

## Massachusetts Provider Frequently Asked Questions (FAQ)

### 1. Who Manages the Physical Health Benefits for Cenpatico's Members?

CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare) is the physical health vendor for Cenpatico's Massachusetts membership.

### 2. How Do I Contact CeltiCare?

You may contact CeltiCare by phone or website:


**Phone:** 866-895-1786

**Website:** [www.celticarehealthplan.com](http://www.celticarehealthplan.com)


### 3. Will Cenpatico's Members Have a Member Identification Card?

Yes, CeltiCare will provide each member with a Member Identification Card. There are four program types; Commonwealth Care, Commonwealth Care Bridge, Commonwealth Choice and CeltiCare Direct.



#### Commonwealth Care ID Card

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXXXX	
PCP Name: John Doe	PCP Number: XXX-XXX-XXXX	
Co-pays		
PCP/Spec: \$X/\$X	ER:\$X	INPX: \$X
Vision: \$X	RX:\$X/\$X/\$X	
If you have an emergency, call 911 or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your PCP or CeltiCare as soon as possible.		
Commonwealth Care Plan Type:		


#### Commonwealth Care Bridge ID Card

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXXXX	
PCP Name: John Doe	PCP Number: XXX-XXX-XXXX	
Co-pays		
PCP/Spec: \$X/\$X	ER:\$X	INPX: \$X
RX:\$X/\$X/\$X		
If you have an emergency, call 911 or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your PCP or CeltiCare as soon as possible.		
Commonwealth Care Bridge		

#### Commonwealth Choice ID Card

			Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXXXX		
PCP Name: John Doe	PCP Number: XXX-XXX-XXXX		
Co-pays			
PCP/Spec: \$X/\$X	ER:\$X	INPX: \$X	
Vision: \$X	RX:\$X/\$X/\$X		
If you have an emergency, call 911 or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your PCP or CeltiCare as soon as possible.			
Commonwealth Choice Plan:			

#### CeltiCare Direct ID Card

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXXXX	
PCP Name: John Doe	PCP Number: XXX-XXX-XXXX	
Co-pays		
PCP/Spec: \$X/\$X	ER:\$X	INPX: \$X
Vision: \$X	RX:\$X/\$X/\$X	
If you have an emergency, call 911 or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your PCP or CeltiCare as soon as possible.		
CeltiCare Plan Name:		

**4. How Will I Know When I Can Begin Seeing Members as a Participating (or, in-network) Cenpatico Provider?**

Cenpatico will send you a Welcome Packet which will include a Cenpatico Commonwealth of Massachusetts Provider Manual, a copy of your fully-executed Agreement and a welcome letter notifying you of your effective date in our network. Welcome Packets are submitted after your credentialing application and contract have been approved and made effective in our system.

**5. How Do I Obtain a Copy of Cenpatico’s Massachusetts Provider Manual?**

You will receive a copy of the Cenpatico Massachusetts Provider Manual in your Welcome Packet one you are made effective, or “PAR”, in our system. If you did not receive a copy of the Cenpatico Massachusetts Provider Manual in your Welcome Packet you can call the Cenpatico Internal Provider Relations department at 512-406-7200 or download a copy from our website at [www.cenpatico.com/providers/forms/massachusetts](http://www.cenpatico.com/providers/forms/massachusetts).

**6. How Do I Obtain a Copy of Cenpatico’s Comprehensive Cultural Competency Program?**

You may obtain a Copy of the Comprehensive Cultural Competency Program by calling the Cenpatico Quality Improvement (QI) department at 512-406-7200 or online at [www.cenpatico.com](http://www.cenpatico.com).

**7. What Services Are Covered By Cenpatico?**

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

- Inpatient hospitalization
- Community Based Acute Residential Treatment
- Crisis Stabilization Services
- Partial Hospitalization
- Day Treatment
- Intensive Outpatient Treatment
- Outpatient Therapy (Individual, Family and Group)
- Medication Management
- Methadone Maintenance
- Psychological Testing
- Electroconvulsive Therapy (ECT)
- Structured Outpatient Addiction Program (SOAP)
- Family Stabilization Team
- Community Support Services
- Diversionary Programs

For a complete listing of professional service codes and authorization requirements, please refer to the Massachusetts Covered Professional Services & Authorization Guidelines document which can be found in the Provider Manual and online at [www.cenpatico.com/providers/forms/massachusetts](http://www.cenpatico.com/providers/forms/massachusetts).

Please refer to your Agreement with Cenpatico to identify which any additional services, like inpatient or step-down services and their respective billing codes, you are contracted to provide. Please note that all services must meet Medical Necessity.

#### **8. How Do I Obtain Prior-Authorization for Covered Behavioral Health Services?**

For prior-authorizations during normal business hours, please call 866-896-5053. You may contact Cenpatico after hours to notify us of an inpatient admission via our after hours call center – Nursewise (calls to Cenpatico after hours are automatically routed to Nursewise). Member demographic information as well as admitting date, time and diagnosis will be requested. Cenpatico UM staff will contact you the next business day to obtain full clinical information. You may also submit inpatient notification via our website at [www.cenpatico.com](http://www.cenpatico.com).

#### **9. How Do I Obtain Additional Sessions?**

When requesting authorization for covered outpatient services, you must complete an Outpatient Treatment Request (OTR) form and fax the completed form to Cenpatico at 866-694-3649 for clinical review. The OTR can be found online at [www.cenpatico.com/providers/forms/massachusetts](http://www.cenpatico.com/providers/forms/massachusetts). You may call the Customer Service department at 866-896-5053 to check status of an OTR.

Treatment requests will be reviewed and responded to within two (2) days. If authorized, providers will receive a Notification of Authorization indicating code and units authorized via fax. If additional information is needed, the provider will be contacted via phone to discuss further.

#### **10. How Can I Verify Member Eligibility?**

You can use any of the following options to verify Member enrollment:

- Call 866-896-5053 to reach Cenpatico
- Verify online at [www.cenpatico.com](http://www.cenpatico.com) (You must have provider login to verify eligibility online)
- Providers who are registered MassHealth providers may also check eligibility for Commonwealth Care and Commonwealth Care Bridge members through the Eligibility Verification System (EVS) of the new MMIS

Eligibility can be verified after hours via the Cenpatico website, or by contacting our after-hours nurse service – Nursewise (after-hours calls will automatically be routed to Nursewise).

#### **11. What Happens If a Service is not Covered?**

If you render a non-covered service to a Member, you may bill the Member only if you have obtained written acknowledgement from the Member, prior to rendering such non-covered service, that the specific service is not a covered CeltiCare benefit and that the Member understands they are financially responsible for such service.

#### **12. My Service Site Address, Phone Number, Fax Number, or Tax Identification Number Changed. How Do I Notify Cenpatico?**

Please use the Cenpatico Massachusetts Provider Information Update Form located in the Forms section of the Provider Manual 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-Massachusetts  
504 Lavaca St., Ste. 850  
Austin, TX 78701

**13. Where Can I Find a Listing of Other Participating Cenpatico Providers for Referrals?**

Participating providers will be listed in the Cenpatico Massachusetts Provider Directory. You can find the Provider Directory online at [www.cenpatico.com](http://www.cenpatico.com).

**14. Where Do I Send My Paper Claims?**

Please submit your claims to the following address:

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

**15. Which Clearinghouses Does Cenpatico Accept for EDI Claims?**

Cenpatico accepts transactions from the following vendors:

- Availity
- Capario/ProxyMed
- Emdeon/WebMD/Envoy

Cenpatico's payor identification number is 68061.

**16. What is the Timely Filing Deadline?**

Claims must be received within ninety (90) days of the date the service(s). Claims submitted after this period will be denied for payment.

**17. What is an EOP?**

An Explanation of Payment (EOP) is provided with each claim payment or denial. The EOP details each service being considered, the amount eligible for payment, co-payments/deductibles from eligible amounts, and the amount reimbursed. If you have questions regarding your EOP, please contact Cenpatico's Claims Customer Service department at 866-324-3632.

**18. What do the EX (Explanation) Codes on My Claim Mean?**

An EX code explains how the claim was processed and why a claim was adjusted or denied. Common EX codes are as follows;

- **MF:** DENY: INAPPROPRIATE MEDICAID# SUBMITTED FOR SVC PROVIDER, PLEASE RESUBMIT – The billed Medicaid# may not have been set up in our system, or may have been billed with additional alpha or numeric characters. Another common cause is inclusion of the Tax ID# in the fields where Medicaid# should be populated. Depending on provider type and state specific rules, this denial can also occur when the Medicaid number or NPI number of the rendering provider is put on the claim instead of the billing provider’s number.
- **A1:** DENY: AUTHORIZATION NOT ON FILE –An authorization has not been obtained for the billing provider, the date of service falls outside the range of an existing authorization, the claim was submitted prior to request for authorization, or an authorization has been obtained but was not showing in the claim system at the time of processing.
- **29:** DENY: THE TIME LIMIT FOR FILING HAS EXPIRED – In the event that timely filing guidelines were not followed, this denial will apply. If effort was made to submit prior to the expiration of timely filing limits then documentation that demonstrates the same can be included with paper claims.
- **18:** DENY: DUPLICATE CLAIM/SERVICE – The claim payment system will attempt to match dates of service and procedures with previously processed claims. If a match is found then a duplicate denial code may be applied. Duplicate denials can occur when adjustment requests are submitted along with additional copies of the original claim or when part of a claim denies and a new claim with all services are resubmitted instead of just submitting an adjustment for the previously denied service lines. Another common submission error pertains to multiple submissions of the same electronic claims file “just to be sure.”
- **28:** DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED – Member eligibility should be verified prior to providing services to ensure payment. Additionally, careful keying of member information on the claim will help insure the correct member is selected in the claims system.
- **MQ:** DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH. PLEASE RESUBMIT – A common submission error pertains to member number containing extra digits, or too few digits. Additionally a restriction on the date of birth field circa March, 2007 now mandates that D.O.B. on claim must match the claim payment system exactly as opposed to a 2-day lenience or transposition of the numbers representing day of month (e.g. 06/12/1980 written as 06/21/1980).
- **90:** PAID: SERVICE IS PAID UNDER CAPITATION OR BLOCK AGREEMENT – This payment code is used to track encounter value for providers on block payment agreements.
- **VI:** GLOBAL FEE PAID – A cash payment will not be made on this service as it has been already made on a primary service.

**19. Do I Use a CMS-1500 or CMS-1450 (UB-04) Form For Billing?**

All CPT and HCPCS codes must be billed on a CMS-1500 form. All revenue codes must be billed on a CMS-1450 Form (“UB-04”) form.

**20. What if I Disagree With How a Claim Was Processed?**

If a claim discrepancy is discovered, in whole or in part, contact Cenpatico’s Claims Customer Service department at 866-324-3632 to speak with a Claims Support Liaison. The majority of

issues regarding claims can be resolved through the Claims Department with the assistance of a Claims Support Liaison.

### **21. Can I Bill a Member for Covered Services?**

Under no circumstances is a Member to be balance billed for covered services or supplies. If you use 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 copayment (if any).

### **22. How Can I Ensure Timely Payment?**

- Submit claims immediately after providing services. Claims must be received within ninety (90) days of the date the service(s). Claims submitted after this period will be denied for payment.
- 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.
- Ensure the billing provider’s NPI number is listed in field 24J if you are billing with a CMS-1500 Form or field 56 if you are billing with a CMS-1450 Form.
- Use the correct mailing address when submitting paper claims.

### **23. What are the Member Copayment Amounts?**

Member contribution amounts vary by program type. Copayment amounts are as follows;

#### **Commonwealth Care:**

##### **Plan Type I:**

- No copayments or out-of-pocket maximum for any covered behavioral health service.

##### **Plan Type II:**

- \$10.00 copayment for outpatient or office visits.
- \$50.00 copayment per stay for inpatient services\*
- No copayment for methadone maintenance
- Maximum out-of-pocket cost per member per benefit year\*\* is \$750.00 (excluding prescriptions)

##### **Plan Type III:**

- \$15.00 copayment for outpatient or office visits.
- \$250.00 copayment per stay for inpatient services\*
- No copayment for methadone maintenance
- Maximum out-of-pocket cost per member per benefit year\*\* is \$1500.00 (excluding prescriptions)

#### **Commonwealth Care Bridge:**

- \$25.00 copayment for outpatient or office visits.

- \$250.00 copayment per stay for inpatient services\*
- No copayment for methadone maintenance
- Maximum out-of-pocket cost per member per benefit year\*\*\* is \$1000.00 (excluding prescriptions)

**Note:**

\*Inpatient copayments are waived if transferred from another inpatient unit.

\*\*Benefit year is July 1st through June 30<sup>th</sup> for Commonwealth Care.

\*\*\*Benefit year is October 1st through June 30th for Commonwealth Care Bridge.

**Commonwealth Choice and CeltiCare Direct:**

**CeltiCare Premier (Gold) Plan:**

- \$20.00 copayment for outpatient or office visits with no copayment for methadone maintenance
- \$150.00 copayment per stay for inpatient services
- No deductible, no maximum out-of-pocket cost per member or family, and no annual limit

**CeltiCare Solution (Silver High) Plan**

- \$25.00 copayment for outpatient or office visits with no copayment for methadone maintenance
- \$500.00 copayment per stay for inpatient services
- No deductible, maximum out-of-pocket cost is \$2,000 per member and \$4,000 per family per benefit year (excluding prescriptions), and no annual limit

**CeltiCare Solution 500 (Silver Medium) Plan**

- \$20.00 copayment for outpatient or office visits with no copayment for methadone maintenance
- Copayment per stay for inpatient services is \$0 after deductible has been met
- Deductible is \$500 per member and \$1,000 per family per benefit year, maximum out-of-pocket cost is \$2,000 per member and \$4,000 per family per benefit year (excluding prescriptions), and no annual limit

**CeltiCare Solution 1000 (Silver Low) Plan**

- \$20.00 copayment for outpatient or office visits with no copayment for methadone maintenance
- Copayment per stay for inpatient services is \$0 after deductible has been metDeductible is \$1,000 per member and \$2,000 per family per benefit year, maximum out-of-pocket cost is \$2,000 per member and \$4,000 per family per benefit year (excluding prescriptions), and no annual limit

**CeltiCare Saver 250 (Bronze High) Plan**

- \$25.00 copayment for outpatient or office visits with no copayment for methadone maintenance
- Coinsurance per stay for inpatient services is 35% after deductible has been met
- Deductible is \$250 per member and \$500 per family per benefit year, maximum out-of-pocket cost is \$5,000 per member and \$10,000 per family per benefit year (excluding prescriptions), and no annual limit

**CeltiCare Saver 2000 (Bronze Medium) Plan**

- \$30.00 copayment for outpatient or office visits with no copayment for methadone maintenance
- Copayment per stay for inpatient services is \$500 after deductible has been met
- Deductible is \$2,000 per member and \$4,000 per family per benefit year, maximum out-of-pocket cost is \$5,000 per member and \$10,000 per family per benefit year (excluding prescriptions), and no annual limit

**CeltiCare Saver HSA (Bronze Low) Plan**

- \$25.00 copayment for outpatient or office visits after deductible has been met, with no copayment for methadone maintenance
- Coinsurance per stay for inpatient services is 20% after deductible has been met
- Deductible is \$2,000 per member and \$4,000 per family per benefit year, maximum out-of-pocket cost is \$5,000 per member and \$10,000 per family per benefit year (including prescriptions), and no annual limit