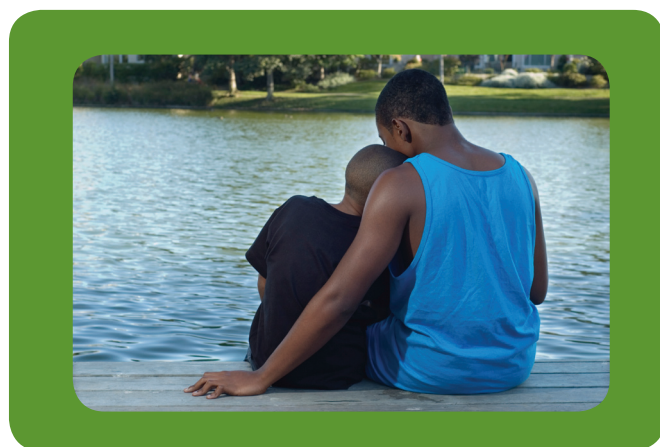


Cenpatico Provider Manual

Commonwealth of Massachusetts



www.cenpatico.com



v. 6/10/11

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Welcome To Cenpatico

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

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 Commonwealth of Massachusetts.

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

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

About Cenpatico

MISSION

Together we inspire hope for a better life

VISION

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

GOAL

Demonstrate value to our customers in everything you do

History and Structure of Cenpatico

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

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

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

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

Cenpatico Managed Care Philosophy

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

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

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

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

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

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

Quick Reference Guide

Important Phone Numbers

Prior-Authorization:	
Commonwealth Care/Bridge	866-896-5053
Commonwealth Choice/Direct	866-595-8130
Claims Customer Service	866-324-3632
Network Development/Provider Relations	866-896-5053
Appeals/Grievances/Complaints	866-896-5053

Important Fax Numbers

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

Verifying Member Eligibility

Network Providers who are registered MassHealth providers may also check Commonwealth Care and Commonwealth Care Bridge member eligibility through the Eligibility Verification System (EVS) of the new MMIS.

Cenpatico Website	www.cenpatico.com
	<i>(You must have a provider log-in to access eligibility online)</i>
Cenpatico	
Commonwealth Care/Bridge	866-896-5053
Commonwealth Choice/Direct	866-895-1786
CeltiCare	866-895-1786

Network Providers who are registered MassHealth providers may also check eligibility through the Eligibility Verification System (EVS) of the new MMIS.

<https://gateway.hhs.state.ma.us/authn/index.jsp>

Cenpatico Website

www.cenpatico.com

Please visit www.cenpatico.com/providers/forms/massachusetts for market-specific materials.

Claims Address

Cenpatico
PO Box 7200
Farmington, MO 63640-3818

Health Plan Contact Information

CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare)
866-895-1786
www.celticarehealthplan.com

The Cenpatico Provider Network

Cenpatico Service Area

Cenpatico manages and reimburses claims for the covered behavioral health and substance abuse benefits for consumers eligible for Commonwealth Care, Commonwealth Care Bridge, CeltiCare Direct and Commonwealth Choice coverage and enrolled with CeltiCare throughout the Commonwealth of Massachusetts.

Network Provider Selection Process

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

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

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

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

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

The Network Provider's Office

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

General Network Practitioner Office Standards

Cenpatico requires the following:

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

- Medication prescription pads and sample medications must be locked up and inaccessible to members.

Network Provider Concerns

Network Providers who have concerns about Cenpatico should contact the Cenpatico Massachusetts Provider Relations department at 866-896-5053 to register these complaints. All concerns are investigated, and written resolution is provided to the Network Provider on a timely basis.

Network Provider Standards of Practice

Network Providers are required to:

- Refer members with known or suspected physical health problems or disorders to the member's PCP for examination and treatment;
- Only provide physical health services if such services are within the scope of the Network Provider's clinical licensure;
- Network Providers (facilities and community mental health centers) must ensure members that are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
- Contact members who have missed appointments within twenty-four (24) hours to reschedule;
- Ensure all members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language;
- Make referrals or admissions of members for covered behavioral health services only to other Participating Healthcare Providers (those that participate in the CeltiCare or Cenpatico provider network), except as the need for Emergency Care may require, or where Cenpatico specifically authorizes the referral, or as otherwise required by law;
- Comply with all State and federal requirements governing emergency, screening and post-stabilization services;
- Provide member's clinical information to other providers treating the member, as necessary to ensure proper coordination and treatment of members who express suicidal or homicidal ideation or intent, consistent with State law;
- Network Providers that are psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age twenty-one (21) agree to comply with all applicable legal requirements relating to restraint and seclusion, and agree to submit to Cenpatico a copy of the Restraint and Seclusion Order Form as required in 104 CMR 27.12 within five (5) days of the occurrence.

Network Providers are requested to:

- Submit all documentation in a timely fashion.
- Comply with Cenpatico Care Management process.
- Cooperate with Cenpatico's QI Program (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.

Reporting Provider or Member Waste, Abuse or Fraud

Waste, Abuse and Fraud (WAF) System

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

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

Cenpatico, in conjunction with its management company, Centene Corporation, operates a WAF unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. 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 CeliCare Health Plan of Massachusetts, 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 CeliCare Health Plan of Massachusetts, at the provider and/or subcontractor's own expense.

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

Medicaid Fraud Control Unit of Massachusetts
Office of the Attorney General
One Ashburton Place
Boston, MA 02108
Phone: (617) 727-2200 x 2366
Fax: (617) 727-2008

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

Providers may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone at 866-896-5053.

Credentialing

Credentialing Requirements

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

Cenpatico Network Providers must adhere to the following requirements:

- In order to continue participation with our organization, all Network Providers must adhere to Cenpatico's Clinical Practice Guidelines and Medical Necessity Criteria which are located in this Manual.
- Network Providers must consistently meet our credentialing standards and Cenpatico guidelines on Primary Care Physician (PCP) notification.
- Failure to adhere to guidelines and standards at anytime can lead to termination from our network.
- Notification is required immediately upon receipt of revocation or suspension of the Network Provider's State License by the Division of Medical Quality Assurance, Department of Public Health.
- In order to be credentialed in the Cenpatico network, all individual Network Providers must be licensed to practice independently in the Commonwealth of Massachusetts.
- For MDs and DOs, Cenpatico will require proof of the Network Provider'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 should have an independent relationship with a supervising physician or under direct personal supervision of the attending physician.
- All Network Providers' graduate degrees must be from an accredited institution.
- All Network Providers are subject to the completion of primary source verification of the Network Provider through our Credentialing Department located in Austin, Texas.
- The Network Provider agrees to complete and provide appropriate documentation for this primary

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

The credentialing and re-credentialing process will include verification of the following for MDs and DOs:

- Good standing of privileges at the hospital designated as the primary admitting facility;
- Valid Drug Enforcement Administration (DEA) certificates (where applicable); and

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

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

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

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

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

Massachusetts Network Providers will be re-credentialed every two (2) years as required by the Commonwealth of Massachusetts. Cenpatico Network Providers will receive notice that they are due to be re-credentialed well in advance of their credentialing expiration date and, as such, are expected to submit their updated information in a timely fashion. Failure to provide updated information in a timely manner can result in suspension and/or termination from the network.

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

Council for Affordable Quality HealthCare (CAQH)

Cenpatico subscribes to the Council for Affordable Quality HealthCare (CAQH) to streamline the credentialing/re-credentialing process. If you are interested in having Cenpatico retrieve your credentialing/re-credentialing application from CAQH, or if you are not enrolled with CAQH, Cenpatico can contact CAQH to obtain your credentialing items or assist you with setting up an account.

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

Cenpatico Credentialing Policies and Procedures

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

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

Cenpatico Credentialing Committee

The Cenpatico Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial and termination. The Cenpatico Credentialing Committee meets monthly, at a minimum 10 times per year.

Credentialing of Health Delivery Organizations (CMHCs and other Mental Health Providers/Facilities)

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

- Hospital or Facility
- CMHC

Cenpatico recognizes the following accrediting bodies:*

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

* This list may not be inclusive of all accrediting organizations

For those organizations that are not accredited, an on-site evaluation will be scheduled to review the scope of services available at the facility, physical plant safety, the quality improvement program, and Credentialing and Recredentialing Policies and Procedures. Cenpatico may substitute a Center for Medicare and Medicaid Services (CMS) or state review in lieu of the site visit. Cenpatico would require the report from the organization to verify that the review has been performed and the report meets its standards. Also acceptable is a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection..

Massachusetts HDO are re-credentialed every two (2) years to assure that the organization is in good standing with state and federal regulatory bodies, has been reviewed and approved by an accrediting body (as applicable), and continues to meet Cenpatico participation and Quality Improvement requirements.

Right to Review and Correct Information

All providers participating with Cenpatico 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 malpractice insurance carriers and the State Board of Medical Examiners. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a provider, you 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 Credentialing Department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Cenpatico. The Cenpatico Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Status Change Notification

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

Network Provider Demographic/Information Updates

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

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

Network Provider Request to Terminate

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

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

Cenpatico's Right to Terminate

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

- Termination of Cenpatico's obligation to provide or arrange mental health/substance abuse treatment services for members of Health Plans;
- Restriction, qualification, suspension or revocation of Network Practitioner's license, certification or membership on the active medical staff of a hospital or Cenpatico participating practitioner group;
- Network Provider's loss of liability insurance required under the Provider Agreement with Cenpatico;
- Network Provider's exclusion from participation in CultiCare programs;
- Network Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's insolvency or bankruptcy or Network Provider's assignment for the benefit of creditors;
- Network Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Network Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Provider's submission of false or misleading billing information;
- Network Provider's failure or inability to meet and maintain full credentialing status with Cenpatico; or
- Network Provider's breach of any term or obligations of the Provider Agreement;
- Any occurrence of serious misconduct which brings Cenpatico to the reasonable interpretation that a Network Provider may be delivering clinically inappropriate care; or

- Network Provider's breach of Cenpatico Policies and Procedures.

Network Provider Appeal of Suspension or Termination of Contract Privileges

If a Network Provider has been suspended or terminated by Cenpatico, contact the Cenpatico Massachusetts Provider Relations department at 866-896-5053 to request further information or discuss how to appeal the decision.

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

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

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

Cenpatico will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the Network Provider with the notification of suspension/termination. To request a copy of Cenpatico's Provider Dispute Policy, please contact the Quality Improvement Department at 866-896-5053.

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

Cultural Competency

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

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

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

Network Providers must ensure the following:

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

Understanding the Need for Culturally Competent Services

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

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

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

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

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

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

Facts about Health Disparities

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

Access and Coordination of Care

Provider Access Standards

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

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

Type of Care	Appointment Availability
Routine – treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting	Within fourteen (14) calendar days
Urgent – is defined as a non life threatening situation that should be treated within forty-eight (48) hours. Urgent care services are not subject to prior authorization or precertification.	Within forty-eight (48) hours for services that are non-Emergent services or routine services

<p>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 her fetus</p>	<p>All non-life threatening emergencies are to be directed to the Emergency Room.</p>
<p>ESP (Emergency Service Provider) Services- Urgent care services are not subject to prior authorization or precertification.</p> <p>*** Please refer to the “Inpatient Notification Process & Non-Contracted Emergency Service Providers (ESPs)” section of this Manual</p>	<p>Immediately, on a twenty-four (24) hour basis, seven (7) days a week</p>
<p>Discharge (from hospital/acute care)</p>	<p>Within seven (7) days of discharge</p>

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

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

Network Providers should call the Cenpatico Provider Relations department at 866-896-5053 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a Network Provider’s status will be considered in the re-credentialing process.

Cenpatico Access Standards

Cenpatico ensures network adequacy and promotes quality of care and service to members in part, by establishing, implementing, and evaluating standards for member geographic access to practitioners and facility services.

- **Practitioner-** 1 provider within 30 miles and/ or a 30 minute drive from the member’s residence
- **Facility-** 1 facility within 60 miles and/ or a 60 minute drive from the member’s residence

No Show Appointments

A “no show” is defined as a failure to appear for a scheduled appointment without notification to the

provider with at least twenty-four (24) hours advance notice. No show appointments must be recorded in the member record.

A “no show” appointment may never be applied against a member’s benefit maximum.

CeltiCare members may not be charged a fee for a “no show” appointment.

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: Massachusetts Provider Relations
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 866-896-5053

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.

Coordination between CeltiCare and Cenpatico

CeltiCare 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 CeltiCare on a monthly basis, and is shared with CeltiCare’s QI committee quarterly. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency.

Quality Improvement

Cenpatico’s Quality Improvement (QI) Program provides a structure and process by which quality of care and services are continually monitored, and improvements implemented and refined across time. The QI Program provides functional support for quality improvement activities in all departments across the organization. The principles of the QI Program are based on a belief that quality is synonymous with

performance. For that reason, the QI Program is highly integrated with clinical services, access issues pertaining to Network Providers and services, credentialing, utilization, member satisfaction, Network Provider satisfaction, PCP communications, and administrative office operations, as well as CeltiCare's Quality Improvement Program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

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

Monitoring Clinical Quality

What does Cenpatico monitor?

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

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

How does Cenpatico monitor quality?

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

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

- Provider quality profiling

Findings are communicated to individual Network 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 Participation in the QI Process

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

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

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

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

Confidentiality and Release of Member Information

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

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

Communication With the Primary Care Physician

CeltiCare encourages 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. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

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

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

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

Network 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 reason why.

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

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

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

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.

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

Critical Incident Reporting

A Critical Incident Report must be completed on any incident involving a Network Provider and any member(s)/ member advocate(s) seen on behalf of Cenpatico.

A Critical Incident is defined as any occurrence which is not consistent with the routine operation of a

Mental Health/Substance Abuse Network Provider. It includes, but is not limited to; injuries to members or member advocates, suicide/homicide attempt by a member while in treatment, death due to suicide/homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

The Critical Incident Report included in the Forms Section of this Manual 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: 866-896-5053
Fax: 866-694-3649

Member Concerns about Network Providers

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

Monitoring Satisfaction

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

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

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

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

Records and Documentation

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

The Network Provider will provide Cenpatico, CeltiCare, and other regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information.

Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and or non-renewal of a Provider Agreement with Cenpatico.

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. Sample forms are located on our website at www.cenpatico.com and 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 Provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the member must sign an authorization for release, which can be found in the Forms Section as well. Chart Audits of member records will be evaluated in accordance with these criteria.

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

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

Treatment Record Guidelines

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

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

1. Each page in the treatment record contains the patient's name or ID number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the treatment record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.
4. The record is legible to someone other than the writer.
5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status and the results of a mental status exam, are documented.
7. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement

- potential, are prominently noted, documented and revised in compliance with written protocols.
8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
 9. A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
 10. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
 11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers and health care institutions are included, as appropriate.
 12. Informed consent for medication and the patient's understanding of the treatment plan are documented.
 13. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

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

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 Peri-natal Depression Screening Program offers screening to members who are pregnant in an effort to identify them and to follow-up. Each member who participates receives a letter from Cenpatico. If a member screens positive for depression while pregnant or after delivery, our staff attempts outreach to assist the member in finding resources. Cenpatico outreaches to the medical provider as well to assure the member has the care needed.

Cenpatico has a structured program for children who have been hospitalized for a mental health issue. These high risk children are especially vulnerable so Cenpatico's Care Coordinator and/or Case Management staff attempts outreach to the parents while the child is still hospitalized to educate them on firearm safety, medication safety and the need to give prescribed medications as ordered by their 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.

Complaints, Grievances and Appeals

Provider Complaints

What is a Complaint?

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

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

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

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

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

Commonwealth Care/Bridge 866-896-5053
Commonwealth Choice/Direct 866-595-8130

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

Member Complaints

What is a Complaint?

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

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

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

CeltiCare

1380 Soldiers Field Road
Third Floor
Brighton, MA 02135

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

Commonwealth Care/Bridge 866-896-5053
Commonwealth Choice/Direct 866-595-8130

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

Member Grievances

What is a Grievance?

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

Cenpatico has developed and maintains a grievance system that complies with applicable Federal and State laws and regulations. A grievance must be filed with Cenpatico within one hundred eighty (180) calendar days from the date of the notice of Cenpatico's action/determination. Members may continue to seek covered services while the grievance is being resolved.

If the member is still receiving the services that are under grievance review and the services are covered services, the services may continue until a decision is made on the grievance. Cenpatico will pay for the cost of continued services regardless of the outcome minus any applicable co-pays or deductibles. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Cenpatico and were not terminated because benefit coverage for the service was exhausted.

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

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

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

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

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

Commonwealth Care/Bridge 866-896-5053
Commonwealth Choice/Direct 866-595-8130

Expedited Adverse Determination Grievances

Members and authorized representatives also have the right to request that Cenpatico expedite a grievance, if:

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

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

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

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

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

Commonwealth Care/Bridge 866-896-5053
Commonwealth Choice/Direct 866-595-8130

If the Expedited Grievance relates to an ongoing emergency or denial to continue a hospital stay, Cenpatico will resolve the Expedited Grievance within one (1) business day. Other Expedited Appeals will be resolved within forty-eight (48) hours after receipt of the request.

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

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

External Review

If a member or the member's authorized representative is not satisfied with the final outcome of the Grievance or Expedited Grievance an External Review of the decision through the Office of Patient Protection (OPP) of the Massachusetts Department of Public Health may be requested

The member or the member's authorized representative may request the External Review Forms and instructions for submitting the request will be included with the Final Adverse Determination sent. The required forms must be completed then submitted to OPP within forty-five (45) days of the receipt of the Final Adverse Determination. External Reviews will be completed and a decision sent within sixty (60) business days of the external agency receipt of the request unless extended or accepted as an Expedited External Review.

An Expedited External Review may be requested if:

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

The request for an Expedited External Review must be made by the end of the second business day following receipt of the Final Adverse Determination. If OPP determines the request qualifies for Expedited Review, a determination will be made within five (5) business days of the external review agency receipt of the request.

If the External Review relates to the denial of ongoing services, the member or member's authorized representative may request from OPP for services to continue during the External Review process. Such a request must be made before the end of the second working day following the receipt of the Final Adverse Determination letter sent. If OPP decides coverage should continue because substantial harm could occur to the member if coverage ended, CeltiCare will continue coverage at our expense minus applicable co-pays and deductibles.

If you have questions, concerns, would like additional information regarding member rights, or have questions about the External Review process you can contact the Office of Patient Protection:

Mail: Department of Public Health
Office of Patient Protection
250 Washington Street
Boston, MA 02108-4619
Phone: 800-436-7757
Fax: 617-624-5046
Website: www.mass.gov/dph/opp

Member Rights and Responsibilities

Cenpatico Member Rights & Responsibilities

Member Rights

- A right to receive information about the organization, its services, its providers and member rights and responsibilities
- A right to be treated with respect and recognition of their dignity and right to privacy
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about the organization or the care it provides
- A right to make recommendations regarding the organization's member rights and responsibilities policy

Member Responsibilities

- A responsibility to supply information (to the extent possible) that the organization and its providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

CeltiCare Member Rights and Responsibilities

Member Rights

Members, legal guardians of members, and legally authorized surrogates for members have certain rights and responsibilities. It is important that you know your rights and responsibilities.

Information: You have the right to get from your PCP information about what might be wrong (to the level known), treatment and any known likely results. Your PCP can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally authorized person. Your doctor will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.

- You have the right to see your medical records.
- You have the right to be informed of changes within our CeltiCare network.
- You have the right to be kept informed of CeltiCare and Commonwealth Care covered and non-covered services, program changes, how to access services, PCP assignment, providers, Advance Directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other CeltiCare rules and guidelines. You have a right to information about CeltiCare and the Commonwealth Care system.
- You have the right to a current list of CeltiCare providers. You can also get
- information on your providers' education, training, and practice.
- You have the right to know, upon request, of any financial arrangements or rules between CeltiCare and its providers that may restrict your treatment options.
- You have the right to talk to your provider about new uses of technology. You
- can also ask CeltiCare for information on our quality plan, how members use the plan and how we review new technology.

Respect & Dignity: You have the right to have considerate, respectful care at all times. You have the right to have assistance in a prompt, courteous and responsible manner. You have the right to be treated with dignity when receiving care. You have the right to be free from harassment by the health plan or the plan's providers if there are any business disagreements between the plan and provider.

You have the right to select a health plan or switch health plans, within the Commonwealth Care guidelines, without any threats or harassment.

Access: You have the right to adequate access to qualified health professionals.

- You have the right to access treatment or services that are medically necessary regardless of age, race, creed, sex, sexual preference, national origin or religion.
- You have the right to access medically necessary urgent and emergency services 24 hours a day and 7 days a week.
- If you have a disability, you have the right to receive information in a different format in compliance with the Americans with Disabilities Act.

Informed Consent: Members or their legal guardians or legal representatives have the right to join in decision making about their healthcare. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success.

You shall not have any treatment without consent freely given by you or your legally authorized surrogate decision-maker. You will be informed of your care options. You have the right to know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly. You have a right to refuse treatment.

Grievance: You have the right to file an Appeal or Grievance if you have had an unsatisfactory experience with CeltiCare or with any of our contracted providers or if you disagree with certain decisions made by CeltiCare.

External Review: You have the right to apply for an independent external review with the Massachusetts Department of Public Health's Office of Patient Protection for appeals or grievances not resolved by CeltiCare to your satisfaction. The Independent External Review process is not available for Grievances regarding routine vision and routine dental services.

Rights and Responsibilities Policies: Members have a right to make recommendations regarding the organization's Member Rights and Responsibilities policies. **Refusal of Treatment:** You may refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the PCP's instructions are not followed. You should discuss all concerns about treatment with your PCP. Your PCP can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.

PCP: You have the right to pick your PCP within the plan network. You also have the right to change your PCP or request information on CeltiCare doctors close to your home or work.

Identity: You have the right to know the name and job title of people giving you care. You also have the right to know which doctor is your PCP.

Language: You have the right to an interpreter when you do not speak or understand the language of the area.

Second Opinions: You have the right to a second opinion by an in-network doctor, at no cost to you, if you believe your provider is not authorizing the requested care, or if you want more information about your treatment.

Advance Directives: All CeltiCare members have a right to make Advance Directives for healthcare decisions. CeltiCare members also have the right to refuse to make Advance Directives. You should not be discriminated against for not having an Advance Directive.

Member Responsibilities

All members are responsible for learning how the CeltiCare plan works by reading the Evidence of Coverage.

Giving Information: You should give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your doctor until you understand the care you are receiving. You need to review and understand the information you receive about CeltiCare. You need to know the proper use of services covered by CeltiCare.

Your Doctor's Advice: You should follow the treatment plan suggested by providers of medical care. You should ask questions if you do not understand any part of the treatment plan. You should work with your PCP to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

ID Card: It is important that you show your CeltaCare ID card before you receive care.

Emergency Room Use: You should use any emergency room only when you think you have a medical emergency. For all other care, you should call your PCP.

Appointments: You need to keep appointments. If you cannot keep an appointment, you must call to cancel or reschedule. You should schedule appointments during office hours whenever possible.

PCP: You should know the name of your assigned PCP. You should establish a relationship with your doctor. You may change your PCP verbally or in writing by contacting our Member Services Department.

Treatment: You should treat all CeltaCare staff, providers, and other members with respect and dignity. Any concerns that you have about your care should be given to CeltaCare in a useful manner.

Changes: You need to tell the Commonwealth Health Connector Authority about any changes in your address, name, telephone number, or any changes in your family.

Other Medical Insurance: When you enroll in the CeltaCare, you need to give all information about any other medical insurance coverage you have. If, at any time, you get other medical coverage besides your CeltaCare coverage, you must tell the Commonwealth Health Connector Authority.

Costs: If you access care without following CeltaCare rules, you may be responsible for the charges. You are responsible to pay your portion of the Commonwealth premium if applicable (due monthly) and all copayments at the time of service.

Civil Rights

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

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

Customer Service

The Cenpatico Customer Service Department

Cenpatico operates a toll free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel, Monday through Friday 8:00 a.m. to 5:00 p.m. EST. 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 and assists the member in selecting a Network Provider who can meet their specific needs. Licensed clinicians on staff in the Utilization Management department are available to provide assessment for the level of urgency of a caller presenting special needs.

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

- Verifying member eligibility
- Verifying member benefits
- Obtaining authorization
- Referrals

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

Verifying Member Enrollment

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

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

- Contact Cenpatico Customer Service:
 - Commonwealth Care/Bridge 866-896-5053
 - Commonwealth Choice/Direct 866-595-8130
- Access the Provider web portal at www.cenpatico.com
- Network Providers who are registered MassHealth providers may also check eligibility through the Eligibility Verification System (EVS) of new MMIS.
<https://gateway.hhs.state.ma.us/authn/index.jsp>


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


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


CeltiCare
c/o Centene EDI Department
Phone: 800-225-2573 x25525
Email: EDIBA@centene.com


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

CeltiCare Member ID Cards

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXX	
PCP Name: John Doe	PCP Number: XXX-XXX-XXXX	
Co-pays		
PCP/Spec: \$X/\$X	ER:\$X	INPX: \$X
Vision: \$X	RX:\$X	
<p>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 Health Plan as soon as possible.</p>		
Commonwealth Care Plan Type:		

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXX	
PCP Name: John Doe	PCP Number: XXX-XXX-XXXX	
Co-pays		
PCP/Spec: \$X/\$X	ER:\$X	
RX:\$X/\$X/\$X	INPX: \$X	
<p>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.</p>		
Commonwealth Care Bridge		

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXX	
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	
<p>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.</p>		
Commonwealth Choice Plan:		

		Rx: US Script BIN:008019
Member Name: Jane Doe	Member ID#: XXXXXXXXXX	
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	
<p>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.</p>		
CeltiCare Plan Name:		

Interpretation/Translation Services

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

Customer Service is staffed with Spanish and English bilingual personnel.

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

To access TDD access for members who are hearing impaired, contact Massachusetts Relay Customer Service:

TTY: 800-720-3480

Voice: 800-720-3479

Key Information: To access interpreter services for Cenpatico members, contact Customer Service at
Commonwealth Care/Bridge 866-896-5053
Commonwealth Choice/Direct 866-595-8130

NurseWise

NurseWise is Cenpatico'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 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 nurse triage and after-hours phone coverage seven (7) days per week including holidays for Cenpatico members. Referral and triage 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.

Benefit Overview

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 listing of service codes and authorization requirements, please refer to the Massachusetts Covered Professional Services & Authorization Guidelines located in this Manual. Network Providers should refer to their Provider Agreement with Cenpatico to identify which services they are contracted and eligible to provide. Please note that all services performed must be medically necessary.

Member Copayments and Contributions

Member plan type, copayments, and contributions are indicated on members' cards. Members have different copayments according to plan type that the member has and the services performed. Unless a member has been granted a copayment waiver, providers are required to collect the copayment amount stated below.

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 with no copayment for methadone maintenance.
- \$50.00 copayment per stay for inpatient services*
- 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 with no copayment for methadone maintenance.
- \$250.00 copayment per stay for inpatient services*
- 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 with no copayment for methadone maintenance.
- \$250.00 copayment per stay for inpatient services*
- 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 30th.

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
- Coinsurance per stay for inpatient services is \$0 after deductible has been met
- Deductible 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

Covered Professional Services & Authorization Grid

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

Service Description	Billable Provider Type(s)	Billing Codes	Modifiers	Auth Required
Initial Hospital Care	MD	99221, 99222, 99223	U6	No
Subsequent Hospital Care	MD	99231, 99232, 99233, 99234, 99235, 99236	U6	No
Initial Inpatient Consultation	MD	99251, 99252, 99253, 99254, 99255	U6	No
Hospital Discharge	MD	99238, 99239	U6	No
Initial Observation Care	MD	99217, 99218, 99219, 99220	U6	No
Individual Inpatient Psychotherapy	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC	90816, 90818	U6, U7, U3, U4, AH, AJ, TD, SA, HO	No
Individual Inpatient Psychotherapy with Medication Management	MD, APNP, NP, Clinic, CMHC	90817, 90819	U6, U7, U4, AJ, TD, SA, HO	No
ECT	MD	90870		Yes
Diagnostic Interview	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	90801	U6, U7, U3, U4, AH, AJ, TD, SA, HO	No
Individual Psychotherapy	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	90804, 90806	U6, U7, U3, U4, AH, AJ, TD, TH, SA, HO	*Yes- See note below
Individual Psychotherapy with Medication Management	MD, APNP, NP, Clinic, CMHC	90805, 90807	U6, SA	No
Med Check	MD, APNP, NP, Clinic, CMHC, FQHC, Physician Assistant	90862	U6, SA	No

Service Description	Billable Provider Type(s)	Billing Codes	Modifiers	Auth Required
Family Psychotherapy with Patient Present	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	90847	U6, U7, U3, U4, AH, AJ, TD, TH, SA, HO	*Yes- see note below
Group Therapy	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	90853	U6, U7, U3, U4, AH, AJ, TD, TH, SA, HO	*Yes- see note below
	MD, APNP, RN, NP, CNS, Master's Level Clinician (LPC, LCSW, LMFT, etc.), PhD, Clinic, CMHC, FQHC	90857	U6, TD, SA, or HO	*Yes- see note below
Psych Testing	MD and PhD	96101, 96110	AH, U3	Yes
Neuropsych Testing	MD and PhD (MD must be a licensed Psychiatrist)	96116, 96118	AH, U3	Yes
Bio-psychosocial Assessment or Intervention	MD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, FQHC (Services only covered at an FQHC)	96150, 96151, 96152, 96153, 96154, 96155		No
Tobacco Cessation	MD, RNCS, RNPC, APRN, ARNP, APNP	99407	SA, HN, TD, TF, U2, HQ, U3	Yes
Individual Methadone Counseling	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	H0020	TF	No
Family Methadone Counseling	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	H0020	HR	No
Group Methadone Counseling	MD, PhD, Master's Level Clinician (LPC, LCSW, LMFT, etc.), APNP, RN, NP, CNS, Clinic, CMHC, FQHC	H0020	HQ	No
Methadone Dosing	MD, APNP, NP, Clinic, CMHC, FQHC, Physician Assistant	H0020		No

*Note: A mix of the following twelve (12) services may be provided to a member without authorization from Cenpatco, however authorization must be obtained from Cenpatco for sessions provided after the 12th visit has been used; 90804, 90806, 90847, 90853 and 90857.

Utilization Management

The Utilization Management Program

The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. EST. Additionally, clinical staff are available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number: 866-896-5053. 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 Massachusetts licensed physician advisor or psychologist for review and peer to peer discussion.

Cenpatico conducts utilization management in a timely manner to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. Utilization Management files 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. It is the responsibility of the Network Provider to monitor the member's ongoing eligibility during the course of treatment.

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

- Contact Cenpatico Customer Service at 866-896-5053
- Access the Provider web portal at www.cenpatico.com
- Network Providers who are registered MassHealth providers may also check eligibility through the Eligibility Verification System (EVS) of new MMIS

Inpatient Notification Process & Non-Contracted Emergency Service Providers (ESPs)

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 notification.

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. If a consumer has accessed a crisis evaluation and has been assessed by an Emergency Service Provider (ESP) as needing to admit to acute inpatient hospitalization, the ESP will notify Cenpatico of this level of care recommendation and forward a copy of the assessment. The receiving hospital should also notify Cenpatico of the admission to acute care when the consumer arrives and is admitted and will be required to provide clinical review information the next business day and at subsequent intervals for concurrent review depending upon the consumer's specific symptoms and progress.

The Commonwealth Health Connector Authority has approved a pilot program with Cenpatico for Commonwealth Care members removing the requirement for a specific crisis evaluation by an Emergency Services Provider (ESP) prior to an inpatient admission, if the ESP has not contracted with Cenpatico in a particular area. If a member presents to an emergency department in crisis, and that hospital falls within a catchment area of an ESP not contracted with Cenpatico, any licensed clinician can conduct an evaluation and make a clinical recommendation for admission to a psychiatric unit. At this point the hospital should contact Cenpatico to discuss Medical Necessity and make a collaborative determination as to whether an inpatient level of care is required or whether diversionary services such as observation, crisis stabilization, partial hospitalization, residential, etc. are more appropriate.

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.

For a listing of providers, including ESPs, participating in our Massachusetts network, please refer to our online provider directory at www.cenpatico.com or contact your network representative by calling 866-896-5053.

Outpatient Notification Process

Network Providers 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 twelve (12) specific outpatient/office location follow-up sessions per par practitioner per member without seeking authorization from Cenpatico. Please refer the Covered Professional Services & Authorization Guidelines to identify which services apply to this requirement. Once the evaluation/assessment and twelve (12) outpatient/office location follow-up sessions per par practitioner per member are utilized, Network Providers 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 should call:
866-896-5053**

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 is located on our website at www.cenpatico.com. Network Practitioners may call the Customer Service department at 866-896-5053 to check status of an OTR. Network Practitioners should allow up to two (2) business days to process non-urgent requests.

IMPORTANT:

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

Guidelines for Psychological Testing

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

It is important to note that;

- Testing will not be authorized by Cenpatico for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment (90801 and 90802) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with Cenpatico.
- Practitioners should submit a request for Psychological Testing that includes the specific tests to be

performed. Cenpatico's Psychological Testing Authorization Request form is located on our website at www.cenpatico.com.

Medical Necessity

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

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

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

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 Providers should use these guidelines in the formulation of treatment plans. Adequate treatment refers to clinical appropriateness, completeness and timeliness. Cenpatico Medical Necessity Criteria is available in this manual and can also be found at www.cenpatico.com.

Concurrent Review

Cenpatico's Utilization Management Department will concurrently review the treatment and status of all members in inpatient (including crisis stabilization units) and partial hospitalization through contact with the member's attending physician or the 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 twenty-four (24) hours after discharge. Cenpatico's Care Coordination/Case Management staff follow-up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, Cenpatico asks that Network Practitioners please inform Cenpatico as soon as possible. Upon notification of a no-show, Cenpatico's Care Coordination staff will follow up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Psychotropic Medications

Cenpatico will monitor psychotropic medication usage in partnership with CeliCare 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.

Continuity of Care

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

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

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

Intensive Case Management (ICM)

The Case Management Department provides a unique function at Cenpatico. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance and

facilitate positive treatment outcomes through the proactive identification of Members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. Cenpatico Case Managers are licensed behavioral health professionals with at least three (3) years experience in the mental health field.

Cenpatico's ICM functions include:

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

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

Cenpatico's Care Coordination functions include:

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

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

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

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

Notice of Action (Adverse Determination)

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

- a. The reason(s) for the proposed action in clearly understandable language.
- b. A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary.
- c. A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request.
- d. Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination.
- e. Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- f. For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal.
- g. The right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

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

Peer Clinical Review Process

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

For both mental health and chemical dependency service continued stay requests, the physician or treating practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available. When a determination is made where no peer-to-peer conversation has occurred, a provider can request to speak with the Peer Reviewer who made the determination within one (1) business day. Providers should contact Cenpatico at 866-896-5053 to discuss UM denial decisions.

The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare practitioner provides good cause in writing.

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

Clinical Practice Guidelines

Cenpatico has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted include but are not limited to: Treatment of Bipolar Disorder, Treatment of Major Depressive Disorder, Treatment of Schizophrenia, Post Traumatic Stress Disorder and Substance Use and Abuse. 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 866-896-5053. 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.

Advance Directives

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

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

Cenpatico recommends:

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

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

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

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

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

Clean Claim

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

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

Explanation of Payment (EOP)

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

If you have questions regarding your EOP, please contact Cenpatico's Claims Customer Service department at 866-324-3632.

Network Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within ninety (90) days of the date the service(s) are rendered. Claims submitted after this period will be denied for payment.

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

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

Please use the correct mailing address.

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

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

Common Claims Processing Issues

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

Some common problem areas are:

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

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

Imaging Requirements For Paper Claims

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

Do:

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

Do Not:

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

Web Portal Claim Submission

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

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

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

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

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

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

EDI Clearinghouses

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

Trading Partner	Payer ID	Contact Number
Availity	68061	800-282-4548
Capario/Proxy Med	68061	800-792-5256
Emdeon	68061	800-845-6592

Cenpatico Billing Policies

Member Hold Harmless

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

Please Note:

- A Network Provider's failure to authorize the service(s) does not qualify/allow the Network Provider to bill the Member for service(s).

- CeltiCare Members may not be billed for missed sessions (“No-Show”).

Non-Covered Services

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

Claims Payment and Member Eligibility

Cenpatico’s Network Providers are responsible for verifying Member eligibility for each referral and service provided on an ongoing basis.

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

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

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

Claim Status

Please do not submit duplicate bills for authorized services. If your Clean Claim has not been adjudicated within ninety (90) days, please call Cenpatico’s Claims Customer Service department at 866-324-3632 to determine the status of the claim.

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

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

Retro Authorization

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

Network Providers must submit their Retroactive Authorization request to:

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

Retro Authorizations will only be granted in rare cases. Repeated requests for Retro Authorizations will result in termination from the Cenpatico provider network due to inability to follow policies and procedures.

If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Customer Service department at 866-896-5053 and ask the representative to extend the end date on your authorization.

Resolving Claims Issues

Claim Reconsideration

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

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

Cenpatico
Claims Resubmission
P.O. Box 7200
Farmington, MO 63640-3813

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

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

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

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

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

Cenpatico Appeals
PO Box 6000
Farmington, MO 63640-3809

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

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

Cenpatico
Attention: Massachusetts Provider Relations
504 Lavaca St., Ste. 850
Austin, TX 78701
Phone: 866-896-5053

National Provider Identifier (NPI)

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

Applying for an NPI

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

To Register Online:

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

To Register By Mail

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

Submitting Your NPI to Cenpatico

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

CMS 1500 (8/05) Claim Form Instructions

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

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

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

Field #	Field Description	Instructions or Comments	Required or Conditional
7	Insured's Address (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. <ul style="list-style-type: none"> • First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). • Second line – In the designated block, enter the city and state. • Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1. 	Not Required
8	Patient Status		Not Required
9	Other Insured's Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured. NOTE: COB claims that require attached EOBs must be submitted on paper.	C
9a	*Other Insured's Policy or Group Number	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	Other Insured's Birth Date/ Sex	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate sex/gender. M=male, F=female for the person listed in box 9.	C
9c	Employer's Name or School Name	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	Insurance Plan Name or Program Name	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	Is Patient's Condition Related To	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	Reserved For Local Use		Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
11	Insured's Policy Group or Feca Number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	Insured's Date of Birth/ Sex	Same as field 3.	C
11b	Employer's Name or School Name	REQUIRED if Employment is marked Yes in box 10a.	C
11c	Insurance Plan Name or Program Name	Enter name of the insurance Health Plan or program.	C
11d	Is There Another Health Benefit Plan	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the Member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	Patient's or Authorized Person's Signature		Not Required.
14	Date of Current : Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date reflecting the first date of onset for the: <ul style="list-style-type: none"> • Present Illness • Injury • LMP (last menstrual period) if pregnant 	C
15	If Patient Has Same or Similar Illness. Give First Date.		Not Required
16	Dates Patient Unable to Work in Current Occupation		Not Required
17	Name of Referring Physician or Other Source	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	C
17a	ID Number of Referring Physician	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI Number of Referring Physician	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization Dates Related to Current Services		Not Required

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

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

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

24H Un-shaded	EPSDT (CHCUP) Family Planning	Enter the appropriate qualifier for EPSDT visit	C
24I Shaded	ID Qualifier	Use ZZ qualifier for Taxonomy	C
24Ja Shaded	Non-NPI Provider ID#	<p>Enter as designated below the Medicaid ID number or taxonomy code.</p> <ul style="list-style-type: none"> • Typical Providers: Enter the Provider taxonomy code or Medicaid Provider ID number that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. • Atypical Providers: Enter the 6-digit Medicaid Provider ID number. 	R
24Jb Un-shaded	NPI Provider ID	<ul style="list-style-type: none"> • Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. Providers that are contracted with Cenpatico under a "Facility Provider Agreement" should enter the <u>organization's</u> NPI number, not the NPI number of the provider rendering the service. 	R

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

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

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

UB-04 Claim Form Instructions

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

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

Field #	Field Description	Instructions or Comments	Required or Conditional*
1	(Unlabeled Field)	<ul style="list-style-type: none"> • Line 1: Enter the complete provider name. • Line 2: Enter the complete mailing address. • Line 3: Enter the City, State, and zip+4 code (include hyphen) • Line 4: Enter the area code and phone number. 	R
2	(Unlabeled Field)	Enter the Pay-To Name and Address.	Not Required
3a	Patient Control No.	Enter the facility patient account/control number	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R

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

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

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

Field #	Field Description	Instructions or Comments	Required or Conditional*
31-34 a-b	Occurrence Code and Occurrence Date	Occurrence Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
35-36 a-b	Occurrence Span Code and Occurrence Date	Occurrence Span Code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.	C

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

General Information Fields 42-47	Service Line Details	The following UB-04 fields – 42-47:	
42 Line 1-22	Rev CD	<ul style="list-style-type: none"> • Have a total of 22 service lines for claim detail information. • Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23. 	R
42 Line 23	Rev CD	Enter the appropriate 4 digit revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
43 Line 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R

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

Field #	Field Description	Instructions or Comments	Required or Conditional*
50 A-C	Payer	Enter the name for each Payer reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	Health Plan Identification Number		Not Required
52			
A-C	Rel. Info	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y".	R
53	ASG. BEN.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	Prior Payments	Enter the amount received from the primary payer on the appropriate line when Medicaid/ Cenpatico is listed as secondary or tertiary.	C
55	Est. Amout Due		Not Required
56	National Provider Identifier or Provider ID	REQUIRED: Enter provider's 10-character NPI ID.	R
57	Other Provider ID	Enter the qualifier "1D" followed by your 6-digit Medicaid Provider ID number.	Not Required
58	Insured's Name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	Patient Relationship		Not Required
60	Insured's Unique ID	REQUIRED: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance / Medicaid ID in the order of liability listed in field 50.	R
61	Group Name		Not Required
62	Insurance Group No.		Not Required
63	Treatment Authorization Codes		Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional*
64	Document Control Number	Enter the 12-character Document Control Number (DCN) of the paid Cenpatico claim when submitting a replacement or void on the corresponding A, B, C line reflecting Cenpatico from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim).	C
65	Employer Name		Not Required
66	DX		Not Required
67	Principal Diagnosis Code	Enter the principal/primary diagnosis or condition (the condition established after study that is chiefly responsible for causing the visit) using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or "5". "E" and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R
67 A-Q	Other Diagnosis Code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or "5". "E" and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with incomplete or invalid diagnosis codes will be denied for payment.	C
68	(Unlabeled)	Not Used	Not Required
69	Admitting Diagnosis Code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or "5". "E" codes and most "V" are NOT acceptable as a primary diagnosis. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R

Field #	Field Description	Instructions or Comments	Required or Conditional*
70 a,b,c	Patient Reason Code	Enter the ICD-9-CM code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or "5". "E" codes and most "V" are NOT acceptable as a primary diagnosis. NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.	R
71	PPS / DRG Code		Not Required
72 a,b,c	External Cause Code		Not Required
73	(Unlabeled)		Not Required
74	Principal Procedure Code /Date	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY). REQUIRED for EDI Submissions.	C
74 a-e	Other Procedure Code Date	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9 procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	(Unlabeled))		Not Required

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

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

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

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

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

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

Medical Necessity Definition

Cenpatico defines medical necessity as:

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

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

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

The Cenpatico Medical Necessity Criteria are located within this Manual and can also be found at www.cenpatico.com, or by calling your local Network Representative.

Hospitalization, Psychiatric Adult

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

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

II. Admission – Intensity of Service

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

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

resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

III. Continued Stay

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

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

Hospitalization, Psychiatric, Child and Adolescent

Quality of Care Standards

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

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

I. Admission - Severity of Need

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

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

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

II. Admission - Intensity of Service

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

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

III. Continued Stay

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

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

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

Hospitalization, Psychiatric, Geriatric

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

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

II. Admission - Intensity of Service

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

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face to face evaluation of the patient performed by an Attending Physician prior to, or within 24 hours following the admission.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. In addition to skilled nursing care for activities of daily living and supervision required for structure and redirection of behavior, the psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and

suicidal/homicidal observation and precautions.

- C. For those patients whose co-morbid medical conditions may contribute to their mental status, there must be the availability of an appropriate initial medical assessment and ongoing medical management.
- D. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs.

III. Continued Stay

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

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

Hospitalization, Eating Disorders

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

- A. Patients must have a primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The illness can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. Patients hospitalized because of another primary psychiatric disorder who have a coexisting Eating Disorder should be reviewed according to the criteria below only if the primary psychiatric disorder no longer requires hospitalization.
- B. Body weight less than 75% of Ideal Body Weight (IBW) or Body Mass Index (BMI) of 16 or below. If body weight is greater than 75% of IBW (or BMI > 16), this criterion can be met if there is evidence of weight loss of >15% in one month or weight loss associated with physiologic instability unexplained

by any other medical condition. This criterion may be satisfied in children and adolescents who have a body weight between 75-85% of ideal, based upon height, during a period of rapid growth.

- C. Medical consequences of the eating disordered behavior that present the potential for imminent harm such that immediate medical and psychiatric stabilization is necessary before ambulatory or residential management can be considered safe or effective. Such medical consequences would include severe malnutrition, emaciation, significant electrolyte or fluid imbalance, cardiac arrhythmias, hypotension, impaired renal function, intestinal atony or obstruction, pancreatitis, gastric dilatation, esophagitis or esophageal tears, and colitis.
- D. In bulimia, immediate interruption of the binge/purge cycle is required to avoid imminent, serious harm, due to the presence of a co-morbid medical or psychiatric condition (e.g. pregnancy, uncontrolled diabetes, severe depression with suicidal ideation, etc.), with the need to ensure adequate nutrition and absorption of pharmaceuticals.
- E. Failure to respond to an adequate therapeutic trial of treatment in a less restrictive setting (partial hospital). An adequate therapeutic trial would, at a minimum, consist of treatment several times per week with twice weekly individual and/or family therapy, either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated.
- F. To meet this criterion, the patient must have significant weight loss (<85% IBW), significant impairment in social or occupational functioning, and be uncooperative with treatment (or cooperative only in a highly structured environment) despite having insight and motivation to recover. If patient has failed to improve in an acute program, there must be evidence to suggest that necessary changes in the treatment plan cannot be implemented in an outpatient setting or that inpatient hospitalization is required due to medical co-morbidity or need for special feeding.

II. Admission – Intensity of Service

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

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

III. Continued Stay

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

- A. The admission criteria Severity of Need A and B, C, or D, and Intensity of Service A, B and C are continually met.
- B. The current treatment plan should include documentation of diagnosis (DSM-IV-TR®, axes I V), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24 hour basis.
- C. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and

patient's response.

- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. The patient's weight remains <85% of IBW and he/she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.
- G. Continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required. In order to satisfy this criterion, there must be evidence that patient is unable to participate in ambulatory treatment, lacks significant insight into the symptoms of his/her illness, and has regressed in response to progressive increases in privilege level.
- H. The patient continues to meet Admission Criteria, I-C with the need for ongoing medical monitoring of medical consequences of the eating disorder.
- I. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- J. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

Residential Treatment Center (RTC), Psychiatric

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

- A. There is clinical evidence that the patient has a long-term and/or severe DSM-IV disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment.
- B. Due to the psychiatric disorder, the patient exhibits an inability to adequately care for his/her own physical needs, representing potential serious harm to self and/or others. The family and/or other non-residential community support systems are unable to safely fulfill these needs.
- C. The patient requires supervision 7 days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him/her to live outside of a residential setting.
- D. The patient's current living environment does not provide the support and access to therapeutic services necessary for recovery.

II. Admission – Intensity of Service

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

- A. The evaluation and assignment of a diagnosis must result from a face-to-face psychiatric evaluation
- B. The program provides supervision 7 days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
- C. An individualized plan of active psychiatric treatment and residential living support is provided. This plan must include evaluation for individual and/or family treatment. This plan must include

weekly family and/or supportive person involvement or identify valid reasons why such a plan is not clinically appropriate.

III. Continued Stay

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

- A. Despite reasonable therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to a degree that continues to meet the admission criteria, or the emergence of additional problems that meet the admission criteria.
- B. There is evidence of therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure housing in anticipation of this event.
- C. There is evidence that treatment plan is focused on the alleviation of psychiatric symptoms that are interfering with the patient's ability to return to a less intensive level of care.
- D. For Children and Adolescents, there is evidence of intensive family involvement occurring several times per week (unless there is an identified valid reason why such a plan is not clinically appropriate or feasible).
- E. The patient's progress confirms that the presenting, or newly defined problem(s) will respond to the current treatment plan, and this is documented in weekly progress notes, written and signed by the provider.

Partial Hospitalization, Psychiatric, Adult

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

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

II. Admission – Intensity of Service

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

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

III. Continued Stay

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

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

Partial Hospitalization, Psychiatric, Child and Adolescent

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

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

1. The patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or
2. The patient is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

II. Admission – Intensity of Need

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

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

III. Continued Stay

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

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

Day Treatment

Quality of Care Standards

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

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

I. Admission Criteria (all must be met):

- A. The individual has received a psychological or psychiatric evaluation that includes a DSM-IV-TR®, axes I-V. The individual demonstrates symptoms that require interventions that cannot adequately be provided in a lower level of care.
- B. The individual has a longstanding psychiatric disorder and is experiencing a worsening of symptoms

- of that disorder (behaviors, mood, psychotic thinking) and there is significant functional impairment.
- C. Traditional mental health services have been attempted (i.e. individual/group/family therapy, medication management) and are inadequate to prevent the functional deterioration.
- D. A clear individualized treatment plan is established including specific behavioral based and objective goals. Amount, scope, and duration as well as specific interventions must be documented in the treatment plan and progress notes.
- E. The individual demonstrates the capability of developing more complex personal and interpersonal life skills including problem solving, self advocacy and the appropriate use of community resources.

II. Continued Stay Criteria (all must be met):

- A. Validated DSM-IV diagnosis which continues to have a broad and persistent negative effect on the individual's functioning.
- B. The treatment plan is regularly updated and documents the individual's functional status changes and documents modifications to the treatment plan in response to changing functional status or lack of progress.
- C. The individual is making progress toward treatment goals as evidenced by a lessening of symptoms and stabilization of functioning but goals of treatment have not yet been achieved.
- D. Discharge planning and coordination is documented.
- E. Services provided are time-limited in nature and tailored to assist in developing autonomy in the least restrictive environment.

III. Discharge Criteria (any one of the criteria is met):

- A. The individual no longer meets continued stay criteria.
- B. The individual appears able to function and remain stable with diminished intensity of service. The risk of immediate functional deterioration is low.
- C. The individual becomes more acutely symptomatic and requires a higher level of care for stabilization.
- D. The individual fails to make progress toward treatment plan goals and no further progress is expected from this level of care.

Intensive Outpatient Treatment, Psychiatric, Adult

Quality of Care Standards

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

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

I. Admission – Severity of Need

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

- A. The clinical evaluation indicates that the individual has a primary DSM-IV-TR®, IV diagnosis or severe emotional disturbance that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The individual's disorder can be expected to improve significantly through medically necessary and appropriate therapy at this level of care. The individual is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
 1. A clear, current threat to the individual's ability to live in his/her customary setting for an

individual who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient care.

2. A clear, current threat to the individual's ability to be employed or attend school.
3. An emerging/impending risk to the safety or property of the individual or of others.

C. Either:

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

II. Admission – Intensity of Service

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

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

III. Continued Stay

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

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

Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Quality of Care Standards

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

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

I. Admission - Severity of Need

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

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

II. Admission – Intensity of Service

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

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

III. Continued Stay

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

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

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

Community Based Services (CBS), Adult

Community Support Services

I. Intensity Guidelines: all three (3) elements are evaluated

1. Severity of the functional impairment
2. Appropriate intensity of services
3. Least restrictive or intrusive services necessary

II. Admission Guidelines (all must be met):

1. The member has received a psychological or psychiatric evaluation that includes a DSM-IV-TR®, axes I-V diagnosis that requires and will respond to therapeutic/supportive interventions and which documents the need for CBS.
2. The member demonstrates an exacerbation of a longstanding psychiatric disorder the symptoms of which (e.g. thought disorder, mood disorder) result in significant functional impairments associated with the mental health diagnosis.
3. Traditional Mental Health Services have been attempted (i.e. individual/family/group therapy, medication management, etc) and are inadequate to prevent the member from deteriorating or to reach identified goals.
4. Services are supervised by a qualified licensed mental health professional.
5. At least one member of the family agrees to participate in the service.
6. A clear individualized treatment plan is established including specific behavioral based and objective goals. Amount, scope and duration as well as specific interventions must be documented in the treatment plan and supported by progress notes.
7. The member demonstrates the capability of developing more complex personal and interpersonal life skills including problem solving, self advocacy, and the appropriate use of community resources.

III. Continued Stay Guidelines (all must be met):

1. Validated DSM IV Diagnosis which continues to have a broad and persistent effect on the member's ability to remain in the home/community.
2. Member is making adequate progress toward treatment goals as evidenced by lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services provided by the CBS.
3. The treatment plan is updated monthly (30 days) and reflects effort to reduce the frequency of service or clinical documentation for inability to decrease the usage of community based services.
4. Techniques are employed in treatment that are time-limited in nature and subordinate to a goal of enhanced autonomy and the least restrictive environment possible.

IV. Discharge Criteria

1. Member no longer meets continued stay criteria.
2. Member has progressed to the extent CBS are no longer necessary.

3. Severity of illness requires higher level of care.

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

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

Please contact the Cenpatico Privacy Officer at 512-406-7200 or in writing (refer to address below) with any questions about our privacy practices.

Cenpatico Compliance Department
504 Lavaca St., Ste. 850
Austin, TX 78701

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

CeltiCare
1380 Soldiers Field Road
Third Floor
Brighton, MA 02135

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".