Cenpatico Provider Manual

www.cenpatico.com

Kansas KanCare Plan

v. 11/2015

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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 behavioral health and substance use disorder services to Sunflower Health Plan Members in Kansas.

The Cenpatico Provider Manual is designed to answer your questions about our behavioral health program and to explain how we manage the delivery of behavioral health and substance use disorder services to the Members we serve.

This Manual provides a description of Cenpatico and Sunflower Health Plan'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 and the performance standards for 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 Kansas Providers on our website including this Manual and Provider forms.

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

About Cenpatico

MISSION

Creating innovative solutions that drive quality health care for vulnerable populations.

VISION

To establish a national presence as an industry leading health solutions organization for children, Medicaid, and specialty therapies.

GOAL

To improve outcomes and deliver savings through innovation.

History and Structure of Cenpatico

Cenpatico is a wholly-owned subsidiary of CenCorp Health Solutions, Inc. (CenCorp). CenCorp is a wholly-owned subsidiary of Centene Corporation (Centene). Sunflower Health Plan (http://www.sunflowerstatehealth.com), a Centene health plan, delegates the provision of covered behavioral health and substance use disorder services to Cenpatico.

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

Cenpatico defines "behavioral health" as inclusive of acute and chronic psychiatric and substance use disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems (current ICD). Cenpatico provides quality, cost effective behavioral healthcare services for Members of Sunflower Health Plan through a comprehensive Provider Network of qualified behavioral health Providers.

An experienced Provider Network is essential to provide consistent, superior services to our Members. To achieve our goals, Cenpatico builds strong, long-term relationships with our Provider Network. This Provider Manual was designed to assist you 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.

Managed Care Philosophy

Cenpatico is strongly committed to the philosophy of providing appropriate treatment at the least restrictive level of care that meets the Member's needs.

We believe careful case-by-case consideration and evaluation of each Member's treatment needs are required for optimal medical necessity determinations. We believe Members need to be fully involved in their care and participate in decisions regarding treatment needs.

Outpatient treatment is generally considered the first choice treatment approach, with the exception of when medical necessity is met for a higher level of care. 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 and policies and procedures in place 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 Sunflower Health Plan Members.

Quick Reference Guide

Cenpatico Contact Information:
Cenpatico
866-896-7293
www.cenpatico.com

Health Plan Contact Information:
Sunflower Health Plan 877-644-4623
http://www.sunflowerstatehealth.com/

Eligibility Verification:
Phone: 866-896-7293
Web: www.cenpatico.com (you must have a Provider log-on to verify eligibility on this site)

ERA/EFT Enrollment:
Please call PaySpan Health at 877-331-7154 or visit www.payspanhealth.com

Cenpatico Customer Service:
Please call Customer Service at 866-896-7293 to assist with eligibility determinations and Provider referrals

Claims Guidelines:
Claims must be submitted within 180 days of the date of service.

Claim Submission:
Claims can be submitted on the Cenpatico website at www.Cenpatico.com

EDI Vendors:
Emdeon (866-369-8805)
Availity (800-282-4548)
Gateway EDI (800-969-3666)
Cenpatico's Payor ID Number is 68068
For further information regarding electronic submission, contact the Cenpatico EDI Department at 800-225-2573, ext. 25525 or email at ediba@centene.com

Paper Claims Address:
Cenpatico Behavioral Health
PO Box 6400
Farmington, MO 63640-3807

Claims Customer Service:
866-324-3632

Claim Appeals Address:
Cenpatico Appeals
PO Box 6000
Farmington, MO 63640-3809

Benefits/ Covered Services:
Please refer to your fee schedule and the Kansas Covered Services & Authorization Guidelines document within the Provider Manual.

Prior Authorization:
Call Medical Management at 866-896-7293
Download and complete an Outpatient Treatment Request (OTR) online at www.cenpatico.com

After-Hours Admissions:
Please notify Cenpatico of after-hours or weekend admissions on the next business day.

Medical Necessity and Administrative Appeals:
Cenpatico
Attn: Appeals Coordinator 12515-8 Research Blvd.
Suite 400
Austin, TX 78759
or Fax to: 866-714-7991

Provider Relations:
Cenpatico
Telephone: 866-896-7293
Fax: 866-263-6521
Email: ProviderRelationsKS@cenpatico.com

The Cenpatico Provider Network

Cenpatico Service Area

Cenpatico reimburses claims for the covered behavioral health and substance use disorder benefits for Sunflower Health Plan Members throughout the State of Kansas.

Network Provider Selection Process

The Cenpatico Network includes, but is not limited to the following provider types:

- Community Mental Health Centers (CMHCs)
- Licensed Psychiatrists
- Licensed Psychologists
- Licensed Psychiatric Advance Practice Nurses
- Licensed Clinical Professional Counselors
- Licensed Specialist Clinical Social Workers
- Licensed Clinical Marriage and Family Therapists
- Licensed Clinical Psychotherapists
- Licensed Master's Level Psychologists*
- Licensed Mental Health Professionals*
- Physician Assistants
- Autism Waiver Providers
- State Licensed Behavioral Health or Substance Use Disorder Programs
- Federally Qualified Health Centers
- Rural Health Clinics
- Psychiatric Residential Treatment Facilities
- Psychiatric Hospitals
- General Hospitals offering psychiatric and/or substance use disorder services

*Supervision is required in accordance with the Kansas Behavioral Sciences Regulatory Board or its equivalent

We work with Providers that consistently meet or exceed Cenpatico clinical quality standards and are comfortable practicing within the managed care arena, including those Providers that demonstrate and support Sunflower Health Plan's integrated care approach to Member care. Network Providers should support a brief, solution-focused approach to treatment and should be engaged in a collaborative approach to the treatment of Sunflower Health Plan's 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 and accessibility standards, including meeting the Americans with Disabilities Act (ADA) requirements, to best meet our Members' needs;
- Ability to accept new Members;
- Ability to act as the Member's medical home; and
- Experience in utilizing evidence-based practices in working with seriously mentally ill (SMI) and developmentally delayed/disabled (DD) populations. This includes but is not limited to Assertive Community Treatment (ACT), Trauma Informed Cognitive Behavioral Therapy, IMR, etc.

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 visits may be conducted as a result of Member dissatisfaction or as part of a chart audit. The site visit auditor reviews the quality of the location where care is provided. The review assesses the accessibility and adequacy of the treatment and waiting areas.

General Network Provider Office Standards

Cenpatico requires the following:

- Office must be professional and secular;
- Offices and facilities must be easily accessible with accommodations for Members with disabilities as required and covered by titles II and III of the Americans with Disabilities Act (ADA) of 1990;
- Provide designated accessible parking spaces;
- Appropriate door sizes for clear openings with easy opening mechanism;
- Provide adequate space in clinic rooms to turn a wheelchair;
- Signs identifying office must be visible;
- Display all marketing and health education materials provided by contracted health plans in an equal fashion;
- 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 twenty-four (24) hour availability;
- Member records and other confidential information must be locked up and 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 Network/Provider Relations department at ProviderRelationsKS@cenpatico.com or Quality Improvement department at 866-896-7293 to register these complaints. All concerns are investigated, and resolution is provided to the Network Provider on a timely basis.

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 either of the following options to verify Member enrollment:

- Access the Kansas Medical Assistance program (KMAP) website at https://www.kmap-state-ks.us/Public/Provider.asp or call 800-933-6593
- Contact Cenpatico Customer Service at 866-896-7293
- Verify online at www.cenpatico.com

Until the actual date of enrollment with Sunflower Health Plan, Cenpatico is not financially responsible for services the prospective Member receives. In addition, Cenpatico is not financially responsible for services Members receive after their coverage has been terminated.

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;
- Send initial and bi-annually (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent;
- Only provide physical health services if such services are within the scope of the Network Provider's clinical licensure;
- Network Providers 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. Cenpatico strives to meet the National Committee for Quality Assurance (NCQA) Health Care Effectiveness Data and Information Set (HEDIS) guidelines for follow up and/or continuing treatment after an inpatient visit. To that end, Cenpatico requires Network Providers offering inpatient psychiatric services to ensure that outpatient treatment is scheduled within seven (7) days following the date of discharge and every effort is made to insure the appointment is available for the member to attend;
- Attempt to outreach to Members who have missed appointments within twenty-four (24) hours to reschedule;
- Comply with State of Kansas appointment access standards;
- Ensure all Members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language (which can be accomplished by engaging professional interpreter services at the onset of treatment);

- 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;
- Exchange information with Member's PCP and/ or other behavioral health providers upon Member consent;
- Comply with all Cenpatico non-discrimination and cultural competency requirements;
- Accommodate the needs of Members with disabilities;
- Ensure behavioral health treatment plans are developed with the Member and Member's family involvement;
- Submit all documentation in a timely fashion;
- Comply with Cenpatico's Case Management and UM processes;
- Cooperate with and participate in all Cenpatico's Quality Improvement (QI) activities as requested;
- Use appropriate Medical Necessity and Evidence-Based Best Practices when formulating treatment plans and requesting ongoing care;
- 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;
- Notify Cenpatico of any change of address/location within thirty (30) days of the change;
- Complete credentialing and re-credentialing materials as requested by Cenpatico; and,
- Maintain an office that meets all standards of professional practice.
- Notify Cenpatico of changes in business operations that may affect members.

Credentialing

Credentialing Requirements

The Cenpatico Provider Network includes but is not limited to: Community Mental Health Centers (CMHCs), Licensed Psychiatrists, Licensed Psychologists, Licensed Psychiatric Advance Practice Nurses, Licensed Clinical Professional Counselors, Licensed Master Social Workers, Licensed Clinical Social Workers, Licensed Clinical Workers, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Psychotherapists, Licensed Master's Level Psychologists, Licensed Mental Health Professionals, Physician Assistants, Autism Waiver Providers, State Licensed Behavioral Health or Substance Use Disorder Programs, Federally Qualified Health Centers, Rural Health Clinics, Psychiatric Residential Treatment Facilities and Psychiatric Hospitals.

Cenpatico Network Providers must adhere to the following requirements:

- Adhere to Cenpatico's Clinical Practice Guidelines and Medical Necessity Criteria.
- Consistently meet our credentialing standards and Cenpatico guidelines on Primary Care Physician (PCP) notification.
- Failure to adhere to guidelines and standards at any time can lead to termination from our network.
- Notify Cenpatico immediately upon receipt of revocation or suspension of the Network Provider's State License by the State of Kansas.
- All solo and group Network Providers must be licensed to practice independently in compliance with Cenpatico's credentialing standards and guidelines.
- Licensed Master's Level Psychologists and Licensed Mental Health Professionals must meet the supervision requirements established by the Kansas Behavioral Sciences Review Board.
- License/Certification must be current, active and in good standing.
- MDs and DOs must have hospital privileges and/or a coverage plan.
- Hospital privileges must be current and active.
- All Network 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.

Providers

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

- Properly completed, signed and dated Kansas Provider Application;
- Properly completed CAQH application;
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation;
- Copy of W-9 form;
- Statement regarding history of loss or limitation or privileges or disciplinary activity;
- A statement from each Network Provider applicant regarding the following: any physical or behavioral health problems that may affect the Provider's ability to provide healthcare; any history or chemical dependency/substance use disorder problems; any history of loss of license and/or felony conviction;
- A copy of current and unrestricted license to practice in the State of Kansas;
- Malpractice face sheet: Network Providers must carry $1/$3M in coverage, or such other amounts as required by State law;
- Proof of the highest level of education—a copy of certificate or letter certifying formal post-graduate training;
- 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 and a copy of the Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable;
- MDs and DOs are also asked to supply Drug Enforcement Administration (DEA) registration, and Board Certification(s);
- For MDs and DOs, good standing of privileges at the hospital designated as the primary admitting facility;
- Providers licensed as LMFT, LPC, LMSW, and LMLP must provider a Supervising Physician Statement indicating that they are following the supervision standards as set forth by The Kansas Behavioral Sciences Regulatory Board;
- Valid Drug Enforcement Administration (DEA) certificates (where applicable);
- A completed Kansas Disclosure of Ownership & Control Interest Statement;
- 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;
- Completed Cenpatico Provider Specialty Profile; and,
- Any sanction or exclusion imposed on the Provider by Medicare or Medicaid.

Facilities

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

- A complete signed and dated Cenpatico facility application;
- List of current professional Behavioral Health/Substance Use Disorder staff privileged to admit and/or treat patients in your facility, (include license type, address, telephone numbers and social security numbers) that you would recommend that we contact for membership on Cenpatico's Individual Provider Panel;
- Copy of The Joint Commission/CARF/COA/AOA accreditation letter with dates of accreditation in addition to a list of all practice locations covered under the applicable accreditation body;
- Copy of the State or local license(s) and/or certificate(s) under which your facility operates;
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable;
- Copy of current Drug Enforcement Administration (DEA) registration certificate, if applicable;
- Copy of professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year);
- Listing of satellite locations and services offered at each location (include copies of accreditation, license, insurance, CLIA, and DEA certificate, if applicable);
- Kansas Disclosure of Ownership and Controlling Interest Statement; and,
- Facilities contracted under a Cenpatico Facility Agreement that list a rendering NPI in box 24-J of the claim form that is different than the Facility's billing NPI (box 33-A), must submit a facility roster of clinicians rendering covered services with their credentialing materials. This information should be submitted in the Cenpatico Facility Roster Format, which can be obtained from the Provider Relations Specialists. Any changes or updates to this list must be submitted to providerrelationsks@cenpatico.com

Non-Accredited Facilities must include the following in addition to the items above:

- Copy of State or local Fire/Health Certificate
- Federal/State Agency site visit
- Copy of Quality Assurance Plan
- Description of Aftercare or Follow-up Program
- Organizational Charts including staff to patient ratio

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

- Lawsuits related to professional role;
- Licensing board actions ;
- Changes or additional NPI and TIN;
- 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;
- Changes in physical address and fiscal/billing address; and
- Any situation that would impact a Provider's ability to carry out the provisions of their Behavioral Health Provider Agreement ("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.

Credentialing of Health Delivery Organizations
(CMHCs and other Behavioral 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
- Community Mental Health Center (CMHC)
- Psychiatric Residential Treatment Facility (PRTF)
- Federally Qualified Health Center (FQHC) and Rural Health Care Centers (RHC)
- Kansas Facilities/Health Delivery Organizations are required to utilize the Cenpatico facility application and provide information on accreditation, license, regulatory status and certificate of insurance. In addition, the facility must complete the Kansas Disclosure of Ownership & Control Interest Statement.

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
- Council on Accreditation of Services for Family & Children

**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 Re-credentialing 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.

Re-Credentialing Requirements and Schedule

Kansas Network Providers will be re-credentialed every 36 months from the initial credentialing date in accordance with the current NCQA guidelines, unless otherwise dictated by State law. Providers will receive notice that they are due to be re-credentialed well in advance of their expiration date and, as such, are expected to submit their updated information in a timely fashion. Failure to do so could 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.

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

- License through appropriate licensing agency;
- Board certification, or residency training, or medical education;
- National Practitioner Data Bank (NPDB) and HIPDB claims;
- Five years of work history; and
- Sanction or exclusion activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS – Excluded Parties Listing).

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

Council for Affordable Quality HealthCare (CAQH)

Cenpatico subscribes to the 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 assist you with contacting CAQH for enrollment.

Once a CAQH Provider ID number is assigned, you can visit the CAQH website or call the help desk, to *complete the* credentialing application. There is no cost for Providers to participate with CAQH and submit their credentialing applications.

CAQH Website: www.caqh.org
Phone Number: 1-888-559-1717

Right to Review and Correct Information

All Network 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 licensing/certification agencies. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a Provider believe any of the information used in the credentialing/re-credentialing process is erroneous, or should any information gathered as part of the primary source verification process differ from that submitted, Providers 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.

Cenpatico Credentialing Policies and Procedures

Cenpatico maintains written credentialing and re-credentialing policies and procedures that 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 Sunflower Health Plan 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 & Approval of Applications
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 ten (10) times per year.

Cenpatico has delegated the approval of credentialing applications that meet all the credentialing standards/criteria to the Medical Director who reviews files on a weekly and or bi-weekly basis.

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 if there is a change in Network Provider's hospital privileges. All changes in a Network Provider's status will be considered in the re-credentialing process.

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 Kansas 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: 866-263-6521
Email: providerrelationsks@cenpatico.com
Mail: Cenpatico Attn: Provider Data Management
12515-8 Research Blvd., Suite 400 Austin, Texas 78759

Provider Rosters

Cenpatico requires a listing of rendering employed professional Behavioral Health/Substance Use Disorder staff privileged to admit and/or treat patients. This list must include the Provider's license type, address, telephone numbers, NPI number, and social security numbers. Cenpatico must be notified of any updates to this listing to ensure data accuracy. In addition, please note that the information provided may be accessed by Cenpatico for network accessibility and Member referral services.

Providers should submit the updates to this listing to providerrelationsks@cenpatico.com

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 sent to the following:

Email: providerrelationsks@cenpatico.com
Fax: 866-263-6521
Mail: Cenpatico Attn: Provider Data Management
12515-8 Research Blvd., Suite 400 Austin, Texas 78759

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 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 behavioral health/ substance use disorder treatment services for Members of Sunflower Health Plan, or any other health plan or agency in the State of Kansas with which Cenpatico is the behavioral health vendor;
- Restriction, qualification, suspension or revocation of Network Providers' license or certification;
- Network Provider's loss of liability insurance required under the Provider Agreement with Cenpatico;
- Network Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's insolvency or bankruptcy or Network Provider's assignment for the benefit of creditors;
- Network Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Network Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Provider's submission of false or misleading billing information;
- Network Provider's failure or inability to meet and maintain full credentialing status with Cenpatico;
- Network Provider's breach of any term or obligations of the 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 Provider Data Management department at 866-896-7293 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
12515-8 Research Blvd.
Suite 400
Austin, TX 78759

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 866-896-7293.

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 described below:
"Davis (1997) defines cultural competence as the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of behavioral health care and outcomes.

Cultural competence occurs in behavioral health service delivery when cultural issues are acknowledged and addressed at all levels of an organization administration, service delivery, and clinician."

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.

The Cenpatico vision for culturally competent care is:

- Care is given with the understanding of, and respect for, the Member's health-related beliefs and cultural values.
- Cenpatico staff respect health related beliefs, interpersonal communication styles and attitude of the Members, families and communities they serve.

- Each functional unit within the organization applies a trained, tailored approach to culturally sensitive care in all Member communications and interactions.
- All Cenpatico Network Providers support and implement culturally sensitive care models to Sunflower Health Plan Members.

The Cenpatico goal for culturally sensitive care is:
To support the creation of a culturally sensitive behavioral health system of care that embraces and supports individual differences to achieve the best possible outcomes for individuals receiving services.

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 on 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 makes 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:
Research indicates that a person has better health outcomes when they experience culturally appropriate interactions with 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 Provider's office;
- Member's confusion and misunderstanding;
- Non-compliance by the Member;
- Member's feelings of being uncared for, looked down upon 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. Cenpatico is committed to helping you reach this goal.

Take the following into consideration when you provide services to 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

Sunflower Health Plan Members may access behavioral health and substance use disorder services through several mechanisms. Members do not need a referral from their Primary Care Physician (PCP) to access covered behavioral health and covered substance use disorder services. Caregivers or medical consenters may self-refer Members for behavioral health and substance use disorder services.

Cenpatico adheres to National Committee for Quality Assurance (NCQA) and State of Kansas 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
Office Wait Time	Not to exceed 45 minutes from the scheduled appointment time
Emergent Care	An assessment and/or treatment shall be provided within 3 hours for outpatient behavioral health services, and within 1 hour from referral for an emergent concurrent utilization review screen.
Urgent Care	An assessment and/or treatment within 48 hours from referral for outpatient behavioral health services, and within 24 hours from referral for an urgent concurrent utilization review screen.
Routine Outpatient	Assessment and/or treatment within 9 working days from referral; 10 working days from previous treatment
Inpatient Psychiatric	An assessment and/or treatment within 5 working days from referral
Discharge from Inpatient	Aftercare appointments within seven (7) calendar days after hospital discharge
Emergency Care	Provided immediately at the nearest facility available.

Post Stabilization	An assessment and/or treatment within 1 hour from referral for post-stabilization services (both inpatient and outpatient) in an emergency room.
Substance Use Disorder Services	Emergent services, for Members who are unsafe or whose condition is deteriorating, must be available immediately or Member referred to a hospital. For urgent (non-emergent) care, an assessment must be given within 24 hours of initial contact and services delivered within 24 hours from assessment. Pregnant women shall be placed in the urgent category. In routine situations, Members shall receive an assessment within 14 days of initial contact and treatment within 14 days from the assessment, without resultant deterioration in the Member's functioning or condition.
IV Drug User	Members who have used IV drugs within the last 6 months and who are not considered Emergent or Urgent, shall receive an assessment within 14 days of initial contact.
Urgent Pregnant Substance Users	IVDU Pregnant & Pregnant women are considered Urgent. This population must be assessed in 24 and offered treatment within 24 hours of the assessment. If the program lacks capacity, SAPT interim services should be offered.

If you cannot offer an appointment within these timeframes, please refer the Member to Cenpatico at 866-896-7293 so that 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, 365 days a year as the nature of the Member's behavioral health condition dictates. These services include all covered behavioral health services provided by Cenpatico's Network Providers that are congruent with the Member's treatment plan and presenting behavioral health issues. Network Providers will offer hours of operation that are no less than the hours of operation offered to commercial insurance members 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 866-944-7588 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 Network Provider and facility services. Cenpatico will strive to meet the following accessibility requirements:

For all behavioral health services, including substance use disorder services, members will travel no more than 30 miles for urban areas, 45 miles for densely settled rural areas and 60 miles for rural and frontier areas.

Exceptions to these standards will be in the western and southwestern regions of Kansas, where health care providers and services are scarce overall, and travel distance standards would default to the closest available providers or community standards.

After Hours Access Standards

Network Providers must have coverage for their practice twenty-four (24) hours per day, seven (7) days per week, 365 days a year. This type of coverage may include a published after hours telephone number, pager, or answering service. Members must be given instructions for what to do and whom they can call after hours; voicemail alone after hours is not acceptable.

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.

Sunflower Health Plan Members may not be charged a fee for a "no show" appointment. Network Providers may contact Cenpatico via email or telephone to inform Cenpatico about Members who do not keep appointments. Cenpatico Care Coordinators will contact the Member to reinforce the importance of attending appointments; assess and help address barriers such as transportation; and assist in rescheduling if needed.

No New Referral Periods

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

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

Network Providers must call or write to the Cenpatico Provider Relations department to set up a "no referral" period. The Cenpatico Provider Relations department can be reached as follows:

Fax: 866-263-6521

Email: providerrelationsks@cenpatico.com

Network Providers must have a start date and an end date indicating when they will be available again for referrals. A "no referral" period will end automatically on the set end date.

Coordination between Sunflower Health Plan and Cenpatico

Sunflower Health Plan and Cenpatico work together to assure quality behavioral health services, including substance use disorder services, are provided to all Members. This coordination includes participation in Quality Improvement (QI) activities 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 providers in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Sunflower Health Plan on a monthly basis and is shared with Sunflower Health Plan's management and executive leadership quarterly. Provider performance is compared to state and national performance thresholds and benchmarks to assess for over and underutilization of services, quality of service provision, and areas for improvement. Performance on any standard that does not meet performance thresholds and/or exhibits continued poor performance will result in a corrective action plan (CAP). Cenpatico works with its Providers on CAP development and interim reporting to resolve performance issues and improve Member quality of care.

Quality Improvement

Cenpatico's Quality Improvement (QI) Program is based on the principles of Continuous Performance Improvement (CPI) and utilizes the Plan, Do, Study Act (PDSA) model of CPI in the development and evaluation of quality activities. All quality activities are designed to improve the quality of care to Sunflower Health Plan Members. The QI Program is data driven and incorporates data feeds from all Cenpatico functional units, creating a culture of quality throughout the organization. The Cenpatico QI Program includes clinical, network, customer service, and service utilization and provider complaints as core business metrics. Further, the Cenpatico QI program coordinates with the Sunflower Health Plan QI program to support continuity, coordination and improved integration of Member care.

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?

- Access to care standards;
- Adherence to Clinical Practice Guidelines;
- Communication with PCPs and other behavioral health providers;
- Critical Incidents;
- Quality of Care (QOC) concerns;
- Member confidentiality;
- High-risk Member identification, management and tracking;
- Inpatient discharge follow-up care;
- Inpatient admissions, readmissions and lengths of stay;
- Member grievances;
- Provider grievances;
- Service utilization patterns;
- Provider satisfaction; and,
- Member satisfaction

How does Cenpatico monitor quality?

Cenpatico evaluates available administrative data (claims and service authorizations) along with Member and Provider surveys as methods to monitor quality. Hybrid methods (those that include administrative as well as medical record review) occur as a result of trends in critical incidents, Provider complaints and QOCs.

Results of ongoing quality monitoring are communicated to Network Provider groups for technical assistance and in the development of performance improvement and Corrective Action Plan (CAPs). Trends in performance and results of CAPs are evaluated and reviewed by Cenpatico during the re-credentialing process.

Network Provider Participation in the QI Process
Cenpatico Providers are expected to monitor and evaluate their own compliance with performance requirements to assure the quality of care and service provided.

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 Provider satisfaction surveys; and
- Cooperating with reviews of quality of care issues and critical incident reporting.

In addition, 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 behavioral health information and alcohol/ substance use disorder treatment records.

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

Communication with the Primary Care Physician
Sunflower Health Plan encourages primary care physicians (PCPs) to consult with their patients' behavioral health Network Providers. In many cases the PCP has extensive knowledge about the Member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with Member consent, when required.

Network Providers should communicate not only with the Member's PCP whenever there is a behavioral health problem or treatment plan that can affect the Member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may also be providing service to the Member.

Network Providers are encouraged to complete a health status screen, at the initial point of contact and as part of the re-assessment process for Members in treatment. Network Providers must refer Members with physical health conditions (as indicated by the screen) to their primary care provider for evaluation and treatment of the physical health condition.

Cenpatico developed a PCP Communication template that may be used by Network Providers in coordination of care activities for a Member, if the Provider does not have an existing form. The form is a template that incorporates key clinical information that should be shared with each Member's PCP. The PCP Communication template 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 Providers should screen for the existence of co-occurring behavioral health and substance

use disorder conditions and make appropriate referrals. Network Providers should refer Members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment. If the Members' assigned PCP is not local (e.g. in the event of a RTC/PRTF facility) and the Member is in need of medical assistance, Sunflower Health Plan staff will be able to assist the Network Provider with linking the Member to provider closer geographically.

Cenpatico requires that Network Providers report specific clinical information to the Member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent, when required under State and/or Federal law, it is the Network Provider's responsibility to keep the Member's PCP abreast of the Member's treatment status and progress in a consistent and reliable manner. If the Member requests this information not be given to their PCP, the Network Provider must document this refusal in the Member's treatment record. Such consent shall meet the requirements set forth in 42 CFR et seq., when applicable. If the Member requests this information not be given to their PCP, the Network Provider must document this refusal in the Member's treatment record, and if possible, the reason why. The following information is valuable to include in the report to the PCP:

- A copy of the behavioral health intake assessment;
- Identified barriers to Member's success with current treatment plan, if applicable;
- The results of an initial psychiatric evaluation;
- Current psychotropic medications, including initiation of and major changes in medication regime, within fourteen (14) days of the visit or medication order;
- The results of functional assessments; and
- Member's functional and clinical status upon completion of treatment.

Consent for Disclosure

Cenpatico recognizes communication as the link that unites all the service components and a key element in any program's success. To further this objective, Network Providers shall obtain consent from Members or their authorized representatives when required by state and/or federal law to exchange confidential information, including but not limited to the disclosures to behavioral health providers and between the behavioral health provider and the Member's physical health provider.

Anytime consent to release information is required and the Member whose information is the subject of the release refuses to provide consent for the release, the Network Provider shall document the refusal along with the reasons for declination in the medical record. Cenpatico monitors compliance by its Network Providers with medical record documentation requirements, including but not evidence of a note in a Member's record if he/she declined to give consent for a release, and whether the Network Provider sends regular to the primary care provider (PCP) or other behavioral health providers for treatment and care coordination.

Critical Incident Reporting

A Critical Incident is defined as any occurrence which is not consistent with the routine operation of a Network Provider. It includes, but is not limited to: injuries to Members, a 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. A Critical Incident Report must be completed for any Cenpatico Member by the Network Provider within twenty four (24) hours of, or notification of, such an occurrence.
The Critical Incident Report Form is located on Cenpatico's website at www.cenpatico.com/providers/forms/kansas. Submit completed Critical Incident Reports to the

following address:

Cenpatico
Attn: Quality Improvement Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759
Fax: 866-694-3733

Abuse and Neglect Reporting

Providers are required to report all incidents that may include abuse and neglect consistent with the Department of Human Services Act, the Adults with Disabilities Domestic Abuse Intervention Act and the Abused and Neglect Child Reporting Act. Reports regarding elderly Members who are over the age of 60 with domestic/community abuse will be reported to Kansas Department for Aging and Disability Services at 800-922-5330. Reports regarding elderly Members for abuse by a nursing home, hospital, home health agency, etc., abuse or neglect should call the Kansas Department of Health and Environment Bureau of Health Facilities, Phone: 800-842-0078. Reports concerning children and adults should be directed to the Kansas Protection Report Center, Phone: 800-922-5330, The Kansas Protection Report Center staffs this hotline 24 hours a day, 7 days a week, 365 days a year.

Cenpatico will offer training to Providers about the signs of abuse or neglect.

Member Concerns about Network Providers

Members who have concerns about Cenpatico Network Providers should contact Sunflower Health Plan 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. Cenpatico alerts a Network Provider through written and oral communication when a complaint has been lodged against a Provider. Cenpatico asks for the Network Provider to submit any and all documentation to support or refute the complaint as part of the complaint investigation process. Cenpatico provides documentation with the complaint resolution to the Provider.

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, Sunflower Health Plan and other regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability, to investigate complaints and grievances, and to meet the reporting requirements specified in the contract between Sunflower Health Plan and KanCare, 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.

Reporting and Metric Requirements
Network Providers may be required to submit timely to Cenpatico reports or performance metrics as required by Sunflower Health Plan's contract with KanCare, and/or Cenpatico's requirements for NCQA accreditation. Such metrics shall include but not be limited to provider rosters by service location, average number of days to receive an emergent appointment, average number of days to receive a routine appointment, network adequacy and complaint trends. Cenpatico and Network Providers shall work together to find solutions when performance standards are not met.

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 Providers 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. Chart Audits of Member records will be evaluated in accordance with these criteria.

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

Cenpatico Compliance Program
The Cenpatico President/CEO and Compliance Department share responsibility and authority for carrying out the provisions of the compliance program. In collaboration with Sunflower Health Plan, Cenpatico is committed to conducting activities in an ethical manner consistent with applicable laws, contracts and regulatory requirements.

The Network Providers 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 Sunflower Health Plan.

The Cenpatico Compliance Program includes a system for identifying and reporting waste, abuse and fraud and for safeguarding the privacy of confidential information as follows;

Waste, Abuse and Fraud (WAF) System
Cenpatico is committed to the detection, investigation and prosecution of waste, abuse and fraud (WAF). WAF is defined as follows:

Waste – Use of healthcare benefits or dollars without a real need. For example, prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.

Abuse – Practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the health plan program, including, but not limited to practices that result in unnecessary cost to the Health Care program for services that are not Medically Necessary, or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the health plan program.

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the health plan program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable federal or State healthcare fraud laws. Examples of Provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and Providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Member fraud include improperly obtaining prescriptions for controlled substances and card sharing.

Reporting Provider or Member Waste, Abuse or Fraud

If you suspect a Member (a person who receives benefits) or a Provider (e.g., doctor, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.

Network Providers can report Providers and Members to Cenpatico by mailing or contacting Cenpatico's Special Investigations Unit (SIU) at:

Cenpatico
Attn: Special Investigations Unit
7711Carondelet Ave.
St. Louis, MO 63105 Phone:
866-685-8664

When reporting a Provider (e.g., doctor, dentist, counselor, etc.) please provide the following:

- Name, address, and phone number of Provider;
- Name and address of the facility (hospital, nursing home, home health agency, etc.);
- Type of Provider (physician, physical therapist, pharmacist, etc.);
- Names and phone numbers of other witnesses who can aide in the investigation;
- Dates of events; and
- Summary of what happened

When reporting a Member (a person who receives benefits through Sunflower Health Plan) please provide the following:

- The Member's name;
- The Member's date of birth, social security number, or case number (if available);
- The city where the Member resides; and
- Specific details about the waste or abuse.

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

Federal and States Laws Governing the Release of Information

The release of certain information is governed by a myriad of federal and/or state laws.

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

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

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance use disorder treatment records (42 CFR Part 2 or —Part 2). These records generally may not be released without consent from the individual whose information is subject to the release. Still other laws at the state level place further restrictions on the release of certain information, such as behavioral health, communicable disease, etc.

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

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

Cenpatico Network Providers are independently obligated to know, understand and comply with these laws.

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

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

Cenpatico Compliance Department
12515-8 Research Blvd. Suite 400
Austin, TX 78759

Please instruct any Member to contact our Customer Services team with any questions about our privacy practices.

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 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 thirteen (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- 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.

Preventative Behavioral Health Programs

Cenpatico, in conjunction with Sunflower Health Plan, offers the Perinatal Depression Screening Program as a preventative behavioral health program for our Members. The Perinatal Depression Screening Program offers depression screening to Members who are pregnant via a brief, easy to answer survey, in order to identify Members who would benefit from behavioral health services. Members can complete the surveys in their PCP offices, CMHC, or submit the survey directly to Cenpatico. If completed at a Provider's office, the Provider submits the screening to Cenpatico for scoring and analysis. Each Member who participates receives communication from Cenpatico regarding the outcome of their survey answers and resources available to them. If a Member screens positive for depression while pregnant or after delivery, a Cenpatico clinical staff person will call to attempt to outreach and engage the Member in services and/or finding community resources. Cenpatico communicates the survey findings and outreach attempts to the Member's medical provider as well to support coordination of care.

Cenpatico appreciates your assistance in promoting this preventative behavioral health program. You can refer your Members to the program directly when you assess a Member is at risk for, or screened positive for, depression while pregnant or post-delivery. If you would like more information about the program or if you have suggestions as to how we can improve our preventative behavioral health program, please contact the Quality Improvement department at 512-406-7200.

Complaints, Grievances and Appeals

Member Grievances and Provider Complaints

Grievances

A Member grievance is defined as any Member expression of dissatisfaction about any matter other than an "adverse action". A Provider complaint is any Provider expression of dissatisfaction about any matter other than a claims dispute.

***Note**: Throughout this Manual, we will consider the term "grievance" to refer to both Member grievances and Provider complaints as the resolution processes are the same. Provider complaints include disputes regarding policies, procedures or any aspect of Sunflower Health Plans' administrative functions including proposed actions.*

The grievance process allows the Member, or the Member's authorized representative (Provider, family Member, etc.) acting on behalf of the Member, to file a grievance either orally or in writing within 180 calendar days of the event covering the dissatisfaction. Sunflower State Health Plan shall acknowledge receipt of each grievance in writing within 5 working days of receipt of the grievance. A Provider MAY NOT file a grievance or appeal on behalf of a Member without written consent by the Member or the Member's representative. Any individual who makes a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Sunflower Health Plan shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the Member's condition or disease. Sunflower Health Plan values its Providers and will not take punitive action against Providers who file a grievance on a Member's behalf. To file a complaint, please call: 866-896- 7293. A Cenpatico Customer Service

Representative will assist you in filing a grievance.

Acknowledgement
Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the Member, representative or Provider, the staff will document the resolution details. Member notification of the grievance resolution shall be made in writing within two business days of the resolution. The Grievance and Appeals Coordinator (GAC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt of the written grievance.

Grievance Resolution Time Frame
Grievance Resolution will occur as expeditiously as the Member's health condition requires, not to exceed thirty (30) calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the GAC, in coordination with other Sunflower State Health Plan staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the Member, representative or Provider filing the grievance. Expedited grievance reviews will be available for Members in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 24 hours.

Sunflower Health Plan may extend the resolution of a grievance by up to 14 calendar days if the Member or a Member representative requests the extension or if Sunflower Health Plan determines that there is a need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, Sunflower Health Plan will give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe.

Notice of Resolution
The GAC will provide written resolution to the Member, representative or Provider within 30 calendar days of receipt. The letter will include, but need not be limited to: all information considered in investigating the grievance, findings and conclusions, the deposition of the grievance, and the right to a second level review by the Grievance Appeal Committee (GAC) if the Member is not satisfied.

The grievance response shall include, but not be limited to, the decision reached by Sunflower Health Plan, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Member. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five years.

Grievances may be submitted by written notification to:

Cenpatico
Attn: Quality Improvement Department
12515-8 Research Blvd. Suite 400
Austin, TX 78759
Fax: 866-704-3063

Appeals
An appeal is the request for review of a "Notice of Adverse Action". A "Notice of Adverse Action" is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a Member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Cenpatico/Sunflower Health Plan Network. The review may be requested in writing or orally within thirty (30) calendar days of receiving the Notice of Adverse Action; an oral request, must be followed up with a written, signed appeal. Requests for appeals within the standard timeframe must be resolved within fourteen (14) days of receipt of the appeal, with a fourteen (14) day extension possible if additional information is required. The legal guardian of the Member (for minors or incapacitated adults), a representative of the minor designated in writing, or a Provider acting on behalf of the Member with the Member's written consent, has the right to file an appeal of an action on behalf of the Member. Sunflower Health Plan shall provide written notice that the appeal has been received within three business days of its receipt, including the expected date of resolution. Members may request that Sunflower State Health Plan review the Notice of Adverse Action to verify if the right decision has been made. Cenpatico ensures that the Cenpatico decision makers on grievance and appeals were not involved in previous levels of review or decision making and are health care professionals with clinical expertise in treatment of the Member's conditions.

If a Member is receiving authorized services that are now denied and wishes to keep getting these services, an appeal must be submitted in writing within 10 calendar days of the denial letter. The request must clearly state that the Member wishes to keep getting the denied services. The Member can keep getting these services until the appeal decision is rendered. If the appeal decision upholds Sunflower Health Plan's denial, the Member may have to pay for the services.

Expedited Appeals
Expedited appeals may be filed when either Sunflower Health Plan or the Member's Provider determines that the time expended in a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum functioning. No punitive action will be taken against a Provider that requests an expedited resolution or supports a Member's appeal. In instances where the Member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the Member's health condition requires, not exceeding three working days from the initial receipt of the appeal. Sunflower Health Plan may extend this timeframe by up to an additional 14 calendar days if the Member requests the extension or if Sunflower Health Plan provides evidence satisfactory to the State that a delay in rendering the decision is in the Member's interest. For any extension not requested by the Member, Sunflower Health Plan shall provide written notice to the Member of the reason for the delay. Sunflower Health Plan shall make reasonable efforts to provide the Member with prompt verbal notice of any decisions that are not resolved wholly in favor of the Member and shall follow-up within two calendar days with a written notice of action.

Written notice shall include the following information:

(a) The decision reached by Sunflower Health Plan;

(b) The date of decision;

(c) For appeals not resolved wholly in favor of the Member, the right to request a State fair hearing and information as to how to do so; and

(d) The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the Member may be held liable for the cost of those services if the hearing decision upholds the Sunflower Health Plan decision;

(e) Notification that in the State Fair Hearing the member may represent him/herself or use legal counsel, a relative, a friend, or a spokesperson;

(f) Any other information required by Kansas Statute that relates to a managed care organization's notice of disposition of an appeal.

Grievances may be submitted verbally or in writing to: Cenpatico
Grievance and Appeals Coordinator
12515-8 Research Blvd., Suite 400
Austin, TX 78759
Phone: 866-896-7293
Fax: 866-714-7991

State Fair Hearing Process

Sunflower Health Plan will include information in the Member Handbook, online and via the appeals process to Members of their right to appeal directly to the State. The Member has the right to appeal to the State at the same time they appeal to Sunflower Health Plan, after exhausting appeal rights with Sunflower Health Plan, or instead of appealing to Sunflower Health Plan.

Any adverse action or appeal that is not resolved wholly in favor of the Member by Sunflower Health Plan may be appealed by the Member or the Member's authorized representative to the State for a fair hearing. Sunflower Health Plans denial of payment for Kansas Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the Member or the Member's representative within 90 days of the Member's receipt of notice of adverse action.

Sunflower Health Plan shall comply with the State's Fair hearing decision. The State's decision in these matters shall be final and shall not be subject to appeal by Sunflower Health Plan.

Reversed Appeal Resolution

If Sunflower Health Plan or the State fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Sunflower Health Plan will authorize the disputed services promptly and as expeditiously as the Member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, Sunflower Health Plan will provide reimbursement for those services in accordance with the terms of the final decision rendered by the States and applicable regulations.

To request a State Fair Hearing, you must file a written request with the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, KS 66612 within 30 days of the written notice. If KDHE-DHCF mailed the notice of denial to you, K.S.A. 77- 531 allows you an additional three days to file such a request.

Or the request for fair hearing can be faxed to:

Office of Administrative Hearings
Phone: 785-296-2433
Fax: 785-296-4848

Member Rights and Responsibilities

Sunflower Health Plan Member Rights and Responsibilities

Sunflower Health Plan Members have the right to:

1. Respect, dignity, privacy, confidentiality and nondiscrimination;
2. Receive information on available treatment options and alternatives;
3. Consent for or refusal of treatment and active participation in decision choices;
4. Assistance with Medical Records in accordance with applicable federal and state laws;
5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and,
6. Freely exercise these rights without adversely affecting the way the Sunflower Health Plan and its Providers or the State agency treat the Member.

It is the responsibility of Sunflower Health Plan Members to:

1. Provide, to the extent possible, information needed by Providers in caring for the Member;
2. Contact their Primary Care Provider (PCP) as their first point of contact when needing medical care;
3. Follow appointment scheduling processes; and
4. Follow instructions and guidelines given by Providers.

In addition to the Member Rights and Responsibilities provided by Sunflower Health Plan, Cenpatico believes that members also have the following Rights and Responsibilities:

Cenpatico Member Rights and Responsibilities

Member Rights

1. A right to receive information about the organization, its services, its Providers and Member rights and responsibilities.
2. A right to participate with providers in making decisions about their health care.
3. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
4. A right to voice complaints about the organization or the care it provides.
5. A right to make recommendations regarding the organization's Member Rights and Responsibilities Policy.

Member Responsibilities

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

Civil Rights

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

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

Customer Service

The Cenpatico Customer Service Department

Cenpatico operates a toll free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel, Monday through Friday 8:00 a.m. to 5:00 p.m. Central Time. 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 supports 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 Cenpatico Customer Service department assists Network Providers with the following:

- Verifying Member eligibility;
- Verifying Member benefits;
- Providing authorization information;
- Referrals; and,
- Troubleshooting 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.

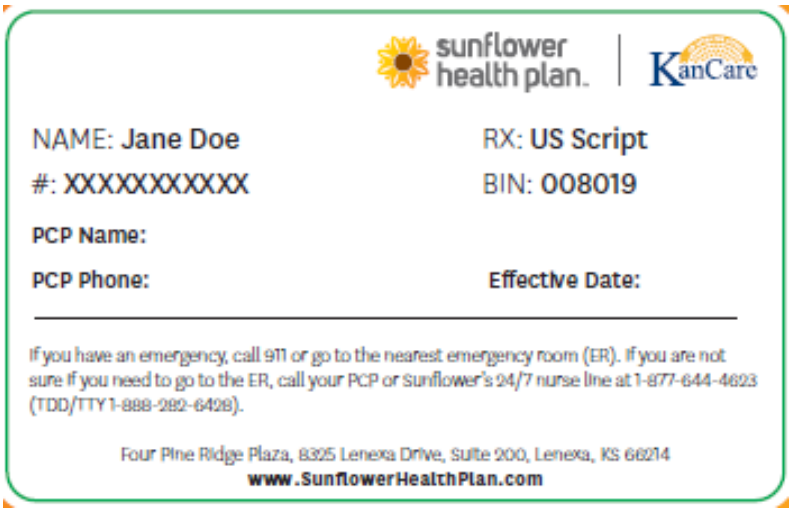
Network Providers should use either of the following options to verify Member enrollment:

- Access the Kansas Medical Assistance program (KMAP) website at https://www.kmap-state-ks.us/Public/Provider.asp or call 800-933-6593
- Contact Cenpatico Customer Service at 866-896-7293
- Access the Cenpatico Provider Website at www. cenpatico.com

Until the actual date of enrollment with Sunflower Health Plan, Cenpatico is not financially responsible for services the prospective Member receives. In addition, Cenpatico is not financially responsible for services Members receive after their coverage has been terminated.

The Provider must implement a policy prior to providing non-emergency services to an adult KanCare Member that requests and inspects the adult Member's KanCare identification card (or other documentation provided by the state agency demonstrating KanCare eligibility) and health plan membership card. If the adult Member does not produce their health plan membership card, and the Provider verifies eligibility and health plan enrollment, the Provider may provide service.

Sunflower Health Plan Member ID Cards



Interpretation/Translation Services
Cenpatico is committed to ensuring staff are educated, aware and sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, Cenpatico's Customer Service team is staffed with Spanish and English bilingual personnel. Trained professional language interpreters, including those proficient in American Sign Language, can be made available face-to-face at your office. Interpreters are also available telephonically 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 Kansas Relay Customer Service:

TTY: **800-766-3777**
Voice: **800-766-3777**

Key Information: To access interpreter services for Sunflower Health Plan Members, contact Customer Service at 866-896-7293.

NurseWise
NurseWise is Cenpatico's after-hours nurse referral line which is a bilingual care line consisting of both Customer Service Representatives and Registered Nurses who respond to inquiries from eligible individuals and their eligible dependents. Verification of eligibility for service, demographic information verification and administrative questions may be answered by NurseWise representatives. NurseWise provides after-hours phone coverage seven (7) days per week including holidays.

NurseWise provides after hours assistance with the following:

- emergency and urgent care matters;
- health questions and identification and treatment of health issues;
- eligibility verification;
- notification of primary care and other Providers when warranted;
- coordination of appropriate transportation for health services; and
- questions regarding participating status of providers.

Benefit Overview
Cenpatico covers all behavioral health services, including substance use disorder services, defined in the KanCare comprehensive benefit package. Services for Sunflower Health Plan Members include, but are not limited to the following;

- Inpatient Mental Health Hospitalization & Medical Detoxification
- Observation
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Electroconvulsive Therapy (ECT)
- Crisis Intervention

- Outpatient Mental Health Services including medication management
- Community Mental Health Center services
- Substance Use Disorder (SUD) Services
- HCBS SED Waiver Services
- Autism Waiver Services
- 1915 (b) 3 Services
- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) behavioral health services
- Positive Behavioral Support (PBS) Services
- Screening, Brief Intervention and Referral for Treatment (SBIRT) for Alcohol and Drug Use Services

For a listing of service codes and authorization requirements, please refer to the Covered Professional Services & Authorization Guidelines located on the Cenpatico Website. 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.

Specialty Therapy and Rehabilitative Services (STRS)
Cenpatico offers Sunflower Health Plan Members access to all covered, medically necessary outpatient home health, physical, occupational and speech therapy services.

Prior authorization is required for outpatient home health, physical, occupational, or speech therapy services and prior authorization requests should be submitted to Cenpatico Specialty Therapy and Rehabilitative Services (STRS) using the Outpatient Treatment Request (OTR) form located at www.cenpatico.com.

Cenpatico STRS Outpatient Therapies Prior Authorization

Fax: 1-866-264-4452

Cenpatico STRS created and applies medical necessity criteria developed using Clinical Practice Guidelines of the physical, occupational and speech Professional Associations, as well as InterQual Criteria for both adult and pediatric guidelines. The criteria can be found on the Cenpatico website at: www.cenpatico.com. Cenpatico STRS utilizes Physical, Occupational and Speech Therapists to process Outpatient Treatment Requests. Our specialized approach allows for interaction in real time with the Provider to best meet the overall therapeutic needs of the Members.

In the event that the Provider is unable to provide timely access for a Member, Cenpatico will assist in securing authorization to a Provider to meet the Member's needs in a timely manner.

For more detailed information about Specialty Therapy and Rehabilitative Services, please read the provider manual on the Sunflower Health Plan website at www.sunflowerhealthplan.com. For additional questions, please contact Cenpatico STRS at 877-644-4623.

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 5:00 p.m., local time. Additionally, clinical staff is available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number at 866-896-7293. 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.

Cenpatico is committed to compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Interim Final Rule and subsequent Final Ruling.

Cenpatico will ensure compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to MH/SUD benefits and non-quantitative limits (NQTLS). Cenpatico administers benefits for Substance Use Disorder (SUD) and/or behavioral health conditions as designated and approved by the State contract and Plan benefits. MHPAE does not preempt state law, unless law limits application of the act. We support access to care for individuals seeking treatment for behavioral health conditions as well as Substance Use Disorders and believe in a "no wrong door" approach. Our strategies, evidentiary standards and processes for reviewing treatment services are no more stringent than those in use for medical/surgical benefits in the same classification when determining to what extent a benefit is subject to NQTLs.

The Cenpatico Utilization Management Program strives to ensure:

- Member care meets Medical Necessity Criteria;
- Treatment is specific to the Member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided are of high clinical quality;
- Utilization Management policies and procedures are systematically and consistently applied; and
- Focus on Member and family recovery, resiliency and hope.

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

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

Cenpatico's Utilization Management Department is under the direction of our licensed Medical Director. 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 either of the following methodologies to verify Member eligibility;

Contact Cenpatico Customer Service at 866-896-7293 Access the Provider web portal at www.cenpatico.com

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

Please see the Covered Professional Services and Authorization Guidelines grid to get detailed information about the authorization limits.

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions
When requesting additional sessions for those outpatient services that require authorization, the Network Provider must complete an Outpatient Treatment Request (OTR) form and fax the completed form to Cenpatico at 866-694-3649. The OTR can be submitted electronically on the secure web portal. The OTR is located on our website at www.cenpatico.com. Network Providers may call Customer Service at 866-896-7293, Network Providers should allow up to two (2) to fourteen (14) calendar days to process non-urgent requests.

IMPORTANT:
The OTR must be completed in its entirety. The diagnosis(es), 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.

Retro Authorization
Retrospective review is an initial review of both inpatient and outpatient services provided to a Member, but for which authorization and/or timely notification to Cenpatico was not obtained. If this is due to extenuating circumstances (i.e. Member was unconscious at time of presentation, Member did not have their Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined Member was not eligible at the time of service), the requests for retrospective review must be within 30 business days of the Network Provider knowing that the Member had Sunflower Health Plan coverage. For those services, both inpatient and outpatient, where the Member was given Medicaid coverage after the service occurred, the requests for retrospective review must be submitted to Cenpatico within thirty (30) business days of the Medicaid card issue date. A decision on retrospective reviews will be made within thirty (30) calendar days following receipt of the request.

Network Providers must submit their Retroactive Authorization request to:

Cenpatico
Attn: Appeals Department
12515-8 Research Blvd. Suite 400
Austin, TX 78759
Fax: 866-714-7991

Retro Authorizations will only be granted in rare cases, such as eligibility issues. All requests for retro authorizations must be submitted within 180 days of the date of service and should include a cover letter explaining why authorization was not obtained. You should provide medical records that will be used to determine if medical necessity was met for the services provided.

Repeated requests for Retro Authorizations will result in termination from the Cenpatico Provider Network due to inability to follow policies and procedures.

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.

Guidelines for Psychological Testing
Prior authorization is required for 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 (90791 and 90792) may be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the provider is contracted and credentialed with Cenpatico.

Network Providers 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.

Guidelines for Requesting SED Waiver Services
When a Member qualifies for the SED Waiver Services the Network Provider is to submit the budget and all required components into KAMIS prior to service delivery. Network Providers must also fax the Member's Plan of Care (POC) including signature page the same day. The number of units allowed prior to submission of the POC is outlined in the Covered Services and Authorization Guideline Grid, located within the Provider Manual.

In the event that an SED Waiver Services Member was not assigned to an MCO at the time of their clinical eligibility determination, but was later assigned to Sunflower Health Plan, Cenpatico would perform a retrospective review back to the date of Medicaid eligibility. If a Member is already assigned to Sunflower Health Plan, Cenpatico would require the Network Provider to follow the Covered Services and Authorization Guidelines Grid to determine when the request needs to be submitted.

SED WAIVER PROCESSING UPDATES
Member participation in treatment planning is a very important part of the treatment process. It greatly enhances treatment success because it guarantees that the Member has a voice. The ability to be heard increases the Member's engagement in their treatment and healing process. Cenpatico and the State of Kansas expect that all Members, age 5 years and above, shall attend treatment planning sessions unless there is a mitigating reason why such Member should not be present for their Plan of Care reviews. (Reference SED Waiver Manual page 19).

In order to facilitate successful treatment planning sessions, Cenpatico recommends:

- Meetings should take place during times and at specific locations that are convenient for the Member.
- Natural support systems will be identified by the facilitator and those supports will be incorporated into the meetings.

If a member presents with challenging behaviors, Cenpatico suggests that the CMHC's explore the following options in an effort to increase the Member's participation in treatment planning meetings. These may include:

- Provision of natural supports
- Attendant care
- Allowing the member to attend part of the meeting to verbalize what will help them be successful in their treatment and help to individualize the goals

If a member is unable to attend treatment planning after reasonable accommodations have been provided, there must be documentation on the signature line of the treatment plan and also documented in the progress notes as to why the member was unable to participate. Inability of a member to participate may include:

- Illness of the member
- Documentation that indicates participation in treatment planning would be emotionally harmful to the member. Note the risk of this should be evaluated on a continued basis to assess readiness to participate in future treatment planning.

The **Plan of Care (POC) update** must be submitted within 2 weeks of the meeting date in order to be considered for approval of the entire timeframe. The POC should be faxed the same day that the budget is entered into KAMIS along with supporting documentation. Cenpatico will only backdate fourteen (14) calendar days from the day of receipt. This timeframe excludes the initial plan of care which remains the same. If the budget has been entered into KAMIS and if all required documentation has been submitted timely, then backdating guidelines would not apply when there are financial eligibility issues.

Plans of Care should be completed at least every 90 days. If it is greater than ninety (90) days since the last review, a request for authorization will not be approved for days where there is no an active Plan of Care.

Cenpatico does not require a signature page or Plan of Care review for SED Waiver Services if the provider is only seeking an increase in the number of units of a service. Please indicate in the note section of KAMIS what types of units are being increased (monthly, crisis, post crisis budget etc.). Also, specify the type of additional services that are being requested. This process is not to be used if there is an addition or deletion of a service as this would be a significant clinical change. Cenpatico will process the request and add the units in to the existing authorization.

Guidelines for SUD Authorizations

Network Providers requesting authorization for SUD services must utilize the KCPC system. The Network Provider will request the services and units via KCPC, and Cenpatico staff will review the authorization in the KCPC system. Beginning January 1, 2014, H0004 and H0005 no longer require prior authorization for participating providers, but must be entered in to the KCPC system for tracking.

Guidelines for the Autism Waiver Services
Providers who are requesting authorization for Autism Waiver Services are to request these services via the Autism Waiver Outpatient Treatment Request Form, located on the Cenpatico website.

Guidelines for Inpatient Screening and Admission to PRTF
Members who are in need of inpatient hospitalization can go to their CMHC to get assistance through their crisis centers if available or present to the acute hospital for an assessment for admission. Bed availability can be located on Kansas Health Solutions website or Cenpatico care managers can assist with admissions during business hours. The Kansas Health Solutions website is kansashealthsolutions.org. The admitting hospital is to send notification of the admission to Cenpatico within 24 hours of admission. Concurrent reviews will occur with the Cenpatico Utilization Manager.

Members who are in need of PRTF placement are to notify Cenpatico and request a preadmission meeting. Cenpatico has 7 business days to conduct the conference to discuss the need and what options have been attempted in the community. Cenpatico case management staff will invite community providers at the member's discretion to participate in the meeting. Cenpatico will work with the family to locate a bed once the decision has been made to move forward with the PRTF admission. Decisions for PRTF placement will be honored for up to fifteen (15) days post the date of the conference meeting. Concurrent reviews will be conducted on an individual basis based on the clinical presentation of the member at the previous review. PRTFs have 14 days to develop their treatment plans and begin treatment before the first review will be conducted. Reviews must be conducted within every 30 days.

Medical Necessity
Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when medical necessity criteria (MNC) are satisfied. 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 Sunflower Health Plan. Utilization management will review OTR's based on MNC, and will outreach to the Provider for further clinical information as needed.

Cenpatico uses InterQual Criteria for behavioral health services, both adult and pediatric guidelines. InterQual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes. Cenpatico utilizes the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance use disorder Medical Necessity Criteria. For Substance Use Disorder (SUD) Providers who are currently utilizing KCPC, Cenpatico will continue to utilize the KCPC system. Additionally, Cenpatico has adopted the Kansas State Medicaid Manual service descriptions and medical necessity guidelines for all community based services.

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

ASAM, InterQual and our Community Based Services criteria are reviewed on an annual basis by the Cenpatico Provider Advisory Committee that is comprised of Network Providers as well as Cenpatico clinical staff.

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

Concurrent Review
Cenpatico's 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.

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 continued stay requests, the physician or treating provider is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available. When a determination is made where no peer-to-peer conversation has occurred, a Provider can request to speak with the Peer Reviewer who made the determination within one (1) business day. Providers should contact Cenpatico at 866-896-7293 to discuss UM denial decisions.

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

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

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 Provider, Providers rendering the service(s) and the Member. The notification will include the following information/ instructions:

1. The reason(s) for the proposed action in clearly understandable language;
2. A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary;
3. A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request;
4. 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;

5. 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;

6. For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal; and

7. 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.

Discharge Planning

Follow up after hospitalization is one of the most important markers monitored by Cenpatico to help Members remain stable and to reduce preventable readmissions into acute levels of care. Follow up after discharge is monitored closely by the National Committee for Quality Assurance (NCQA), which has developed and maintains the Health Care Effectiveness Data Information Set (HEDIS). Even more importantly, increased compliance with this measure has been proven to minimize no-shows in outpatient treatment, thereby improving Member engagement in behavioral health services.

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

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within seven (7) days after discharge. Network Providers should make every effort to ensure the appointments are not cancelled by the Provider or rescheduled outside of the 7-day period. Cenpatico Coordination/Case Management staff will 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, Network Providers should inform Cenpatico as soon as possible. Upon notification of a no-show, Care Coordination staff will follow up with the Member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Continuity of Care

When Members are newly enrolled and have previously received behavioral health services, Cenpatico will 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 the transfer of a Member's care 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.

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, and Post Traumatic Stress Disorder. Clinical practice guidelines may be accessed through our web site, www.cenpatico.com, or you may request a paper copy of the guidelines by contacting your network representative or by calling 866-896-7293. Copies of our evidence based practices can be obtained in the same manner. Cenpatico uses associated HEDIS measures for assessing Provider compliance with the Treatment of Major Depressive Disorder and Treatment of ADHD clinical practice guidelines. Cenpatico encourages Network Providers to review the full suite of Cenpatico clinical practice guidelines to support the Network Provider's clinical treatment strategy.

Advance Directives
Cenpatico is committed to ensuring that Sunflower Health Plan 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 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.

Case Management Program
The Cenpatico/ Sunflower Health Plan case management model uses an integrated team of registered nurses, licensed behavioral health professionals, social workers and non-clinical staff. The model is designed to help Members obtain needed services and assist them in coordination of their healthcare needs whether they are covered within the Sunflower Health Plan or Cenpatico array of covered services, from the community, or from other non-covered venues. We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the Member and all treating Providers to assist our Members to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members' needs through screening and assessment. In partnership with our Members, we will develop and implement an individualized care plan that is comprehensive and will incorporate the full range of needed services we identify with our Members. Our teams will engage Members to be fully participatory in their health decisions and offer education as well as support for achieving Member goals. Care plans will be shared with all treating Providers and our Care Coordinators will serve to facilitate exchange of information between Providers and with Members.

Members who are eligible for the waiver programs and have either an SED TCM through the community mental health center, or a TCM through Sunflower Health Plan are eligible for this care coordination/intensive care coordination program as appropriate and the Cenpatico staff will work collaboratively with the Community TCM or the Sunflower Health Plan TCM.

We look forward to hearing from you about any Sunflower Health Plan Members you think can benefit from outreach by a case management team member.

To contact a case manager please call Cenpatico at 866-896-7293.

Disease Management

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

Claims

Cenpatico Claims Department Responsibilities

Cenpatico's claims processing responsibilities are as follows:

- Reimburse Clean Claims (see Clean Claim section below) within the timeframes outlined by the Prompt Payment Statute.
- 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 Sunflower Health Plan) on the date of service;
- The service provided is a covered service (benefit of Sunflower Health Plan) on the date of service; and
- Cenpatico's prior-authorization processes were followed.

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

It is the responsibility of the Network Provider to collect any applicable copayments or deductibles from the Member.

CENPATICO DOES NOT ACCEPT BLACK OR COPIED FORMS. Providers need to use only original forms that meet CMS requirements. The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS-1500 version 02/12 form can be downloaded, the copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form.

Clean Claim
A clean claim is a claim submitted on an approved or identified claim format (CMS-1500 version 02/12 or CMS-1450 ["UB-04"] or their successors or electronic equivalents) that contains all data fields required by Cenpatico and the State, for final adjudication of the claim. A clean claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. 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. Clean Claims do not include claims submitted by or on behalf of a Provider who is under investigation for fraud or abuse, or a claim that is under review for medical necessity.

Effective Jan. 1, 2015, all Corrected Claims, and effective Feb, 1, 2015, all Paper Claims submissions should be free of handwritten verbiage and submitted on a standard red and white UB-04 or CMS1500 claim form along with the original Explanation of Payment (EOP).

Any Uniform Billing (UB)-04 or CMS1500 forms received that do not meet the Centers for Medicare and Medicaid Services (CMS) printing requirements will be rejected back to the provider or facility upon receipt.

The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 and 22 of the CMS 1500 version 02/12.

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 one hundred and eighty (180) days of the date the service(s) are rendered. Claims submitted after this period will be denied payment for untimely filing.

Claim Submission Options
Network Providers are strongly encouraged to utilize our available electronic means for claim submission. Electronic claim submission results in improved processing accuracy as well as quicker claim adjudication and payment.

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.

The following information is available on www.cenpatico.com:

- Provider Directory
- Frequently Used Forms
- EDI Companion Guides
- Secure Web Portal Manual
- Provider Manual
- Managing EFT

Cenpatico also offers our all 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 these additional available services:

- Submit Professional and Institutional claims individually or as batches
- Submit corrected claims
- View and check claim status
- View and download payment history
- View and print Member eligibility
- Contact us securely and confidentially

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

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

Emdeon (866-369-8805)
Cenpatico's Payor ID Number is 68068

For further information regarding electronic submission, contact the Cenpatico EDI Department at 800-225-2573, ext. 25525 or email at ediba@centene.com

Paper Claim Submission
All paper claims and encounters or claims that have been corrected for resubmission, or claims for which the Provider is requesting reconsideration should be mailed or submitted to the below address. All claims must be filed on a CMS-1500 version 02/12 Form or a CMS-1450 Form ("UB-04") or their successors.

Cenpatico Behavioral Health
P.O. Box 6400
Farmington, MO 63640-3807

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:

- Use original red claim forms
- 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 version 02/12 or CMS-1450 ("UB04")
- Whenever possible refrain from submitting hand written claims

Do Not:

- Use red ink on claim forms
- Handwritten information 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

Common Claim 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 version 02/12, or its successor claim form and/or CMS-1450 ("UB-04"), or its successor claim form, prior to submitting claims to Cenpatico for payment. This prevents delays in processing and reimbursement.

Some common problem areas are as follows:

- Failure to obtain prior-authorization
- Federal Tax ID number not included
- Provider's NPI number not included in field 24J (CMS-1500 version 02/12) 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 CMS-1500 version 02/12 claim form are not listed on separate claim detail lines
- Diagnosis code is incomplete or not specified to the highest level available – be sure to use 4th and 5th digit when applicable

Services that require prior-authorization may be denied if authorization was not obtained. Cenpatico reserves the rights to deny payment for services provided that are not medically necessary.

Electronic Funds Transfer and Electronic Remittance

Cenpatico and PaySpan Health are in a partnership to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to Providers and allows online enrollment.

Using this free service, Providers can take advantage of EFTs and ERAs to settle claims electronically, without making an investment in additional software. Following a fast online enrollment, you will be able to receive ERAs and import the information directly into your Practice Management or Patient Accounting System, eliminating the need to key remittance data off of paper advices.

Visit www.payspanhealth.com to enroll, or call PaySpan Health at 1-877-331-7154.

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).
- Sunflower Health Plan 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 he/ she has obtained written acknowledgement from the Member, prior to rendering such non-covered service, that the specific service is not a covered benefit under Sunflower Health Plan or Cenpatico, and that the Member understands they are responsible for reimbursing the Network Provider for such services.

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

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

In this case, the Network Provider should 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.

Coordination of Benefits
Coordination of benefits will be done for all Members with two or more types of insurance coverage. The insurance plan that is primary pays its full benefits first. The primary insurance carrier's explanation of payment (EOP) or explanation of benefits (EOB) is then sent to the secondary carrier (Cenpatico) for coordination of benefits. The EOP or EOB will explain the primary's payment or denial process. Cenpatico will coordinate benefits for Members as the secondary payer.

Claims requiring coordination of benefits must be submitted to Cenpatico within 365 calendar days from the date of disposition (final determination) of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

For Medicare cross-over claims, Cenpatico shall coordinate benefits for dual eligible Members by paying the lesser amount of: Cenpatico's allowed amount minus the Medicare payment, or the Medicare co-insurance and deductible up to Cenpatico's allowed amount. For services that are not covered by Medicare, or other primary payer, Cenpatico will process claims as primary payer so long as other insurance information has been supplied on the claim.

Cenpatico follows KMAP TPL policy. All KMAP TPL billing requirements still apply. Please refer to KMAP General TPL Payment Provider manual.

Claim Status
Please do not submit duplicate bills for previously submitted services. If your Clean Claim has not been adjudicated within thirty (30) days, please call Cenpatico's Claims Customer Service department at 866-324-3632 to determine 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

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 Customer Service at 866-324-3632. The majority of issues regarding claims can be resolved with the assistance of our Claims Customer Service.

2. A corrected claim may be sent to Cenpatico through the Cenpatico Web Portal, Electronic Data Interchange (EDI) or the address below. In order for Cenpatico to consider the corrected claim it must be received within 180 calendar days of the date on the EOP which contains the disputed payment or denial unless otherwise stated in your contract. If submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as **RESUBMISSION**. In addition to submitting corrected claims on a standard red and white form, the previous claim number should be referenced in field 64 of the UB-04 and field 22 of the CMS 1500 version 02/12 as outlined in the National Uniform Claim Committee (NUCC) guidelines. Failure to mark the claim may result in the claim being denied as a duplicate. Corrected paper claim resubmissions should be sent to the following address:

   Cenpatico Behavioral Health
   P.O. Box 6400
   Farmington, MO 63640-3807

3. For cases where authorization has been denied because the case does not meet the necessary criteria, the Appeals Process, described in the denial letter is the appropriate means of resolution. If a claim was denied due to no authorization on file, please send a request in writing for a retro- active authorization, explaining in detail the reason for providing services without an authorization. Cenpatico contracts with physicians who are not Network Providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider appeal. The physician resolving the dispute will hold the same specialty or a related specialty as the appealing Provider. Mail requests to the following address:

   Cenpatico Behavioral Health
   Attention: Appeals Department
   12515-8 Research Suite 400
   Austin, TX 78759

   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 Cenpatico Customer Service and ask the representative to extend the end date on your authorization.

Disagreement with Determination, Payment or Explanation of Payment (EOP)

If you disagree with this decision for payment, you have a right to access the Cenpatico Dispute Resolution process. This process includes three steps, outlined below, that must occur in sequential order. The steps include Reconsideration, Claim Dispute/Appeal, and Fair Hearing.

Step 1: Reconsideration
If you disagree with this decision for payment, you have a right to request reconsideration. You may request reconsideration by calling Claims Customer Service at 1-866-324-3632 or by mailing your written reconsideration request, and additional documentation that supports reimbursement of the claim for review. You must make this request within 90 days of the date on this EOP/determination notice. We will respond to your reconsideration request by delivery of a new EOP for this claim number. Please provide this information to the Cenpatico address at the bottom of this page.

What Happens Next?
Upon receipt of your reconsideration request, Cenpatico will review the original payment determination and any additional information submitted in support of your request. Cenpatico will send you a response within 30 business days by delivery of an updated EOP for this claim showing the claim to be paid or denied and the denial reason if applicable. If you disagree with the reconsideration response you have the right to submit a claims dispute within 30 days (33 if mailed to you) of the date on this EOP/determination notice.

Step 2: Claim Dispute/Appeal
If you disagree with the reconsideration response, file your claim dispute/appeal in writing to Cenpatico, with new supporting documentation and explanation using the "Provider Claim Dispute Form", found at the following:

http://www.sunflowerhealthplan.com/for-providers/provider-resources/forms/.

All claim disputes must be requested in writing via the "Provider Claim Dispute Form", mailed or delivered to the address shown below within 30 days (33 if mailed to you) of the date on the most recent/reconsideration processed EOP/determination notice for the disputed claim. Each claim in dispute must have a separate form. Please provide this information to the Cenpatico address at the bottom of this page.

What Happens Next?
Upon receipt of your claim dispute form, Cenpatico will acknowledge your dispute request within 10 business days. Cenpatico will review the payment determination and any additional information submitted in support of your request and make every effort to provide a final determination on your dispute in writing no later than 30 business days of receipt.

Cenpatico Mailing and Contact Information

Cenpatico Claim Appeals
PO Box 6000
Farmington, MO 63640-3809

If you have any questions, please contact Cenpatico Claims Customer Service at 1-866-324-3632, Monday – Friday from 8:00 AM to 5:00 PM CST/CDT.

Step 3: Request for State Fair Hearing
You may only file for a State Fair Hearing after you have completed the appeal process that includes both reconsideration and dispute/appeal filing with determinations received by Cenpatico. If you disagree with the decision made in the dispute/appeal response, you may then appeal to the Office of Administrative Hearings and request a State Fair Hearing within 30 days of the dispute/appeal response.

Please mail your request to:

STATE FAIR HEARINGS
Office of Administrative Hearings (OAH)
1020 S. Kansas Ave
Topeka, Kansas 66612

Refunds and Overpayments

Cenpatico routinely audits all claims for payment errors. Claims identified to have been underpaid or overpaid will be reprocessed appropriately. Providers have the responsibility to report overpayments or improper payments to Cenpatico. Providers have 30 days from the date of notification to refund overpayments or to establish a payment plan (when available) before claims are reprocessed. Providers have the right to appeal.

Providers have the option of requesting future off-sets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified) to the following address:

CENPATICO REFUNDS
Cenpatico Behavioral Health
3057 Paysphere Circle
Chicago, IL 60674

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

Telephone: 866-896-7293 (Customer Service)
Fax: 866-263-6521
Email: ProviderRelationsKS@cenpatico.com

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.

What Is the National Provider Identifier?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for healthcare providers. The final rule for the National Provider Identifier (NPI), which was issued on January 23, 2004, adopts the NPI as this national standard and applies to all health care providers. The NPI is a 10-byte, all-numeric identifier that will replace all proprietary identifiers used in HIPAA-covered electronic transactions to identify a provider. The first character is a 1 or a 2 and the last character is a check digit designed to help ensure validity of the number. There is no embedded intelligence in the NPI—it is simply a unique number to identify a provider regardless of the provider's location, type, or specialty.

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 www.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).

Obtaining the NPI
Cenpatico will not contract nor credential a provider that does not have an NPI unless otherwise allowed for by the State for services provided by an atypical provider (as defined below). When applying for a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES), a health care provider must select the Healthcare Provider Taxonomy Code or code description that the health care provider determines most closely describes the health care provider's type/classification/ specialization, and report that code or code description in the NPI application.

In some situations, a health care provider might need to report more than one Healthcare Provider Taxonomy Code or code description in order to adequately describe the type/classification/specialization. Therefore, a health care provider may select more than one Healthcare Provider Taxonomy Code or code description when applying for an NPI, but must indicate one of them as the primary.

Providers that qualify for an NPI, can apply for their NPI(s) at
https://nppes.cms.hhs.gov/NPPES/Welcome
(Click on the link to *National Provider Identifier* and follow the instructions for applying). All HIPAA-covered physicians, suppliers, and other health care providers must apply for and be issued an NPI number.

NPI Subparts
Any health care provider, including individuals and organizations (such as health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form) must have an NPI. A group or organizational provider may elect to subpart, or request multiple NPIs, for specific entities within their organization. A provider is a legal entity; a subpart is not a legal entity, but it furnishes health care. An example of a subpart is a hospital that subparts its NPI into separate NPIs for specific units within the hospital. The subparts would all have the same Tax Identification Number (TIN).

Atypical Providers
"Atypical" providers are individuals or businesses that bill Medicaid for services rendered but do not meet the definition of a healthcare provider according to the NPI Final Rule 45 CFR 160.103 (for example, non-emergency transportation providers). Atypical providers may provide certain services directly or indirectly related to medical care to Medicaid recipients but the individual provider does not qualify to obtain an NPI. Cenpatico will not allow atypical providers to render and bill for covered behavioral health and/or substance use disorder services unless otherwise required or allowed under the State's Medicaid program.

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 Representative by telephone or email to submit their NPI.

Taxonomy Codes

Network Providers that submit Cenpatico claims through KMAP should include their Taxonomy Code. Claims billed without a Taxonomy Code may be routed to Sunflower Health Plan and subsequently denied payment.

Healthcare Provider Taxonomy Code Set and NPI

A taxonomy code is a standard 10-character code that represents a provider's type and specialty. The Healthcare Provider Taxonomy Code or code description information collected by NPPES is used to help uniquely identify health care providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care. Providers may refer to the Washington Publishing Company website (http://www.wpc-edi.com/taxonomy) in order to determine the appropriate taxonomy. The recommended taxonomy code list on DMA's website is not all inclusive and is to be used for claims processing only.

NPI & Taxonomy Claims Submission Guidelines

For purposes of claim submission to Cenpatico, providers should list the NPI of the person rendering the service in box 24 J of the claim form. The NPI of the billing entity should be listed in box 33 A of the claim form. If the provider is both the rendering and billing entity, both boxes should contain the same NPI number.

Providers that bill with a rendering NPI that is different than the billing NPI must ensure a roster of rendering clinicians is provided to Cenpatico for claims system loading. The roster should include pertinent information such as: rendering provider first and last name, license type (e.g. MD, PHD, LPC, LCSW, etc.), NPI number, date of birth, Social Security Number (for exclusions, sanctions and Social Security Death Master File checks), Medicaid Number, and Medicare Number, as applicable. Failure to submit this information to Cenpatico may result in claim rejects or denials. In addition to these elements, and unless otherwise deemed a required claim requirement for billing purposes (please refer to Cenpatico's sample claim forms for the particular market to determine required and conditional claim for elements), providers are encouraged to also provide the rendering provider's taxonomy code and include it on the claim in box 33 B.