Provider Reference Guide
An array of advantages for healthcare providers.

The Arizona Foundation for Medical Care (Arizona Foundation) realizes it is the network of physicians, behavioral and allied health providers, and many other health professionals that allows us to offer high-quality, comprehensive network plans. As a result, we are a provider-friendly company that supports participating providers and encourages their involvement.

In addition to this Guide, the Arizona Foundation offers an array of advantages to healthcare providers, including:

**Network Clarity:** The Network logo appears prominently on member ID cards, so it’s easy to confirm network participation and claims submission address.

**Quick Claim Turnaround**

**Large Membership Base**

**Steering Members to Network Providers:** Network providers are listed in our online printed directories and search tool.

**Physician-led Organization:** Our Board of Trustees is physician-led, so decisions are made by doctors, not accountants. Providers are part of a comprehensive system of healthcare, where they, hospitals and other facilities, third party administrators, carriers, medical management companies and Arizona Foundation work in tandem to help members make cost-effective, quality decisions about their healthcare.

**Local Presence:** When enrolled in the Arizona Foundation provider network you will experience an Arizona-based call center with highly-trained Provider Unit Representatives, and a Provider Relations department whose sole purpose is to help you with whatever you need.

They can be reached by e-mail to providerrelations@azfmc.com or 800-624-4277.
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Section 1

About Arizona Foundation for Medical Care
How to Use AFMC’s Provider Reference Guide
This Guide will assist your office staff in administration of AFMC’s network plans. It is an extension of your AFMC contract. Updates and revisions will be sent to you via Chart Notes, as notices posted on our Web site and through other communication channels. You will be responsible for maintaining records of updates. As you receive updates, please insert them in your copy to ensure you have the most current information. Whenever you have a question about any aspect of AFMC’s operations, first check the appropriate section of this manual. If you don’t find the answer to your question in the manual, contact AFMC’s Provider Relations Team or Call Center. We are always willing to help. Also, please let us know if you have suggestions about improvements we can make to this Guide to make it easier for you to use.

1.1 – Welcome
Arizona Foundation for Medical Care (AFMC) would like to welcome you to our Network of Providers.
As a provider you play a very important role in the delivery of healthcare services to the members of the employer groups we service. The AFMC Provider Reference Guide is intended as a guideline for the provision of your contract with AFMC.
This manual contains policies, procedures, and general reference information, which include minimum standards of care that are required of AFMC Providers. As an AFMC Provider, we hope this information will help you better understand how AFMC operates.
Should you or your staff have any questions about information contained in this Guide or anything else about AFMC, please feel free to contact our Provider Relations Team. We look forward to working with you and your staff.

1.2 – Introduction to Arizona Foundation for Medical Care
Founded in 1969, Arizona Foundation for Medical Care (AFMC) is the largest, Arizona-based, independent healthcare network with more than 14,000 physicians in over 39,000 locations. AFMC is also contracted with many hospitals, laboratories, outpatient surgical centers, urgent care centers, and radiology centers throughout Arizona and bordering states.
Utilization of AFMC’s extensive network gives your patients maximum benefits from their healthcare plan; ample physicians – including specialists - to meet their healthcare needs; in addition to quality customer service when they need help.

Affordable, High-quality Care – For over 40 years, AFMC has been committed to providing affordable, high-quality healthcare. Physicians and providers in the network are peer-reviewed to ensure the highest level of quality and leadership in the industry.

Comprehensive Care – AFMC enhances patients overall quality of life by offering a full array of medical management programs and wellness services.

Customer Service in Your Backyard – AFMC is a Phoenix-based company run by Arizonans who are committed and empowered to solve regional problems that may arise. AFMC employees strive to provide impeccable service and client satisfaction.

1.3 – What is AFMC?
AFMC is not a single plan or insurance company. Rather AFMC is a Preferred Provider Organization (PPO) that works with many employers and claim administrators all of which retain their own benefit plans. A Preferred Provider Organization, or PPO, is a network of selected providers of healthcare: physicians, hospitals, home health agencies, ancillary providers, and others. AFMC is a traditional PPO giving your patients - our employer group members - a financial incentive or disincentive in their benefit plan that encourages them to seek care from participating providers. Since these benefit plan differentials could significantly impact the patient’s out-of-pocket cost, network utilization under AFMC program is very high. Members are encouraged to use these selected providers because they receive better benefits when they do. This gives patients true freedom of choice, but rewards them for making cost-effective decisions. Details regarding benefit differentials should be determined by contacting the claim or benefit administrator.

A PPO is not an insurance plan. AFMC works with many employers and claim administrators, all of which retain their own benefit plans. AFMC does not pay claims, but assists in collecting information, then preparing the claim for payment. Once AFMC has repriced the claim it is routed to the appropriate claim administrator for benefit determination. These services are provided by our many insurance companies and plan administrators. For a complete listing and the most recent update, log onto www.azfmc.com; click on “Provider”, “AdminList/Commonly Used Forms”.

Insurance companies and third party administrators do not provide AFMC with certain basic information, i.e. eligibility files, claim history, payments, benefit determinations, etc. To verify eligibility, benefits or to check claims status, please call the Plan Administrator/Payor directly for these details. Contact information can be found on your patient’s ID card. Please remember, AFMC is neither able, nor authorized, to provide this data. AFMC will, when appropriate, act as a liaison in order to facilitate a resolution for a provider member or patient.

1.4 – How are the AFMC Networks Structured?
AFMC Provider Networks - in addition to the individual Physician’s group - include Hospitals, Urgent Care Centers, Outpatient/Ambulatory Surgery, Laboratories, X-Ray and Imaging sites, and other miscellaneous healthcare services combined in a variety of packages for the benefit plan designs of insurance companies, third party administrators, self-funded employer groups and carriers.
1.5 – What are the different AFMC Plan Types?
AFMC offers Arizonans freedom of choice by endorsing a variety of health plans through insurance agents and brokers. AFMC network plans include Foundation PPO, Foundation EPO/PPO Plus, Foundation Point of Service (POS), Foundation SELECT and Foundation COMP (a Worker’s Compensation plan).

Currently, AFMC network product offerings include:

**PPO: Traditional** – The PPO network includes all providers that are contracted with AFMC; including all hospitals, physicians, and ancillary services such as laboratories, imaging, and urgent care centers, to name a few. The PPO network is a perfect fit for employer groups that have employees throughout the state of Arizona and desire the broadest coverage without restrictions.

**PPO Plus/EPO** – This is AFMC’s exclusive plan most often used for employer groups or individuals residing in Maricopa and Pima Counties. It includes all physicians and specialists that are contracted with AFMC, but unlike AFMC’s PPO: Traditional plan, the PPO Plus/EPO plan has a fewer amount of hospitals and ancillary facilities. Creating a smaller, tighter network of hospitals and ancillary facilities allows AFMC to negotiate deeper discounts which are passed down to the employer group and their employees.

Please Note: In accordance with Arizona’s DOI, the name “Foundation EPO” is reserved for ERISA qualified self-funded plans. The Foundation EPO program is available to fully insured plans as “Foundation PPO Plus”. Both plans utilize the same participating provider network.

**POS: Best Value** – The POS Plan is broken down into three tiers – Best Value Hospitals (PPO Plus/EPO or Tier One), Traditional Hospitals (PPO or Tier Two) and Out-of-Network Hospitals (Tier Three) – and is structured much like a pharmacy benefit plan that has generic, brand, and non-formulary drugs to choose from. In like fashion, if members choose a better value hospital (Tier One) they will pay less than if they chose a hospital in Tier Two, or pay out of network costs if Tier Three is chosen. These differentials exist between the three tiers to incentivize plan members to use the most cost effective providers. All AFMC contracted providers and specialists are in the POS network.

**Foundation SELECT** – Foundation SELECT is AFMC’s customized plan for employer groups or individuals residing outside Maricopa and Pima Counties. This plan allows members living outside major metropolitan cities to seek care at rural hospitals with in-network benefits. However, if they seek care in Maricopa or Pima counties, they MUST go to an PPO Plus/EPO hospital. If care is sought in a hospital other than a PPO Plus/EPO hospital in Maricopa or Pima Counties, it will be considered out-of-network.

**Foundation COMP** – Foundation COMP is AFMC’s all-inclusive workers’ compensation plan for fully insured and self-funded employers. This plan, along with reviewing, recording and re-pricing processed claims offers the largest, most accessible network of occupational medical centers, urgent care centers, physical therapy centers, and outpatient surgery centers, as well as a comprehensive network of 6500 plus physicians in over 19,500 locations. Foundation Comp is the workers’ compensation network endorsed by the Arizona Self-Insurers Association (ASIA).

1.6 – The types of Providers in AFMC’s Network
AFMC providers are categorized in three ways on the AFMC Web site: Medical, Chiropractic and Worker’s Comp.

- **Medical** includes providers and facilities contracted with AFMC. Each network plan type offers a combination of physicians and facilities dependent upon contracted rates.
- **Chiropractic** (Chiropractic Cost Containment System (CCCS) - offered in conjunction with Chiro Source) is a stand-alone network of chiropractors that offer employer groups and individuals sound management of chiropractic care at lower costs. Policyholders access a growing network of chiropractors that have agreed to comply with a strict utilization management and re-pricing structure.
- **Workers’ Compensation** includes AFMC contracted physicians and facilities that have elected to participate in this plan.

For contracting purposes, AFMC divides medical providers into the following categories:

- **Allied Health** - Allied health professions are clinical healthcare professions distinct from medicine, dentistry, and nursing. They work in a healthcare team to make the healthcare system function. Because their job descriptions become more specialized, they must adhere to national training and education standards, their professional scope of practice, and often prove their skills through diplomas, certified credentials, and continuing education. Examples of Allied Health professionals are: Nurse Practitioners, Medical Assistants and Surgical Technologists.
- **Behavioral Health** – Treats and prevents mental, emotional and/or behavioral disorders.
- **DPM** – Podiatrists treat corns, calluses, ingrown toenails, bunions, heel spurs, and arch problems; ankle and foot injuries, deformities, and infections; and foot complaints associated with diabetes and other diseases.
- **MD/DO** – This category includes all specialties not listed in the previous three categories and includes areas of interest such as allergists, anesthesiologist, cardiologists, dermatologists, emergency medicine, family medicine, internal medicine, pediatricians, urologists, and many others.
- **Physical Therapy Providers** - Physical therapists, sometimes referred to as simply PTs, are healthcare professionals who diagnose and treat individuals of all ages, from newborns to the very oldest, who have medical problems or other health-related conditions, illnesses, or injuries that limits their abilities to move and perform functional activities as well as they would like in their daily lives. Physical therapists examine each individual and develop a plan using treatment techniques to promote the ability to move, reduce pain, restore function, and prevent disability. In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness and wellness-oriented programs for healthier and more active lifestyles. Physical therapists often consult and practice with a variety of other professionals, such as physicians, dentists, nurses, educators, social workers, occupational therapists, speech-language pathologists, and audiologists.
1.7 – How is AFMC’s Fee Schedule Established?
AFMC’s Fee Schedule is set by the Reimbursement/Fee Committee, which is comprised of seven non-AFMC member physicians and employer group representatives that are utilizing AFMC’s Network Plans. The term of office for a Committee member is one year, January 1 - December 31. The Committee meets several times each year and its responsibility includes reviewing, amending and setting the procedure allowances that comprise the maximum reimbursement fee schedules utilized by AFMC. The Fee Schedule is based upon an allowable amount for each Current Procedural Terminology (CPT) code. AFMC fees are designed to produce fair market rates for providers and employers and to be competitive. AFMC uses a composite of statewide industry data and third party resources (relative value scales, etc.) when establishing provider or facility rates. The schedule is evaluated several times a year against market and industry pricing.

Physician members agree to accept the Fee Schedule as payment in full for covered services rendered to their patients (AFMC members). Because AFMC is a not-for-profit service to the community, it does not receive any portion of any fee adjustment. The savings are passed along as an added benefit to employer groups in the form of lower out of pocket costs and insurance premiums.

AFMC is not an insurance company, nor does it underwrite group health plans. Insurance companies, as well as third party administrators, contract with AFMC for the use of its networks and administrative management services it selects to use. AFMC manages the provider network, and reviews and re-prices claims. AFMC endorses a broad range of plans offered by insurance companies and third party administrators. This creates a broad choice of plans for individuals, families, and employer groups. It also provides services to self-funded plans, including labor unions, municipalities, school districts and employer groups.

1.8 – When and How to Contact AFMC
We want to make it easy for you to communicate with us. Should you or your staff have any questions, concerns, and/or feedback, please contact AFMC’s Provider Relations Team by calling 800-624-4277 or by e-mail to providerrelations@azfmc.com.

Contact our Call Center, Provider Unit at 800-624-4277, Monday through Friday from 8 am – 5 pm, Mountain Standard Time to:

- Verify provider participation status.
- Request assistance on a claims repricing issue.
- Ask general administrative questions.

Call the Provider Relations Team at 800-624-4277 for questions pertaining to a facility or physician contract.

To check the payment status of a claim or to verify benefits and eligibility, contact the patient’s plan administrator; their contact information is located on the back of the patient’s ID card (see Section 5 ID Card for ID card and logo samples; see Section 1 for AFMC Plan Definitions) or in AFMC’s Listing of Plan Administrators located on the AFMC Web site.

To check precertification status for groups using AFMC medical management services, call AFMC’s CHOICE unit at 800-624-4277.

1.9 – The place to find answers - www.azfmc.com
One place to find answers to your questions is the AFMC Web site - www.azmfc.com. Whether you’re a first time user or a frequent visitor of our site, you’ll find helpful information such as:

- AFMC’s Listing of Administrators (payors/administrators who work with AFMC);
- Forms - Provider Change Form, which allows you to submit to AFMC current practice information such as a change of address, Tax ID# or specialty change; “Disclosure of PHI” form and “Fee Schedule Request” form;
- AFMC’s Fully-insured and Self-funded Guides to research what plans/companies are endorsed by AFMC;
- Claims Status - Verify that AFMC received and re-priced your claims or request assistance with problematic claims/appeal a claim;
- Claims Appeal;
- Pre-certification request form;
- Provider Search and Custom Directory tools;
- Enrollment search - Verify your patient’s access to AFMC’s Network, not benefits or eligibility;
- Answers to frequently asked EDI questions, FTP access and support for your transactions;
- Submit your NPI number;
- Annual renewal portal, and/or;
- Provider communications such as Chart Notes (our provider newsletter) and other general communications/e-bulletins.

1.10 – How to log in to www.azfmc.com secure areas
Several designated areas on the AFMC Web site have been “locked down” (the areas are noted by a padlock graphic). AFMC has created these areas to safeguard proprietary information and to ensure adherence to all privacy laws.

There are two ways to log onto a secure area:

1. Once you reach AFMC’s Web site, click on the “Sign In” link at the top right of the page. As you navigate through the site and choose to visit a secure area, you will see the selected page thus negating the need to Sign In from the secure page.
2. As you search the site and click on a link that requires a login, a screen will appear asking you to either login or register. If you have not yet registered, follow the steps for registration. Keep your User ID and password in a safe place or future reference.
Once you complete your session on the AFMC Web site, don’t forget to sign out before you leave by clicking on the “Sign Out” link at the top of your computer screen.

1.11 – Call Center Tips
In the rare instance the AFMC Web site does not contain the information you seek, the AFMC’s Call Center is available, Monday - Friday, 8 am - 5 pm, MST. The Call Center receives many calls every day and they have found that many of these calls fall into certain categories that are highlighted below. The following tips and suggestions will significantly speed up claim processing time and eliminate unnecessary and time-consuming phone calls for you and your staff.

General Tips
- Please do not use the online claim status tools to check payment status; instead directly contact the Payor.
- Use AFMC’s Listing of Administrators to help you verify patient Benefits and Eligibility. The most current listing can be found on our Web site (www.azfmc.com) under the “Provider” link, “Admin List”, sub-link.
- When submitting a claim to AFMC, please complete box 24J with the individual NPI number, not the group NPI. AFMC uses only the individual NPI to process claims. In addition, please make sure that all claims are complete, especially boxes 11, 11a, 11b & 11c. Incomplete claims will be returned.
- To avoid claims processing delays, please maintain a current record of your patient’s insurance information.
- We encourage all providers to use AFMC’s online Claim Status option. For those providers who have retained the services of a billing company, please make them aware of AFMC’s online Claim Status capabilities.

Claim Appeals Tips
The AFMC Call Center agents cannot appeal a claim on your behalf. You or your staff will need to appeal the claim. There are two ways to appeal a claim:

1. **On the Web:** You may use the on-line appeal function by visiting AFMC’s Web site www.azfmc.com. Click on the “Provider” link on the right side of the page, then the “Claim Appeal” sub-link; and

2. **By mail:** To appeal a medical claim, please mail it to: P.O. Box 2909, “Attn: Medical Review”, Phoenix, AZ 85062-2909.
   To appeal a hospital claim, please mail your claim to the address above “Attn: Hospital Appeals.

If you have questions on any day-to-day issues, please call AFMC’s Provider Unit at 800-624-4277 and follow the phone prompts.
Section 2

New Membership
Credentialing/Re-credentialing
Membership Renewal
2.1 – Membership
AFMC membership is based on a calendar year; it starts January 1, or such other date, and continues for the remainder of the current calendar year. The membership is only terminated by mutual agreement in accordance with AFMC’s bylaws and/or rules and regulations.

Membership is renewed for successive periods of one (1) year each. Non-renewal of membership may be made by either AFMC or the provider upon written notice provided to the other during the period of 60 days between October 1 and November 30 of each membership year. Membership applications submitted and approved after September 1 of each membership year, are in effect until December 31 of the following membership year.

2.2 – Membership Renewal
In the fall of every year, AFMC’s membership renewal season starts and continues through the end of December. The membership renewal process is required by all providers that belong to AFMC’s network.

Membership for individual and group providers can be completed online (www.azfmc.com/renewal). The individual renewal portal should be used if you are an individual physician who is currently active in the AFMC network. The group renewal portal should be used if you are a group provider currently active in the AFMC Network.

All AFMC providers - individual and group - will receive notification containing instructions for the AFMC Membership Renewal Process.

Individual Providers
AFMC individual providers have three ways to complete their renewal:

1. Renew online using your license number and password PIN supplied in your renewal notification. Please make sure to fill out the entire form and pay your dues (if applicable).

2. Download a renewal form from the AFMC Web site; complete, sign, and mail it, along with membership dues, (if applicable) to:
   Arizona Foundation for Medical Care
   Attention: Renewals
   326 East Coronado Road
   Phoenix, Arizona 85004

3. Contact AFMC at 800-624-4277 to request your renewal form be mailed to you.

Group Providers
AFMC Group providers can complete their renewal online using your tax ID number and password PIN. Please make sure to fill out the entire form and pay your dues (if applicable).

Important Information about AFMC’s Renewal Process
- If you misplaced your notification and need your license number and password PIN, and/or for questions regarding the renewal process, call the AFMC Provider Relations Team at 800-624-4277 or e-mail to individualrenewal@azfmc.com (individual providers) or grouprenewal@azfmc.com (group providers).
- Please remember to completely fill out your renewal form; submit all applicable documents; and pay your dues (if applicable) to AFMC in order for your renewal to be processed. Incomplete information will delay the processing of your renewal.
- Failure to submit any of the required information to process your renewal will terminate your AFMC membership for the next calendar year.
- In accordance with Chapter 2, Section 2 of AFMC’s Bylaws, the Board of Trustees has voted to implement membership dues. The membership dues must accompany your signed Membership Renewal Form.
- For inclusion in the hard copy of AFMC’s Directory of Participating Providers and the online Provider Search/Customized Directory tools, a provider’s signed renewal form and dues must be received no later than November 1, of the current calendar year.
- Continued membership with no lapse in participation will not be accepted until the completed, signed form AND membership dues are received via Web site or mail.
- For your convenience, AFMC’s Fee Schedule is available by logging onto www.azfmc.com/fees using your license number and Password PIN (supplied on the letter). AFMC’s Reimbursement Schedule is Proprietary and Confidential and for reference of AFMC member providers only. It may not be reproduced without the expressed written permission of AFMC and is not to be used for billing purposes or to be disclosed to any other entity. NOTE: AFMC’s Online Fee Schedule is available only during renewal season. To obtain a fee schedule, log on to http://www.azfmc.com/index/provider and download the Fee Schedule Request form located under the Quick Links section.

2.3 – Credentialing - Individual Physicians and Groups
All providers must be credentialed with AFMC before a contract can be accepted, or the provider added to an existing group contract. A provider that has not been credentialed cannot treat and will not receive payment for services rendered to AFMC members.

Please Note:
The renewal process is very different than the credentialing process.
Filling out an AFMC application means you are either joining the AFMC network, or renewing your existing membership (i.e. you have a contract in place with AFMC and you are renewing for another year).
Credentialing is a process all providers must go through to join AFMC’s network of providers.
Initial verification is made at the time of application; the process can take up to 90-120 days to complete.
To aid AFMC employees with the Credentialing process, the Board of Trustees established a Credentialing Committee. The Committee sets guidelines for AFMC’s staff to follow; provides oversight and technical knowledge otherwise not available to AFMC employees; and serves as the regulatory arm in the credentialing process ensuring a system of checks and balances remain in place.

Please Note: The renewal process is very different than the credentialing process.

Filling out an AFMC application means you are either joining the AFMC network, or renewing your existing membership (i.e. you have a contract in place with AFMC and you are renewing for another year).

Credentialing is a process all providers must go through to join AFMC’s network of providers. Initial verification is made at the time of application; the process can take up to 90-120 days to complete.

A few key points about AFMC’s credentialing process:

- The Committee is comprised of member physicians of a variety of specialties that oversee the credentialing process.
- Per AFMC policy, Individual Physician Review must review files with issues. A credentialing file with issues outside of the Committee Physicians expertise will be referred to Peer Review for an opinion and/or recommendation.
- It is AFMC’s policy to credential/re-credential all MD, DOs, DPMs, Allied Health and Behavioral health Providers. Initial verification (credentialing) is made at the time of application; the process can take up to 90-120 days to complete. Re-credentialing occurs every two years thereafter. It is important that all AFMC-contracted providers complete the re-credentialing application as quickly as possible. Failure to maintain a credentialed status with AFMC can result in contract termination and non-repricing of claims. AFMC Credentialing Criteria follow NCQA guidelines and include verification of a provider’s:
  - Medical License.
  - Board Certification.
  - Felony Convictions.
  - DEA License.
  - Quality Assurance.
  - Hospital Affiliation.
  - Utilization Patterns.
  - Work History.
  - Managed Care Affiliations.
  - Professional Liability.

Applicants must provide AFMC with a completed membership application with copies of the following documents (see provider application for a complete listing of requirements pertaining to each specialty):

- A current DEA license.
- Clinical privileges in good standing at the hospital designated by the provider as the primary admitting facility.
- Five year history of Malpractice Insurance.
- Copy of Board Certification.

The provider has the right to review the information submitted in support of the credentialing application. Incomplete applications will be returned to the provider. Upon completion of credentialing, the file is approved by AFMC’s Credentialing Committee. After approval, notification of the effective date is sent to the provider.

Participating providers are re-credentialed every two years. AFMC will mail providers a letter informing them that re-credentialing is due. It is extremely important that the re-credentialing information is returned as soon as possible to avoid possible termination.

Providers who have been terminated from AFMC’s network and join another practice or open a solo practice are required to repeat the credentialing process if AFMC is not notified within six months of the date the provider was terminated and/or the provider’s credentialing has expired.

2.3 – Facility & Ancillary Provider Criteria for Participation

1. The following documentation is required; attach copies of the following documents:

   - Current Arizona medical license.
   - JCAHO or other applicable accreditation*.
   - Professional liability insurance of at least $1 million/$3 million.
   - Medicare certificate*.
   - W-9 Form.

* Must be valid without significant deficiencies or suspension.
2. **Scope of Services Provided**

Healthcare Services Provided

- Patient education programs offered (Are they included in the price of services? If not, provide program and pricing information).
- List any subcontracted services (submit their qualifications).

Geographic Service Area

- List branches denoting service locations.
- Indicate ownership - owned by parent company or franchise.
- Type of accreditation held by each branch.

3. **Protocols for Services**

- Provide evidence of written or codified clinical protocols to identify patient candidates for surgery services.
- Contingency plans for emergency situations.

4. **Policy for Grievance Resolution**

5. **Pharmacy Arrangements, if applicable**

6. **Contact Personnel - list all that are applicable:**

   Medical Director, Clinical Manager, Account Representative, Contracting Coordinator, Quality Director, Billing Supervisor and their name, title, address, phone, fax and e-mail.

7. **Provider Network Contracting Requirements**

   - **Reimbursement** – Arizona Foundation for Medical Care (AFMC) is a managed care organization and not a claims payor. AFMC represents many separate health insurers and payors which are ultimately responsible for claims adjudication and payment. AFMC will assist in identifying patients with employers and employers with claims payors.
   - **Billing** – All billing for medical services/supplies will be completed on a UBO4 OR CMS 1500 form using valid and appropriate ICD-9, CPT4 and HCPCS codes. Failure to comply with this requirement may result in denied claims from the claims payor(s).
   - **Audit** – AFMC will reserve the right to audit patient records and determine the extent to which inappropriate or over utilization of services, if any, have been provided. In situations in which inappropriate or over utilization of services have been identified, a participating facility will agree to reduce the maximum allowable fee by 50%.
   - **Utilization Management** – AFMC started CHOICE (Continuous Hospital, Outpatient and Individual Case Evaluation) in 1974 to provide Utilization Management services to employer groups. CHOICE Nurse Coordinators actively refer members into alternative treatments and alternative treatment settings whenever appropriate to balance quality of care with cost. A participating facility will be expected to provide appropriately proficient personnel to interface with CHOICE Nurse Coordinators in the determination of treatment modalities and length of treatment.
   - **Selection Criteria** – Selection of participating facilities is determined on the basis of scope of services, CQI practice and program and geographical coverage. Applications which include the outline of criteria may be addressed to:

     Director, Provider Relations
     Arizona Foundation for Medical Care
     326 E. Coronado Rd.
     Phoenix, AZ 85004

2.4 – **Your Listing in the AFMC Directory of Providers**

Upon completion of your credentialing with AFMC, your demographic information will be listed in our online provider directory at [www.azfmc.com](http://www.azfmc.com) and in directories distributed to employer groups accessing the AFMC network.

Your office must notify AFMC of any changes in demographic information prior to the effective date of the change. If you do not, it could affect claims processing. This will ensure that we are publishing the most current information and providing our participating claim administrators with updated provider demographics. For your convenience, AFMC has created the Provider Change Form located on the Web site in the following path: [www.azfmc.com/index/provider/page/adminlist](http://www.azfmc.com/index/provider/page/adminlist) Note: This is a secure area which requires registration. If you have not registered, visit the following URL to do so: [www.azfmc.com/index/register](http://www.azfmc.com/index/register)

2.5 – **Termination**

AFMC is privileged to have a very comprehensive provider network, with low turnover through termination of agreements. However, we understand that due to unforeseen circumstances, either party to the agreement may choose to terminate the relationship. Your agreement with AFMC allows you or AFMC to terminate the agreement with or without cause if submitted in writing to the other party. Refer to your agreement for the time frame specific to you.
There are also detailed instructions in your AFMC agreement about the continuation of care and payment for AFMC members under your care at the time of termination of the agreement. This part of your agreement is in compliance with Arizona Department of Insurance guidelines and is meant to ensure a smooth transition of patient care. AFMC believes that the guidelines are an effective means of maintaining quality of care.

In order to ensure continuity of care, it is important that your office manager notify AFMC in writing of changes in the provider’s location prior to the date the changes occur. This will allow us sufficient time to make necessary changes in our system.

2.6 – Provider Profiles
AFMC analyzes claims data and turns it into a valuable tool that our clients can use to effectively manage their health plans. We evaluate claims data, health management data, case management data, and disease management data, along with claim classification codes like DRGs and CPTs. We study this information to determine how a provider compares to peer providers in Arizona.

AFMC looks at the information in three different ways. First, from a utilization perspective: how does the provider utilize services compared to peers? Next, we look at information from an age, gender, and demographic perspective: How does the practice compare to peers in terms of the AFMC population that is accessing it? Finally, we look at information in terms of costs per patient as a result of how providers bill for services. If you receive feedback from AFMC as a result of this data analysis, utilize this data to help examine your own practice patterns. AFMC does these reviews as a quality initiative. The long-term goal is to have the highest quality, most cost-effective network of providers.

AFMC’s security measures exceed HIPAA minimum requirements to protect your confidential information and our network from viruses and unauthorized use. Electronic files containing Protected Health Information (PHI) or individually identifiable information; or other information considered proprietary, including providers personal information such as TIN and NPI numbers; information submitted for the credentialing/re-credentialing process; and/or mailing, billing, practice addresses, etc., and distributed outside AFMC are encrypted and/or password protected, or sent via secure transmission. E-mails sent to outside parties are encrypted or password protected if they contain PHI.

AFMC also requires individual passwords, and secures data by utilizing data encryption and user authentication by digital certificate. Any employee of AFMC will execute a signed confidentiality agreement prior to the release of electronic files to external parties.
Section 3

Provider Services
3.1 – Robust Web site
AFMC’s valuable claim repricing service and on-line Claim Activity Status offers many benefits for our network of providers, including:

Convenience and improved customer service: Our Web-based on-line claim status and claim appeal functions provide 24/7 access to your claim information at AFMC.

HIPAA compliance: AFMC’s Web-based functions meet HIPAA guidelines for security and privacy. We can assure providers that all patients’ protected health information (PHI) is secure.

Interaction: Providers can send AFMC information about claims that have not been successfully repriced. The “E-PHI” feature allows providers to send us patient policy information - securely - so that we can correct, update, and release claims for payment consideration.

3.2 – Provider Communication
AFMC is committed to assisting you with the administration of our PPO network. We believe communication is the best way to ensure administrative ease so we will keep you up-to-date on any changes regarding administration of our programs; helpful facts for ease in administration; large employer additions or terminations, and much more. You may receive communication from AFMC in various ways, including our e-newsletter (Chart Notes), Web site, direct mail, e-mail, or telephone calls from our Provider Relations staff.

AFMC encourages all providers to supply their e-mail address to AFMC to receive communications electronically. Not only will you receive important updates and information much faster, we will be able to save a tree and reduce costs at the same time. To submit your e-mail address, e-mail your information to providerrelations@azfmc.com.

3.3 – Customer Service - Call Center
AFMC’s Call Center Provider Unit is available to assist you Monday – Friday, 8 am to 5 pm MST. Our toll free number is 1-800-624-4277. Our mission is to provide our clients with outstanding customer service, performed in a timely manner by well trained, highly skilled representatives operating under the absolute highest standard of quality.

3.4 – Verifying Patient Participation in AFMC’s Network - Online
In an effort to streamline processes and reduce administrative burdens for our providers, AFMC offers on-line patient enrollment verification. The process is easy:

• Go to the AFMC Web site at www.azfmc.com.
• Click on the “Provider” link.
• Click on the “Enrollment Search” sub-link. Log into the secure area.
• You will be asked to enter your TIN and PIN, then the patient’s ID number or last name and date of birth.

This area of the Web site will only show if the patient is able to access AFMC’s network. You will need to verify benefits and eligibility with the member’s Plan Administrator whose name and phone number will be listed on the Enrollment Search screen, or from the patient’s health plan member ID Card.

3.5 – Reviewing and Researching Claims
Response to AFMC’s Online Claim status and Claim Appeal features has been overwhelming. More and more providers are taking advantage of these latest Web site enhancements and are able to instantly find out when their claims were received and re-priced by AFMC; print an Explanation of Review (EOR); and appeal a claim, all in once session. For those providers who utilize the services of a billing company, please inform them of AFMC’s on-line claim status capabilities.

It’s easy to gain access to this information. Simply visit www.azfmc.com; click on “Log In” in the upper right hand corner; then click on “Providers” and go to “Claim Status”.

If you have not registered to use the Claim Status tool on the AFMC Web site, you can do so by logging on to the Site at www.azfmc.com.
1. From the Home page, click on “Log In” in the upper right hand corner. Then, click on “Register now”.
2. Fill out the entire form to include your e-mail address, password of choice, first/last name, and select your group from the pull down menu.
3. Once you complete the entire form, click “Submit”.
4. An e-mail will be sent to the address you provided for account activation.
5. Once you receive the confirmation e-mail, click the link to activate your registration. If you are not registered, follow the registration instruction to set up your account.

Accessing Claim Status
From the home page of AFMC’s Web site, click on “Provider”, then “Claim Status”. Enter your e-mail address (ex. johnsmith@yahoo.com) and password. You are now logged into the Claim Status Portal. If you have not used AFMC’s Claim Status portal, you will need to set up an account:
1. Click on “Access Management”.
2. Enter your Tax Identification Number (TIN) and the password PIN supplied by AFMC. To obtain your PIN, call AFMC’s Provider Relations
Team at 800-624-4277 ext. 8695. Click on “add”. Please delete your TIN upon account set-up.

3. Upon system confirmation, the user will be added to the list on the bottom of the screen. You may add and delete users at any time. The steps above can be repeated for each member physician of the practice by entering his or her valid TIN and PIN. The Access Management tool can be used at any time to update physicians listed under your log-in.

Claims Look-up
This function will not show you payment status. To check payment status on a claim, contact your patient’s plan administrator at the information listed on the back of the ID card. How to check claim repricing status:
1. Enter in the claim number and click on “submit”. If you do not know the claim number, enter in one or more of the following:
2. Patient’s last name
3. Patient first name
4. Patient ID number
5. From service date
6. To service date
7. A few items of note: To view more than 10 claims on your screen, click on the results per page drop down box.
8. Click on the claim # to show a printable EOR for claims with a completed status.
9. Click on any column header to sort by that column of data.
10. You can manage your list of providers and/or facilities with Access Management.
11. There is a legend available to describe the meaning of each status code.

If you are having trouble viewing EORs, please upgrade to the latest version of Adobe Acrobat Reader available, for free, at http://get.adobe.com/reader.

Claims Appeal
AFMC providers can appeal a claim electronically.

How to access Claims Appeal:
1. From the Home page, click on “Provider” then “Claims Appeal”.
2. Log into the secure area.
3. Fill out all form fields.
4. Submit supporting documentation (if applicable) to include operative report, chart notes, diagnostic testing, and/or x-ray reports. To add attachments: click “Browse” to choose the file, then click “Add Attachment”. Note: If you are unable to add attachments, please use the fax cover sheet from the confirmation page and fax physician claims and/or documentation to 602-495-8684.
5. When all required information is entered, click “Submit”. An e-mail will be sent to AFMC’s Provider Relations Team to initiate the review process.

3.6 – Problematic Claim Status Inquiries
AFMC’s Payor Service Team is available to assist you with problematic claims. AFMC defines a claim as “problematic” when:
1. It has been outstanding more than 60 days from the re-pricing date; and/or
2. Your efforts to resolve the issue with the claim administrator have been unsuccessful.

Claims must be less than 18 months from the date of service. If you would like us to assist you with research on a problematic claim, please call the AFMC Call Center at 800-624-4277 for the Payor Unit. Our Payor Service Team will contact the appropriate claim administrator and obtain the status of your claim.
Section 4

Provider Role and Responsibilities
4.1 – Fee Schedules

Providers that contract with AFMC agree to follow a pre-determined fee schedule. It is the provider’s responsibility to review the maximum reimbursement schedule adopted by AFMC’s Independent Reimbursement Committee so they are fully aware of the payments they will receive for covered services rendered to patients insured under AFMC-sponsored and/or endorsed healthcare plans.

The Fee Schedule is directed by the Reimbursement Committee, which meets throughout the year to review, amend and set procedure allowances. The Fee Schedule can change twice a year - January 1 and again July 1.

**Note:** Covered services are defined as a treatment for which a person is entitled to receive benefits based on stipulations of the insured’s policy.

Providers should understand that during their AFMC membership, they agree not to seek payment from patients – insured under AFMC – sponsored healthcare plans - for covered services that are above the maximum reimbursement level or seek payment from patients for covered services that are disallowed as a result of the Peer Review process.

AFMC’s Fee Schedule Request Form is available on the Web site [www.azfmc.com](http://www.azfmc.com) in an easy to use interactive pdf format. The form can be found at the bottom of the page under “Provider”, “Administrator List/Commonly Used Forms.”

Please note: In order to expedite your request, please send one (1) form with multiple codes; not multiple forms with one code each.

Upon receiving the form, AFMC will price your codes accordingly and fax back to your office. Please allow three business days for processing. Please remember to include the required supporting documentation and to sign the form. In addition, it is important that you please remember to request all of your codes at one time. You also have the option to go online, and if you have any questions or problems with the form, please contact AFMC’s Provider Relations Team.

AFMC’s fee schedule is proprietary and confidential and for reference of AFMC member physicians only. It may not be reproduced without the expressed written permission of AFMC, and is not to be used for billing purposes, or to be disclosed to any other entity.

4.2 – Utilize In-Network Providers and/or Facilities

As stated in your contract with AFMC, providers are required to refer their patients covered under an AFMC-sponsored and/or endorsed healthcare plan to in-network services, especially for lab services, pathology groups, and DME providers. If it is necessary to refer a member out-of-network, please remember to inform your patients of that referral before the service is provided. The patient should be aware of any, and all, out-of-network (out-of-pocket) expenses they could incur by using out-of-network providers or facilities.

4.3 – Precertification Review

Medical necessity is certified for all inpatient stays, either through AFMC Medical Management or a payor’s designated Medical Management Organization. Please refer to your patient’s ID card for full instructions. Below are some points to remember when precertification is necessary:

Determine the Patient’s Plan: PPO, EPO/PPO Plus, POS, SELECT, etc. Check the patient’s insurance ID card for this information (See Section 5 ID Card for ID card and logo samples. See Section 1 for AFMC Plan Definitions.). Be certain to use a hospital, ambulatory surgery center and other providers that participate in your patient’s plan. Verify enrollment status on [www.azfmc.com](http://www.azfmc.com) (see section 3.4 or 5.4 for Enrollment Status instructions). It is imperative you follow these steps; there may be a penalty to the patient for out-of-network utilization.

Insurance plans that use AFMC’s Medical Management Services require that before a patient can be admitted to a hospital for elective procedures, the activity must be certified in advance. This is required for any scheduled elective treatment. If an elective or planned medical admission is not precertified, healthcare benefits may be reduced or lost.

**Concurrent Review**

Insurance plans require that a patient’s progress be monitored after admission. Nurse Coordinators work with the admitting physician, hospital and medical advisors to evaluate the patient’s progress. Based on this evaluation, the number of certified days may be adjusted. In addition, Nurse Coordinators are also prepared to assist with discharge planning requirements.

**Emergency Admission**

In the case of an emergency or urgent admission, call AFMC or the payor’s Medical Management organization within 24-48 hours of an emergency admission. Follow the instructions listed on your patient’s ID card, and refer to Section 7 - Medical Management for more information.

4.4 – Providing Medical Records to AFMC

In accordance with HIPAA, Providers are required to furnish AFMC with medical records (operative reports and chart notes), at no charge, as necessary to adjudicate their patients’ claim(s), and for the purposes of cost containment, quality assurance and peer review. Upon joining AFMC, each provider signs a Business Associate Agreement with AFMC to permit the disclosure of PHI to AFMC in connection with the services the provider performs on behalf of AFMC employer group members.

4.5 – Maintaining Professional Liability Insurance

As a stipulation of AFMC membership, providers must maintain professional liability insurance in an amount likely to be carried by a prudent physician in the same area of practice or specialty and geographical area within the state they practice in.
4.6 – Situations That Require Notification

There are five circumstances a provider must notify AFMC, in writing, within five (5) days of the occurrence of any of the following:

1. License to practice medicine in Arizona is lost, restricted or suspended.
2. Hospital privileges are lost, restricted or they have been suspended for a cumulative total of 30 days or more for any 12-month period.
3. Any other situation arising, which might materially affect the ability to carry out duties or obligations under this agreement.
4. Professional liability insurance is canceled or reduced for any reason.
5. Intent to terminate AFMC membership/contract within 60 day window of December 31 term date.

In addition to the situations listed above, it is a provider’s responsibility to notify their patients at least 30 days in advance, of their decision to terminate their AFMC membership.

If the provider continues to treat their patient who is still enrolled in an AFMC network plan, the provider will receive payment(s) in accordance with the terms of the maximum reimbursement fee schedule covered by the applicable benefit agreement until the conclusion of the course of treatment, or for thirty (30) days following termination of their contract, whichever comes first. In the event payment, or notification of claim status, is not received within ninety (90) days after submission of claim(s), the provider has the right to bill the patient for services rendered, accepting the rates as referred to in their contract.

4.7 – Notifying AFMC of Provider Demographic Changes

Providers must notify AFMC of changes in their demographic information by utilizing AFMC’s Provider Change Form. The Provider Change Form should be used to submit a change in address, Tax ID# or specialty change, etc. A provider may add or delete contracted physicians by notifying AFMC in writing within 30 days of status change. Please utilize the Provider Change Form located on the AFMC Web site to submit status changes. A sample of this form can be found on pages 19 and 20 and can be downloaded from the AFMC Web site under the “Provider” link, “Admin List/Commonly Used Forms” sub-link located at: https://www.azfmc.com/index/provider/page/adminlist

Claims for dates of service greater than 30 days prior to notification of physician status change shall be deemed as an out-of-network claim and forwarded to the insureds payor for processing. Balance billing the insured for these claims is prohibited under this agreement.

4.8 – Version 5010 File Format Requirements

The current compliance date for the version 5010 file format begins January 1, 2012. The 5010 rules require the adoption of new ICD-10 Codes. As a result, effective September 1, 2010, AFMC now requires that all providers submit a zip+4 and one active physical address on any new provider applications., which include the following:

- All addresses must have a full zip code, including zip+4. To find the zip+4 for an address, visit the USPS Zip Code Lookup Web site (http://zip4.usps.com/zip4/welcome.jsp).
- Each physician must have at least one active physical address. Therefore, P.O. Boxes will no longer be accepted as a physician’s only active address.

For more information about the 5010 standard by visiting the Centers for Medicare & Medicaid Services Web site (http://www.cms.gov/).
Arizona Foundation for Medical Care
Provider Change Form

Please note: Provider is entirely responsible for keeping AFMC informed about current practice information.
If AFMC does not receive updated information from the provider in writing, AFMC will continue to send correspondence to the addresses currently in our database. AFMC will not responsible for lost or returned mail if we do not receive this completed form from the provider at least five (5) days prior to the effective date of change.

Please complete all applicable information, including REQUIRED fields (required fields are in red).
Failure to complete required fields may result in the request not being processed. Please allow 5-7 business days for this request to be processed.

If you should have any questions, please contact AFMC’s Provider Relations Team at 800-624-4277.

Type of Change

If you select other, please list your type of change here:

Provider Name - Please list current Provider Information

Last Name: ___________________________ MI: ______ First Name: ___________________________

Tax ID #: ___________________________ Corp Name: ___________________________

AZ License #: ___________________________

Specialty Change

Primary: ___________________________ Board Certified ☐ Yes (Req. Documentation) ☐ No

Secondary: ___________________________ Board Certified ☐ Yes (Req. Documentation) ☐ No

Tax ID Change

Termed TIN#: ___________________________ Effective Date: ___________________________

New/Replacement TIN#: ___________________________ Effective Date: ___________________________

New/Additional TIN#: ___________________________ Effective Date: ___________________________

Reason for TIN Term/Change: ___________________________
Address - Please make sure to list phone and fax numbers. Also, please note that as of September 1, 2010, AFMC requires that all addresses must have a full zip code, including zip +4. Each physician must also have at least one physical address. Therefore, P.O Boxes will no longer be accepted as a physician's only active address.

Tax ID: ___________________________ Address: ___________________________

City: ___________________ State: ___________ Zip Code + 4: ______________

Phone Number: ______________________ Fax Number: ______________________

☐ Term    ☐ Add    ☐ Office    ☐ Mailing    ☐ Billing

Tax ID: ___________________________ Address: ___________________________

City: ___________________ State: ___________ Zip Code + 4: ______________

Phone Number: ______________________ Fax Number: ______________________

☐ Term    ☐ Add    ☐ Office    ☐ Mailing    ☐ Billing

Tax ID: ___________________________ Address: ___________________________

City: ___________________ State: ___________ Zip Code + 4: ______________

Phone Number: ______________________ Fax Number: ______________________

☐ Term    ☐ Add    ☐ Office    ☐ Mailing    ☐ Billing

Tax ID: ___________________________ Address: ___________________________

City: ___________________ State: ___________ Zip Code + 4: ______________

Phone Number: ______________________ Fax Number: ______________________

☐ Term    ☐ Add    ☐ Office    ☐ Mailing    ☐ Billing

E-mail Address: ___________________________

Signature: ___________________________

Date: ___________________________

To fax this form to AFMC, please follow these easy steps:
1. Fill out the form.
2. Click the print button.
3. Sign the form and fax it to: AFMC Provider Relations Team at 602-495-8884.
Section 5
ID Card Information
5.1 – Member ID Card

Benefits, Eligibility and Claim Payment Information - AFMC’s ID card does not guarantee coverage. Instead it lists the information necessary for your office to verify benefits and eligibility through your patient’s plan administrator.

For information regarding benefits, eligibility or payment on a claim, contact the patient’s plan administrator using the eligibility verification number printed on the back of the patient’s ID card.

Please note: AFMC does not verify or provide health insurance benefits and/or eligibility, and we do not know what benefits the patient’s plan offers. AFMC does not pay claims. We re-price them according to a predetermined rate schedule. In addition, patient identification as a member that can access an AFMC contracted provider will help your office when issuing a referral to other providers.

The ID card below is a sample only and the fields you see are variable fields, which will be populated with the patient’s employer group/administrator specific information. For a detailed listing of administrators that AFMC works with, please visit our Web site at www.azfmc.com.

The FRONT of an ID card usually contains:
- The logo of the plan administrator and/or the logo of the network of providers;
- The ID number and group number;
- Prescription drug information/number;
- Patient’s name;
- Patient’s group (employer) name; and
- Lab information.

The BACK of an ID card usually contains:
- Pre-certification or prior authorization contact information;
- Eligibility/Benefits verification contact information;
- Claims billing contact information; and
- Information on how to locate a provider.

To help you better identify the different AFMC network plans, we’ve placed the logos below.
5.2 – Requests for Verification of Eligibility and Benefits
AFMC does not maintain benefit or eligibility information for members. Providers should contact the administrator indicated on the patient’s identification card for benefit and eligibility information. The claim administrator name and phone number can also be found in AFMC’s Listing of Administrators.

AFMC recommends that providers verify benefits for all services rendered to AFMC members. Verifying benefits allows the provider to collect any co-payment, co-insurance, deductible, etc. at the time of service.

5.3 – AFMC Listing of Administrators
When an AFMC member arrives in your office, check the Listing of Administrators on the AFMC Web site for the company through which your patient is insured. The guide provides specific information about the coverage provided by the company’s plan. This may assist you in determining what your patient is obligated to pay for each service. If you have any questions about any of the companies listed in AFMC’s Listing of Administrators contact AFMC’s Call Center at 800-624-4277.

5.4 – Enrollment Search
AFMC offers providers on-line patient enrollment verification. This information DOES NOT guarantee coverage or payment, but rather indicates that the specified patient has access to AFMC for the date of service, according to enrollment records. To verify benefits and eligibility, you MUST contact the Administrator listed on the enrollment screen or from the patient’s health plan member ID card.

To access online enrollment verification log onto www.afmc.com then:

• Click on the “provider” link, then on “enrollment search.
• Log into the secure area.
• Enter the providers TIN and PIN, then the Member’s ID number or Last Name and Date of Birth. Please note, the fields are case sensitive and the date should be entered in this pattern: MM/DD/YYYY.
Section 6

Claims
6.1 – Claims Filing

AFMC strongly encourages providers to submit claims electronically (typically, the electronic claims interface reduces payment turnaround cycles by 5-10 working days) either directly to AFMC or through a clearinghouse as quickly as possible after services are rendered - the faster you file the claim, the faster AFMC will re-price the claim; send to the administrator; and you receive payment for services. Should you choose to file your claims in paper format, please mail the claim to the claims routing address indicated on the patient’s ID card.

Some self-funded plans have timely filing limits that can affect whether a claim is payable if filed after a designated timeframe. Some reinsurance contracts will not reimburse for claims that fall outside the contract period. For these reasons it is important to file claims promptly. AFMC advises that claims should be submitted to AFMC within 90 days from the date of service.

Should your office need to re-file a claim to AFMC to correct a previously re-priced claim (such as a retrospective audit), please do so in writing within 12 months from the re-pricing date. If not re-filed promptly, some of these re-filed claims might be denied by the claim administrator because they fall outside of the plan’s timely filing limitations. If you receive denials on these claims due to untimely filing, please be advised that the patient should not be penalized.

Following are a few tips that will assist you with the Claims Filing process:

- Upon claim submission to AFMC, please complete box 24J with the individual NPI number, not the group NPI. AFMC uses only the individual NPI to process claims. In addition, please make sure that all claims are complete, especially boxes 11, 11a, 11b & 11c. Incomplete claims will be returned.
- NSF and 4010 standards do not allow “None”, “Unknown”, 123456789 and 000000000 in the policy number field.
- Use AFMC’s Listing of Administrators to help you verify patient Benefits and Eligibility.
- If you have retained the services of a billing company, please make them aware of AFMC’s online Claim Status capabilities.
- When a corrected claim is re-submitted it must be sent directly to the attention of AFMC’s Medical Review Department. Review and adjudication of the claim will be delayed if the claim is sent to the “general” address.
- When a claim is forwarded to a Third Party Administrator, you must send a copy of the claim generated by your office (CMS 1500 or HCFA) along with AFMC’s re-pricing sheet printed from AFMC’s Web site. Payment will be delayed if the claim does not accompany the re-pricing sheet.
- AFMC scans paper claims into its system using imaging technology. This technology reduces data entry and improves our service to you. To make this technology as effective as possible, please follow these claims filing guidelines:
  - File all claims in the appropriate current electronic format or on the current CMS/UB approved paper version.
  - If filing on paper, make sure your claims are typed or computer generated and that the print is dark and legible.
  - Do not staple items to your claims unless absolutely necessary.
- We have identified various reasons an electronic claim may reject at your clearinghouse/vendor level, or result in the claim being converted to paper and mailed to AFMC. To assist in ensuring your electronic claims are successfully received at AFMC, please review the following tips:
  - Routinely review your rejection/confirmation report. Your vendor should provide a report which confirms receipt of your claim transmissions and flags rejections. It is vital that you routinely receive and review this report. If you are not receiving this report, please contact your vendor.
  - Ensure your carrier file for AFMC is set up to transmit claims electronically.
  - Ensure your claim contains an employer group number. AFMC has an edit in place with our vendors, which requires submitters to file a policy number. In order to re-price your electronic claim, we must be able to identify the group. If this segment is blank, your claim will be rejected. Please do not file Self, Unknown, Individual, None, 123456789, or all zeros as this will result in a reject by your vendor.
  - Ensure your claim contains complete diagnosis codes.
  - Diagnosis codes not carried out to the 5th digit can result in a rejected claim.
  - Ensure your claim contains a valid patient date of birth. If the patient is the subscriber please ensure you have entered a valid date of birth (mmddyyyy). If the patient is not the subscriber, please ensure you have entered a valid date of birth.
  - Ensure your claim contains an insured’s valid 9-digit SSN/alternate member ID. Please do not submit the patient’s group number or name in this segment or include the patient relationship code. Please do not file a SSN with greater than or less than 9 digits. This can result in a reject at the payer level when AFMC sends your electronic claim on to the payer on your behalf.

The claims look-up function is designed to help you search for claims re-pricing status. If your claim appears in this area, AFMC has re-priced the claim and sent it to the designated payer either by EDI or by paper. Please call the payer first to check claim payment status. If the payer does not show receipt of the claim, then contact AFMC at 800-624-4277.

6.2 – NPI Number

Effective May 23, 2007, all providers are now required to bill with their unique NPI which is assigned by the CMS Enumerator. The NPI number consists of nine numeric digits followed by one numeric check digit. Providers should refer to CMS’ Website: www.nppes.cms.hhs.gov to begin the NPI application process, which is free of charge.
Any provider that submits claims electronically must have provided AFMC with their NPI number and have it included on their claims submitted to AFMC. This includes claims sent through a clearinghouse.

If you have not already done so, you may submit your NPI Number online via the AFMC Web site - www.azfmc.com. Click on the “Provider” link then “Submit NPI”. Providers will need to logon with their TIN and PIN in order to submit.

If you do not have an NPI number, you may submit an NPI application via the CMS Web site: www.nppes.cms.hhs.gov, which has an expected turnaround time of 15 days, or you can call 800-465-3203, and request a paper NPI application with an expected turnaround time between 30-60 days.

The e-mail address to request a NPI application is: customerservice@npienumerator.com

The mailing address is: NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059. For further NPI information, please log on to the Center for Medicare & Medicaid Services Web site at: www.cms.hhs.gov.

Important Claims Information to Remember:

• AFMC does not generate a unique Provider ID for its members. Please use your Tax ID Number (TIN) when submitting claims.

• Claims repricing by AFMC does NOT guarantee benefit coverage or payment. All AFMC providers must contact the Plan Administrator/Carrier to verify benefits and/or eligibility for each patient.

• Remember: Claims without NPI numbers will be rejected. Please note, this includes facility claims! If the attending physician NPI is not included on a facility claim, it will be rejected.

For any questions, contact AFMC’s Call Center Provider Unit at 800-624-4277.

6.3 – Federal Tax ID

Providers must report the Tax ID Number (TIN) under which they will be paid. The Federal Tax ID (Employer Identification Number, EIN) also goes on the CMS 1500 form.

6.4 – AFMC Claims Processing and Requirements

Ancillary Benefit Services (ABS), a wholly owned subsidiary of AFMC, can accept claims electronically from AFMC providers. In addition to Medicare requirements, AFMC follows the coding standards described in the *UB-92 Manual; Classification of Disease Manual* (current ICD-9); current editions of the *Physicians’ Current Procedural Terminology (CPT) Manual and HCFA Common Procedure Coding System (HCPCS) Manual*; and/or *The First Data Bank Blue Book for Pharmacy Information*. It is AFMC policy to re-price all medical claims accurately and in a timely manner in accordance with CMS guidelines and regulations.

We strongly encourage providers to file claims electronically to take advantage of the numerous benefits of electronic filing, which include:

• Enhanced claim accuracy due to electronic edits.

• Reject/confirmation reports provided by software vendors to track claim routing.

• Reduction in time and cost associated with mail preparation.

• EDI claims can be reproduced and released by our Customer Service Call Center if a claim status inquiry or request for additional information is received.

• EDI filing support services offered by our experienced AFMC EDI Coordination Team.

• Reduction in accounts receivable due to increased efficiencies for submitters and receivers.

• Electronic claim submission can improve claim accuracy and payment timeliness.

Filing claims electronically to AFMC is simple and quick to setup. If you are currently submitting paper claims and want to submit electronically AFMC can help. If you would like to begin submitting claims electronically directly to AFMC or through a clearinghouse, submit a request for information to AFMC’s IS department at cedi@azfmc.com and an IS Representative will e-mail the appropriate information to the provider’s office. An additional contact option is to call the EDI Help Line at (602) 252-4042. An IS Development Analyst will work with the provider on the claims transmission process.

If you choose to send the claim to AFMC through your office and your software does not produce 4010 837 HIPAA compliant files, SolAce EMC software can help*. To get started with SolAce EMC, visit AFMC’s Web site (www.azfmc.com), click on “Provider” then “FTP Access Request” and fill out the online form. Once you have filled out the form, a representative from AFMC will contact your office with further instructions. Please have the following information ready before filling out your forms:

<table>
<thead>
<tr>
<th>Your Submitter Information</th>
<th>Software Vendor Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Vendor Name – Ivertex</td>
</tr>
<tr>
<td>Address</td>
<td>Contact – EDI Team</td>
</tr>
<tr>
<td>Phone and Fax Numbers</td>
<td>Vendor Code – n/a</td>
</tr>
<tr>
<td>E-mail Address (if any)</td>
<td>Phone: 602-439-2525</td>
</tr>
</tbody>
</table>
Contact Name (if other than name above) Fax: 602-439-0808

Provider PIN numbers for this payer Address – PO Box 86609
Phoenix, AZ 85080

Organization or Group PINs for this payer Software Name – SolAce EMC

E-mail: support@ivertex.com

Once you have received your Submitter ID and password from AFMC, please call the Ivertex Support Team and set an appointment for a Mailbox setup and Test Transmission, and have 25 test claims ready for testing. Test files should consist of a variety of claims that represent the type of claims you will be submitting once production status is achieved. Test claims will not be processed for payment but will be validated against production files; therefore, they must contain valid patient procedure, diagnosis, and provider information.

*SolACE is the name of a software product from Ivertex (www.snapinhipaa.com/products.asp) that allows a provider to create and submit claim files directly to AFMC without using a clearinghouse.

To work with an AFMC-preferred clearinghouse that has an existing connection with AFMC and can also assist you in implementing the technology needed to forward your claims to them (who will then forward your claims to AFMC for repricing), please refer to the list below. If the Payor ID is not listed below, please contact the clearinghouse and work with them to set up the process. AFMC does not need to be notified when a provider starts sending claims via a clearinghouse.

**AFMC does not pay claims and does not have a government-associated payor ID. The clearinghouse assigns Payor ID’s if they utilize our services. Note: If the clearinghouse is not associated with AFMC, they will not send claims to AFMC electronically and will not have a payor ID. If your clearinghouse is not on this list or does not send claims electronically to AFMC, then the claims are either forwarded to one of the companies listed below or printed to paper and mailed to AFMC. Please contact your clearinghouse for more information and remember the claims paying process can be delayed.**

### EDI Clearinghouse List

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Payor ID</th>
<th>Clearinghouse Contact/Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dynamic/HCSI</td>
<td>Call Clearinghouse</td>
<td>480-237-2020</td>
<td>NA</td>
</tr>
<tr>
<td>Enterprise</td>
<td>Call Clearinghouse</td>
<td>480-998-5452</td>
<td>NA</td>
</tr>
<tr>
<td>ENS</td>
<td>A2FMCC</td>
<td>800-341-6141</td>
<td><a href="http://www.enshealth.com">www.enshealth.com</a></td>
</tr>
<tr>
<td>ET &amp; T</td>
<td>ET352</td>
<td>480-325-0901</td>
<td><a href="http://www.ettch.com">www.ettch.com</a></td>
</tr>
<tr>
<td>Mars Medical</td>
<td>Call Clearinghouse</td>
<td>800-521-8751</td>
<td><a href="http://www.marsmedical.com">www.marsmedical.com</a></td>
</tr>
<tr>
<td>Relay Health (Formerly McKesson)</td>
<td>3438</td>
<td>563-557-3925</td>
<td><a href="http://www.infosolutions.mckesson.com">www.infosolutions.mckesson.com</a></td>
</tr>
<tr>
<td>Emdeon Business Services (Formerly Medifax/WebMD)</td>
<td>3890 HCFA</td>
<td>800-444-4336</td>
<td><a href="http://www.medifax.com">www.medifax.com</a></td>
</tr>
<tr>
<td></td>
<td>3891 UB92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Ally</td>
<td>Call Clearinghouse</td>
<td>949-464-9129</td>
<td><a href="http://www.officeally.com">www.officeally.com</a></td>
</tr>
<tr>
<td>Emdeon (Formerly Web MD)</td>
<td>86062</td>
<td>615-885-3700</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
</tr>
</tbody>
</table>

As a benefit of membership with AFMC, there is no charge to providers who choose to send claims directly to AFMC. There are also no special enrollment forms to complete. A clearinghouse may charge your office a fee to send to AFMC. AFMC does not receive any fees from the clearinghouse for claims transmission.

If you are currently sending claims to AFMC electronically, utilizing a clearinghouse listed above, and the claims are not reaching you or are not in the claim status function on AFMC’s Web site, please call AFMC at 602-252-4042 or 800-624-4277 and ask to speak with the Call Center Payor Unit. If the clearinghouse is not on the list and the claim is not listed on the AFMC Web site (claim status screen), call the Clearinghouse to determine where the claims were sent.

A few reasons why your claim might not be processed: invalid member enrollment; invalid procedures; member enrollment is/was not effective at the time of service; and/or the clearinghouse does not send claims electronically to AFMC.

### 6.5 – CMS 1500 Claim Submission Requirements (see pg 29 for a sample of the CMS 1500)

Please Note: Fields 11, 11b, 11c, 24j and 33a MUST be completed or claims will be returned.

1a. **INSURED IDENTIFICATION NUMBER** – Enter the identification number found on the current ID card.

2. **PATIENT’S NAME** – Enter the patient’s last name, full first name and middle initial.

3. **PATIENT’S BIRTH DATE AND GENDER** – Enter the patient’s birth date in each sectioned block using the date format of MM/DD/YY and mark either the M or F block indicating the patient’s gender.

4. **INSURED’S NAME** – Enter insured’s last name, full first name and middle initial.

5. **PATIENT RELATIONSHIP TO INSURED** – The insured is the person on the identification card. Indicate the relationship of the patient to the insured by marking the appropriate box.

6. **INSURED’S ADDRESS** – Enter the insured’s complete address.
11. **INSURED’S POLICY GROUP OR FECA NUMBER (required)** – Enter the group number (including all alpha and numeric characters) as shown on the identification card.

11b. **EMPLOYER’S NAME OR SCHOOL NAME (required)** – Enter the actual name of the employer. If it is an individual policy enter “Individual Policy”.

11c. **INSURANCE PLAN NAME OR PROGRAM NAME (required)** – Enter “AFMC/The Actual Payor Organization Name” as shown on the individual patient insurance card or the administrative code found in the Listing of Administrators.

11d. **ANOTHER PLAN** – If the answer is YES, please complete boxes 9a – d.

12. **RELEASE OF INFORMATION INDICATOR** – Enter a Y or N.

13. **AUTHORIZATION** – Must be signed or indicate “signature on file”.

14. **DATE OF CURRENT** – Complete if Box 10 is filled in.

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** – Complete for DME, lab claims and PCP Plans.

20. **OUTSIDE LAB** – If Yes is marked complete Box 32 appropriately.

21-1. **PRIMARY DIAGNOSIS CODE** – Enter the diagnosis/condition of the patient indicated by ICD9 code number. Enter up to 4 codes in priority order.

24A. **SERVICE FROM AND TO DATE** – Enter the month, day and year formatted as MM/DD/YY for each procedure, service or supply. If “from” and “to” dates are shown here for a series of identical services, enter the number in column 24G. If the identical services are billed for the same charge, the “from” and “to” dates must be within the same month.

24B. **PLACE OF SERVICE CODE** – Enter the appropriate place of service code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>05</td>
<td>IHS Free-standing Facility</td>
</tr>
<tr>
<td>06</td>
<td>IHS Provider-based Facility</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-standing Facility</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-based Facility</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>ER – Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>28</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>31</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>35</td>
<td>Ambulance – Land</td>
</tr>
<tr>
<td>36</td>
<td>Ambulance – Air or Water</td>
</tr>
<tr>
<td>37</td>
<td>Independent Clinic</td>
</tr>
</tbody>
</table>

24d. **CPT/HCPCS PROCEDURE CODE** – Enter the current CPT procedure code or the appropriate HCPCs code. When CPT modifiers are used, they must be placed in the modifier section.

24e. **DIAGNOSIS CODE POINTERS 1-4** – Enter the diagnosis reference number as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis. Show at least one diagnosis related number but no more than 4 in order of their priority. Separate diagnosis reference numbers by commas. Diagnosis codes not carried out to the 5th digit can result in a rejected claim.

24f. **MEDICAL LINE CHARGES** – Enter the charge for each service in dollars and cents.

24g. **DAYS OR UNITS** – Enter the number of days or units (services) when billing for identical/multiple services and anesthesia services.

24j. **RENDERING PROVIDER ID NUMBER (Required)** – Enter the Physician or Supplier’s NPI that furnished the services or supplies to the patient.

25. **FEDERAL TAX ID/PROVIDER TAX TYPE** – Enter the Federal Tax ID number of the provider performing the services. Also mark either SSN or EIN, to identify the provider tax type.

26. **PATIENT’S ACCOUNT NUMBER** – Enter the account number assigned to the patient by the individual provider office.

27. **ACCEPT ASSIGNMENT** – Indicate acceptance of the amount paid by the Medicare program for claims submitted under that program.

28. **TOTAL CLAIM CHARGE** – Enter the sum of the charges listed in items 24F, lines 1-6.

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS** – Physician or Supplier name must be entered and dated.

32. **SERVICE FACILITY LOCATION INFORMATION** – The facility and address of the place services were performed or provided.

33. **PHYSICIAN’S BILLING NAME, ADDRESS, ZIP CODE AND PHONE NUMBER** – Enter the Physician or Supplier’s name that furnished the services or supplies to the patient.

33a. **PROVIDER NPI (Required)** – Enter the Physician or Supplier’s NPI that furnished the services or supplies to the patient. Enter the individual NPI NOT the group NPI. Include your zip+4. Do not list PO Box as the primary billing address.
6.6 – UB-04 Submission Requirements (see the page 31 for a sample form)

Please Note: Boxes 17 & 56 MUST be completed or claims will be returned.

The field number indicates the corresponding box number on the UB-04 form.

1. **FACILITY’S BILLING NAME, ADDRESS, AND PHONE NUMBER** – Enter the facility’s name, full address, and telephone number. Include the Zip+4. DO NOT list a PO Box as the primary billing address.

2. **PATIENT CONTROL NUMBER** – Enter the account number assigned to the patient by the facility.

3. **FEDERAL TAX ID NUMBER** – Enter the Federal Tax ID number of the facility performing the services.

4. **STATEMENT FROM AND TO DATE** – Enter the beginning and ending dates of the period included on this bill using the MM/DD/YY format.

5. **PATIENT NAME** – Enter the patient’s last name, full first name and middle initial.

6. **PATIENT ADDRESS** – Enter the patient’s full mailing address.

7. **PATIENT BIRTH DATE** – Enter the patient’s birth date using the date format MM/DD/YY.

8. **PATIENT GENDER** – Enter either M or F block indicating the patient’s gender.

9. **ADMISSION DATE** – Enter the first date of the admission for inpatient care using the date format MM/DD/YY.

10. **STATUS (required)** – Enter 01 or 02.

11. **RESPONSIBLE PARTY NAME AND ADDRESS** – Enter the full name and full address of the responsible party.

12. **REVENUE CODE** – Enter the appropriate revenue code to explain each charge.

13. **DESCRIPTION** – In addition to describing provided services, CPT codes are also required if a surgical procedure is performed.

14. **SERVICE UNITS** – Enter the total number of services billed for each revenue code.

15. **TOTAL CHARGES** – Enter the total charges for each revenue code in dollars and cents.

16. **PAYOR** – Enter “AFMC/The Actual Payor Organization Name” as shown on the individual patient insurance card or the administrative code found in the Listing of Administrators. EXAMPLE: AFMC/American Community Mutual or AFMC/ACMI.

17. **RELEASE OF INFORMATION INDICATOR** – Enter a Y or N.

18. **ASSIGNMENT OF BENEFITS INDICATOR** – Enter a Y or N.


20. **INSURED’S NAME** – Enter insured’s last name, full first name and middle initial.

21. **PATIENT RELATIONSHIP** – The insured is the person on the identification card. Indicate the relationship of the patient to the insured by using the appropriate code.

   - **01** Patient
   - **08** Employee
   - **02** Spouse
   - **09** Unknown
   - **03** Natural Child/Insured has Financial Responsibility
   - **04** Natural Child Insured does not have Financial Responsibility
   - **12** Cadaver Donor
   - **05** Step Child
   - **06** Foster Child
   - **15** Injured Plaintiff
   - **11** Organ Donor

22. **CERTIFICATE/SSN/HI CLAIM NUMBER/IDENTIFICATION NUMBER** – Enter the identification number of the insured. This is usually the SSN or a policy number assigned by the insurance company.

23. **GROUP NAME** – Enter the actual name of the employer. If it is an individual policy enter “Individual Policy”.

24. **INSURANCE GROUP NUMBER** – Enter the group number (including all alpha and numeric characters) as shown on the identification card.

25. **PRINCIPAL DIAGNOSIS CODE** – Enter the chief diagnosis/condition of the patient indicated by ICD-9-CM code number.

26. **ATTENDING PHYSICIAN NPI** – Enter in the attending physician’s individual NPI number (NOT group NPI number).
# UB-04 Claim Form

## Admission
- **Admit Date:** [ ]  
- **Discharge Date:** [ ]  
- **Payment Date:** [ ]  

## Diagnosis
- **Diagnosis Code:** [ ]  
- **Diagnosis Description:** [ ]  

## Procedure
- **Procedure Code:** [ ]  
- **Procedure Description:** [ ]  

## Charges
- **Charge:** [ ]  
- **Amount:** [ ]

## Insurance
- **Insured's Name:** [ ]  
- **Unique ID:** [ ]  
- **Group Name:** [ ]  

## Payment
- **Payer Name:** [ ]  
- **Payment Date:** [ ]  

## Certification
- **Certifications:** [ ]

## OMB Number
- **Approved OMB No:** [ ]  

---

The certifications on the reverse apply to this bill and are made a part hereof.
6.7 – How AFMC Collects Information and Adjusts Claims
When AFMC receives a claim electronically, the information on the claim is uploaded into our claims management system. If a claim is received on paper all of the information on the claim is scanned or manually entered into the same computer system. Each participating provider’s negotiated contracted rates are stored in AFMC’s database. When the claim is entered into our system, the screen displays your contracted rates, and the claim is repriced based upon contracted arrangements. The claim is then forwarded to the appropriate claim administrator electronically for payment consideration within 24 hours to two working days depending on the arrangement made with the employer group and administrator.

6.8 – AFMC’s Claims Adjustment Policies
Claims adjustment policies are part of the claims repricing process and may impact the amount allowed by AFMC. Any disallowed amounts will appear on your Explanation of Review – which can be viewed and printed from the AFMC Web site – and should be adjusted off the patient’s account. Each claim administrator may have their own policies and procedures that may affect the ultimate determination of coverage or benefits.

6.9 – Modifiers that Affect AFMC Repricing
There are modifiers that affect AFMC repricing. Some may allow repricing for an individual detail line that would not normally be allowed, based on AFMC adjustment policies. Others may reduce the allowable amount based on factors such as multiple procedures. AFMC’s allowable may be affected when the following modifier is added to the CPT code:

- **Filling Claims for Anesthesia Services** - AFMC requires all claims to be billed with an ASA code for anesthesia (new or retro) and submitted from a Certified Registered Nursing Assistant to include HCPCS modifiers QX (service performed under physician supervision) or QZ (service performed without physician supervision). Under our policy, if a claim does not include the previously mentioned modifiers, it will not be adjudicated; instead it will be returned for correct coding which could result in delayed payment for services.

6.10 – Claims Repricing Errors or Disputes
AFMC makes every attempt to reprice claims accurately and per contract terms. Stringent system testing and audit processes are conducted when new or revised contract terms are implemented, but we do advise providers to review repricing amounts on their Explanation of Review (EOR), which can be reviewed and printed from the AFMC Web site, to assure repricing is per current contract terms.

If a repricing discrepancy is noticed, please notify us as soon as possible through a claim appeal. If a claim dispute is not made within 12 months of the AFMC repricing date, the provider has agreed to accept the negotiated amount and no repricing or payment adjustment will be made.

6.11 – Claims Appeal
AFMC providers can appeal a claim electronically on the AFMC Web site (www.azfmc.com) by either clicking on the appeal hyperlink in the Claim Status screen or by clicking on “Claims Appeal”.

Facts to Note:
- From the Home page, click on “Provider” then “Claims Appeal” (note this is a secure area.)
- All fields are required.
- Submit supporting documentation (if applicable) to include operative report, chart notes, diagnostic testing, and/or x-ray reports electronically by clicking on “Browse” to choose the file, then click “Add Attachment”.
- Complete the question at the bottom of the page by selecting yes or no to “Will you be sending supporting documentation via fax or mail?”
- Click “Submit. Your request will be sent to the appropriate departments for processing. Please allow 3-5 days for your request to be processed before contacting AFMC to inquire on status.

Note: If you are unable to add attachments, please fax supporting documentation (including the claim appeal confirmation page) to 602-417-2870.

6.12 – Explanations of Benefits
Claims will be adjudicated by the claim administrator based on the negotiated allowable. Providers should convert patient accounts to self-pay when applicable. Amounts from co-payments, co-insurance, etc. should not remain in your AFMC accounts receivable categories. Any amount
not paid up to the AFMC allowable is considered patient responsibility. Non-payment explanation of benefits should be posted and the charges
converted to patient responsibility.

6.13 – Non-covered Services
Providers who verify that a patient’s service is non-covered by the plan may collect their actual charge at the time of service. However, you
should credit the patient’s account or refund the patient accordingly if a fee reduction amount is indicated on the Explanation of Review (EOR)
found on the Provider Claim Status page on the AFMC Web site. This benefit is to provide an incentive for the patient to select a network
provider even though services may not be covered by their benefit plan.

6.14 – Individual Office Policies
Individual office policies (including signed patient waivers) do not supersede your contract with AFMC.

6.15 – Coordination of Benefits
It is the responsibility of the claim administrator to handle all coordination of benefits, including, but not limited to, cases involving worker’s
compensation claims, Eligible Persons covered by more than one Health Benefits Plan, and Eligible Persons who have a right to recover costs
of Covered Services through subrogation (i.e., third-party insurance) or first-party insurance (i.e., automobile or medical). AFMC providers are
required to file claims for all plans regardless of the order of benefit determination. Providers cannot pursue collection from the patient for more
than the AFMC contractual allowance if the payment was based on AFMC’s allowable.

6.16 – Collection Follow-up
AFMC encourages network providers to follow up on outstanding claims instead of refiling duplicate claims. You may follow up with the claim
administrator directly by calling the telephone number listed on the patient’s identification card. If after following up with the claim administrator,
your claim issue is still not resolved, you may ask AFMC for assistance in resolving the issue.
Section 7
Medical Management
7.1 – Continuous Hospital Outpatient and Individual Case Evaluation (CHOICE)

What is CHOICE? CHOICE is a Continuous Case Evaluation within the patient care setting whether it is in a hospital, outpatient facility, and/or provider’s office. Medical necessity is certified for all inpatient stays, either through CHOICE, or a Payor’s designated Utilization Review (UR) organization (please refer to the patient’s ID card for instructions).

How CHOICE Works

A Nurse Coordinator follows CHOICE patients, and progress is monitored via system derived criteria and a physician advisor if criteria is not met. As a concurrent review is performed, coordination for discharge planning and/or large Case Management (CM) also occurs to assure the appropriate level of care for the patient.

How CHOICE Works for your Patients

CHOICE provides a major role in the medical management services AFMC offers its insurance carriers and administrators. Through our partnership with American Health Holding, AFMC follows the nationally accepted benchmarks required by the Utilization Review Accreditation Committee (URAC). As a result, CHOICE has strengthened its service between network providers and AFMC employer group members.

7.2 – Pre-certification

Pre-certification is the process of collecting information prior to inpatient hospital admission and selected ambulatory procedures and services. We evaluate the medical necessity of a member’s proposed stay and how many days are required to treat the condition. The pre-certification process also helps us identify members who might need pre-service discharge planning and/or specialized programs such as Case Management or Disease Management upon discharge. Any stay greater than 23 hours must be pre-certified, except maternity admission for a routine delivery or emergency care.

Some insurance plans require that a patient’s progress be monitored after admission. CHOICE Nurse Coordinators work with the admitting physician and the hospital to monitor the patient’s progress via the telephone. This progress is monitored using system derived criteria and/or a physician advisor, if the criteria is not met. CHOICE Nurse Coordinators are also prepared to assist with discharge planning requirements.

In the case of an emergency or urgent admission, call AFMC CHOICE ASAP. Notification must be received with 24-48 hours of an emergency admission.

Please follow the procedure listed on your patient’s insurance ID card. CHOICE is equipped with an after-hours voice mailbox Monday – Thursday, Friday – Sunday and holidays, an answering service is available by calling 800-624-4277.

How to pre-certify your patient for a procedure or hospital stay.

At AFMC, we want to help you make the most of your time and spend less time on administrative details. That’s why we offer you the option of submitting your pre-certification request on line. Being able to submit your pre-certification request on-line can allow you to spend more time treating patients, help reduce paperwork, and is more convenient than a phone call!

AFMC pre-certifies for medical necessity. We encourage you to first call the claims payor regarding benefits, eligibility, and how this claim will be paid. A few plans do not use AFMC’s Medical Management Services. Please verify this information on the patient’s insurance ID card.

Determine the patient’s AFMC Network Plan: PPO, EPO/PPO Plus, POS or SELECT. Check the patient’s insurance ID card for this information.

As stated in your AFMC contract, providers must select a hospital, ambulatory surgery center, and/or other providers that participate in your patient’s plan (especially labs, pathology groups, and durable medical equipment (DME) providers). A provider/facility search tool is located on the AFMC Web site to aid you in this selection.

If it is necessary to refer a member out-of-network, please remember to inform patients of that referral before the service is provided. Your patient should be aware of any, and all, out-of-network (out-of-pocket) expenses they could incur by using out-of-network providers and/or facilities.

Once you determine what AFMC Network plan your patient is in and you know the patient needs a treatment or procedure that requires admission to a hospital, or use of a hospital outpatient facility or ambulatory surgery center, log onto www.azfmc.com/index/provider/page/precert (please note, this is a secure area so you will need to enter a e-mail address and password). If you do not have access to the internet, you may call CHOICE at 800-624-4277. You may also fax 602-254-3086.

When you call CHOICE, a representative will gather procedure/service information. If the payor/administrator requires pre-certification, a CHOICE Nurse Coordinator will review the information with the system-derived criteria. If criteria cannot be met, a physician advisor will review the request for service. The determination will be given to the requesting party and the claims payor.

A few items to note:

• All outpatient surgeries performed in a hospital, hospital-affiliated outpatient surgery center, or freestanding ambulatory surgery center (facility), will usually require pre-certification.

• Outpatient services that usually indicate verification of medical necessity (this list is not inclusive):

  Durable Medical Equipment (DME)  Hospice  Home Infusion Services
  CT/PET Scans  Pain Management  Speech and Occupational Therapy
  Discogram/Myelogram  Medical Transport via an Ambulance  Physical Therapy
  MRIs  Home Health Nursing
7.3 – Physical Therapy

- Below is our physical therapy diagnosis guideline chart that is applied to those payor/administrators requiring precertification for physical therapy.

- If a diagnosis is not listed, or if further treatment is requested beyond the stated guideline, notification is required. All physical therapy certifications are reviewed on a case-by-case basis.

- Medical documentation should be received from both the attending physician and the physical therapist and must include the following:
  - Patient history.
  - The current status of the disability for which physical therapy was ordered.
  - A description of the patient’s progress throughout the course of treatment.
  - Prognosis to include the projected length and frequency of treatment required.
  - Individual treatment notes.

CPT Codes requiring physician review PRIOR to services rendered are as follows: 97005, 97006, 97028, 97033, 97034, 97039, 97112, 97124, 97139, 97150, 97535, 97537, 97542, 97545, 97546, 97799, 97851, 95852, 95831-95834, 97999.

**Physical Therapy Diagnosis Guidelines – Maximum visits allowed without physician review/certification.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Notes</th>
<th>Maximum Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>711.20-711.27</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>711.50-711.57</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>711.60-711.67</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>714.0</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>714.1</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>714.4-714.9</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>715.10-715.17</td>
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<td>729.30-729.39</td>
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831.10-831.19  | 24 |
832.00-832.19  | 12 |
833.0-833.19  | 12 |
836.0-834.4  | 12 |
836.50-836.69  | 12 |
840.0-840.8  | 24 |
840.9  | 9 |
841.0-841.9  | 9 |
842.00-842.19  | 9 |
843.0-843.9  | 9 |
844.0-844.8  | 12 |
844.9  | 9 |
845.0-845.03  | 9 |
845.10-845.13  | 9 |
847.0-847.9  | 9 |
880.00-880.29  | 12 |
881.00-881.22  | 24 |
883.0-883.2  | 24 |
885.0-885.1  | 24 |
886.0-886.1  | 24 |
887.0-887.7  | 36 |
895.0-897.7  | 36 |
927.00-927.09  | 18 |
927.10-927.21  | 24 |
927.3  | 24 |
928.0-928.8  | 12 |
952  | REV |
955.0-955.7  | 24 |
309.89  | 12 |
7.4 – Health Plan Differences: Fully-Insured vs. Self-Insured

Employers that offer health insurance benefits finance those benefits in one of two ways: they purchase health insurance from an insurance company (fully insured plans), or they provide health benefits directly to employees (self-insured plans). Typically, these plans differ by who assumes the insurance risk, plan characteristics, employer size, and market share. Here are some of the details:

**Fully Insured Plans**

- **Risk**: In a fully insured plan, the employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.
- **Plan characteristics**: In fully insured arrangements, premiums vary across employers based on employer size, employee population characteristics, and healthcare use. Premiums can also change over time within the same employer because of changes in the demographics of the employed group. However, employers are charged the same premium for each employee.
- **Employer size**: Small employers that offer health benefits are typically fully insured. In 2008, 88 percent of workers in firms with 3–199 employees were in fully insured plans. Smaller firms are typically located in one office or region (if they are on the large side of small).
- **Market share**: Overall, 45 percent of workers with health insurance were covered by a fully insured plan in 2008.

**Self-Insured Plans**

- **Risk**: In a self-insured plan, instead of purchasing health insurance from an insurance company and paying the insurer a per-employee premium, the employer acts as its own insurer. In the simplest form, the employer uses the money that it would have paid the insurance company and instead directly pays healthcare claims to providers. Self-insured plans often contract with an insurance company or other third party to administer the plan, but the employer bears the risk associated with offering health benefits.
- **Plan characteristics**: Large employers often offer multiple self-insured health plans to different classes of workers. Benefits may vary for management and labor, and benefits may vary by occupation or even hours of work. Even when an employer offers a uniform benefits program across all locations and geographic regions, the cost of providing the program - commonly known as the premium equivalent – will vary because the cost of health care services is not uniform across the United States.
- **Employer size**: In 2008, 89 percent of workers employed in firms with 5,000 or more employees were in self-insured plans.
- **Market share**: Overall, 55 percent of workers with health insurance were covered by a self-insured plan in 2008.

7.5 – Appeal Process Fully Insured

AFMC complies with A.R.S. §20-2530 et.seq. in the following appeal process:

- **An appeal may be initiated by any member as defined by A.R.S. §20-2530. “Member” means a person who is covered under a healthcare plan provided by a healthcare insurer or that person’s treating provider, parent, legal guardian, surrogate who is authorized to make healthcare decisions for that person by a power of attorney, a court order or the provisions of Section §36-3231, or agent who is an adult and who has the authority to make healthcare treatment decisions for that person pursuant to a healthcare power of attorney.**
- **Arizona now effectively has two different forms of appeals, Expedited and Standard.**
- **Expedited Appeals are for urgently needed services that an insured has not yet received.**
- **Standard Appeals are for non-urgent services or for services that have already been provided.**
- **Each type of appeal has three levels, as follows:**

<table>
<thead>
<tr>
<th>Level</th>
<th>Expedited Appeals</th>
<th>Standard Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Expedited Medical Review</td>
<td>Informal Reconsideration</td>
</tr>
<tr>
<td>Level 2</td>
<td>Expedited Appeal</td>
<td>Formal Appeal</td>
</tr>
<tr>
<td>Level 3</td>
<td>Expedited External Independent Review</td>
<td>External Independent Review</td>
</tr>
</tbody>
</table>

- **The two types of appeals operate in a similar fashion. The primary distinction is that the Expedited Appeal has a much shorter time frame and the request for an Expedited Medical Review must be made in writing along with a certification from the treating provider indicating that the time required to process a Standard Appeal is likely to cause a significant negative change in the medical condition of the patient.**
- **The treating provider may use the Provider Certification Form created by the Arizona Department of Insurance, a letter, or a personalized form, which contains similar information. For more information, visit the ADOI’s Web site: [http://www.id.state.az.us/](http://www.id.state.az.us/).**
- **A board certified specialist in active practice who typically manages or treats the condition under review will conduct all levels of appeals.**
- **The External Independent Reviews will only be offered to those insureds that have fully insured policies.**
<table>
<thead>
<tr>
<th>Level</th>
<th>Self-Funded Appeals</th>
<th>Deadline to Request</th>
<th>Time Line of Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Expedited Medical Review</td>
<td>Immediately following the original non-certification decision.</td>
<td>One (1) business day from the receipt of all necessary information.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Expedited Appeal</td>
<td>Immediately following the non-certification decision of an Expedited Medical Review.</td>
<td>Three (3) business days from the receipt of all necessary information.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Expedited External Independent Review</td>
<td>Within five (5) business days of the Expedited Appeal non-certification decision.</td>
<td>Nine (9) business days from the written request for an External Independent Review.</td>
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<table>
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<tr>
<th>Standard Appeals</th>
<th>Deadline to Request</th>
<th>Time Line of Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Informal Reconsideration</td>
<td>Two (2) years from the last non-certification decision.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Formal Appeal</td>
<td>Sixty (60) days following the last non-certification decision or two (2) years for services that have already been provided.</td>
</tr>
<tr>
<td>Level 3</td>
<td>External Independent Review</td>
<td>Thirty (30) days after the insured received written notice of the last non-certification decision.</td>
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</table>

**7.6 – Appeal Process Self Funded**

AFMC complies with the Department of Labor regulations in the following appeal process.

- Any member may request an appeal of a determination not to certify. A member is defined as a person who is covered under a self-funded healthcare plan or that person’s treating provider, parent, legal guardian or surrogate who is authorized to make healthcare decisions for that person by a power of attorney, or court order.

- There are two levels of internal appeals, Expedited Appeal and Standard Appeal.

- The Expedited Appeal and Standard Appeal are required levels of appeal and must be exhausted prior to bringing civil action under section 502(a) or ERISA.

- Expedited Appeals and Standard Appeals will be conducted by a board certified physician that holds an active unrestricted license in the same or similar specialty as the ordering provider or as indicated by the case under review.

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<thead>
<tr>
<th>Level</th>
<th>Self-Funded Appeals</th>
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<tbody>
<tr>
<td>Level 1</td>
<td>Expedited Appeal</td>
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<tr>
<td>Level 2</td>
<td>Standard Appeal</td>
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</tbody>
</table>

- An Expedited Appeal is a request by telephone or in writing for an additional review of a determination not to certify imminent or ongoing services requiring a review by a clinical peer who is not involved in the original decision not to certify.

- A Standard Appeal is a request by telephone or in writing to review a determination not to certify an admission, extension of stay or other healthcare service, conducted by a peer reviewer who was not involved in any previous non-certification pertaining to the same episode of care.
7.7 – Request AFMC’s Appeal Processes
AFMC’s appeal processes are available in their entirety. For a copy please fax your request to 602-417-2870 or mail your request to:

Arizona Foundation for Medical Care
Attention: Medical Management Department
326 E. Coronado Rd.
Phoenix, AZ 85004

7.8 – Medical Review
Medical Policies and Protocols have been established by AFMC Member Physicians. Peer Review was an innovation of AFMC in 1971 and is the Independent Review Process used by us to assure the quality of medical care received, and the propriety of the fees charged. Physicians servicing all levels of Medical Review must be in private practice where there are the same daily problems present as in the practice of the physician who claim is being reviewed.

Please Note: Review of any claim does increase the processing time of that claim and timely receipt of requested information from the physician’s office is very important.

AFMC invites participating member physicians to join its Peer Review Committee to ensure that quality care is provided across all specialties. For more information on how to participate, contact AFMC Provider Relations Team at 800-624-4277.

7.9 – Grievances
All healthcare insurers must have an internal grievance system for resolving provider disputes. The Insurance Department requires each healthcare insurer to:

• Describe the grievance system in a written form that is available to providers; and
• Provide the Department with contact information for the person designated to receive grievances. To obtain this information from the Department of Insurance, call the Department’s Provider Information Line at (602) 912-8468.

Should you have questions regarding AFMC’s Grievance Policies and Procedures, please contact the Medical Review Department by calling 800-624-4277.
Section 8

Patient Privacy and HIPAA
8.1 – Privacy and HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 has created many changes in healthcare. AFMC has implemented numerous safeguards and processes to ensure our compliance with HIPAA.

During some functions of AFMC’s repricing process, we operate as a clearinghouse. Because of this, AFMC has signed Business Associate Agreements (BAA) with our clients (claim administrators and third party administrators). We have also signed BAA’s with our clearinghouse vendors with whom we have partnered for electronic claims transactions. It is not necessary for AFMC to execute these agreements with providers as we are performing repricing functions only on behalf of our clients.

AFMC is fully compliant with HIPAA privacy regulations and has numerous precautions and security safeguards in place to ensure the confidentiality of protected health information (PHI). Disclosures of PHI between AFMC and providers for purposes of treatment, payment, and healthcare operations are permitted under HIPAA. In cases of requests from insureds regarding PHI, AFMC will refer the inquirer to the originator of the PHI (i.e. the claim administrator or the provider).

AFMC is happy to offer physicians the convenience of filling out and printing the “Authorization for Use or Disclosure of Protected Health Information” form on-line. We’ve made the process easy for the end user – they simply have to click on the “Privacy Notices” link that is located at the bottom of each page on the AFMC Web site, scroll down to the “Authorizations” section, read the directions, fill out the form, print, sign and return to AFMC.

8.2 – Provider’s Role
The HIPAA Privacy Rule requires authorization or waiver of authorization for the use or disclosure of identifiable health information for research (among other activities). The authorization must indicate if the health information used or disclosed is existing information and/or new information that will be created. The authorization form may be combined with the informed consent form, so that a patient need sign only one form. An authorization must include the following specific elements: a description of what information will be used and disclosed and for what purposes; a description of any information that will not be disclosed, if applicable; a list of who will disclose the information and to whom it will be disclosed; an expiration date for the disclosure; a statement that the authorization can be revoked; a statement that disclosed information may be redisclosed and no longer protected; a statement that if the individual does not provide an authorization, s/he may not be able to receive the intended treatment; the subject’s signature and date.
Section 9
Value Added Services
9.1 – About AFMC’s Value Added Services
The following vendors provide value added services that can be utilized by all AFMC Members. AFMC Providers also have the opportunity to refer and/or inform their patients (AFMC Members) about these vendors if needed. For more information about AFMC’s value added services, please visit our Web site at www.azfmc.com.

9.2 – Convenience Clinics
Convenience clinics diagnose and treat a variety of common illnesses and minor injuries for patients 18 months and older. They also offer wellness and preventive services and vaccinations. It is important to remember that convenience clinics do not provide emergency care, treatment for injuries, or wound care. A person requiring x-rays, stitches or any life-threatening situation is not an appropriate patient for convenience clinics and should go to their nearest hospital for treatment.

Convenience Clinics are staffed by board-certified family nurse practitioners and physician assistants trained to diagnose, treat, and write prescriptions when clinically appropriate for common illnesses. They also provide health screenings and vaccinations all year long to help individuals stay healthy. No appointment is necessary.

**AFMC Members have access to Walgreens/Take Care Clinics and MinuteClinic, the medical clinic in CVS/Pharmacy.** Both of these providers follow nationally established clinical practice guidelines from the American Academy of Family Physicians and the American Academy of Pediatrics. Pricing for their menu of services starts around $20 and increases depending on the service (or the insurance co-pay). They accept most major credit cards, and of course, cash. It is highly recommended that a member contact their insurance company before their visit to verify coverage, including co-pays, coinsurance or deductible.

For a complete listing of locations and more information such as treatments, pricing, hours of operation (each location varies) and much more, please visit the Web sites or call the phone numbers listed below:

- **Convenience Clinics are on the AFMC Web site at www.azfmc.com.** The complete listing can be downloaded and saved in pdf format for easy review and printing by utilizing AFMC’s Physician Search or Custom Directory tools.
- **To Find Walgreens/Take Care Clinics** - Visit their Web site at www.takecarehealth.com, or call their information line at 1-866-825-3227.
- **To Find MinuteClinic, the medical clinic in CVS/Pharmacy** - Visit the their Web site at www.minuteclinic.com, or call their information line at 1-866-389-2727.

9.3 – Urgent Care Centers
An Urgent Care may be the perfect solution for AFMC patients with minor aches and pains if they cannot get an appointment to see their primary care physician on short notice, and they are not experiencing an emergency. The wait in an emergency room can be long and it can cost patients a lot of money. Urgent Cares provide your patients with after-hours care that can be cheaper and quicker than going to an emergency room or waiting for a scheduled appointment.

Urgent Care centers are walk-in clinics that offer a variety of services. They are ideal for situations requiring immediate attention that aren’t true emergencies. No two centers are the same, but most can treat a broad range of symptoms. These usually include:

- Minor injuries.
- Seasonal illnesses.
- Vomiting or diarrhea.
- Skin rashes.
- Mild asthma symptoms.
- Sore throats and coughs.
- Bruises and animal bites.
- Sprains and strains.
- Other non-emergencies.

Many urgent care centers now offer more advanced care. Some can even provide X-rays, EKG tests, blood work and other lab tests; and/or an in-house pharmacy. Services such as these usually cost less than they would in an ER. But there are other conveniences too. The majority of urgent care centers are open evenings and weekends; accept most health insurance plans; and operate on a first-come, first-served basis.

When It’s an Emergency
It is important for providers who do refer their AFMC patients to an urgent care center to remind them that an urgent care center isn’t always the best place to go. If a patient shows up with an actual emergency, they will be rerouted to the ER. That could mean a wasted trip and a loss of precious time. That’s why it’s important to provide patients with enough information to use good judgement when seeking urgent care.

Under some circumstances, remind patients to call 9-1-1 at once. These include:

- Uncontrollable bleeding.
- Chest pain (or pressure).
- Difficulty breathing.
• Sudden loss or change of vision.
• Disorientation or mental confusion.
• Sudden trouble speaking or understanding speech.
• Dizziness or vertigo.
• Numbness or weakness in face, arms or legs.
• Sudden, severe headache.
• Fainting or seizures.
  • If a patient suspects that someone might be having a stroke, heart attack or other life threatening emergency.
  • Possibility that someone may hurt himself or others.
  • Any severe abdominal pain, or severe vomiting or diarrhea should also be checked out in the emergency room.

Not for Everyday Medical Needs Either
Providers should also remind their patients that they shouldn’t use urgent care centers for routine purposes, such as getting prescriptions filled or physical exams. They should be aware that their day-to-day healthcare is in the hands of their provider, as this is the person who best understands their long-term needs.

Please remind patients that it is important for them to inform you as their provider of any urgent care center visit they made. As this is important information that needs to go into their records. Let them know that as their physician, you want to make sure they receive the best possible care and that you may want to do a follow-up exam. As a provider, you know that an urgent care center, while it can offer vital services, is no substitute for long-term quality healthcare.

How to locate an Urgent Care
The AFMC Call Center is available Monday - Friday, 8am - 5pm at 800-624-4277 to help your AFMC patients locate the most cost-effective healthcare provider for their benefit plan.

Patients can also visit the AFMC Web site at www.azfmc.com for an updated urgent care listing with locations and hours of operation. They can also utilize AFMC’s Custom Directory tool located at https://www.azfmc.com/index/customdirectory/. This list can be downloaded and saved in PDF format for easy review and printing.
Section 10

Glossary
10.1 – Definitions of Important Words
Following are key terms and their definitions to the most commonly used in healthcare. AFMC is not a benefits administrator or a payer. As such, some of these terms may not apply to our business operations. These terms are being provided as a courtesy to our contracted providers and are meant to provide general background information/education.

**Adjudication** – Processing claims according to contract.

**Administrator** – An entity that administers benefits, claims handling and consideration of payment.

**Administrative Services Organization (ASO)** – An entity that contracts as an insurance company with a self-funded plan but where the insurance company performs administrative services only and the self-funded entity assumes all risk.

**Allowed Amount** – Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a maximum allowable.

**Appeal** – An appeal is something you do if you disagree with a decision to deny a request for healthcare services or payment for services.

**Authorization** – In healthcare, authorization may refer to “authorization to disclose” private information, “authorization to treat” or “authorization to pay”, as in “pre-authorization” required by many insurance companies, health plans and healthcare networks. In the case of pre-authorization, the managed care organization may require approval prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MCO whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)

**Balance Billing** – The practice of billing a patient for the fee amount remaining after insurer payment and co-payment have been made. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge.

**Benefits and Eligibility** – Refers to the coverage parameters within a particular insurance plan. Providers should refer to the insured’s ID card to identify the Plan Administrator and call them for verification of benefits and eligibility.

**Benefit Levels** – The limit or degree of service a person is entitled to receive based on the coverage and policy contracted health plan or insurer.

**Business Associate Agreement** – An agreement between two entities that allows the exchange of PHI.

**Claim** – A request by an individual (or his or her provider) to that individual’s insurance company to pay for services obtained from a health care professional. An itemized statement of healthcare services and their costs provided by a hospital, physician’s office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

**Claimant** – The person or entity submitting a claim.

**Claim Form** – An application for payment of benefits under a health plan.

**Claims Administration** – The process of receiving, reviewing, adjudicating, and processing claims.

**Claims Examiners** – Employees in the claims administration department who consider all the information pertinent to a claim and make decisions about the MCO’s payment of the claim. Also known as claims analysts.

**Claims Investigation** – The process of obtaining all the information necessary to determine the appropriate amount to pay on a given claim.

**Claims Review** – The method by which an enrollee’s health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

**Claim Status Codes** – A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction, and is maintained by the Health Care Code Maintenance Committee.

**CMS-1500** – The uniform professional claim form.

**Corrected Claim** – A “corrected claim” is a claim that is being resubmitted because something has changed on the claim or being added to the original claim. This would include, but not limited to, diagnosis codes, CPT codes and ICD-9 codes.

**Coverage Determination** – A decision about whether a medical service or drug prescribed is covered by the plan and the amount, if any, the member is required to pay for the service or prescription. In general, if a member brings their prescription to a pharmacy and the pharmacy informs them the prescription isn’t covered under their plan, that isn’t a coverage determination.

**Covered Services** – The general term used to explain healthcare services and supplies that are covered by a health plan.

**Credentialing** – Refers to the examination of a physician’s credentials to determine whether he or she should be approved for membership with AFMC.
Deductible – The amount you must pay before a health plan begins to pay its share of a covered medical service or drug.

Disallowance – A denial by a payor for portions of the claimed amount. Examples could include services that are not covered or amounts over the fee maximum.

Disenrollment or Disenrollment – The process of ending a membership in a health plan. Disenrollment may be voluntary (member’s choice) or involuntary (not a member’s choice).

Durable Medical Equipment – Certain medical equipment that is ordered by a doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

EDI Translator – Used in electronic claims and medical record transmissions, this is a software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

Explanation of Benefits (EOB) – A statement sent to covered individuals explaining services provided, amount to be billed, and payments made. A summary of benefits provided subscribers by the carrier.

Explanation of Review (EOR) – A document that accompanies a claim sent to a payor for consideration of payment. It explains how the claim was repriced (reflecting the billed, allowed and disallowed amounts).

Fee Schedule – A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures. The fee determined by an MCO to be acceptable for a procedure or service, which the physician agrees to accept as payment in full. Also known as a fee allowance, fee maximum, or capped fee.

Fully Funded Plan – A health plan under which an insurer or MCO bears the financial responsibility of guaranteeing claim payments and paying for all incurred covered benefits and administration costs.

Global Fees – Negotiated fee that are all inclusive. One fee is paid for the entire range of services for a specific episode or episodes of care.

Grievance – A type of complaint you make about us or one of our administrators/payors etc., including a complaint concerning the quality of a member’s healthcare. This type of complaint does not involve coverage or payment disputes.

Midlevel Practitioner – Nurse practitioners, certified nurse-midwives and physicians’ assistants who have been trained to provide medical services that otherwise might be performed by a physician. Depending upon state rules and regulations, midlevel practitioners may practice under the supervision of a doctor of medicine or osteopathy who takes responsibility for the care the midlevels provide. Physician extender is another term for these personnel. It is important to note that, in many states now, nurse practitioners are not required to practice under the supervision of an MD or DO and are permitted to perform many medical services, such as non-invasive procedures, prescription authorization, tests and examinations, diagnoses and others.

Medically Necessary – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of a medical condition; used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not mainly for a patient’s convenience or that of their provider.

Network Provider – “Provider” is the general term we use for doctors, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified by Medicare and by the State to provide healthcare services.

Out-of-network Provider or Out-of-network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of an AFMC network plan.

Participating Physician – A primary care physician in practice in the payer’s managed care service area who has entered into a contract.

Participating Provider – Any provider licensed in the state of provision and contracted with an insurer. Usually this refers to providers who are a part of a network. That network would be a panel of participating providers. Payers assemble their own provider panels.

Payer (usually Third Party Payer) – The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers.

Peer Review – The mechanism used by the medical staff to evaluate the quality of total healthcare provided by the Managed Care Organization. The evaluation covers how well all health personnel perform services and how appropriate the services are to meet the patients’ needs. Evaluation of healthcare services by medical personnel with similar training. Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers. This is the most common method utilized in managed care for monitoring the utilization by physicians. In other words, other physicians will review the decisions made by a physician.

Peer Review Committee – The hospital, clinic or MCO committee that reviews cases of health care services delivery in which the quality of care is questionable or problematic.
Preadmission Review, Pre-Admission Certification, Pre-Certification, or Pre-Authorization – Review of “need” for inpatient care or other care before admission. This refers to a decision made by the payer, MCO or insurance company prior to admission. The payer determines whether or not the payer will pay for the service. Most managed care plans require pre-cert. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered. The practice of reviewing claims for inpatient admission prior to the patient entering the hospital in order to assure that the admission is medically necessary. A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed. The process of notification and approval of elective inpatient admission and identified outpatient services before the service is rendered. An administrative procedure whereby a health provider submits a treatment plan to a third party before treatment is initiated. The third party usually reviews the treatment plan, monitoring one or more of the following: patient’s eligibility, covered service, amounts payable, application of appropriate deductibles, co-payment factors and maximums. Under some programs, for instance, predetermination by the third party is required when covered charges are expected to exceed a certain amount. Similar processes: preauthorization, precertification, pre-estimate of cost, pretreatment estimate, and prior authorization.

Prior Approval – A formal process for obtaining approval from a health insurer before a specific treatment, procedure, service or supply has been provided. Completing this process ensures that the patient receives full benefits for the specified services. Health insurers may require prior approval for specific services or products, including home health assistance, durable medical equipment, surgery, or skilled nursing facility stays. While this is a process of obtaining approval from the insurer that the insurer will pay for the service or supply, patients often confuse this with medical authorization, which it is not. A patient and physician may still seek the treatment or supply even though the insurer has not agreed to pay for it. Prior authorization is usually required for non-emergency services that are expensive or likely to be overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be reimbursed or the patient may not be reimbursed. Typically, prior approvals are valid for a set length of time as long as the patient’s benefits do not change between the date the approval is given and the date the service or product is provided.

Pre-Authorization – A cost containment feature of many group medical policies whereby the insured must contact the insurer prior to a hospitalization or surgery and receive authorization for the service.

Recredentialing – An MCO’s periodic review of the qualifications of a current network provider to verify that the provider still meets the standards for participation in the network. See Credentialing.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Renewal – The process of renewing providers membership with AFMC.

Review Claim – A “review” claim is reserved for claims where there is a dispute regarding an AFMC denial or allowed amount. For providers, these claims should be directed to AFMC’s Medical Review department for processing.

Self-Funding or Self-Funded Plan – Employer or organization assumes complete responsibility for healthcare losses of its covered employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization. In this case, the employer does not pay premiums to an insurance carrier, but, rather pays administrative costs to the insurance company or health plan, and, in essence, treats them as a third party administrator (TPA) only. However, the employee may not be able to detect any difference because the plan description and membership card may carry the name of the insurance company not the employer.

Third Party Administrator (TPA) – An independent organization that provides administrative services including claims processing and underwriting for other entities, such as insurance companies or employers. Often insurance companies will contract as TPAs with other insurance companies or health plans. TPAs are not always insurance companies. TPAs are organizations with expertise and capability to administer all or a portion of the claims process. Self-insured employers will often contract with TPAs to handle their insurance functions. Insurance companies will sometimes outsource the claims, UR or membership functions to a TPA. Sometimes TPAs will only manage provider networks, only claims or only UR. Hospitals or provider organizations desiring to set up their own health plans will often outsource certain responsibilities to TPAs. TPAs are prominent players in the managed care industry.

Tracer Claim – A “tracer” claim is a claim that is being resubmitted because payment has not yet been received. In order for AFMC to research these claims and resend them to the plan administrators more efficiently, please use the term “tracer” on your claims when re-submitting.

UB-04 – Bill form that replaced UB-92 in 2007. Also know as the Form CMS-1450 like its predecessor, the UB-92. The UB04 is a uniform institutional provider claim form suitable for billing multiple third party payers for the inpatient component of health services (typically hospitals, skilled nursing facilities, home health agencies, etc.). All payers will not require the use of the same data elements; check with each payer to determine individual requirements. The UB-04 used to submit hospital insurance claims for payment by third parties for the inpatient component of health services. The UB-04 incorporates the National Provider Identifier (NPI) as well as other updates.

Unbundling – The act of separating a medical procedure or operation into its many components.

Utilization Review – Designed to reduce unnecessary medical services, inpatient and outpatient. They may be prospective, retroseptive, concurrent or in relation to discharge planning.