CENPATICO MAGNOLIA HEALTH MANUAL

state of Mississippi

v.9/2015

magnolia health™

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Welcome To Cenpatico

Welcome to the Cenpatico Behavioral Health, LLC (Cenpatico) Provider Network. We look forward to a long and mutually rewarding partnership as we work together in the delivery of mental health to Magnolia Health (Magnolia) members in the State of Mississippi.

The Cenpatico Provider Manual has been developed to answer your questions about Cenpatico's behavioral health program and to explain how we manage the delivery of mental health 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 Mississippi.

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

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

About Cenpatico

MISSION

Creating innovative solutions that drive quality healthcare for vulnerable populations

VISION

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

GOAL

To improve outcomes and deliver savings through innovation

History and Structure of Cenpatico

Cenpatico is a wholly-owned subsidiary of CenCorp Health Solutions, Inc. (CenCorp). CenCorp is a wholly-owned subsidiary of Centene Corporation (Centene). Magnolia Health, Inc. (Magnolia) (**www.Magnoliahealthplan.com**) has delegated the provision of covered behavioral health and substance use disorder to Cenpatico.

Cenpatico has provided comprehensive managed behavioral healthcare services for more than eleven (11) years, and currently operates in Arizona, California, Florida, Georgia, Indiana, Illinois, Kansas, Massachusetts, Missouri, New Hampshire, Ohio, South Carolina, Texas, Washington, Wisconsin and Mississippi. 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" to include both acute and chronic psychiatric disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems (ICD-10). Cenpatico provides quality, cost effective behavioral managed healthcare services for members of Magnolia. Cenpatico provides these services through a comprehensive provider network of qualified behavioral health practitioners, providers, and community mental health centers.

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

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

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

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

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

- The use of appropriate outpatient treatment helps the member preserve available benefits for potential future use. Benefits are maximized for the member's healthcare needs.

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

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

Quick Reference Guide

Cenpatico Contact Information:
Cenpatico
Phone: **866-912-6285**
www.cenpatico.com

Magnolia Health, Inc. Contact Information:
Magnolia Health, Inc.
866-912-6285
www.Magnoliahealthplan.com

Eligibility Verification:
Phone: **866-912-6285**
Web: www.cenpatico.com (you must have a provider log-on to verify eligibility on this site)

Cenpatico Customer Service:
Please call Customer Service at **866-912-6285** to assist with eligibility determinations and provider referrals

Claims Guidelines:
Claims must be submitted within one hundred eighty (180) days of the date of service.

Claims Address:
Cenpatico
PO Box 7600
Farmington, MO 63640-3834

Claims Support:
Phone: 866-324-3632

Claims Appeals Address:
Attn: Appeals Department
P.O. Box 6000
Farmington, MO 63640

Pharmacy Services (Magnolia Health):
Customer Service: 1-800-460-8988
Prior-Authorization: 1-866-399-0928

EDI Vendor:
Emdeon (1-800-845-6592) please note that Cenpatico's Payer ID Number is 68068

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

Prior Authorization:
Download and complete an Outpatient Treatment Request (OTR) online at www.cenpatico.com for outpatient services including IOP, ECT, Injectable medications and psychological testing.

Please call Utilization Management at **866-912-6285** for partial hospitalization or crisis residential placement prior authorization.

After-Hours Assistance:
Please call NurseWise at **866-912-6285**

Medical Necessity Appeals:
Cenpatico
Attn: Appeals Coordinator
12515-8 Research Blvd. Suite 400
Austin, TX 78759
Or Fax to: 1-866-694-3649

Provider Relations Contact:

Diandra Lee,
Provider Relations Specialist
111 East Capitol Street, Ste. 500
Jackson, MS 39201
Phone: 866-912-6285 x66605
Fax: 601-948-8730

Nakisha Montgomery,
Provider Relations Specialist
111 East Capital Street, Ste. 500
Jackson, MS 39201
Phone: 866-912-6285 X66745
Fax: 601-948-8730

Quality of Care Concerns/Complaints
Fax: 866-704-3063

The Cenpatico Provider Network

Cenpatico Service Area

Cenpatico reimburses claims for the covered behavioral health benefits for Magnolia Health members across the State of Mississippi.

Network Provider Selection Process

Cenpatico contracts with a comprehensive provider network, which includes the following provider types; Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs) that offer behavioral health services, hospitals that offer outpatient behavioral health services, and independent behavioral health practitioners. All participating providers must render covered services in accordance with the Division of Medicaid Administrative Code for mental health services. We work with providers that consistently meet or exceed Cenpatico clinical quality standards and are comfortable practicing within the managed care arena, including those providers that demonstrate and support Magnolia's integrated care approach to Member care. Network Providers should support a brief, solution-focused approach to treatment and should be engaged in a collaborative approach to the treatment of members.

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

- Clinical expertise;
- Geographic location considering distance, travel time, means of transportation and access for members with physical disabilities;
- Potential for high volume referrals;
- Specialties and accessibility standards, including meeting the Americans with Disabilities Act (ADA) requirements, to best meet our members' needs;
- Ability to accept new members;
- Ability to act as the member's medical home; and
- Experience in utilizing evidence-based practices in working with seriously mentally ill (SMI) population.

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

The Network Provider's Office

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

General Network Practitioner Office Standards

Cenpatico requires the following:

- Office must be professional;
- Offices and facilities must be easily accessible with accommodations for members with disabilities as required and covered by titles II and III of the Americans with Disabilities Act (ADA) of 1990;
- Provide designated accessible parking spaces;
- Appropriate door sizes for clear openings with easy opening mechanism;
- Provide adequate space in clinic rooms to turn a wheelchair;
- Provide sign language interpreters, large-print materials, audio recordings, videotapes with captioning, notepads, pencils and readers to meet alternative communication needs;

- 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 Practitioners must have a professional and fully-confidential telephone line and twenty-four (24) hour availability;
- Member records and other confidential information must be locked up and out of sight during the work day; and
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

Network Provider Concerns

Network Providers who have concerns about Cenpatico should contact the Cenpatico Mississippi Provider Relations department at **866-912-6285** to register these complaints. All concerns are investigated, and written resolution is provided to the Network Provider on a timely basis.

Network Provider Standards of Practice

Network Providers are required to:

- Refer members with known or suspected physical health problems or disorders to the member's PCP for examination and treatment;
- Only provide physical health services if such services are within the scope of the Network Provider's clinical licensure;
- Contact members who have missed appointments within twenty-four (24) hours to reschedule;
- Comply with Magnolia appointment access standards;
- Ensure all members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language (which can be accomplished by engaging professional interpreter services at the onset of treatment);
- Comply with all State and federal requirements governing emergency, screening and post-stabilization services;
- Provide member's clinical information to other providers treating the member, as necessary to ensure proper coordination and treatment of members who express suicidal or homicidal ideation or intent, consistent with State law;
- Exchange information with member's PCP with member consent;
- Comply with all Cenpatico non-discrimination and cultural competency requirements; and
- Accommodate the needs of members with disabilities.

Network Providers are requested to:

- Submit all documentation in a timely fashion;
- Comply with the Cenpatico Case Management and UM processes;
- Cooperate with Cenpatico's quality improvement (QI) Program (allow review of or submit requested charts, receive feedback);
- Support Cenpatico access standards;
- Use appropriate Medical Necessity and evidence-based Best Practices when formulating treatment plans 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;
- Notify Cenpatico of any change of address/location within thirty (30) days of the change;
- Complete credentialing and re-credentialing materials as requested by Cenpatico; and
- Maintain an office that meets all standards of professional practice.

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 Magnolia program, including, but not limited to practices that result in unnecessary cost to the Magnolia program for services that are not medically necessary or that fails to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the Magnolia 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 Magnolia 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 and inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Member fraud include improperly obtaining prescriptions for controlled substances and card sharing.

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 Magnolia Health, 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 Magnolia Health, 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 Mississippi within the Office of the Attorney General at the following address:

Medicaid Fraud Control Bureau
Medicaid Fraud Control Unit of Mississippi Office of the Attorney General
PO Box 56
Jackson, MS 39205

Phone: (601) 359-4220
Fax: (601) 359-9681

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

Providers may also contact the Cenpatico Compliance Department with WAF questions or concerns by phone at **877-264-6550.**

Verifying Member Enrollment

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

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

- Contact Cenpatico Customer Service at **866-912-6285**
- Verify online at www.cenpatico.com

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

Credentialing

Credentialing Requirements

The Cenpatico provider network consists of Community Mental Health Centers (CMHCs), Licensed Psychiatrists (MD/DO), Licensed Psychologists, Licensed Psychiatric Advanced Practice Nurses, Federally Qualified Health Centers, Rural Health Clinics, and Psychiatric Hospitals. 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.
- 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.
- In order to be credentialed in the Cenpatico Network, all individual Network Practitioners must be licensed to practice independently and registered as a Medicaid Provider in the State of Mississippi using the same NPI Numbers.

- For MDs and DOs, Cenpatico will require proof of the Network Practitioner's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, as applicable.
- License must be current, active and in good standing.
- Complete Disclosure of Ownership & Control Interest Statement
- MDs and DOs must have hospital privileges and/or a coverage plan. Hospital privileges must be current and active.
- All Network Practitioners' graduate degrees must be from an accredited institution.
- All Network Providers are subject to the completion of primary source verification of the Network Provider through our Credentialing Department located in Austin, Texas.
- The Network Provider agrees to complete and provide appropriate documentation for this primary source verification in a timely manner.
- The Network Provider further agrees to provide all documentation in a timely manner required for credentialing and/or re-credentialing.
- The Network Provider agrees to maintain adequate professional liability insurance as set forth in the Provider Agreement with Cenpatico.
- All credentialing applications are subject to consideration and review by the Cenpatico Credentialing Committee which meets twice monthly.

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

- Good standing of privileges at the hospital designated as the primary admitting facility;
- Valid Drug Enforcement Administration (DEA) certificates (where applicable). Network Providers selected for participation must successfully complete the Cenpatico credentialing process.

As part of that process, Network Providers must submit the following documentation:

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

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 & State of Mississippi Rescheduling Requirements and Schedule

Mississippi Network Providers will be re-credentialed every three years based on the Mississippi Department of Insurance. Cenpatico Network Providers will receive notice that they are due to be re-credentialed well in advance of their credentialing expiration date and, as such, are expected to submit their updated information in a timely fashion. Failure to provide updated information in a timely manner can result in suspension and/or termination from the network.

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

Council for Affordable Quality HealthCare (CAQH)

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

Once a CAQH Provider ID number is assigned, you can visit the CAQH website located at www.CAQH.org, or call the help desk at 888-599-1771, to complete the credentialing application. There is no cost to Network Providers to submit their credentialing applications and participate with CAQH.

Cenpatico Credentialing Policies and Procedures

Cenpatico maintains written credentialing and re-credentialing policies and procedures that include the following:

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

Cenpatico Credentialing Committee

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

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

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

- Hospital or Facility
- Community Mental Health Center (CMHC)
- Private Community Mental Health Center (PCMHC)
- Federally Qualified Health Center (FQHC)

Cenpatico recognizes the following accrediting bodies:*

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

** This list may not be inclusive of all accrediting organizations*

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

Right to Review and Correct Information

All providers participating with Cenpatico have the right to review information obtained by Cenpatico to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as malpractice insurance carriers and the State Board of Medical Examiners. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

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

Status Change Notification

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

Network Provider Demographic/Information Updates

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

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

Fax: 866-694-3735
Email: Provider_Change-cbh-tx@centene.com
Mail: Cenpatico
Attn: PDM Unit - Mississippi
12515-8 Research Blvd. Suite 400
Austin, TX 78759

Network Provider Request to Terminate

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

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

Cenpatico's Right to Terminate

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

- Termination of Cenpatico's obligation to provide or arrange mental health treatment services for members of Health Plans;
- Restriction, qualification, suspension or revocation of Network Practitioner's license, certification or membership on the active medical staff of a hospital or Cenpatico participating practitioner group;
- Network Provider's loss of liability insurance required under the Provider Agreement with Cenpatico;
- Network Provider's exclusion from participation in the Medicare or Medicaid program;
- Network Provider's insolvency or bankruptcy or Network Provider's assignment for the benefit of creditors;
- Network Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Network Provider's ability to provide services has become impaired, as determined by Cenpatico, at its sole discretion;
- Network Provider's submission of false or misleading billing information;

Network Provider's failure or inability to meet and maintain full credentialing status with Cenpatico;

- Network Provider's breach of any term or obligations of the Provider Agreement;
- Any occurrence of serious misconduct which brings Cenpatico to the reasonable interpretation that a Network Provider may be delivering clinically inappropriate care; or
- Network Provider's breach of Cenpatico Policies and Procedures.

Network Provider Appeal of Suspension or Termination of Contract Privileges

If a Network Provider has been suspended or terminated by Cenpatico, contact the Cenpatico Mississippi Provider Relations department at 866-912-6285 to request further information or discuss how to appeal the decision.

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

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

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

Cenpatico will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the Network Provider with the notification of suspension/ termination. To request a copy of Cenpatico's Provider Dispute Policy, please contact the Quality Improvement Department at 866-704-3063.

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

Cultural Competency

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

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

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

Network Providers must ensure the following:

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

Understanding the Need for Culturally Competent Services

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

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

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

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

Take the following into consideration when you provide services to members:

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

Facts about Health Disparities

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

Access and Coordination of Care

Provider Access Standards

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

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

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 Mississippi does not prescribe standards, but, Cenpatico 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 Providers must make every effort to assist Cenpatico in providing appointments within the following Magnolia timeframes:

Type of Care	Appointment Availability
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.
Crisis Stabilization – services must be provided within 6 hours of the request.	Within six (6) hours of request.
Discharge (from hospital/ acute care)	Within seven (7) days of discharge
Urgent – defined as a non-life threatening situation that should be treated within twenty-four (24) hours of the request. Urgent care services are not subject to prior authorization or precertification.	Within twenty-four (24) Hours of the request.
Routine - defined as treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting within ten (10) working days of the request .	Within ten (10) working days of the request.

If you cannot offer an appointment within these timeframes, please refer the member to Magnolia at 866-912-6285 so that the member may be rescheduled with an alternative provider who can meet the access standards and member's needs.

Network Providers shall ensure that services provided are available on a basis of twenty-four (24) hours a day, seven (7) days a week, 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 members and shall ensure members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit members from accessing services.

Network Providers should call the Cenpatico Provider Relations department at 866-912-6285 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a Network Provider's status will be considered in the re-credentialing

After Hours Access Standards

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

No Show Appointments

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

A "no show" appointment may never be applied against a member's benefit maximum. Members may not be charged a fee for a "no show" appointment. Network Practitioners may contact Magnolia via the Provider Portal, email or phone to inform Cenpatico about members who do not keep appointments. Member Connections Representatives will contact the member to reinforce the importance of attending appointments; assess and help address barriers such as transportation; and assist in rescheduling if needed

No New Referral Periods

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

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

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

Cenpatico
Attn: Mississippi Provider Relations
12515-8 Research Blvd. Suite 400
Austin, TX 78759
Phone: 866-912-6285

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

Coordination between Magnolia Health and Cenpatico

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

In addition, Cenpatico works to educate and assist physical health and behavioral health practitioners in the appropriate exchange of medical information. Behavioral health utilization reporting is prepared and provided to Magnolia on a monthly basis and is shared with Magnolia'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 sustained over 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, as well as Magnolia'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 to care standards;
- Adherence to Clinical Practice Guidelines;
- Treatment record compliance;
- Communication with PCPs and other behavioral health practitioners;
- Critical Incidents;
- Member safety;
- Member confidentiality;
- High-risk member identification, management and tracking;
- Discharge appointment timeliness and reporting;
- Re-admissions;
- Grievance procedures;
- Potential over- and under-utilization;
- Provider satisfaction; and
- Member satisfaction

How does Cenpatico monitor quality?

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

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

Findings are communicated to individual Network Practitioners and Network Practitioner groups for further discussion and analysis to reinforce the goal of continually improving the appropriateness and quality of care rendered. Cenpatico may request action plans from the Network Practitioner. Findings are considered during the re-credentialing process.

Network Provider Participation in the QI Process

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

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

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

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 use disorder treatment records.

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

Communication with the Primary Care Physician

Magnolia encourages primary care physicians (PCPs) to consult with their members' mental health Network Practitioners. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

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

- Prescription medication.
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse).
- The member's progress toward meeting the goals established in their treatment plan. A form to be used in communicating with the PCP and other behavioral health providers is located on our website at www.cenpatico.com. Network Providers can identify the name and number for a member's PCP on the front-side of the Member ID Card.

Network practitioners should screen for the existence of co-occurring mental health conditions and substance use disorders and make appropriate referrals. Practitioners should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment.

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

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

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

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

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

Consent for Disclosure

Cenpatico recognizes communication as the link that unites all the service components and a key element in any program's success. To further this objective, Network Practitioners shall obtain consent for disclosure of information from the member when required by federal and/or state law to release clinical information to a member's physical health practitioner and, if applicable, other behavioral health practitioners as needed.

If the member refuses to consent to a release, when required by law, such as in relation to alcohol and substance use disorder treatment records, the Network Practitioner should document the refusal along with the reasons for declination in the medical record.

Cenpatico monitors compliance to confirm that regular reports are being sent to the primary care physician (PCP) or other behavioral health practitioners for care coordination or case management and treatment purposes.

Critical Incident Reporting

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

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

The Critical Incident Report included in the Forms Section of this Manual must be used to document critical incidents. Submit completed Critical Incident Reports to the following address:

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

Abuse and Neglect Reporting

Providers are required to report all incidents that may include abuse and neglect consistent with the Department of Human Services Act, the Adults with Disabilities Domestic Abuse Intervention Act and the Abused and Neglect Child Reporting Act. Reports regarding elderly Members who are over the age of 60 will be reported to the Mississippi Department of Aging by using the Elder Abuse Hotline number at 1-800-222-8000. Cenpatico will offer training to providers about the signs of abuse or neglect.

Member Concerns about Network Providers

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

Monitoring Satisfaction

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

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

Network Providers should call the Cenpatico Provider Relations department at 1-866-912-6285 to address concerns as they arise. Feedback from Network Providers enables Cenpatico to continuously improve systems, policies and procedures.

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

Records and Documentation

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

The Network Provider will provide Cenpatico, Magnolia 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 member care. This provision shall survive the termination and or non-renewal of a Provider Agreement with Cenpatico.

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. Sample forms are located on our website at www.cenpatico.com and Network Practitioners are encouraged to use for members.

As part of our ongoing quality improvement program, clinical records may be audited to assure the quality and consistency of Network Provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the member must sign an authorization for release, which can be found in the Forms Section as well. Chart Audits of member records will be evaluated in accordance with these criteria.

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

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

Treatment Record Guidelines

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

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

1. Each page in the treatment record contains the patient member's name or ID number.

2. Each record includes the patient member'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 member 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 member'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 members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.

10. A DSM diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.

11. Treatment plans are consistent with diagnosis(es), 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 member's understanding of the treatment plan are documented.

13. Progress notes describe member 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.

The following elements should be included in the medical record:

1. Member identification (to include date of birth, gender, race).
2. Copy of the member's birth certificate and/or social security card.
3. Copy of any legal documents verifying custody or guardianship of the member, when the responsible party is anyone other than the participant's legal parent(s).
4. Name, address and phone number of party bearing legal responsibility for the member should be clearly identified, along with their relationship to the member.
5. If member is in the custody of DHS, the county of custody should be specified and the caseworker identified as an agent of DHS.
6. Documents signed and dated by the member and/or family that inform them of:
    a. Member rights and responsibilities
    b. Consent for treatment
    c. Complaints and grievances procedures
    d. Appeals and right to fair hearing
7. Assessments to include assessment of resources, developmental profile, behavioral assessment, medical history, current educational functioning, family and participant strengths and needs.
8. Treatment Plan to include signature and date Medication management documentation
9. Psychotherapy notes that contain the following elements:
    a. Date of session, time session began and ended
    b. Types of therapy (either Individual, Family or Group)
    c. Person participating in session
    d. Clinical observations about the member and/or family, including demeanor, mood, affect, mental alertness, and thought process

e. Content of session

f. Therapeutic interventions attempted and member/family response to intervention

g. Member's response to any significant others who may be present in the session, h. Outcome of the session

i. Statement summarizing the member and/or family's degree of progress towards treatment goals

j. Signature, credentials and printed name of therapist

10. Discharge planning is done with member and family.

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

Preventative Behavioral Health Programs

Cenpatico offers a preventative behavioral health program for our members. A brief description of the program including who is eligible to participate is listed below. You can refer your members to the program directly when you see an unmet need. If you would like more information about the program or if you have suggestions as to how we can improve our preventative behavioral health program please contact the Quality Improvement department at 866-912-6285.

The Perinatal Depression Screening Program offers depression screening to members who are pregnant to identify those members who may be in need of outreach and engagement. 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 contacts the medical provider as well to assure the member has the care needed.

Complaints, Grievances and Appeals

Provider Complaints

What is a Complaint?

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

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

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

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

To express a Complaint by phone, please call Cenpatico at 866-912-6285.

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

Member Grievances

The Cenpatico/Magnolia Grievance System includes an informal complaints process and a formally structured grievance and appeals process. Magnolia's Grievance System is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Section 438 Subpart F, including procedures to ensure expedited decision making when a member's health so necessitates. The filing of a grievance will not preclude the member from filing a complaint with the Mississippi Department of Insurance (DOI), nor will it preclude DOI from investigating a complaint pursuant to its authority under Section 4-6 of the Health Maintenance Organization Act.

A grievance is an expression of dissatisfaction about any matter or aspect of Cenpatico or its operation, other than an "action," which is defined below:

An **action** is:

(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or
(5) The failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.
(6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.

Acknowledgement

Cenpatico/Magnolia shall acknowledge receipt of each grievance in writing, unless the grievance was received telephonically or the member requests an expedited resolution. The Cenpatico staff member will document the substance of an oral grievance, and attempt to resolve it immediately. For informal complaints, defined as those received verbally and resolved immediately to the satisfaction of the member or appointed representative, the staff will document the resolution details. The Grievance and Appeals Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five (5) business days of receipt.

Timeframe and Notice of Resolution

Grievance investigation and review by the Grievance Committee (for those grievances not resolved informally) will occur as expeditiously as the member's health condition requires, not to exceed fifteen (15) days from the receipt of all information or thirty (30) days from the date the grievance is received by Cenpatico. The determination by the Committee may be extended for a period not to exceed fourteen (14) days in the event of a delay in obtaining the documents or records necessary for the resolution of the grievance. Members have the right to attend and participate in the formal grievance proceedings and may be represented by a designated representative of his or her choice. Resolution is determined by majority vote. Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Cenpatico shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease [see 42 CFR § 438.406].

Written notification of the grievance resolution will be made within five (5) days after the determination and will include the resolution and HFS requirements, including but not be limited to, the decision reached by Cenpatico , the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the member.

Grievances may be submitted verbally or in writing to:

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

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.

Cenpatico has developed and maintains an appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act, the Health Carrier External Review Act, and 42 CFR Section 438 Subpart F. An appeal must be filed with Cenpatico within thirty (30) calendar days from the date of the notice of Cenpatico's action/determination. Members may continue to seek covered services while the appeal is being resolved if *all* of the following conditions hold true:

- The member or their authorized representative files an appeal within ten (10) calendar days from the mail date of the notice of adverse action *or* prior to the intended effective date of Cenpatico's notice of adverse action or the member asks for a State Fair Hearing within thirty (30) calendar days from the date on Cenpatico's notice of adverse action and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
- The services were ordered by an authorized provider; and
- The original period covered by the initial authorization has not expired; and
- The member requests a continuation/extension of benefits.

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

Members have the opportunity to present their Appeal in person as well as in writing. Every oral appeal received must be confirmed in writing by the member or his/her representative within thirty (30) calendar days of the filing date, unless an Expedited Appeal is requested. All other appeals will be acknowledged in writing within ten (10) calendar days and resolved within forty five (45) calendar days from the date Cenpatico receives the request for the appeal. Cenpatico/Magnolia may extend the forty-five (45) calendar day time frame by fourteen (14) calendar days if the member requests the extension, or Cenpatico/Magnolia determines there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, Cenpatico/Magnolia shall give the member written notice of the extension and the reason for the extension within two (2) business days of the decision to extend the time frame. Cenpatico will notify the member and the health care provider of the decision of the appeal orally followed by a written notice of the determination.

Expedited appeals will be resolved within three (3) business days from the date Cenpatico receives the request for an Expedited Appeal. Cenpatico/Magnolia may extend the time frame by fourteen (14) calendar days if the member requests the extension, or Cenpatico/Magnolia demonstrates to the Division of Medicaid that there is need for additional information and the extension is in the member's best interest. For any extension not requested by the member, Cenpatico/Magnolia shall give the member written notice of the reason for the delay.

Cenpatico/Magnolia shall ensure that punitive Action is not taken against a member or a service provider who requests an Expedited Resolution or supports a member's Expedited Appeal.

Cenpatico/Magnolia shall provide an Expedited Resolution, if the request meets the definition of an Expedited Appeal, in response to a verbal or written request from the member or service provider on behalf of the member.

Cenpatico/Magnolia shall inform the member of the limited time available to present evidence and allegations in fact or law.

If the Cenpatico/Magnolia denies a request for an Expedited Resolution of an Appeal, it shall:

1. Transfer the Appeal to the forty-five (45) calendar day time frame for standard resolution, in which the forty-five (45) calendar day period begins on the date that Cenpatico/Magnolia received the original request for Appeal; and
2. Make reasonable efforts to give the member prompt verbal notice of the denial, and follow up with a written notice within two (2) calendar days.

Cenpatico/Magnolia shall document in writing all verbal requests for Expedited Resolution and shall maintain the documentation in the case file.

To express an Appeal in writing please mail or fax the request to the following:

Cenpatico

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

To express an appeal by phone, please call Cenpatico at 866-912-6285.

State Fair Hearing Process

Any adverse action or appeal that is not resolved wholly in favor of the member by Cenpatico/Magnolia may be appealed by the member or the member's authorized representative. The member or the member's authorized representative may also ask for a State Fair Hearing with the Division of Medicaid. You must ask for this in writing within thirty (30) calendar days of the final decision by Cenpatico/Magnolia. The member must exhaust all Cenpatico/Magnolia level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division of Medicaid. Please include your name, address, phone number, and reason(s) why you are requesting a State Fair Hearing. If you have questions or want to ask for a State Fair Hearing, contact the Division of Medicaid at:

Division of Medicaid, Office of the Governor
Attn: MississippiCAN
550 High Street, Suite 1000
Jackson, MS 39201

Phone: 601-359-6050 or 1-800-421-2408
Fax: 601-359-5252

Magnolia and Cenpatico is responsible for providing to the Mississippi Division of Medicaid an appeal summary describing the basis for the denial. Magnolia will comply with DOM's fair hearing decision. The DOM's decision in these matters shall be final and shall not be subject to appeal by Cenpatico/Magnolia.

Magnolia Member Rights and Responsibilities

Patients have the rights and responsibilities:

- To receive information about Magnolia, its benefits, its services, its practitioners and providers and member rights and responsibilities
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law
- To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition
- To receive assistance from both Mississippi Division of Medicaid and Magnolia in understanding the requirements and benefits of Magnolia.
- To receive family planning services from any participating Medicaid doctor without prior authorization
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- To receive information on the Grievance, Appeal and Medicaid Fair Hearing procedures
- To voice grievances or file appeals about Magnolia decisions that affect their privacy, benefits or the care provided
- To request and receive a copy of your medical record
- To make recommendations regarding Magnolia's member rights and responsibilities policy
- To request that your medical record be corrected
- To expect their medical records and care be kept confidential as required by law.
- To receive Magnolia's policy on referrals for specialty care and other benefits not provided by the member's PCP
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information)
- To exercise his or her rights, and that the exercise of these rights does not adversely affect the way Magnolia and its providers treat the members
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law
- To choose a PCP and to change to another PCP in Magnolia's network
- To receive timely access to care, including referrals to specialists when medically necessary without barriers
- To file for a Medicaid Fair Hearing
- To receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc. - in a manner and format that may be easily understood
- To make an advance directive, such as a living will
- To choose a person to represent them for the use of their information by Magnolia if they are unable to

- To get a second opinion from a qualified healthcare professional
- To receive oral interpretation services free of charge for all non-English languages
- To be notified that oral interpretation is available and how to access those services
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and Magnolia responsibilities for coordination of care in a timely manner in order to make an informed choice
- To receive information on the following:
  - Benefits covered
  - Procedures for obtaining benefits, including any authorization requirements
  - Cost sharing requirements
  - Service area
  - Names, locations, telephone numbers of and non-English language spoken by current Magnolia providers, including at a minimum, PCPs, specialists and hospitals
  - Any restrictions on member's freedom of choice among network providers
  - Providers not accepting new members
  - Benefits not offered by Magnolia but available to members and how to obtain those benefits, including how transportation is provided
- To receive a complete description of disenrollment rights at least annually
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services?
  - Emergency services do not require prior authorization
  - The process and procedures for obtaining emergency services
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
  - Member's right to use any hospital or other setting for emergency care
  - Post-stabilization care services rules in accordance with Federal Guidelines
- To inform Magnolia of the loss or theft of their ID card
- To present their ID card when using healthcare services
- To be familiar with Magnolia procedures to the best of their ability
- To call or contact Magnolia to obtain information and have questions clarified
- To provide information (to the extent possible) that Magnolia and its practitioners and providers need in order to provide care
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers.
- To inform your provider on reasons you cannot follow the prescribed treatment of care recommended by your provider
- To understand your health problems and participate in developing mutually agreed- upon treatment goals to the degree possible
- To keep your medical appointments and follow-up appointments
- To access preventive care services
- To follow the policies and procedures of Magnolia and the State Medicaid program
- To be honest with providers and treat them with respect and kindness
- To get regular medical care from their PCP before seeing a specialist
- To follow the steps of the appeal process
- To notify Magnolia, Division of Medicaid and your providers of any changes that may affect your membership, healthcare needs or access to benefits. Some examples may include:
  - If you have a baby
  - If your address changes
  - If your telephone number changes
  - If you or one of your children are covered by another plan

- If you have a special medical concern
- If your family size changes

- To keep all your scheduled appointments; be on time for those appointments, and cancel twenty-four (24) hours in advance if you cannot keep an appointment
- If you access care without following Magnolia rules, you may be responsible for the charges

In addition to the Member Rights and Responsibilities provided by Magnolia, Cenpatico believes that members also have the following Rights and Responsibilities.

Cenpatico Member Rights and Responsibilities
Member Rights

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

Member Responsibilities

1. A responsibility to supply information (to the extent possible) that the organization and its providers need in order to provide care.
2. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
3. A responsibility to understand their health problems and participate in developingmutually 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. CST. After hours services are available during evenings, weekends and holidays. The after-hours service is staffed by customer service representatives with registered nurses and behavioral health clinicians available 24/7 for urgent and emergent calls.

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

The Customer Service department's primary focus is to facilitate the authorization of covered services for members for treatment with a specific clinician or clinicians.
The Cenpatico Customer Service department assists Network Providers with the following:

- Verifying member eligibility
- Verifying member benefits
- Providing authorization information
- Referrals
- Trouble-shooting any issues related to eligibility, authorizations, claims, referrals, or researching prior services

Verifying Member Enrollment

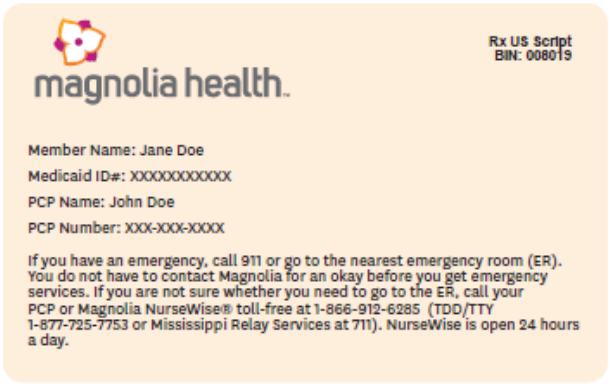
Network Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services.

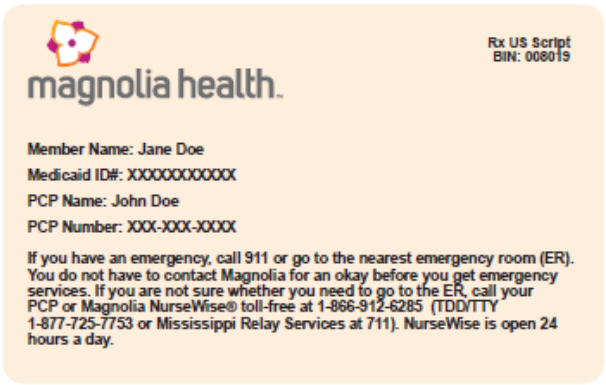
Network Providers should use either of the following options to verify member enrollment:

- Contact Cenpatico Customer Service at 866-912-6285
- Access the Cenpatico Secure Provider Portal at https://provider.cenpatico.com.

Until the actual date of enrollment with Magnolia, Cenpatico is not financially responsible for services the prospective member receives. In addition, Cenpatico is not financially responsible for services members receive after their coverage has been terminated.

Magnolia Member ID Cards





Interpretation/Translation Services
Cenpatico is committed to ensuring 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 telephonically, to assist Providers with discussing technical, medical, or treatment information with members as needed. Cenpatico requests a five-day prior notification for face-to-face services.

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

TTY: 800- 582-2233
Voice: 800- 855-1000

Key Information:
To access interpreter services for members, contact Customer Service at 866-912-6285.

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 after hours phone coverage seven (7) days per week including holidays. Please call NurseWise at 866-912-6285.

NurseWise provides after-hours assistance with the following:

- Provider referrals
- Verification of member eligibility
- Crisis Intervention
- Emergency assessment for acute care services
- After-hours emergency refills
- Documentation and notification of inpatient admissions that occur after hours
- Determining the appropriate level of care in accordance with clinical criteria, as applicable

Secure Website

Cenpatico's Secure Provider Portal services allows providers to check member eligibility, submit and check status of claims, check payment status, and send/receive messages to communicate with Cenpatico staff. Cenpatico's providers and their office staff have an opportunity to register for the secure provider portal by visiting https://provider.cenpatico.com. It's easy and secure!

Once registered, providers can:

- View and submit claims
- View and submit claims adjustments
- Check member eligibility
- Contact us securely and confidentially

The Cenpatico Secure Provider Portal is continually updated with the latest news and information. Please contact a Provider Relations Representative at 866-912-6285 to schedule a tutorial on the secure provider website.

Benefit Overview

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

- Crisis Stabilization
- Observation
- Electroconvulsive Therapy (ECT)
- Intensive Outpatient Program (IOP)
- Psychiatrist and Outpatient Services including medication management
- Title 23 Services provided by a certified community mental health center
- *Federally Qualified Health Center (FQHC) behavioral health services*
- Inpatient Hospital Services
- Psychiatric Residential treatment

For a listing of service codes and authorization requirements, please refer to the Mississippi Covered Professional Services & Authorization Guidelines located in this Manual. Network Providers should refer to their Provider Agreement with Cenpatico to identify which services they are contracted and eligible to provide.

Please note that all services performed must be medically necessary.

Outpatient Covered Professional Services & Authorization Guidelines

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

Facility Behavioral Health Services

Service Description	Billable Provider Type(s)	Billing Codes	Auth Required
ECT	Hospital	901/90870	Yes
Observation	Hospital	760, 761, 762/G0378, G0379	No

Professional Behavioral Health Services

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Psychiatric diagnostic (no medical services)	Psychiatrist(MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Master's Level Professional (LCSW, LPC, LMFT), Psychologist (PhD/ PsyD)	90791		04, 11, 12, 20, 21, 22, 23, 51, 52, 53, 55, 71, 72, 99	No
Interactive psychiatric diagnostic with medical services (E/M new patient codes may be used in lieu of 90792)	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	90792		04, 11, 12, 20, 21, 22, 23, 51, 52, 53, 55, 71, 72, 99	No
Individual psychotherapy	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Psychologist (PhD/PsyD), Master's Level Professional (LCSW, LPC, LMFT)	90832, 90834, 90837	59	04, 11, 20, 21, 22, 51, 53, 99	No

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Individual psychotherapy with medication management	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	90833, 90836, 90838		04, 11, 20, 21, 22, 51, 53, 99	No
Interactive complexity add-on code	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Psychologist (PhD/PsyD), Master's Level Professional (LCSW, LPC, LMFT)	90785		04, 11, 20, 21, 22, 51, 53, 99	No
Psychoanalysis	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Psychologist (PhD/PsyD), Master's Level Professional (LCSW, LPC, LMFT)	90845		21, 22, 51, 53, 72	No
Family psychotherapy without patient	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Psychologist (PhD/PsyD), Master's Level Professional (LCSW, LPC, LMFT)	90846	59	04, 11, 20, 21, 22, 23, 51, 52, 53, 55, 71, 72, 99	No

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Family psychotherapy with patient	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Psychologist (PhD/PsyD), Master's Level Professional (LCSW, LPC, LMFT)	90847	59	04, 11, 20, 21, 22, 23, 51, 52, 53, 55, 71, 72, 99	No
Group Psychotherapy	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS), Psychologist (PhD/PsyD), Master's Level Professional (LCSW, LPC, LMFT),	90849, 90853	59	04, 11, 20, 21, 22, 23, 51, 52, 53, 55, 71, 72, 99	No
Electroconvulsive therapy	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	90870, 90871		21, 51, 22	Yes
Psychological testing	Psychiatrist (MD/DO), Psychologist (PhD/PsyD)	96101		03, 11, 12, 21, 22, 51, 99	Yes
Developmental testing	Psychiatrist (MD/DO), Psychologist (PhD/PsyD)	96110, 96111		03, 11, 12, 22, 99	Yes
Neuropsychological testing	Psychiatrist (MD/DO), Psychologist (PhD)	96118		03, 11, 12, 21, 22, 51, 99	Yes
Office Visits Unlimited benefit Maximum of 1 unit of any 99xxx code per day. 1 unit = 1 visit	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	99201-99205, 99211-99215, 99241-99245, 99251-99255	HI	11, 22	No

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Initial Hospital Care	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	99221-99223	HI	21, 51	No
Subsequent Hospital Care	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	99231-99236	HI	21, 51	No
Hospital Discharge Management	Psychiatrist (MD/DO),	99238, 99239	HI	21, 51	No
Initial Observation Care	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	99217-99220	HI	22, 23	No
Home visits	Psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), Clinical Nurse Specialist (CNS)	99341–99350	HI	12	No

Community Mental Health Center (CMHC) Services

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Psychiatric diagnostic evaluation 1 unit per day 72 unit max per year	CMHC	90791, 90792	HW	53	No
Individual psychotherapy 1 unit per day 36 unit max per year	CMHC	90832, 90834, 90837	HW, 59	53	No

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Individual psychotherapy with medication management 1 unit per day 12 unit max per year	CMHC	90833, 90836, 90838	HW	53	No
Family psychotherapy without patient 1 unit per day 24 unit max per year	CMHC	90846	HW, 59	53	No
Family psychotherapy with patient 1 unit per day 24 unit max per year	CMHC	90847	HW, 59	53	No
Group Psychotherapy 2 units per day 40 unit max per year	CMHC	90853	HW, 59	53	No
Psychological testing 4 units per day 4 unit max per year 1 unit = 1 hour	CMHC	96101	HW	53	Yes
Assessment 1 unit per day 4 unit max per year	CMHC	H0031	HW	53	No
Treatment Plan Review 1 unit per day 4 unit max per year	CMHC	H0032	HW, HT	53	No
Mental health partial hospitalization, treatment, less than 24 hours 1 unit per day 100 unit max per year	CMHC	H0035	HW	53	Yes

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Community Support Services 6 units per day 400 unit max per year 1 unit = 15 mins	CMHC	H0036	HW	53	Yes
Peer Support 6 units per day 200 unit max per year 1 unit = 15 mins	CMHC	H0038	HW	53	No
Assertive Community Treatment (ACT) 40 units per day 1600 unit max per year 1 unit = 15 mins	CMHC	H0039	HW	53	Yes
Restorative partial hospitalization, per half day 5 units per day 1 unit = 1 hour	CMHC	H2012	HW	53	Yes
Day Support 20 units per day 1 unit = 15 mins	CMHC	H2017	HW	53	Yes
Wraparound Facilitation 16 units per day 200 unit max per year 1 unit = 15 mins	CMHC	H2021	HW	53	Yes
Psychosocial Rehab 20 units per day 1 unit = 15 mins	CMHC	H2030	HW, HB, HC	53	Yes

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Intensive Outpatient Psychiatric 1 unit per day 270 unit max per year	CMHC	S9480	HW	53	Yes
Crisis Services 32 units per day 224 unit max per year 1 unit = 15 mins	CMHC	H2011	HW	53	No
Nursing Assessment 4 units per day 144 unit max per year 1 unit = 15 mins	CMHC	T1002	HW	53	No
Case Management 2 units per day 260 unit max per year 1 unit = 15 mins	CMHC	T1017	HW, HB, HA	53	Yes
Injectable Medication 2 units per day 1 unit =per injection	CMHC	T1502	HW	53	No
Crisis Residential Limit one unit per day Must notify within 24 hours of admission 1 unit per day 60 unit max per year	CMHC	T2048	HW	53	Yes

Early Periodic Screening, Diagnostic, and Testing (EPSDT) Services

Service Description	Billable Provider Type(s)	Billing Codes	Modifiers	Auth Required
Adolescent Counseling	Clinic	99401	EP	No

Injectable Medications and Covered Drugs

Service Description	Trade Name	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Injectable Medication		T1502	HW	53	No
Injectable Medication		90471, 90472		03, 11, 12, 32, 53, 99	No
Ziprasidone Mesylate	Geodon	J3486		03, 11, 12, 32, 53, 99	No
Olanzapine Pamoate	Zyprexa (Relprevv)	J2358		03, 11, 12, 32, 53, 99	Yes
Paliperidone Palmitati	Invega Sustenna	J2426		03, 11, 12, 32, 53, 99	Yes
Risperidone	Risperdal Consta (long acting)	J2794		03, 11, 12, 32, 53, 99	Yes
Aripiprazole	Abilify	J0400		03, 11, 12, 32, 53, 99	No
Aripiprazole	Abilify Maintena	J0401		03, 11, 12, 32, 53, 99	Yes
Chlorpromazine HCL	Thorazine	J3230		03, 11, 12, 32, 53, 99	No
Fluphenazine Decanoate	Prolixin	J2680		03, 11, 12, 32, 53, 99	No
Prochlorperazine Edisylate	Compazine	J0780		03, 11, 12, 32, 53, 99	No
Haloperidol Lactate	Haldol	J1630		03, 11, 12, 32, 53, 99	No
Haloperidol Decanoate	Haldol D	J1631		03, 11, 12, 32, 53, 99	No
Lorazepam	Ativan	J2060		03, 11, 12, 32, 53, 99	No
Diazepam	Valium	J3360		03, 11, 12, 32, 53, 99	No

Inpatient Covered Professional Services & Authorization Guidelines

Please note that the listing below does not fully comprise all Cenpatico Mississippi covered services. Please refer to your Provider Agreement with Cenpatico to identify additional services you are contracted and eligible to provide. All non-par providers are required to obtain prior authorization for covered services.

Facility Behavioral Health Services

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Inpatient Admission – Mental Health	Hospital - HO	100, 114, 124, 134, 144, 154, 204		21,51,52,53, 55,56,57	Yes
Inpatient Services Chemical	Hospital - HO	116, 126, 136, 146, 156		21,51,52,53, 55,56,57	Yes
Inpatient Rehab (Substance Abuse)	Hospital – HO	118, 128, 138, 148, 158		21,51,52,53, 55,56,57	Yes
Emergency Room	Hospital – HO	450, 451, 452, 459		23	No
Observation *Limited to a 23-hour stay, then patient must either be discharged or admitted as inpatient before end of 24th hour*	Hospital – HO	760, 761, 762		22	YES
Discharge Consultation Appointment	Hospital – HO	510,513,519,		21,22,51,52,53,55,56, 57,	No
Psychiatric /Psychological Treatment: General classification	Hospital – HO	900		22, 52, 53, 57	No
ECT	Hospital – HO	901/90870		21,22,23,51, 52,55,56,57,	Yes
Mental Health IOP	Hospital – HO	905		22, 51, 52, 53, 55, 56, 57	Yes
Chemical Dependency IOP	Hospital – HO	906		22, 51, 52, 53, 55, 56, 57	Yes
Psychiatric/Psychological Treatment: IOP	Hospital – HO	907		22, 51, 52, 53, 55, 56, 57	Yes

Psychiatric/Psychological Services	Hospital – HO	914, 915, 916		22, 52, 53, 57	Yes
Residential: Mental Health Diagnosis	Hospital – HO	944		21, 22, 51, 52, 53, 55, 56, 57	No
Alcohol Rehab	Hospital – HO	945		21, 22, 51, 52, 53, 55, 56, 57	No
Residential Treatment	Hospital - HO	1001, 1002		21,51,56	Yes
Injectable Medication	Hospital – HO	90471, 90472, 96372		21, 22, 23, 51, 52, 53, 56, 57	No
Psychiatric Diagnostic Evaluation	Hospital - HO	90791, 90792		21, 22, 53, 51, 52, 53, 56, 57	No
Individual Psychotherapy	Hospital – HO	90832, 90834, 90837		22, 52, ,53, 57	No
Family Psychotherapy without Patient	Hospital – HO	90846, 90847		21, 22, 23, 51 52, 53, 56, 57	No
Family Psychotherapy	Hospital – HO	90849		21, 22, 23, 51 52, 53, 56, 57	No
Group Psychotherapy	Hospital - HO	90853		22, 52, 53, 57	No
Office Visit	Hospital - HO	99201 – 99205, 99211 – 99215		21, 22, 51, 52, 53, 55, 56, 57	No

Professional Behavioral Health Services

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Injectable Medication	MD/DO – 26 CNS - 50 ARNP/NP/MHNP - 89	90471, 90472, 96372		03, 11, 12, 32, 53, 99	No
Psychiatric diagnostic evaluation (no medical services)	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90791		03, 04, 11, 12, 14, 21, 22, 31, 32, 33, 51, 53, 55, 56, 99	No

Interactive psychiatric diagnostic with medical services (E/M new patient codes may be used in lieu of 90792)	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90792		03, 04, 11, 12, 14, 21, 22, 31, 32, 33, 51, 53, 55, 56, 99	No
Individual psychotherapy	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90832, 90834, 90837		03, 04, 11, 12, 14, 21, 22, 31, 32 33, 51, 55, 56, 99	No
Interactive complexity add-on code	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90785		03, 04, 11, 12, 14, 22, 31, 32, 33, 56, 99	No
Individual psychotherapy with medication management	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90833, 90836, 90838		03, 04, 11, 12, 14, 21, 22, 23, 31, 32, 33, 51, 52, 53, 55, 56, 71, 99	No
Psychoanalysis	M.D.- 26 Ph.D. – 62 Clinical Psy - 68 Masters - 80 NP/APNP – 89 CNS - 50	90845		03, 04, 11, 12, 14, 21, 22, 31, 32 33, 51, 55, 56, 99	No
Family psychotherapy without patient	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90846		03, 04, 11, 12, 14, 21, 22, 31, 32, 33, 51, 55, 56, 99	No
Family psychotherapy with patient	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90847		03, 04, 11, 12, 14, 21, 22, 31, 32, 33, 51, 55, 56, 99	No
Family Psychotherapy	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90849		03, 04, 11, 12, 14, 21, 22, 31, 32, 33, 51, 55, 56, 99	No

Group Psychotherapy	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	90853	HA	03, 04, 11, 12, 14, 22, 31, 32, 33, 56, 99	No
Electroconvulsive therapy	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	90870, 90871		21, 22, 23, 51, 52, 53, 55, 56, 57	Yes
Medication Management	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80	M0064		03, 04, 11, 12, 14, 21, 22, 23, 31, 32, 33, 51, 52, 53, 55, 56, 71, 99	No
Psychological testing	MD/DO – 26 PhD/ PsyD – 62	96101		03, 04, 11, 12, 14, 22, 33, 53,56, 99	Yes
Developmental testing	MD/DO – 26 PhD/ PsyD – 62	96110, 96111		03, 04, 12, 14, 22 33, 53, 56, 99	Yes
Neuropsychological testing	MD/DO – 26 PhD/ PsyD – 62	96118		03, 04, 12, 14, 22 33, 53, 56, 99	Yes
Office Visits *Unlimited benefit* *Maximum of 1 unit of any 99xxx code per day. 1 unit = 1 visit*	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50 Masters – 80 PhD/ PsyD – 62 Clinical Psy - 68	99201 - 99205, 99211 - 99215	HI	03, 04, 11, 12, 14, 21, 22, 23, 31, 32, 33, 51, 52, 53, 55, 56, 71, 99	No
Initial Hospital Care	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	99221-99223	HI	21, 51, 55, 56	No
Subsequent Hospital Care	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	99231-99236	HI	21, 51, 55, 56	No
Hospital Discharge Management	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	99238, 99239	HI	21, 51, 55, 56	No
Initial Observation Care	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	99217 - 99220	HI	22, 23	No
Consultation	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	99241 - 99245		04, 11, 12, 15, 22, 23, 33	No
Inpatient Consult	MD/DO – 26	99251 - 99255		21, 51	No
ER Visits	MD/DO – 26 ARNP/NP/MHNP - 89 CNS - 50	99281 - 99285		23	No

Home visits	MD/DO – 26 ARNP/NP/MHNP - 89 CNS – 50 Masters – 80	99341 – 99350	HI	12	No

FQHC/RHC Services

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Evaluation and Management 1 per day 12 per year	FQHC-FQ RHC-RH	99201-99205 99212-99215		50, 72	No
Evaluation and Management 1 per day	FQHC-FQ RHC-RH	99211		50, 72	No
All other CPT/HCPS codes Payment included in encounter rate	FQHC-FQ FHC-RH			FQHC-FQ FHC-RH	No

Community Mental Health Center (CMHC) Services

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Psychiatric diagnostic evaluation (no medical services) 1 unit per day 72 unit max per year Combined , 90791,90792 and M0064	CMHC-70	90791 90792	HW	03,23,31, 32,53,99	No

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Medical Management 1 unit per day 72 unit max per year Combined , 90791,90792 and M0064	CMHC-70	M0064	HW	12,31,32, 53,99	No
Interactive complexity 1 per day	CMHC-70	90785	HW	03, 12, 31, 32, 53, 99	No
Individual Psychotherapy 1 unit per day 36 unit max per year	CMHC-70	90832, 90834, 90837	HW	03,12,31, 32,53,99	No
Individual psychotherapy with medication Management 1 unit per day 12 unit max per year	CMHC-70	90833, 90836, 90838	HW	03, 12, 31, 32, 53, 99	No
Family psychotherapy without patient 1 unit per day 24 unit	CMHC-70	90846	HW	03, 12, 31, 32, 53, 99	No
Family psychotherapy with patient 1 unit per day 24 unit max per year	CMHC-70	90847	HW	03, 12, 31, 32, 53, 99	No
Multi-Family Group Therapy 1 per day 40 per year	CMHC-70	90849	HW	31, 32, 55, 99	No

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Group Psychotherapy 1 units per day 40 unit max per year	CMHC-70	90853	HW	03,31,32, 53,99	No
Psychological testing 4 units per day 4 unit max per year	CMHC-70	96101	HW	03, 11, 12, 53, 99	Yes
Medical Administration 1 per day	CMHC-70	90471, 90472, 96372	HW	03, 11, 12, 32, 53, 99	No
Evaluation and Management 1 per day	CMHC-70	99201-99205 99211-99215	HW	03, 11, 12, 22, 32, 53, 99	No
Prolonged Service (60 minutes) 1 per day	CMHC-70	99354	HW	03,12,31, 32,53,99	No
Prolonged Service (30 minute add on)	CMHC-70	99355	HW	03,12,31, 32,53,99	No
Assessment 1 unit per day 4 unit max per year	CMHC-70	H0031	HW	03,12,31, 32,53,99	No
Treatment Plan Review 1 unit per day 4 unit max per year	CMHC-70	H0032	HW, HT	03,12,31, 32,53,99	No
Mental health partial hospitalization, treatment, less than 24 hours 1 unit per day 100 unit max per	CMHC-70	H0035	HW	22,53,99	Yes
Community Support Services 6 units per day 400 unit max per year	CMHC-70	H0036	HW	03,12,53, 99	Yes

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Peer Support 6 units per day 200 unit max per year 1 unit = 15 mins	CMHC-70	H0038	HW	03,12,53, 99	No
Assertive Community Treatment (ACT) 40 units per day 1600 unit max per year	CMHC-70	H0039	HW	11,12,14,53,99	Yes
Crisis Services 32 units per day 224 unit max per year 1 unit = 15 mins	CMHC-70	H2011	HW, HE	03,12,15, 23,33,53, 99	No
Crisis Services 32 units per day 224 unit max per year 1 unit = 15 mins	CMHC-70	H2011	HW, TF	03,12,15, 23,33,53, 99	No
Restorative partial hospitalizatio n, per half day 5 units per day	CMHC-70	H2012	HW	03, 53	Yes
Wraparound Facilitation 16 units per day 200 unit max per year 1 unit = 15 mins	CMHC-70	H2021	HW	03,12,53, 99	Yes
Psychosocial Rehab 20 units per day 1 unit = 15 mins	CMHC-70	H2030	HW,HC	31,32,53, 99	Yes

Service Description	Billable Provider Type(s)	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Psychosocial Rehab 20 units per day 1 unit = 15 mins	CMHC-70	H2030	HW, HB,	31,32,53, 99	Yes
Intensive Outpatient Psychiatric 1 unit per day 270 unit max per year	CMHC-70	S9480	HW,U1	03,11,12, 14,53,99	Yes
Nursing Assessment 4 units per day 144 unit max per year	CMHC-70	T1002	HW	03,12,31, 32,53,99	No
Case Management 2 units per day 260 unit max per year 1 unit = 15 mins	CMHC-70	T1017	HW, HA	12,53,99	No
Case Management 2 units per day 260 unit max per year	CMHC-70	T1017	HW,HB	03,12,53, 99	No
Injectable medication 2 units per day 1 unit = per injection	CMHC-70	T1502	HW	12,31,32, 53,99	No
Crisis Residential Must notify within 24 hours of admission 1 unit per day 60 unit max per year	CMHC-70	T2048	HW	53,99	Yes

Benefit limits defined by MS DOM CMHC billing guidelines
http://www.medicaid.ms.gov/Documents/2013CMHCBillingGuidelines.pdf

Injectable Medications and Covered Drugs

Service Description	Trade Name	Billing Codes	Allowed Modifiers	Allowed Locations	Auth Required
Injectable Medication		T1502	HW	12,31,32,53,99	No
Injectable Medication		90471, 90472		03, 11, 12, 32, 53, 99	No
Ziprasidone Mesylate	Geodon	J3486		03, 11, 12, 32, 53, 99	No
Olanzapine Pamoate	Zyprexa (Relprevv)	J2358		03, 11, 12, 32, 53, 99	Yes
Paliperidone Palmitati	Invega Sustenna	J2426		03, 11, 12, 32, 53, 99	Yes
Risperidone	Risperdal Consta (long acting)	J2794		03, 11, 12, 32, 53, 99	Yes
Aripiprazole	Abilify	J0400		03, 11, 12, 32, 53, 99	No
Aripiprazole	Abilify Maintena	J0401		03,04,11,12,14,21,22,23,31,32,33,51,52,53,55,56,71,99	Yes
Chlorpromazine HCL	Thorazine	J3230		03, 11, 12, 32, 53, 99	No
Fluphenazine Decanoate	Prolixin	J2680		03, 11, 12, 32, 53, 99	No
Prochlorperazine Edisylate	Compazine	J0780		03, 11, 12, 32, 53, 99	No
Haloperidol Lactate	Haldol	J1630		03, 11, 12, 32, 53, 99	No
Haloperidol Decanoate	Haldol D	J1631		03, 11, 12, 32, 53, 99	No
Lorazepam	Ativan	J2060		03, 11, 12, 32, 53, 99	No
Diazepam	Valium	J3360		03, 11, 12, 32, 53, 99	No

Utilization Management

The Utilization Management Program

The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. CST. Additionally, clinical staff is available after hours, if needed to discuss urgent UM issues. UM staff can be reached via our toll-free number at 866-912-6285. 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 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;
- Utilization Management policies and procedures are systematically and consistently applied; and
- Focus for members and their families 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. Medical Necessity Criteria are used for the review and approval of treatment. Plans of care that do not meet Medical Necessity guidelines are referred to a Mississippi licensed physician advisor for review.

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

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

Member Eligibility

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

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

- Contact Cenpatico Customer Service at 866-912-6285
- Access the Provider web portal at www.cenpatico.com

Outpatient Notification Process

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

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

When requesting additional sessions for those outpatient services that require authorization, the Network Practitioner must complete an Outpatient Treatment Request (OTR) form and fax the completed form to Cenpatico at 866-694-3649 for clinical review. The OTR is located on our website at www.cenpatico.com. Network Practitioners may call the Customer Service department at 866-912-6285 to check status of an OTR. Network Practitioners should allow up to two (2) business days to process non-urgent requests. Cenpatico has the ability to extend the response time if additional information is required in order to make a determination.

IMPORTANT:

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

Guidelines for Psychological Testing

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

It is important to note that;

- Testing will not be authorized by Cenpatico for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment (90791 and 90792) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with Cenpatico.
- Practitioners should submit a request for Psychological Testing that includes the specific tests to be performed. Cenpatico's Psychological Testing Authorization Request form is located on our website at www.cenpatico.com.

Medical Necessity

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

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.

InterQual Criteria, used by over 3000 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.
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

Cenpatico utilizes the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for substance use disorder Medical Necessity Criteria. ASAM 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.

Additionally, Cenpatico has adopted the Mississippi Administrative Code service descriptions and medical necessity guidelines for all community based services. InterQual, ASAM, and our Community Based Services criteria are reviewed on an annual basis by the Cenpatico Provider Advisory Committee that is comprised of Network Providers as well as Cenpatico clinical staff.

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

Concurrent Review

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

Continuity of Care

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

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

Notice of Action (Adverse Determination)

When Cenpatico determines that a specific service does not meet criteria and will therefore not be authorized, Cenpatico will submit a written notice of action (or denial) notification to the treating Network Practitioner providers, whether par or non-par, 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 continue 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 Mississippi licensed physicians or PhDs will 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 mental health service outpatient continued stay requests, the Peer Reviewer will review the information submitted on the Outpatient Treatment Request (OTR) form in order to make a determination. A Peer Reviewer may outreach telephonically to a provider in order to obtain additional information. Providers should contact Cenpatico at 866-912-6285 to discuss UM denial decisions.

The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare practitioner provides good cause in writing. As a result of the Peer Clinical Review process, Cenpatico makes a decision to approve or deny authorization for services.

Clinical Practice Guidelines

Cenpatico has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted include but are not limited to: Treatment of Bipolar Disorder, Treatment of Major Depressive Disorder, Treatment of Schizophrenia, 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 866-912-6285.

Copies of our evidence based practices can be obtained in the same manner. Compliance with Clinical Practice Guidelines is assessed annually as part of the quality process.

Advance Directives

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

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

Cenpatico recommends:

- The first point of contact in the Network Provider office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.
  If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the Network Provider's office and document this request.

- An Advance Directive should be included as a part of the member's medical record, including mental health directives.
- If a Behavioral Health Advance Directive exists, the Network Provider should discuss potential emergencies with the member and/ or family members (if named in the Advance Directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives.
- If the member requests further information, member Advance Directive education/information should be provided.
- Cenpatico's Quality Improvement Department will monitor compliance with this provision during site visits and visits scheduled thereafter.

Case Management Program

The case management department provides a unique function at Cenpatico. The essential function of the department is to conduct outreach to high-risk members and to help overcome barriers to obtaining behavioral services or compliance with treatment. Cenpatico's case management team is an integrated team of licensed mental health professionals, social workers and non-clinical staff.

Cenpatico's Case Management initiatives include:

- Outreach to Inpatient hospitals and serve as a resource to inpatient discharge planners needing services for members. Assist discharge planners in coordinating outpatient follow up for members discharging from hospitals to ensure members are compliant with treatment.
- Coordinate with Magnolia Health Plan, member advocates or Network Providers for members who may need behavioral health services
- Assist members with locating a Network Provider
- Coordinate requests for out-of-network providers by determining need/access issues involved
- Facilitate requests for inpatient psychiatric consults for members in a medical bed

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

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

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

We look forward to hearing from you about any members you think can benefit from outreach by a Cenpatico case management team member.

To contact a case management staff, please call the Magnolia Health Case Management Department at 866-912-6285.

Disease Management

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

All members enrolled in a disease management program are stratified based on acuity to determine the appropriate level of intervention.

- Low Risk (Population Based) – All members of target population
- Moderate Risk (Case Management)– member with identified diagnosis and defined predictive modeling criteria
- High (Care Management) – Members with eligible diagnosis and inpatient behavioral health admission within past 6 months

Cenpatico Care Managers are licensed behavioral health professionals with at least 3 years of experience in the mental health field. In Indiana, all members discharged from an inpatient psychiatric or substance abuse hospital will be admitted and followed by care management for no fewer than 180 days.

Claims

Cenpatico Claims Department Responsibilities

Cenpatico's claims processing responsibilities are as follows:

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

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through Magnolia) on the date of service;
- The service provided is a covered service (benefit of Magnolia) on the date of service; and
- Cenpatico's prior-authorization processes were followed.

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

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

Cenpatico does NOT accept black or copied forms. Providers need to use only original forms that meet CMS requirements. The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS-1500 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. Cenpatico strongly discourages the use of handwritten forms.

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 or electronic equivalents) 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. Clean Claims do not include claims submitted by or on behalf of a Provider who is under investigation for fraud or abuse, or a claim that is under review for medical necessity.

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

Explanation of Payment (EOP)

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

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

Network Provider Billing Responsibilities

Please submit claims immediately after providing services. Claims must be received within ninety (180) days of the date the service(s) are rendered. Claims submitted after this period will be denied payment for untimely filing. Providers have ninety (90) days from explanation of billing date to file and adjusted or corrected claims. Please see *Claims Reconsideration* section for instructions.

Claim Submission Options

Cenpatico's providers are strongly encouraged to utilize our available electronic means for claim submission. Electronic claim submission results in improved processing accuracy as well as quicker claim adjudication and payment.

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

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

- Provider Directory
- Preferred Drug List
- Frequently Used Forms
- EDI Companion Guides
- Billing Manual
- 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 Professional and Institutional claims
- View and check claim status

- View and download payment history
- View and print member eligibility
- Contact us securely and confidentially

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

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

Trading Partner	Payer ID	Contact Number
Emdeon	68068	800-845-6592

Paper Claim Submission
Please submit Clean Claims 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. **However, if you are billing under a facility, please use the facilities' NPI NOT the rendering provider.**

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

Cenpatico
Attn: Claims
PO Box 7600
Farmington, MO 63640-3834

Imaging Requirements for Paper Claims

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

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

Do Not:
- Use red ink on claim forms
- Circle any data on claim forms
- Add extraneous information to any claim form field
- Use highlighter on any claim form field
- Submit carbon copied claim forms
- Submit claim forms via fax

Common Claim Processing Issues

It is the Network Provider's responsibility to obtain complete information from Cenpatico and the member and then to carefully review the CMS-1500, 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
- Hand written claims are often illegible and require manual intervention, thereby increasing the risk of error and time delay in processing claims.

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

Electronic Funds Transfer and Electronic Remittance

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

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

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

Cenpatico Billing Policies

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

Please Note:

- A Network Provider's failure to authorize the service(s) does not qualify/ allow the Network Provider to bill the member for service(s).
- 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 Provider may bill the member only if he/ she has obtained written acknowledgement from the member, prior to rendering such non-covered service, that the specific service is not a covered benefit under Magnolia or Cenpatico, and that the member understands they are responsible for reimbursing the 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 Magnolia or benefits were exhausted), a denial of payment will occur and the reason for denial will be indicated on the Explanation of Payment (EOP) accompanying the denial.

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

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

Claim Status
Please do not submit duplicate bills for authorized services. If your Clean Claim has not been adjudicated within thirty (30) days, please call Cenpatico's Claims Customer Service department at 866-324-3632 to determine status of the claim. Or, check Cenpatico's secured website for claim details.

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

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

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

Network Providers must submit their Retroactive Authorization request to:

Cenpatico
Attn: Appeals Department
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 Authorizations will result in termination from the Cenpatico provider network due to inability to follow policies and procedures.

If the authorization contains unused visits, but the end date has expired, please call the Cenpatico Customer Service department at 866-912-6285 and ask the representative to extend the end date on your authorization.

Claim Reconsideration

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

1. Call the Cenpatico Claims Support Liaisons at 866-324-3632. The majority of issues regarding claims can be resolved through the Claims Department with the assistance of our Claims Support Liaisons.

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

   Cenpatico
   Claims Resubmission
   P.O. Box 7600
   Farmington, MO 63640-3834

   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 the denial letter is the appropriate means of resolution. If a claim was denied due to no authorization on file, please send a request in writing for a retro-active authorization, explaining in detail the reason for providing services without an authorization. Mail requests to the following address:

   Cenpatico
   Appeals Department
   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 the Network Provider is dissatisfied with Cenpatico's response, an appeal of this decision may be filed by writing to the address listed below. Note: Appeals must be filed in writing. Place APPEAL within the request. In order for Cenpatico to consider the appeal it must be received within forty-five (45) days of the date on the EOP which contains the denial of payment that is being appealed, unless otherwise stated in the Network Provider's contract. Should the response to the appeal remain unsatisfactory, Network Providers may appeal within forty-five (45) days of Cenpatico's final decision.

   Cenpatico Appeals
   PO Box 6000
   Farmington, MO 63640-3809

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

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

   Cenpatico
   Attention: Mississippi Provider Relations
   111 East Capitol Street, Suite 500
   Jackson, MS 39201
   Phone: 866-912-6285

National Provider Identifier (NPI)

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

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

- **To Register Online:**
  To register for an NPI using the web-based process, please visit the following website;

  https://nppes.cms.hhs.gov/NPPES/

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

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

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

Claim Form Requirements:

Cenpatico accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) claim forms.

Federal and States Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance use disorder treatment and communicable disease records.

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

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance use disorder treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

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

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

Contracted providers within the Cenpatico network are independently obligated to know, understand and comply with these laws.

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

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

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

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

Magnolia Health
111 East Capitol Street, Suite 500
Jackson, MS 39201