CMSP
COUNTY MEDICAL SERVICES PROGRAM

County Medical Services Program (CMSP) Provider Operations Manual

AMM
ADVANCED MEDICAL MANAGEMENT, INC.

Third Party Administrator

Version 5.0 - March 2024

Provider Operations Manual - Table of Contents

For additional information regarding CMSP, please visit:
https://cmsp.amm.cc/ and https://cmspcounties.org/

Section 1.0 - Introduction

1.1 Welcome to the County Medical Services Program (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.

The CMSP Governing Board provides health coverage to medically indigent adults in 35 primarily rural California counties. AMM knows providers are essential in delivering high-quality, cost-effective medical services to low-income Californians. We further acknowledge that the success of CMSP would not be possible without your participation. We are dedicated to earning your ongoing support and we look forward to working with you to provide the best service possible to CMSP members.

1.2 Background

The CMSP Governing Board contracts with Advanced Medical Management, Inc. for the administration of medical and dental benefits for CMSP. The CMSP Governing Board contracts with MedImpact Healthcare Systems, Inc. to provide pharmacy benefit management services.

The CMSP Governing Board provides limited-term health care coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health programs like Medi-Cal and who meet CMSP eligibility requirements (such as income limits, asset limits, county residence). Eligibility for CMSP benefits is determined by the County Social Services Department in each participating CMSP county. CMSP eligibility information is available online at https://cmspcounties.org/eligibility-information-resources/.

1.3 Mission

The mission of the County Medical Services Program is to assist participating counties in meeting their indigent health care responsibilities by partnering with these counties to deliver cost-effective, high quality health care services to CMSP members. Maintaining the fiscal soundness of CMSP is essential for CMSP to fulfill its mission.

1.4 Important Contact Information

Advanced Medical Management, Inc. (AMM) – **(877) 589-6807**

- ✓ *Types of Inquiries:* Customer Service, Medical, Utilization Management, Provider Network, Provider Contracting, Dental, Claims, Grievances and Appeals
- ✓ AMM's authorization for hospital admission – **(877) 589-6807**
  - For after-hours: **(562) 310-2145**

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

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

1.5 Service Area

Advanced Medical Management, Inc. administers health care services on a self- funded basis for medically indigent adults served by the CMSP Governing Board in 35 participating California counties. See the California CMSP Participating Counties Map at https://cmspcounties.org/cmsp-map/.

1.6 Claim Submission

Paper claims are to be submitted to the following contracted clearinghouses or mailed to this address:

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

Electronic claim submissions are preferred.

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

For a complete list of AMM/CMSP clearinghouses please visit:
https://cmsp.amm.cc/Payer/ClaimBilling

Please refer to Section 8.0 for additional claims filing instructions.

Section 2.0 – Administrative Procedures

2.1 Provider Operations Manual

The Provider Operations Manual explains the policies and administrative procedures of CMSP. 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 you hold with the CMSP Governing Board. Any updates, revisions and amendments to this Manual will be provided on a periodic basis on https://cmsp.amm.cc/. It is important that you and/or your office staff read the communications from AMM regarding CMSP 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:

- ✓ 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 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 **(877) 589-6807**.

2.3 Privacy & 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 go to https://cmsp.amm.cc/.

2.4 Fraud & 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 go to https://cmsp.amm.cc/.

2.5 Misrouted Proprietary & 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)589-6807**.

2.6 EZ Net Website (Provider Portal)

While this Provider Operations Manual is used as the source of CMSP information, CMSP network providers may also access EZ Net, a secure online provider portal, to obtain authorization for services and other important information, including but not limited to:

- ✓ Prior authorization requirements
- ✓ Claim history
- ✓ Member eligibility

Once you register for an account you will receive additional training on how to navigate the system.

Please refer to Section 9.0 for additional instructions on submitting authorizations.

2.7 Member Eligibility

Current CMSP eligibility requirements are posted on https://cmspcounties.org/. AMM electronically updates member eligibility each day following notification by CMSP or its contracted eligibility agent of changes in member eligibility in CMSP. On occasion, member eligibility may be reported to Advanced Medical Management, Inc. retroactively.

Following enrollment in CMSP, the member receives the following member identification cards:

- ✓ A State of California Beneficiary Identification Card (BIC) - this card is also used for the Medi-Cal program
- ✓ Member Identification Card for the CMSP Benefit

At each visit, before rendering services, the provider must ask for both cards to verify program and plan eligibility and to determine if share of cost (SOC) applies. The provider can verify eligibility by:

- ✓ Swiping the Benefit Identification Card (BIC) in the POS device (some members may have share of cost)
- ✓ Accessing the EZ Net website by going to https://logineznet.amm.cc/EZ-NET60/login.aspx
- ✓ Contacting AMM at (877) 589-6807

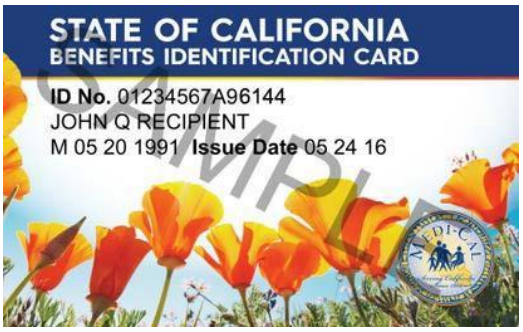
2.8 Beneficiary Identification Card

Providers may use the BIC to verify eligibility through various California state eligibility verification resources:

- ✓ Swipe the BIC in the point-of-service (POS) device at each visit to verify eligibility and to determine if a SOC needs to be collected or obligated
- ✓ Log on to the Medi-Cal website
- ✓ Call the Automated Eligibility Voice System (AEVS) at 1-800-456-2387

These mechanisms also provide information on the member's outstanding monthly share of cost (SOC), if applicable.

At the time of application for CMSP, if a new member has an immediate medical need, the County Social Services Department may issue an Immediate Need Card to the member. The member uses this card until receiving the plastic BIC card.



New Version

Old Version

Please note, both versions are valid.

2.9 CMSP Benefit Member ID Card

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)
- ✓ Hospital inpatient admission phone number

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 CMSP Member Guide, to notify providers of their coverage at each visit or as soon as possible.

Front

Back

2.10 CMSP Aid Codes

When verifying eligibility through the AEVS or POS device, the member's aid code information is provided. CMSP members are assigned one of the following aid codes:

Aid Code	Beneficiary Description
88	CMSP no share of cost
89	CMSP with share of cost
50	CMSP member is undocumented; may or may not have share of cost
8F	CMSP Companion code used in conjunction with Medi-Cal aid code 53 - eligible medically indigent beneficiary who received state-only SNF/ICF services and is eligible for CMSP inpatient services

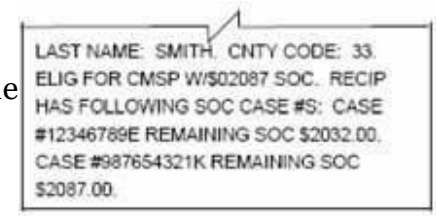
2.11 CMSP & Medi-Cal Coverage

To identify a case involving an individual with both CMSP and Medi-Cal coverage, all the following must be true:

- ✓ The Medi-Cal eligibility verification message lists the member in multiple SOC cases
- ✓ On the member's share of cost Case Summary form, the member receiving services is named in two or more SOC cases

In addition, one of the following must also be true:

- ✓ The CMSP member's aid code is 50. The Medi-Cal SOC lists this member with an ID aid code and the other family members with an aid code of 50.
- ✓ The Medi-Cal member's aid code is 17, 27, 37, 67, or 83.
- ✓ The CMSP SOC lists this recipient with an IE aid code and the other family members with an aid code of 50
- ✓ See example of the printout you will receive.


LAST NAME: SMITH. CNTY CODE: 33.
ELIG FOR CMSP W/$02087 SOC. RECIP
HAS FOLLOWING SOC CASE #S: CASE
#12346789E REMAINING SOC $2032.00.
CASE #987654321K REMAINING SOC
$2087.00.

2.12 Share of Cost

Some CMSP recipients must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for CMSP benefits. This dollar amount is called share of cost (SOC). A CMSP member's SOC is similar to a private insurance plan's out-of-pocket deductible. However, some primary/preventative services do not require the member to meet their monthly Share of Cost. *Refer to list of covered medical services without a SOC in Appendix 4. See Section 8.3 regarding or Section 3.8 regarding Pharmacy Copay.*


MEDICAL OFFICE
T999999

98-06-15
17:16:36

PROVIDER NUMBER:
GR0000000

TRANSACTION TYPE: ELIGIBILITY INQUIRY

RECIPIENT ID:
123456789

YEAR & MONTH OF BIRTH:
1966-12

DATE OF ISSUE:
94-02-01

DATE OF SERVICE:
98-03-15

LAST NAME: ROBERTS. CMPS RECIP
HAS A $00050 SOC. REMAINING SOC
$50.00.

How to Find Out if a Member Must Pay SOC

Providers access the state eligibility verification system to determine if a member must pay a SOC. The message returned by the eligibility verification system includes the SOC dollar amount the member must pay. The eligibility verification system is accessed through the Point of Service (POS) device, Automated Eligibility Verification System (AEVS), state-approved vendor software and the state website on the Internet at https://medi-cal.ca.gov/.

Some services do not require the provider to collect a Share of Cost from the member. See Appendix 4 – Covered Medical Services without a Share of Cost.

⇦ *The sample POS device printout reflects a $50 SOC still to be paid.*

Obligating Payment

Providers can collect SOC payments from a member on the date that services are rendered, or providers can allow a recipient to "obligate" payment for rendered services. Obligating payment means the provider allows the member to pay for the services at a later date or through an installment plan. Obligated payments can be used to clear share of cost.

Certifying SOC

Recipients are not eligible to receive coverage for Standard CMSP benefits until their monthly share of cost dollar amount has been certified online as "cleared." Certifying SOC means that the CMSP eligibility verification system shows the recipient has paid or become obligated for the entire monthly dollar SOC amount owed and the SOC for the month is cleared.

Claims submitted for services rendered to a recipient whose SOC is not certified through the CMSP eligibility verification system will be denied.

For a list of CMSP approved procedures codes with no SOC, visit: https://cmsp.amm.cc/Providers

Members May Use Unpaid Medical Expenses to Clear SOC
This means that CMSP members having unpaid medical expenses for which they are still legally liable, regardless of when the expenses were incurred, can use these bills toward meeting their SOC in the current and, if necessary, future months.

SOC Clearance Transaction
To clear a recipient's SOC, the provider accesses the state eligibility verification system, enters a provider number, Provider Identification Number (PIN), National Provider Identifier (NPI), recipient identification number, BIC issue date, billing code and service charge.

The SOC information is updated and a response is displayed on the screen or relayed over the telephone.

Several "clearance" transactions may be required to fully certify SOC. In other words, providers should continue to clear SOC until it is completely certified. (Clearing Share of Cost is also referred to as "spending down" the SOC.)

Providers should perform a SOC "clearance" transaction immediately upon receiving payment, or accepting obligation from the recipient, for the service rendered. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

Submit only one SOC clearance transaction for each rendered service used to clear the member's share of cost, even if a payment plan is used to meet the obligation.

Reversing SOC Transactions
To reverse SOC transactions, providers enter the same information as a "clearance" but specify that the entry is a reversal transaction. After the SOC file is updated, providers receive confirmation that the reversal is completed. Please note: Once a member has been certified as having met the share of cost, reversal transactions can no longer be performed. Reversals may only be performed for partial clearance prior to the time the recipient is certified as eligible.

Document	Section Title
POS Device User Guide	Transaction Procedures, Section 500-10
Medi-Cal Part 1 Provider Manual	AEVS: Transactions
Vendor-Supplied User Guide	Refer to vendor
Medi-Cal Website Quick Start Guide	Using Transaction Services

Eligibility Verification Confirmation (EVC) Number
Once SOC has been certified, an Eligibility Verification Confirmation (EVC) number is displayed in the message returned by the Medi-Cal eligibility verification system. Return of an EVC number does not guarantee that a member qualifies for all CMSP benefits.

Carefully read the eligibility message to identify what CMSP service limitations may apply to the member.

Providers are not required to incorporate the EVC number on the claim but may choose to do so for their own record keeping purposes. When the EVC number is included, enter the EVC number in the remarks area of the claim.

Do not attach the POS printout to the original claim. Attachments delay claims processing.

Multiple Case Numbers
Eligibility messages may include multiple case numbers. This occurs in rare cases when an individual is eligible for CMSP and their family members are eligible for Medi-Cal. In these cases, verify the aid code.

Share of Cost Policy Application
SOC policy applies to County Medical Services Program (CMSP) members.

Share of cost is calculated independently for CMSP and Medi-Cal; however, the same member income

is included in both calculations. Therefore, the same medical expenses may be used to clear SOC for both programs.

Providers may apply the same services used to clear a Medi-Cal SOC obligation to clear a CMSP SOC obligation.

Two separate transactions are required. Clearing share of cost for one program does not automatically clear SOC for the other program.

Section 3.0 – Covered Benefits & Non-Covered Benefits

The County Medical Services Program (CMSP) offers a wide array of inpatient and outpatient benefits and services to its members including emergency, medical, mental health, vision, audiology, pharmacy, and dental services. This Section provides a general overview of benefits, as well as benefit limitations and exclusions.

Before providing services to CMSP members, providers must verify eligibility, check to see if share of cost (SOC) applies and determine if any other restrictions or limitations apply. Covered benefits and services are subject to treatment authorization requirements and utilization limits.

3.1 CMSP Covered Benefits & Non-Covered Benefits

CMSP covered benefits are subject to treatment authorization requirements and utilization limits and generally include the following services:

Acute inpatient hospital care *(including acute inpatient rehabilitation and mental health)*	Medical supplies dispensed by physicians, licensed pharmacies, or durable medical equipment dealers and prosthetic or orthotic providers
Adult day health care	Mental health services *(mild to moderate)*
Blood and blood derivatives	Non-emergency medical transportation when medically necessary
Chronic hemodialysis services	Outpatient audiology services
Chiropractic services	Outpatient occupational therapy services
COVID vaccine administration	Outpatient physical therapy services
Dental services *(including diagnostic and preventative care, oral surgery and selected endodontic, restorative and prosthodontics services)*	Outpatient substance use disorder services
Durable medical equipment (DME)	Outpatient rehabilitation services in a rehabilitation facility
Emergency ambulance services and medically necessary transportation from the acute hospital to other facilities for medically necessary, specialized, or tertiary care	Outpatient speech pathology services
Family planning services, including sterilization *(when no other coverage, including F-PACT)*	Physician services
Audiology services and appliances	Podiatry services
Home health agency services	Prosthetic and orthotic appliances
Hospital outpatient and outpatient clinic services	Psychiatric services provided by a licensed psychiatrist
Infusion therapy	Transplants
Inpatient and outpatient heroin detoxification services *(excluding methadone maintenance)*	Vision services and appliances

Specific services that are **NOT** covered by the CMSP 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)*	Public transportation, such as airplane, bus, car or taxi rides
Cosmetic procedures	Services provided by non-contracting providers, except providers of emergency services
Family planning services when covered by another coverage *(F-PACT)*	Skilled nursing facility services
Long-term care	Sexual reassignment surgery
Pregnancy-related and infertility services	Transplants for Aid Code 50 members

If a member needs medical care not covered by CMSP, the member should call the Customer Service department at (877) 589-6807 or see the CMSP Member Guide on our website at https://cmsp.amm.cc/Members. AMM may be able to refer the member to other services.

3.2 Emergency Services

CMSP covers in-network and out-of-network emergency medical services, including emergency dental services, for CMSP members in California and in the border state areas of Arizona, Nevada and Oregon that are in ZIP codes within 30 miles of the California state line.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including without limitation severe pain) such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably believe that the absence of immediate medical attention could reasonably result in any of the following:

- ✓ Serious and/or permanent dysfunction to any bodily organ or part
- ✓ Serious impairment to bodily function
- ✓ Placing the member's health in jeopardy
- ✓ Other serious medical consequences

For purposes of this definition, a "prudent layperson" includes, but is not limited to a reasonable member.

Out-of-network providers must notify Advanced Medical Management, Inc., within 24 hours of an emergency encounter, as a condition of receiving payment for emergency services. The out-of-network provider must accept payment made in accordance with payment policies of CMSP and its Governing Board.

3.3 Inpatient Mental Health

CMSP covers inpatient mental health services provided by specified facilities participating in the CMSP network. Inpatient mental health services and Psychiatric health facilities must be authorized by county mental health departments in the county where the member resides. See Section 3.5 for instructions on authorizations and billing requirements for these services. Services may include:

- ✓ Inpatient psychiatric services provided in a contracted general acute care hospital or contracted psychiatric health facility (PHF)
  - Limit of six days per episode and up to 10 days per fiscal year (July 1– June 30)
- ✓ Psychiatrist services
  - Up to eight hours per six-day inpatient stay
  - Broad range of mental health medications

No payment will be made for inpatient mental health services rendered by out-of- network providers.

3.4 Outpatient Psychiatry

CMSP covers outpatient psychiatric services provided by licensed psychiatrists who are participating in the CMSP network. CMSP will not pay for services rendered by out-of-network providers. Prior authorization is not required for services rendered by contracted licensed psychiatrists. Services include:

- ✓ Maximum 10 visits per 120 calendar days
- ✓ CMSP will not make payment for services rendered by out-of-network providers or facilities.
- ✓ Medication management allowed by provider during routine office visits.

See Section 8.0 Claims and Billing for a reference for a list of allowable codes.

3.5 Billing & Authorizations for Inpatient & Outpatient Psychiatry

To facilitate timely claims processing and payment, AMM requires that standardized billing procedures be followed when submitting claims for inpatient and outpatient psychiatric services.

Obtain inpatient mental health prior authorizations from the mental health department in the county where the member resides. Upon approval, the county mental health department provides an 11-digit authorization number for billing. The authorization number must be included on the appropriate claim form.

Providers who receive a prior authorization number from AMM or the county should indicate that number in Box 23 of the CMS-1500 claim form and Box 63 of the UB-04 claim form.

3.6 Outpatient Mental Health (Mild to Moderate)

CMSP covers individual and group mental health evaluation and treatment (psychotherapy), psychological testing when clinically indicated to evaluate a mental health condition, outpatient services for the purposes of monitoring medication therapy.

- ✓ Limit of twelve (12) visits per enrollment period.
- ✓ No authorization required if member is diagnosed with a mental health disorder defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.
- ✓ Services must be rendered by psychologist, Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Associate Therapists and Assistants billing under director supervision of licensed mental health professional.
- ✓ Family therapy is covered.
- ✓ No share of cost or copayment.

3.7 Outpatient Substance Use Disorder Services

CMSP covers outpatient substance use disorder services (including alcohol misuse screenings and behavioral health counseling interventions for alcohol misuse).

- ✓ Limit of twelve (12) visits per enrollment period.
- ✓ Services may be performed by in-network providers rendering services in an outpatient setting including FQHC, RHC, and THP providers.
- ✓ Services must be rendered by psychologist, Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), Certified Drug and Alcohol Counselor, Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Associate Therapists and Assistants billing under director supervision of licensed mental health professional.
- ✓ No share of cost or copayment required.

3.8 Heroin Detoxification Inpatient Stay Benefit

Heroin Detoxification is an inpatient stay benefit only in conjunction with a medical condition. Prior authorization is required for the entire length of stay. This benefit can only be provided by contracted providers who are approved to provide this benefit to CMSP members. CMSP does not cover services performed by a non-contracted mental health provider or facility.

The detoxification benefit is applicable for 21-Day Heroin Detoxification Treatment Programs only. Once a 21-day treatment program begins, it must be completed in consecutive days to receive reimbursement. If treatment stops for any reason before the 21-day treatment program is complete; the benefit is not available again for 120 days.

3.9 Pharmacy

Pharmacy benefits are administered for CMSP members by MedImpact Healthcare Systems, Inc. (MedImpact) a pharmacy benefits manager (PBM). Members must have prescriptions filled by participating local retail pharmacies. The pharmacy benefit emphasizes the use of generic medications, where available and appropriate, and requires prior authorization and other utilization controls for select medications based upon clinical efficacy, medical necessity and cost.

Self-injectable medications and certain non-self-injectable medications are covered by the pharmacy benefit administered by MedImpact. For more information regarding covered self-injectable and non-self-injectable medications, call the MedImpact Customer Service Line at (800) 788-2949. Visit the CMSP website for additional information on the CMSP Drug Formularies and Medication Request forms (for prior authorization) at https://cmspcounties.org/pharmacy/.

Providers or members with questions involving the CMSP 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.

3.10 Home Infusion Therapy Services

Advanced Medical Management, Inc. administers the home infusion therapy benefit for CMSP members. AMM preauthorizes all home infusion therapy services.

For information on how to request an authorization please refer to Provider Authorization under Section 9.0 Utilization Management.

3.11 Dental Services

CMSP covers dental services when rendered by an in-network provider, including:

- ✓ Diagnostic & preventative dental hygiene (e.g., exams, x-rays, teeth cleanings)
  - One (1) oral evaluation every six (6) months
- ✓ Periodontal & restorative services (e.g., crowns)
- ✓ Emergency services for pain control
- ✓ Endodontic services (e.g., fillings, root canals, scaling & root planing)
- ✓ Prosthetics, implants, & prosthodontics (e.g., dentures)
- ✓ Oral & maxillofacial surgery (e.g., extractions)
- ✓ Acceptable Provider Types:
  - Dentist (DDS)
  - Registered Dental Hygienist

Members with a share of cost (SOC) must meet their SOC for the month in order for these services to be eligible for coverage by CMSP.

For a complete list of benefits, prior authorization requirements and benefit limitations, refer to https://cmsp.amm.cc/Providers under the Resources section.

For additional dental information refer to Section 14.0 of this manual.

3.12 Chiropractic Services

CMSP covers treatment of the spine by manual manipulation resulting in significant health problems in the form of a neuromusculoskeletal condition as caused by a sprain, deformity, degeneration, or malalignment. Services rendered must have a direct therapeutic relationship to the recipient's condition specifically with regards to the spinal level and the direct causal relationship of symptoms corresponding to that level.

- ✓ Limited to 2 visits per calendar month (Authorization required after 2 visits)
- ✓ Limited to procedure codes 98940-98942
- ✓ Diagnosis resulting in anatomic cause of symptoms (i.e., sprain, deformity, degeneration, or malalignment); patient must exhibit significant health problems in the form of a neuromusculoskeletal condition that requires treatment.
- ✓ Maintenance therapy is not covered nor is a diagnosis of generalized or diffuse "pain".
- ✓ Services only payable when rendered at a CMSP contracted Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Health Program Provider (THP) or hospital outpatient department.
- ✓ Services must be rendered by a chiropractor (DC), MD, or DO.
- ✓ Member's share of cost must be met.
- ✓ Services must be billed in conjunction with specific ICD-10 diagnosis codes allowable under Medi-Cal.
- ✓ Providers may be reimbursed for chiropractic services when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

ICD-10_CM Code	Description
M50.11 thru M50.13	Cervical disc disorder with radiculopathy
M51.14 thru M51.17	Intervertebral disc disorders with radiculopathy
M54.17	Radiculopathy, lumbosacral region
M54.31, M54.32	Sciatica
M54.41, M54.42	Lumbago with sciatica
M99.00 thru M99.05	Segmental and somatic dysfunction
S13.4XXA thru S13.4XXS	Sprain of ligaments of cervical spine
S16.1XXA thru S16.1XXS	Strain of muscle, fascia and tendon at the neck level
S23.3XXA thru S23.3XXS	Sprain of ligaments of thoracic spine
S29.012A thru S29.012S	Strain of muscles and tendon of back wall of thorax
S33.5XXA thru S33.5XXS	Sprain of ligaments of lumbar spine
S33.6XXA thru S33.6XXS	Sprain of sacroiliac joint
S33.8XXA thru S33.8XXS	Sprain of other parts of lumbar spine and pelvis
S39.012At thru S39.012S	Strain of muscle, fascia and tendon of lower back

3.13 COVID Vaccine Administration for FQHCs, RHCs, & THPs

CMSP will cover reimbursement for COVID-19 vaccine administrations during vaccine-only encounters. A vaccine-only encounter is a visit solely for the administration of the COVID-19 vaccination and does not meet the criteria for an office visit. FQHCs, RHCs, and THPs will receive a reimbursement of $67 for the administration of COVID-19 vaccines. If a vaccine was billed with a qualifying office visit, then the provider will be reimbursed for the PPS rate and no additional payment will be made for the vaccine administration.

There will be no additional reimbursement for vaccine administration when clinics are billing with a qualifying office visit and reimbursed at their PPS rate. For a claim to be payable, the visit must meet the criteria of a standard office visit.

If a vaccine-only encounter is billed and paid at the vaccine administration rate and a provider also submits a separate office visit claim for the same date of service, AMM will deduct the vaccine administration reimbursement amount of $67 from the PPS rate payment for the office visit on the same date of service.

3.14 Pregnancy

All pregnancy related services are not a covered benefit of CMSP. Women who are pregnant may be eligible for the Medi-Cal program. If a CMSP member becomes pregnant, please instruct her to contact her eligibility worker at the County Social Services Department.

3.15 Audiology Services

CMSP covers audiology services including:

- ✓ Two (2) audiometry assessments per month
- ✓ One (1) tympanometry assessment every 6 months
- ✓ Hearing Aid Evaluations, Hearing Aids, & Accessories
- ✓ Evoked Response testing
- ✓ Electronystagmography
- ✓ Cochlear implants (including certain supplies & repairs)
- ✓ Speech therapy & speech generating devices
- ✓ Acceptable Provider Types:
  - Doctor of Audiometry (AuD)

Members with a share of cost (SOC) must meet their SOC for the month in order for these services to be eligible for coverage by CMSP.

Covered audiology services rendered by non-contracted providers are eligible for payment at the contracted provider rate as long as the non-contracted provider meets the criteria specified in CMSP's Rate Policy. CMSP's Rate Policy is available to view at: https://cmspcounties.org/billing-claims-payment/

For a complete list of benefits, prior authorization requirements and benefit limitations, refer to https://cmsp.amm.cc/Providers under the Resources section.

3.16 Vision Services

CMSP covers vision services including:

- ✓ One (1) routine eye exam & prescription glasses every two (2) years
- ✓ Contact lens testing (if use of glasses are not possible due to eye disease or condition)
- ✓ Low vision testing for those with vision impairments that are not correctable by standard glasses, contact lenses, medicine, or surgery that interferes with the person's ability to perform every day activities (i.e., age-related macular degeneration)
- ✓ Artificial eye services & materials for individuals that have lost an eye or eyes to disease or injury
- ✓ Acceptable Provider Types:
  - Optometrists
  - Ophthalmologists
  - Opticians
  - Ocularists

Members with a share of cost (SOC) must meet their SOC for the month in order for these services to be eligible for coverage by CMSP.

Covered vision services rendered by non-contracted providers are eligible for payment at the contracted provider rate as long as the non-contracted provider meets the criteria specified in CMSP's Rate Policy. CMSP's Rate Policy is available to view at: https://cmspcounties.org/billing-claims-payment/

For a complete list of benefits, prior authorization requirements and benefit limitations, refer to https://cmsp.amm.cc/Providers under the Resources section.

Section 4.0 – Access Standards

While there is no mandate for professional standards for health care providers, County Medical Services Program (CMSP), California Department of Health Care Services (DHCS) and other regulatory agencies require that members receive medically necessary services in a timely manner.

4.1 Appointment Access Standards

Advanced Medical Management, Inc.'s appointment standards for CMSP members to access providers are provided in the table below:

General Appointment Scheduling	
Emergency examinations	Immediate access 24 hours a day, 7 days a week.
Urgent examinations	Within 24 hours of request (or 96 hours if authorization is required).
Non-urgent sick examinations	Within 48 to 72 hours of request, as needed.
Routine care, non-urgent primary care	Within 10 days of request.
Non-urgent care with specialist physicians	Within 15 business days of request.
Non-urgent care for ancillary services (services for which charges are made in addition to routine services)	Within 15 business days of request.

The waiting time for an appointment, including preventive care services, may be extended by the referring or treating provider or the provider rendering triage and screening services. The provider must be acting within the scope of his/her license and consistent with professionally recognized standards of practice. The provider must determine and note in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member. When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled within a time that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.

4.2 Office Hours

Providers must be available for CMSP members at least an equal number of hours to those offered to privately insured or Medi-Cal fee-for-service participants. The provider must be available 24 hours a day by telephone or have an on-call physician take calls. Office hours must be noticeably posted. The provider must inform members of the provider's availability at each site.

Section 5.0 – Roles & Responsibilities for All Providers

5.1 Roles & Responsibilities of All Providers

- ✓ Providers must verify CMSP eligibility and/or determine authorization status before providing care, except in emergencies.
- ✓ Verify the member's eligibility at each appointment, admission 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 CMSP 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.

- ✓ Refer all pregnant CMSP members for enrollment in Medi-Cal.
- ✓ 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 Emergency Services

No authorization is required for treatment of an emergency medical condition by in-network or out-of-network providers. In the event of an emergency, CMSP members can access emergency services and/or required post- stabilization care services 24 hours a day, 7 days a week. Post-stabilization services required to maintain stabilization do require prior authorization by AMM.

Out-of-network providers must notify Advanced Medical Management, Inc. within 24 hours of an emergency encounter, as a condition of receiving payment for emergency services. Out-of-network providers must accept payment made in accordance with CMSP and its Governing Board.

5.3 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.

5.4 Members' Rights & Responsibilities

All providers shall actively support the Members' Rights and Responsibilities as written and provided on AMM's website at http://cmsp.amm.cc/members.

5.5 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.

5.6 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.

5.7 Providing Access to Medical Records & 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.

5.8 Language & 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) 589-6807 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.

5.9 Telephone Interpreter Services

Members and providers may call the Customer Service department (877) 589-6807 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 - Hospital & Ancillary Provider Roles & Responsibilities

Acute care hospitals provide medically necessary inpatient care. Ancillary providers such as physical therapists, occupational therapists and speech therapists provide medically necessary health care modalities in the outpatient and home settings.

Ancillary providers are providers of health care services in the outpatient or home setting including, but not limited to:

- ✓ Hemodialysis
- ✓ Home health agencies
- ✓ Home infusion therapy
- ✓ Ambulatory surgical centers
- ✓ Vision Services
- ✓ Hearing centers
- ✓ Physical, occupational and speech therapy
- ✓ Ambulance services
- ✓ Durable medical equipment, devices, or supplies

All providers share responsibility in working collaboratively with AMM, members and their families, specialists and others for the united goal of providing timely, medically necessary and quality health care services.

Hospitals shall give discharge-planning services and provide concurrent reviews to AMM at intervals established by AMM. Notify the Care Management Department of initial reviews:

- ✓ At least 24 hours prior to a scheduled admission
- ✓ The next business day, or as soon as is reasonably possible, for an emergency admission

6.1 Admission Notification

Acute care hospitals are required to report all members admitted to an inpatient setting by calling AMM at (877) 589-6807 or after hours at (562) 310-2145.

Hospitals shall report clinical reviews to the Care Management department within 24 hours prior to

admission for nonemergency admissions. Hospitals shall report clinical reviews for emergency admissions the next business day, or as soon as reasonably possible.

Contact the county mental health department in the county where the CMSP member resides for prior authorization for inpatient hospital mental health services.

All acute care hospitals and ancillary providers must:

- ✓ Verify the member's eligibility at each appointment including any applicable Share of Cost at admission and immediately before rendering non-emergent services, supplies or equipment (for example, a member who is verified eligible on the last day of the month may not be eligible the first day of the following month).
- ✓ Not intentionally segregate CMSP members in any way from other persons receiving services, 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.
- ✓ Comply with all state laws relating to communicable disease and domestic violence/child abuse/elder abuse reporting requirements.
- ✓ Obtain signed consent prior to rendering care, except as limited by emergency situations.
- ✓ Permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment.
- ✓ Provide, on request by us, timely responses and medical information.
- ✓ Give considerate and respectful care.
- ✓ Provide information to the member or the member's legal representative about the illness, the course of treatment and prospects for recovery in terms they can understand.
- ✓ Provide members with an adequate supply of medications upon discharge from the emergency room or the inpatient setting to allow reasonable time for the member to access a pharmacy to have prescriptions filled.
- ✓ Maintain legible and accurate medical records in a secured location.
- ✓ Forward medical records to us on request and within our established time frames.

6.2 Clinical Information

Acute care hospitals are required to provide clinical information in the time parameter outlined in Admission Notification to facilitate concurrent review, certify approved inpatient days and expedite discharge planning and authorizations. If timely clinical information is not provided for post-hospital services, inpatient claims are subject to retrospective review.

Assistance with discharge planning is provided, as needed, to facilitate and coordinate the timely transition of care when medically indicated.

6.3 Home Health Agencies

Appropriate use of home health care encourages safe discharge and may prevent readmission to acute care. Authorized home health services should begin within 24 hours of the referral, unless the provider orders an alternate period. Contact AMM before ordering home health services to ascertain benefit coverage and obtain prior authorization.

6.4 Durable Medical Equipment & Supplies

All durable medical equipment and medical supplies should be delivered within 24 hours of the referral unless the provider orders an alternate period or if the item is to be custom made.

Section 7.0 – Credentialing & Re-Credentialing

All AMM CMSP network providers not enrolled in the California Medi-Cal program is required to go through AMM's credentialing and re-credentialing process.

7.1 Credentialing Program

This list contains the pertinent policies for the credentialing process:

- ✓ *Credentialing Program Structure* - This policy describes the AMM Credentials Committee, composed of a Chairman, medical director and committee members. This group has oversight of matters relating to the policies used in the Credentialing Program.
- ✓ *Credentialing Program Scope* - This policy specifically details which providers fall within the scope of the Credentialing Program.
- ✓ *Professional Competence and Conduct Criteria* - This policy outlines the various standards of conduct and competence, and the data elements required for network participation.
- ✓ *Verification of Data Elements* - This policy details the sources acceptable for verification of the various elements required to complete the credentialing process.
- ✓ *Criteria for Selecting Practitioner Leveling and Committee Presentations* - This policy provides the specific criteria that dictate applicants for both initial and continued participation will be presented for individual review by a credentialing committee.
- ✓ *Health Delivery Organizations* - In this policy, the criteria and scope of the credentials process, relative to health delivery organizations (HDOs) are outlined.
- ✓ *Re-credentialing* - In this policy, re-credentialing requirements, frequency and the decision-making processes are communicated in this document.
- ✓ *Termination and Immediate Termination* - This policy discusses the process for termination and immediate termination.
- ✓ *Reporting of Adverse Actions* - This policy describes the mechanisms for compliance with regulatory requirements for reporting to appropriate agencies.
- ✓ *Continuous Monitoring* - In order to support the maintenance of standards of professional conduct and competence, ongoing, continuous monitoring of sanctions and complaints occurs; the principles and mechanisms governing this activity are described in this policy.
- ✓ *Appeals* - This policy establishes the mechanism available to providers who want to appeal a credentialing committee's determination.

For more information and details regarding the credentialing program please contact AMM's Provider Network Department at (877) 589-6807.

Section 8.0 – Claims and Billing

This section identifies Advanced Medical Management, Inc.'s claims process for claims submittals for covered benefits and services provided to County Medical Services Program (CMSP) participants. 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.

8.1 Fee Schedule

Provider rates of reimbursement or compensation for serving CMSP members is dependent upon the provider's professional or participating medical group CMSP Provider Agreement and its specified reimbursement rates. For assistance with understanding the fee schedule, please contact Customer Services at (877) 589-6807. For the CMSP Rate Policy, please refer to: https://cmspcounties.org/billing-claims-payment/.

8.2 Timely Filing of Claims

AMM will deny claims submitted by non-contracted providers for medical and dental services when a provider does not receive authorization prior to services, except for 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: ✓ **Professional** medical, clinic, and ancillary claims, file within **150 calendar days of date of service** ✓ **Hospital** claims, file within **180 calendar days of 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) 589- 6807 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 Form located at: https://claims.amm.cc/ under the Forms section.	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: ✓ **Professional** medical, clinic, and ancillary claims, file within **150 calendar days of date of service** ✓ **Hospital** claims, file within **180 calendar days of date of service**
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: ✓ **Professional** medical, clinic, and ancillary claims, file within **150 calendar days of date of service** ✓ **Hospital** claims, file within **180 calendar days of date of service**

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) 589-6807 with questions regarding the completion of the CMS-1500, UB-04, or ADA claim forms. 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.

8.3 Share of Cost

Providers must verify if CMSP members have a share of cost (SOC) and are responsible for collecting or obligating payment toward clearing the SOC at the time of service if a SOC applies (see Appendix 4). When SOC applies, the amount collected may not exceed the cost of the service. AMM denies claims submitted prior to a member having met the SOC. Please complete any SOC transactions prior to billing claims. An Explanation of Benefits (EOB) is generated and forwarded to the provider.

A provider may not necessarily collect all of the SOC at the time of service.

It frequently occurs that members pay part of their SOC by paying for the full cost of the medical service. The amount paid to the provider is deducted from the member's SOC, but the SOC still may not be fully paid (met). *Refer to Section 2.11 Share of Cost in this Manual for additional information.*

Providers determine SOC in any of three ways:

- ✓ Swiping the member's plastic Beneficiary Identification Card (BIC) in the point of service (POS) device
- ✓ Accessing the state website medi-cal.ca.gov
- ✓ Using the Automated Eligibility Voice System (AEVS) at (800) 456-2387

This determines if the member has met the SOC and if the provider needs to collect payment from the member. *Refer to List of Covered Medical Services without a SOC in Appendix 4.*

If the member has fully met or paid (cleared) his/her SOC or if the member does not have a SOC for the month in which services are rendered, do not collect payment from the member. First, send the bill to other applicable carriers or programs for services who are treated as primary payers, and then to CMSP with the primary insurance EOB. Remember, CMSP is always the payer of last resort. CMSP will Coordinate Benefits if the primary payer denies services that are otherwise covered under CMSP. CMSP requires a copy of the initial payer's denial in order to consider payment for covered services. *Refer to Section 8.4 Coordination of Benefits.*

AMM is not responsible for collections of SOC on behalf of the provider. If AMM determines that AMM paid the provider for amounts collected as SOC, AMM will request reimbursement from the provider or deduct that amount from the provider's future claims payments.

AMM does not have real-time access to share of cost information. This information is supplied to AMM at a later date.

There is no need to submit a claim to AMM if the share of cost amount collected is equal to or greater than the expected payment amount.

All providers are required to report the share of cost amount collected on the appropriate claim form or EDI transaction. Providers should bill SOC claims in full (total charges). Do not deduct or subtract the SOC amount from the total billed charges. AMM will deduct the share of cost amount reported from payment to the provider.

Providers Billing Advanced Medical Management, Inc. on a CMS-1500 Claim Form
Enter any share of cost collected from the patient using the patient paid field Location 29 on the CMS-1500 Form or Loop 2300 AMT – Patient Amount Paid for EDI claims.

Providers Billing Advanced Medical Management, Inc. on a UB-04 Claim Form
For UB-04 claim forms use value code "23" in Box 39 and enter the share of cost collected in the corresponding amount field. For EDI claims report share of cost in Loop 2300 HI – Value Information segment. Do not enter decimal points or dollar signs. Enter the full dollar amount, including cents.

County Social Services Department (CSSD) Process for Old Medical Bills
Old medical bills (incurred before the month of eligibility) applied toward SOC must be brought by the recipient to their County Social Services Department (CSSD). The CSSD, not the provider, is responsible for processing old medical bills for application toward the recipient's SOC.

SOC Claims Adjustment
Once the SOC has been certified (met/cleared) for an individual, the state notifies AMM. Once AMM is notified, all claims for the individual for the entire month that SOC was certified (met/cleared) will be paid at contracted rates, subject to satisfying any requirements. *Refer to list of covered medical services without a SOC in Appendix 4.*

SOC Billing
After obligating or collecting a share of cost, providers should bill the claim with total (full) billed charges. SOC should not be deducted/subtracted from the total billed charges. *For more information, refer to Section 2.11 Share of Cost and Appendix 4 Covered Medical Services without a SOC.*

8.4 Coordination of Benefits

When applicable, AMM coordinates benefits with any other carrier or program that the member has for health care coverage, including, but not limited to, Medicare or other private insurances. CMSP will pay for services initially denied by the primary payer if the services rendered are covered under the CMSP benefit. CMSP requires a copy of the denied services from the initial payer in order to consider payment for these covered services. Indicate other member coverage in Boxes 9a-d of the CMS-1500 or Box 57 of the UB Since CMSP is always the payer of last resort, AMM expects the provider to submit the claim to all other carriers or programs, including Medi-Cal, before submitting the claim to AMM.

Claims submitted to AMM as COB must include one of the following items:

- ✓ Remittance Advice (RA)
- ✓ Provider Explanation of Benefits (EOB)
- ✓ Explanation of the denial of coverage or reimbursement from other carriers or programs

AMM will mail claims back to the submitting provider with a request to resubmit the claims with the primary insurance EOB.

Claims submitted with the primary insurance EOB must be received within the contracted filing limit from the date of the other carrier or program's EOB, or letter of denial of coverage or reimbursement.

Due to HIPAA's (Health Insurance Portability and Accountability Act of 1996) standardization of electronic data, providers may now send the following claims electronically to us:

- ✓ Coordination of Benefits
- ✓ Medicare coordination claims

Providers should contact their software vendor or clearinghouse for details on how to generate these claims for submission.

Many CMSP members 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)

8.5 California Family Planning, Access, Care & Treatment (Family PACT) Program

To be considered for reimbursement for family planning services, a Record of Denied Program Eligibility form or a Client Eligibility Certification (CEC) form must be attached to the claim.

Family PACT is a comprehensive family planning clinical program that includes family planning methods and related reproductive health together with client-centered health education and counseling. Family PACT offers access to a three-part package of benefits, which includes initiation and management of all temporary and permanent methods of contraception.

8.6 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 and code sets.

Providers can contact EDI services by telephone at (877) 589-6807 or by email at support@amm.cc.

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

Enrollment is required. Providers can enroll by contacting EDI services at (877) 589-6807 You may also visit https://cmsp.amm.cc/Payer/ClaimBilling and complete the contact form.

AMM accepts the following HIPAA compliant claim formats:

- ✓ Professional Claim - ASCX12 5010 837P
- ✓ Institutional Claims - ASCX12 5010 837I
- ✓ Dental Claims - ASCX12 5010 837D

For a complete list of AMM clearinghouses please visit: https://cmsp.amm.cc/Payer/ClaimBilling

Providers should contact EDI services by telephone at (877) 589-6807 or by email at support@amm.cc if their preferred clearinghouse is not listed.

Clearinghouse	Payer ID	Support Phone #	Website
Office Ally	AMM15	(360) 975-7000 Opt. 1	https://cms.officeally.com/
Emdeon/Caparo	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

8.7 Paper Claims

All paper claims must be submitted on the appropriate claim form. For Dental claims, use the ADA approved claim form. You can locate a sample ADA approved claim form (2012 ADA J430D form) on AMM's website at: https://cmsp.amm.cc/Providers

Providers should mail all paper claims to:

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

8.8 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 precertification/prior authorization/ predetermination (or some other form of utilization review) including but not limited to:
  - Claims pending for lack of precertification or prior authorization.
  - Claims involving Medical Necessity or Experimental/Investigative determinations.
- ✓ 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 to emergency service-prudent layperson reviews, 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 for individuals involved in case management or disease management.
- ✓ 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
  - Coordination of benefits
  - Recovery/subrogation

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

8.9 Claim Itemizations

Itemizations are required for any inpatient stay where the complete length of stay (LOS) was not authorized.

- ✓ Itemization is not required as a regular billing practice; however, itemization may be required on a case-by-case basis.
- ✓ Itemizations must contain the total for the LOS (each DOS).
- ✓ Discharge DOS is not a payable fee.

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

8.11 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.

8.12 Mental Health Inpatient Services

To facilitate timely claims processing and payment, AMM requires that standardized billing procedures be followed when submitting claims for inpatient and outpatient psychiatric services.

Obtain inpatient mental health prior authorizations from the mental health department in the county where the member resides. See the list of local contacts in the *Inpatient Mental Health Services Program: Plan-Authorization Directory*. Upon approval, the county mental health department provides an 11-digit authorization number for billing. The authorization number must be included on the appropriate claim form.

Providers who receive a prior authorization number from us or the county should indicate that number in Box 23 of the CMS-1500 claim form and Box 63 of the UB-04 claim form.

Providers or members with questions involving prescription drug program issues or with any specific questions about pharmacy benefit coverage should contact MedImpact's Customer Service Line at 1-800-788-2949. The MedImpact Customer Service Line Help Desk is available 24 hours a day.

8.13 Information Pertaining to FQHC

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 contracts with all FQHCs that bill for medical services.
- ✓ All FQHC bills should be completed on the UB-04 claim form or ADA claim form for dental services. To be HIPAA compliant and meet CMSP 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. FQHCs must comply with prior authorization guidelines for medical services.
- ✓ Patients must be seen by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Doctor of Audiometry (Aud), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Marriage and Family Therapist (MFT), Dentist (DDS), Registered Dental Hygienist, Optometrist, Ophthalmologist, Optician, Ocularist, 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

8.14 Durable Medical Equipment

Durable medical equipment (DME) is covered when prescribed to preserve bodily functions or

prevent disability.

The Department of Health Care Services (DHCS) has implemented Health Insurance Portability and Accountability Act (HIPAA)-mandated changes to billing requirements for disposable and incontinence medical supplies.

Below is a reminder of billing criteria required for these claims:

- ✓ Bill disposable incontinence and medical supplies with HCPCS Level II codes for contracted items using either ASC X12N 5010A1Pelectronic format or CMS-1500 form for paper claims.
- ✓ Do not use local "99" codes for disposable incontinence and medical supplies.
- ✓ The state requires the use of the Universal Product Number (UPN) information as specified in Section 8.15.

DHCS has revised their provider manual to include the billing requirements, which providers can access through their web site. Providers also must adhere to the new standards when submitting CMSP claims for disposable incontinence and medical supplies. The current version of Healthcare Common Procedures Coding System (HCPCS) code does not necessarily indicate benefit coverage or payment for a particular service.

Services requiring prior authorization are denied if approval is notobtained from AMM's UM department. The UM department reviews medical necessity for all requested services requiring prior authorization.

8.15 Universal Product Number

Claims submitted for medical supplies require Universal Product Numbers (UPNs). The following chart lists the medical supplies products that will require UPNs, or if one does not exist, an invoice/catalog page.

Medical Supplies Category	Code Range
Diabetic supplies	N/A - Pharmacy benefit
Gloves	A4927, A4930
Ostomy products	A4361 – A4399, A4400-A4456, A5051-A5093, A5120-A5131
Tracheostomy products	A4481–A7527, L8501, S8189
Miscellaneous medical supplies	A4206-A4932, A7002-A7016, A9274, B9999, S1015-S8186, T4537, T5999
Urological products	A4310 - A5200
Wound care	A4461 - A6457
Incontinence supplies	A4335-A6250, T4521-T4543
Enteral nutritional supplies	B4034-B4088, B4102-B4162, B9000-B9002, B9998-B9999, T5999

An NDC (National Drug Code) number is required when billing for enteral nutritional supplies.

Providers of DME should bill with the appropriate modifier to identify rentals versus purchases (new or used). Providers not billing with appropriate modifiers are reimbursed at rental price or rejected for corrected billing.

Providers should follow these general guidelines for DME billing:

- ✓ Use Medi-Cal Local Use Only or HCPCS codes for DME for supplies.
- ✓ Use miscellaneous codes (such as E1399) when a HCPCS codes does not exist or is not on the Medi-Cal Formulary. Submit all miscellaneous codes with a description of service on the claim.
- ✓ When billing with a miscellaneous code, attach the manufacturer's invoice to the claim. Example: Hearing aids, wheelchair accessories and other custom DME.
- ✓ Unlisted codes are not accepted if valid HCPCS codes exist for the DME
- ✓ and supplies being billed.
- ✓ Catalog pages are not acceptable.

Bill for DME sales tax and supplies by billing:

- ✓ The code for the service with the appropriate modifier for rental or purchased for the amount charged less the sales tax.
- ✓ The sales tax on a different line for procedure code S9999.

8.16 DME Rental

Medical documentation from the prescribing doctor is required for DME rentals. Some DME is dispensed on a rental basis only, such as oxygen. Items rented remain the property of the DME provider until the purchase price is reached. DME providers may use normal equipment collection guidelines.

AMM is not responsible for equipment not returned by members. Charges for rentals exceeding the reasonable charge for a purchase are rejected; rental extensions may be obtained only on items approved.

8.17 DME Purchase

DME may be reimbursed on a rent-to-purchase basis over a period of ten months, unless specified otherwise at the time of review by the UM department.

8.18 Home Health Care

Pre-authorization is required for all home health care services. Submit claims for these services using the UB-04 claim form with all required fields completed. For non-self- injectable medications, providers must bill us using either the CPT code or HCPCS code, along with the corresponding 11-digit National Drug Code (NDC) number.

For self-injectable medications, providers must bill directly to MedImpact Healthcare Systems, Inc. They can be reached at 1-800-788-2949 for questions.

8.19 Home Infusion Therapy

AMM must preauthorize all home infusion therapy services. Submit claims for these services on the CMS-1500 claim form with all required fields completed. Providers should bill all medications with the most specific HCPCS codes, along with the corresponding 11-digit NDC number.

Total payment for home infusion therapy services is composed of two components: the per diem payment for services and supplies (at rates set and approved by the CMSP Governing Board), plus payment for the medication (as reflected through the J-code), which is based upon the average wholesale price less a specified percentage.

Reimbursement for medication billed with a Medi-Cal Local Code (“X”) is based on the provider’s contracted rate of reimbursement in accordance with the CMSP fee schedule.

While the NDC number is not required for claims payment for services to CMSP members, for faster claims payment providers should include the NDC number when billing claims for drug codes. This is particularly important for drug codes that do not have pricing in AMM’s system. In general, drug codes starting with “X” have pricing identified in AMM’s system. Miscellaneous drug codes, for example “J3490”, do not have pricing in AMM’s system. When providers include the NDC number, claims payment is expedited.

8.20 Wastage

Pharmaceuticals delivered to a member’s home but not used by the member are allowed at the CMSP fee schedule rate on file with AMM for no more than seven days dosage as previously prescribed by the physician. Per diems on the wastage days, however, are not an allowable expense.

Providers should use modifier SV to identify delivered but unused pharmaceuticals. Reasons why members may not use the delivered pharmaceuticals may include hospitalization, adverse reaction or change in prescription.

8.21 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 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.

8.22 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.

8.23 Claims Appeals Process

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

Providers must submit their request for consideration in writing or by fax within 60 business days from the date of the provider's receipt of our Explanation of Benefits (EOB). Providers may download a Claim Appeal/Dispute form on AMM's website at https://cmsp.amm.cc/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, Suite 150
Long Beach, CA 90815-1260

or

Fax: (562) 766-2007

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.

8.24 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 recovery@amm.cc. 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 9.0 – Utilization Management

Advanced Medical Management's Care Management Department consists of the Utilization Management (UM) program and the Case Management program. It is designed to create a holistic approach to effectively manage patients' health conditions and achieve improved health outcomes.

The Utilization Management (UM) program is collaboration with physicians and providers to promote and document appropriate use of health care resources. To contact Care Management (CM) department, call the following numbers as indicated below:

- ✓ General utilization inquiries: (877) 589-6807 from 8 a.m. to 5 p.m., Monday through Friday, except all major holidays.
- ✓ After hours, ER, and hospital admissions: (562) 310-2145

9.1 Utilization Management Role

Utilization Management is the process of influencing the continuum of care by evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the appropriateness of care.

The CM department helps to assure prompt delivery of medically appropriate health care services to CMSP members. In conjunction with physicians and providers, UM performs discharge planning and care management, and authorizes services when indicated. AMM does not reward providers or other individuals conducting utilization review for issuing denials of coverage or service care and does not encourage decisions that result in under-utilization.

9.2 Continued Access to Care

Continued access to care is the process of authorizing continuation of services with a terminating physician under specified conditions and for a limited period with a plan of care to transition the member to a network physician.

The medical conditions that qualify for continued access to care may include, but are not limited to:

- ✓ Terminal illness
- ✓ Surgery or other procedures authorized by AMM and scheduled to occur within 180 business days of the date of the contract's termination or within 180 business days of the effective date of coverage for a newly covered member
- ✓ Degenerative and disabling conditions (a condition or disease caused by a congenital or acquired injury or illness that requires a specialized rehabilitation program, or a high level of care, service, resources or continued coordination of care in the community)
- ✓ An acute condition or a serious chronic condition

AMM has an established UM multidisciplinary approach to provide health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria and the community standards of care.

9.3 Availability of CM Staff

AMM ensures availability of CM staff at least eight hours a day during normal business days to answer CM-related calls. Member, physician or provider CM- related calls received through the Customer

Service department are triaged to, and handled by, CM staff.

9.4 Decision & Screening Criteria

Decision and notification of approval, deferral and denial periods are in alignment with contracts and applicable legislation.

AMM applies Milliman Care Guidelines for Utilization Management screening and decisions. Application of the criteria is not absolute or completely relied on by AMM but is a factor in determining medical necessity along with the clinical information provided by the requesting provider and the individual health care needs of the member.

9.5 Provider Authorization

Providers are responsible for verifying eligibility and obtaining authorization for non-emergent services prior to rendering the services.

Prior authorization review for authorization of certain procedures and services is required to ensure that services are:

- ✓ CMSP medical benefits
- ✓ Based on medical necessity
- ✓ Provided by the appropriate provider

Providers should obtain inpatient mental health prior authorization review from the mental health department in the county where the member resides. Upon approval, the county mental health department provides an 11-digit authorization number for billing.

Providers who receive a prior authorization number from AMM or the county should indicate that number in Box 23 of the CMS-1500 claim form and Box 63 of the UB-04 claim form.

Obtaining prior authorization is not a guarantee that a payment will be made by AMM. Providers seeking reimbursement for unauthorized non-emergent services will be denied for lack of prior authorization.

Providers are responsible for verifying eligibility and authorization for non-emergent services prior to rendering the services. Prior authorization of certain procedures and services is required to assure that services are based on medical necessity and benefit coverage and are provided by the appropriate providers.

Services requiring prior authorization include, but are not limited to, the following:

- ✓ Inpatient hospital care
- ✓ Select surgical procedures (performed in an outpatient or ambulatory surgical center)
- ✓ Chemotherapy
- ✓ Chiropractic Services after 2 visits in one calendar month
- ✓ Transplants
- ✓ Radiology services, such as PET, MRIs and CT scans
- ✓ Select durable medical equipment
- ✓ Physical, occupational or speech therapy (physical and occupational therapies require authorization for out-of-network providers or after first 24 visits by an in-network provider)
- ✓ Home health care
- ✓ Home infusion therapies
- ✓ Hospice
- ✓ Out-of-network specialist, hospital referrals and laboratory services
- ✓ Audiology services and accessories
- ✓ Vision services and accessories

To see a complete list, go to AMM's website at http://cmsp.amm.cc/providers.

To request a prior authorization:

- ✓ Submit all requests on **EZ Net** website accessible via: eznet.amm.cc
- ✓ Complete the online form by including current ICD and CPT code(s) with all supporting documentation. Requests submitted without appropriate documentation will automatically suspend the referral in a deferred status until further information is received.
- ✓ Identify and select one of three levels of priority for the request. The levels of priority are as follows:
  - **Urgent**: The patient care must be expedited on an urgent basis. The turnaround time is 24 to 72 hours.
  - **Routine**: The patient can wait for the appointment. This level should be used for non-urgent/non-emergent request. Do not make an appointment for the member without a referral. Turnaround time is approximately 3-5 business days following submission of a complete request.
  - **Retro**: This level may be used for services provided within the last 30 days and must include supporting documentation such as medical records. Services that were provided beyond the last 30 days should be submitted as a claim.
- ✓ Request to non-contracted/out of network providers cannot be submitted to UM as an Urgent request. Place in the notes section of the request that this is a non-contracted provider and needs immediate attention.
- ✓ Upon approval or denial, the authorization number will be available on EZ Net within the specified timeframe. The website must be checked at least daily as this is how you are notified of referral decisions. Providers can also receive email notifications alerting them that there is an update for your review. No PHI regarding the authorization will be sent in the email notification. Authorizations generally expire ninety 90 business days after the date of the decision. A written notification is sent to the member by mail within two business days of the decision.
- ✓ The requesting provider must print and file a copy of the approval or denial letter from EZ Net in the member's chart.
- ✓ The UM committee will review all redirected requests or denials. If the provider disagrees with the decision, the provider may contact the CM department at (877) 589-6807 from 8 a.m. to 5 p.m., Monday through Friday, except all major holidays. *For more information on AMM's provider appeal process, see Section 11.0 Provider Grievance and Appeals.*

It is AMM's responsibility to determine whether services are medically necessary. AMM does not authorize:

- ✓ Non-emergency inpatient admissions to non-participating hospitals, or
- ✓ Continued inpatient hospital stays at non-participating hospitals that are available at a participating network hospital.

9.6 Durable Medical Equipment Prior Authorization

All custom-made DME requires prior authorization. Some other DME services may require prior authorization. Contact the Utilization Management department for authorization prior to dispensing.

The presence of a Healthcare Common Procedures Coding System (HCPCS) code does not necessarily indicate benefit coverage or payment for a particular service.

Services requiring prior authorization are denied if approval is not obtained from AMM's UM department. The UM department reviews medical necessity for all requested services requiring prior authorization.

9.7 Concurrent Review (Admission & Continued Stay Reviews)

Clinical reviews are required on all members admitted as inpatients in an acute-care hospital. The reviews are performed to assess that the medical care rendered is medically necessary, and the facility

and level of care are appropriate.

AMM identifies members admitted to the inpatient setting by:

- ✓ Facilities reporting admissions
- ✓ Providers reporting admissions
- ✓ Members or their representatives reporting admissions
- ✓ Prior authorization requests for inpatient care

The UM department completes concurrent inpatient reviews within 24 hours of receipt of the information reasonably necessary to make the determination. The hospital shall provide AMM with all clinical information necessary to make a Utilization Review determination as requested by AMM. UM nurses who perform concurrent review functions request clinical information from the hospital on the same day they are notified of the member's admission. If the information provided meets medical necessity review criteria, the request is approved within 24 hours from the time of receipt of the information. When a request does not meet medical policy guidelines, the case is sent to a physician or medical director for review.

In the event CMSP eligibility is reported to AMM retroactively, inpatient stays incurred during the retroactive reporting period will be reviewed through the retrospective review process.

9.8 Admission Notification

Acute care hospitals are required to report to AMM all members admitted to an inpatient setting by faxing face sheet to (562) 766-2001 or calling CM department at (877) 589-6807 or after-hours at (562) 310-2145.

Prospective admissions should be reported no less than 24 hours prior to admission for nonemergency admissions and the next business day, or as soon as reasonably possible, for emergency admissions.

9.9 Clinical Information

Acute care hospitals are required to provide timely clinical information in the time parameter outlined in the Admission Notification in order to facilitate concurrent review, certify approved inpatient days, and expedite discharge planning and authorizations.

Assistance with discharge planning is provided, as needed, to facilitate and coordinate the timely transition of care when medically indicated.

9.10 Deferral of Service

AMM sends an initial written notice to inform the member and the provider of the deferred status of the case and of the period for submission of additional information.

If information is not received within the 14-calendar day period from the date of the request, AMM will provide notice to the provider via EZ Net and send a written notice to the member informing them that the request has been denied for lack of medical information. This deferral process does not apply to the concurrent review process.

9.11 Denial of Service

Only a medical or behavioral health physician who possesses an appropriate active professional license or certification can determine a denial of service (procedure, hospitalization or equipment) based on a lack of medical necessity. When a request is determined to be not medically necessary, the requesting provider is notified of the opportunity for a peer-to-peer discussion of the case and is informed of the opportunity for an appeal.

Providers can contact AMM's physician clinical reviewer to discuss any UM decision by calling the CM department at (877) 589-6807.

9.12 Emergency Medical Conditions & Services

Out-of-network providers must notify AMM within 24 hours of an emergency encounter, as a condition of receiving payment for emergency services. The out-of-network provider must accept payment made in accordance with CMSP and its Governing Board.

No authorization is required for treatment of an emergency medical condition. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week. For CMSP members, payment for emergency services is limited to services provided by providers in California and in the border state areas of Arizona, Nevada and Oregon that are in ZIP codes within 30 miles of the California state line.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis and the psychosocial condition of such member with the member's providers to ensure coordination of the member's care.

9.13 Authorization of Mental Health Services

CMSP provides benefits and services for inpatient mental health. Mental Health (mild to moderate) and outpatient SUD services do not require authorization.

AMM covers inpatient mental health hospital services provided to members at in-network facilities and authorized by county mental health departments. Contact the county mental health department in the member's county of residence to report and obtain authorization for any inpatient admission to a participating hospital pertaining to a mental health diagnosis.

Refer to Section 8.0 Claims and Billing and/or Section 3.0 Covered Benefits for further information regarding mental health benefits for members.

9.14 Pharmacy

MedImpact Healthcare Systems, Inc. is responsible for the administration of the CMSP pharmacy benefit. The pharmacy benefit emphasizes the use of generic medications where available and appropriate and requires prior authorization and other utilization controls for selected medications based upon clinical efficacy, medical necessity and cost. *Refer to Section 3.8 regarding covered pharmacy benefits.*

Section 10.0 – Case Management

10.1 Case Management Program

The purpose of AMM's CMSP Case Management program is to ensure that medically necessary care is delivered in the most cost-efficient setting for members who require extensive or ongoing services. The program will be focused on the delivery of cost-effective, appropriate healthcare services for members with complex and chronic care needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions and severe mental illness.

Case managers assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs of these members across the care continuum. Case Management is defined as:

> *"A collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members' health care across the care continuum. It includes empowering members to exercise their options and access the services appropriate to meet their individual health needs, using communication, education, and available resources to promote quality outcomes and optimize health care benefits."*

10.2 Referral Process

Providers, nurses, social workers and members or their representative may refer members to Case Management:

- ✓ By calling the Care Management department (877) 589-6807
- ✓ By faxing a completed Case Management Referral form to (562) 766- 2001. A case manager responds to the person who submitted the faxed request within three business days.

Case Management referral forms may be obtained at http://cmsp.amm.cc/providers under Forms.

10.3 Provider Responsibility

It is the provider's responsibility to participate in the case management process through information sharing (such as medical records) and facilitation of the case management process by:

- ✓ Referring members who could benefit from case management
- ✓ Collaborating with case management staff
- ✓ Providing medical information

Examples of member cases appropriate for referral include:

- ✓ Members with chronic conditions
- ✓ Members on 10 or more medications
- ✓ Members with two or more hospitalizations and/or ER visits in the last 6 months
- ✓ Potential transplants
- ✓ HIV/AIDS

10.4 Role of the Case Manager

AMM case managers have educational and experience-based background as registered nurses and/or social work case managers who:

- ✓ Facilitate communication and coordination between all members of the health care team, involving the member and family in the decision-making process in order to minimize fragmentation in the health care delivery system.
- ✓ Educate the member and all providers of the health care delivery team about case management, community resources, benefits, cost factors and all related topics so that informed decisions can be made.
- ✓ Encourage appropriate use of medical facilities and services, improving the quality of care and maintaining cost-effectiveness on a case-by-case basis.

Upon identification of a potential member for the Case Management program, the case manager contacts the referring provider and member and completes an initial assessment. The case manager develops an individualized care plan based on information from the assessment and with the involvement of the member, the member's representative and the referring provider.

The care plan is re-assessed to monitor progress toward goals, any necessary revisions and any new issues to ensure that the member receives support and teaching to achieve care-plan goals. Once the member meets AMM's care goals or the member is unresponsive to the case manager's interventions, the member's case is closed.

10.5 Accessing Specialists

AMM case managers are available to help Primary Care Providers access Specialists. For help locating a Specialist, call the Customer Service department at (877) 589-6807 or visit https://cmsp.amm.cc/ProviderSearch.

Please have the following information ready:

- ✓ Member's name
- ✓ Member's identification number
- ✓ Date of birth
- ✓ Type of specialty requested
- ✓ County of member's residence

10.6 Advance Directives

Recognizing a person's right to dignity and privacy, members have the right to execute a living will to identify their wishes concerning health care services should they become incapacitated. Members may request that physicians and/or office staff assist members in procuring and completing necessary forms. Providers should document their efforts to educate their patients on advance directives.

Section 11.0 – Provider Grievance and Appeals

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

11.1 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://cmsp.amm.cc/providers and fax the form to (562) 766-2006 or in writing to the following address:

CMSP – Advanced Medical Management, Inc.
Attn: Customer Service - Grievances
5000 Airport Plaza Drive, Suite 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) 848-3349

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

11.2 Provider Appeals Regarding Clinical Decisions

Providers acting on behalf of themselves may submit an appeal of a denied service in whole or in part by completing the provider appeal form at http://cmsp.amm.cc/providers and fax the form to (562) 766-2007 or in writing to the following address:

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

The appeal may be requested up to 60 business days after the notification of a denial. Providers also may request an appeal on behalf of the member for denial, deferral, or modification of a prior authorization or an expedited appeal. In this case, AMM follows the Member Appeal Process. The provider is given an opportunity to submit written comments, documents, records or other information relevant to the appeal. AMM maintains confidentiality throughout the 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.

Once AMM receives an appeal form request, AMM's appeals staff investigates the case and sends a written acknowledgement of the provider's appeal.

The provider(s) is asked to submit documentation within 10 business days of the date of the request, if more information is required to complete the investigation.

Standard post-service appeals are resolved within 45 business days of the receipt date of the appeal request. A notice of action is sent to the provider in writing within the resolution timeframes for post-service appeals.

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) 848-3349

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

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

11.3 Provider Appeals of Non-medical Necessity Claims Determinations

A provider may appeal a decision regarding the payment of a claim that is not related to a medical necessity determination. *For these appeals, providers should follow the Claims Appeal procedures set forth in Section 8.0 Claims and Billing*.

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.

Section 12.0 – Member Grievance and Appeals

12.1 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:

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

Members or their representatives may submit complaints and grievances orally to AMM's Customer Service at (877) 589-6807 or in writing to the following address:

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

Member Grievance or Complaint forms are available on AMM's website at: https://cmsp.amm.cc/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.

12.2 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) 589-6807or by completing the Member Appeal form at https://cmsp.amm.cc/members/ and faxing the form to (562) 766-2007 or in writing to the following address:

CMSP – Advanced Medical Management, Inc.
Attn: Care Management Appeals
5000 Airport Plaza Drive, Suite 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.

12.3 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.

12.4 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.

12.5 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.

12.6 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 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 13.0 – 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 calendar days of receipt of AMM's Appeal resolution letter.

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

Completed forms and other written requests should be sent to:

CMSP Governing Board
Attn: Second Level Appeals
1545 River Park Drive, Suite 435
Sacramento, CA 95815

or

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 calendar days of receipt of the request to advise of their resolution decision.

Section 14.0 – Dental Services

CMSP covers dental services when rendered by an in-network provider, including:

- ✓ Diagnostic & preventative dental hygiene (e.g., exams, x-rays, teeth cleanings)
  - One (1) oral evaluation every six (6) months
- ✓ Periodontal & restorative services (e.g., crowns)
- ✓ Emergency services for pain control
- ✓ Endodontic services (e.g., fillings, root canals, scaling & root planing)
- ✓ Prosthetics, implants, & prosthodontics (e.g., dentures)
- ✓ Oral & maxillofacial surgery (e.g., extractions)
- ✓ Acceptable Provider Types:
  - Dentist (DDS)
  - Registered Dental Hygienist

Members with a share of cost (SOC) must meet their SOC for the month in order for these services to be eligible for coverage by CMSP.

For a complete list of covered dental codes and limitations please visit http://cmsp.amm.cc/providers.

14.1 Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating providers to submit "documentation" associated with certain dental services for a Member. Participating providers will not be paid if this "documentation" is not provided to AMM. Participating providers must hold the Member, AMM, and

CMSP harmless as set forth in the Agreement with CMSP Governing Board if coverage is denied for failure to obtain authorization (either before or after service is rendered).

AMM utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. The Covered Dental Benefits and Limitations list is available at http://cmsp.amm.cc/providers.

14.2 Non-emergency Prior Authorization Requirements

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, AMM and/or CMSP Governing Board. Submission of "documentation" should include:

- ✓ Radiographs, narrative, or other information where requested
- ✓ CDT codes on the claim form

Please use EZ Net to request authorization or fax an ADA approved claim form to (562) 766-2001. The Covered Services list contains a column marked Authorization Required. A "Yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After AMM's director reviews the documentation, the submitting office shall be provided an authorization number via EZ Net or fax. The authorization number will be provided within approximately 3-5 business days from the date the documentation is received.

The authorization number will be issued to the submitting office and must be submitted to AMM with the other required claim information after the treatment is rendered.

14.3 Emergency Treatment Required Documentation

AMM recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations, services that require authorization, but are rendered under emergency conditions, will require the same "documentation" be provided with the claim when the claim is sent for payment. It is essential that the contracted provider understand that claims sent without this "documentation" will be denied.

14.4 Payment for Non-Covered Services

Contracted providers shall hold Members, AMM and CMSP Governing Board harmless for the payment of non-covered services except as provided in this paragraph. Providers may bill a member for non-covered services only if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- ✓ The services to be provided;
- ✓ AMM and CMSP Governing Board will not pay for or be liable for said services; and
- ✓ Member will be financially liable for such services.

14.5 FQHC PPS Encounter Billing

Only specified CPT codes will be eligible for payment. FQHC's are reimbursed directly by AMM according to their contracted PPS/Encounter rate as stipulated by CMSP. To ensure timely and accurate reimbursement, all clinic provider claims MUST be submitted with code D0999 along with the applicable clinic rate and all CDT codes for services performed on the most current version of the ADA claim form. Certain services require prior review and approval; contact AMM customer service or view the Dental Benefit Limitations and Authorization Guide located on-line at http://cmsp.amm.cc/providers.

Evaluation Definitions:

D0120 – Periodic Oral Evaluation

An evaluation preformed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

D0140 – Limited Oral Evaluation – Problem Focused

An evaluation limited to a specific oral health problem. This may require interpretation of information acquired though additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections etc.

D0150 – Comprehensive Oral Evaluation

Typically used by a general dentist and/or specialist when evaluating a patient comprehensively, it is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired though additional diagnostic procedures. Accordingly, diagnostic procedures should be reported separately. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

Dental Program Benefit Limitations

Before rendering dental care please check the Dental Benefit Limitations & Authorization Guideline for a list of ALL covered dental codes eligible for review and reimbursement.

Appropriate Billing Procedures and use of Encounter Code D0999 – Section Two

1. The billing office must submit ALL service codes performed along with the associated UCR rate on an ADA claim form in order for payment to be processed appropriately.
2. The billing office must submit code D0999 –PPS/ Encounter rate, along with CDT codes for service performed, on the ADA claim form in order for payment to be processed appropriately.
3. Submission of code D0999 must include the approved PPS/Encounter rate for the servicing location.
4. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis, and treatment planning are the responsibility of the dentist.
5. A comprehensive oral evaluation includes documentation of the chief complaint, clinical examination of the head and neck and charting of dentition, periodontium, occlusion, intra- and extra- oral soft tissues, radiographic interpretation, a complete review of the medical and dental history, blood pressure (recommended), and a dental diagnosis, prognosis and treatment plan (including available treatment options).
6. All documentation must be documented and maintained by the dentist for CMSP and members in the same manner as other patients.
7. The billing office is encouraged to review patient history before submitting claim forms in order to determine which evaluation code, if any is appropriate.
    a. Has the provider already submitted procedure code D0150 for this patient?
    b. Is the patient eligible for procedure code D0120? Has it been 6 months since the last D0120 was billed?
    c. Is procedure code D0140 appropriate? Does the appointment address a specific oral health need? Will procedure code D9110 be billed?
8. In the event of a dental emergency, the office must submit for procedure code D9110 – Palliative Treatment of Dental Pain – Minor Procedures – when the only other procedure code

billed is a diagnostic radiograph. If any other services (filling, endodontic, oral surgery, etc.) are billed for on the same day, the palliative treatment code will be denied.

Extended Care Cases – Section Three Prosthetic Billing Procedures

To accommodate Clinics for prosthetic cases where the number of treatment occurrences may extend beyond two appointments CMSP will reimburse clinics at the PPS/Encounter rate accordingly. To receive payment the added treatment encounters should be coded as D5899 and submitted along with the standard D0999 code plus applicable clinic rate. Treatment can be submitted on an ADA claim form or electronically and should be coded as indicated below:

Example #1 Full Denture - ONE Arch

(Services do require review and approval prior to payment)

Beneficiary Receives a Mandibular OR Maxillary Complete Denture	Services Provided	Procedure Codes Billed	PPS Average Value (PPS rate example varies by clinic)
PPS Billing of D5899	Impression, Bite Registration, Try-In, or post placement Adjustments	Allow payment of up to 3 codes D5899 when prosthesis is provided for ONE arch. Bill procedure code D5899 along with code D0999 and applicable clinic rate	$100 per code
PPS Billing for Denture – Single Arch	Final Placement	Must bill one of (one upper OR one lower) of (D5110, D5120) along with code D0999 and applicable clinic rate.	$100 each (one upper OR one lower)
		ESTIMATED REIMBURSEMENT	$400

Extended Care Cases – Section Four Major Restorative Billing Procedures

To accommodate Clinics for endodontic (root canal therapy) and crown cases that extend to two appointments CMSP will reimburse for two PPS/Encounter payments. Codes are subject to a prepayment review to ensure that services are being billed in line with program guidelines. Treatment can be submitted on an ADA claim form or electronically and should be coded as indicated below:

Example #2 Crown Treatment

Beneficiary Receives a Full Cast or Porcelain Crown (PVC or FCC)	Services Provided	Procedure Codes Billed	PPS Average Value (PPS rate example varies by clinic)
First	Crown preparation	Must bill one of (D2751/ D2791) along with code D0999 and applicable clinic rate.	$100
Second	Crown Insert	Allow payment of 1 code D2999 when crown is provided. Bill procedure code D2999 along with code D0999 and applicable clinic rate.	$100
		ESTIMATED REIMBURSEMENT	$200

Example #3 Root Canal Therapy

Beneficiary Receives a Full Cast or Porcelain Crown (PVC or FCC)	Services Provided	Procedure Codes Billed	PPS Average Value (PPS rate example varies by clinic)
First	Root Canal Therapy appt (open tooth, begin procedure)	Must bill one of (D3310/D3320/D3330) along with code D0999 and applicable clinic rate.	$100
Second	Root Canal Therapy final appt (place temporary filling)	Allow payment of 1 code D3999 when crown is provided. Bill procedure code D3999 along with code D0999 and applicable clinic rate.	$100
		ESTIMATED REIMBURSEMENT	$200

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.

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 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'snSignature	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; 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 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 and 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 ortyped/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 2

UB-04 Claim Form Specifications

All facilities (including FQHCs) should bill AMM using the most current version of the UB-04 (CMS-1450) claim form. FQHCs must use ADA claim form for billing dental services.

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
9 (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	Leave blank

Appendix 3

ADA Claim Form Specifications

Professional dental providers and dental clinics (including FQHCs) should bill using the most current version of the ADA Claim form.

Locator #	Box Title	Description
1 (R)	Type of Transaction	There are three boxes that may apply to the submission. They include "Statement of Actual Services" if services have been performed, "Request for Predetermination/ Preauthorization" if there are no dates of service, and "EPSDT/Title XIX" if the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program.
2	Pre-determination/Pre-Authorization Number	Enter the predetermination or preauthorization number provided by the insurance company if you are submitting a claim for a procedure that has been pre- authorized by a third-party payer.
3 (R)	Company/Plan Name, Address, City, State, Zip Code	Enter the information for the insurance company or dental benefit plan that is the third-party payer receiving the claim.
4 (R)	Other Coverage: Dental or Medical	Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.
5 (R)	Name of Policyholder/ Subscriber in #4 (Last, First, Middle Initial, Suffix)	If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.
6 (R)	Date of Birth	Enter the date of birth of the person listed in Item #5. Enter date of birth as MM/DD/YYYY
7(R)	Gender	Mark the gender of the person who is listed in Item #5. Mark "M" for Male or "F" for Female as applicable.
8	Policyholder/Subscriber ID	Enter the patient's CIN number
9 (R)	Plan/Group Number	Leave blank
10 (R)	Patient's Relationship to Person named in #5	Mark the patient's relationship to the other insured named in Item #5.
11 (R)	Other insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.
12 (R)	Policyholder/Subscriber Name	Enter the complete name, address and zip code of the policyholder/subscriber with coverage from the company/plan named in #3.
13 (R)	Date of Birth	Enter date of birth as MM/DD/YYYY
14 (R)	Gender	For the primary insured individual, mark "M" for male or "F" for female.
15 (R)	Policy/Subscriber ID	Enter patient's CIN number
16	Plan/Group Number	Leave blank
17	Employer Name	Leave blank
18 (R)	Relationship to Policyholder/ Subscriber in #12 Above	Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage.
19	Reserved For Future Use	Leave blank
20 (R)	Name, Address, City, State, Zip Code	Enter the complete name, address and zip code of the patient.
21 (R)	Date of Birth	Enter date of birth of the patient as MM/DD/YYYY.

22 (R)	Gender	Mark “M” for male or “F” for female. This applies to the patient.
23(R)	Patient ID/Account #(Assigned by Dentist)	Enter the dentist’s account number used to identify the patient.
24 (R)	Procedure Date	Enter procedure date for actual services performed or leave blank if the claim is for preauthorization/ predetermination. Enter date as MM/DD/YYYY.
25	Area of Oral Cavity	Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure’s nomenclature.
26 (R)	Tooth System	Enter “JP” when designating teeth using the ADA’s Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition). Enter “JO” when using the International Standards Organization System.
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen “-” to separate the first and last tooth in the range (e.g., 1-4; 7- 10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10; 3-5, 22-27).
28	Tooth Surface	This Item is necessary when the procedure performed by tooth involves one or more tooth surfaces. The following single letter codes are used to identify surfaces: B = Buccal, D = Distal, F = Facial (or labial), I = Incisal, L = Lingual, M = Mesial, O = Occlusal.
29 (R)	Procedure Code	Enter the appropriate procedure code found in the version of the Code on Dental Procedures and Nomenclature in effect on the “Procedure Date” (Item #24).
29a (R)	Diagnosis Pointer	Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b (R)	Quantity	Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24.
30 (R)	Description	Provide a brief description of the service provided (e.g., abbreviation of the procedure code’s nomenclature).
31 (R)	Fee	Report the dentist’s full fee for the procedure.
31a (R)	Other Fee(s)	When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.
31b (R)	Total Fee	The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a.
33	Missing Teeth Information	Mark an “X” on the number of the missing tooth – for identifying missing permanent dentition only.
34 (R)	Diagnosis Code List Qualifier	Enter the appropriate code to identify the diagnosis code source: B = ICD-9-CM or AB = ICD-10-CM

34a (R)	Diagnosis Code(s)	Enter up to four applicable diagnosis codes after each letter (A – D.). The primary diagnosis code is entered adjacent to the letter "A."
35	Remarks	This space may be used to convey additional information for a procedure code that requires a report, for multiple supernumerary teeth, or used to convey additional information you believe is necessary for the payer to process the claim.
36	Patient/Guardian Signature & Date	By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.
37	Subscriber Signature & Date	The signature and date are required when the Policyholder/Subscriber named in Item #12 wishes to have benefits paid directly to the dentist/provider.
38 (R)	Place of Treatment	Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard.
39	Enclosures	Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).
40	Is Treatment for Orthodontics?	If no, skip to Item #43. If yes, answer Items 41 & 42.
41	Date Appliance Placed	Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.
42	Months of Treatment	Enter the total number of months required to complete the orthodontic treatment. (Note: This is the total number of months from the beginning to the end of the treatment plan).
43	Replacement of Prosthesis	This Item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures).
44	Date of Prior Placement	Complete if the answer to Item #43 was "YES." Enter date as MM/DD/YY (Month/Day/Year).
45	Treatment Resulting From	If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item and proceed to Items #46 and #47.
46	Date of Accident	Enter the date on which the accident noted in Item #45 occurred. Enter date as MM/DD/YY (Month/Day/Year).
47	Auto Accident State	Enter the state in which the auto accident noted in Item #45 occurred.
48 (R)	Name, Address, City, State, Zip Code	Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).
49 (R)	NPI (National Provider Identifier)	A Type 2 NPI is entered when the claim is being submitted by an organizational type group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.

50	License Number	If the billing dentist is an individual, enter the dentist's license number. Otherwise, leave blank
51 (R)	SSN or TIN	Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.
52 (R)	Phone Number	Enter the business phone number of the billing dentist or dental entity.
52a.	Additional Provider ID	This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN).
53 (R)	Signed (Treating Dentist) & Date	Signature of the treating or rendering dentist and the date the form is signed.
54 (R)	NPI	Enter the treating dentist's Type 1 Individual Provider NPI in Item # 54. (See Item #49 for more NPI information.)
55 (R)	License Number	Enter the license number of the treating dentist.
56(R)	Address, City, State, Zip Code	Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.
56a (R)	Provider Specialty Code	Enter the code that indicates the type of dental professional who delivered the treatment.
57(R)	Phone Number	Enter the business telephone number of the treating dentist.
58	Additional Provider ID	This is an identifier assigned to the treating dentist other than a Social Security Number (SSN) or Tax Identification Number (TIN).

Appendix 4

Covered Medical Services without a SOC

For the most updated list of covered services without a SOC, visit: https://cmsp.amm.cc/providers

Appendix 5

CMSP Contracted Provider Roster

The CMSP Contracted Provider Roster is updated monthly. To see the most updated list of contracted CMSP providers, visit: https://cmsp.amm.cc/ProviderSearch

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