enrolled in the CHIP Program.

STAR Newborn Enrollment

If a woman is a Superior STAR Member at the time of delivery, the newborn is automatically a Superior STAR Member from the date of birth. If the mother is not a Superior Member at the time of birth, the newborn must follow the enrollment process for the STAR program. The local HHSC office should be contacted to obtain Medicaid eligibility, and the STAR Help Line (1-800-964-2777) should be contacted for STAR enrollment information.

STAR Enrollment and Member ID Cards

The Texas Health and Human Services Commission (HHSC) is responsible for determining Medicaid eligibility. Contact Superior Member Services if you need information or locations of HHSC eligibility offices. The State's Enrollment Broker, Maximus, is responsible for enrolling individuals into the STAR and STAR+PLUS Programs. Maximus can be contacted through the Texas Medicaid Program Help Line at 1- 800-964-2777.

Key Enrollment Information: *Until the actual date of enrollment with Superior, Superior is not financially responsible for services the prospective Member receives, nor is Superior financially responsible for Members who have lost their Superior coverage.*

STAR and STAR+PLUS Members receive a Medicaid Form 3087 from the State, confirming eligibility on a month to month basis. This eligibility form also identifies the health plan in which the STAR or STAR+PLUS Member is enrolled. If the Member loses their Medicaid form, the Texas Health and Human Services Commission will provide, upon request from the Member, a temporary ID Card- Form 1027-A. This form may be used until the Member receives their Medicaid Form 3087. Should a 3087 form be misplaced, the Texas Health and Human Services Commission will provide, upon request from the Member, a temporary ID Card- Form 1027-A. This form may be used until the Member receives their Medicaid Form 3087.

STAR+PLUS Newborn Enrollment

If a woman is a Superior STAR+PLUS Member at the time of delivery, the newborn is automatically a Superior STAR Member from the date of birth for service areas/counties where Superior participates in the STAR+PLUS program.

Key Newborn Information: Newborns should receive a Medicaid ID number within 30 days of their birth. All claims related to the care of the newborn should be filed with the newborn's Medicaid ID number.

Disenrollment

Superior STAR and STAR+PLUS Members are eligible through the Texas Medicaid program. When a Member becomes ineligible for Texas Medicaid, the Member is disenrolled from the STAR or STAR+PLUS program and from Superior. The Health and Human Services Commission (HHSC) is solely responsible for determining if and when a Member is disenrolled and will make the final decision. Members can be disenrolled from Superior but still be eligible for Medicaid.

Under no circumstances can a Provider/Practitioner take retaliatory action against a Member due to disenrollment from either the Provider/Practitioner or a plan.

There may be instances when a PCP feels that a Member should be removed from his or her panel. Superior requests notification of such requests so that they may arrange educational outreach with the member. All notifications to remove a patient from a panel must be made in writing, contain detailed documentation and must be directed to Superior's Member Advocate for your service area (Table 2-2 Member Advocate contact information below):

Table 2-2 Superior Member Advocate Contact Information			
CHIP RSA	Bexar Service Area	Travis Service Area	El Paso & Lubbock/Amarillo Service Areas
8431 Fredricksburg Rd, Ste 340	8431 Fredricksburg Rd, Ste 340	2100 South IH 35, Suite 202	6070 Gateway East, Ste 400
San Antonio, Texas 78229	San Antonio, Texas 78229	Austin, Texas 78704	El Paso, Texas 79905
210-562-2700	210-562-2700	512-692-1465	915-778-7475
1-866-615-9399	1-866-615-9399	1-800-218-7508	1-877-391-5923
210-615-9383 Fax	210-615-9383 Fax	512-692-1438 Fax	915-778-7776 Fax

Upon receipt of such request, staff may:

- Interview the provider/practitioner or his/her staff that are requesting the disenrollment, as well as any additional relevant providers/practitioners
- Interview the Member
- Review any relevant medical records

Examples of reasons a PCP may request to remove a patient from their panel could include, but not be limited to:

- A Member is disruptive, unruly, threatening, or uncooperative to the extent that the Member seriously impairs the provider's ability to provide services to the Member, or to other Members and the Member's behavior is not caused by a physical or behavioral condition or
- If a Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the provider to treat the underlying medical condition.

A PCP should never request Member be disenrolled for any of the following reasons:

- Adverse change in the Members health status or utilization of services which are medically necessary for the treatment of a Member's condition;
- On the basis of the Member's race, color, national origin, sex, age, disability, political beliefs or religion.

Medicaid Automatic Re-Enrollment

If a Member becomes temporarily (for six months or less) ineligible for Medicaid and regains eligibility status during the initial six-month timeframe, the Member will be automatically reenrolled in Superior.

Superior and the State's enrollment Broker, Maximus, will make every effort to re-enroll the Member with the previous PCP.

Span of Eligibility

Member can change health plans by calling the Texas MEDICAID MANAGED CARE Program Helpline at 1-800-964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If the member asks to change plans on or before April 15, the change will take place on May 1.
- If the member asks to change plans after April 15, the change will take place on June 1.

Inpatient Notification Process

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

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

All inpatient admissions require authorization. The number of initial days authorized is dependent on Medical Necessity and continued stay is approved or denied based on the findings in concurrent reviews.

Members meeting criteria for inpatient treatment must be admitted to a contracted hospital or crisis stabilization unit. Members in need of emergency and/or after hours care should be referred to the nearest participating facility for evaluation and treatment, if necessary.

The following information must be readily available for the 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 Providers/Practitioners need to 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) follow-up sessions per participating practitioner per member without seeking authorization from Cenpatico. Only specific covered outpatient/office services are covered without authorization. Please refer to 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 Providers/Practitioners should call:

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

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. The OTR can be at www.cenpatico.com under Providers/Resources/Forms. Network Practitioners may call the Customer Service department to check status of an OTR. Network Practitioners should allow up to 2 business days to process non-urgent requests.

IMPORTANT:

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

Guidelines for Psychological Testing

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

It is important to note that;

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

Court Ordered Commitments

A Member under the age of 19 who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code must receive the services ordered by that court of competent jurisdiction. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. The Member cannot appeal the commitment through Cenpatico's complaint or appeals process.

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/Practitioners are expected to work closely with Cenpatico's Utilization Management department in exercising judicious use of a member's benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Cenpatico.

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

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

Determining Medical Necessity

Cenpatico Utilization Managers follow specific guidelines when evaluating whether treatment is medically necessary. These guidelines apply to all levels of care for both mental health and substance abuse services. Network Practitioners should use these guidelines in the formulation of treatment plans. Adequate treatment refers to clinical appropriateness, completeness and timeliness. A copy of the Cenpatico medical necessity criteria is available in this manual and can also be obtained at www.cenpatico.com.

Concurrent Review

Cenpatico's Utilization Management Department will concurrently review the treatment and status of all members in inpatient (including crisis stabilization units) and partial hospitalization through contact with the member's attending physician or the facility's Utilization and Discharge Planning departments. The frequency of review for all higher levels of care will be determined by the member's clinical condition and response to treatment. The review will include evaluation of the member's current status, proposed plan of care and discharge plans.

Discharge Planning

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

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

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within seven (7) days after discharge. Cenpatico's Care Coordination/Case Management staff follow-up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, Cenpatico asks that Network 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 to identify any medications for physical conditions prescribed by psychiatric practitioners as well as to review psychotropic medications prescribed by primary care physicians (PCP).

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

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

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or prior authorization edit and would need prescriber prior approval.

Continuity of Care

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

In addition, if Cenpatico determines that a member is in need of services that are not covered benefits, the member will be referred to an appropriate practitioner 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.

There are some instances when Members care may be coordinated by a Practitioner other than the PCP. The following are some examples:

- Pregnant Members with 12 weeks or less remaining before the expected delivery date will be allowed to remain under the care of the current OB/GYN through the Member's postpartum check-up.
- An existing out-of-network Practitioner has been treating a new Member and Superior and/or Cenpatico has been notified of such arrangements. The out-of-network Practitioner must comply with Superior's Utilization Management Program and accept standard managed care rates. The out-of-network Practitioner must transfer the

- patient's records to the Superior Practitioner and will not be authorized for on-going care for more than 90 days or for nine months in the case of a Member, who at the time of enrollment, is diagnosed with a terminal illness.
- Cenpatico will not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Medicaid or CHIP-eligible.
 - Cenpatico will continue to provide and coordinate services for Members who move out of the service area until such time that Member is removed from Superior's eligibility.

Intensive Case Management (ICM)

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

Cenpatico ICM functions include:

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

For members discharging from an acute inpatient psychiatric hospital stay, Case Management Staff provide discharge summary information to identified outpatient behavioral health practitioners and identified primary care physician. Information is provided to ensure continuity of care and coordination among treating providers. Following discharge, assigned Case Management Staff follow up with behavioral health practitioners to ensure treatment compliance.

For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, Cenpatico offers Care Coordination.

Cenpatico's Care Coordinators are not licensed clinical staff and cannot make clinical decisions about what level of care is needed or assess members who are in crisis.

Cenpatico's Care Coordination functions include:

- Coordinate with Superior HealthPlan, member advocates or Network Practitioners for members who may need behavioral health services;
- Assist members with locating a Network Provider;

- Serve as a resource to inpatient discharge planners needing services for members;
- Coordinate requests for out-of-network providers/practitioners by determining need/access issues involved; and
- Facilitate all requests for inpatient psychiatric consults for members in a medical bed.

Care Coordinators can also arrange a Single Case Agreement (SCA) when it becomes necessary to utilize out-of-network practitioners (practitioners not contracted with Cenpatico) to provide covered services. Cenpatico will utilize out-of-network practitioners, 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 practitioner, Cenpatico makes every attempt to refer members to participating Network Practitioners 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 Practitioners 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; and
- Transition of care from an established out-of-network provider/practitioner to a participating Cenpatico practitioner (Network Practitioner).

Peer Clinical Review Process

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

For both mental health and chemical dependency service continued stay requests, the physician or treating provider/practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available. When a determination is made where no peer-to-peer conversation has occurred, a provider/practitioner can request to speak with the Peer Reviewer who made the determination within 1 business day. Providers/Practitioners should contact Cenpatico at 1-800-716-5650 to discuss UM denial decisions.

The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare provider/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 877-264-6550. 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.

The web citations to retrieve the guidelines are: for the American Psychiatric Association:

http://www.psych.org/MainMenu/PsychiatricPractice/PracticeGuidelines_1.aspx

For the American Academy of child and Adolescent Psychiatry:

http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters

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 Cenpatico) on the date of service;
- The service provided is a covered service (benefit of Cenpatico) on the date of service; and
- Cenpatico's prior-authorization processes were followed.

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

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

CHIP Perinate Cost Sharing

Children eligible for the CHIP Prenatal Care Program are exempt from all cost-sharing, including enrollment fees and co-pays, for the duration of the CHIP Perinate Program enrollment period.

CHIP Co-Pay Requirements

Federal Poverty Level	Office Visits	Emergency Room Visits	Inpatient Hospitalizations	Annual Reporting Caps
Native Americans	\$0	\$0	\$0	\$0
At or Below 100%	\$3	\$3	\$10	1.25% of family income
101%-150%	\$5	\$5	\$25	1.25% of family income
151%-185%	\$7	\$50	\$50	2.5% of family income
186%-200%	\$10	\$50	\$100	2.5% of family income

(Portions taken from Table 5-3 of Superior HealthPlan Provider Manual)

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/Practitioner for completion before processing or information may be requested from the provider/practitioner on an Explanation of Benefit (EOB) form. This will cause a delay in payment. At the receipt of a clean claim, Cenpatico has a 30 day timeframe to process a claim without applying interest. Initial clean claims that take longer than 30 days will have interest applied in accordance with state regulations.

Each claim payment check will be accompanied by a payment voucher entitled Explanation of Payment (EOP), which itemizes your charges for that reimbursement and the amount of your check from Cenpatico.

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, co-payments/deductibles deducted from eligible amounts, and the amount reimbursed.

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

Billing Members

By entering into a Participating Practitioner Agreement with Cenpatico, you have agreed to accept the Cenpatico fee schedule as payment in full minus any applicable co-payment. You have agreed only to bill Members for applicable co-payments. STAR and STAR+PLUS Members do not have any co-payments. If you render a non-covered service to a Member, you may bill the Member; however, only if you have obtained written acknowledgement from the Member, prior to rendering the service that the specific service you are providing is not a covered benefit. A provider's/practitioner's failure to authorize service does not qualify for billing the Member for service.

If a Member elects to have services provided that are not a covered benefit and for which the Member will be financially responsible, the provider/practitioner must fully inform the Member of the prices for the services in advance of rendering such services. Furthermore the provider/practitioner must document by the Member signing a statement that they have been informed that the services to be performed are not covered services and the participant is shown the cost of the services to be performed. This statement must be signed before any such service is performed and cannot be signed up front to provide blanket notice to the Member.

Member Acknowledgement Statement

The only occasion when a Provider/Practitioner may bill a Member is when the Member has completed the Member Acknowledgement Statement.

A Provider/Practitioner may bill a Member for a claim denied as not being medically necessary or not a part of a covered service if both of the following conditions are met:

- A specific service or item is provided at the request of the client; and
- The Provider/Practitioner has obtained and kept a written Member Acknowledgement Statement signed by the client. The Member Acknowledgment Statement must read as follows, as included below:

Member Acknowledgement Statement

“I understand that, in the opinion of (Provider’s/Practitioner’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medicaid Assistance or CHIP Program as being reasonable and medically necessary for my care. I understand that Superior through its contract with HHSC determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”

Private Pay Form

There are instances when the provider/practitioner may bill the Member. For example, if the Provider/Practitioner accepts the Member as a private pay patient and informs the Member at the time of service that the Member will be responsible for paying for all services. In this situation, it is recommended that the Provider/Practitioner use a Private Pay Form. It is suggested that the Provider/Practitioner use the Member Acknowledgement Statement provided above as the Private Pay Form. Without written, signed documentation that the Member has been properly notified of their private pay status, the Provider/Practitioner could not ask for payment from a Member.

Network Provider/Practitioner Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within ninety (95) days of the date the service(s) are rendered. Claims submitted after this period will be denied for payment.

Please submit a Clean Claim on a CMS-1500 Form or a CMS-1450 Form (“UB-04”) or their successors. A Clean Claim is one in which every line item is completed in its entirety. Please ensure the billing provider’s/practitioner’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/Practitioners must submit claims to the following address for processing and reimbursement:

Cenpatico
Attn: Claims
PO Box 6300
Farmington, MO 63640-3818

Network Providers should submit Emergency Services claims to the following address for processing and reimbursement:

Superior HealthPlan Claims Department
PO Box 3003
Farmington, MO 63640-3803

STAR+PLUS Inpatient claims

All inpatient Hospital Facility Claims submitted for STAR+PLUS members should be submitted to the Texas Medicaid Claims Administrator TMHP as they are not processed by Superior. To contact TMHP, call 1-800-925-9126 and Cenpatico after hours phone number at 800-716-5650 to verify Medicaid Hospitals participating in the Medicaid program.

Superior STAR+PLUS Inpatient Hospital facility claims should be sent to:

TMHP
P.O. Box 200555
Austin, Texas 78720-0555

Common Claims Processing Issues

It is the Network Provider's/Practitioner'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/practitioner's NPI number not included in field 24J (CMS-1500) or field 56 (CMS-1450)
- Insufficient Member ID Number. Network providers/practitioners 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/Practitioner 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/Practitioner
- 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

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

Imaging Requirements For Paper Claims

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

Do's

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

Don'ts

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

WEB PORTAL Claim Submission

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

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

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

Cenpatico's also offers our contracted providers/practitioners 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 you favorites and check back often.

EDI Clearinghouses

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

Trading Partner	Payer ID	Contact Number
Emdeon	68053	800-845-6592
Availity	68053	800-282-4548

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/Practitioner 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 co-payments (if any).

Please Note:

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

Non-Covered Services

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

Claims Payment and Member Eligibility

Cenpatico's Network Providers/Practitioners 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/Practitioner, 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 Cenpatico 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/Practitioner 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/Practitioner of any changes in his/her insurance coverage and/or benefits.

Claim Status

Please do not submit duplicate bills for authorized services. If your Clean Claim has not been adjudicated within forty-five (45) days, please call Cenpatico’s Claims Customer Service department at 877-730-2117 for STAR, STAR+PLUS and CHIP 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/Practitioner’s Name
- Network Provider’s/Practitioner’s NPI Number
- Network Provider’s/Practitioner’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/Practitioners 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 may result in termination from the Cenpatico provider/practitioner network due to inability to follow policies and procedures.

If the authorization contains unused visits, but the end date has expired, please contact the Cenpatico Customer Service department and ask the representative to extend the end date on your authorization.

CHIP Program.....	888-471-4357
STAR Program.....	800-716-5650
STAR+PLUS Program.....	800-466-4089
CHIP RSA Program.....	800-213-9927

Resolving Claims Issues

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

1. Call the Claims Support Liaisons for Texas at 1-877-730-2117. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of our Claims Support Liaisons.
2. When a provider/practitioner 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.

Integrated Mental Health Services
Claims Resubmission
P. O. Box 6300
Farmington, MO 63640-3806

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. 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 within 120 days of date of denial. Place APPEAL within your request. In order for Cenpatico to consider the appeal it must be received within 95 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 30 days for Medicaid specific patients, you may contact the HMO for the final decision.

Cenpatico Appeals
PO Box 6000
Farmington, MO 63640-3809
877-730-2117

4. If your claim was denied because you did not have an authorization, please send a request in writing for a retro-active authorization, explaining in detail the reason for providing services without an authorization. Retro authorizations will only be granted in rare cases. Repeated requests for retro authorizations will result in termination from the network due to inability to follow policies and procedures. If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Service Center and ask the representative to extend the end date on your authorization.

Mail requests to the following address:

Cenpatico
Appeals
Attn. Retro Review
504 Lavaca St., Ste 850
Austin, TX 78701-2939

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. After contacting Provider Relations at the address below, your dispute will be investigated.

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

Note: 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.

National Provider Identifier (NPI)

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

Applying for an NPI

Providers/Practitioners 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 practitioner, the NPI is your unique identifier." Then click on the link that says "Apply online for an NPI." This should be the first link. Follow the instructions on the web page to complete the process.

To Register By Mail

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

Submitting Your NPI to Cenpatico

Please visit www.cenpatico.com to submit your NPI number. Network Practitioners 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.

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
CMS 1500 Claim Form			
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 BEHAVIORAL HEALTH 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

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
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

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
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CMS 1500 Claim Form

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9		10 IS PATIENT'S CONDITION RELATED TO: 10		11. INSURED'S POLICY GROUP OR FECA NUMBER 11		PATIENT AND INSURED INF
a. OTHER INSURED'S POLICY OR GROUP NUMBER 9a		a. EMPLOYMENT? (Current or Previous) 10		a. INSURED'S DATE OF BIRTH 11a		
b. OTHER INSURED'S DATE OF BIRTH 9b		b. AUTO ACCIDENT? 10		b. EMPLOYER'S NAME OR SCHOOL NAME 11b		
c. EMPLOYER'S NAME OR SCHOOL NAME 9c		c. OTHER ACCIDENT? 10		c. INSURANCE PLAN NAME OR PROGRAM NAME 11c		
d. INSURANCE PLAN NAME OR PROGRAM NAME 9d		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 11d		
12 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		

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 PTIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	RESERVED FOR LOCAL USE		Not Required

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
11	INSURED'S POLICY GROUP OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C
11b	EMPLOYER'S NAME OR SCHOOL NAME	REQUIRED if Employment is marked Yes in box 10a.	C
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Enter name of the insurance Health Plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The practitioner must have the Member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Not Required.

CMS 1500 Claim Form

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
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FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
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 ITEM 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 – 4 th 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

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
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

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	PHYSICIAN OR SUPPLIER INFORMATION
From To				PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY		MODIFIER							
24a				24b	24c	24d		24e	24f	24g	24h	24i	24j	
												NPI		
												NPI		
												NPI		
												NPI		
												NPI		
												NPI		

24A-J General Information	<p>Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24J. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.</p> <ul style="list-style-type: none"> ➤ The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid Number qualifier, and Provider Medicaid Number. ➤ Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below and in Appendix 4 for information on how to complete. ➤ The un-shaded area of a claim line is for the entry of claim line item detail. 	
24A-G Shaded	<p>SUPPLEMENTAL INFORMATION</p> <p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <ul style="list-style-type: none"> ➤ NDC ➤ Anesthesia Start/Stop time & duration ➤ Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. ➤ HIBCC or GTIN number/code. <p>For detailed instructions and qualifiers refer to Appendix 4 of this manual.</p>	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL																				
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="716 1686 1135 1837"> <tbody> <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> </tbody> </table>	AH	HN	HO	SA	TD	U2	U3	U4	U6	U7	U8	UB	UC	UD		HQ	HR	TF	UA	AJ	R
AH	HN	HO	SA	TD																			
U2	U3	U4	U6	U7																			
U8	UB	UC	UD																				
HQ	HR	TF	UA	AJ																			

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24E Un-shaded	DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9 codes for the date of service or the claim will be rejected/denied.	R
24F Un-shaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24G Un-shaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R
24H Shaded	EPSDT (CHCUP) Family Planning	Leave Blank	Not Required
24H Un-shaded	EPSDT (CHCUP) Family Planning	Enter the appropriate qualifier for EPSDT visit	C
24I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy	C
24Ja Shaded	Non-NPI PROVIDER ID#	<p>Enter as designated below the Medicaid ID number or taxonomy code.</p> <ul style="list-style-type: none"> ➤ <i>Typical Practitioners:</i> 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. ➤ <i>Atypical Practitioners:</i> Enter the 6-digit Medicaid Provider ID number. 	R

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24Jb Un-shaded	NPI PROVIDER ID	Typical Practitioners ONLY: Enter the 10-character NPI ID of the practitioner who rendered services. If the practitioner is billing as a Member of a group, the rendering individual practitioner's 10-character NPI ID may be entered.	R

CMS 1500 Claim Form

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <small>For govt. claims, see back</small> <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____	a. _____ b. _____	a. _____ b. _____			

25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the practitioner or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the practitioner'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 practitioner 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

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
29	AMOUNT PAID	<p>REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Cenpatico BEHAVIORAL HEALTH . Medicaid programs are always the payers of last resort.</p> <p>Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p>	C
30	BALANCE DUE	<p>REQUIRED when #29 is completed.</p> <p>Enter the balance due (total charges minus the amount of payment received from the primary payer).</p> <p>Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p>	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	<p>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.</p>	Required

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
32	SERVICE FACILITY LOCATION INFORMATION	<p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the name and physical location. (P.O. Box #'s are not acceptable here.)</p> <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	<p>Typical Practitioners ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI ID of the facility where services were rendered.</p>	C
32b	OTHER PROVIDER ID	<p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <ul style="list-style-type: none"> ➤ <u>Typical Practitioners</u> Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). ➤ <u>Atypical Practitioners</u> Enter the 2-character qualifier 1D followed by the 6-character Medicaid Provider ID number (no spaces). 	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
33	BILLING PROVIDER INFO & PH #	<p>Enter the billing practitioner's complete name, address (include the zip + 4 code), and phone number.</p> <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	<p>Typical Practitioners ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI ID.</p>	R
33b	GROUP BILLING OTHER ID	<p>Enter as designated below the Billing Group Medicaid ID number or taxonomy code.</p> <ul style="list-style-type: none"> ➤ <i>Typical Practitioners:</i> Enter the Practitioner taxonomy code. Use ZZ qualifier. ➤ <i>Atypical Practitioners:</i> Enter the 6-digit Medicaid Provider ID number. 	R

NOTE: Required fields denoted by an **R** Conditional fields denoted by a **C**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA							
1. MEDICARE (Medicare #) <input type="checkbox"/>	MEDICAID (Medicaid #) <input type="checkbox"/>	TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/>	CHAMPVA (Member ID) <input type="checkbox"/>	GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>	FECA BLK LUNG (SSN) <input type="checkbox"/>	OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) *****R*****	1b. INSURED'S NAME (Last Name, First Name, Middle Initial) *****R*****	1c. INSURED'S DATE OF BIRTH *****C*****	1d. EMPLOYER'S NAME OR SCHOOL NAME *****C*****	1e. INSURANCE PLAN NAME OR PROGRAM NAME *****C*****	1f. IS THERE ANOTHER HEALTH BENEFIT PLAN? *****R***** <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 9 a-d.					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) *****R*****				3. PATIENT'S BIRTH DATE *****R*****		4. INSURED'S NAME (Last Name, First Name, Middle Initial) *****R*****		5. PATIENT'S ADDRESS (No., Street) *****R*****		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY *****R*****		STATE *****R*****		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE		ZIP CODE		TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) *****C*****				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER *****C*****				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					
a. OTHER INSURED'S POLICY OR GROUP NUMBER *****C*****				b. OTHER INSURED'S DATE OF BIRTH *****C*****				c. EMPLOYER'S NAME OR SCHOOL NAME *****C*****				d. INSURANCE PLAN NAME OR PROGRAM NAME *****C*****					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				SIGNED				DATE					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) *****C*****				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. *****R***** 2. *****C*****				22. MEDICAID RESUBMISSION CODE *****C***** ORIGINAL REF. NO. *****C*****					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DENTS OR UNITS	H. SEQUIT FOR Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	23. PRIOR AUTHORIZATION NUMBER				
1	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****	*****R*****				
2													NPI				
3													NPI				
4													NPI				
5													NPI				
6													NPI				
25. FEDERAL TAX I.D. NUMBER *****R*****				26. PATIENT'S ACCOUNT NO. *****C*****				27. ACCEPT ASSIGNMENT? For gov. claims, see Item 1. <input type="checkbox"/> YES <input type="checkbox"/> NO *****R*****				28. TOTAL CHARGE \$ *****R*****		29. AMOUNT PAID \$ *****C*****		30. BALANCE DUE \$ *****C*****	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) *****R*****				32. SERVICE FACILITY LOCATION INFORMATION *****C*****				33. BILLING PROVIDER INFO & PH # () *****R*****				34. *****R*****					
SIGNED				DATE				35. *****C*****				36. *****C*****					

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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.

The image shows a UB-04 Claim Form with various fields numbered 1 through 29. The fields are: 1 (Practitioner Name), 2 (Mailing Address), 3a (Patient Control No.), 3b (Medical Record Number), 4 (Type of Bill), 5 (FED. TAX NO.), 6 (Statement Covers Period From/Through), 7 (City, State, Zip+4), 8 (Patient Name), 9 (Patient Address), 10 (Birthdate), 11 (Sex), 12 (Date), 13 (Admission HR), 14 (Type), 15 (SFC), 16 (DHR), 17 (STAT), 18-21 (Condition Codes), 22-24 (Condition Codes), 25-27 (Condition Codes), 28 (ACDT STATE), 29 (ACDT STATE).

Field #	Field Description	Instructions and Comments	Required or Conditional*
1	(UNLABELED FIELD)	Line 1: Enter the complete practitioner 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: ➤ 1 st 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,	R

		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)	
7	(UNLABELED FIELD)	Not Used	Not Required
8 a-b	PATIENT NAME	8a – Enter the patient’s 10-digit Medicaid identification number on the Member’s Cenpatico BEHAVIORAL HEALTH I.D. card.	Not Required
		8b – Enter the patient’s last name, first name, and middle initial as it appears on the Cenpatico BEHAVIORAL HEALTH ID card. Use a comma or space to separate the last and first names. <ul style="list-style-type: none"> ➤ <u>Titles</u> (Mr., Mrs., etc.) should not be reported in this field. ➤ <u>Prefix</u>: No space should be left after the prefix of a name e.g. McKendrick, <u>H</u> ➤ <u>Hyphenated names</u>: Both names should be capitalized and separated by a hyphen (no space). ➤ <u>Suffix</u>: A space should separate a last name and suffix. 	R
9 a-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	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services . 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	R

		08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59									
14	ADMISSION TYPE	Required for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn	C								
15	ADMISSION SOURCE	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: 1 Physician Referral 2 Clinic Referral 4 Transfer from a hospital 6 Transfer from another healthcare facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available	R								
16	DISCHARGE HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge . 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								
17	PATIENT STATUS	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: <table border="1"> <thead> <tr> <th>STAT</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>US</td> <td></td> </tr> <tr> <td>01</td> <td>Discharged to home or self care</td> </tr> <tr> <td>02</td> <td>Transferred to another short-term general</td> </tr> </tbody> </table>	STAT	Description	US		01	Discharged to home or self care	02	Transferred to another short-term general	C
STAT	Description										
US											
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 practitioner	
		20 Expired	
		30 Still patient or expected to return for outpatient services	
		31 Still patient – SNF administrative days	
		32 Still patient – ICF administrative days	
		62 Discharged/Transferred to an IRF, distinct rehabilitation unit of a hospital	
		65 Discharged/Transferred to a psychiatric hospital or distinct psychiatric unit of a hospital	
18-28	CONDITION CODES	<p>REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing.</p> <p>Each field (18-24) 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>	C
29	ACCIDENT STATE		Not Required
30	(UNLABELED FIELD)	Not Used	Not Required

UB-04 Claim Form

31 CODE	32 CODE	33 CODE	34 CODE	35 CODE	35a	35b	36a	36b	37
OC	OC	OC	OC	OC	FROM	THROUGH	OC	OC	
DATE	DATE	DATE	DATE	DATE			FROM	THROUGH	
38					39	40	41		
					CODE	CODE	CODE	AMOUNT	
					a	b	c	d	

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. 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
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UB-04 Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
42	43	44	45	46	47	48	49

General Information Fields 42-47	Service Line Detail	<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. 	
42 Line 1-22	REV CD	<p>Enter the appropriate 4 digit revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.</p>	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="0"> <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> </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																				
304-307	333	363-366	615-616																				
309-312	340-342	368-369	618-619																				
314	349-352	400-404	634-636																				
319-324	359	490-499	923																				
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY)	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	TOTALS	Enter the total non-covered charges for all service lines.	C																				
49	(UNLABELED FIELD)	Not Used	Not Required																				

UB-04 Claim Form

50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	57	56
50		51		52	53	54		55		57		
58 INSURED'S NAME		59 P. REL.	60 INSURED'S UNIQUE ID			61 GROUP NAME			62 INSURANCE GROUP NO.			
58		59	60			61			62			
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME				
63				64				65				

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). Practitioners 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 Practitioner for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid/ Cenpatico BEHAVIORAL HEALTH is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER or PROVIDER ID	Required: Enter practitioner'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 Cenpatco BEHAVIORAL HEALTH claim when submitting a replacement or void on the corresponding A, B, C line reflecting Cenpatco BEHAVIORAL HEALTH 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

UB-04 Claim Form

The diagram shows a UB-04 Claim Form with various fields highlighted by blue circles and labeled with numbers. The fields are arranged in a grid-like structure. At the top, there are columns labeled A through H. Below these are rows for 69 ADMIT DX (69), 70 PATIENT REASON DX (70), 71 PPS CODE (71), 72 ECI (72), and 73 (73). The 74 section contains five rows for PRINCIPAL PROCEDURE CODE and OTHER PROCEDURE CODE (74a-e), each with a corresponding DATE field. The 75 section contains a large field for 75. The 76-79 sections contain rows for ATTENDING, OPERATING, and OTHER providers, each with NPI, LAST, and FIRST name fields. The 80 REMARKS section contains a large field for 80, and the 81 section contains a field for 81. The 81CC section contains four rows for 81CC a, b, c, and d.

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.	R
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		Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4 th 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.	
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 – 4 th 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 – 4 th 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 – 4 th 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	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p> <p>REQUIRED for EDI Submissions.</p>	C
74 a-e	OTHER PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9 procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	C
75	(UNLABELED)		Not Required
76	ATTENDING PHYSICIAN	<p>Enter the NPI and Name of the physician in charge of the patient care:</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code</p> <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>	C

		<p>QUAL: Enter one of the following qualifier and ID number</p> <p>0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code</p> <p>LAST: Enter the operating physician’s last name</p> <p>FIRST: Enter the operating physician’s first name.</p>	
78 & 79	OTHER PHYSICIAN	<p>Enter the Practitioner Type qualifier, NPI, and Name of the physician in charge of the patient care: (Blank Field): Enter one of the following Practitioner Type Qualifiers: DN – Referring Practitioner ZZ – Other Operating MD 82 – Rendering Practitioner</p> <p>NPI: Enter the other physician 10-character NPI ID.</p> <p>QUAL: Enter one of the following qualifier and ID number</p> <p>0B – State License # 1G – Provider UPIN G2 – Provider Commercial #</p> <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 practitioner. Use ZZ qualifier	R

Medical Necessity Criteria

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

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

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

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

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

Medical Necessity Definition

Cenpatico defines medical necessity as:

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

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

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

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

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:

Superior HealthPlan
2100 S. IH-35 Ste 202
Austin, TX 78704
800-218-7453