PATH TO HEALTH™

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Path to Health Pilot Program
Provider Operations Manual

(Benefit period February 1, 2019 – August 31, 2021)

AMM
ADVANCED MEDICAL MANAGEMENT, INC.
Third Party Administrator
Version 1.0 February 2019

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For additional information regarding the Path to Health Program, please visit www.mypathtohealth.org

Section 1.0 - Introduction

1.1 Welcome to the Path to Health Pilot Project

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.

Please refer to the CMSP Provider Operations Manual for information regarding CMSP benefits at https://cmsp.amm.cc/providers/.

1.2 Background

The Path to Health Pilot Project expands access to primary care services for up to 25,000 undocumented adults between the ages of 21 and 64 that are enrolled in an emergency services only (restricted scope) Medi-Cal program aid code and reside in one of CMSP's 35 counties. Eligibility for Path to Health benefits is dependent on the County Social Services Departments processing of restricted scope Medi-Cal applications. Contracting Community Health Centers are responsible for enrolling patients into the Path to Health Pilot Program.

The pilot project will terminate on August 31, 2021 (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 the population in order to improve their health outcomes, reduce their utilization of emergency services and inpatient hospitalization, and enable contracting Community Health Centers to redirect resources otherwise dedicated to serving the population to other needs of high priority in the Community Health Center's service area.

1.4 Important Contact Information

Advanced Medical Management, Inc. (AMM) types of inquiries: Customer Service, Medical, Provider Network, Provider Contracting, Claims, Grievances and Appeals.

(877) 283-PATH (7284)

MedImpact Healthcare Systems, Inc. types of Inquiries: Pharmacy, Finding a Pharmacy, and Pharmacy Appeals.

(800) 788-2949

Additional contact information can be found on our website at:
http://pathtohealth.amm.cc/Home/Contact

1.5 Service Area

Advanced Medical Management, Inc. administers health care services on a self-funded basis for Path to Health members. Members must be enrolled in restricted-scope Medi-Cal in order to qualify for Path to Health benefits. Members are assigned to a specific clinic organization, which will be noted on their Path to Health ID card, within the Path to Health network. For a list of clinics participating in the Path to Health program, please visit:
http://pathtohealth.amm.cc/Provider/ProviderSearch

1.6 Claim Submission

New and corrected paper claims with dates of service February 1, 2019 and beyond 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

Clearinghouse	PayerID	Support Phone#	Website
Office Ally	AMM15	(360) 975-7000 Opt. 1	http://www.officeally.com
Emdeon/Caparios	CMSP1	(888) 363-3361	https://cda.changehealthcare.com/Portal/
Claimremedi	CMSP	(800) 763-8484	https://claimremedi.providersportal.com

For a complete list of AMM/CMSP clearinghouses please visit:
http://pathtohealth.amm.cc/Home/Providers

Please refer to Section 8.0 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 this Claims and Billing section, but here are a few items providers should keep in mind:

- CMSP Governing Board has a contract amendment with all FQHCs participating in the Path to Health Pilot Project.
- All FQHC bills should be completed on a UB-04 or CMS 1500 claim form. To be HIPAA compliant and meet Path to Health requirements, claims

must identify all services rendered with the appropriate CPT, HCPCS and Revenue Codes. Claims submitted with incorrect or obsolete codes will be rejected.

Section 2.0 – Administrative Procedures

2.1 Provider Operations Manual

The 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:

- Open the Attachment and click on "Click to Read Message"
- 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 is able to 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 our Customer Service department 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 Pilot Program participants are enrolled in the Emergency Medi-Cal program through the existing Statewide Automated Welfare System at the county and/or through the Hospital Presumptive Eligibility (HPE) process. Secondarily, to complete the Path to Health enrollment process, Community Health Centers will be 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 eligibility support or questions please contact the Path to Health Enrollment Help Desk at (800) 548-5880.

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.

The member 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 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).

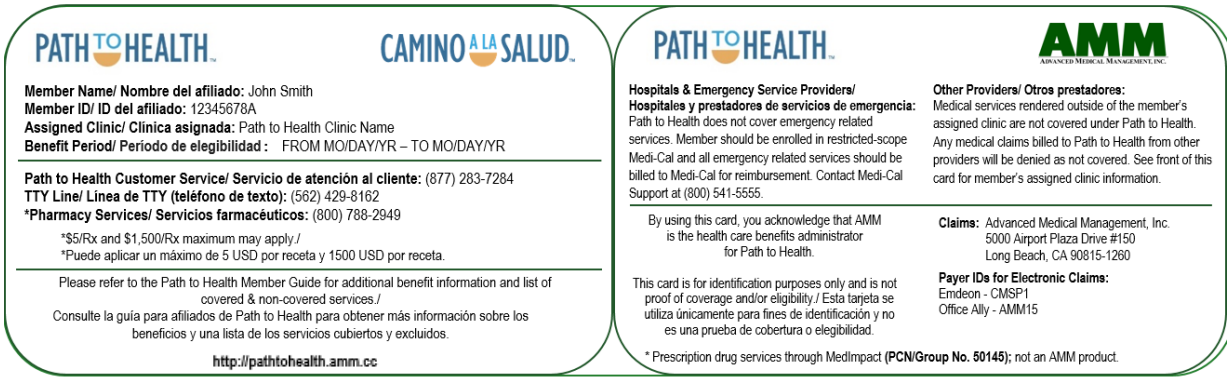
2.7 Beneficiary Identification Card (BIC)

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 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 cards is the member to whom the BIC and member ID card were issued. Claims submitted for services rendered to non-eligible members are not eligible for payment. Members are instructed, through their Path to Health Program Guide, to notify providers of their coverage at each visit or as soon as possible.

2.9 Path to Health and Medi-Cal Coverage

In order to qualify for the Path to Health Pilot Project, the member must be enrolled in 1 of 17 restricted-scope/emergency only Medi-Cal Aid Codes:

- 3T, 55, 58, 5F, 5T, C5, C6, C7, J3, J4, J8, K3, K5, K7, K9, M2, or M4

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 in order for the provider to receive payment for emergency services.

Section 3.0 – Covered Benefits and Services

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 benefits generally include the following services:

- Office visit with primary care provider or specialist
- In-Office minor medical procedures
- Preventative screenings, routine lab tests, and adult immunizations
- Screening for depression, alcohol misuse, obesity counseling
- Screening for HIV, HPV, Hepatitis B/C, and STI screening
- 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.

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

Acupuncture, including podiatry-related acupuncture services	Methadone maintenance services
Breast and cervical cancer treatment services when covered by other coverage (Breast and Cervical Cancer Treatment Program/Medi-Cal)	Optometry services and eye appliances
Chiropractic care	Public transportation, such as airplane, bus, car or taxi rides
Cosmetic procedures	Pregnancy-related and infertility services
Dental services	Services by a Psychologist, LCSW, MFT or substance use disorder counselor
Family planning services when covered by another coverage (F-PACT)	Any medical service provided at a location other than member's assigned clinic as well as any prescription drug provided at an out-of-network pharmacy

*See Section 3.2 regarding emergency services coverage

3.2 Emergency Services

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. Clinics 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.

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.

3.3 Outpatient Psychiatry

Path to Health covers specialist visits provided that the services are being rendered within the clinic. Path to Health will only cover outpatient psychiatric care services provided that licensed psychiatrist are available at the member's assigned clinic. Path to Health will not pay for services rendered by providers other than the member's assigned clinic organization and pharmacies participating in the Path to Health Program. Services include:

- Medication management allowed by provider during routine clinic visits.

See the Claims and Billing Section for a reference to a list of allowable codes.

3.4 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 www.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 Formularies and Medication Request forms, visit www.mypathtohealth.org. Providers or members with questions involving the Path to Health Prescription Drug Program issues 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.

3.5 Pregnancy

All pregnancy related services are not a covered benefit of Path to Health. Pregnancy services are a covered benefit under restriced-scope 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, except in emergencies.
- 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

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:
http://pathtohealth.amm.cc/Home/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 expediently.

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. contracts with AT&T for telephone interpreter services to ensure access for all limited English proficiency (LEP) members. In addition, Spanish, Korean and Vietnamese representatives are available onsite by contacting Customer Service at (877) 283-PATH (7284) during normal office hours Monday – Friday from 8 a.m. to 5 p.m.

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 to Path to Health. All provider claims, electronic or paper, should be "clean", which means that providers should submit claims with all fields completed with

valid HCPCS, CPT or Local Codes.

6.1 Fee Schedule

Provider rates of reimbursement or compensation for serving Path to Health members is dependent upon the provider's professional or participating medical group CMSP Provider Agreement and Path to Health Addendum and its specified reimbursement rates. For assistance with understanding the fee schedule, please contact Customer Services at (877) 283-PATH (7284). For the Rate Policy, please refer to:
www.cmspcounties.org/pdf_files/provider_rates.pdf

6.2 Timely Filing of Claims

AMM will deny claims submitted by non-contracted providers for medical and emergency services.

Action and Description	Required Timeline
First Time Claims	All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement: • Clinic claims should be filed within 150 calendar days of the date of service.
Checking Claim Status The claims status feature is accessible anytime by logging onto https://claims.amm.cc/ 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.	After 5 business days from Advanced Medical Management, Inc.'s receipt of claim providers may verify receipt of claim. Please allow up to 15 calendar days before checking claim status.
Claim Appeal Process Request a claim reconsideration/appeal in writing with a Claim Follow-up Form located at http://pathtohealth.amm.cc/Home/Providers	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.
Third Party Liability (TPL) or Coordination of Benefits (COB) 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.	All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement: • Clinic claims should be filed within 150 calendar days from the date of the denial from the third party.
Claim Filing with Wrong Health Plan/Insurance Carrier 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.	All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement: • Clinic claims should be filed within 150 calendar days from the date of the denial from the third party.

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 and/or CMS 1500 claim form. Hours are Monday through Friday, 8 a.m. to 5 p.m. except major holidays.

Use the member's identification (CIN) number when billing, whether submitting electronically or by paper.

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)
- Genetically Handicapped Persons Program (GHPP)

Please see the CMSP Provider Operations Manual for a list of other programs at https://cmsp.amm.cc/providers/.

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.

Provider can contact EDI services by telephone at (877) 283-PATH (7284) or by email at support@amm.cc.

AMM will accept 5010 complaint 837 transactions directly from provider. Implementation guides are available at http://store.x12.org/store. Enrollment is required. Providers can enroll by contacting EDI services at (877) 283-PATH (7284). You may also visit: http://pathtohealth.amm.cc/Home/Providers

AMM accepts the following HIPAA compliant claim formats:

- Professional Claim - ASCX12 5010 837P
- Institutional Claims - ASCX12 5010 837I

For a complete list of AMM clearinghouses please visit http://pathtohealth.amm.cc/Home/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.

Clearinghouse	PayerID	Support Phone#	Website
Office Ally	AMM15	(360) 975-7000 Opt. 1	http://www.officeally.com
Emdeon/Caparo	CMSP1	(888) 363-3361	https://cda.changehealthcare.com/Portal/
Claimremedi	CMSP	(800) 763-8484	https://claimremedi.providersportal.com

6.4 Paper Claims

All paper claims must be submitted on the appropriate claim 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 Request for Additional Information in this Section.

- Claims involving certain modifiers, including but not limited to Modifier 22
- 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

Regardless of the method you use, all providers must bill using the appropriate claim form, with appropriate codes, and in a manner acceptable to us.

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 procedure codes must be in Boxes 74(a-e) of the UB-04 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 through 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 timely filing. Include a copy of the reject letter with your corrected claim submission. Refer to Section 8.2 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, we 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: http://pathtohealth.amm.cc/Home/Providers

The provider's submission must include a complete Claim Appeal/Dispute form, a copy of the original and/or corrected CMS 1500 or UB04 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 and trended and resolved within established periods.

Providers may obtain a complaint or grievance form at http://pathtohealth.amm.cc/Home/Providers and may fax the form to (562) 766-2006 or via mail 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
Fax: (916) 848-3349

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 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 Agreements and Path to Health Addendum.

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
Fax: (916) 848-3349

In addition, contracted providers may request arbitration pursuant to the conditions set forth in their CMSP Provider Agreement and Path to Health Addendum.

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 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) or in writing to the following address:

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

Member Grievance or Complaint forms are available on AMM's website at: http://pathtohealth.amm.cc/Home/Members

The completed form may be faxed to Customer Service- Grievances at (562) 766-2006. 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 appeals orally to AMM's Customer Service department at (877) 283-PATH (7284) or by completing the Member Appeal form at http://pathtohealth.amm.cc/Home/Members and faxing the form to (562) 766-2005 or in writing to the following address:

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.

When the appeal is the result of an Adverse Determination for a request of medical services, a physician clinical reviewer (PCR) specialist of the same or similar specialty and who was not involved in the initial determination reviews the case and makes a determination. If appropriate, the PCR contacts the treating provider to discuss possible alternatives.

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 cmspcounties.org.

Completed forms and other written requests should be sent to:

Attn: Path to Health
CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815
Fax: (916) 848-3349

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

UB-04 Claim Form Specifications

All facilities should bill AMM using the most current version of the UB-04 (CMS-1450) claim form.

Locator #	Box Title	Description
1 (R)	Facility name and address and telephone number	Enter the facility name, address and telephone number
2	Pay to Provider name, address and telephone number	Enter when pay to provider is different than facility listed in FL1
3a (R)	Patient Control No.	Enter the patient's account number
3b (R)	Medical Record #	Enter patient's medical record number
4 (R)	Type of Bill	Type of bill (TOB) code
5 (R)	Fed Tax No.	Enter the billing provider's federal tax identification number (TIN)
6 (R)	Statement Covers Period From/Through	The FROM and THROUGH dates for the claim being submitted
7	Unlabeled Field	
8a (R)	Patient's ID number	Enter patient's CIN number
8b (R)	Patient Name	Enter patient's name
9a-e(R)	Patient Address	Enter patient's complete address (number, street, city, state and Zip code)
10(R)	Birthdate	Enter patient's date of birth using MM/DD/YYYY format
11 (R)	Gender	Enter patient's gender (M,F,U)
12 (R)	Admission Date	Enter the date patient was admitted to facility
13 (R)	Admission Hour	Enter the patient's admission hour to facility in military time (00 to 23) format
14 (R)	Admission Type	Enter the type of admission
15 (R)	Admission Source	Enter the source of admission
16	Discharge Hour	If patient has been discharged from the facility, enter patient's discharge hour in military time (00 to 23) format
17 (R)	Discharge Status	Enter the patient's discharge status at the ending date of service reported in FL 6 or by the date of discharge when reported in occurrence code 42 FLs (31-34)
18 - 28	Condition codes	Enter Condition codes
29	Accident State	When a claim is related to an auto accident, enter the state where the accident occurred
30	Reserved	Leave blank
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 (FL31a, 32a, 33a, 34a, 31b, 32b etc.)
35 - 36 (R)	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
37	Reserved	Leave blank
38	Responsible Party Name and Address	Enter the name and address of the party responsible for the bill
39-41	Value Codes (Code / Amount)	Enter if any value span codes are applicable to the claim
42 (R)	Revenue Code	Enter Revenue Code
43 (R)	Revenue Code Description	Description of Revenue Code
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	The accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient and FQHC
45	Service Date	For outpatient claims, enter the date on which the indicated service was provided
46 (R)	Service Units	Enter the quantitative measure of services rendered by revenue category for the patient.
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 (FL 6)
48	Non Covered Charges	Enter non-covered charges
49	Reserved	Leave blank
50 (R)	Payer Name	Enter the name of each plan from which the provider might expect some payment for the bill
51 (R)	Payer Health Plan Identification Number	Enter the number used to identify the payer or health plan.
52 (R)	Release of Information Certification Indicator	Enter I (Informed Consent) or Y (Signed statement permitting release of medical billing data)
53	Assignments of Benefits Certification Indicator	Enter Y (Benefits Assigned) or N (Benefits Not Assigned or W (Not Applicable)
54	Prior Payments	Prior payments
55	Estimated Amount Due - Payer	Enter the estimated amount due from the indicated payer in FL 50 on lines A, B and C
56 (R)	NPI – Billing Provider	Enter the NPI assigned to the provider submitting the bill
57	Other (Billing) Provider Identifier	Leave blank
58 (R)	Insured's Name	Enter the name of patient or insured individual
59 (R)	Patient's relationship to Insured	Enter the code that indicates the relationship of the patient to the insured individual identified in FL 58
60 (R)	Insured's Unique Identifier	Enter patient's CIN number

61	Group Name	Leave blank
62	Insurance Group Number	Leave Blank
63	Authorization Code / Referral Number	Enter Referral number or Prior authorization number
64	Document Control Number	Enter the internal control number assigned to the original bill by the payer
65	Employer Name	Leave blank
66	Diagnosis and Procedure Code Qualifier (ICD version)	Enter (0 for 10th revision or 9 for ninth revision)
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 hospitalization)
67a - q	Other Diagnosis Codes Present on Admission Indicator (POA)	Use the current version of ICD-CM; enter all diagnosis codes that coexist at the time of admission, that develop subsequently or that affect the treatment received and/or the length of stay. Use the eighth digit following the diagnosis code to report POA - Y - Yes - N –No - U – No information - W – clinically undetermined
68	Reserved	Leave blank
69 (R)	Admitting Diagnosis	Use the current version of ICD-CM; enter the code describing the patient's diagnosis at the time of admission.
70	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.
71	Prospective Payment System (PPS) Code	Enter the PPS code that identifies the MS-DRG assigned to the claim.
72 a-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.
73	Reserved	Leave blank
74	Principal Procedure Code and date	Use the current version of ICD-PCS; Enter the code for the inpatient 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.
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.

75	Reserved	Leave blank
76 (R)	Attending Provider Name and Identifiers	For inpatient claims, enter attending physician's NPI, Last Name, and First Name.
77	Operating Physician Name and Identifiers	Enter Operating physician's NPI, Last Name, and First Name.
78 – 79	Other Provider Names and Identifiers	Enter Other physician's NPI, Last Name, and First Name.
80	Remarks	Use this field to explain special situations.
81	Code- Code	Leave blank

Appendix 2

CMS-1500 Claim Form Specifications

All professional providers and third party billing agents should bill AMM using the most current version of the CMS-1500 claim form.

Field Number	Title	Explanation
Field 1	Medicare / Medicaid / TRICARE / CHAMPUS / CHAMPVA / Group Health Plan / FECA Blk Lung / Other ID	If claim is for Medicare, put an X in the Medicare box. If the member has both Medicare and Medicaid, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.
Field 1a (R)	Insured's ID Number	Use patient's CIN number
Field 2 (R)	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 (R)	Patient's Birth Date / Patient's Sex	Enter date of birth as MM/DD/YY (Month/Day/Year). For example, enter September 1, 1993 as 09/01/1993. Check the appropriate box for the patient's gender.
Field 4 (R)	Insured's Name	"Same" is acceptable if the insured is the patient.
Field 5 (R)	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.
Field 6 (R)	Patient Relationship to Insured	Enter the relationship to the member or subscriber.
Field 7 (R)	Insured's Address	"Same" is acceptable if the insured is the patient.
Field 8	Reserved for NUCC	
Field 9 (R)	Other Insured's Name	If there is other insurance coverage in addition to the member's CMSP

		coverage, enter the name of the insured.
Field 9a (R)	Other Insured's Policy or Group Number	Enter the name of the insurance with the group and policy number.
Field 9b	Reserved for NUCC use	
Field 9c	Reserved for NUCC use	
Field 9d (R)	Insurance Plan Name or Program Name	Enter the name of plan carrier
Field 10 (R)	Patient's Condition Related To	Describe the injury or accident, including whether or not it occurred at work.
Field 10a (R)	Related to Employment?	Check Y or N. If insurance is related to workers' compensation, check Y.
Field 10b (R)	Related to Auto Accident / Place?	Check Y or N. Enter the state abbreviation in which the accident occurred.
Field 10c (R)	Related to Other Accident?	Check Y or N.
Field 10d	CLAIM CODES (Designated by NUCC)	
Field 11 (R)	Insured's Policy Group or FECA Number	Insured's group number. Complete information about insured, even if same as patient.
Field 11a (R)	Insured's Date of Birth / Sex	Use the date of birth format – MM/DD/YY. Check M (male) or F (female).
Field 11b (R)	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 (R)	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). For professional emergency services billing, enter the Injury Date.
Field 15	Other Date	Enter the date of the first consultation for the patient's condition. Date format is MM/DD/YY.
Field 16	Dates Patient Unable to Work in Current Occupation (From - To)	Date format is MM/DD/YY.
Field 17 (R)	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)	NPI	Enter the provider's National Provider Identifier number.
Field 18	Hospitalization Dates Related to Current Services (From - To)	Required for all inpatient claims. Enter hospitalization dates. Date format is MM/DD/YY.
Field 19	Additional Claim Information	Enter up to 80 characters of free form text
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 10th revision or 9 for ninth revision) Add up to 12 diagnosis codes and related A-L to service line below (24E)
Field 22	Resubmission Code Original Ref. No	Enter the appropriate frequency code: - 7 Replacement of prior claim - 8 Void/cancel of prior claim 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 the to
Field 24b (R)	Place of Service	This is a 2-digit code. Use current coding as indicated in the CPT Manual.
Field 24c	EMG	Enter the appropriate EMG number.
Field 24d (R)	Procedure, Services, or Supplies CPT/ HCPCS and Modifiers	Enter the appropriate CPT codes 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 Box 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 Family Plan	Indicate if the services were the result of Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services checkup or a family planning referral.
Field 24i (R)	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 listed on your W-9.
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?	All providers of Medicaid services are required to check Y.
Field 28 (R)	Total Charge	Enter the total charge for each single line item.
Field 29 (R)	Amount Paid	Enter any payment that you have received for this claim.
Field 30	Reserved for NUCC use	
Field 31 (R)	Full Name and Title of Physician or Supplier	Either the actual signature or typed / printed designation is acceptable.
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 3

Path to Health Approved Procedure Code List

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
10060	Incision & drainage of abscess	Simple or single
10061	Incision & drainage of abscess	Complicated or multiple
10160	Incision & drainage of abscess	Puncture aspiration of absess
11200	Removal of skin tags - 15 skin tags	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	Removal of skin tags - each additional 10 skin tags	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions; each addition 10 lesions, or part thereof (list separately in addition to code for primary procedure)
11300	Shaving of epidermal or dermal lesions - 0.5 cm or less	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301	Shaving of epidermal or dermal lesions - 0.6-1.0 cm	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 cm to 1.0 cm
12001	Minor Laceration Repair - Simple Repair 2.5 cm or less	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002	Minor Laceration Repair - Simple Repair 2.6 cm to 7.5 cm	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
12004	Minor Laceration Repair - Simple Repair 7.6 cm to 12.5 cm	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm
12005	Minor Laceration Repair - Simple Repair 12.6 cm to 20.0 cm	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm
12006	Minor Laceration Repair - Simple Repair 20.1 cm to 30.0 cm	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm
12007	Minor Laceration Repair - Simple Repair over 30.0 cm	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm
12011	Minor Laceration Repair - Simple Repair 2.5 cm or less	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013	Minor Laceration Repair - Simple Repair 2.6 cm to 5.0 cm	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
12014	Minor Laceration Repair - Simple Repair 5.1 cm to 7.5 cm	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12015	Minor Laceration Repair - Simple Repair 7.6 cm to 12.5 cm	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12016	Minor Laceration Repair - Simple Repair 12.6 cm to 20.0 cm	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12017	Minor Laceration Repair - Simple Repair 20.1 cm to 30.0 cm	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018	Minor Laceration Repair - Simple Repair Over 30.0 cm	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; Over 30.0 cm
12020	Minor Laceration Repair - Simple Repair	Treatment of superficial wound dehiscence; simple closure
12021	Minor Laceration Repair - Simple Repair; with packing	Treatment of superficial wound dehiscence; simple closure; with packing
13100	Benign Skin Tag, mole, wart removal (no pathology needed) - Repair, complex, trunk; 1.1 cm to 2.5 cm	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Benign Skin Tag, mole, wart removal (no pathology needed) - Repair, complex, trunk; 2.6 cm to 7.5 cm	Repair, complex, trunk; 2.6 cm to 7.5 cm
11400	Excision - benign lesions (trunk, arms and legs) 0.5 cm or less	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms, or legs; excised diameter 0.5 cm or less
11401	Excision - benign lesions (trunk, arms and legs) 0.6 to 1.0 cm	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms, or legs; excised diameter 0.6 cm to 1 cm
11420	Excision - benign lesions (scalp, neck, hands, feet) 0.5 cm or less	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genetalia; excised diameter 0.5 cm or less
11421	Excision - benign lesions (scalp, neck, hands, feet) 0.6 cm to 1.0 cm	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genetalia; excised diameter 0.6 cm to 1.0 cm
11440	Excision - benign lesions (face, ears, eyelids, nose, lips, mucous membrane) 0.5 cm or less	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision - benign lesions (face, ears, eyelids, nose, lips, mucous membrane) 0.6 to 1.0 cm	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
17000	Destruction, Benign or premalignant lesions- 1st lesion	Destruction (e.g., laser surgery, electro surgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g. actinic kerotoses); first lesion

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
17003	Destruction, premalignant lesions - 2-14 lesions	Destruction (e.g., laser surgery, electro surgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g. actinic kerotoses); second thru 14 lesions
17004	Destruction, premalignant lesions - 15 or more lesions	Destruction (e.g., laser surgery, electro surgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g. actinic kerotoses); 15 or more lesions
17110	Destruction, Benign lesions - up to 14 lesions	Destruction (e.g., laser surgery, electro surgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascualar proliferative lesions; up to 14 lesions
17111	Destruction, Benign lesions - 15 or more lesions	Destruction (e.g., laser surgery, electro surgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascualar proliferative lesions; 15 or more lesions
11765	Ingrown toenail removal	Wedge excision of skin of nail fold (eg, for ingrown toenail)
20550	Injection of tendon sheaths	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")
20551	Injection of tendon sheaths	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia") - Single tendon origin/insertion
20552	Injection of trigger points	Injection(s); single or multiple trigger point(s), 1 or 2 muscle (s)
20553	Injection of trigger points	Injection(s); single or multiple trigger point(s),3 or more muscles
20600	Injection of buse	Arthrocentesis, aspiration and/or injection, small joint or burse (e.g., fingers, toes); without ultrasound guidance
20605	Injection of buse	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20610	Injection of buse	Arthrocentesis, aspiration and/or injection,major joint or busa (e.g., shoulder, hip knee, subcromial bursa); without ultrasound guidance
36415	Venipuncture	Collection of venous blood by venipuncture
36416	Venipuncture	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
45330	Sigmoidscopy	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing
45331	Sigmoidscopy	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	Sigmoidscopy	Sigmoidoscopy, flexible; with removal of foreign body
45333	Sigmoidscopy	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
45334	Sigmoidscopy	Sigmoidoscopy, flexible; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	Sigmoidscopy	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	Sigmoidscopy	Sigmoidoscopy, flexible; with decompression of volvulus, any method
45338	Sigmoidscopy	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45340	Sigmoidscopy	Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures
45341	Sigmoidscopy	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	Sigmoidscopy	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45346	Sigmoidscopy	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45378	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45382	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45384	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more structures
45388	Colonoscopy	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45391	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
45392	Colonoscopy	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
46083	Treatment of minor hemorrhoids	Incision of thrombosed hemorrhoid, external
46320	Treatment of minor hemorrhoids	Incision of thrombosed hemorrhoid, external
71250	Lung Cancer Screening	Computed tomography, thorax; without contrast material
70360	X-Ray - Neck	Radiologic examination; neck, soft tissue
71045	X-Ray - Chest	Radiologic examination, chest; single view
71046	X-Ray - Chest	Radiologic examination, chest; 2 views
71100	X-Ray - Ribs	Radiologic examination, ribs; Unilateral; 2 views
71101	X-Ray - Ribs	Radiologic examination, ribs; Unilateral; 2 views; including posteroanterior chest, minimum of 3 views
71110	X-Ray - Ribs	Radiologic examination, ribs; Bilateral; 3 views
71111	X-Ray - Ribs	Radiologic examination, ribs; Bilateral; 3 views; including posteroanterior chest, minimum of 4 views
72020	X-Ray - Spine	Radiologic examination; spine, single view, specify level
72040	X-Ray - Spine, Cervical	Radiologic examination; spine, cervical; 2 or 3 views
72050	X-Ray - Spine, Cervical	Radiologic examination; spine, cervical; 4 or 5 views
72052	X-Ray - Spine, Cervical	Radiologic examination; spine, cervical; 6 or more views
72070	X-Ray - Spine, Thoracic	Radiologic Examinaition, spine; thoracic, 2 views
72072	X-Ray - Spine, Thoracic	Radiologic Examinaition, spine; thoracic, 3 views
72110	X-Ray - Spine, Lumbosacral	Radiologic Examination, spine, lumbosacral; minimum of 4 views
72114	X-Ray - Spine, Lumbosacral	Radiologic Examination, spine, lumbosacral; complete, including bending views, minimum of 6 views
72170	X-Ray - Pelvis	Radiologic Examination, pelvis; 1 or 2 views
72190	X-Ray - Pelvis	Radiologic Examination, pelvis; complete; minimum of 3 views
72220	X-Ray - Sacrum and Coccyx	Radiologic Examination, sacrum and coccyx, minimum of 2 views
73000	X-Ray - Clavicle	Radiologic Examination, clavicle, complete
73010	X-Ray - Scapula	Radiologic Examination, scapula, complete
73020	X-Ray - Shoulder	Radiologic Examination, shoulder, 1 view
73030	X-Ray - Shoulder	Radiologic Examination, shoulder, complete, 2 views

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
73060	X-Ray - Humerus	Radiologic Examination, humerus, minimum of 2 views
73070	X-Ray - Elbow	Radiologic Examination, elbow, 2 views
73080	X-Ray - Elbow	Radiologic Examination, elbow, complete, minimum of 3 views
73090	X-Ray - Forearm	Radiologic Examination, forearm, 2 views
73100	X-Ray - Wrist	Radiologic Examination, wrist; 2 views
73110	X-Ray - Wrist	Radiologic Examination, wrist; complete; minimum of 3 views
73120	X-Ray - Hand	Radiologic Examination, hand; 2 views
73130	X-Ray - Hand	Radiologic Examination, hand; minimum of 3 views
73140	X-Ray - Fingers	Radiologic Examination , fingers; minimum of 2 views
73501	X-Ray - Hip	Radiologic Examination, hip , unilateral, with pelvis when performed, 1 view
73502	X-Ray - Hip	Radiologic Examination, hip , unilateral, with pelvis when performed, 2-3 views
73503	X-Ray - Hip	Radiologic Examination, hip , unilateral, with pelvis when performed, minimum of 4 views
73521	X-Ray - Hip	Radiologic Examination, hip , bilateral, with pelvis when performed, 2 views
73522	X-Ray - Hip	Radiologic Examination, hip , bilateral, with pelvis when performed, 3-4 views
73523	X-Ray - Hip	Radiologic Examination, hip , bilateral, with pelvis when performed, minimum of 5 views
73551	X-Ray - Femur	Radiologic Examination, femur, 1 view
73552	X-Ray - Femur	Radiologic Examination, femur, minimum of 2 views
73560	X-Ray - Knee	Radiologic Examination, knee, 1 or 2 views
73562	X-Ray - Knee	Radiologic Examination, knee, 3 views
73564	X-Ray - Knee	Radiologic Examination, knee, 4 or more views
73565	X-Ray - Knee	Radiologic Examination, both knees, anteroposterior
73590	X-Ray - Tibia and Fibula	Radiologic Examination, tibia and fibula, 2 views
73600	X-Ray - Ankle	Radiologic Examination, ankle, 2 views
73610	X-Ray - Ankle	Radiologic Examination, complete ankle, minimum of 3 views
73620	X-Ray - Foot	Radiologic Examination, foot, 2 views
73630	X-Ray - Foot	Radiologic Examination, complete foot, minimum of 3 views
73650	X-Ray - Calcaneus	Radiologic Examination, calcaneus, minimum of 2 views
73660	X-Ray - Toe(s)	Radiologic Examination, toe(s) minimum of 2 views

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
74018	X-Ray - Abdomen	Radiologic Examination, abdomen; single view
74019	X-Ray - Abdomen	Radiologic Examination, abdomen; 2 views
74021	X-Ray - Abdomen	Radiologic Examination, abdomen; 3 or more views
74022	X-Ray - Abdomen	Radiologic Examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest
74263	Colorectal Cancer	Computed tomographic (CT) colonography, screening, including image postprocessing
76536	Ultrasound, Head and Neck	Ultrasound, Soft tissues of head and neck (E.g., thyroid, paratyroid, parotid), real time with image documentation
76604	Ultrasound, Chest	Ultrasound, chest (includes mediastinum), real time with image documentation
76642	Ultrasound, Chest	Limited, only once per breast, per session
76700	Ultrasound, Abdomen and Retroperitoneum	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, Abdomen and Retroperitoneum	Limited (e.g., single organ, quadrant, follow-up)
76770	Ultrasound, Abdomen and Retroperitoneum	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, Abdomen and Retroperitoneum	Limited
76800	Ultrasound, Spinal Canal	Ultrasound, spinal canal and contents
76830	Ultrasound, nonobstetrical	Ultrasound, transvaginal
76831	Ultrasound, nonobstetrical	Saline infusion sonohysterography(SIS), including color flow Doppler, when performed
76856	Ultrasound, nonobstetrical	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, nonobstetrical	limited or follow up (eg, for follicles)
76870	Ultrasound, Genitalia	Ultrasound, scrotum and contents
76872	Ultrasound, Genitalia	Ultrasound, transrectal
76873	Ultrasound, Genitalia	prostate volume study for brachytherapy treatment planning (separate procedure)
76881	Ultrasound, Extremities; complete	Ultrasound, extremity, nonvascualar, real-time with image documentation; complete
76882	Ultrasound, Extremities; Limited	Ultrasound, extremity, nonvascualar, real-time with image documentation; Limited, anatomic specific
77078	DXA Scan Osteoporosis	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
77080	DXA Scan Osteoporosis	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	DXA Scan Osteoporosis	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	DXA Scan Osteoporosis	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	DXA Scan Osteoporosis	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
80061	Lipid Disorders in Adults	Lipid panel
82270	Occult Blood - Colorectal Cancer Screening	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening
82274	Fecal Hemoglobin - Colorectal Cancer Screening	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82465	Lipid Disorders in Adults	Cholesterol, serum or whole blood, total
82947	Type 2 Diabetes Mellitus	Glucose; quantitative, blood (except reagent strip)
82948	Type 2 Diabetes Mellitus	Glucose; blood, reagent strip
83036	Hemoglobin; Glycosylated (A1C)	High performance liquid chromatography and ion exchange chromatography.
83718	Lipid Disorders in Adults	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83719	Lipid Disorders in Adults	Lipoprotein, direct measurement; VLDL cholesterol
83721	Lipid Disorders in Adults	Lipoprotein, direct measurement; LDL cholesterol
84478	Lipid Disorders in Adults	Triglycerides
86592	Syphilis - Sexually Transmitted Infections (STI) Screening	Syphilis test, non-treponemal antibody; qualitative
86592	Syphilis - Sexually Transmitted Infections (STI) Screening	Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis - Sexually Transmitted Infections (STI) Screening	Syphilis test, quantitative e.g.. VDRL, RPR
86631	Chlamydia - Sexually Transmitted Infections (STI) Screening	Chlamydia antibody
86632	Chlamydia - Sexually Transmitted Infections (STI) Screening	Chlamydia IGm
86689	HIV Antibody Screening - Sexually Transmitted Infections (STI) Screening	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	HIV-1 Screening	Antibody; HIV-1
86702	HIV -2 Screening	Antibody; HIV-2
86703	HIV -1 and HIV -2 Screening	Antibody; HIV-1 and HIV-2, single assay
86704	Hepatitis B Virus Screening	Hepatitis B core antibody (HBcAb); total

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
86706	Hepatitis B Virus Screening	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis B Virus Screening	Hepatitis Be antibody (HBeAb)
86803	Hepatitis C Virus Screening	Hepatitis C antibody
87110	Chlamydia and Gonorrhea	Culture, chlamydia, any source
87270	Chlamydia and Gonorrhea	Infectious agent antigen detection by immunofluorescent technique
87320	Chlamydia and Gonorrhea	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method
87340	Hepatitis B Virus Screening	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87390	HIV Screening	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1
87391	HIV Screening	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2
87491	Chlamydia and Gonorrhea	Infectious agent detection by nucleic acid (DNA or RNA); amplified probe technique
87492	Chlamydia and Gonorrhea	Infectious agent detection by nucleic acid (DNA or RNA); quantification
87590	Chlamydia and Gonorrhea	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591	Chlamydia and Gonorrhea	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87592	Chlamydia and Gonorrhea	Neisseria gonorrhea, quantification
87623	HPV DNA Testing for Women ages 30 or older	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification
87801	Chlamydia and Gonorrhea	Infectious agent detection by DNA or RNA, direct probe technique
87810	Chlamydia and Gonorrhea	Chlamydia antigen detection by immunoassay with direct optical observation
87850	Chlamydia and Gonorrhea	Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
90471	Adult Immunizations - Administration	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472	Adult Immunizations - Administration	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
90473	Adult Immunizations - Administration	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474	Adult Immunizations - Administration	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90581	Adult Immunizations - Anthrax	Anthrax vaccine, for subcutaneous or intramuscular
90585	Adult Immunizations - BCG	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Adult Immunizations - BCG	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90620	Adult Immunizations - Meningococcal	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular
90621	Adult Immunizations - Meningococcal	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use
90630	Adult Immunizations - Influenza	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90632	Adult Immunizations - Hepatitis A	Hepatitis A vaccine, adult dosage, for intramuscular use
90636	Adult Immunizations - Hepatitis A & B	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90649	Adult Immunizations - HPV: ages 9-26	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90650	Adult Immunizations - HPV: ages 9-26	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90651	Adult Immunizations - HPV: ages 9-26	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use
90653	Adult Immunizations - Influenza	Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
90654	Adult Immunizations - Influenza	Influenza virus vaccine, split virus, preservative-free, for intradermal use
90655	Adult Immunizations - Influenza	Influenza virus vaccine, split virus, preservative-free, 0.25 mL dosage, for intramuscular use
90656	Adult Immunizations - Influenza	Influenza virus vaccine, split virus, preservative-free, when administered to individuals 3 years and older, for intramuscular use
90658	Adult Immunizations - Influenza	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660	Adult Immunizations - Influenza	Influenza virus vaccine, live, for intranasal use

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
90661	Adult Immunizations - Influenza	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Adult Immunizations - Influenza	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Adult Immunizations - Pneumococcal (polysaccharide)	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90672	Adult Immunizations - Influenza	Influenza virus vaccine, quadrivalent, live, for intranasal use
90673	Adult Immunizations - Influenza	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90675	Adult Immunizations - Rabies	Rabies vaccine, for intramuscular use
90676	Adult Immunizations - Rabies	Rabies vaccine, for intradermal use
90686	Adult Immunizations - Influenza	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90688	Adult Immunizations - Influenza	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90690	Adult Immunizations - Typhoid	Typhoid vaccine, live, oral
90691	Adult Immunizations - Typhoid	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use
90697	Adult Immunizations - DTP	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
90698	Adult Immunizations - DTP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for intramuscular use
90707	Adult Immunizations - MMR (Measles, Mumps, Rubella)	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Adult Immunizations - MMRV (Measles, mumps, rubella, and varicella)	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90714	Adult Immunizations - DTP	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use
90715	Adult Immunizations - DTP	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Adult Immunizations - Varicella	Varicella virus vaccine, live, for subcutaneous use
90717	Adult Immunizations - Yellow Fever	Yellow fever vaccine, live, for subcutaneous use

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
90721	Adult Immunizations - DTP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	Adult Immunizations - DTP	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90732	Adult Immunizations - Pneumococcal (polysaccharide)	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90733	Adult Immunizations - Meningococcal	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734	Adult Immunizations - Meningococcal	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90736	Adult Immunizations - Zoster	Zoster (shingles) vaccine, live, for subcutaneous injection
90738	Adult Immunizations - Japanese Encephalitis	Japanese encephalitis virus vaccine, inactivated, for intramuscular use
90739	Adult Immunizations - Hepatitis B	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use
90740	Adult Immunizations - Hepatitis B	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 does schedule), for intramuscular use
90746	Adult Immunizations - Hepatitis B	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Adult Immunizations - Hepatitis B	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748	Adult Immunizations - Hepatitis B	Hepatitis B and Haemophilus influenza b vaccine (Hep- B-Hib), for intramuscular use
93000	Electrocardiogram (EKG)	Electrocardiogram, Routine ECG with at least 12 leads; with interpretation and report
93005	Electrocardiogram (EKG); Tracing only & no interpretation/report	Electrocardiogram, Routine ECG with at least 12 leads; with interpretation and report; Tracing only, without interpretation and report
93010	Electrocardiogram(EKG); Interpretation/report	Interpretation and report only
93040	Electrocardiogram(EKG); Rhythm ECG	Rhythm ECG, 1-3 leads; with interpretation and report
93041	Electrocardiogram(EKG); Rhythm ECG; Tracing only & no interpretation/report	Tracing only, without interpretation and report
93042	Electrocardiogram(EKG); Rhythm ECG; interpretation/report	Interpretation and report only
96127	Depression Screening	Brief emotional/behavioral assessment (for example, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
96160	Health Risk Assessment	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
96161	Health Risk Assessment	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
99000	Lab handling of specimens	Handling and preparation specimens if sending to an outside lab or state lab
99078	Tobacco Use Counseling and intervention	Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
99201	Office Visit - New Patient Level 1	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 min are spent face-to-face with the patient and/or family.
99202	Office Visit - New Patient Level 2	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office Visit - New Patient Level 3	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
99204	Office Visit - New Patient Level 4	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office Visit - New Patient Level 5	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99211	Office Visit - Established Patient Level 1	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office Visit - Established Patient Level 2	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office Visit - Established Patient Level 3	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
99214	Office Visit - Established Patient Level 4	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office Visit - Established Patient Level 5	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99241	Office Consultation - Level 1	Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and or/family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	Office Consultation - Level 2	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused histroy; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	Office Consultation - Level 3	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
99244	Office Consultation - Level 4	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	Office Consultation - Level 5	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
99385	Preventative Office Visit - Comprehensive Initial 18-39 years	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Preventative Office Visit - Comprehensive Initial 40-64 years	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99395	Preventative Office Visit - Reevaluation 18-39 years	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Preventative Office Visit - Reevaluation 40-64 years	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99401	Preventative Medicine Counseling 15 minutes - Obesity or other	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99401	Preventative Medicine Counseling 15 minutes - STI Behavioral	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
99402	Preventative Medicine Counseling 30 minutes - Obesity or other	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99402	Preventative Medicine Counseling 30 minutes - STI Behavioral	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventative Medicine Counseling 45 minutes - Obesity or other	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99403	Preventative Medicine Counseling 45 minutes - STI Behavioral	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventative Medicine Counseling 60 minutes - Obesity or other	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99404	Preventative Medicine Counseling 60 minutes - STI Behavioral	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Tobacco Use Counseling and intervention 3-10 minutes	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Tobacco Use Counseling and intervention greater than 10 minutes	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol Misuse: Screening and Behavioral Counseling for Adults 15 - 30 minutes	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol Misuse: Screening and Behavioral Counseling for Adults > 30 minutes	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
G0104	Colonoscopy - Colorectal Cancer	Colorectal cancer screening; flexible sigmoidoscopy
G0105	Colonoscopy - Colorectal Cancer	Colorectal cancer screening; colonoscopy on individual at high risk
G0106	Colonoscopy - Colorectal Cancer	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0120	Colonoscopy - Colorectal Cancer	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	Colonoscopy - Colorectal Cancer	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122	Barium Enema Colorectal Cancer	Colorectal cancer screening; barium enema
G0297	Low dose CT scan (LDCT) for lung cancer screening	Low-dose computed tomography for lung cancer screening
G0328	Fecal occult blood test immunoassay - colorectal cancer screening	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations

CPT Code	*Procedure*	*CPT/HCPCS Code Description*
G0442	Alcohol Misuse: Screening and Behavioral Counseling for Adults	Annual alcohol misuse screening, 15 minutes
G0443	Alcohol Misuse: Screening and Behavioral Counseling for Adults	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Depression Screening	Annual depression screening, 15 minutes
G0445	Sexually Transmitted Infections: Behavioral Counseling	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, performed semi-annually, 30 minutes
G0446	Healthy Diet Counseling	Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes
G0447	Obesity Counseling	Face-to-face behavioral counseling for obesity, 15 minutes
G0472	Hepatitis C Virus Screening	Hepatitis C antibody screening for individual at high risk and other covered indication(s)
G0473	Obesity Counseling	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
Q2035	Immunizations Adult Influenza	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)
Q2036	Immunizations Adult Influenza	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)
Q2037	Immunizations Adult Influenza	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)
Q2038	Immunizations Adult Influenza	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	Immunizations Adult Influenza	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)
S8092	CT - electron beam for lung cancer screening	Electron beam computed tomography (also known as Ultrafast CT, Cine CT)
S9453	Tobacco Use Counseling and intervention - smoking cessation classes	Smoking cessation classes, non-physician provider, per session

Please note, a PDF version of the Path to Health Pre-Approved Codes list is available at:
http://pathtohealth.amm.cc/Home/Providers

Please refer to the prescription formulary located at:
www.mypathtohealth.org

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