CONNECT TO CARE BY CMSP

CONEXION A LA SALUD DE CMSP

Connect to Care

by CMSP

Provider Operations Manual

AMM
ADVANCED MEDICAL MANAGEMENT, INC.
Third Party Administrator

Version 2.0 September 2021

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For additional information regarding the Connect to Care Program, please visit:

https://connecttocare.amm.cc/

Section 1.0 - Introduction

1.1 Welcome to the Connect to Care Program by CMSP

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

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

This manual is a guide for providers participating in the Connect to Care Program by CMSP. For information regarding CMSP benefits, please refer to the *CMSP Provider Operations Manual* available at https://cmsp.amm.cc/providers/.

1.2 Background

In April 2019, the Governing Board approved development and implementation of the Connect to Care program for eligible adults that are not otherwise enrolled in CMSP (full scope or emergency services only). This program is intended to extend primary care services to residents of CMSP counties who are uninsured and otherwise eligible for CMSP but have not applied for CMSP.

1.3 Mission

The mission of the Connect to Care program is to extend access to primary care services to eligible uninsured residents of CMSP counties in order to improve their health outcomes, reduce their utilization of emergency services, inpatient hospitalization, and enable select community health centers to enroll new members.

1.4 Important Contact Information

Advanced Medical Management, Inc. (AMM) – **(888) 614-0846**

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

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

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

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

1.5 Service Areas

The service areas for Connect to Care are CMSP's 35 counties. The income range to qualify for the new benefit is over 138% FPL and up to 300% FPL. Applications can be submitted through participating community health centers using the Connect to Care online eligibility enrollment system.

1.6 Claim Submission

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

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

Electronic claim submissions are preferred.

Below are the payer IDs for approved clearinghouses:

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

You can also find this list of approved clearinghouses at:
https://connecttocare.amm.cc/Providers

Please refer to Section 6.0 for additional claims filing instructions.

1.7 Information Pertaining to FQHC

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

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

- CMSP Governing Board has a contract amendment with all FQHCs serving as Enrollment providers in the Connect to Care Program.
- All FQHC claims must be completed on a UB-04 claim form.
- Claims must identify all services rendered with the appropriate CPT, HCPCS and Revenue Codes. Claims submitted with incorrect or obsolete codes will be rejected.
- Patients must be seen by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Marriage and Family Therapist (MFT), Certified Drug and Alcohol Counselor, or psychologist in

order for FQHC claims to be considered for reimbursement. Patients may also be seen by the following assistant and associate-level providers under the direct supervision of a licensed mental health professional:

- Associate MFT
- Associate Professional Clinical Counselor
- Associate Clinical Social Worker
- Psychology Assistant

- Billed codes must be on the Connect to Care Approved Procedure Code List to be eligible for payment. For the most updated version of the Connect to Care Approved Procedure Code List, visit: https://connecttocare.amm.cc/Providers

Section 2.0 – Administrative Procedures

2.1 Provider Operations Manual

The Provider Operations Manual explains the policies and administrative procedures of the Connect to Care 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 any 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 Connect to Care website. It is important that you and/or your office staff read the communications from AMM regarding Connect to Care 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 to access the encrypted email:

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

The secure system provides additional features that include, password resetting, and replying to or creating messages. If you need technical assistance or have questions about Secure email, contact our Customer Service department at (888) 614-0846.

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 **(888) 614-0846**.

2.6 Member Eligibility

Connect to Care participants are in the income range of over 138% FPL and up to 300% FPL, live in one of the 35 CMSP counties, and are between the ages of 21-64 years old. To complete the Connect to Care member enrollment process, participating community health centers are responsible for registering the patient's information through the secure registration/enrollment online portal maintained by the CMSP Governing Board as well as with consent from the patient to participate in the program. For eligibility support or questions please visit https://myconnecttocare.org/ or contact the Connect to Care Enrollment Help Desk at (800) 548-5880.

2.7 Eligibility Verification and ID Cards Overview

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

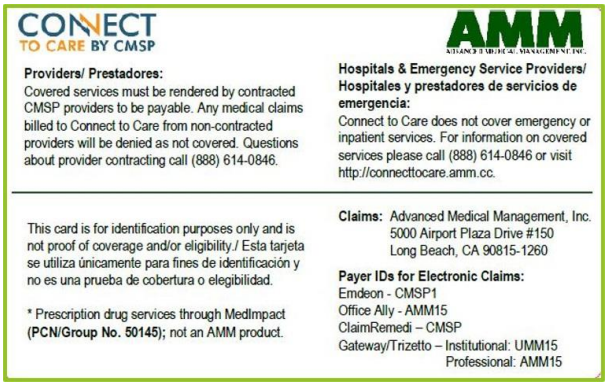
At each visit, before rendering services, the provider must ask the member for their ID card to verify program eligibility. The provider can verify eligibility by:

- Checking the Connect to Care enrollment portal online.
- Verifying the eligibility effective dates on the member's Connect to Care ID Card.
- Contacting AMM at (888) 614-0846.

2.8 Connect to Care Benefit Member ID Card


CONNECT TO CARE BY CMSP
CONEXION A LA SALUD DE CMSP
Member Name/ Nombre del afiliado:
Member ID/ ID del afiliado:
Benefit Period/ Periodo de elegibilidad :
Connect to Care Customer Service/ Servicio de atención al cliente: (888) 614-0846
TTY Line/ Linea de TTY (teléfono de texto): (562) 429-8162
*Pharmacy Services/ Servicios farmacéuticos: (800) 788-2949
*$5/Rx and $1,500/Rx maximum may apply.
*Puede aplicar un máximo de 5 USD por receta y 1500 USD por receta.
Please refer to the Connect to Care website below for additional benefit information and list of covered & non-covered services.
Por favor de consultar el sitio web de Connect to Care disponible abajo para obtener información adicional sobre los beneficios y una lista de los servicios que estan cubiertos y los que no.
http://connecttocare.amm.cc

Front


CONNECT TO CARE BY CMSP
AMM
Providers/ Prestadores:
Covered services must be rendered by contracted CMSP providers to be payable. Any medical claims billed to Connect to Care from non-contracted providers will be denied as not covered. Questions about provider contracting call (888) 614-0846.
Hospitals & Emergency Service Providers/ Hospitales y prestadores de servicios de emergencia:
Connect to Care does not cover emergency or inpatient services. For information on covered services please call (888) 614-0846 or visit http://connecttocare.amm.cc.
This card is for identification purposes only and is not proof of coverage and/or eligibility./ Esta tarjeta se utiliza únicamente para fines de identificación y no es una prueba de cobertura o elegibilidad.
* Prescription drug services through MedImpact (PCN/Group No. 50145); not an AMM product.
Claims: Advanced Medical Management, Inc.
5000 Airport Plaza Drive #150
Long Beach, CA 90815-1260
Payer IDs for Electronic Claims:
Emdeon - CMSP1
Office Ally - AMM15
ClaimRemedi – CMSP
Gateway/Trizetto – Institutional: UMM15
Professional: AMM15

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 member ID card was issued. Members are instructed, through their Connect to Care Member Guide, to notify providers of their coverage at each visit or as soon as possible.

Section 3.0 – Covered and Non-Covered Benefits

The Connect to Care Program offers primary care and preventative 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 Connect to Care 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 Connect to Care Covered Benefits

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

- Outpatient visits with primary care provider or specialist
  - ✓ **Note:** Physical Therapy services limited to twenty-four (24) visits per benefit period. Physical Therapy services in excess of twenty-four (24) visits within a member's benefit period will not be payable by Connect to Care.
- In-Office minor medical procedures
- Preventative screenings, routine lab tests, and adult immunizations

- Specified radiology services
- Screening for depression, alcohol misuse, obesity counseling
- Screening for HIV, HPV, Hepatitis B/C, and STI screening
- Outpatient Mental Health Services (mild to moderate)
  - ✓ **Note:** Six (6) visits per enrollment period for Connect to Care of any combination of covered individual, family, and/or group treatment or evaluations
- Outpatient Substance Abuse Disorder Services
  - ✓ **Note:** Six (6) visits per enrollment period for Connect to Care of any combination of covered individual and/or group treatment or screenings.
- Tobacco use counseling and intervention (performed by physician)
- Prescription medications (specialty medications excluded) with $5 copay and $1500 limit per benefit period and $500 limit per claim.

Services Covered under Connect to Care Include:

Primary care or specialist office visits	**Screenings for HIV, HPV, Hepatitis B & C, STI Screenings**
Routine screening laboratory testing	**Screening for depression, alcohol misuse, obesity counseling (performed by a physician)**
Prescription medications with a $5 copay per prescription (up to $500 per claim and $1500 maximum benefit limit)	**Preventative health screenings**
Various in-office minor medical procedures	**EKG, Osteoporosis, DEXA Scan**
Specified X-rays of head, neck, chest, trunk, upper and lower extremities	**Colorectal cancer screening**
Adult Immunizations	**Tobacco use counseling and intervention (performed by a physician)**
Mental Health Services (Mild to Moderate)	**Outpatient Substance Abuse Disorder Services**

For a complete list of covered benefits and procedure codes, please visit:
https://connecttocare.amm.cc/Providers

3.2 Pharmacy

Pharmacy benefits are administered for Connect to Care members by MedImpact Healthcare Systems, Inc. (MedImpact) a pharmacy benefits manager (PBM). Members must have prescriptions filled by participating local retail pharmacies (visit https://myconnecttocare.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 Connect to Care enrollment period.

For additional information on the Connect to Care Drug Formulary, visit https://myconnecttocare.org/. Providers or members with issues involving the Connect to Care Prescription Drug Program or with specific questions about pharmacy benefit coverage should contact MedImpact's Customer Service Line at (800) 788-2949. This service line is available 24/7.

3.3 Services Not Covered by Connect to Care

Connect to Care will not pay for services rendered by providers not contracted by CMSP, services not listed on Connect to Care Approved Procedure Code List (see Appendix C), or for pharmacies not participating in the Connect to Care Program.

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

- Associate MFT
- Associate Professional Clinical Counselor
- Associate Clinical Social Worker
- Psychology Assistant

Specific services that are **NOT** covered by Connect to Care include:

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

3.4 Emergency Services
Connect to Care benefits do not include emergency services. For more information on qualifying for emergency services coverage please have the member contact their local social services office.

3.5 Pregnancy and Postpartum Services
Pregnancy and postpartum services are not covered by Connect to Care. Please refer any pregnant Connect to Care member to the county social services department to initiate an application for Medi-Cal.

3.6 Breast or Cervical Cancer
Please refer any Connect to Care 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 Connect to Care 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 Connect to Care eligibility before providing care
- Verify the member's eligibility at each appointment and immediately before giving 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 Connect to Care 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
- Provide, upon request, timely responses and medical information to AMM
- Provide timely responses to reasonable requests by the CMSP Governing Board, Advanced Medical Management, Inc. or the member for information regarding services provided to the member
- Give information to the member or member's legal representative about the illness, course of treatment and prospects for recovery in terms the member can understand
- Maintain legible and accurate medical records in a secured location
- Keep all member information confidential, as required by state and federal law
- All providers who are involved in the treatment of a member share responsibility in communicating clinic findings, treatment plans, prognosis, and the psychosocial condition of such member with the member's providers to ensure coordination of the member's care.

5.2 Oversight of Non-Physician Providers

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

5.3 Members' Rights and Declarations

All providers shall actively support the *Members' Rights and Declarations* as written and provided on AMM's website at: https://connecttocare.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

Multilingual representatives are available by contacting Customer Service at (888) 614-0846 during normal office hours Monday – Friday from 8 a.m. to 5 p.m.

For language interpretation in Chinese, Tagalog, Arabic, French, and other languages, contact the Language Line at: (888) 808-9008, PIN: 20810990.

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

Section 6.0 – Claims and Billing

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

6.1 Fee Schedule

Provider rates of reimbursement or compensation for serving Connect to Care members are specified in the clinic or provider's CMSP Provider Agreement and Connect to Care Addendum. For assistance with understanding the fee schedule, please contact Customer Services at (888) 614-0846. For CMSP's Rate Policy, please refer to: https://www.cmspcounties.org/billing-claims-payment/.

6.2 Timely Filing of Claims

Please refer to the grid below on the timely filing of claims. Claims submitted by non-contracted providers are not covered under Connect to Care and will be denied.

Action and Description	Required Timeline
First Time Claims Submissions	All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement: • 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 (888) 614-0846 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 Appeal/Dispute Form located at https://connecttocare.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: • Claims should be filed within 150 calendar days from the date of the denial from the third party.
Submitting Corrected Claims If the provider originally billed with the wrong information (i.e., incorrect member ID or DOB), the filing limit starts from the denial date of the original claim.	All providers should refer to their Agreement for timely filing details. In lieu of any other period provided in the Agreement: • Corrected claims must be filed within 60 business days from the denial date of the originally submitted claim.

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

Call Customer Service at (888) 614-0846 with questions regarding the completion of the claim form. Customer Service hours are Monday through Friday, 8 a.m. to 5 p.m. except major holidays.

Use the member's Connect to Care ID number when billing, whether submitting electronically or by paper.

Many Connect to Care members may also qualify for other programs, such as:

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

Please see the *CMSP Provider Operations Manual* for a list of other programs available 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:

- Reduced costs (saves on staffing, overhead, claim forms, mailing materials, and postage)
- Tracking and monitoring of claims (no claims "lost in the mail")
- Faster turnaround times
- 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 to 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.

Providers can contact EDI services by telephone at (888) 614-0846 or by email at support@amm.cc.

AMM will accept 5010 compliant 837 transactions directly from providers. Implementation guides are available at: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/5010a1837bcg.pdf

Please note, enrollment is required. Providers can enroll by contacting EDI services at (888) 614-0846 or by email at support@amm.cc.

AMM accepts the following HIPAA compliant claim format:

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

Below are the payer IDs for approved clearinghouses:

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

You can also find this list of approved clearinghouses at:
https://connecttocare.amm.cc/Providers

Providers should contact EDI services by telephone at (888) 614-0846 or by email at support@amm.cc if their preferred clearinghouse is not listed.

6.4 Paper Claims

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

CMSP – Advanced Medical Management, Inc.
ATT: Claims Department
5000 Airport Plaza Drive, STE 150
Long Beach, CA 90815

6.5 Clinical Record Submissions Categories

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

- Claims involving certain modifiers, including but not limited to Modifier 22 and/or Modifier 95 for telemedicine services
- Claims involving unlisted codes
- Claims for which AMM cannot determine from the face of the claim whether it involves a covered service, thus the benefit determination cannot be made without reviewing medical records (including but not limited to 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 FQHCs must bill using a UB-04 claim form, with appropriate codes, and in a manner acceptable to AMM. Professional claims should bill using a CMS 1500 form along with the appropriate codes.

All Connect to Care 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

All clean claims will be processed within 30 days from the day of receipt. 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 untimely filing. Include a copy of the reject letter with your corrected claim submission. Refer to Section 6.2 regarding *Timely Filing of Claims*.

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

6.10 Claims Appeals Process

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

Providers must submit their request for consideration in writing or by fax within 60 business days from the date of the provider's receipt of the Explanation of Benefits (EOB). Providers may download a *Claim Appeal/Dispute Form* on AMM's website at: https://connecttocare.amm.cc/Providers. The provider's submission must include a complete *Claim Appeal/Dispute form*, a copy of the original and/or corrected claim form, and supporting documentation not previously considered to:

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

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 the 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 (888) 614-0846. For a claim's 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.

Provider *Complaint/Grievance Forms* available at: https://connecttocare.amm.cc/Providers. Providers may fax the form to (562) 766-2006 or submit the form 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

or

Fax: (916) 649-2606

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

7.2 Provider Appeals of Non-Medical Necessity Claims Determinations

A provider may appeal a decision regarding the payment of a claim that is not related to a medical necessity determination. For these appeals, providers should follow the Claims Appeal procedures set forth in the Claims and Billing Section.

If contracted providers exhaust the AMM appeal resolution process and are dissatisfied with the resolution, contracted providers have the right to arbitration as specified in their Participating CMSP Provider Agreement and Connect to Care Amendment.

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

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

or

Fax: (916) 649-2606

In addition, contracted providers may request arbitration pursuant to the conditions set forth in their CMSP Provider Agreement and Connect to Care Amendment.

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

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.

Section 8.0 – Member Grievance and Appeals

8.1 Member Grievances or Complaints

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

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

1. Identify areas of physician practice, which could be improved.
2. Discover specific instances of inappropriate or sub-standard medical practice on the part of a provider.
3. Correct the problems identified in items 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 (888) 614-0846 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: https://connecttocare.amm.cc/Members.

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 the 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 (888) 614-0846 or by completing the Member Appeal form at https://connecttocare.amm.cc/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.

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 fax, 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:

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

or

Fax: (916) 649-2606

CMSP will send a letter to the member:

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

Appendix 1

CMS 1500 Claim Form Specifications

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

(R) = Required Field

Field Number	Title	Description
Field 1	Type of Insurance Medicare / Medicaid / TRICARE / CHAMPUS / CHAMPVA / Group Health Plan / FECA Blk Lung / Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box; Only one box can be marked
Field 1a **(R)**	Insured's ID Number	Enter the patient's Connect to Care ID number as shown on the patient's ID card
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/YYYY (Month/Day/Year). Check the appropriate box for the patient's sex; If sex is unknown, leave blank
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; If patient is homeless or address is unknown, enter "Unknown" or "Homeless"
Field 6 **(R)**	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to insured
Field 7 **(R)**	Insured's Address	"Same" is acceptable if the insured is the patient
Field 8	Reserved for NUCC	LEAVE BLANK
Field 9 **(R) – if applicable**	Other Insured's Name	If there is other insurance coverage in addition to the member's Connect to Care coverage, enter the name of the insured
Field 9a **(R) – if applicable**	Other Insured's Policy or Group Number	Enter the name of the other insurance coverage with the group and policy number
Field 9b	Reserved for NUCC use	LEAVE BLANK
Field 9c	Reserved for NUCC use	LEAVE BLANK
Field 9d **(R) – if applicable**	Insurance Plan Name or Program Name	Enter the name of the other insurance plan or program name
Field 10 **(R)**	Patient's Condition Related To	Enter an X in the correct box to indicate whether one or more of the services described in Field 24 are for a condition/injury that occurred on the job or as a result of an automobile or other accident; Only one box on each line can be marked
Field 10a **(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. If Y, 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)	LEAVE BLANK
Field 11	Insured's Policy Group or FECA Number	Insured's group number; Complete information about insured, even if same as patient
Field 11a	Insured's Date of Birth / Sex	Use the date of birth format – MM/DD/YY. Check M (male) or F (female); If sex is unknown, leave blank
Field 11b	Other Claim ID (Designated by NUCC)	For Workers; Compensation of Property & Casualty. Required if known; Enter the claim number assigned by the payer
Field 11c	Insurance Plan Name or Program Name	Enter the name of the plan carrier
Field 11d **(R)**	Is There Another Health Benefit Plan?	Check Y or N. If yes, complete items 9A-9D
Field 12	Patient's or Authorized Person's Signature	Sign and date the form ("Signature on file" indicates that the appropriate signature obtained by the provider is acceptable for this field.)
Field 13	Insured's or Authorized Person's Signature	Sign and date the form ("Signature on file" is acceptable for this field.)
Field 14 **(R)**	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the date of the injury, illness or pregnancy (if applicable)
Field 15	Other Date	Enter the date of the first consultation for the patient's Condition; Date format is MM/DD/YYYY
Field 16	Dates Patient Unable to Work in Current Occupation (From - To)	Date format is MM/DD/YYYY
Field 17 **(R) – if applicable**	Name of Referring Physician or Other Source	Enter the name of physician, clinic or facility referring the patient to the provider
Field 17a	Other ID#	This field is available to enter another identification number
Field 17b **(R) – if applicable**	NPI	Enter the provider's National Provider Identifier number
Field 18	Hospitalization Dates Related to Current Services (From - To)	If applicable, enter hospitalization dates; Date format is MM/DD/YY
Field 19	Additional Claim Information	Enter up to 80 characters of free form text; add assistant/associate level provider in this section and bill under supervising physician.
Field 20	Outside Lab? (Yes or No); $ Charge	Check Yes if lab services were sent to an outside lab; check No if not.
Field 21 **(R)**	ICD Indicator Diagnosis or Nature of Illness or Injury	Enter the appropriate ICD indicator (0 for 10th revision or 9 for 9th revision) Add up to 12 diagnosis codes and related A-L to service line below (24E)

Field 22 **(R) – if applicable**	Resubmission Code Original Ref. No	Enter the appropriate frequency code: - 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" and "to"; If there is only one date of service, re-enter the "from" date in the "to" field
Field 24b **(R)**	Place of Service	This is a 2-digit code; Use current coding as indicated by CMS
Field 24c	EMG	Enter the appropriate EMG number if service was an emergency
Field 24d **(R)**	Procedure, Services, or Supplies CPT/ HCPCS and Modifiers	Enter the appropriate CPT or HCPCS code(s) or nomenclature. Indicate appropriate modifier when applicable. Do not use NOC codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description
Field 24e **(R)**	Diagnosis Pointer	Enter up to 4 diagnosis reference letters (A-L) from diagnosis codes listed in Field 21
Field 24f **(R)**	$ Charges	Enter the charge for each line item
Field 24g **(R)**	Days or Units	Enter the quantity of services for each itemized line
Field 24h	EPSDT?	Indicate if the services were the result of Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services checkup
Field 24i	ID Qualifier / NPI	In the shaded area, enter the identifying qualifier if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24j in the shaded area
Field 24j **(R)**	Rendering Provider NPI	Entering the rendering provider NPI in the unshaded field of Box 24J
Field 25 **(R)**	Federal tax identification number (TIN)	This is the 9-digit tax ID number of the billing provider in Field 33
Field 26	Patient's Account Number	This is for the provider's use in identifying patients and allows up to nine numbers or letters (no other characters are allowed)
Field 27 **(R)**	Accept Assignment?	Enter an X in the correct box; This indicates the provider agrees/disagrees to accept assignment under the payer's program
Field 28 **(R)**	Total Charge	Enter the total charge/billed amount for the services in Field 24F
Field 29 **(R)**	Amount Paid	If applicable, enter any payment that you have received for this claim from the patient or other payers
Field 30	Reserved for NUCC use	LEAVE BLANK
Field 31 **(R)**	Full Name and Title of Physician or Supplier	Enter the legal signature of the practitioner including degrees/credentials or enter "Signature on File"; Enter the date the form was signed using the MM/DD/YYYY format

Field 32 **(R)**	Service Facility Location Information	Required when the service location is different than that of the billing provider; Facility Name, Address, City, State, Zip and NPI fields are required
Field 32a **(R)**	NPI	Enter the service facility's National Provider Identifier number (if appropriate)
Field 32b	Facility secondary ID	This field is available for you to enter another identification number
Field 33 **(R)**	Billing Provider Info and PH #	Enter the billing provider name, street, city, state, ZIP code and telephone number
Field 33a **(R)**	NPI	Enter the billing provider's National Provider Identifier number
Field 33b	Billing Provider Secondary ID	This field is available for you to enter another identification number

Appendix 2

UB-04 Claim Form Specifications

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

(R) = Required Field

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

Field 37	Reserved	LEAVE BLANK
Field 38	Responsible Party Name and Address	Enter the name and address of the party responsible for the bill
Field 39-41	Value Codes (Code / Amount)	Enter if any value span codes are applicable to the claim
Field 42 **(R)**	Revenue Code	Enter Revenue Code
Field 43 **(R)**	Revenue Code Description	Description of Revenue Code
Field 44 **(R) – if applicable**	HCPCS/Accommodation Rates/HIPPS Rate Codes	The accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient and FQHC
Field 45 **(R)**	Service Date	For outpatient claims, enter the date on which the indicated service was provided using MM/DD/YYYY format
Field 46 **(R)**	Service Units	Enter the quantitative measure of services rendered by revenue category for the patient.
Field 47 **(R)**	Total Charges	Enter the total charges pertaining to the revenue code for the current billing period as entered in the statement covers period (Field 6)
Field 48	Non-Covered Charges	Enter non-covered charges
Field 49	Reserved	LEAVE BLANK
Field 50 **(R)**	Payer Name	Enter the name of each plan from which the provider might expect some payment for the bill in order of liability
Field 51	Payer Health Plan Identification Number	Enter the number used to identify the payer or health plan.
Field 52 **(R)**	Release of Information Certification Indicator	Enter I (Informed Consent) or Y (Signed statement permitting release of medical billing data)
Field 53	Assignments of Benefits Certification Indicator	Enter Y (Benefits Assigned) or N (Benefits Not Assigned or W (Not Applicable)
Field 54	Prior Payments	Enter dollar amount of any payments received applicable towards this bill
Field 55	Estimated Amount Due - Payer	Enter the estimated amount due from the indicated payer in Field 50on lines A, B and C
Field 56 **(R)**	NPI – Billing Provider	Enter the NPI assigned to the provider submitting the bill
Field 57	Other (Billing) Provider Identifier	LEAVE BLANK
Field 58 **(R)**	Insured's Name	Enter the name of patient or insured individual
Field 59 **(R)**	Patient's relationship to Insured	Enter the code that indicates the relationship of the patient to the insured individual identified in Field 58
Field 60 **(R)**	Insured's Unique Identifier	Enter patient's Connect to Care ID number
Field 61	Group Name	LEAVE BLANK
Field 62	Insurance Group Number	LEAVE BLANK
Field 63	Authorization Code / Referral Number	Enter Referral number or Prior Authorization number
Field 64	Document Control Number	Enter the internal control number assigned to the original bill by the payer
Field 65	Employer Name	LEAVE BLANK
Field 66	Diagnosis and Procedure Code Qualifier (ICD version)	Enter (0 for 10th revision or 9 for 9th revision)
Field 67**(R)**	Principal Diagnosis Code	Use the current version of ICD-CM; enter the principal diagnosis code (the condition to be chiefly responsible for causing the visit)
Field 67a - q	Other Diagnosis Codes	Use the current version of ICD-CM; enter all diagnosis codes that coexist at the time of visit, that develop subsequently or that affect the treatment received

Field 68	Reserved	LEAVE BLANK
Field 69 **(R)**	Admitting Diagnosis	Use the current version of ICD-CM; enter the code describing the patient's diagnosis or reason for visit
Field 70 **(R)**	Patient's Reason for Visit	Use the current version of ICD-CM; enter the code describing the patient reason for the visit at the time of outpatient registration
Field 71	Prospective Payment System (PPS) Code	Enter the PPS code
Field 72a-c	External Cause of Injury codes	Use the current version of ICD-CM; Enter the code pertaining to the external cause of injury, poisoning or adverse effect
Field 73	Reserved	LEAVE BLANK
Field 74	Principal Procedure Code and Date	Use the current version of ICD-PCS; Enter the code for the principal procedure performed at the claim level during the period covered by this bill and the corresponding date on which the principal procedure was performed
Field 74a-e	Other Procedure Codes and Dates	Use the current version of ICD-PCS; Enter up to 5 additional PCS codes other than the principal procedure, and the corresponding dates
Field 75	Reserved	LEAVE BLANK
Field 76 **(R)**	Attending Provider Name and Identifiers	Enter attending physician's NPI, Last Name, and First Name
Field 77	Operating Physician Name and Identifiers	Enter Operating physician's NPI, Last Name, and First Name
Field 78 – 79	Other Provider Names and Identifiers	Enter Other physician's NPI, Last Name, and First Name.
Field 80	Remarks	Use this field to explain special situations
Field 81	Code - Code	LEAVE BLANK

Appendix 3

Connect to Care Approved Procedure Code List

For the most updated version of the Connect to Care Approved Procedure Code List, visit https://connecttocare.amm.cc/Providers.

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

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