Cenpatico Provider Manual

State of Ohio

buckeye health plan

buckeye health plan Advantage

MyCareOhio
Connecting Medicare + Medicaid

JULY 2016

WWW.CENPATICO.COM

Table of Contents

Welcome To Cenpatico

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

The Cenpatico Ohio Provider Manual has been developed to answer your questions about Cenpatico's behavioral health program and to explain how we manage the delivery of mental health and substance abuse services to the members we serve. The Manual will also provide you with specific and detailed information about the Cenpatico service delivery system within the state of Ohio.

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

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

About Cenpatico

Our Mission
Together we inspire hope for a better life.

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

Goal
Demonstrate value to our customers in everything we do.

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) www.centene.com. Buckeye Health Plan of Ohio, Inc. has delegated the provision of covered behavioral health and substance abuse services to Cenpatico.

Cenpatico has provided comprehensive managed behavioral healthcare services since 1994, and currently operates in 17 states. As an integral part of our core philosophy we believe that quality behavioral healthcare is best delivered locally. Cenpatico is a clinically driven organization that is committed to building collaborative partnerships with Providers.

Cenpatico has defined "behavioral health" as both acute and chronic psychiatric and substance abuse disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems. Cenpatico provides quality, cost effective behavioral healthcare services for members of Buckeye Health Plan. Cenpatico provides these services through a comprehensive network of qualified behavioral health clinicians and facilities.

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

Cenpatico Managed Care Philosophy

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

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

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

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

At Cenpatico, we take privacy and confidentiality seriously. We have processes, policies and procedures to comply with applicable federal and state regulatory requirements. We appreciate your partnership with Cenpatico in maintaining the highest quality and most appropriate level of care for our members.

Provider Quick Reference Guide

Cenpatico Phone Numbers

Customer Service/Authorizations	(800) 224-1991
Care Management/ Quality Improvement	(800) 224-1991
Claims Customer Service	(877) 730-2117
Provider Relations	(800) 224-1991 ext. 24211 or 84084
Network Management	(800) 224-1991 ext. 24183

Fax Numbers

Outpatient Treatment Requests	(866) 694-3649
Care Management/ Care Coordination	(866) 694-3730
Provider Relations	(866) 719-5436
Incident Reports/ Quality Issues	(866) 704-3663
Appeals	(866) 714-7991
Credentialing	(866) 694-3735

Addresses

Cenpatico Claims
PO Box 6150
Farmington MO 63640

Claim Appeals
PO Box 6000
Farmington MO 63640

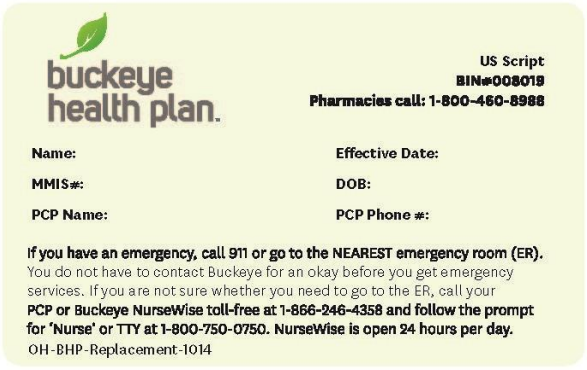
Websites

Cenpatico	Buckeye Health Plan
cenpatico.com	buckeyehealthplan.com

Cenpatico Website Includes

- Provider Resources/Forms including the Provider Manual
- Directory Look-up
- Claim Submission and Claim Status look-up
- Member Eligibility
- Relias Learning link
- Medical Necessity Criteria and Best Practices

Buckeye Member ID Cards


buckeye health plan.

US Script
BIN#008019
Pharmacies call: 1-800-460-8988

Name: Effective Date:
MMIS#: DOB:
PCP Name: PCP Phone #:

If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Buckeye for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Buckeye NurseWise toll-free at 1-866-246-4358 and follow the prompt for 'Nurse' or TTY at 1-800-750-0750. NurseWise is open 24 hours per day.
OH-BHP-Replacement-1014


MEMBER SERVICES: 1-866-246-4358 (TTY 1-800-750-0750)

PROVIDERS: THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR AUTHORIZATION.

FOR ELIGIBILITY, CALL BUCKEYE AT 1-866-296-8731. FOR PRIOR AUTHORIZATION AND CARE MANAGEMENT REFERRAL, CALL 1-866-246-4359.

NON-PARTICIPATING PROVIDERS MUST HAVE ALL SERVICES PRIOR AUTHORIZED THROUGH BUCKEYE, EXCEPT FOR EMERGENCY SERVICES OR SERVICES THAT ARE SELF-REFERRED. PLEASE CALL BUCKEYE AT 1-866-246-4359 FOR MORE INFORMATION ON SERVICES THAT ARE SELF-REFERRED.

FOR PHARMACY PRIOR AUTHORIZATION, CALL 1-866-399-0928. FOR TRANSPORTATION AND PHARMACY CLAIMS, REFER TO THE BUCKEYE PROVIDER MANUAL.

CLAIMS SUBMISSIONS: BUCKEYE HEALTH PLAN
PO BOX 6200
FARMINGTON, MO 63640

OH-BHP-Replacement-1014

Cenpatico Service Area

Cenpatico manages and reimburses claims for the covered behavioral health and substance abuse benefits for consumers eligible for Medicaid managed care coverage and enrolled with Buckeye Health Plan throughout the State of Ohio. At present, Buckeye Health Plan serves members throughout the state of Ohio. Members may self-refer to outpatient services offered through Community Mental Health Centers (CMHCs) as well as substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified Medicaid Providers. In the event that a CMHC or ODADAS physician or practitioner is unable to provide timely access for a member, Cenpatico will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner.

If you have additional questions regarding coverage of behavioral health services, please contact the Cenpatico Customer Service Department at (800) 224-1991.

Network Provider Selection Process

Cenpatico contracts with behavioral health clinicians and facilities that consistently meet or exceed Cenpatico clinical quality standards, and are comfortable practicing within the managed care arena, including an understanding of Buckeye Health Plan covered benefits and utilization practices. Network Practitioners should support a brief, solution-focused approach to treatment. Network Practitioners should be engaged with a collaborative approach to the treatment of Cenpatico members.

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

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

In addition to hospitals, Cenpatico also contracts with selected independently-licensed behavioral health practitioners, including psychiatrists, psychologists, counselors/social workers, and nurse practitioners.

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

The Network Practitioner's Office

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

General Network Practitioner Office Standards

Cenpatico requires the following;

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

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

- The Network Practitioner has a complete copy of the Patient's Bill of Rights and Responsibilities, available upon request by a member, at each office location; and
- The Network Practitioner's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area.

Credentialing

Credentialing Requirements

The Cenpatico Provider Network consists of licensed Psychiatrists (MD/DO), Licensed Clinical Psychologists, Licensed Professional Clinical Counselors, Licensed Independent Social Workers, Licensed Marriage & Family Therapists, Clinical Nurse Specialists or Psychiatric Nurse Practitioners, and facilities.

Cenpatico Network Providers must adhere to the following requirements:

- In order to continue participation with our organization, all Network Providers must adhere to Cenpatico's Clinical Practice Guidelines and Medical Necessity Criteria which is located at www.cenpatico.com.
- Network Providers must consistently meet our credentialing standards and Cenpatico guidelines on Primary Care Physician (PCP) notification.
- Failure to adhere to guidelines and standards at any time can lead to termination from our Network.
- Notification is required immediately upon receipt of revocation or suspension of the Network Provider's State License by the State authority responsible for issuing licenses for the Provider.
- In order to be credentialed in the Cenpatico Network, all individual Network Practitioners must be licensed to practice independently in the State of Ohio.
- For MDs and DOs, Cenpatico will require proof of the Network Practitioner's medical school graduation, completion of residency and other post graduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, as applicable.
- License must be current, active, and in good standing.
- MDs and DOs that have Hospital Privileges must keep them current and active. MD's and DO's that choose to relinquish their privileges must notify Cenpatico.
- Network Practitioner's graduate degrees must be from an accredited institution.
- All Network Practitioners are subject to the completion of primary source verification of the Network Practitioner through our Credentialing Department in Austin, Texas.

- The Network Practitioner agrees to complete and provide appropriate documentation for this primary source verification in a timely manner.
- The Network Provider 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 Agreement with Cenpatico.

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

- Under the Ohio Credentialing Legislative Bill practitioners must have a current and active registration with Council for Affordable Quality Health Care (CAQH)Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and Practitioner's name, or evidence of compliance with Ohio regulations regarding malpractice coverage.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate (if applicable).
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
- Copy of current unrestricted Medical License to practice in the state of Ohio.
- Current copy of specialty/board certification certificate, if applicable.
- Curriculum vitae listing, at minimum, a five-year work history.
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training.

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

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

The credentialing process must be completed within 90 days from date of receipt of all completed and up to date credentials. Once the application is completed and has no malpractice history that may require Peer Review, the clean application will be reviewed by the Medical Director for approval.

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

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

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

Re-Credentialing Requirements
Ohio Network Practitioners will be re-credentialed every three (3) years as required by the State of Ohio and a CAQH application is the only acceptable application for the re-credentialing process. Cenpatico Network Practitioners will receive notice that they are due to be re-credentialed well in advance of their credentialing expiration date and, as such, must have a current CAQH registration on file. Failure to attest and/or update your information on CAQH in a timely manner can result in termination from the network. Cenpatico must obtain the CAQH application directly from the CAQH web site.

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.

Right to Review and Correct Information
Providers going through the initial credentialing and recredentialing process have the right to review information obtained by Cenpatico to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, Malpractice Insurance carriers and the Composite State Board of Medical Examiners and other State Board Agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

If the provider finds any of the information used in the credentialing/re-credentialing process to be erroneous, or if any information gathered as part of the primary source verification process differs from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to Cenpatico Credentialing Department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Cenpatico. Cenpatico Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

In addition, Cenpatico must notify the Practitioner of any discrepancies electronically, by facsimile, or by certified mail, return receipt requested, no later than twenty-one days after Cenpatico receives the credentialing CAQH application.

Network Provider Demographic/Information Updates
Network Practitioners should advise Cenpatico with as much advance notice as possible for demographic/information updates. Network Practitioner information such as address, phone and office hours are used in our Provider Directory and having the most current information accurately reflects our Ohio Provider Network. Please use the Cenpatico Ohio Provider Change Form located at www.cenpatico.com to provide your information to Cenpatico.

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

Fax: (866) 694-3735
Email: provider_change-cbh-tx@centene.com

Mail: Cenpatico
Attn: Provider Data Management
12515-8 Research Blvd, Suite 400
Austin, TX 78759

Network Provider Termination
Network Practitioner/Provider Request to Terminate

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

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

Cenpatico's Right to Terminate

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

- Termination of Cenpatico's obligation to provide or arrange mental health/substance abuse treatment services for members of Health Plans;
- Restriction, qualification, suspension or revocation of Network Practitioner's license, certification or membership on the active medical staff of a hospital or Cenpatico participating provider group;
- Network Provider's loss of liability insurance required under the Agreement with Cenpatico;
- Network Provider's exclusion from participation in Buckeye Health Plan programs;
- Network Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's insolvency or bankruptcy or Network Provider's assignment for the benefit of creditors;
- Network Provider's conviction, guilty plea, or plea of any felony or crime involving moral turpitude;
- Network Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Provider's submission of false or misleading billing information;
- Network Provider's failure or inability to meet and maintain full credentialing status with Cenpatico;
- Network Provider's breach of any term or obligations of the Practitioner/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, he/she may contact the Cenpatico Ohio Provider Relations department at (800) 224-1991 x84084, 24211 OR 24183 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 (800) 224-1991.

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

Right to Appeal Adverse Credentialing Determinations
New applicants who are declined participation in the Cenpatico Network have the right to request a reconsideration of the decision in writing within fourteen (14) days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation.

Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two (2) weeks of the final decision.

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

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

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

Network Practitioner 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:

Mail: Cenpatico
Attn: Ohio Provider Relations
12515-8 Research Blvd, Suite 400
Austin, TX 78759

Phone: (800) 224-1991

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

Network Provider Concerns
Network Providers who have concerns about Cenpatico should contact the Cenpatico Ohio Provider Relations department at (800) 224-1991 x84084, 24211 OR -24183 to register these complaints. All concerns are investigated, and written resolution is provided to the Network Provider on a timely basis.

Member Concerns about Network Providers
Members who have concerns about Cenpatico Network Providers should contact Buckeye 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 or Buckeye Health Plan 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 Agreement with Cenpatico.

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

A critical incident is defined as any occurrence which is not consistent with the routine operation of a Network Provider. It includes, but is not limited to; injuries to members or member advocates, suicide/homicide attempt by a member while in treatment, death due to suicide/homicide, sexual battery, medication errors, member escape or elopement, altercations involving medical interventions, or any other unusual incident that has high risk management implications.

The Critical Incident Report is found at www.cenpatico.com and must be used to document critical incidents. You may also request the report form by phone. Submit completed Critical Incident Reports to the following address:

Mail: Cenpatico
Attn: Quality Improvement Department
12515-8 Research Blvd, Suite 400
Austin, TX 78759

Phone: (800) 224-1991
Fax: (866) 704-3063

No Show Appointments
A "no show" is defined as a failure to appear for a scheduled appointment without notification to the 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. Buckeye Health Plan members may not be charged a fee for a "no show" appointment.

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 Records are confidential. 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 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 current 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.

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

Preventative Behavioral Health Programs

Cenpatico offers preventative behavioral health programs for our members. A brief description of the programs including who is eligible to participate is listed below. You can refer your members to the programs directly when you see an unmet need. If you would like more information about the programs or if you have suggestions as to how we can improve our preventative behavioral health programs please contact the Quality Improvement department at (800) 224-1991. Paper copies of the programs may also be requested.

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

Cenpatico has a structured program for children who have been hospitalized for a mental health issue. These high risk children are especially vulnerable so Cenpatico's Care Coordinator and/or Case Management staff attempts outreach to the parents while the child is still hospitalized to educate them on firearm safety, medication safety and the need to give prescribed medications as ordered by their physician. Parents are also encouraged to keep their child's follow-up appointment within seven days of discharge. When they do, they receive a Build-a-Bear and a book called My Feelings and the parents receive a gift card for Wal-Mart.

Cenpatico appreciates your assistance in promoting these preventative behavioral health programs. If you have recommendations regarding other areas where we might make a difference, please contact us at (800) 224-1991.

Cultural Competency

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

Cenpatico maintains a Cultural Competency Plan. You may access it through the Cenpatico website at www.cenpatico.com or you may receive a copy by contacting the quality department at (800) 224-1991. Cenpatico is committed to the development, strengthening, and sustaining of healthy provider/ member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

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

Network Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them.
- Care is provided with consideration of the members' race/ ethnicity and language and its impact/ influence of the members' health or illness.
- Office staff that routinely comes in contact with members has 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

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

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

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

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

Take the following into consideration when you provide services to Buckeye Health Plan /Cenpatico members;

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

Facts about Health Disparities

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

Advance Directives

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

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

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

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

Access and Coordination of Care

Provider Access Standards

Buckeye Health Plan members may access behavioral health and substance abuse services through their local Community Mental Health Center or any other Medicaid-Certified recovery agency. Members do not need an authorization from Cenpatico or a referral from their Primary Care Physician (PCP) to access behavioral health and substance abuse services. Caregivers or medical consenters may also self-refer members for behavioral health services. Cenpatico is responsible for arranging for outpatient services ONLY when a member is "unable or unwilling" to access services through the community system of care.

Cenpatico adheres to National Commission for Quality Assurance (NCQA) and State accessibility standards for member appointments. Semiannually, Cenpatico measures the accessibility of Network Practitioners thru a GeoAccess analysis to insure members have convenient access. The State of Ohio does not prescribe standards, but, Cenpatico's standards are as follows;

Urban Members- A choice of practitioners within 30 miles
Rural Members- A choice of practitioners within 60 miles

Cenpatico also assures an adequate number of practitioners by ensuring at least one prescribing practitioner per 5,000 members and one other practitioner per 3,000 members. Network Practitioners must make every effort to assist Cenpatico in providing appointments within the following timeframes:

Appointment Availability

Routine – treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting within fourteen (14) calendar days

Urgent – is defined as a non-life threatening situation that should be treated within twenty-four (24) hours. Urgent care services are not subject to prior authorization or precertification. Within twenty-four (24) hours for services that are non-Emergent services or routine services

Emergent/Non-Life Threatening – defined as inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize a behavioral health condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care to result in injury to self or bodily harm to others; placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction to any bodily organ or part; serious harm to self or others due to an alcohol or drug abuse emergency; with respect to a pregnant woman having contractions – (i) that there is not adequate time to affect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or her fetus

All non-life threatening emergencies are to be directed to the Emergency Room.

Discharge (from hospital/acute care) -Within seven (7) days of discharge

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

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

Network Providers should call the Cenpatico Provider Relations department at (866) 246-4356 x84084, 24211 or 24183 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 Practitioner's status will be considered in the re-credentialing process.

Consent for Disclosure
Cenpatico recognizes communication as the link that unites all the service components and a key element in any program's success. To further this objective, Network Providers are required to obtain consent for disclosure of information from the member permitting exchange of clinical information among behavioral health Providers and between the behavioral health Practitioner/Provider and the member's physical health Provider.

If the member refuses to release the information, the Network Provider should document their refusal along with the reasons for declination in the medical record. Cenpatico monitors compliance of the behavioral health Providers, to ensure consent for release of information form has been signed by the member, and for those agreeing to disclosure, that regular reports are being sent to the primary care Provider (PCP) or other behavioral health Providers.

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

In addition, Cenpatico works to educate and assist physical health and behavioral health providers in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Buckeye Health Plan on a monthly basis, and is shared with Buckeye Health Plan's QI committee quarterly. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency.

Quality Improvement

Cenpatico's Quality Improvement (QI) Program provides a structure and process by which quality of care and services are continually monitored, and improvements implemented and refined across time. The QI Program provides functional support for quality improvement activities in all departments across the organization. The principles of the QI Program are based on a belief that quality is synonymous with performance. For that reason, the QI Program is highly integrated with clinical services, access issues pertaining to Network Providers and services, credentialing, utilization, member satisfaction, Network Provider satisfaction, PCP communications, and administrative office operations, as well as Buckeye Health Plan's Quality Improvement Program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

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

Monitoring Clinical Quality

What does Cenpatico monitor?
Each year, and at various intervals throughout the year, Cenpatico audits and measures the following:

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

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

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

Findings are communicated to individual Network Providers and groups for further discussion and analysis to reinforce the goal of continually improving the appropriateness and quality of care rendered. Cenpatico may request action plans from the Network Provider. Findings are considered during the re-credentialing process. The Cenpatico evaluation of its Quality Improvement program is posted in its entirety to the Cenpatico website: http://www.cenpatico.com/providers/ohio/oh-provider-tools/oh-quality-resources/?state=Ohio.

Network Provider Participation in the QI Process

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

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

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

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

Confidentiality and Release of Member Information

Cenpatico abides by applicable federal and State laws which govern the use and disclosure of mental health information and alcohol/substance abuse treatment records. Similarly, Cenpatico contracted Practitioners are independently obligated to comply with applicable laws and shall hold confidential all member records and agree to release them only when permitted by law, including but not limited to 42 CFR 2.00 et seq., when applicable.

Communication with the Primary Care Physician

Buckeye Health Plan encourages primary care physicians (PCPs) to consult with their members' mental 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. Examples of some of the items to be communicated include:

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

A form to be used in communicating with the PCP and other behavioral health Practitioners is included for your review in the Forms section of the website, 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 mental health and substance abuse conditions and make appropriate referrals. Practitioners should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

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

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

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

Caution must be exercised in conveying information regarding substance abuse, which is protected under separate federal law.
Cenpatico monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Network Provider Treatment Requirements

Network Providers are required to:

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

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

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

Network Providers should call the Cenpatico Provider Relations Department at (800) 224-1991 x84084, 24211 or 24183 to address concerns as they arise. Feedback from Network Providers enables Cenpatico to continuously improve systems, policies and procedures.
Network Provider satisfaction is a key component to our overall success.

Network Provider Standards of Practice

Network Providers are requested to:

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

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, Buckeye Health Plan, and other regulatory agencies access to these documents to assure financial solvency and healthcare delivery capability and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information.

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

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. Please go to www.cenpatico.com for forms that 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, which can be found in the Forms Section as well. Chart Audits of member records will be evaluated in accordance with these criteria.

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

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.

Domestic Violence Reporting

Cenpatico's members may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that Providers are vigilant in identifying these members. Customer Service can help members identify resources to protect them from further domestic violence. Providers should report all suspected domestic violence.

For Ohio residents, you may refer victims of domestic violence to the Ohio Domestic Violence Network hotline, at 1-(800) 934-9840 for information about local domestic violence programs and shelters within the State of Ohio. The Ohio Domestic Violence Network help line operates 24 hours a day.

State law requires reporting by any person if he or she has "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse". Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report any suspected child abuse or neglect immediately to Children's Services at the appropriate county.

Reporting Provider or Member Waste, Abuse or Fraud
Waste, Abuse and Fraud (WAF) System

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

- Waste – Use of healthcare benefits or dollars without real need. For example, prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.
- Abuse – Practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Health Plan program, including, but not limited to practices that result in unnecessary cost to the Health Plan program for services that are not Medically Necessary, or that fail to meet professionally recognized standards for healthcare. It also includes Enrollee practices that result in unnecessary cost to the Health Plan program.

- Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Health Plan program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or State healthcare fraud laws.

  Examples of provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

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

Authority and Responsibility

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

Cenpatico, in conjunction with Buckeye Health Plan, is committed to identifying, investigating, sanctioning and prosecuting suspected WAF.

The Cenpatico provider network shall cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations by Buckeye Health Plan, at the provider and/or subcontractor's own expense.

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

Mail: Medicaid Fraud Control Unit of Ohio
Office of the Attorney General
150 East Gay Street, 17th Floor
Columbus, OH 43215

Phone: (614) 466-0722
Fax: (614) 644-9973

Hotline Number - A toll-free hotline number has been established to report potential WAF issues. The hotline number is 1-(866) 685-8664. The number is available for use by any person, including Cenpatico employees and subcontractors. It is against corporate policy to retaliate against anyone who makes a referral. All callers have the option to remain anonymous.

Providers may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone at **1-(800) 224-1991**.

Verifying Member Enrollment

Network Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services.
Network Providers should use any of the following options to verify member enrollment:

- Contact Cenpatico Customer Service at (800) 224-1991
- Access the Cenpatico Provider Website at www.cenpatico.com

Until the actual date of enrollment neither Buckeye Health Plan nor Cenpatico is financially responsible for services the prospective member receives. In addition, Buckeye Health Plan/Cenpatico is not financially responsible for services members receive after their coverage has been terminated, however, Buckeye Health Plan or Cenpatico is responsible for those individuals who are Buckeye Health Plan members at the time of a hospital inpatient admission and change health plans during that confinement.

Enrollment Guidelines for Providers

Cenpatico Providers must adhere to enrollment/marketing guidelines as outlined by the Ohio Department of Job and Family Services (ODJFS). Those guidelines include the following:

Providers cannot:

- Influence a patient to choose one health plan over another
- Influence patients based upon reimbursement rates or methodology used by a particular plan
- Enroll patients in a plan unless the physicians' office, clinic or site has been designated by the state as an enrollment center

Providers may:

- Stock and distribute to Cenpatico members only state approved Cenpatico Member Educational Materials
- Inform the patients of particular hospital services, specialists, or specialty care available at Cenpatico
- Assist a patient in contacting Cenpatico to determine if a particular specialist or service is available
- Only directly contact Cenpatico members with whom they have an established relationship

Member Rights and Responsibilities

Buckeye Health Plan member rights and responsibilities:

1. A right to receive all services that Buckeye must provide.
2. A right to be treated with respect and with regard for your dignity and privacy.
3. A right to be sure that your medical record information will be kept private.
4. A right to be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
5. A right to be able to take part in decisions about your healthcare unless it is not in your best interest.
6. A right to get information on any medical care treatment, given in a way that you can follow.
7. A right to be sure that others cannot hear or see you when you are getting medical care.
8. A right to be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
9. A right to ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
10. A right to be able to say yes or no to having any information about you given out unless Buckeye has to by law.
11. A right to be able to say no to treatment or therapy. If you say no, the doctor or Buckeye must talk to you about what could happen and they must put a note in your medical record about it.
12. A right to be able to file an appeal, a grievance (complaint) or state hearing.

13. A right to be able to get all Buckeye written member information from Buckeye:
    a. at no cost to you;
    b. in the prevalent non-English languages of members in Buckeye's service area;
    c. in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
14. A right to be able to get help free of charge from Buckeye and its providers if you do not speak English or need help in understanding information.
15. A right to be able to get help with sign language if you are hearing impaired.
16. A right to be told if the healthcare provider is a student and to be able to refuse his/her care.
17. A right to be told of any experimental care and to be able to refuse to be part of the care.
18. A right to make advance directives (a living will). See the pamphlet in your new member packet which explains about advance directives. You can also contact member services for more information.
19. A right to file any complaint about not following your advance directive with the Ohio Department of Health.
20. A right to change your primary care provider (PCP) to another PCP on Buckeye's panel at least monthly. Buckeye must send you something in writing that says who the new PCP is by the date of the change.
21. A right to be free to carry out your rights and know that Buckeye, Buckeye's providers or ODJFS will not hold this against you.
22. A right to know that Buckeye must follow all federal and state laws, and other laws about privacy that apply.
23. A right to choose the provider that gives you care, whenever possible and appropriate.
24. If you are a female, a right to be able to go to a woman's health provider on Buckeye's panel for covered woman's health services.
25. A right to be able to get a second opinion from a qualified provider on Buckeye's panel. If a qualified provider is not able to see you, Buckeye must set up a visit with a provider not on our panel.
26. A right to get information about Buckeye from us.
27. A right to contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Phone: (312) 886-2359
TTY: (312) 353-5693

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 E. Broad Street, 37th Floor
Columbus, Ohio 43215

Phone: (614) 644-2703; or 1-(866) 227-6353;
TTY: (866) 221-6700; **Fax:** (614) 752-6381

28. A responsibility to ask questions if you don't understand your rights.
29. A responsibility to make any changes in your health plan and primary care provider in the ways established by the Medicaid program and Buckeye.
30. A responsibility to keep your scheduled appointments.
31. A responsibility to have your ID card with you.

32. A responsibility to notify PCP of emergency room treatment.
33. A responsibility to cancel appointments in advance when you can't keep them.
34. If Buckeye is providing transportation for you to a medical appointment, you must provide a car seat for any child riding with you if the child is 4 years of age or younger, or if the child weighs less than 40 pounds.
35. A responsibility to always contact your PCP or Buckeye's NurseWise first for your non-emergency medical needs.
36. A responsibility to only go to the emergency room when you think it is an emergency.
37. A responsibility to be sure you have approval from your PCP before going to a specialist except for self-referrals.
38. A responsibility to share information relating to your health status with your PCP and become fully informed about service and treatment options. That includes the responsibility to:
    a. Tell your PCP about your health.
    b. Talk to your providers about your healthcare needs and ask questions about the different ways your healthcare problems can be treated.
    c. Help your providers get your medical records.
    d. Actively participate in decisions relating to safe service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
        i. Work as a team with your provider in deciding what healthcare is best for you.
        ii. Do the best you can to stay healthy.
        iii. Treat providers and staff with respect.

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

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

Civil Rights

Cenpatico provides covered services to all eligible members regardless of: Age, Race, Religion, Color, Disability, Sex, Sexual Orientation, National Origin, Marital Status, Arrest or Conviction Record, or Military Participation. All Medically Necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with Cenpatico who refer or recommend members for services shall do so in the same manner for all members.

Customer Service

The Cenpatico Customer Service Department

Cenpatico operates a toll free emergency and routine Behavioral Health Services Hotline, answered by a live voice and staffed by trained personnel, Monday through Friday 8:00 a.m. to 5:00 p.m. EST. After hours services are available during evenings, weekends and holidays. The after-hours service is staffed by customer service representatives with registered nurses and behavioral health clinicians available 24/7 for urgent and emergent calls.

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

The Customer Service department's primary focus is to facilitate the authorization of covered services for members for treatment with a specific clinician or clinicians. The Customer Service Department provides the member with information about Network Providers and assists the member in selecting a Network Provider who can meet their specific needs. Licensed clinicians on staff in the Clinical department are available to provide assessment and referrals for the level of urgency of a caller presenting special needs.

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

- Verifying member eligibility
- Verifying member benefits
- Obtaining authorization
- Referrals
- Trouble-shooting any issues related to eligibility, authorizations, referrals, or researching prior services
- Interpretation/Translation Services

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

- Customer Service is staffed with Spanish and English bilingual personnel.
- Trained professional language interpreters, including American Sign Language, can be made available face-to-face at your office if necessary, or telephonic, to assist Providers with discussing technical, medical, or treatment information with Members as needed. Cenpatico requests a five-day prior notification for face-to-face services.
- TDD access for members who are hearing impaired:
  Voice: (866) 246-4356 **TTY:** (800) 750-0750

Key Information: To access interpreter services for Cenpatico members, contact Customer Service at (800) 224-1991.

NurseWise

NurseWise is Cenpatico's after-hours nurse referral line through which callers can reach both customer service representatives and bilingual nursing staff. NurseWise provides nurse referrals and assessments and after-hours phone coverage seven (7) days per week including holidays for Cenpatico members. The NurseWise triage service provides Members and Network Providers with the following:

- Provide referrals after hours;
- Verify member eligibility;
- Crisis Interventions;
- Emergency assessment for acute care services;

- After hours emergency refills;
- Documentation and notification of inpatient admissions that occur after hours; and
- Assistance with determining the appropriate level of care in accordance with clinical criteria, as applicable.

Complaints, Grievances and Appeals
Provider Complaints

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

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

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

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

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

(800) 224-1991

Cenpatico will acknowledge the Network Provider's complaint within five (5) business days and will resolve the complaint within thirty (30) calendar days. (If however, we need additional time, you will be notified when to expect a resolution.)

Member Complaints

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

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

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

Buckeye Health Plan
4346 Easton Way, Suite 400
Columbus, Ohio 43219

To express a Complaint by phone, please Buckeye Health Plan at:

(866) 296-8731

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

Appeals

What is an appeal?

An appeal is a written or oral request for review of an action/determination made by Cenpatico. An appeal can be filed by the member or authorized representative acting on behalf of the member, with the member's written consent. An appeal must be filed within ninety (90) calendar days from the date of the notice of Cenpatico's action/determination. The appeal will be resolved within fifteen (15) calendar days. Members may continue to seek covered services while the appeal is being resolved.

If the member is still receiving the services that are under review, the services are covered services, and the appeal is requested on or before 10 working days of the mailing date of the notice or the effective date of the action, the services may continue until a decision is made on the appeal. This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Cenpatico and were not terminated because benefit coverage for the service was exhausted.

Member appeals should be directed to:

Buckeye Health Plan
4346 Easton Way, Suite 400
Columbus, Ohio 43219

To request a member appeal by phone or for assistance in requesting an appeal, please call:

(866) 246-4356
TTY (800) 750-0750

Provider appeals should be directed to:

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

To request a provider appeal by phone, please call Cenpatico at:

(800) 224-1991

Expedited Appeals

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

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

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

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

(800) 224-1991

Cenpatico will resolve the Expedited Appeal within seventy-two (72) hours. If Cenpatico determines that the appeal does not qualify to be expedited, the member will be notified immediately and the resolution will be made within fifteen (15) days calendar days.

Benefit Overview
Cenpatico covers a comprehensive array of behavioral health and substance abuse services in Ohio. Services for Buckeye Health Plan members may include, but are not limited to the following;

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

For a listing of service codes and authorization requirements, please refer to the Ohio Covered Professional Services & Authorization Guidelines located on our website www.cenpatico.com.

Member Copayments and Contributions

Member plan type, copayments, and contributions are indicated on members' cards. As of the publication date, Members have no copayment.

OHIO MEDICAID Pharmacy
Effective February 1, 2010 the Ohio Department of Job & Family Services (ODJFS) made changes to the administration of prescription drug coverage for all Medicaid Managed Care enrollees. Questions pertaining to prior authorization and prior authorization requests should be addressed to ACS, the Ohio Medicaid vendor:

Telephone: (877) 518-1545
Fax: (800) 396-4111

All Buckeye Health Plan members have received Buckeye ID cards with the Ohio Medicaid pharmacy contract and billing information.

The list of covered drugs may be found at:
http://www.cenpatico.com/files/2012/04/BuckeyeQRG-Drug-List_080911Final1.pdf

Utilization Management
The Utilization Management Program

The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. Eastern Standard Time (EST). Additionally, clinical staff is available after hours if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number - (800) 224-1991. 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 services for mental health conditions as designated and approved by the 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 Mental 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 that:

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

Cenpatico's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Cenpatico's Medical Necessity Criteria are used for the approval of medical necessity; plans of care that do not meet medical necessity guidelines are referred to a 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 or physician designee(s). The Utilization Management Staff regularly confer with the Medical Director or physician designee on any cases where there are questions or concerns.

Member Eligibility

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. It is the responsibility of the Network Provider to monitor the member's ongoing eligibility during the course of treatment.

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

- Contact Cenpatico Customer Service at (800) 224-1991
- Access the Cenpatico Provider web portal at www.cenpatico.com (registration for login required)

Inpatient Notification Process

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

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

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

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

The following information must be readily available for the Cenpatico Utilization Manager when requesting initial authorization for inpatient care:

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

Outpatient Notification Process
Network Providers need to adhere to the Covered Professional Services & Authorization Guidelines located on our website at www.cenpatico.com, 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.

For prior-authorizations during normal business hours, Network Providers should call:
(800) 224-1991

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

Provider should verify eligibility and benefits prior to rendering services each month. Some outpatient services may require an authorization after a certain number of visits have been completed. When requesting additional sessions for outpatient services that require authorization, the network provider must complete a request for authorization. The fastest way to submit your Outpatient Treatment Report (OTR), is using our secure provider portal at www.cenpatico.com/providers and selecting the link to the secure provider portal. If the provider is unable to submit a request via our portal, then an OTR form can be completed and faxed to Cenpatico at 866-694-3649 for clinical review. The OTR can be found at www.cenpatico.com under Providers/Resources/Forms. Please refer to the notification regarding prior authorizations. This information can be found at:

www.cenpatico.com/providers/Ohio/provider-tools/notifications.

Network providers may call the Customer Service department at 800-224-1991 to check the status of an OTR. Network providers should allow up to 2 business days to process non-urgent requests.

IMPORTANT:

- The OTR must be completed in its entirety. The diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
- Cenpatico will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Failure to submit a completed OTR can result in delayed authorization and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.

Guidelines for Psychological Testing

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

It is important to note that;

- Testing will not be authorized by Cenpatico for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment should 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.
- Practitioners should submit a request for Psychological Testing that includes the specific tests to be performed. Cenpatico's Psychological Testing Authorization Request form can be found at www.Cenpatico.com under Provider/Resources/Forms.

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when Medical Necessity Criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health practitioners providing treatment for the member. Network Providers are expected to work closely with Cenpatico's Utilization Management department in exercising judicious use of a member's benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Buckeye Health Plan.

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

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

Determining Medical Necessity

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

Concurrent Review

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

Discharge Planning

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

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

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within twenty-four (24) hours after discharge. Cenpatico's Care Coordination/Case Management staff follow-up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, Cenpatico asks that Network Providers inform Cenpatico as soon as possible. Upon notification of a no-show, Cenpatico's Care Coordination staff will follow-up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Psychotropic Medications

Cenpatico will monitor psychotropic medication usage in partnership with Buckeye Health Plan to identify any medications for physical conditions prescribed by psychiatric Practitioners as well as review psychotropic medications prescribed by primary care physicians (PCP).

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

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

Continuity of Care

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

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

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

Intensive Case Management (ICM)

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

Cenpatico's ICM functions include:

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

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

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

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

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

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

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, facilities rendering the service(s) and the member. The notification will include the following information/ instructions:

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

Cenpatico ensures that only licensed behavioral health clinician's review and make adverse determinations.

Peer Clinical Review Process

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

For both mental health and chemical dependency service continued stay requests, the physician or treating Practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available. When a determination is made where no peer-to-peer conversation has occurred, a practitioner can request to speak with the Peer Reviewer who made the determination within 1 business day. Practitioners should contact Cenpatico at (800) 224-1991 to discuss UM denial decisions.
The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare Practitioner provides good cause in writing.

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

Clinical Practice Guidelines

Cenpatico has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to: Treatment of Bipolar Disorder, Treatment of Major Depressive Disorder, Treatment of Schizophrenia, Post Traumatic Stress Disorder, and Substance Use and Abuse. For children, Cenpatico has adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/ Hyperactivity Disorder. Evidence-based practice guidelines have been adopted from a wide variety of recent publications. They are on topics such as, ADHD, Adjustment Disorder, Anxiety Disorder, and Post Traumatic Stress Disorder. Clinical Practice Guidelines may be accessed through our web site www.cenpatico.com, or you may request a paper copy of the guidelines by contacting your network representative or by calling (866) 694-3649. Copies of our evidence based practices can be obtained in the same manner. Compliance with Clinical Practice Guidelines is assessed annually as part of the quality process.

Claims
Cenpatico Claims Department Responsibilities

Cenpatico's claims processing responsibilities are as follows:

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

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through Buckeye Health Plan) on the date of service;
- The service provided is a covered service (benefit of Buckeye 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.

Clean Claim

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

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

Explanation of Payment (EOP)
An Explanation of Payment (EOP) is provided with each claim payment or denial. The EOP will detail each service being considered, the amount eligible for payment, copayments/deductibles deducted from eligible amounts, and the amount reimbursed.
If you have questions regarding your EOP, please contact Cenpatico's Claims Customer Service department at (877) 730-2117.

Network Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within three hundred and sixty-five (365) days of the date the service(s) are rendered. Claims submitted after this period will be denied for payment.

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

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

- Please use the correct mailing address. Network Providers submit claims to the following address for processing and reimbursement:

  Cenpatico
  Attn: Claims
  PO Box 6150
  Farmington, MO 63640-3818

Common Claims Processing Issues

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

Some common problem areas are as follows:

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

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

Imaging Requirements for Paper Claims

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

Do's

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

Don'ts

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

Web Portal Claim Submission

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

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

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

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

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

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

EDI Clearinghouses

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

Emdeon	68068	(800) 845-6592

Cenpatico Billing Policies
Member Hold Harmless

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

Please Note:

- A Network Provider's failure to authorize the service(s) does not qualify/allow the Network Provider to bill the member for service(s).
- Buckeye 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 the Network Provider has obtained written acknowledgement from the member, prior to rendering such non-covered service, that the specific service is not a covered benefit under Buckeye 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 Buckeye 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/Practitioner of any changes in his/her insurance coverage and/or benefits.

Claim Status

Please do not submit duplicate bills for authorized services. If your Clean Claim has not been adjudicated within ninety (90) days, please call Cenpatico's Claims Customer Service department at (877) 730-2117 to determine the status of the claim.

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

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

Retro Authorization

If your claim was denied because you did not have an authorization number, please send a request in writing for a Retrospective Review, explaining in detail the reason for providing services without an authorization. A retrospective review must be filed within one hundred and eighty (180) calendar days from date of service. The retro-review will be resolved within thirty (30) calendar days from the date of receipt.

Network Providers must submit their Retroactive Authorization request to:

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

If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Customer Service department at (800) 224-1991 and ask the representative to extend the end date on your authorization.

Resolving Claims Issues
Claim Resubmission

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

1. Call the Cenpatico Claims Support Liaisons at (877) 730-2117. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of our Claims Support Liaisons.

2. When a provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim should be submitted on a paper claim form. When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as RESUBMISSION along with the original claim number written at the top of the claim. Failure to mark the claim may result in the claim being denied as a duplicate. Corrected resubmissions should be sent to the address below.

   Cenpatico
   Claims Resubmission
   P. O. Box 6150
   Farmington, MO 63640-6150

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

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

   Cenpatico
   Care Management
   12515-8 Research Blvd, 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 the Cenpatico Service Center and ask the representative to extend the end date on your authorization.

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

   Cenpatico Appeals
   PO Box 6000
   Farmington, MO 63640-3809

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

Mail: Cenpatico
Attention: Ohio Provider Relations
12515-8 Research Blvd, Suite 400
Austin, TX 78759

Phone: (800) 224-1991

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. If your claim was processed with an overpayment or has resulted in a request for recoupment, you may submit all payments to the following address:

Post Office Address
Cenpatico Behavioral Health LLC
P.O. BOX 3656
Carol Stream, IL 60132-3656

Express Mail Address
FIRST DATA – CHICAGO
Cenpatico Behavioral Health LLC: LBX 3656
8430 W. BRYN MAWR AVE 3RD FLR
Chicago, IL 60631

Ohio Assigned Lockbox Number: 3656

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

Applying for an NPI

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

To Register Online
To register for an NPI using the web-based process, please visit the following website;
https://nppes.cms.hhs.gov/NPPES/Welcome.do

Click on the link that says "If you are a healthcare provider, the NPI is your unique identifier." Then click on the link that says "Apply online for an NPI." This should be the first link. Follow the instructions on the web page to complete the process.

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

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

Medical Necessity Criteria

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when medical necessity criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health practitioners providing treatment for the member. Network Providers are expected to work closely with Cenpatico's Utilization Management department in exercising judicious use of a member's benefit and to carefully explain the treatment plan to the member in accordance with the member's benefits offered by Buckeye Health Plan.

Cenpatico uses *InterQual* Criteria for mental health for 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 abuse Medical Necessity Criteria. Additionally, Cenpatico has adopted the Illinois State Medicaid Manual service descriptions and medical necessity guidelines for all community based services.

InterQual Criteria, used by over 3,000 organizations and agencies, are developed by physicians and other healthcare professionals who review medical research and incorporate the expertise of a national panel of over 700 clinicians and medical experts representing community and academic practice settings throughout the U.S. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from practitioners.

ASAM and the McKesson *InterQual* criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Community-Based Services criteria can be found in this manual and 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.

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

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

Please contact the Cenpatico Privacy Officer in writing (refer to address below) or by phone with any questions about our privacy practices.

Mail: Cenpatico Compliance Department **Phone:** 512.406.7200
12515-8 Research Blvd, Suite 400
Austin, TX 78759

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

Mail: Buckeye Health Plan
4349 Easton Way, Suite 400
Columbus, Ohio 43219

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