

# Path to Health Pilot Program by CMSP

## Provider Operations Manual

(Pilot Program Period February 1, 2019 – December 31, 2023)



# Provider Operations Manual - Table of Contents

---

## Section 1.0 – Introduction

- 1.1 Welcome
- 1.2 Background
- 1.3 Mission
- 1.4 Important Contact Information
- 1.5 Service Area
- 1.6 Claim Submission
- 1.7 Information Pertaining to FQHC

## Section 2.0 – Administrative Procedures

- 2.1 Provider Operations Manual
- 2.2 Secure Email
- 2.3 Privacy and Security
- 2.4 Fraud and Abuse
- 2.5 Misrouted Proprietary and Protected Health Information (PHI)
- 2.6 Member Eligibility
- 2.7 Eligibility Verification and ID Cards Overview
- 2.8 Path to Health Member ID card
- 2.9 Path to Health and Medi-Cal Coverage
- 2.10 Share of Cost

## Section 3.0 – Covered and Non-Covered Benefits

- 3.1 Path to Health Covered Benefits
- 3.2 Emergency Services
- 3.3 Outpatient Psychiatry
- 3.4 Pharmacy
- 3.5 Pregnancy
- 3.6 Breast or Cervical Cancer

## Section 4.0 – Access Standards

## Section 5.0 – Roles and Responsibilities of All Providers

- 5.1 Roles and Responsibilities of All Providers
- 5.2 Oversight of Non-physician Providers
- 5.3 Members’ Rights and Declaration
- 5.4 Confidentiality
- 5.5 Medical Records
- 5.6 Providing Access to Medical Records and Information
- 5.7 Language and Interpreter Services
- 5.8 Telephone Interpreter Services

## **Section 6.0 – Claims and Billing**

- 6.1 Fee Schedule**
- 6.2 Timely Filing of Claims**
- 6.3 Electronic Data Interchange**
- 6.4 Paper Claims**
- 6.5 Clinical Record Submissions Categories**
- 6.6 Claims Coding**
- 6.7 Coding Guidelines**
- 6.8 Checking Claim Status**
- 6.9 Request for Additional Information**
- 6.10 Claims Appeals Process**
- 6.11 Claims Overpayment Recovery Procedure**

## **Section 7.0 – Provider Grievance and Appeals**

- 7.1 Provider Grievance Process**
- 7.2 Provider Appeals of Non-Medical Necessity Claims Determinations**

## **Section 8.0 – Member Grievance and Appeals**

- 8.1 Member Grievances or Complaints**
- 8.2 Member Appeals**
- 8.3 Standard Appeals**
- 8.4 Response to Standard Appeal**
- 8.5 Expedited Appeals**
- 8.6 Response to Expedited Appeals**

## **Section 9.0 – CMSP Governing Board Appeals**

### **Appendix 1**

**CMS-1500 Claim Form Specifications**

### **Appendix 2**

**UB-04 Claim Form Specifications**

### **Appendix 3**

**Path to Health Approved Procedure Code List**

---

**For additional information regarding the Path to Health Program, please visit:**

<https://pathtohealth.amm.cc/> and <https://mypathtohealth.org/>

## Section 1.0 – Introduction

### **1.1 Welcome to the Path to Health Pilot Program by CMSP**

As the third-party administrator for the CMSP Governing Board, Advanced Medical Management, Inc. (AMM) would like to thank all providers for partnering with us in the communities we serve.

AMM knows providers are essential in delivering high-quality, cost-effective medical services to low income Californians. We are dedicated to earning your ongoing support and we look forward to working with you to provide the best service possible to Path to Health members.

This manual is a guide for CMSP contracted providers rendering services to Path to Health members. For information regarding the CMSP benefit program, please refer to the *CMSP Provider Operations Manual* available at <https://cmsp.amm.cc/providers/>.

### **1.2 Background**

The Path to Health Pilot Project expands access to primary care services to undocumented adults residing in one of CMSP's 35 counties. Contracting community health centers are responsible for enrolling patients into the Path to Health Pilot Program.

The pilot project will terminate on January 31, 2025 (unless extended by the CMSP Governing Board).

### **1.3 Mission**

The mission of the Path to Health Pilot Project is to promote timely delivery and preventative medical services to eligible residents of CMSP's 35 counties in order to improve their health outcomes, reduce their utilization of emergency services and inpatient hospitalization, and enable select community health centers to enroll new members.

### **1.4 Important Contact Information**

Advanced Medical Management, Inc. (AMM) - (877) 283-PATH (7284)

Types of Inquiries: Customer Service, Medical, Provider Network, Provider Contracting, Claims, Grievances and Appeals.

MedImpact Healthcare Systems, Inc. - (800) 788-2949

Types of Inquiries: Pharmacy, Finding a Pharmacy, and Pharmacy Appeals.

**Additional contact information can be found on our website at:**

<https://pathtohealth.amm.cc/Contact>

### **1.5 Service Area**

The service areas for Path to Health are CMSP's 35 counties. The income range to qualify for the benefit is 0-138% FPL. Applications can be submitted through participating community health centers using the Path to Health online eligibility enrollment system.

Advanced Medical Management, Inc. administers health care services on a self-funded basis for Path to Health members. Members will receive covered services from providers within the CMSP network. For a list of Path to Health enrollment clinics, please visit: <https://mypathtohealth.org/provider-locator/>

### **1.6 Claim Submission**

New and corrected paper claims are to be submitted to the following contracted clearinghouses or mailed to this address:

Path to Health - Advanced Medical Management, Inc.  
 Attn: Claims Department  
 5000 Airport Plaza Drive, Suite 150  
 Long Beach, CA 90815-1260

***Electronic claim submissions are preferred.***

***Below are the payer IDs for approved clearinghouses:***

Clearinghouse	Payer ID	Support Phone #	Website
Office Ally	AMM15	(360) 975-7000 Opt. 1	<a href="https://cms.officeally.com/">https://cms.officeally.com/</a>
Emdeon/Capario	CMSP1	(888) 363-3361	<a href="https://cda.changehealthcare.com/Portal/">https://cda.changehealthcare.com/Portal/</a>
Claimremedi	CMSP	(800) 763-8484	<a href="https://claimremedi.providersportal.com">https://claimremedi.providersportal.com</a>
Cognizant/Trizetto	<i>Institutional Claims: UMM15 Professional Claims: AMM15</i>	(800) 556-2231	<a href="http://www.trizetto.com">http://www.trizetto.com</a>

**For a complete list of AMM/CMSP clearinghouses please visit:**  
<https://pathtohealth.amm.cc/Providers>

Please refer to Section 6.0 for additional claims filing instructions.

### **1.7 Information Pertaining to FQHC**

Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribal Health Clinics (THC) are referred cumulatively as FQHCs in this Manual.

Providers can find details pertaining to FQHCs throughout Section 6.0 *Claims and Billing*, but here are a few items FQHCs should keep in mind:

- CMSP Governing Board has a contract amendment with all FQHCs serving as enrollment providers in the Path to Health program.
- All FQHC claims must be completed on a UB-04 claim form.
- Claims must identify all services rendered with the appropriate CPT, HCPCS and Revenue Codes. Claims submitted with incorrect or obsolete codes will be rejected.

- Patients must be seen by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Marriage and Family Therapist (MFT), Certified Drug and Alcohol Counselor, or psychologist in order for FQHC claims to be considered for reimbursement. Patients may also be seen by the following assistant and associate-level providers under the direct supervision of a licensed mental health professional:
  - Associate MFT
  - Associate Professional Clinical Counselor
  - Associate Clinical Social Worker
  - Psychology Assistant
- Billed codes must be on the *Path to Health Approved Procedure Code List* to be eligible for payment. For the most updated version of the *Path to Health Approved Procedure Code List*, visit: <https://pathtohealth.amm.cc/Providers>

## Section 2.0 – Administrative Procedures

### **2.1 Provider Operations Manual**

The *Path to Health Provider Operations Manual* explains the policies and administrative procedures of the Path to Health program. You may use it as a guide to answer questions about member benefits, claim submissions, and many other issues. This Manual also outlines day-to-day operational details for you and your staff. It will describe and clarify the requirements identified in the Provider Agreement and amendment you hold with the CMSP Governing Board. Any updates, revisions and amendments to this Manual will be provided on a periodic basis on AMM’s Path to Health website. It is important that you and/or your office staff read the communications from AMM regarding Path to Health and retain them with this *Provider Operations Manual* so you can integrate the changes into your practice.

### **2.2 Secure Email**

AMM uses a secure email encryption system (website) to ensure all proprietary information and protected health information (PHI) is kept private and secure. When an external recipient receives the first encrypted email from AMM the following steps must be taken with the email received in order to access the encrypted email:

- Upon receiving the e-mail notification, follow the directions to open the message using the “Secure Messaging Service” link.
- Create and register a password for your email address
- Click to open the secure email message OR
- You may need to verify your email address from an activation link in a new email from the secure email system (not all recipients are required to do this).
- Log in to open the secure email message
- After registering, the external recipient can access their encrypted email by entering their registered password.

The secure system provides additional features that include, password resetting, and replying to or creating messages. If you need technical assistance or have questions about Secure email, contact Customer Service at (877) 283-PATH (7284).

### ***2.3 Privacy and Security***

All AMM websites or affiliated vendors are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its federal regulatory guidelines. For more information, visit <https://cmsp.amm.cc>.

### ***2.4 Fraud and Abuse***

AMM is committed to protecting the integrity of the clients and members we serve and the efficiency of our operations by preventing, detecting and investigating fraud and abuse. For more information, visit <https://cmsp.amm.cc>.

### ***2.5 Misrouted Proprietary and Protected Health Information (PHI)***

AMM's proprietary or Protected Health Information (PHI) can be inadvertently routed to Providers and facilities by mail, fax, e-mail, or electronic remittance advice. Providers and facilities are required to immediately destroy any proprietary and misrouted PHI and notify AMM of the disclosure by contacting Customer Service at (877) 283-PATH (7284).

### ***2.6 Member Eligibility***

Path to Health participants are undocumented adults without full scope Medi-Cal coverage, live in one of CMSP's 35 counties, and have an income range of 0 to 138% FPL. To complete the Path to Health enrollment process, community health centers are responsible for registering the patient's information through the secure registration/enrollment online portal maintained by the CMSP Governing Board as well as consent from the patient to participate in the Pilot Program. For additional information on Path to Health eligibility, refer to the *Path to Health Eligibility Manual* available at <https://mypathtohealth.org/> or contact the Path to Health Enrollment Help Desk at (800) 548-5880 or at [eligibility@cmspcounties.org](mailto:eligibility@cmspcounties.org).

### ***2.7 Eligibility Verification and ID Cards Overview***

Following enrollment in the Path to Health program, the member will receive a Path to Health Identification (ID) Card from AMM. The Path to Health ID Card is for the member's Path to Health Benefit coverage. The member's Path to Health ID Card is enclosed with the Member Guide. The member should receive their Path to Health ID Card within 10 days of enrollment.

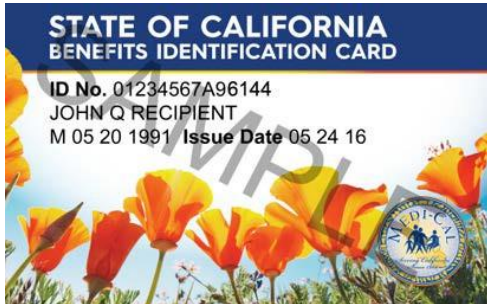
Members enrolled in emergency-only Medi-Cal should keep their State of California Benefits Identification Card (BIC). This card is sent to the member from the State of California. The BIC will be used for any emergency services.

At each visit, before rendering services, the provider must ask for both of these cards (if applicable) to verify program and plan eligibility.

The provider can verify eligibility by:

- Checking the Path to Health enrollment portal online.
- Verifying the eligibility effective dates on the member's Path to Health ID Card.
- Contacting AMM at (877) 283-PATH (7284)

### Beneficiary Identification Card (BIC)



**New Version**



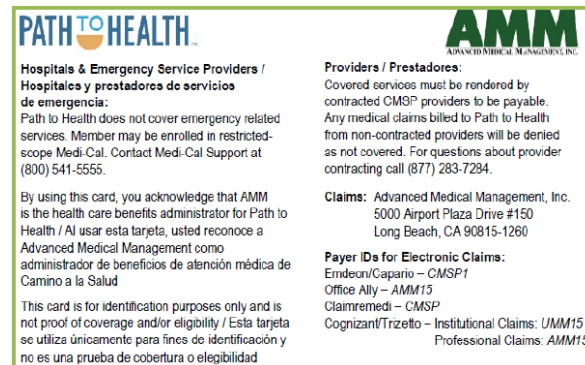
**Old Version**

Please note, both versions are valid.

### 2.8 Path to Health Benefit Member ID Card



(ID card front)



(ID card back)

This card, provided by AMM, contains information on the front and back including the member's name, ID number, and customer service numbers for:

- AMM Customer Service Department
- MedImpact Healthcare Systems, Inc. (Pharmacy)

To prevent fraud and abuse, providers should confirm that the person presenting the Path to Health ID card is the member to whom the ID card was issued. Claims submitted for services rendered to non-eligible members are not eligible for payment. Members are instructed, through their *Path to Health Member Guide*, to notify providers of their coverage at each visit or as soon as possible.

### 2.9 Path to Health and Medi-Cal Coverage

Path to Health members are either eligible for or are currently enrolled in 1 of 30 restricted-scope/emergency only Medi-Cal Aid Codes:

- 1U, 3T, 55, 58, 5F, 5T, C1, C2, C3, C4, C5, C6, C7, C8, D2, D3, D4, D5, D6, D7, J3, J4, J6, J8, K3, K5, K7, K9, M2, or M4



Any emergency services rendered to a Path to Health member will not be payable by the Path to Health Program. Members interested in applying for health care coverage for emergency services should contact their county's social services department to initiate an application for Medi-Cal. See Section 3.4 for more information regarding Emergency Services.

Please note, that when verifying the member's Medi-Cal eligibility on the Medi-Cal website, there will be no reference to the member's enrollment in the Path to Health Program.

### **2.10 Share of Cost**

Path to Health Members are not responsible for a monthly Share of Cost (SOC) under the Path to Health Program. However, the member may be responsible for meeting a SOC for Medi-Cal (if enrolled) in order for the provider to receive payment from Medi-Cal for emergency services.

## **Section 3.0 – Covered Benefits and Non-Covered Benefits**

The Path to Health Pilot Program offers outpatient benefits and services to its members including medical and pharmacy benefits. This section provides a general overview of benefits, as well as benefit limitations and exclusions.

Before providing services to Path to Health members, providers must verify eligibility, and determine if any other restrictions or limitations apply. Covered benefits and services are subject to utilization limits.

### **3.1 Path to Health Covered Benefits**

Path to Health will not pay for services rendered by providers not contracted by CMSP or for pharmacies not participating in the Path to Health Program. Path to Health benefits generally include the following services rendered by CMSP contracted providers:

- Outpatient visits with a primary care provider or specialist
  - **Note:** Physical Therapy services limited to twenty-four (24) visits per benefit period. Physical Therapy services in excess of twenty-four (24) visits within a member's benefit period will not be payable by Path to Health.
- In-Office minor medical procedures
- Preventative screenings, routine lab tests, and adult immunizations
- Specified radiology services
- Screening for HIV, HPV, Hepatitis B/C, and STI screening
- Screening for depression, alcohol misuse, and obesity counseling
- Outpatient Mental Health Services (mild to moderate)
  - **Note:** Limited to six (6) visits per enrollment period for any combination of covered individual, family, and/or group treatment or evaluations

- Outpatient Substance Abuse Disorder Services
  - **Note:** Limited to six (6) visits per enrollment period for any combination of covered individual and/or group treatment or screenings
- Tobacco use counseling and intervention (performed by physician)
- Prescription medications (specialty medications excluded) with \$5 copay and \$1500 limit per benefit period and \$500 limit per claim.

**For a complete list of covered benefits and procedure codes, please visit:**

<https://pathtohealth.amm.cc/providers>

### **3.2 Pharmacy**

Pharmacy benefits are administered for Path to Health members by MedImpact Healthcare Systems, Inc. (MedImpact) a pharmacy benefits manager (PBM).

Members must have prescriptions filled by participating local retail pharmacies (visit <https://mypathtohealth.org/> for a list of participating pharmacies). The pharmacy benefit emphasizes the use of generic medications, where available and appropriate, utilization controls for select medications based upon clinical efficacy, medical necessity and cost.

Covered medications are available at a \$5 copayment per prescription. Prescription coverage is limited to a maximum of \$500 per claim and a \$1500 maximum benefit per Path to Health enrollment period.

For additional information on the *Path to Health Drug Formulary* and Medication Request forms, visit <https://mypathtohealth.org/>. Providers or members with questions involving the Path to Health Prescription Drug Program or with specific questions about pharmacy benefit coverage should contact MedImpact's Customer Service Line at (800) 788-2949. This service line is available 24 hours a day, 7 days a week.

### **3.3 Services Not Covered by Path to Health**

Path to Health will not pay for services rendered by providers not contracted by CMSP, services not listed on the *Path to Health Approved Procedure Code List* (see Appendix 3), medications not listed on the *Path to Health Drug Formulary*, or for pharmacies not participating in the Path to Health Program.

Additionally, services rendered at FQHC's must be rendered by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Marriage and Family Therapist (MFT), Certified Drug and Alcohol Counselor, or psychologist in order for FQHC claims to be considered for reimbursement. Patients may also be seen by the following assistant and associate-level providers under the direct supervision of a licensed mental health professional:

- Associate MFT
- Associate Professional Clinical Counselor

- Associate Clinical Social Worker
- Psychology Assistant

Specific services that are **NOT** covered by Path to Health include:

- Acupuncture, including podiatry-related acupuncture services
- Breast and cervical cancer treatment services when covered by other another benefit (Breast and Cervical Cancer Treatment Program/Medi-Cal)
- Chiropractic care
- Cosmetic procedures
- Dental services
- Family planning services (including contraceptive-related visits and abortion services) when covered by another benefit (F-PACT)
- Hospital inpatient and emergency room services
- Methadone maintenance services
- Optometry services and eye appliances
- Pregnancy-related and infertility services
- Public transportation, such as airplane, bus, car, or taxi rides

### ***3.4 Emergency Services***

Some Path to Health members are covered under restricted-scope Medi-Cal for emergency services. Any emergency services rendered to a Path to Health member will not be payable by the Path to Health Program. Providers are responsible for submitting claims to Medi-Cal in order to receive payment for emergency services. Please refer to the *DHCS Medi-Cal Manual* for instructions regarding billing for emergency services.

For more information on qualifying for emergency services coverage, please have the member contact their local social services office.

### ***3.5 Pregnancy and Postpartum Services***

Any services rendered to a Path to Health member that is pregnant or within the postpartum period covered by Medi-Cal will not be payable by the Path to Health Program. Clinics are responsible for submitting claims to Medi-Cal in order to receive payment for pregnancy and postpartum services.

Please refer to the *DHCS Medi-Cal Manual* for instructions regarding billing for pregnancy and postpartum services.

Path to Health members seeking pregnancy-related health care coverage should contact their county's social services department to initiate an application for Medi-Cal.

### ***3.6 Breast or Cervical Cancer***

Please refer any Path to Health members diagnosed with breast or cervical cancer to the Breast and Cervical Cancer Treatment Program (BCCTP).

## Section 4.0 – Access Standards

While there is no mandate for professional standards for health care providers, the Path to Health Program, California Department of Health Care Services (DHCS) and other regulatory agencies require that members receive medically necessary services in a timely manner. For more information regarding standard practices, please refer to the *CMSP Provider Operations Manual* at <https://cmsp.amm.cc/providers/>.

## Section 5.0 – Roles and Responsibilities for All Providers

### 5.1 Roles and Responsibilities of All Providers

- Providers must verify the member's Path to Health eligibility before providing care
- Verify the member's eligibility at each appointment and immediately before giving non-emergency services, supplies or equipment (for example, a member verified to be eligible on the last day of the month may not be eligible the first day of the following month)
- Comply with all state laws relating to communicable disease and domestic violence/child abuse reporting requirements
- Not intentionally segregate Path to Health members in any way from other persons receiving similar services, supplies or equipment, or discriminate against any members on the basis of race, color, creed, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental disability in accordance with *Title VI of the Civil Rights Act of 1964, 42 USC Section 2000(d)*, and rules and regulations promulgated thereunder
- Offer interpreter services when appropriate
- Give considerate and respectful care
- Permit members to participate actively in all decisions regarding their medical care, including, except as limited by law, their decision to refuse treatment
- Obtain signed consent prior to rendering care, except as limited by emergency situations
- Provide, upon request, timely responses and medical information to AMM
- Provide timely responses to reasonable requests by the CMSP Governing Board, Advanced Medical Management, Inc. or the member for information regarding services provided to the member
- Give information to the member or member's legal representative about the illness, course of treatment and prospects for recovery in terms the member can understand
- Maintain legible and accurate medical records in a secured location
- Keep all member information confidential, as required by state and federal law
- All providers who are involved in the treatment of a member share responsibility in communicating clinic findings, treatment plans, prognosis, and the psychosocial condition of such member with the member's providers to ensure coordination of the member's care.

## **5.2 Oversight of Non-Physician Providers**

All providers using non-physician providers must provide supervision and oversight of such non-physician providers consistent with state and federal laws. The provider and the non-physician provider must have written guidelines for adequate supervision, and all supervising physicians must follow state licensing and certification requirements.

## **5.3 Members' Rights and Declarations**

All providers shall actively support the *Members' Rights and Declarations* as written and provided on AMM's website at: [https://pathtohealth.amm.cc /Members](https://pathtohealth.amm.cc/Members)

## **5.4 Confidentiality**

All providers shall prepare and maintain all appropriate records in a system that permits prompt retrieval of information on members receiving covered services from acute care hospitals and ancillary providers.

Providers shall only make member's information, including but not limited to, medical records available in accordance with applicable state and federal law.

AMM may use aggregate patient information or summaries for research, experimental, educational or similar programs if no identification of a member is or can be made in the released information.

## **5.5 Medical Records**

All providers must keep, maintain and have readily retrievable medical records as are necessary to disclose fully the type and extent of services provided to a member in compliance with state and federal laws. Documentation must be signed, dated, legible and completed at or near the time at which services are rendered. Providers must ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

## **5.6 Providing Access to Medical Records and Information**

Providers must make available to the CMSP Governing Board and Advanced Medical Management, Inc. during regular business hours, all pertinent financial books and all records concerning the provision of health care services to members. AMM may request the provider to provide medical records or information for quality management or other purposes during audits, grievances and appeals, and quality studies. Providers shall have procedures in place to provide timely access to medical records in their absence.

Mandated time limitations for the completion of reviews and studies require the cooperation of the provider to provide medical records expeditiously.

For public health communicable disease reporting, providers are required to provide all medical records or information as requested and within the period established by state and federal laws.

### **5.7 Language and Interpreter Services**

Advanced Medical Management, Inc. is contracted with a third-party vendor for telephone interpreter services to ensure access for all limited English proficiency (LEP) members. In addition, multilingual representatives are available by contacting Customer Service at (877) 283-PATH (7284) during normal office hours Monday – Friday from 8 a.m. to 5 p.m (PST).

TTY/TDD services are available for hearing impaired by contacting (562) 429-8162 or use the California Relay Services for TTY/TDD.

### **5.8 Telephone Interpreter Services**

Members and providers may call the Customer Service department (877) 283-PATH (7284) during business hours, Monday through Friday from 8 a.m. to 5 p.m. to arrange for telephone interpreter services and/or services for the hearing-impaired.

## **Section 6.0 – Claims and Billing**

This section identifies Advanced Medical Management, Inc.’s claims process for claims submittals for covered benefits and services provided for Path to Health. All provider claims, electronic or paper, should be “clean”, meaning providers should submit claims with all fields completed using valid HCPCS, CPT or Local Codes.

### **6.1 Fee Schedule**

Provider rates of reimbursement or compensation for serving Path to Health members are specified in the clinic or provider’s *CMSP Provider Agreement*. For assistance with understanding the fee schedule, please contact Customer Service at (877) 283-PATH (7284). For the Rate Policy, please refer to: <https://www.cmspcounties.org/billing-claims-payment/>.

### **6.2 Timely Filing of Claims**

Please refer to the grid below on the timely filing of claims. Claims submitted by non-contracted providers for medical and emergency services are not covered under Path to Health and will be denied.

Providers must submit claims in a timely manner. Claims received by AMM past the contracted filing limit will be denied.

Call Customer Service at (877) 283-PATH (7284) with questions regarding the completion of the UB-04 or CMS 1500 claim forms. Hours are Monday through Friday, 8 a.m. to 5 p.m. (PST) except major holidays.

Use the member’s Path to Health ID number when billing, whether submitting electronically or by paper.

Action and Description	Required Timeline
<p><b>First Time Claims Submissions</b></p>	<p>All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement:</p> <ul style="list-style-type: none"> <li>➤ Claims should be filed within 150 calendar days of the date of service.</li> </ul>
<p><b>Checking Claim Status</b></p> <p>The claims status feature is accessible anytime by logging onto <a href="https://claims.amm.cc/">https://claims.amm.cc/</a> to check the status of a claim. Registration is required. You may also call Customer Service at (877) 283-PATH (7284) if you are not able to find your claim.</p>	<p>Providers may verify Advanced Medical Management's receipt of claim after 5 business days. Please allow up to 15 calendar days before checking claim status.</p>
<p><b>Claim Appeal Process</b></p> <p>Request a claim reconsideration/appeal in writing with a <i>Provider Claim/Appeal Dispute Form</i> located at <a href="https://pathtohealth.amm.cc/Providers">https://pathtohealth.amm.cc/ Providers</a></p>	<p>File within 60 business days from the date of the explanation of benefits. AMM will acknowledge all provider claim appeals in writing within 15 calendar days of receipt and sends a written resolution notice 45 working days from receipt of appeal.</p>
<p><b>Third Party Liability (TPL) or Coordination of Benefits (COB)</b></p> <p>If the claim has COB, TPL or requires submission to a third party before submitting to AMM, the filing limit starts from the date on the notice from the third party.</p>	<p>All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement:</p> <ul style="list-style-type: none"> <li>➤ Claims should be filed within 150 calendar days from the date of the denial from the third party.</li> </ul>
<p><b>Claim Filing with Wrong Health Plan/Insurance Carrier</b></p> <p>If the provider originally billed with the wrong health plan/insurance carrier, the provider must submit the original claim to AMM with proof of timely filing. If the provider originally billed with the wrong information (i.e., incorrect member ID or DOB), the filing limit starts from the denial date of the original claim.</p>	<p>All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement:</p> <ul style="list-style-type: none"> <li>➤ Claims should be filed within 150 calendar days from the date of the denial from the third party.</li> </ul>

Many Path to Health members may also qualify for other programs, such as:

- California AIDS Drug Assistance Program (ADAP) (applicable to MedImpact only)
- California Family Planning, Access, Care and Treatment Program (Family PACT)
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Every Woman Counts (EWC)
- Genetically Handicapped Persons Program (GHPP)

### 6.3 Electronic Data Interchange

AMM prefers electronic billing or electronic data interchange (EDI). EDI is a computer to computer transfer of information. EDI is a fast, inexpensive and safe method for automating the claims business processes. The benefits of using EDI are:

- Reduces costs (saves on staffing, overhead, claim forms, mailing materials and postage)

- Full tracking (no claims “lost in the mail”)
- Faster turnaround time
- Consistent processing (no data conversion errors)
- Data security and privacy (data exchange occurs in secure and private environments)

Providers can submit EDI claims electronically through a HIPAA approved billing system, software vendor or clearinghouse. Using a clearinghouse can streamline the provider’s billing processes by using a single system.

Clearinghouses are connected with numerous insurance payers including AMM. Electronic transactions must contain HIPAA required data elements in all fields in order to be successfully processed. A clearinghouse and/or AMM will return claims submitted with incomplete or invalid information for correction. Billing providers are responsible for working with their EDI vendor or clearinghouse to ensure that claims with error are corrected and resubmitted. Many clearinghouses have web portals that allow for manual correction and resubmission.

All provider claims must be submitted and accepted by their clearinghouse within the contracted filing limit to be considered for payment.

Electronic data transfers and claims are HIPAA compliant and meet federal requirements for electronic data interchange (EDI) transactions & code sets.

Implementation guides are available at:

<https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/5010a1837bcg.pdf>

AMM will accept 5010 compliant 837 transactions directly from providers. AMM accepts the following HIPAA compliant claim format:

- CMS 1500 – ASCX12 5010 837P
- UB-04 - ASCX12 5010 837I

Please note, enrollment is required. Providers can enroll by contacting EDI services at (877) 283-PATH (7284) or by email at [support@amm.cc](mailto:support@amm.cc).

Below are the payer IDs for approved clearinghouses:

Clearinghouse	Payer ID	Support Phone #	Website
Office Ally	AMM15	(360) 975-7000 Opt. 1	<a href="https://cms.officeally.com/">https://cms.officeally.com/</a>
Emdeon/Capario	CMSP1	(888) 363-3361	<a href="https://cda.changehealthcare.com/Portal/">https://cda.changehealthcare.com/Portal/</a>
Claimremedi	CMSP	(800) 763-8484	<a href="https://claimremedi.providersportal.com">https://claimremedi.providersportal.com</a>
Cognizant/Trizetto	<i>Institutional Claims:</i> UMM15 <i>Professional Claims:</i> AMM15	(800) 556-2231	<a href="http://www.trizetto.com">http://www.trizetto.com</a>



**For a complete list of AMM clearinghouses please visit:**

<https://pathtohealth.amm.cc/Providers>

Providers should contact EDI services by telephone at (877) 283-PATH (7284) or by email at support@amm.cc if their preferred clearinghouse is not listed.

**6.4 Paper Claims**

All paper claims for FQHC's must be submitted on the UB-04 claim form. Professional claims should be billing using the CMS 1500 form. Providers should mail all paper claims to:

CMSP – Advanced Medical Management, Inc.  
Attn: Claims Department  
5000 Airport Plaza Drive, Ste. 150  
Long Beach, CA 90815-1260

**6.5 Clinical Record Submissions Categories**

The following is a list of claims categories where AMM may routinely require submission of clinical information before or after payment of a claim (For information about time frames for submission of clinical information, see Section 6.9):

- Claims involving certain modifiers, including but not limited to Modifier 22 and/or Modifiers 95 or GT for telemedicine services
- Claims involving unlisted codes
- Claims for which AMM cannot determine from the face of the claim, whether it involves a covered service, thus the benefit determination cannot be made without reviewing medical records (including but not limited specific benefit exclusions)
- Claims that AMM has reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external) including high dollar claims
- Claims that have been appealed (or that are otherwise the subject of a dispute or reconsideration, including claims being mediated, arbitrated or litigated)
- Other situations in which clinical information might routinely be requested:
  - Requests relating to underwriting (including but not limited to member or physician misrepresentation and fraud reviews)
  - Accreditation activities
  - Quality improvement/assurance activities
  - Credentialing
  - Recovery/subrogation

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

## **6.6 Claims Coding**

All FQHCs must bill using the UB-04 claim form, with appropriate codes, and in a manner acceptable to AMM. Professional claims should bill using a CMS 1500 form along with the appropriate codes.

All Path to Health claims submitted for payment need to include the current HIPAA-compliant code sets required by the state and federal government.

## **6.7 Coding Guidelines**

Providers must use the following national guidelines when coding claims:

- International Classification of Diseases, 10th Revision (ICD diagnostic and Procedure Codes): Applicable ICD codes must be in Boxes 74(a-e) of the UB-04 form and Boxes 21 and 24e of the CMS 1500 form when the claim indicates a procedure was performed.
- Medi-Cal Local Only Codes (Local Only Codes): Use Local Only Codes until the state remediates the codes. Do not use Local Only Codes for dates of service after the remediation date. Local Only Codes billed after the remediation date are denied for use of an invalid procedure code.
- Healthcare Common Procedure Coding System (HCPCS): Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services (CMS).
- Current Procedural Terminology (CPT) Codes: Refer to the current edition of the Physicians' CPT manual, published by the American Medical Association.
- Modifier Codes: Use modifier codes when appropriate with the corresponding HCPCS or CPT Codes.
- Local Only, HCPCS or CPT Codes.

## **6.8 Checking Claim Status**

Providers should receive a response within 30 calendar days of receipt of a claim. If the claim contains all required information, the claim will enter into AMM's claims system for processing. Providers will receive an explanation of benefits (EOB) when the claim is finalized.

Providers may confirm receipt of their claims after 5 business days from the date the claim was submitted by using the AMM Claim manager website at <https://claims.amm.cc/>. Providers must first register to use the site by clicking on the registration link or by visiting <https://claims.amm.cc/Register.aspx>.

AMM or the provider's contracted clearinghouse will return claims submitted with incomplete or invalid information for correction. Billing providers are responsible for working with AMM, their EDI vendor or clearinghouse to ensure that claims with errors are corrected and resubmitted. Many clearinghouses have web portals that allow for manual correction and resubmission.

### **6.9 Request for Additional Information**

Providers have 60 business days from the date on the Explanation of Benefits (EOB) to submit the corrected claim information to AMM. If the provider resubmits the corrected claim after 60 business days, the claim will be denied for untimely filing. Include a copy of the reject letter with your corrected claim submission. Refer to Section 6.2 regarding *Timely Filing of Claims*.

If a provider files a claim with the wrong insurance carrier and provides documentation verifying the initial timely claims filing was within the contracted filing limit, AMM will process the provider's claim.

### **6.10 Claims Appeals Process**

AMM offers a claim appeal process for issues pertaining to processing of provider claims. Providers may submit one appeal (or dispute) per claim.

Providers must submit their request for consideration in writing or by fax within 60 business days from the date of the provider's receipt of our Explanation of Benefits (EOB). Providers may download a *Claim Appeal/Dispute Form* on AMM's website at: <https://pathtohealth.amm.cc/Providers>

The provider's submission must include a completed *Claim Appeal/Dispute Form*, a copy of the original and/or corrected claim form, and supporting documentation not previously considered to:

CMSP – Advanced Medical Management, Inc.  
Attn: Claim Appeals  
5000 Airport Plaza Drive, Ste. 150  
Long Beach, CA 90815-1260

or

Fax (562) 766-2007

Please note that providers receive an EOB with every claim, whether paid or denied.

Claim appeals are reviewed on a case-by-case basis. AMM will acknowledge all provider claim appeals in writing within 15 calendar days of receipt and will send a written resolution notice 45 business days from receipt of the reconsideration request. If providers are dissatisfied with the resolution after exhausting the appeal process, refer to the dispute resolution process in the CMSP Governing Board participating *Provider Agreement*.

### **6.11 Claims Overpayment Recovery Procedure**

AMM seeks recovery of all excess claim payments from the payee to whom the benefit check is made payable. When an overpayment is discovered, AMM initiates the overpayment recovery process by sending written notification of the overpayment to a physician, hospital, facility or other health care professional (provider). Please return all overpayments to AMM upon the provider's receipt of the notice of overpayment.

If providers want to contest the overpayment, contact AMM's Recovery Department at (877) 283-PATH (7284). For a claims reevaluation, please send correspondence to the address on the overpayment notification.

If AMM does not hear from the provider or receive payment within 60 business days, the overpayment amount is deducted from future claims payments to the provider or referred to a collection service.

## Section 7.0 – Provider Grievance and Appeals

Advanced Medical Management, Inc. (AMM) offers a grievance process and an appeals process for adverse determinations. Both of these processes are outlined in the following section.

### 7.1 Provider Grievance Process

AMM allows providers to file a grievance or complaint that is related to any aspect of AMM services **not** related to an action, medical procedure, or authorization for service. All grievances must be submitted to AMM within 60 calendar days of the date giving rise to grievance. AMM maintains confidentiality throughout the process. Grievances submitted to AMM are tracked, trended and resolved within established periods.

Providers may obtain a *Provider Grievance or Complaint Form* at <https://pathtohealth.amm.cc/Providers>. Completed forms may be faxed to (562) 766-2006 or mailed to the following address:

CMSP – Advanced Medical Management, Inc.  
Attn: Customer Service - Grievances  
5000 Airport Plaza Drive, Ste. 150  
Long Beach, CA 90815-1260

AMM will send a written acknowledgement of the provider's grievance or complaint. AMM investigates the provider's grievance or complaint to develop a resolution. The investigation includes reviews by appropriate staff. AMM may request medical records or a provider's explanation of the issues raised in the grievance or complaint by telephone, email, fax or mail. AMM expects providers to comply with request for additional information with 10 calendar days of the request.

AMM notifies providers in writing of the grievance or complaint resolution within 60 calendar days of the receipt of the grievance. AMM does not disclose findings or decisions of quality-of-care issues.

Providers dissatisfied with AMM's grievance or complaint resolution may contact the CMSP Governing Board at the address listed below:

CMSP Governing Board  
1545 River Park Drive, Suite 435  
Sacramento, CA 95815

or

Fax: (916) 649-2606

In addition, contracted providers may request arbitration pursuant to the conditions set forth in their *Provider Agreement* with CMSP's Governing Board.

## **7.2 Provider Appeals of Non-medical Necessity Claims Determinations**

A provider may appeal a decision regarding the payment of a claim that is not related to a medical necessity determination. For these appeals, providers should follow the Claims Appeal procedures set forth in Section 6.2 of the *Claims and Billing* Section. If contracted providers exhaust the AMM appeal resolution process and are dissatisfied with the resolution, contracted providers have the right to arbitration as specified in their *Participating CMSP Provider Agreement*.

Providers dissatisfied with AMM's appeal decision may appeal to the CMSP Governing Board. Providers must submit the request to the CMSP Governing Board within 30 days from the date of the notice of action letter to the address listed below:

CMSP Governing Board  
1545 River Park Drive, Suite 435  
Sacramento, CA 95815

or

Fax: (916) 649-2606

In addition, contracted providers may request arbitration pursuant to the conditions set forth in their *Provider Agreement* with CMSP's Governing Board.

Advanced Medical Management, Inc. does not discriminate against a provider for requesting an appeal or for filing an appeal with the CMSP Governing Board.

## **Section 8.0 – Member Grievance and Appeals**

### **8.1 Member Grievances or Complaints**

A member, or his or her authorized representative, has the right to file an oral or written grievance regarding any aspect of services not related to an Action (for complaints related to Actions, see Section 8.2 *Member Appeals*). All grievances must be submitted to AMM within 60 calendar days of the date giving rise to grievance. AMM maintains confidentiality throughout the process.

Grievances submitted to AMM are tracked and trended, resolved within established periods and referred to Peer Review when needed. It is the responsibility of Peer Review to conduct activities, which are designed to:

1. Identify areas of physician practice which could be improved.
2. Discover specific instances of inappropriate or sub-standard medical practice on the part of a provider.
3. Correct the problems identified in the course of 1 and 2, above.
4. Oversight of credentialing process.

Members or their representatives may submit complaints and grievances orally to AMM's Customer Service at (877) 283-PATH (7284). Complaints and grievances may also be submitted in writing by completing the *Member Grievance or Complaint form*. This form is available on AMM's website at: <https://pathtohealth.amm.cc/Members>.

The completed form may be faxed to AMM Customer Service at (562) 766-2006 or mailed to:

CMSP – Advanced Medical Management, Inc.  
Attn: Customer Service -Grievances  
5000 Airport Plaza Drive, Ste. 150  
Long Beach, CA 90815-1260

AMM acknowledges member grievances or complaints in writing to the member.

AMM investigates the member's grievance to develop a resolution. The investigation includes reviews by appropriate staff. AMM may request medical records or a provider's explanation of the issues raised in the grievance by telephone, email, fax or mail. AMM expects providers to comply with requests for additional information within 10 calendar days of the request.

AMM notifies members in writing of the grievance resolution within 60 calendar days of the receipt of the grievance. AMM does not disclose findings or decisions of quality-of-care issues.

AMM may extend the resolution period up to 14 calendar days if the member or his or her representative requests an extension or AMM shows that there is a need for additional information and how the delay is in the member's interest. If AMM extends the resolution timeframe for any reason other than by request of the member, AMM will provide written notice of the reason for the delay to the member.

AMM will not discriminate or take any punitive action against a member or his or her representative for submitting a grievance. Grievances are not appealable to the CMSP Governing Board.

## **8.2 Member Appeals**

A member or his or her authorized representative may submit an oral or written appeal of a denied service or a denial of payment for services in whole or in part to AMM. Members or their representatives must submit appeals within 60 calendar days from date on the notice of action. With the exception of expedited appeals, members must confirm all oral appeals in writing, signed by the member or his or her authorized representative. AMM maintains confidentiality throughout the process.

Members or their representatives may submit complaints and grievances orally to AMM's Customer Service at (877) 283-PATH (7284). Complaints and grievances may also be submitted in writing by completing the *Member Claim Appeal/Dispute Form*. This form is available at: <https://pathtohealth.amm.cc/Members>. The completed form may be faxed to AMM Customer Service at (562) 766-2006 or mailed to:

CMSP – Advanced Medical Management, Inc.  
Attn: Care Management Appeals  
5000 Airport Plaza Drive, Ste.150  
Long Beach, CA 90815-1260

Once an oral or written appeal request is received, AMM’s staff investigates the case. The member, the member’s authorized representative, the provider or the provider on behalf of a member is given the opportunity to submit written comments, documents, records or other information relevant to the appeal.

The member and his or her representative are given a reasonable opportunity to present evidence and allegations of fact or law and cross-examine witnesses in person, in writing, or by telephone if so requested. AMM will inform the member of the time available for providing the information, and that limited time is available for expedited appeals.

The member and his or her authorized representative are given an opportunity, before and during the appeal process, to examine the member’s case file, including medical records and any other documents considered during the appeal process.

### ***8.3 Standard Appeals***

AMM sends an acknowledgement letter to the member within five calendar days of receipt of a standard appeal request. AMM may request medical records, or a provider explanation of the issues raised in the appeal by telephone or in writing by facsimile, mail or email. AMM expects providers to comply with the request for additional information within 10 calendar days.

### ***8.4 Response to Standard Appeal***

AMM notifies members in writing of the appeal resolution, including their appeal rights (if any), within 45 business days of receipt of the appeal request. AMM does not disclose findings or decisions regarding peer review or quality- of-care issues.

AMM may extend the resolution period up to 15 calendar days if the member or his or her representative requests an extension or we show that there is a need for additional information and how the delay is in the member’s interest. If AMM extends the resolution period for any reason other than by request of the member, AMM will provide written notice of the reason for the delay to the member.

### ***8.5 Expedited Appeals***

If the amount of time necessary to participate in a standard appeal process could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. A member may request an expedited appeal in the same manner as a standard appeal, but should include information informing AMM of the need for the expedited appeal process. Within one business day of receipt of the request for an expedited appeal, AMM will make reasonable attempts to acknowledge the request by telephone.

If AMM denies a request for an expedited appeal, AMM will:

- Transfer the appeal to the period for standard resolution.
- Make a reasonable effort to give the member prompt oral notice of the denial and follow up within 2 calendar days with written notice that the expedited appeal request will be resolved under the standard appeal timeframe.

AMM may request medical records or a provider explanation of the issues raised in the expedited appeal by telephone or in writing by facsimile, mail or email. We expect providers to comply with the request within one calendar day of receipt of the request for additional information.

### ***8.6 Response to Expedited Appeals***

AMM resolves expedited appeals as expeditiously as possible. AMM makes reasonable efforts to investigate, resolve, and notify the member of the resolution by telephone and we send a written resolution within thirty (30) business days of receipt of the expedited appeal request.

AMM may extend the resolution period up to 15 calendar days if the member or his or her representative requests an extension or AMM show that there is a need for additional information and how the delay is in the member's interest.

## **Section 9.0 – CMSP Governing Board Appeal**

If the member does not agree with what AMM decides after they review the member's appeal regarding a denial, delay or change of a service, the member can file a second-level appeal with the County Medical Services Program (CMSP) Governing Board.

The member must exhaust all internal appeal rights with AMM before seeking review by the CMSP Governing Board. The member must ask for review by the CMSP Governing Board within 30 days of receipt of AMM's appeal resolution letter.

Requests for a CMSP Governing Board appeal should be made directly to the CMSP Governing Board by phone at (916) 649-2631, option 1 or the CMSP website at <https://cmspcounties.org/>.

Completed forms and other written requests should be sent to:

CMSP Governing Board  
Attn: Path to Health  
1545 River Park Drive, Suite 435  
Sacramento, CA 95815

or

Fax: (916) 649-2606

CMSP will send a letter to the member:

- Within 5 business days of receipt of the second-level appeal request to advise that the request is being processed.
- Within 30 days of receipt of the request to advise of their resolution decision.



## Appendix 1

### CMS 1500 Claim Form Specifications

All professional providers and third-party billing agents (excluding FQHCs) should bill AMM using the most current version of the CMS 1500 claim form. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribal Health Clinics (THC) are referred cumulatively as FQHCs in this Manual.

**(R)** = Required Field

Field Number	Title	Description
Field 1	Type of Insurance Medicare / Medicaid / TRICARE / CHAMPUS / CHAMPVA / Group Health Plan / FECA Blk Lung / Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box; Only one box can be marked
Field 1a <b>(R)</b>	Insured's ID Number	Enter the patient's Path to Health ID number as shown on the patient's ID card
Field 2 <b>(R)</b>	Patient's Name	Enter the last name first, then the first name, then middle initial (if known); Do not use nicknames or full middle names
Field 3 <b>(R)</b>	Patient's Birth Date / Patient's Sex	Enter date of birth as MM/DD/YYYY (Month/Day/Year). Check the appropriate box for the patient's sex; If sex is unknown, leave blank
Field 4 <b>(R)</b>	Insured's Name	"Same" is acceptable if the insured is the patient
Field 5 <b>(R)</b>	Patient's Address / Telephone	Enter complete address and telephone number. Include any unit or apartment number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable; If patient is homeless or address is unknown, enter "Unknown" or "Homeless"
Field 6 <b>(R)</b>	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to insured
Field 7 <b>(R)</b>	Insured's Address	"Same" is acceptable if the insured is the patient
Field 8	Reserved for NUCC	LEAVE BLANK
Field 9 <b>(R)</b> <b>(if applicable)</b>	Other Insured's Name	If there is other insurance coverage in addition to the member's Path to Health coverage, enter the name of the insured
Field 9a <b>(R)</b> <b>(if applicable)</b>	Other Insured's Policy or Group Number	Enter the name of the other insurance coverage with the group and policy number
Field 9b	Reserved for NUCC use	LEAVE BLANK
Field 9c	Reserved for NUCC use	LEAVE BLANK
Field 9d <b>(R)</b> <b>(if applicable)</b>	Insurance Plan Name or Program Name	Enter the name of the other insurance plan or program name
Field 10 <b>(R)</b>	Patient's Condition Related To	Enter an X in the correct box to indicate whether one or more of the services described in Field 24 are for a condition/injury that occurred on the job or as a result of an automobile or other accident; Only one box on each line can be marked
Field 10a <b>(R)</b>	Related to Employment?	Check Y or N. If insurance is related to workers' compensation, check Y
Field 10b <b>(R)</b>	Related to Auto Accident / Place?	Check Y or N. If Y, enter the state abbreviation in which the accident occurred
Field 10c <b>(R)</b>	Related to Other Accident?	Check Y or N

Field 10d	CLAIM CODES (Designated by NUCC)	LEAVE BLANK
Field 11	Insured's Policy Group or FECA Number	Insured's group number; Complete information about insured, even if same as patient
Field 11a	Insured's Date of Birth / Sex	Use the date of birth format – MM/DD/YY. Check M (male) or F (female); If sex is unknown, leave blank
Field 11b	Other Claim ID (Designated by NUCC)	For Workers; Compensation of Property & Casualty. Required if known; Enter the claim number assigned by the payer
Field 11c	Insurance Plan Name or Program Name	Enter the name of the plan carrier
Field 11d (R)	Is There Another Health Benefit Plan?	Check Y or N. If yes, complete items 9A-9D
Field 12	Patient's or Authorized Person's Signature	Sign and date the form ("Signature on file" indicates that the appropriate signature obtained by the provider is acceptable for this field.)
Field 13	Insured's or Authorized Person's Signature	Sign and date the form ("Signature on file" is acceptable for this field.)
Field 14 (R)	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the date of the injury, illness or pregnancy (if applicable)
Field 15	Other Date	Enter the date of the first consultation for the patient's Condition; Date format is MM/DD/YYYY
Field 16	Dates Patient Unable to Work in Current Occupation (From - To)	Date format is MM/DD/YYYY
Field 17 (R) (if applicable)	Name of Referring Physician or Other Source	Enter the name of physician, clinic or facility referring the patient to the provider
Field 17a	Other ID#	This field is available to enter another identification number
Field 17b (R) (if applicable)	NPI	Enter the provider's National Provider Identifier number
Field 18	Hospitalization Dates Related to Current Services (From - To)	If applicable, enter hospitalization dates; Date format is MM/DD/YY
Field 19	Additional Claim Information	Enter up to 80 characters of free form text; add assistant/associate level provider in this section and bill under supervising physician.
Field 20	Outside Lab? (Yes or No); \$ Charge	Check Yes if lab services were sent to an outside lab; check No if not.
Field 21 (R)	ICD Indicator  Diagnosis or Nature of Illness or Injury	Enter the appropriate ICD indicator (0 for 10 <sup>th</sup> revision or 9 for 9 <sup>th</sup> revision)  Add up to 12 diagnosis codes and related A-L to service line below (24E)
Field 22 (R) (if applicable)	Resubmission Code  Original Ref. No	Enter the appropriate frequency code: <ul style="list-style-type: none"> <li>• Replacement of prior claim</li> <li>• Void/cancel of prior claim</li> </ul> Under "Original Ref. No." enter the 17-digit transaction control number (TCN) associated with any claim being resubmitted
Field 23	Prior Authorization Number	Enter authorization number in this field, which can be a pre-service review or reference number
Field 24a (R)	Date(s) of Service	Enter service dates "from" and "to"; If there is only one date of service, re-enter the "from" date in the "to" field

Field 24b (R)	Place of Service	This is a 2-digit code; Use current coding as indicated by CMS
Field 24c	EMG	Enter the appropriate EMG number if service was an emergency
Field 24d (R)	Procedure, Services, or Supplies CPT/ HCPCS and Modifiers	Enter the appropriate CPT or HCPCS code(s) or nomenclature. Indicate appropriate modifier when applicable. Do not use NOC codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description
Field 24e (R)	Diagnosis Pointer	Enter up to 4 diagnosis reference letters (A-L) from diagnosis codes listed in Field 21
Field 24f (R)	\$ Charges	Enter the charge for each line item
Field 24g (R)	Days or Units	Enter the quantity of services for each itemized line
Field 24h	EPSDT?	Indicate if the services were the result of Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services checkup
Field 24i	ID Qualifier / NPI	In the shaded area, enter the identifying qualifier if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24j in the shaded area
Field 24j (R)	Rendering Provider NPI	Entering the rendering provider NPI in the unshaded field of Box 24j
Field 25 (R)	Federal tax identification number (TIN)	This is the 9-digit tax ID number of the billing provider in Field 33
Field 26	Patient's Account Number	This is for the provider's use in identifying patients and allows up to nine numbers or letters (no other characters are allowed)
Field 27 (R)	Accept Assignment?	Enter an X in the correct box; This indicates the provider agrees/disagrees to accept assignment under the payer's program
Field 28 (R)	Total Charge	Enter the total charge/billed amount for the services in Field 24F
Field 29 (R)	Amount Paid	If applicable, enter any payment that you have received for this claim from the patient or other payers
Field 30	Reserved for NUCC use	LEAVE BLANK
Field 31 (R)	Full Name and Title of Physician or Supplier	Enter the legal signature of the practitioner including degrees/credentials or enter "Signature on File"; Enter the date the form was signed using the MM/DD/YYYY format
Field 32 (R)	Service Facility Location Information	Required when the service location is different than that of the billing provider; Facility Name, Address, City, State, Zip and NPI fields are required
Field 32a (R)	NPI	Enter the service facility's National Provider Identifier number (if appropriate)
Field 32b	Facility secondary ID	This field is available for you to enter another identification number
Field 33 (R)	Billing Provider Info and PH #	Enter the billing provider name, street, city, state, ZIP code and telephone number
Field 33a (R)	NPI	Enter the billing provider's National Provider Identifier number
Field 33b	Billing Provider Secondary ID	This field is available for you to enter another identification number

## Appendix 2

All FQHCs must bill AMM using the most current version of the UB-04 (CMS 1450) claim form. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribal Health Clinics (THC) are referred cumulatively as FQHCs in this Manual.

**(R)** = Required Field

Field Number	Title	Description
Field 1 <b>(R)</b>	Facility name, address, and telephone number	Enter the facility name, address and telephone number
Field 2	Pay to Provider name, address, and telephone number	Enter when pay to provider is different than facility listed in Field 1
Field 3a	Patient Control No.	Enter the patient's account number
Field 3b	Medical Record #	Enter patient's medical record number
Field 4 <b>(R)</b>	Type of Bill	Enter 4-digit code to indicate specific bill type
Field 5 <b>(R)</b>	Fed Tax No.	Enter the billing provider's federal tax identification number (TIN)
Field 6 <b>(R)</b>	Statement Covers Period From/Through	The FROM and THROUGH dates of service for the claim being submitted
Field 7	Unlabeled Field	LEAVE BLANK
Field 8a <b>(R)</b>	Patient's Insurance ID number	Enter patient's Path to Health ID number
Field 8b <b>(R)</b>	Patient Name	Enter patient's last name, first name and middle initial
Field 9a-e <b>(R)</b>	Patient Address	Enter patient's complete address (number, street, city, state and zip code)
Field 10 <b>(R)</b>	Patient Birth date	Enter patient's date of birth using MM/DD/YYYY format
Field 11 <b>(R)</b>	Patient Sex	Enter patient's sex (M, F, U)
Field 12 <b>(R)</b>	Admission Date	Enter the date patient care began at facility
Field 13	Admission Hour	Enter the patient's admission hour to facility in military time (00 to 23) format
Field 14	Priority (type) of Visit	Enter the 1-digit code indicating the priority of visit
Field 15	Referral Source	Enter the 1-digit code indicating the source of visit
Field 16	Discharge Hour	If patient has been discharged from the facility, enter patient's discharge hour in military time (00 to 23) format
Field 17	Discharge Status	Enter the patient's discharge status at the ending date of service reported in Field 6
Field 18 - 28	Condition codes	Enter Condition codes related to this bill
Field 29	Accident State	When a claim is related to an auto accident, enter the 2-digit state abbreviation where the accident occurred
Field 30	Reserved	LEAVE BLANK
Field 31-34	Occurrence Codes / Dates	Enter any occurrence codes that are applicable to the claim along with date using MM/DD/YYYY format. Report occurrence codes in alphanumeric sequence (Fields 31a, 32a, 33a, 34a, 31b, 32b etc.)
Field 35 - 36 <b>(R)</b>	Occurrence Span (Code, From & Through Date)	Enter any occurrence codes that happened over a span of time that are applicable to the claim. Enter dates using MM/DD/YYYY format
Field 37	Reserved	LEAVE BLANK
Field 38	Responsible Party Name and Address	Enter the name and address of the party responsible for the bill
Field 39-41	Value Codes (Code / Amount)	Enter if any value span codes are applicable to the claim

Field 42 (R)	Revenue Code	Enter Revenue Code
Field 43 (R)	Revenue Code Description	Description of Revenue Code
Field 44 (R) (if applicable)	HCPCS/Accommodation Rates/HIPPS Rate Codes	The accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient and FQHC
Field 45 (R)	Service Date	For outpatient claims, enter the date on which the indicated service was provided using MM/DD/YYYY format
Field 46 (R)	Service Units	Enter the quantitative measure of services rendered by revenue category for the patient.
Field 47 (R)	Total Charges	Enter the total charges pertaining to the revenue code for the current billing period as entered in the statement covers period (Field 6)
Field 48	Non-Covered Charges	Enter non-covered charges
Field 49	Reserved	LEAVE BLANK
Field 50 (R)	Payer Name	Enter the name of each plan from which the provider might expect some payment for the bill in order of liability
Field 51	Payer Health Plan Identification Number	Enter the number used to identify the payer or health plan.
Field 52 (R)	Release of Information Certification Indicator	Enter I (Informed Consent) or Y (Signed statement permitting release of medical billing data)
Field 53	Assignments of Benefits Certification Indicator	Enter Y (Benefits Assigned) or N (Benefits Not Assigned) or W (Not Applicable)
Field 54	Prior Payments	Enter dollar amount of any payments received applicable towards this bill
Field 55	Estimated Amount Due - Payer	Enter the estimated amount due from the indicated payer in Field 50 on lines A, B and C
Field 56 (R)	NPI – Billing Provider	Enter the NPI assigned to the provider submitting the bill
Field 57	Other (Billing) Provider Identifier	LEAVE BLANK
Field 58 (R)	Insured's Name	Enter the name of patient or insured individual
Field 59 (R)	Patient's relationship to Insured	Enter the code that indicates the relationship of the patient to the insured individual identified in Field 58
Field 60 (R)	Insured's Unique Identifier	Enter patient's Connect to Care ID number
Field 61	Group Name	LEAVE BLANK
Field 62	Insurance Group Number	LEAVE BLANK
Field 63	Authorization Code / Referral Number	Enter Referral number or Prior Authorization number
Field 64	Document Control Number	Enter the internal control number assigned to the original bill by the payer
Field 65	Employer Name	LEAVE BLANK
Field 66	Diagnosis and Procedure Code Qualifier (ICD version)	Enter (0 for 10 <sup>th</sup> revision or 9 for 9 <sup>th</sup> revision)
Field 67 (R)	Principal Diagnosis Code	Use the current version of ICD-CM; enter the principal diagnosis code (the condition to be chiefly responsible for causing the visit)
Field 67a - q	Other Diagnosis Codes	Use the current version of ICD-CM; enter all diagnosis codes that coexist at the time of visit, that develop subsequently or that affect the treatment received
Field 68	Reserved	LEAVE BLANK
Field 69 (R)	Admitting Diagnosis	Use the current version of ICD-CM; enter the code describing the patient's diagnosis or reason for visit

Field 70 (R)	Patient's Reason for Visit	Use the current version of ICD-CM; enter the code describing the patient reason for the visit at the time of outpatient registration
Field 71	Prospective Payment System (PPS) Code	Enter the PPS code
Field 72a-c	External Cause of Injury codes	Use the current version of ICD-CM; Enter the code pertaining to the external cause of injury, poisoning or adverse effect
Field 73	Reserved	LEAVE BLANK
Field 74	Principal Procedure Code and Date	Use the current version of ICD-PCS; Enter the code for the principal procedure performed at the claim level during the period covered by this bill and the corresponding date on which the principal procedure was performed
Field 74a-e	Other Procedure Codes and Dates	Use the current version of ICD-PCS; Enter up to 5 additional PCS codes other than the principal procedure, and the corresponding dates
Field 75	Reserved	LEAVE BLANK
Field 76 (R)	Attending Provider Name and Identifiers	Enter attending physician's NPI, Last Name, and First Name
Field 77	Operating Physician Name and Identifiers	Enter Operating physician's NPI, Last Name, and First Name
Field 78 - 79	Other Provider Names and Identifiers	Enter Other physician's NPI, Last Name, and First Name.
Field 80	Remarks	Use this field to explain special situations
Field 81	Code - Code	LEAVE BLANK

## Appendix 3

### ***Path to Health Approved Procedure Code List***

For the most updated version of the Path to Health Approved Procedure Code List, visit <https://pathtohealth.amm.cc/Providers>.

Please refer to the prescription formulary located at: <https://mypathtohealth.org/>

Created by  
*Advanced Medical Management, Inc.*  
*CMSP's Third Party Administrator*