

# FirstCare Health Plans Provider Manual

## HMO/PPO



Health plans that  
work for Texans

Provider Relations 1-800-264-4111  
[FirstCare.com](http://FirstCare.com)

FC\_ProviderManual\_HMOPPO\_0120

**FirstCare**<sup>™</sup>  
HEALTH PLANS  
PART OF BAYLOR SCOTT & WHITE HEALTH

# FirstCare HMO/PPO Provider Manual

FirstCare prepared this manual, which is an extension of the contract, for use by FirstCare Commercial HMO/PPO contracted providers and all appropriate staff. Please ensure this manual is made available to your contracted off site billing departments and/or billing services utilized by the provider.

FirstCare has included an address and telephone guide in the introduction section of this manual for your reference.

We welcome your suggestions for future editions of our manual. Please send any comments or suggestions to the following address:

FirstCare Health Plans  
Attention: Contracts Administration  
12940 N. Highway 183  
Austin, TX 78750

When writing to us about the manual, please include your name, phone number with area code and your return address and tax ID number.

Thank you.

The Staff of FirstCare Health Plans

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# SECTION 1

## Introduction

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Welcome to FirstCare Health Plans! Our network of hospitals, physicians, and ancillary health care providers work together to provide comprehensive health services to our members. Thank you for joining us in our goal to offer quality, accessible healthcare to individuals and families in Texas.

FirstCare is a National Committee for Quality Assurance (NCQA) accredited licensed Health Maintenance Organization (HMO).

### **Our Mission**

Working together to serve our customers and build healthier communities—one member at a time.

## 1.1 – About the Manual

This manual outlines the FirstCare HMO/PPO (FirstCare) network and its procedures. The information in this manual offers general guidelines that are applicable to both HMO and PPO benefit plans except where noted. Language provided by the State of Texas in regards to certain HMO/PPO policies are also included and noted in this manual.

In the event any discrepancies arise between this manual and a Provider Agreement with respect to FirstCare policies and procedures, the language in the more current of the two documents will prevail. In all other cases of discrepancies, the Provider Agreement shall prevail, unless the differences are caused by the actions of State or Federal regulatory bodies or any of the health benefit programs operated by these entities.

This manual is for the benefit of Participating Providers. FirstCare policies include, but are not limited to, what is identified in the manual. The policies described in this manual are subject to modification, addition, and/or deletion. Any updates that may occur will be communicated in the form of newsletters, mailings from FirstCare, and/or manual revisions that will be incorporated into the online manual.

## 1.2 – Confidentiality

Confidentiality is the responsibility of every FirstCare employee and FirstCare Provider. FirstCare and you, the Provider, are “Covered Entities” under the Privacy Regulations in the 1996 Health Insurance Portability and Accountability Act (HIPAA). All of the normal transfers of the confidential member information between us are allowed under HIPAA, within the prescribed security limits of the Act. There is a FirstCare corporate policy of zero-tolerance for any infraction of the policy by FirstCare employees. Access to all files (manual and computerized) is provided with security clearance at the time of employment with FirstCare and revoked formally at the time of termination.

Providers are to comply with FirstCare policies regarding confidentiality to the extent that confidential treatment is provided for under State and Federal laws and regulations. All records



and all other documents deemed confidential by law, and disclosure or transfer of confidential information will be in accordance with applicable law.

### 1.3 – FirstCare Contact Information

<b>FirstCare Website</b>	<a href="http://FirstCare.com">FirstCare.com</a>
<b>FirstCare Providers</b>	<a href="http://FirstCare.com/Providers">FirstCare.com/Providers</a>
<b>Customer Service Department</b> (Member Eligibility and Benefit Questions)	
HMO	1-800-884-4901
PPO	1-800-240-3270
<b>Claims</b>	
Claims Mailing Address <i>(Please use this address for all claim-related correspondence including original claim submissions, adjustment requests and recovery correspondence).</i>	FirstCare Health Plans Attn: Claims Department P.O. Box 211342 Eagan, MN 55121
<b>FirstCare Electronic Claim Clearinghouses</b>	
Availity (formerly THIN)	1-800-282-4548
CareVu	1-806-473-2433
EDI Healthcare	1-210-684-2983
Emdeon (Formerly WebMD)/Availity	1-800-845-6592
ClaimShuttle	<a href="http://www.claimshuttle.com/portal/Firstcare">www.claimshuttle.com/portal/Firstcare</a>
<b>Medical Management</b>	
Online Authorization Request	<a href="http://FirstCare.com/Providers">FirstCare.com/Providers</a>
Authorization Department	1-800-884-4905
Toll Free Fax Number	1-800-248-1852 (fax)
DME Fax Number	1-800-431-7738 (fax)
Medical Director	1-800-264-4111
Case Management	1-800-264-4111
<b>Mental Health/Behavioral Health Services</b>	
FirstCare Behavioral Health Services	1-800-327-6943
	1-215-241-4766 (fax)
<b>Provider Numbering Unit</b>	1-800-365-1051 (Option 5)
<b>Coordination of Benefits (COB Units)</b>	1-800-431-7737
	1-512-257-6086 (fax)

## 1.4 – Additional Contact Information

<b>Regional Offices</b>	
Abilene	1-800-475-8156
Office Number	1-325-933-2408
Office Fax Number	1-325-695-8142 (fax)
Amarillo	1-806-467-5650
Toll Free Fax Number	1-800-239-5649 (fax)
Provider Relations	1-806-356-3200
Office Fax Number	1-806-467-3280 (fax)
Medical/Case Management	1-800-239-5650
	1-806-784-4300
	Email: <a href="mailto:CaseMgmt@FirstCare.com">CaseMgmt@FirstCare.com</a>
Austin (Includes Statewide Providers)	
Provider Relations	1-800-431-7737
Office Fax Number	1-512-257-6043 (fax)
Medical/Case Management	1-800-264-4111
	1-806-784-4300
	Email: <a href="mailto:CaseMgmt@FirstCare.com">CaseMgmt@FirstCare.com</a>
Lubbock (includes New Mexico Providers)	
Provider Relations	1-806-784-4300
Office Fax Number	1-806-784-4396 (fax)
Medical/Case Management	1-800-264-4111
	Email: <a href="mailto:CaseMgmt@FirstCare.com">CaseMgmt@FirstCare.com</a>

### **Claims Mailing Address**

FirstCare Health Plans  
 Attn: Claims Department  
 P.O. Box 211342  
 Eagan, MN 55121

### **Claims Redetermination**

FirstCare Health Plans  
 Attn: Claims Department  
 P.O. Box 211342  
 Eagan, MN 55121

### **Claims Refund Request**

FirstCare Health Plans  
 Attn: Claims Department  
 P.O. Box 211342  
 Eagan, MN 55121

# SECTION 2

## Provider Services

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### 2.1 – Provider Numbers and Automated Services

#### 2.1.1- National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The Centers of Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

The National Provider Identifier (NPI) is a unique, ten-digit numeric identifier assigned to covered health care providers by the National Plan and Provider Enumeration System (NPPES). This identifying number does not carry any information about health care providers, such as the state in which they practice or their provider type or specialization. The intent of the NPI is to improve the efficiency and effectiveness of electronic transmission by allowing providers and business entities to submit the same identification number(s) to all payers, such as insurance plans, clearinghouses, systems vendors, and billing services.

Individual health care providers are eligible to obtain the Type 1 permanent identifier that will identify the provider for their lifetime. This identifier does not change for this provider regardless of group affiliation, regional location, or licensure changes.

Business entities, which include incorporated individuals, groups, and facilities, are eligible for a Type 2 NPI. With few exceptions identified by CMS, business entities are able to define and obtain one or more NPI to represent their business as they choose.

For more information about NPI and how to obtain an NPI, please visit the NPPES website at <https://nppes.cms.hhs.gov/NPPES> or contact NPPES directly by phone at 1-800-456-3203.

#### 2.1.2 – FirstCare Provider ID Numbers

FirstCare assigns unique provider ID numbers to each contracted provider which includes physicians, ancillaries, and facilities. The nine (9) digit number is used by FirstCare to identify providers in all areas of interaction between the provider and FirstCare, such as accessing of FirstCare's provider services web portal.

Providers are reminded that their provider ID number should be made available to all appropriate office and billing services staff that require access to FirstCare's provider portal.

Providers who have not received their nine (9) digit FirstCare unique provider ID number should contact their FirstCare Provider Relations representative or the FirstCare Customer Service department.

### 2.1.3 – FirstCare Provider Portal

FirstCare’s provider web portal gives providers confidential, 24-hour access to information and services such as:

- Member eligibility and benefit verification – including quick access to copayment information, if applicable;
- Submission and updating of specialist referrals and authorization requests;
- Status checks on previously submitted claims, referrals and authorization requests;
- Prevent and appeal claim denials by submitting corrected or additional information online;
- Use of a secure message center mailbox feature to send a message to FirstCare. You can also check status of a message. Each message will have its own unique ID number for reference.

FirstCare Health Plans provider portal is a secure location for providers to access personal information, member benefit information, and claims information. You may access this site by clicking on “Providers” from the [FirstCare.com](http://FirstCare.com) website. From this website you will also be able to verify and/or update:

- Provider Information
  - View provider demographic information
- Claims
  - Update demographic information
  - Claim information
  - Check claim status
  - Submit corrected or additional information for pending claims
  - Submit an appeal or additional information for a previously processed claim
- Authorizations
  - Request a referral or authorization
  - Check the status of a referral or authorization
- Member Information
  - Verify member demographic information
  - Verify member eligibility
  - Verify member benefit information
  - Other insurance
- Renounces/Documents
  - Payment Discrepancy report
  - Panel reports
  - General documents
  - Policy changes
  - Provider Manual

If you do not know your FirstCare ID or password, please contact your Provider Relations Representative or Customer Service at 1-800-884-4901 (HMO) or 1-800-240-3270 (PPO).

## 2.2 – Changes in Provider Status/Information

In order to ensure prompt and accurate payment to providers, it is essential that FirstCare be kept informed of changes in provider information and/or status. Demographic changes, such as those listed below, can be submitted electronically by visiting our Provider Services Web Portal:

- Primary service address changes
- Billing address changes
- Telephone number changes

- Fax number changes
- E-mail address changes

For all other changes, such as those listed below, providers may use the “General Demographic” form (following this page) to keep FirstCare informed of such changes or they may submit a letter to their Provider Relations Representative.

- Name changes
- Tax ID changes
- Terminations and/or
- New or discontinued services

Some of the changes indicated above may require submission of a new W9 by the provider. For example, Tax ID changes and/or name changes (if they are the result of a new business entity being formed, for instance) require new W9s. Updates to W9s are to be submitted to the FirstCare Provider Relations Representative along with the notification of the change.

# SECTION 3

## Customer Service

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Customer Service Representatives are available between the hours of 8 a.m. and 5 p.m. Monday through Friday. Our website can be accessed 24 hours a day, 7 days a weeks at [FirstCare.com](http://FirstCare.com).

Please call Customer Service or visit our web portal if you have questions regarding:

<b>Member Eligibility &amp; Benefit Questions</b>	
HMO Members	1-800-884-4901
PPO Members	1-800-240-3270
<b>Claim Inquiries</b>	1-800-461-3742

### 3.1 – Eligibility and Benefits

#### 3.1.1 - Member Eligibility Statements

Participating providers may request a member eligibility statement from FirstCare to determine if the member is eligible for health services at the time of visit. Such eligibility statements are available for view and print through FirstCare's Provider Web Portal and will include the following information:

- Member's FirstCare ID number;
- Member's name, birth date, and gender;
- Member's current enrollment and eligibility status with FirstCare;
- Description of member's benefits and excluded benefits or limitations;
- Copayment requirements, if any;
- The un-met amount of the member's deductible or other financial responsibility.

#### 3.1.2 - Member Identification (ID) Card

FirstCare members receive a member identification (ID) card from their employer or payer/ insurance company. Members should present these ID cards when they are seeking services from FirstCare network providers. If the member does not have his/her ID card or enrollment form for new members, the provider's office can call Customer Service or the employer to verify member eligibility

Remember that possession of an ID card does not guarantee eligibility. Providers are encouraged to verify the effective date of benefit coverage as well as member identity prior to rendering services to the member.

This ID card will contain the following information:

- Member Number - The FirstCare member ID number of the employee
- Effective Date - The initial date of eligibility
- Name of Member - This is the name that should be used for claims filing and prior authorization requests
- Group Number - The number assigned to the member's employer or payer
- Member Date of Birth




- Benefit Description and Copayments – Copayment amounts are due at the time of service for the following services or benefits rendered to the member. (Office visit, emergency room, ambulance, outpatient surgery, inpatient surgery, allergy testing, infertility, and prescriptions (Brand Name and Generic))

Emergency numbers and important notices are located on the back of the card.

**\*\*Important**

- Each physician or provider is responsible for verifying eligibility each time services are rendered.
- Copayments are to be paid by the member at the time of service
- Notify FirstCare immediately if an ID card has been used fraudulently
- For specific plan design or coverage information contact the Customer Service Department
- Copy the member's ID card on the first visit and keep it in the member's file
- Note the effective date of eligibility and remember to update this information.




PPO ID Card (front)

		
<b>Group:</b> XYZ Inc <b>Group #:</b> P33A26 <b>Network:</b> FirstCare Access PPO <b>Benefit Effective Date:</b> 01/01/2020		
<b>SUBSCRIBER</b> John Sample <b>DOB:</b> 00/00/0000	<b>MEMBER ID</b> 00000000000	<b>IN-NETWORK PLAN BENEFITS</b> <b>Adult Non-Spec/Spec:</b> \$00/\$00 <b>Pediatric Non-Spec/Spec:</b> \$00/\$00 <b>Emergency Room:</b> 00%* <b>Coinsurance:</b> 00% <b>Deductible:</b> I/\$0000 F/\$0000 <b>Rx:</b> \$00/\$00/\$00/\$00/00%* <small>*Deductible may apply.</small> <b>PHARMACISTS ONLY</b>  OptumRx® Help Desk: 855-205-9182 <b>BIN:</b> 610011 <b>PCN:</b> IRX <b>GRP:</b> SWPFCHCOM
<b>DEPENDENTS</b> Jane Sample Jack Sample Jill Sample James Sample Julie Sample Joe Sample Jackie Sample	00000000000 00000000000 00000000000 00000000000 00000000000 00000000000 00000000000	
		

PPO ID Card (back)

<b>FOR PROVIDERS</b> <b>Electronic Claims:</b> • Availity: 94999 • CareVu: 94999 • Change Healthcare/Emdeon P: TH003 I: 12T03  <b>Paper Claims:</b> FirstCare Health Plans PO Box 211342 Eagan, MN 55121  <b>Prior Authorization:</b> 1-800-884-4905  <b>Card Issue Date:</b> 12/01/2019	<b>FOR MEMBERS</b> This card is for identification only and does not guarantee current membership or coverage.  <b>Important Information:</b> <ul style="list-style-type: none"> <li>• In a medical emergency, call 9-1-1 or go to the nearest emergency facility.</li> <li>• <b>Customer Service: 1-800-240-3270</b> (TTY/TDD: 7-1-1)</li> <li>• Virtual Care (telehealth): 1-800-718-5082</li> <li>• 24/7 Nurse Line: 1-855-828-1013</li> <li>• Self-Service Portal: my.FirstCare.com</li> <li>• To avoid out-of-network costs and provider balance billing, find a provider at FirstCare.com/FindAProvider.</li> </ul> <small>Underwritten by Southwest Life and Health Insurance Company.</small>
<b>CUSTOMER SERVICE: 1-800-240-3270 • FirstCare.com</b>	

HMO ID Card (front)

		
<b>Group:</b> XYZ Inc <b>Group #:</b> 000000 <b>Network:</b> FirstCare Select Plus HMO <b>Benefit Effective Date:</b> 01/01/2020		
<b>SUBSCRIBER</b> John Sample <b>DOB:</b> 00/00/0000	<b>MEMBER ID</b> 00000000000	<b>IN-NETWORK PLAN BENEFITS</b> <b>Adult PCP/Spec:</b> 00% <b>Pediatric PCP/Spec:</b> 00% <b>Emergency Room:</b> 00%* <b>Coinsurance:</b> N/A <b>Deductible:</b> I/\$0000 F/\$0000 <b>Rx:</b> 00%* <small>*Deductible may apply.</small> <b>PHARMACISTS ONLY</b>  OptumRx® Help Desk: 855-205-9182 <b>BIN:</b> 610011 <b>PCN:</b> IRX <b>GRP:</b> SWPFCHCOM
<b>DEPENDENTS</b> Jane Sample Jack Sample Jill Sample James Sample Julie Sample Joe Sample Jackie Sample	00000000000 00000000000 00000000000 00000000000 00000000000 00000000000 00000000000	
		

HMO ID Card (back)

<b>FOR PROVIDERS</b> <b>Electronic Claims:</b> • Availity: 94999 • CareVu: 94999 • Change Healthcare/Emdeon P: TH003 I: 12T03  <b>Paper Claims:</b> FirstCare Health Plans PO Box 211342 Eagan, MN 55121  <b>Prior Authorization:</b> 1-800-884-4905  <b>Card Issue Date:</b> 12/01/2019	<b>FOR MEMBERS</b> This card is for identification only and does not guarantee current membership or coverage.  <b>Important Information:</b> <ul style="list-style-type: none"> <li>• In a medical emergency, call 9-1-1 or go to the nearest emergency facility.</li> <li>• <b>Customer Service: 1-800-884-4901</b> (TTY/TDD: 7-1-1)</li> <li>• Virtual Care (telehealth): 1-800-718-5082</li> <li>• 24/7 Nurse Line: 1-855-828-1013</li> <li>• Self-Service Portal: my.FirstCare.com</li> <li>• To avoid out-of-network costs and provider balance billing, find a provider at FirstCare.com/FindAProvider.</li> </ul>
<b>CUSTOMER SERVICE: 1-800-884-4901 • FirstCare.com</b>	

## 3.2 - Verification

Verification is guarantee of payment for health care or medical care services if the services are rendered within the required time frame to the member for whom the services are proposed. Verification may include a prior authorization or pre-certification. Not all services and members are eligible for verification requests.

- Any request for verification must contain the following information:
- Member name;
- Member ID number; if included on the ID card;
- Member date of birth;
- Name of enrollee or subscriber, if included on the ID card;
- Member relations to member (self, spouse, child);
- Presumptive diagnosis, if known, otherwise presenting symptoms;
- Procedure code(s) or description of proposed procedure(s);
- Place of service code where services will be provided and, if place of service is other than provider's office or provider location, name of hospital or facility where proposed service will be provided;
- Proposed date of service;
- Group number, if included in the ID card;
- Name and contact information of any other carrier, if known to the provider, including name, address, and telephone number, name of enrollee, plan or ID number, group number (if applicable), and group name (if applicable);
- Name of provider providing the proposed services; and
- Provider's federal tax ID number

The provider may request verification via contacting the prior authorization and Customer Service Department. Prior Authorization Representatives are available between the hours of 6 a.m. and 6 p.m. Monday through Friday, and 9 a.m. and 12 p.m. weekends and holidays. Customer Service Representatives are available between the hours of 8 a.m. and 5 p.m., Monday through Friday. For all after hours calls, providers may leave a message on our automated voicemail and your request will be responded to by the next business day. Providers may also submit a written request for verification to the Customer Service Department's fax number at:  
1901 West Loop 289 Ste. 9  
Lubbock, TX 79407

FirstCare shall respond to requests for verification within the following time periods:

FirstCare shall provide a verification or declination in response to a request for verification without delay, and as appropriate to the circumstances of the particular request, but not later than three days after the date of receipt of the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel, the determination must be provided within three (3) days from the beginning of the next time period requiring such personnel.

FirstCare will respond to verification requests regarding concurrent hospitalization within 24 hours after receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel, the determination must be provided within 24 hours from the beginning of the next time period requiring such personnel.



FirstCare will respond to verification requests for post-stabilization care and life threatening conditions no later than one hour after receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel, the determination must be provided within one hour from the beginning of the next time period requiring such personnel.

FirstCare may make only one (1) request for additional information. The request for additional information must be made within one (1) day of receipt of the verification request.

A verification or declination may be delivered via telephone call or in writing. If the verification or declination is delivered via telephone call, FirstCare shall, within three (3) calendar days of providing a verbal response, provide a written response which must include, at a minimum, the following:

- Enrollee name
- Enrollee ID number
- Requesting provider's name
- Hospital or other facility name, if applicable
- A specific description, including relevant procedure codes, of the services that are verified or declined
- If the services are verified, the effective period for the verification, which shall not be less than 30 days from the date of verification
- If the services are verified, any applicable deductibles, copayments, or coinsurance for which the enrollee is responsible
- If the verification is declined, the specific reason for the declination
- A unique verification number that allows FirstCare to match the verification and subsequent claims related to the proposed service
- A statement that the proposed services are being verified or declined pursuant to
- Title 28 Texas Administrative Code § 19.1724

### 3.3 - Copayments

Copayment means the amount required to be paid by the member to a participating provider, or other authorized provider, for the provision of Covered Health Services.

#### 3.3.1 - Determining the Amount of Required Copayment

The amount of the copayment varies according to the plan selected by the member's employer and by the type of service (i.e. pain management, allergy services, maternity care, infertility testing, etc.)

A summary of copayments can be found on the left side of the member's ID card. Provider should verify the copayment amount on each visit.

*\*Note - Visit FirstCare's website at [FirstCare.com](http://FirstCare.com) or use FirstCare's IVR system, 24 hours a day, 7 days a week to verify copayment amounts and the existence of any special copayment requirements. This information can also be obtained by contacting FirstCare's Customer Service Department.*

#### 3.3.2 - Special Copayment Issues

Some FirstCare members may have a benefit design with unique rules for the collection of copayments on certain covered health services. For example, copayments may or may not be applicable for administration of injections or administration of medications in the physician's office depending, not only on the type of injection or medication, but also on whether or not additional services were rendered during the same visit. OB/GYN care, allergy services, and

certain diagnostic radiology procedures are examples of other services that may carry unique copayment requirements.

### 3.3.3 - Collection of Copayments

Copayments are to be paid by members at the time of service. The physician is responsible for collecting any applicable copayments if services are rendered in the office setting. Copayments for surgical procedures being performed in a hospital or surgery center setting are collected by the facility.

## 3.4 – Member Rights & Responsibilities

### All Members have a Right to:

- Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities
- To be treated with respect and recognition of their dignity and right to privacy
- To participate with practitioners in decision making regarding their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To voice complaints or appeals about the managed care organization or the care provided.
- Right to make recommendations regarding the organization's member rights and responsibilities policy

### All Members have a Responsibility to:

- Provide to the extent possible, information that FirstCare and physicians need in order to provide their health care.
- Follow FirstCare's Evidence of Coverage. The Evidence of Coverage is the document used to determine their benefits.
- Follow instructions for care that they have agreed on with their physicians.
- Carry their FirstCare member ID card with them at all times. Present it to each provider (physician, hospital, laboratory, etc.) before every appointment.
- Be on time for appointments.
- Notify their physician's office at least 24 hours in advance if they need to cancel or reschedule an appointment.
- Make the lifestyle changes their physician recommends to help the member be healthier.
- Understand the medications they take, know what they are, what they are for and how to take them properly.
- Notify FirstCare and their PCP within 24 hours after receiving emergency care
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

# SECTION 4

## Quality Improvement Program

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### 4.1 – Introduction

The FirstCare Quality Improvement program is a comprehensive system designed to assess and continually improve the processes and outcomes of care and services provided to members and providers. The program identifies opportunities for improvement, develops interventions, and measures to improve processes of care and services, evaluates results of interventions, and identifies additional opportunities to improve care and services for internal and external customers, (i.e. members, providers, practitioners, regional partners). The scope of this program is broad and includes the monitoring of administrative processes, quality of care, quality of service, and utilization of services for corporate and regional operations.

All contracted providers are required to cooperate with the Utilization Management program and Quality Improvement program which include providing clinical data related to prior authorization requirements, cooperation with focused study data collection and medical record review requests, re-credentialing requirements, cooperation with complaint resolution, and verification required by federal and state regulations. The organization may use performance data in conducting quality improvement activities.

#### 4.1.1 Data Safe guards

A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use of disclosure. For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or passcode, and limiting access to keys or passcodes.

### 4.2 – Quality Improvement Program Scope & Objectives

The Quality Improvement (QI) program encompasses both clinical care and services provided to members and providers. QI clinical indicators and studies are selected based on regional or plan-wide needs and demographic and epidemiological data.

QI activities provide a check and balance of content areas essential to regulatory compliance and desirable performance outcomes. Monitoring of these areas allows FirstCare to identify areas of risk and opportunities for improvement; and to initiate corrective action and performance improvement in a timely manner. These areas include:

- Network Adequacy;
- Availability and Accessibility of Care;
- Clinical Practice Guidelines;
- Disease Management;
- Grievances and Appeals Process;
- Claims Payment Processes;

- Delegation Oversight;
- Utilization and Care Management;
- Credentialing;
- Customer Service;
- Pharmacy Services;
- Provider Involvement and Education;
- Performance Improvement Projects (PIPs);
- Behavioral Health Care;
- Quality of Care and Quality of Service Indicators;
- Continuity of Care and Coordination of Care between Medical and Behavioral Care;
- Q-Tag Process when sentinel events impact quality of care;
- HEDIS® Data Collection and Reporting;
- CAHPS® Data Collection and Reporting;
- Provider Satisfaction Survey Reporting.

## 4.3 – QI Program Evaluation

### 4.3.1 FirstCare’s 2016 Quality Improvement Program Evaluation

FirstCare conducts an evaluation of their quality improvement program annually. An annual notification is sent to providers informing them of QI program processes, goals, and objectives as they relate to member care and services. It includes care and services where FirstCare performed well as well as those in which there are opportunities for improvement. This notification is sent out in the 3rd quarter of each year.

## 4.4 – Clinical Practice Guidelines

FirstCare’s quality improvement committees adopt clinical practice guidelines every two years. These guidelines are generally obtained from professional organizations with expertise in the area, but may be developed internally by designated board certified specialists. The practice guidelines assist providers in standardizing evidence based care in areas related to preventative screening/care, care of chronic medical conditions, behavioral health, and medication management.

The practice guidelines are continually updated throughout the year and are available for viewing at the FirstCare provider services web portal. Providers can access a list of guidelines and electronic links on the FirstCare Provider Portal at [FirstCare.com](http://FirstCare.com). Click on the Resources/ Documents tab, then General Documents, and search for “practice guidelines” to view the guidelines.

Providers may also contact their Provider Relations Representative to obtain a copy of the practice guidelines.

FirstCare’s approved clinical practical practice guidelines and their sources are provided below. FirstCare encourages providers to review these guidelines and associated recommendations. FirstCare does monitor provider adherence annually and provides feedback and requests corrective action where appropriate.

- Attention-Deficit/Hyperactivity Disorder (ADHD)
  - American Academy of Pediatrics Subcommittee on Attention-Deficit/Hyperactivity Disorder and Committee on Quality Improvement - Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder – October 2001

- Asthma
  - National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma - 2007
- Depression
  - American Psychiatric Association practice guidelines for the treatment of members with major depressive disorder-Third Edition - 2010
- Diabetes
  - American Diabetes Association - Standards of Medical Care in Diabetes - 2011
- High Blood Cholesterol
  - Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) -September 2002
- Hypertension
  - Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure - August 2004
- Preventive Care (Children, Teens, and Adults)
  - United States Preventive Services Task Force Preventive Care Guidelines (excluding recommendations against breast self-exam in adult women and testicular cancer screening in adult and adolescent males, as well as recommendations for dental caries screening in preschool children)
- Immunizations (Children, Teens, and Adults)
  - Department of Health and Human Services - Centers for Disease Control and Prevention current recommendations for immunization
- Well Child Visits
  - American Academy of Pediatrics, current recommendations for preventive pediatric healthcare - 2008

## 4.5 - Credentialing

### 4.5.1 Physician/Physician Group

Credentialing is required for all providers who have an independent physician or medical group contract with FirstCare. Each provider is credentialed separately. As required by NCQA, and Texas Department of Insurance (TDI), FirstCare uses the Texas Standardized Credentialing Application for credentialing and re-credentialing of all physicians and physician extenders. Re-credentialing is required at least every three years.

FirstCare is currently using the Council for Affordable Quality Healthcare (CAQH) which is a free online service that allows physicians and other professional providers to fill out one application to meet the credentialing requirements of many organizations. This process streamlines the credentialing process and reduces administrative costs. You may access the CAQH website at <http://www.caqh.org> or contact the CAQH Help Desk at 1-888-599-1771. You may enroll in CAQH at this website or you may call the help desk or specific answers to your questions.

FirstCare initial credentialing criteria include:

- Graduation from an accredited medical school or training program
- Hold a valid, current professional state license to practice in their designated field
- Possess a valid, current Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable to their practice
- Board certification for MDs, DOs, and DPMs is not required for participation in the FirstCare network but is verified if the provider states board certification on the

- credentiaing application
- Hospital privileges, if applicable based on specialty, in good standing at a FirstCare contracted facility
- Possess and maintain current professional liability insurance that meets or exceeds FirstCare’s minimum liability insurance limits
- Detailed explanation of malpractice history and/or Medicare and Medicaid sanctions identified from the provider application and the NPDB search
- Explanation regarding items listed on the C-Tag credentialing criteria list
- Information for unexplained gap in work history of 6 months or more in the last 5 years
- Mid-level providers must have a supervising physician who is a participating provider in the FirstCare network

Verification from the primary source is obtained within 180 days of credentialing for a current state license to practice, education or training, board certification and hospital privileges. Verification from other sources includes copies of a medical license, DEA or DPS, work history and professional liability coverage. The National Practitioner Data Bank (NPDB) is queried within 180 days of credentialing to verify a provider’s history of paid professional liability claims and Medicare and Medicaid sanctions activity.

Practitioners retain the right to:

- Review information submitted to support their credentialing application
- Correct erroneous information by submitting a correction request to the Provider Relations or Credentialing Representative
- Receive the status of the credentialing or re-credentialing application upon request
- Receive notification of these rights

#### **4.5.2 - Expedited Credentialing**

The expedited credentialing process allows providers to participate in the FirstCare network on a provisional basis. This provisional status is available if:

- Provider is a first time applicant to FirstCare and provisional credentialing request is based on a critical need of the members.
- Provider is joining as a partner, shareholder, or employee of a currently contracted and credentialed FirstCare provider in good standing
- Provider has submitted the appropriate paperwork, including a completed Texas Standard Credentialing Application with current attestation
- The applicable Regional Medical Director has reviewed the request and determined the application cannot be completed in 30 days or less
- The required verifications must indicate the file is clean. This includes a state license in good standing with the appropriate medical board, as well as a clean NPDB query.

All provisionally approved providers must agree to comply with the terms of the FirstCare contract currently in force with the applicant physician’s established medical group. The full credentialing process must be completed within 60 calendar days of the date a physician is granted provisional status.

#### **4.5.3 - Institutional Providers**

FirstCare has written policies and procedures for the initial and ongoing quality assessment of the institutional providers with which it intends to contract and with which an ongoing contractual relationship exists. At a minimum, FirstCare confirms before contracting and then every three years thereafter that the institutional provider meets NCQA, TDI, and FirstCare standards. Institutional providers credentialed by FirstCare include, but not limited to:

- Hospitals
- Nursing homes
- Skilled nursing facilities
- Home health agencies
- Rehabilitation facilities
- Dialysis centers
- Free-standing surgical centers
- Diagnostic imaging centers
- Cancer centers
- Inpatient behavioral health facilities
- Residential behavioral Health Facilities
- Ambulatory behavioral health facilities
- Rural health clinics
- Federal qualified health centers

Prior to contracting with an institutional provider, FirstCare requires the following:

- A copy of state licensure, if one is required by the State of Texas
- Documentation of an appropriate Medicare certification as required by state or federal regulations. A copy of the Medicare certificate or provision of the Medicare number will be acceptable proof of participation certification. New facilities awaiting a Medicare number can be considered for participation if they have received accreditation.
- Evidence of applicable state or federal requirements, e.g. Bureau of Radiation Control certification for diagnostic imaging centers, Texas Mental Health and Mental Retardation certification for community mental health centers and CLIA (Clinical Laboratory Improvement Amendments of 1998) certification for laboratories.
- The most recent accreditation certificate, if applicable to the institution. FirstCare accepts certifications from recognized accrediting bodies that assure an independent measure of the quality of services. Recognized accrediting entities include, but may not be limited to the following:

Diagnostic Imaging Center	ACR
Dialysis Centers	ESRD*
Home Health Agencies	TJC, CHAP, or AAAHC
Hospice Facilities	TJC or CHAP
Hospitals	TJC or AOA
Free-Standing Surgical Centers	AAAHC, TJC, AAAAPSF, or AAAASF
Infusion Services Providers	TJC or CHAP
Laboratories	CLIA, CAP
Nursing Homes	State of Texas
Rehabilitation Facilities	CARF
Skilled Nursing Facilities	TJC
Urgent Care Centers	AAAHC

AAAAPSF	American Accreditation Association for Ambulatory Podiatric Surgical Facilities
AAAASF	American Accreditation Association for Ambulatory Surgical Facilities
AAAHC	Accreditation Association for Ambulatory Health Care
ACR	American College of Radiology
AOA	American Osteopathic Association
CARF	Certification of Acute Rehabilitation Facility
CHAP	Community Health Accreditation Program
CLIA	Clinical Laboratory Improvement Amendment
ESRD*	End Stage Renal Disease
TJC	The Joint Commission

If the institution is not accredited, FirstCare requests a copy of the most recent state or Medicare site survey results. If a national accrediting body does not accredit the institution and if the institution has not had a recent State or Medicare site visit, FirstCare will delay credentialing of the institution pending Medicare site visit or FirstCare will conduct an on-site evaluation. FirstCare reviews state or Medicare site surveys for the deficiencies found by the accrediting body or Medicare

Institutional providers provide a current copy of their malpractice liability coverage face sheet showing expiration and coverage amounts.

FirstCare re-credentials institutional providers at least once every three (3) years. The re-credentialing process updates the information obtained at initial credentialing including evidence of: state licensure, Medicare certification, applicable state and federal requirements (e.g. Bureau of Radiation Control for diagnostic imaging centers, Texas Mental Health and Mental Retardation certification for community mental health centers, and CLIA certification for laboratories), accreditation by a national accrediting body, and on-site evaluation if not accredited.

#### **4.5.4 – Practitioner Site Visit Evaluation**

FirstCare may conduct an office site visit to any provider at any time for cause. The function of the site visit for cause is to gather data to evaluate that network providers are meeting the FirstCare quality standards. The methods by which the deficiencies are identified include, but are not limited to: monitoring member and provider complaints, internal Quality Tags (Q-Tags), and reports or valid concerns from provider relations department, medical department and/or other internal departments. The survey includes an evaluation of the accessibility, appearance, appointment availability, and space of an office.

#### **4.5.5 – On-Going Monitoring**

FirstCare monitors network providers to encourage the provision of safe, quality care to FirstCare members between provider credentialing cycles. FirstCare has an on-going monitoring process to determine providers' performance between periods of credentialing.

On a monthly basis, FirstCare reviews the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the Office of Personnel Management (OPM), SAM, the state licensing board of each provider, as well as member and provider complaints, quality tags (Q-Tags), and adverse events.



#### 4.5.6 – Credentialing Decisions

All credentialing decisions are made by regional committees defined as peer review bodies and all proceedings are confidential and privileged under the Texas Occupations Code as a medical peer review body. Information obtained or documentation created by FirstCare credentialing staff for credentialing and re-credentialing is treated in a confidential manner. FirstCare complies with HIPAA guidelines regarding the release of credentials information to third parties. Providers or groups are not denied participation with FirstCare or have any such contract terminated on the basis of sex, race, creed, color, national origin, age, or disability. The selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions.

Providers are notified within 60 calendar days of their status in the network according to the determination made by the committee. If initial provider participation is denied or existing participation is altered based on quality of care or service, the provider is notified in writing of the reason for the denial and is given an opportunity for a review process that includes a review panel.

### 4.6 – Case Management Program

FirstCare provides a broad array of local and national Case Management services to support participating providers in managing complex medical cases. In addition, the Case Management program is designed to focus on providing the highest quality of care by assisting in coordinating the multiple resources needed for specific medical conditions. By using FirstCare's Case Management program, hospitals and physician/Providers can alleviate some of the burden of caring for complex cases.

Hospitals can take advantage of FirstCare's Case Management for cases such as:

- Catastrophic illness (all ages)
- Accidents (all ages; i.e., MVAs, burns)
- High risk pregnancy
- Premature infants
- Stroke, disability, and rehabilitation cases
- Organ transplants

To initiate FirstCare's Case Management program, please contact the Case Management department by calling FirstCare Customer Service or by emailing [casemgmt@FirstCare.com](mailto:casemgmt@FirstCare.com)

#### 4.6.1 – Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW), provides services to high-risk Medicaid children (under age 21) and high-risk Medicaid pregnant women. CPW helps high-risk members get help in the following areas:

- Supplies and equipment;
- Family problems;
- Financial concerns;
- Accesses to medical services;
- Education and school problems; and
- Finding help near the member

For more information about CPW, visit the program's website at <http://www.dshs.state.tx.us/caseman/default.shtm>

FirstCare coordinates services with CPW when member's needs are identified. Disclosure of medical records or information between providers, MCO's and CPW case managers does not require a medical release form from the member.

#### **4.6.2 - FirstCare Disease Management Program**

Disease management is a system of coordinated healthcare interventions and communications for populations with identified conditions in which member self-care efforts are significant.

#### **4.6.3 - Program Populations**

FirstCare focuses on managing disease conditions common to the population and demographics. Conditions currently being managed include the following:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)

To refer a member to our Disease Management program, send an email to [casemgmt@FirstCare.com](mailto:casemgmt@FirstCare.com), or call FirstCare Customer Service. Information on this program and how to make a referral is also posted at [FirstCare.com/Providers](https://www.FirstCare.com/Providers).

# SECTION 5

## Medical Services (HMO)

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### 5.1 – Roles & Responsibilities of a PCP

A Primary Care Physician (PCP) with FirstCare HMO is responsible for providing, arranging, and coordinating all aspects of the member's health care for those members assigned to the PCP, and for directing and managing appropriate utilization of health care resources. The PCP is the focal point of all care management for members in the HMO. FirstCare recognizes General Practice, Family Practice, Internal Medicine, and Pediatric physicians as PCPs. Female members may also designate an OB/GYN provider in addition to a PCP.

A PCP is expected to provide all necessary care required by a member that is within the scope of his or her practice and expertise.

- The PCP is expected to provide qualified, consistent, easily accessible on-call coverage 7 days a week, 24 hours a day, either personally or by a reasonable call coverage arrangement with other appropriate individuals. Members are instructed to contact their PCP first when they need urgent or emergent care. The PCP is responsible for evaluating the member's needs and directing their care, including working them into the schedule during normal office hours when at all practical. In urgent or emergent situations after office hours, the PCP, or his/her qualified coverage, is expected to provide access to a health care provider to advise the member on the course of care they should follow. After-hours coverage may not solely consist of directing members to a hospital emergency room.
- The PCP must refer members to in-plan providers unless approval is received in advance from FirstCare, or in an emergency situation where in the prudent medical judgment of the PCP, physical harm will result if the member is not referred on an emergency basis. In such instances, appropriate medical documentation may be required.

#### 5.1.1 – Member Assignments

- The PCP will receive a listing of member, with monthly updates, which have selected or been assigned to him or her, for which they are responsible to oversee delivery of health care services.
- If a member is not on the PCP's eligibility list, the PCP is required to contact the FirstCare Customer Service Department to determine eligibility when contacted by the member seeking care. Failure to verify assignment to the PCP may prevent the PCP from receiving reimbursement for services rendered.

### 5.2 – Designated OB/GYN for Female Members

Female members of FirstCare, in addition to designating a PCP, may designate an OB/GYN physician to provide for their needs relating to:

- Once well-woman exam per year;

- Care related to pregnancy;
- Care for all active gynecological conditions; and
- Gender-related care within the OB/GYN scope of professional practice, including treatment of medical conditions concerning the breasts, genital tract, female endocrinology, reproductive physiology, infertility, and pregnancy.

## 5.3 – Roles & Responsibilities of Specialist

The role of an in-network FirstCare Specialist is to provide consulting expertise, as well as specialty diagnostic, surgical, and other medical care. Specialists shall support the role of a PCP in coordinating and managing a member’s health care. Open, prompt communication with the PCP concerning follow-up instructions, circumstances of further visit requirements, medications, lab work, x-rays, etc. are essential to the coordination of care.

- Specialists shall provide qualified, consistent, easily accessible on-call coverage 24 hours a day, 7 days a week, either personally or by a reasonable call coverage arrangement with other appropriate individuals.
- Specialists are to submit to the PCP of each member, which Specialist is treating, within industry standards after referral and treatment of a member, a report concerning the treatment provided to such member. Such reports may be given verbally initially, provided a written report is submitted within 10 calendar days following the verbal report.
- Specialist providers should order all laboratory testing, radiology studies or other diagnostic testing through a contracted, in-network facility unless an emergency situation clearly indicates emergency lab or radiology services are required.

### 5.3.1 – Specialists Acting as a PCP

The hospital is responsible for rendering services to our HMO members admitted by a participating physician in accordance with such participating physician’s orders, or which are ordered by a participating physician on an outpatient basis and only when such services have been prior authorized by FirstCare, as applicable.

Any such admissions shall be consistent with the hospital’s policies for admission and treatment, but may only be made by a participating physician who has appropriate admitting and clinical privileges at the hospital.

A hospital is expected to treat each member only as ordered and prior authorized, as applicable, by the attending participating physician of each such member. Covered health services required by a member and provided by the hospital shall be of good quality and in accordance with accepted health care standards prevailing in the community served by the hospital.

- The hospital agrees to notify FirstCare, on a reasonable basis (at least 90 days in advance), prior to any substantial change in the type of services, which it is providing as of the effective date of this agreement.
- The hospital agrees to notify FirstCare of all admissions of member, during regular working hours, but in no event later than 24 hours or the next working day following the admission of a member.
- Except in case of emergency care, the hospital agrees to only admit members upon orders of a participating physician, and with prior authorization by FirstCare or FirstCare’s Medical Director that certifies the covered health services, and the specific services and duration of services that have been authorized under FirstCare’s Utilization Review program. In the event that a physician does not provide the hospital with an authorization

number prior to an admission for the services requested for a member, the hospital shall contact FirstCare to verify the existence of an authorization number. If an authorization has not been issued for the admission by FirstCare, the hospital agrees to notify the admitting physician.

- FirstCare shall pay for emergency services in the event a member requires emergency medical care. However, the hospital shall obtain prior authorization from FirstCare before providing post-stabilization care for services originating in a hospital emergency department. FirstCare shall approve or deny such a request within the time appropriate to the circumstances and the condition of the member, but in no case exceed one (1) hour.
- FirstCare may deny payment for services that are not appropriately prior authorized. The hospital may not bill the member for those denied services.
- The hospital further agrees that it shall not transfer members to another inpatient hospital without prior authorization from FirstCare except in emergency care situations. Such admissions, whenever possible, should only be to hospitals that are participating providers.
- The hospital agrees to verify member eligibility with FirstCare prior to the non-emergency admission of, or provision of services to, any member. Failure to verify eligibility as required, may subject the hospital to denial of payment with respect to services rendered.
- Failure to comply with FirstCare's policies and procedures may result in denial of payment to the hospital and/or termination of this agreement. If any payment to the hospital is denied due to the hospital's failure to comply with FirstCare's policies and procedures, the hospital shall not bill them ember for such denied amounts.

## 5.4 – Access to Care

FirstCare has established standards for all participating physicians in areas such as appointment scheduling and office wait time.

In addition, FirstCare has established that all contracted hospitals provide qualified, consistent, and easily accessible coverage 7 days a week, 24 hours a day.

As noted previously, a PCP or designee physician is expected to be available to the members at all times or to arrange for coverage with another participating physician to meet the standard of immediate access. Other standards for access include:

- Emergency Consultations & Care Immediate access at all times
- Urgent within 24 hours
- Routine within 3 weeks
- After hours telephone access to PCP or covering provider
- Office wait time 15 minutes or less
- Physical/annual within 2 months

## 5.5 – On Call Providers

We understand that physicians/practitioners cannot always provide coverage for their own practice during after hours, weekends, and vacation times. Participating physician agreements require that on-call physicians/practitioners be a participating FirstCare physician/practitioner.

Providers that share the same tax ID number, same office location, and specialty type are considered to be an on-call partner.

### 5.5.1 - Where to Send Notification for On-Call or Covering Providers

Providers should furnish this information directly to their FirstCare Provider Relations Representative. Providers should also contact their Provider Relations Representative with any changes to call share coverage.

### 5.5.2 - Who Can Serve as an On-Call/Covering Provider

On-call/covering providers should be of the same or similar specialty type as the physician/practitioner for whom they cover. Exceptions to this must be approved by a FirstCare Medical Director.

Physician agreements require that physicians/practitioners make appropriate arrangements with other participating FirstCare providers for call coverage to assure availability of care on a 24 hour per day, 7 days a week basis.

*\*Note - PCPs are not placed on call for Specialists; however, Specialists can be on call for PCPs if within the same clinic. Also, physician extenders will be considered on call for physicians but not vice versa.*

## 5.6 - OB/GYN Care

(Refer to: Claims Submission section, "OB/GYN Services" for additional information)

### 5.6.1 - Ultrasound/Sonograms

FirstCare's standard of practice for ultrasounds during normal, uncomplicated pregnancies includes two ultrasounds for determination of fetal size. Ultrasounds solely for the purpose of sex determination are not covered. Ultrasounds beyond the two screenings will only be covered with a diagnosis of high-risk pregnancy.

### 5.6.2 - Inpatient Delivery Care

FirstCare does not require authorization for inpatient care for delivery, for both mother and newborn, for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following and uncomplicated delivery by cesarean section. Any inpatient care following the 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery will require authorization.

The member, in consultation with their physician, may choose to be discharged from an inpatient setting prior to the initial length of stay authorized if medically appropriate.

If coverage exists through different insurance carriers on the parents/guardians, FirstCare encourages notification of infants who are born to non-FirstCare covered mothers but who will be added under the father's FirstCare policy within 30 days from delivery. Authorization is required for the inpatient newborn services if newborn is added to the father's policy.

## 5.7 - Referrals to Out-of-Network Providers

Referrals to out-of-network providers for medically necessary and covered health services will require prior authorization by the FirstCare. Referrals should be submitted to FirstCare at least 5 days in advance in order to allow FirstCare enough time to determine medical necessity.

### 5.7.1 - To Initiate an Out-of-Network Referral

Complete and fax the FirstCare Prior Authorization request form (available on website [FirstCare.com](http://FirstCare.com)). Or you may contact the authorization department by phone or provider portal and provide the following information:

- Member's name;
- Member ID number
- Member's date of birth
- PCP requesting the referral and NPI and TIN;
- Specialist provider requested and NPI and TIN;
- Diagnosis (ICD 10);
- Visits or services to be performed (if a procedure the procedure code must be included); and
- Information about other insurance the member may have.

### 5.7.2 - Approval Requirements

Referrals to out-of-network providers are pre-authorized and covered by FirstCare when, one or more of the following conditions are present:

- Life threatening conditions exists and appropriate or timely;
- Access to an in-network facility or service is not reasonably practical or possible;
- Covered transplant is required and approved;
- Medically necessary, covered medical service is not available through an in-network Provider;
- Service or care is available in-network, but not accessible; and/or
- Service is available in-network, but there is a continuity of care concern for a new member (e.g. any high risk pregnancy in the second trimester, a pregnancy in the third trimester or any other situation which, in the judgment of the Medical Director warrants an out-of-network authorization to complete a particularly complex episode of care).

Failure to obtain prior authorization for out-of-network referrals may result in denial of payment for services rendered. The provider may not bill the member for services so denied.

### 5.7.3 - Out-of-Network Services

FirstCare has developed contractual arrangements with a number of specialists, hospitals and centers of excellence throughout the State of Texas and nationally. Before recommending a specific specialist or facility to a member for care, the referring physician should consult with the FirstCare medical department about providers available through the FirstCare STAR or CHIP network.

The referring physician should discuss with the out-of-network provider any lab or radiology studies expected to be performed prior to the member's visit and have those services performed by an in-network provider or facility before the visit to the out-of-network provider. Lab, X-ray and/or ancillary services performed by, or ordered by, an out-of-network provider not specifically authorized by FirstCare in advance, will not be covered.

When a covered transplant is required, members must have that procedure performed through a FirstCare STAR or CHIP contracted transplant facility. Consult with the FirstCare medical department on available centers and the process of evaluation necessary to make a valid referral for transplants.

### 5.7.4 - Extending a Referral

There may be occasions when a treatment by a specialist or other provider may need to be extended beyond the initial referral. Extension require prior authorization.

Any follow up care to the out-of-network provider must also be pre-authorized by FirstCare prior to care being rendered. Follow-up care is not included in the initial out-of-network prior authorization.

## 5.8 – Prior Authorization Program & Requirements

### 5.8.1 – Services Requiring Prior Authorization

FirstCare defines “prior authorization” as having received FirstCare’s approval for a service to be delivered based on evaluation of medical necessity prior to the time the service is rendered.

### 5.8.2 – Prior Authorization Requirements

We require that certain medical services, care, or treatments be pre-authorized before we will pay for all related Covered Health Services. Prior authorization means that we review and confirm that proposed services, care, or treatments are Medically Necessary. You or your Physician are responsible to preauthorize any proposed services at least five days before you receive them. If you fail to get proper Prior Authorization, care or treatment may not be covered or you may incur payment penalties. For a list of services requiring prior authorization please visit [FirstCare.com/Providers](https://www.firstcare.com/providers) or your provider portal. Please contact Customer Service, 1-800-884-4901, if you have any questions.

### 5.8.3 – Admitting Physician Responsibilities

It is the admitting physician’s responsibility to obtain authorization for services specified in this section and to provide the necessary clinical and member information to process authorization requests. Although any physician participating in an admission, either directly or through consultation, may supply prior authorization information, responsibility for this authorization falls to the admitting physician. Failure to obtain prior authorization for the specified services will result in denial of payment for services rendered. In such cases, providers may not bill members for denied services.

### 5.8.4 – How to Obtain a Prior Authorization

Authorization requests are accepted from either in network PCP or in network specialist. Contact FirstCare for prior authorization by accessing the provider web portal or by either calling or faxing the prior authorization department. If faxing a prior authorization request to FirstCare, complete the “FirstCare Prior Authorization Request Form” in the ATTACHMENTS section of this manual and include any pertinent clinical information. For after-hours emergencies or weekend/holiday admissions, a physician should call the prior authorization department within 24 hours of admission or the next business day.

### 5.8.5 – Information Required for Authorization

- Member’s name, date of birth, member ID number;
- Ordering provider’s name, Group and Individual NPI and TIN;
- Servicing Provider’s name, Group and Individual NPI and TIN;
- Expected date of service (if date changes, please notify FirstCare);
- Diagnosis (ICD-10 );
- Procedure (CPT/HCPCS) code number;
- Clinical information for determining coverage may include but not limited to:
  - Office and hospital records
  - A history of the presenting problem
  - Physical exam results
  - Diagnostic testing results
  - Treatment plans and progress notes
  - Patient psychosocial history
  - Information on consultations with the treating practitioner
  - Evaluations from other practitioners
  - Operative and pathological reports
  - Rehabilitation evaluations



- A printed copy of criteria related to the request
- Information regarding benefits for services
- Information regarding the local delivery system
- Patient characteristics and information
- Information from family members
- Expected length of stay;
- Anticipated discharge needs;
- Treatment plan; and
- Other carrier information.

#### 5.8.6 - Elective Service re-authorization Lead Time Requirements

For non-emergent elective admissions and procedures, contact FirstCare at least 2 working days before the planned service or admission. Failure to meet the lead times specified for elective admissions or procedures may result in FirstCare's inability to approve the procedure or admission for the original scheduled date. Late requests for authorization for elective services that do not meet the lead time requirements shall not be given priority nor treated as emergencies, and therefore, shall not be approved on a priority basis.

#### 5.8.7 - Emergency Admissions and Direct Admissions

It is the responsibility of the admitting physician to contact FirstCare's Authorization department within 24 hours or the next business day of any emergency or direct admission.

**Failure of the physician to contact FirstCare may result in denial of payment or delay of payment for services rendered by the admitting physician and/or other providers involved in the case. Physicians and hospitals may not bill the members for services denied as a result of failure to contact FirstCare following an emergency or direct admission.** (See also "Routine, Urgent, and Emergent Care Services" which appears under a separate heading in this section of the manual).

#### 5.8.8 - Inpatient Admission and Length of Stay Authorization

FirstCare uses the nationally recognized standards of "MCG Care Guidelines" as well as internal guidelines, peer literature review, or direct physician supervision for review of clinical information in determining if inpatient level of care will be authorized. At the time initial clinical and discharge plans are received and reviewed for level of care medical necessity, FirstCare will assign an expected length of stay. Additional days may be authorized based on clinical information supplied by the physician.

Please note that many denials during the prior authorization process are a result of incomplete, absent or inadequate medical information. FirstCare requires participating provider to provide specific and accurate clinical information to process a request for authorization properly. It is essential that the physician or physician's representative submitting the request have the information available at the time of prior authorization in order to avoid possible delay and/or denial of authorization request.

#### 5.8.9 - Concurrent Review of Inpatient Admissions

FirstCare will monitor the course of inpatient care services received by a member. The Concurrent Review Nurse may conduct any of the following:

- Review of member's chart;
- Communicate with the member/guardian/parent;
- Discuss the case with the hospital UM staff;
- Speak directly to the admitting physician regarding the progress of the case;
- Identify discharge or alternative care needs; and

- Assist the facility, physician, and/or member with post-facility care arrangements, coverage information, benefit information, etc.

If, during the course of the review, the Concurrent Review Nurse determines, based on established guidelines, that the available documentation indicates the member can be transitioned to a lower level of care, the attending physician or the facility will be contacted to discuss the justification of any continued services and possible alternatives. The Concurrent Review Nurse, in collaboration with the FirstCare Medical Director, may reduce the authorized level of services and notify the attending Physician of same, and suggest appropriate alternatives to current services.

If the attending physician disagrees with FirstCare's determination regarding denial of continued services, he or she may request a further review by the FirstCare Medical Director (Refer to: COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "Appeals to Adverse Determinations").member

#### **5.8.10 - Requesting Extensions to the Authorized Length of Stay**

If, during the course of hospitalization or other services, the attending physician believes the approval for reimbursement of hospitalization or other services should be extended beyond what has been authorized, he or she should submit a clinical update to the concurrent review nurse to request an extension of the length of stay or other services. Failure to obtain authorization for additional days of inpatient stay or other services may result in denial of payment for services.

The request for extension will be evaluated based on the clinical information provided. If the extension is denied by the Medical Director, the attending physician may pursue the next level of the appeals process (Refer to: COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "Appeals to Adverse Determinations").

#### **5.8.11 - Availability of Criteria**

Providers are notified that clinical criteria are available upon request. They are provided to all providers within 10 days of request. A copy of the most recent version of the requested clinical criteria will be faxed, emailed or mailed to the provider based upon their request.

### **5.9 - Lab Testing and Radiology Services**

All laboratory and radiological services are to be performed by a provider/facility contracted and approved with FirstCare for these services. If you have any questions, please contact your Provider Relations Representative.

*\*NOTE - HMO providers may not bill for tests that are not done in the office. This will be considered a fraudulent billing and cause for termination of participation.*

### **5.10 - DME, Orthotics, Prosthetics, and Medical Supplies**

All Durable Medical Equipment (DME) and orthotic/prosthetic devices requiring a physician order may need prior authorization. This applies to both purchased and rental items. FirstCare will not be responsible for items dispensed that are not a covered benefit under the member's plan. Prior authorization may be obtained by calling or faxing the request to the pre-authorization department. Clinical information to support the request must be provided. The HCPCS code on the submitted claim must correlate with the authorized service/diagnosis, or the claim will be denied.

Any medical supply that can be purchased over-the-counter without a physician order does not require authorization and is not a covered benefit for FirstCare members. However, for members with Diabetes Mellitus, some supplies that would otherwise not be covered are covered when the equipment is obtained from a Participating Provider. Specific questions concerning these diabetic supplies should be directed to FirstCare.

To confirm a member's eligibility for DME benefits, providers may access the member's specific benefit plan on the FirstCare Provider Web Portal at [FirstCare.com](https://www.firstcare.com). For more details on how to view and print member eligibility statements from the Provider Web Portal, please refer to the Provider Portal Handbook in the ATTACHMENTS section of this manual.

### **5.10.1 - Rental vs. Purchase of DME**

FirstCare will determine whether DME will be rented or purchased based upon the duration and usage needs of the FirstCare member. Rental payments are made only for the period of time the equipment is medically necessary or when the total monthly rental payments equal the reasonable purchase cost for the equipment. Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

## **5.11 – Routine, Urgent, and Emergent Care Services**

### **5.11.1 – Routine Care Services**

Those covered health services a physician commonly performs within the scope of the physician's practice or license are considered routine care. Routine care services are to be performed in the same manner, in accordance with the same standards, and within the same time availability as offered by other physicians to private pay members. Services must be provided in compliance with generally accepted medical and behavioral health standards for the community in which services are rendered. Routine Care is to be scheduled within two (2) weeks of the member's request.

### **5.11.2 – Urgent Care Services**

Those medical conditions which are not an emergency but are severe or painful enough to cause a prudent layperson, possessing average knowledge of medicine and health, to believe that the condition requires medical treatment or evaluation within 24 hours to prevent serious deterioration of the member's condition or health is considered Urgent Care. Urgent Care is to be scheduled within 24 hours of request.

### **5.11.3 – Emergency Care Services**

Health Care provided in a hospital emergency facility or trauma center for evaluating and stabilizing the onset of a severe medical condition that could reasonably be expected to cause permanent and significant physical harm, or loss of life or limb, is considered Emergency Care.

FirstCare uses the following set of criteria to determine when a member has an emergency condition: a medical condition of recent or sudden onset and severity that would lead a prudent layperson possessing an average knowledge of medicine, to believe the condition, sickness, or injury was of such a nature that failure to obtain immediate medical attention could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily function;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus;
- Serious dysfunction of any bodily organ or part; and/or
- Serious disfigurement.

FirstCare members should contact their PCP regarding a need for emergency care before receiving the care whenever possible and/or practical. The PCP shall determine the emergent nature of the situation and use professional discretion in directing the member to the most appropriate location to receive the service (i.e. the office, urgent care center, minor emergency room, or hospital ER or trauma center). When the PCP directs the member to the nearest emergency facility, the PCP should notify FirstCare of the referral for the emergency care. Notification of emergency services should be made to the FirstCare Prior authorization Department within 24 hours or next business day of the member being directed to seek emergency care.

Should it not be reasonable to contact the PCP before obtaining emergency attention due to the serious nature of the illness or injury, FirstCare should be notified by the member or the PCP within 24 hours, or as soon as possible and/or practical following the treatment. Notification can be made by the PCP or their designee (e.g., emergency room staff, hospital admitting department, physician office personnel, member's family, or the member). Failure of the PCP to notify FirstCare of a member being directed to the hospital for emergency services may result in no authorization for services, and may result in the member's medical services being denied or payment being significantly delayed.

FirstCare will cover the professional, facility, and ancillary services that are medically necessary to perform the medical screening examination and stabilization of a member with an emergency condition. Emergency services claims will be processed according to FirstCare's standard claims adjudication process in accordance with state and federal regulations.

Any need for post-emergency stabilization, including admission to inpatient or observation status, must be authorized within the appropriate time frame by the FirstCare Pre-Authorization Department.

Outpatient follow-up care resulting from an emergency facility visit or facility stay must be rendered by an in-network provider.

## 5.12 – Ambulance Services

Medically necessary ambulance services do not require authorization when used for emergency transportation to the nearest hospital emergency room or trauma center. All non-emergent ambulance transfers require authorization.

To avoid denial in payment, prior authorization should be obtained before the transport occurs for ambulance transports between facilities.

*\*NOTE – All ambulance services should be billed according to the FirstCare contract.*

## 5.13 – Technical Denials and Adverse Determinations

### 5.13.1 – Technical Denials

A “technical denial” is a denial of reimbursement for requested or provided services based on non-medical issues such as: non-covered services, benefit limits, and failure to obtain pre-certification within the required time frame. Technical denials are issued by the Prior Authorization Department.

FirstCare will notify the member or a person acting on behalf of the member and the member's provider of record of a technical denial made during the course of Utilization Review activities.

The notification of a technical denial will include:

- Principal reason for the technical denial;
- Description or the source of any screening criteria that were utilized as guidelines in making the technical denial; and
- Description of the procedure for the complaint process, including notification of:
  - The member's right to file a complaint related to a technical denial; and
  - The member's right to contact the Texas Department of Insurance (TDI), including TDI's toll-free telephone number and address.

## 5.14 – Adverse Determinations – Denials Based on Lack of Medical Necessity

Anytime FirstCare is questioning the medical necessity or appropriateness of healthcare services, the healthcare provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the member and the clinical basis for the FirstCare Medical Director's decision with a physician or dentist prior to the issuance of the adverse determination.

With the issuance of an adverse determination, the requesting/ordering provider will be given the opportunity to request a peer-to-peer review with a FirstCare Medical Director. The Care Management Services Department informs each requesting and treating practitioner how to contact a FirstCare Medical Director or other appropriate reviewer to discuss a denial.

When the Care Management Services Department notifies the physician or office staff by fax and/or telephone, the denial file must include:

- The name of the contact and the practitioner/facility,
- The time and date of the denial notification, and
- Notification of the physician reviewer availability (normal business hours of 8am-5pm Monday through Friday for non-urgent peer-to-peer communication and 24/7 availability for urgent and post stabilization reconsiderations).

FirstCare will notify the member or a person acting on behalf of the member and the member's provider of record of an adverse determination made during the course of utilization review activities.

The notification of an adverse determination will include:

- Principal reason(s) for the adverse determination;
- Clinical basis for the adverse determination;
- Description or the source of the screening criteria that were utilized as guidelines in making the determination; and
- Description of the procedure for the appeal process, including:
  - Notification to the member of the member's right to appeal, including provisions for filing an expedited (72 hour) appeal; (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you).
  - Notification to the member of the procedures for appealing FirstCare will provide notification of the adverse determination:
    - Within one (1) working day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the adverse determination, along with a letter notifying the member advising of the right to appeal;
    - Within three (3) working days in writing to the provider of record and
    - the member if the member is not hospitalized at the time of the adverse

- determination;
- Within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member, but in no case to exceed one (1) hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or health care provider.

*\*NOTE - Retroactive reviews of Adverse Determinations are not subject to an Independent Review Organization (IRO) appeal process.*

# SECTION 6

## Utilization Management Program (PPO)

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### 6.1 – Overview

FirstCare PPO has specific requirements for pre-certification of hospital admissions and other services, emergency hospital admissions, continued stay review, discharge planning, and medical case management. The following is a description of the requirements for each component of FirstCare’s PPO Utilization Management Program.

Although a given plan of treatment has been certified as medically appropriate, FirstCare PPO will review the actual claim to make sure that the member was eligible for covered health services at the time of treatment and that the services rendered were the covered health services which were pre-certified.

### 6.2 – Pre-Certification

FirstCare requires that certain medical services, care, or treatments be pre-authorized before we pay for all related covered health services. Prior authorization means that we review and confirm that proposed services, care, or treatments are medically necessary. You, or your physician, are responsible for pre-authorizing any proposed services at least five (5) days before you receive them. If you fail to get proper prior authorization, care or treatment may not be covered or you may incur payment penalties.

For a list of services requiring prior authorization and/or to request prior authorization, visit [FirstCare.com/Providers](https://www.firstcare.com/providers) or the Provider Portal. If you have questions, please contact Customer Service at 1-800- 884-4901.

At the back of the Provider Manual you will find a “FirstCare Authorization Request Form” for fax or mail use. Pre-certification telephone and fax numbers can be found in the telephone guide at the beginning of the Provider Manual.

Pre-certification is designed to evaluate the medical necessity, appropriate location of service, and expected length of confinement for proposed provider services, prior to the delivery of the provider services listed on the FirstCare Authorization Requirements matrix located at [FirstCare.com](https://www.firstcare.com).

Certification is not a guarantee of payment. All services listed may not be covered under all plans. Please refer to the member’s Evidence of Coverage (EOC) available on the provider portal . Plans with group numbers containing “SF” may have slightly different certification requirements.

Failure to pre-certify covered health services may result in reduced payment or nonpayment and will cause the member to pay a significant monetary penalty.

Additionally, the ‘Failure to pre-certify’ penalty applies each time a procedure or treatment is

provided. Without pre-certification, the provider cannot be sure that the major services are a covered benefit. The pre-certification coordinator will require the following information:

- Member name, date of birth, FirstCare Member ID #;
- Facility name/Tax ID/NPI, address, and telephone number to provider service;
- Expected date of admission/procedure (if date changes, notify FirstCare);
- Diagnosis Code(s) and description;
- Pertinent clinical information (a clear concise description of the work-up, pertinent lab, x-ray, or other test data, and any other pertinent information reasonably proving justification for the requested services);
- Expected length of stay;
- Anticipated discharge needs;
- Treatment plan; and
- Other carrier information

FirstCare uses the nationally recognized standards of “MCG Care Guidelines” as well as internal guidelines, peer literature review, or direct physician supervision for review of clinical information in determining if inpatient level of care will be authorized. At the time initial clinical and discharge plans are received and reviewed for level of care medical necessity, FirstCare will assign an expected length of stay. Additional days may be authorized based on clinical information supplied by the physician.

*\*NOTE - Pre-Certification is ONLY valid for dates given by the pre-certification staff*

When a determination has been made by FirstCare to deny coverage of the proposed admission/procedure or otherwise limit covered health services, the requesting provider will be notified verbally and in writing. The requesting provider should immediately inform the insured person of this adverse determination and that he/she may be responsible for payment of the costs associated with the plan of treatment upon submission of the claim to FirstCare PPO.

Emergency Admissions require notification within 24 hours or by the next business day after the admission of a member. The participating hospital or participating provider may perform the required notification for an emergency admission by contacting FirstCare’s pre-certification coordinator at the pre-certification telephone number shown on the member’s identification card. The pre-certification number can also be found on the Important Contact Information guide at the beginning of the Provider Manual.

## 6.3 – Concurrent Review

FirstCare will monitor the course of inpatient care services received by a member. The Concurrent Review Nurse may conduct any of the following:

- Review of member’s chart;
- Communicate with the member/guardian/parent;
- Discuss the case with the hospital UM staff;
- Speak directly to the admitting physician regarding the progress of the case;
- Identify discharge or alternative care needs; and
- Assist the facility, physician, and/or member with post-facility care arrangements, coverage information, benefit information, etc.

If, during the course of the review, the Concurrent Review Nurse determines, based on established guidelines, that the available documentation indicates the member can be transitioned to a lower level of care, the attending physician or the facility will be contacted to



discuss the justification of any continued services and possible alternatives. The Concurrent Review Nurse, in collaboration with the FirstCare Medical Director, may reduce the authorized level of services and notify the attending Physician of same, and suggest appropriate alternatives to current services. If the attending physician disagrees with FirstCare's determination regarding denial of continued services, he or she may request a further review by the FirstCare Medical Director.

## 6.4 - Discharge Planning

Discharge planning begins at the time of admission, seeking to evaluate the potential needs that the member may have at the time of discharge. This process is designed to assist the participating provider in the coordination of the member's discharge when acute care (hospitalization) is determined to be no longer medically necessary. If, during the course of hospitalization or other services, the attending physician believes the approval for reimbursement of hospitalization or other services should be extended beyond what has been authorized, he or she should submit a clinical update to the concurrent review nurse to request an extension of the length of stay or other services. Failure to obtain authorization for additional days of inpatient stay or other services may result in denial of payment for services. The request for extension will be evaluated based on the clinical information provided. If the extension is denied by the Medical Director, the attending physician may pursue the next level of the appeals process.

# SECTION 7

## Drug Coverage for Medical & Pharmacy Benefits

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FirstCare members and their physicians have access to a wide selection of prescription drugs. Knowing how our prescription drug program works will help our members, and your members get the most from their drug benefit.

Navitus Health Solutions, your full service pharmacy benefit company, is committed to lowering drug costs, improving health, and providing superior customer service in a manner that instills trust and confidence. This partnership will help us make health care work better for everyone by improving deliver, clinical management, and overall affordability of prescription medications.

### 7.1 – Pharmaceuticals List, Restrictions, and Preferences

The formulary list and updates are posted on FirstCare website under the Pharmacy tab. Practitioners are notified of formulary changes, via the website, and/or provider newsletters. The posted formulary indicates if any Step Therapy, quantity limitations or prior authorization are required for a medication to be obtained. The formulary is distributed in its entirety via the web at least annually. Providers may also request a hard copy of the formulary by contacting their Provider Relations representatives.

### 7.2 – Pharmaceuticals Management

The FirstCare website contains information about access to medications. FirstCare utilizes a closed formulary. Medications not on the formulary can still be accessible via exception or the prior authorization process.

### 7.3 – Limits and Quotas

Medications that have limits or additional requirements will be noted in the formulary list as follows:

- QL – quantity limits
- PA – prior authorization
- ST – Step Therapy – failure of generic or equivalent medication is required.

These items are noted next to the medication name in the formulary list in the FirstCare website:

- Commercial Plans, TRS and Lubbock Chamber of Commerce Plans - <http://www.firstcare.com/en/Group-Health-Plans/Pharmacy-Drugs>
- Marketplace(HIM) and ACA Small Group Plans - <http://www.FirstCare.com/marketplace>

## 7.4 – Exception Requests

For medications that are not covered by FirstCare, a practitioner can submit an exception request and provide supporting information when a member either tried a reasonable number of similar medications, used optimal doses and duration without appreciable results, is intolerable, or formulary drugs are inappropriate. Criteria for approval are determined by the P&T Committee unless contractually prevented by state contract. Exception requests are reviewed by a physician who is authorized to make UM decisions. FirstCare will notify the provider via mail or fax about the decision.

## 7.5 – Generic Substitution, Therapeutic Interchange, and Step Therapy Protocols

Generic Substitution – Generic medications rate “A” by the FDA indicate a substitute is available. This substitution is automatic at the point of service by the pharmacist. If the member requests a brand in this situation, a cost differential will apply.

Therapeutic Interchange – Changes within a therapeutic class will not be automatic. A pharmacist or medical director may call or write a provider notifying them of a potential cost saving opportunity to the member, but the request will not be automatically changed.

Step Therapy Protocol – Medication alternative(s) listed on the covered drug list must be used in accordance with the Step Therapy requirements when:

- The drug has been ineffective in a member’s treatment of disease or medical condition;
- Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen is likely to be ineffective or adversely affect the drug’s effectiveness or member’s compliance;
- The drug has caused or, based on sound clinical evidence and medical and scientific evidence is likely to cause, an adverse reaction or other harm to the member.

## 7.6 – Prior Authorization

Navitus Health Solutions is the exclusive pharmacy benefit manager for FirstCare members. Below is a summary of contact information of our partners. For additional questions, please contact FirstCare Health Plans at 1-800-884-4901, Monday through Friday 8 a.m. – 5 p.m. or visit [FirstCare.com/Providers](https://www.FirstCare.com/Providers).

	Company Name	Contact Information
Prior Authorization	<b>Pharmacy RX PA (RX from pharmacy)</b>  Login to the Navitus prescriber portal for: Standard Texas PA form Drug specific PA form Exception form	Navitus  <a href="http://www.Navitus.com">www.Navitus.com</a> 1-855-673-6504 (Commercial/Exchange) 1-877-908-6023 (Medicaid/CHIP)  FAX: 1-855-668-8551 (Commercial/Exchange) 1-855-668-8553 (Medicaid/CHIP)  MAIL: Navitus Health Solutions LLC Attn: Prior Authorizations 1025 West Navitus Drive Appleton, WI 54913
	<b>Medical RX PA (RX from Provider's Office)</b>	FirstCare  <a href="http://www.FirstCare.com/Providers">www.FirstCare.com/Providers</a> 1-800-884-4905  FAX: 1-800-248-1852  MAIL: FirstCare Health Plans Attn: Prior Authorization 1901 W Loop 289, Suite 9 Lubbock, TX 79407
Pharmacy	<b>Mail Order Pharmacy</b>	NoviXus  <a href="http://www.NoviXus.com">www.NoviXus.com</a> 1-888-240-2211 (Press #2) or 1-877-269-1159  FAX: 1-877-395-4836  MAIL: PO Box 8004 Novi, MI 48376-800
	<b>Specialty Pharmacy</b>	Lumicera  <a href="http://www.Lumicera.com">www.Lumicera.com</a> 1-855-847-3553 (Members) 1-855-847-3554 (Prescribers)  FAX: 1-855-847-3558  MAIL: 2601 West Beltline Highway, Suite 302 Madison, WI 53713

For more information, please visit [FirstCare.com](http://FirstCare.com), email [provider\\_relations@FirstCare.com](mailto:provider_relations@FirstCare.com), or contact your provider relations representative.

FirstCare has established a Drug Covered List (DCL) to serve as a guide to help assist participating providers when prescribing medications to members. The specific drugs on the DCL, as well as guidelines for their use, are described in separate FirstCare formulary Handbooks. The DCL handbooks may be viewed at:

- Commercial Formulary - <http://www.FirstCare.com/FirstCare/media/First-Care/PDFs/RX/2016-FirstCare-Commercial-and-Self-Funded-Formulary.pdf>
- Marketplace/SHOP Formulary - <http://www.FirstCare.com/FirstCare/media/First-Care/PDFs/RX/2016-FirstCare-Commercial-and-Self-Funded-Formulary.pdf>

A copy of the DCL handbook is available at no cost to in-plan providers.

The FirstCare Pharmacy & Therapeutics Committee assigns drug placement on one of five tiered copayment levels\*. Assignment criteria include the drugs' safety profile, effectiveness, cost, and overall place of therapy:

Tier 1	Low cost generics (\$0-\$4, depending on group)
Tier 2	Generics
Tier 3	Preferred Brand AND Non-Preferred Generics
Tier 4	NON-Preferred Brand AND NON-Preferred Generics
Tier 5	Specialty and Injectable Drugs

*\*NOTE - Exceptions for groups/plans moving to 5-tier formulary:*

- Self-funded groups will have the option of using the new 5-tier formulary or remain on their current 4-tier structure
- All grandfathered and transitional plans will not move to the 5-tier structure
- Formulary changes adopted by the Pharmacy & Therapeutics (P&T) Committee will apply to all plans.

## 7.7 – Drugs Subject to Prior Authorization and Quantity Dosing Limitations

Drugs listed in the DCL handbook or found on our website flagged as “(PA) Prior Authorization Required” will require FirstCare approval before the drug will be covered. Following the prior-authorization process is required to determine coverage. Drugs listed as “(QL) Quantity Limitations” are established by benefit design following FDA guidelines and are not subject to medical review.

The process of obtaining a prior authorization should be followed by prescribing physicians and may be initiated online or via telephone. To initiate the request electronically, visit the Provider Portal at [FirstCare.com](https://www.firstcare.com).

# SECTION 8

## Dental & Vision Care

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### 8.1 – Dental

Some FirstCare members may have limited dental-related services (i.e., accidental dental services) depending on the benefits purchased by their employer. Since benefits can vary from plan to plan. We recommend that you contact FirstCare customer service at the phone number shown on the Important Contact Information guide in the INTRODUCTION section of this manual for verification prior to rendering any dental services.

### 8.2 – Vision

Routine vision benefits may be limited depending on the benefit design purchased by the FirstCare member's employer. Since benefits can vary from plan to plan, it is recommended that providers contact FirstCare customer service at the phone number shown on the Important Contact Information guide in the INTRODUCTION section of this manual for verification prior to rendering any routine eye exams or relations services.

*\*NOTE – Eye Examinations for Diabetic Members – FirstCare covers dilated funduscopy eye examinations to be performed by an ophthalmologist or therapeutic optometrist for all insured diabetic members, whether they have a vision rider or not.*

# SECTION 9

## Behavioral Health

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FirstCare defines “behavioral health” as both acute and chronic psychiatric and substance use disorders as referenced in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

### 9.1 – Covered Services

For all covered behavioral health services, please refer to the member’s benefit plan and/or call FirstCare’s Customer Service department.

FirstCare Health Plans provides utilization management for all levels of care including inpatient hospital services in freestanding psychiatric facilities for children and adults.

#### 9.1.1 – Behavioral Health Scope of Services

FirstCare will coordinate the behavioral health services, which include but are not limited to, the services listed in the Covered Services section. These services include acute, diversionary and outpatient services.

FirstCare will work with other participating behavioral health care practitioners, primary care providers, medical/surgical specialists, organizational providers, and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health. These programs may include:

- Educational programs to promote prevention of substance use
- Parenting skills training
- Developmental screening for children
- ADHD screening
- Postpartum depression screening
- Depression screening in adults

#### 9.1.2 – Primary Care Providers

- May treat mental health and/or substance use disorders within the scope of their practice and bill using the appropriate ICD diagnosis code(s);
- Inform members how and where to obtain behavioral health services: and
- Understand that members may self-refer to any behavioral health care provider without a referral from the member’s primary care provider.

### 9.2 – Coordination of Care

Behavioral health service providers are expected to communicate at least quarterly and more frequently, if necessary, regarding the care provided to each member with other behavioral health service providers and PCPs. Behavioral health service providers are required to refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. Copies of prior authorization/referral forms and other relevant communication between providers should be maintained in both providers’ files for the member. Coordination of care is vital to ensuring members receive appropriate and timely care. Compliance with this coordination is reviewed closely during site visits for credentialing and re-credentialing, as well as during quality improvement and utilization management reviews.

### 9.2.1 - Coordination between Physical and Behavioral Health

FirstCare is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated, and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation, or developmental disabilities.

FirstCare will designate behavioral health liaison personnel to facilitate coordination of care and case management efforts.

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below based on NCQA standards. All documentation must be clear and legible. Further, the treatment record should contain clear documentation using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications:

#### Member Identification Information:

The treatment record contains the following member information

- Member name and health plan identification # on each page
- Member's address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

#### Informed Member Consent for Treatment:

The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan
- Any prescribed medications
- Consent forms related to interagency communications
- For adolescents, ages 12-17, the treatment record contains consent to discuss substance use disorder issues with their parents.
- Signed document indicating review of member's rights and responsibilities

#### Medication Information:

Treatment records contain medication logs clearly documenting the following:

- All medications prescribed
- Dosage of each medication
- Dates of initial prescriptions
- Information regarding allergies and adverse reactions are clearly noted
- Lack of known allergies and sensitivities to substances are clearly noted

#### Medical and Psychiatric History:

Treatment record contains the member's medical and psychiatric history including:

- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

#### Substance Use Information:

Documentation for any member 12 years and older of past and present use of the following:



- Cigarettes
- Alcohol, and illicit, prescribed, and over-the-counter drugs

Adolescent Depression Information:

Documentation for any member 13-18 years was screened for depression

- If yes, was a suicide assessment conducted?
- Was the family involved with treatment?

ADHD Information:

Documentation the members aged 6-12 years were assessed for ADHD

- Was family involved with treatment?
- Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information:

- Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures
- All relevant medical conditions are clearly documented, and updated as appropriate
- Member's presenting problems and the psychological and social conditions that affect his/her medical and psychiatric status

A complete mental status evaluation is included in the treatment record, which documents the member's:

- Affect
- Speech
- Mood
- Thought control, including memory
- Judgment
- Insight
- Attention/concentration
- Impulse control
- Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
- Diagnoses updated at least on a quarterly basis

Treatment Planning

The treatment record contains clear documentation of the following:

- Initial and updated treatment plans consistent with the member's diagnosis, goals, and progress
- Objective and measurable goals with clearly defined timeframes for achieving goals or resolving the identified problems
- Treatment interventions used and their consistency with stated treatment goals and objectives
- Member, family, and/or guardian's involvement in treatment planning, treatment plan meetings, and discharge planning
- Copy of Outpatient Review Form(s) submitted, if applicable

Treatment Documentation:

The treatment record contains clear documentation using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications and the following:

- Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives

- Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality suicidality, or the inability to function on a day-to-day basis
- Referrals and/or member participation in preventive and self-help services (e.g. stress management)
- Relapse prevention (Alcoholics Anonymous, etc.) is included in the treatment record
- Member's response to medications and somatic therapies

#### Coordination and Continuity of Care:

The treatment record contains clear documentation of the following:

- Documentation of communication and coordination among behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities
- Dates of follow-up appointments, discharge plans and referrals to new providers

#### Additional Information for Outpatient Treatment Records:

These elements are required for the outpatient medical record:

- Telephone intake/request for treatment
- Face-sheet
- Termination and/or transfer summary, if applicable
- The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information:
  - Clinician's Name
  - Professional Degree
  - Licensure
  - NPI
  - Clinician signatures with dates

#### Additional Information for Inpatient and Diversionary Levels of Care:

These elements are required for inpatient medical records:

- Admission history and physical condition
- Admission evaluations
- Medication records
- Consultations
- Laboratory and X-ray reports
- Discharge summary and Discharge Review Form

#### Information for Children and Adolescents

A complete developmental history must include the following information:

- Physical, including immunizations
- Psychological
- Social
- Intellectual
- Academic
- Prenatal and perinatal events are noted

## 9.3 – Focus Studies

FirstCare has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services provided to FirstCare members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the member's overall

care. FirstCare will routinely monitor claims, encounters, referrals, and other data for patterns of potential over-and-under-utilization, and target areas where opportunities to promote the effective use of services exist.

## 9.4 – Utilization Management Reporting Requirements

Services	Authorization Required?	
<b>Outpatient Services</b>	Initial assessment	No
	Individual therapy	No
	Family therapy	No
	Group therapy	No
	Psychiatric evaluation	No
	Medication management	No
	Electro-convulsive therapy	Yes
	Psychological testing	Yes
<b>Higher levels of Care: Mental Health and Substance Abuse</b>	Intensive outpatient program	Yes
	Partial hospital program	Yes
	Residential treatment program	Yes
	Inpatient program	Yes
<b>Emergency Services (crisis)</b>	No prior authorization is required but the provider must notify FirstCare within 24 hours of the emergency.	

### 9.4.1 – Procedures for follow-up on missed appointments

Providers must document attempts to conduct follow-up calls within 24 hours to all members who have missed appointments.

### **Member discharge from inpatient psychiatric facilities need to have follow-up within 7 days from the date of discharge.**

FirstCare requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The follow-up/outpatient treatment must occur within seven days from the date of discharge. FirstCare providers will follow up with members and attempt to reschedule missed appointments.

### 9.4.2 – Treatment Record Reviews

FirstCare reviews member charts and uses data generated to monitor and measure provider performance in relation to the Treatment Record Standards.

The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, adolescent depression, and ADHD;
- Continuity and coordination with primary care providers and other providers’
- Explanation of member rights and responsibilities;
- Inclusion of all applicable required medical record elements as listed below; and
- Allergies and adverse reactions, medications, and physical exam

FirstCare may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of member’s medical record to FirstCare.

HIPAA regulations permit providers to disclose information without member authorization for the following reasons: “oversight of the health care system, including quality assurance activities.” FirstCare chart reviews fall within this area of allowable disclosure.

### **9.4.3 – Accessible Intervention and Treatment**

FirstCare promotes early intervention and health screening for identification of behavioral health problems and member education. Providers are expected to screen, evaluate, and treat and/or refer (as medically appropriate) any behavioral health problem.

Providers who need to refer members for further behavioral health care should contact FirstCare.

## **9.5 – Member Access to Behavioral Health Services**

### **9.5.1 – Routine, Urgent, and Emergency Services**

Routine Care: Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent

Urgent Behavioral Health Situation: A behavioral health condition that requires attention and assessment within 24 hours but that does not place the member in immediate danger to himself or others and the member is able to cooperate with treatment

Emergency Services: Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition, including post-stabilization care services.

### **9.5.2 – Accessibility Standards**

Appointment Standards and After-Hours Accessibility

Providers must offer the following service appointment availability:

General Appointment Standards:

- Routine/Non-Urgent Services within 14 calendar days, sooner if required
- Emergency Services Immediately, 24 hours per day, 7 days per week

Aftercare Appointment Standards:

- Inpatient and 24 hour diversionary service must schedule and aftercare follow-up prior to a member’s discharge

Type of Appointment/Service Appointment must be offered:

- Non-24 hour diversionary with 2 calendar days
- Psychopharmacology services/ Medication Management within 14 calendar days
- All other outpatient services within 10 business days
- Crisis Intervention Services must be available 24 hours per day, 7 days per week
- Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours.
- After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician agency-affiliated staff, crisis team, or hospital emergency room
- Outpatient providers should have services available Monday through Friday, from 8 a.m.

to 5 p.m., CST, at a minimum, evening and/or weekend hours should also be available at least 2 days per week.

- Interpreter Services under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

*\*NOTE - Providers are required to meet these standards, and to notify FirstCare if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider the waiting time access standard was not met.*

Emergency Transportation:

Emergency transportation by ambulance is reimbursable with limitation to basic life support (BLS) ambulance services provided to the member in two situations:

- Emergency
- Non-emergency for the severely disabled

Emergency transportation does not require authorization. Ambulance transports are covered for emergent transports and for transport from facility to facility. FirstCare staff will assist providers and members as needed to ensure appropriate transportation is available. Claims for ambulance transports should be submitted to the plan. FirstCare staff will assist providers and members as needed to ensure appropriate transportation is available.

# SECTION 10

## Claims Submission

### 10.1 – Filing a Claim

FirstCare’s goal is to provide prompt processing of claims. Clean claims, as defined by law, are processed by the carrier within the following payment deadlines from the date of receipt:

- 30 days – Electronic Claims
- 45 days – Non-Electronic (Paper Claims)
- 21 days – Electronic Pharmacy Claims

Claims that do not meet clean claim requirements will be denied, rejected, or considered deficient. Resubmission of rejected claims is subject to timely filing requirements. Appeals to denied claims are subject to appeal filing requirements.

Please refer to the ATTACHMENTS section, CMS 1500 (08-05) – Physicians and Non-Institutional Provider Data Element Requirements for Non-Electronic Clean Claims for more specific detail on required fields and elements.

FirstCare will scan paper claims to improve the accuracy and efficiency of processing the claims. Providers are encouraged to file claims that meet the elements required to enable scanning. Failure to do so results in delays in claims processing.

#### Paper Claim Submission Guidelines

DO	DON'T
Use original red forms	Submit a copy of the original form
Use black ink for data entered on the claim	Use red ink- this color cannot be read by the OCR system
Print/Type data on claims	Use mixed fonts on the same form
Use a eight-digit date format (01022016)	Use dashes or slashes on date field
Make sure data prints within the defined boxes on the claim form	Submit more than six lines on the CMS-1500 (08-05) claim form
Select a standard font with clear characters (Times Roman works well)	Use italics or script fonts
Ensure print on claim/attachment is dark, clear, and legible. Photocopies and faxed copies with small print are often blurry and unreadable. Circle information on attachments to identify critical criteria	Highlight information on the claim – highlighting is not visible to the OCR system
Use ALL CAPITAL LETTERS	Use correction fluid
Use laser printer for best results. Characters printed by dot matrix or impact printer may be difficult to “read” by OCR	Use proportional fonts (Courier is a good example of a font that is not proportional)

DO	DON'T
Use white correction tape for corrections	Put notes on the top or bottom of the claim form
Submit notes on 8 ½ " x 11" paper	Fold claims forms
Replace printer toner often	Print slashes over the zeros
	Submit handwritten forms

## 10.2 – FirstCare Provider ID Number Requirements

### 10.2.1 – FirstCare Provider ID Numbers

FirstCare assigns unique provider ID numbers to each contracted provider which includes physicians, ancillaries, and facilities. This nine (9) digit number is used by FirstCare to identify providers in all areas of interaction between the provider and FirstCare, such as accessing of FirstCare's provider web portal.

Providers are reminded that their provider ID numbers should be made available to all appropriate office and billing services staff that require access to FirstCare's automated services.

*\*NOTE – Contact Customer Service to verify your FirstCare Provider ID number(s). For more information, please refer to Section 2, Provider ID Numbers & Automated Services*

### 10.2.2 – National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

The National Provider Identifier (NPI) is a unique, ten-digit numeric identifier assigned to covered health care providers by the National Plan and Provider Enumeration System (NPPES). This identifying number does not carry any information about health care providers, such as the state in which they practice or their provider type or specialization.

NPI is required on all claims submitted to FirstCare:

- Individual NPI – Box 24J
- Organizational NPI – Box 33A

## 10.3 – Electronic Claims Submission

### 10.3.1 – Advantages to Electronic Claim Filing

FirstCare recognizes the importance of having medical claim submissions processed accurately and promptly. Therefore, it is strongly encouraged that providers file claims electronically.

Benefits of filing via electronic media include:

- Decrease in turnaround time for payment;
- Streamline the billing process;
- Reduction in costs for filing (i.e. postage costs, forms cost, printing costs, labor);
- Confirmation of receipt;
- Prompt identification of omitted/incorrect information; and
- Ability for the provider to quickly track number of rejected versus accepted claims

### 10.3.2 - Initiating Electronic Claim Filing

To begin submitting your claims electronically contact either of the following electronic claim clearinghouses:

- Availity (formerly THIN)  
1-800-282-4548 Provider Automation Help Line  
FirstCare Payor ID: 94999  
Commercial Insurance Type Code: F
- HealthSmart (Formerly CareVu)  
1-888-744-6638  
FirstCare Payor ID: 94999
- Claim Shuttle  
1-602-439-2525  
FirstCare Payor ID: 94999
- Emdeon (formerly WebMD)  
1-800-845-6592 Emdeon is an intermediary to Availity  
FirstCare Payor ID: TH003

Availity, HealthSmart, and Claim Shuttle serve as the clearing houses for electronic claims submission. The unique FirstCare Provider ID number is required on electronically (and paper) submitted claims. Contact Customer Service if you need to verify your assigned FirstCare Provider ID.

### 10.3.3 - Validating Electronic Claims and Notices of Receipt

The contracted clearing houses edit electronic claims received for file format and required fields only. The clearing houses do not perform validation of the provider's claim information. Upon completion of the editing, the clearing house will send the provider a confirmation notice for the batch indicating whether the batch was accepted.

This confirmation provides acknowledgment that the clearing house is in receipt of the claims. This confirmation does not verify the receipt of the claims by FirstCare. Clearing houses also have the ability to accept or reject claim records on an individual basis.

Rejected claims and/or batches are the responsibility of the provider to correct and resubmit. The clearing house confirmation notice will not service to support any claim appeals to FirstCare should one become necessary (i.e., for filing deadlines)

A sample copy of the Clearinghouse Report is available in the ATTACHMENTS section of this manual. Please note that this report from the clearinghouse is not the same as the FirstCare confirmation report.

The clearinghouse submits the accepted claims to FirstCare and upon receipt of them from the clearinghouse; FirstCare runs the claims through an edit program for format and detailed validity check. Each claim will either be accepted or rejected in its entirety, not on a line by line basis, based upon information provided in the service lines. FirstCare will provide a confirmation report to the clearinghouse of both accepted and rejected claims.

It is the provider's responsibility to retrieve the FirstCare confirmation notice from the clearinghouse electronic mailbox or bulletin board system. The clearinghouse archives FirstCare confirmation reports for 60 days and is made available for reloading during the 60 day time



period. Providers unsure of how to send or retrieve items from their electronic mailbox or bulletin board system should contact their clearinghouse or software vendor for instructions.

\*NOTE - The FirstCare confirmation report is the only acceptable acknowledgment of receipt of FirstCare of an electronically filed claim. A sample copy of the FirstCare Report is available in the ATTACHMENTS section of this manual

Providers are encouraged to reconcile FirstCare confirmation receipts and EOPs prior to submitting a duplicate claim. Providers are also encouraged to verify the claim status on the web portal. Appeals to adjudicated claims are accepted in 837 format, via the web portal, or on paper.

Claims that require attachments (i.e., Third Party Payment EOBs, operative reports) are not accepted electronically. The claim should be submitted as a paper claim with attachment(s).

#### **10.3.4 - Transmission Frequency**

Electronic claims can be transmitted daily; however, claims transmitted on non-business days, i.e., Saturday, Sunday, and nationally recognized holidays are not downloaded into FirstCare's claims processing system until the following business day.

#### **10.3.5 - Resolving Technical Questions**

For issues or questions concerning your clearinghouse confirmation notices contact either your software vendor or the electronic claim clearinghouse. Please have your submitter ID ready when contacting the electronic claim clearinghouse.

For technical questions concerning your FirstCare confirmation report, contact FirstCare Customer Service Department:

FirstCare  
Customer Service Department  
1-800-431-7737

## **10.4 - Paper Claims Submission**

Although we recommend electronic filing, you may occasionally need to submit your claims on paper. To help expedite the process, we've implemented new technology that electronically scans, sorts, and stores your paper claims. This reduces manual keying errors and improves the response time on your paper claims.

### **10.4.1 - General Requirements**

FirstCare requires paper claims to be filed on a UB-04 form or a CMS-1500 form with accurate and valid information. Paper claims received on non-standard claim forms will be returned to the provider for resubmission on the appropriate claim form. In order to facilitate prompt processing and payment of claim, all required sections of the UB-04 and CMS-1500 should be completed.

Please refer to the following tables in the ATTACHMENTS section for more specific detail on required fields and elements.

- *CMS-1500 (08-05) - Physicians and Non-Institutional Providers Data Element Requirements for Non-Electronic Clean Claims; or*
- *UB-04 - Institutional Providers Data Element Requirements for Non-electronic Clean Claims*

FirstCare will not accept super-bills or similar submissions as valid claims. Claims should be computer generated or typed. Hand written claims will be rejected without being entered into the claim system.

#### **10.4.2 - Claim Signature Requirements**

When filing a paper claim, the provider representative's handwritten signature (or signature stamp) must be in the appropriate block of the CMS-1500 (08-05) -Box 31.

Providers delegating signature authority to office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

Claims prepared by computer billing services or office-based computers may have "Signature on File" in the signature block along with the printed name of the provider. For claims prepared by a billing service, the billing service should retain a letter on file from the provider authorizing the service.

Initials are only acceptable for first and middle names. The last name should be spelled out.

#### **10.4.3 - Where to Submit Paper Claims**

For paper claims, mail to:

FirstCare Health Plans  
Attn: Claims Department  
P.O. Box 211342  
Eagan, MN 55121

## **10.5 - Claims Filing Deadlines**

### **10.5.1 - Initial Claim Filing**

Claims should be submitted within 95 days following the date on which the covered health services were rendered, or for continuous covered health services, for which one charge will be made, the date on which the covered health services are completed by the provider. Claims not received by FirstCare within 95 days will be denied and considered waived by the provider. These services are not to be billed to the member for payment. It is recommended that hospitals provide current insurance information to hospital-based physicians when available to allow those physicians to file claims to FirstCare in a timely manner.

For hospital inpatient stays and continuous services (i.e., PT/OT or chemotherapy) that exceeds 30 days, FirstCare requests that the hospital split the bill every 30 days. Cycle billing is recommended to avoid denials for beginning dates of service that fall beyond the 95 day filing deadline.

Billing for OB services should occur after the date of delivery using the appropriate CPT code(s) and within 95 days of the date of delivery.

### **10.5.2 - Initial Claim Filing When There is Other Insurance**

If the member has other insurance and that insurance is the primary payor, the claims is required to meet the following criteria:

- Claims should be filed with FirstCare within 95 days of the date on the primary payor's Explanation of Benefits (EOB) or Remittance Advise (RA) not to exceed 18 months of the date of service; and
- The primary EOB is not required to file for secondary payment. The claim may be filed with the primary paid amount within 18 months of the date of service. FirstCare requires ~~the provider to adhere to the primary payor's criteria (e.g. filing deadlines).~~

*\*NOTE - FirstCare payment as a secondary payor will not exceed the amount payable under the FirstCare contract.*

### **10.5.3 - Exceptions to the Filing Deadline**

Providers who fail to meet the filing deadline may request reconsideration of their claim through the appeal process. FirstCare recognizes there are instances where extenuating circumstances may result in missing the filing deadline (e.g., theft or destruction of provider records, complete system failure). In these instances, providers should submit a written appeal to the FirstCare Claims Department/Appeals Unit. FirstCare may waive the filing deadlines at its sole discretion.

*\*NOTE - If an exception to the filing deadline is granted by FirstCare and multiple claims are involved, the provider should submit all claims as a batch to the Claims Department/Appeals Unit and not just several claims at a time.*

## **10.6 - Customer Service Unit**

The goal of the Customer Service Unit is to provide quality service to our provider community and provider clear explanations regarding status and detail for processed claims.

To reach the Customer Service Unit for claim inquiries, please call the phone numbers shown on the Important Contact Information in the INTRODUCTION section of this manual.

Hours: Monday through Friday, 8 a.m. to 5 p.m.

All after calls will be directed to an answering service. Incoming phone messages will be responded on the next business day.

The Customer Service Unit is available to assist with inquiries on claim status (via phone or fax). Providers who elect to inquire by phone must be ready to provide the following information:

- Member number
- Member name
- Date of service
- Provider's name and Tax Id number

Providers should wait 45 days from the date of the claim was sent to FirstCare before inquiring as to the status of the claim. If an immediate answer is unavailable about the claim in question, the Customer Service Unit staff will research the issue and call the provider back with the results of their research.

If the issue is not resolved after working through the Customer Service Department, the provider is advised to contact his or her Provider Relations representative for assistance.

For most efficient service, FirstCare providers are encouraged to check claims status by logging on to the Provider Portal at [FirstCare.com](https://www.firstcare.com).

FirstCare will only accept telephone appeals when the error in the processing was caused by FirstCare. All other appeals must be submitted in writing to the FirstCare Appeal Unit for reconsideration. For additional information, see Appeal Guidelines in this section of the manual.

## 10.7 – Checking the Status of a Claim

### 10.7.1 – How to Inquire About a Claim

If a provider wishes to inquire on the status of a submitted claim, or if there is a question regarding a claim denial or amount paid, claim inquiries may be made in any of the following ways:

- Log on to [FirstCare.com](https://www.firstcare.com) and access the Provider Web Portal; or
- Call the Customer Service Department.

## 10.8 – Appeal Guidelines

A claim appeal is defined as a formal written or verbal request from a physician/provider for reconsideration of a claim already processed by FirstCare. All appeals of denied claims and requests for adjustments on paid claims must be received by FirstCare within 90 days from the initial date of payment/EOP on which the claim appears. Appeals received after the 90 day filing limit will be denied and the original claim determination will be upheld.

### 10.8.1 – Electronic Appeals

To ensure that claim appeals are processed accurately and in a timely manner, providers are encouraged to submit appeals electronically through the Provider Web Portal. This eliminates the need to call Customer Service, fax, or mail an appeal within the required information needed to process appealed claims correctly. This feature also allows providers the ability to prevent claim denials by submitting corrected or additional information via the Web Portal prior to the denial.

### 10.8.2 – Written Appeals

If a provider wishes to submit a written appeal of a claim decision with FirstCare, one of the following steps should be taken:

Submit an Appeal Form or a formal letter of appeal that includes the following information:

- Claim number,
- Member's name and ID number,
- Date of service,
- Billed amount,
- Copy of the EOP or claim (optional)

Provide corrected or missing information (i.e. diagnosis code, procedure code, etc.) and/or attach any appropriate documentation (i.e. referral copy, operative report, etc.) needed to support the appeal.

Providers may find a sample of the FirstCare Claims Department Submission Form in the ATTACHMENTS section of this provider manual for use when appealing a previously adjudicated claim. Submit the appeal to the FirstCare Claims Department to:

FirstCare Health Plans  
Attn: Claims Department  
P.O. Box 211342  
Eagan, MN 55121

#### 10.8.4 – Appeals Due to Corrected Billing/Corrected Charges

When a claim is being re-submitted as a corrected billing or because of late charges, the claim should be submitted as an appeal to the original claim, not submitted as a new claim. The corrections should be clearly indicated on the claim form and the claim should be marked “Corrected Claim” or “C” to avoid being denied as a duplicate claim. On the CMS-1500, mark “C” in field 10d (reserved for local use) and on the UB-04, include a Type of Bill ending in “7”.

If additional money is due to the provider, reimbursement will be made during the normal processing and payment cycle. If an overpayment exists, a refund will be sent to the provider.

#### 10.8.5 – Appeals/Exceptions for Services Denied as Past Filing Deadlines

FirstCare physician/provider contracts state that claims must be filed within 95 days from the date of service. FirstCare encourages providers to check the status of a claim by either using the FirstCare Provider Service Web Portal at [FirstCare.com](http://FirstCare.com) or by contacting Customer Service at 1-800-461-3742, if you have not received payment or denial information within 45 days from the date of submission.

FirstCare will accept the following documentation from the provider in support of appeals for claims denied as past filing deadline:

- FirstCare’s electronic filing confirmation report that indicates the claim was accepted by FirstCare. A vendor’s confirmation notice (including from Availity) is not acceptable proof that FirstCare has received a provider’s claims.

*\*NOTE – If the claim was rejected, it is the provider’s responsibility to re-file within the filing deadline. Filing deadlines are applicable to rejected claims.*

Provider(s) that experience computer issues or lost data should contact the Customer Service Unit for assistance in filing your claims.

#### 10.8.6 – Services Denied for Other Primary Coverage

If a claim is submitted for a member who has other primary coverage but an Explanation of Benefits (EOB) or the primary paid amount from the primary carrier is not submitted, it will be denied.

When a claim is denied because of other coverage, re-submit a copy of the claim with a copy of the primary carriers’ Explanation of Benefits (EOB) or the primary paid amount as an appeal. The appeal deadline of 90 days from the date of the primary carriers’ EOB applies when submitting secondary claims. Refer to Appeal Guidelines.

### 10.8.8 – Services Denied as not Prior Authorized

Before appealing services denied for no prior authorization, the physician/provider should review for the following:

- The date span of the referral compared to the actual dates of service;
- The number of visits performed during the referral time span, compared to the number of visits approved; and
- The provider of service on the referral.

If after verifying the above items, the provider believes the claim was incorrectly processed, an appeal should be submitted with a copy of the referral.

### 10.8.9 – Appeals to Medical Management Determinations

Providers must follow the complaint and appeal guidelines established in the COMPLAINT AND MEDICAL APPEAL PROCEDURES section of this manual.

## 10.9 – Overpayments

When FirstCare identifies an overpayment, a letter is sent to the physician/provider that identifies the overpayment (see sample of Refund Request Letter in the ATTACHMENTS AND FORMS SAMPLES section. This letter requests a refund of the overpaid amount within forty-five (45) days. If no refund from the physician/provider is received within forty-five (45) days, the money is recouped from the next claims payment.

Failure to respond during this period triggers recoupment. It is the provider's responsibility to contact FirstCare if they disagree with the overpayment request.

When the provider identifies an overpayment, the provider should contact FirstCare's Customer Service Unit for assistance in determining if an overpayment did indeed occur. If a true overpayment did occur, the provider should proceed with refunding the money back to FirstCare by following the process in the next paragraph.

Providers may refund the overpaid dollars directly to FirstCare by sending a check along with a Refund Submission Form. This will expedite the processing time to post the refund check. Mail the form to:

FirstCare Health Plans  
Attn: Claims Department  
PO Box 211342  
Eagan, MN 55121

FirstCare requests overpayment refunds according to the time frame indicated in the Participating Provider contract. In cases when it is necessary, the same refund process and timeliness outlined above will apply.

If an overpayment was made because FirstCare is not the primary payer, the payment made by FirstCare must be refunded in full. Upon receipt of the primary payer's EOB, FirstCare will reprocess the claim issuing the corrected payment amount as the secondary payer.

## 10.10 – Coordination of Benefits (COB)

Coordination of Benefits (COB) is a function that audits for the non-duplication of benefit reimbursement. It is designed to ensure that total reimbursement does not exceed the billed amount or FirstCare's maximum allowable rate.

The rules establishing the order of benefit determination between FirstCare and any other Health Care Plan covering the member on whose behalf a claim is made are as follows:

- If a Healthcare Plan does not contain a coordination of benefits provision, that Healthcare Plan must be primary. The primary Healthcare Plan pays benefits before the secondary Healthcare Plan pays. When FirstCare is determined to be the secondary plan based on the coordination of benefits rules described in this section, then FirstCare will be liable only for the amount due under the secondary plan rules, regardless of whether or not payment is actually made by the primary plan.
- Whenever a Healthcare Plan contains a coordination of benefits provision, benefits will be determined according to the Rules of Coordination below.
- When a FirstCare member has other coverage that is primary, FirstCare will provide secondary coverage only when those services are pre-authorized through our Medical Services Department. It is the member's responsibility to contact the Customer Service Department to assure prior authorization has been obtained for any referral to a physician, a health care professional, or a facility.

### 10.10.1 – Rules of Coordination

Rules establishing the order of benefit determination as to a member's claim for the purposes of this section are as follows:

### 10.10.2 – Non-Dependent/Dependent

The benefits of the Healthcare Plan which covers the member as a subscriber are determined before those of the Healthcare Plan which covers the member as a dependent except, if the member is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- Secondary to the Healthcare Plan covering the member as a dependent; and
- Primary to the Healthcare Plan covering the member as other than a dependent (i.e. retired employee), then the benefits of the Healthcare Plan covering the member as a dependent are determined before those of the Healthcare Plan covering that member as other than a dependent.

### 10.10.3 – Dependent Child/Separated or Divorced

If two or more Healthcare Plans cover a member as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. Healthcare Plan of the parent with custody of the child;
2. Healthcare Plan of the spouse of the parent with custody; and
3. Healthcare Plan of the parent not having custody of the child

However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expense of the child and the entity obligated to pay or provide the benefits of the Healthcare Plan of that parent has actual knowledge of those terms, the benefits of the Healthcare Plan are determined first. The Healthcare Plan of the other parent shall be the secondary Healthcare plan.

### **10.10.5 – Joint Custody**

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the Healthcare Plans covering the child shall follow the order of benefit determination rules outlined above in the Dependent Child/Parents Not Separated or Divorced provision.

### **10.10.6 – Active/Inactive Employee**

The benefits of a Healthcare Plan which covers a member as an employee who is neither laid off nor retired, are determined before those of a Healthcare Plan which covers that member as a laid off or retired employee or as that employee's dependent. If the other Healthcare Plan does not have this rule, and if, as a result, the Healthcare Plans do not agree on the order of benefits, this rule is ignored.

### **10.10.7 – Continuation Coverage**

If a member whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Healthcare Plan, the following shall be the order of benefit determination:

- The benefits of a Healthcare Plan covering the member as a subscriber (or as that subscriber's dependent); and
- The benefits under the continuation coverage.

If the other Healthcare Plan does not have the rule described above, and if, as a result, the Healthcare Plans do not agree on the order of benefits, this rule is ignored.

### **10.10.8 – Longer/Shorter Length of Coverage**

If none of the above rules determines the order of benefits, the benefits of the Healthcare Plan that covered a subscriber or member longer are determined before those of the Healthcare Plan that covered that member for the shorter term.

*\*NOTE – All authorization, referral, and benefit restrictions apply, even when FirstCare is the secondary payer*

### **10.10.9 – Employer Hospitals**

Benefits, provided directly through a specified hospital of an employer, and in all cases shall be primary before the benefits of the member's FirstCare Evidence of Coverage.

### **10.10.10 – Military Hospitals**

Services and benefits for military service connected disabilities for which a member is legally entitled and for which facilities are reasonably available, in all cases shall be primary before the benefits of the member's FirstCare Evidence of Coverage.

### **10.10.11 – Release of Information**

For purposes of the member's FirstCare Evidence of Coverage, FirstCare may, subject to applicable confidentiality requirements, set forth the member's company or other organization necessary information to implement these Coordination of Benefit provisions. Any member claiming benefits under their FirstCare Evidence of Coverage must furnish to FirstCare all information deemed necessary by it to implement these Coordination of Benefits provisions.

### **10.10.12 – Rules of Coordination of Benefits for Members Eligible for Medicare**

FirstCare will coordinate benefits for members who are eligible for coverage under Medicare Part A and/or Part B (whether or not the member is enrolled or has applied for Medicare) as follows:



- For the member and the member’s spouse age 65 or older, FirstCare shall be the primary payor, if an employer with 20 or more employees actively employs the member.
- For members who have become entitled to Medicare benefits solely on the basis of being diagnosed as having end-stage renal disease, benefits shall be determined in accordance with Medicare guidelines.
- For members who are entitled to Medicare based on disability, FirstCare shall be the primary payor if an employer with 100 or more employees actively employs the member or his/her family member.

FirstCare will be the secondary payor to Medicare whether or not the member enrolls in Medicare:

- When the member age 65 or older and is no longer actively employed and is not covered by a group health plan of a working spouse.
- When a member age 65 or older is actively employed by an employer with fewer than 20 employees.
- When a member age 65 or older is covered through a group health plan of a spouse and is actively employed by an employer with less than 20 employees.

When Medicare benefits are primary, claims must be filed with Medicare first for determination of benefits. The member is responsible for sending the Medicare explanation of benefits form to FirstCare for determination of benefits under this Evidence of Coverage.

FirstCare will coordinate benefits secondary to Medicare in the following manner:

- Medicare Part A: FirstCare will pay all of the Medicare Part A hospital deductible.
- Medicare Part B: If the provider accepts the Medicare assignment, FirstCare will pay the difference between the Medicare allowed amount and the Medicare paid amount. If the provider does not accept the Medicare assignment, FirstCare will pay the difference between the FirstCare contracted amount and the Medicare paid amount.

## 10.11 – Medicare Reimbursement Methodology

When the member has other coverage such as Medicare, the following rules may be applied by FirstCare in determining order of benefits. All scenarios are not captured in the matrix below:

Reimbursement Methodology	Condition	Primary Payor	Secondary Payor
Age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	The employer has less than 20 employees	Medicare	FirstCare
	The employer has 20 or more employees	FirstCare	Medicare
Has an employer retiree plan and are age 65 or older	Eligible for Medicare	Medicare	FirstCare
Disabled and covered by a large group health plan from your work, or from family member who is working	The employer has less than 100 employees	Medicare	FirstCare
	The employer has 100 or more employees	FirstCare	Medicare
Reimbursement Methodology	Condition	Primary Payor	Secondary Payor

Have End Stage Renal Disease (ESRD) permanent kidney failure. Group health coverage including retirement plan	First 30 months of eligibility or entitlement to Medicare	FirstCare	Medicare
	After 30 months	Medicare	FirstCare
Are covered under Worker's Compensation due to a job related injury	Eligible for Medicare	Worker's compensation for related injuries	Medicare
Have Black Lung Disease and covered under the Federal Black Lung Program	Eligible for Federal Black Lung Program	Federal Black Lung Program for related services	Medicare
Been in an accident where no-fault or liability insurance is involved	Eligible for Medicare	No-Fault Liability insurance for accident related services	Medicare
Age 65 or over OR disabled and covered by Medicare and Cobra coverage	Eligible for Medicare	Medicare	Cobra

## 10.12 - Subrogation

Subrogation is a procedure under which FirstCare can recover from third parties the full or some proportionate part of benefits paid to a member. For example, should a member who has received benefits under a state's statutory plan covering disability benefits enter into litigation or make a claim against a third party, FirstCare has a right to place a lien against any benefit the third party action may provide.

FirstCare retains the First Recovery Group to recover benefits paid by FirstCare for services payable by a third party. Examples of when the First Recovery Group may be involved in recovery include the following situations:

- Motor vehicle accidents;
- Injuries recoverable by a homeowner's policy;
- Personal injuries; and
- All other injuries not related to workers compensation.

Members may seek provision of direct health services within the FirstCare provider network and according to their benefits as provided for in their Evidence of Coverage.

Providers should give any necessary treatment and follow all policies and procedures established by FirstCare as they normally would.

Claims processed by FirstCare as they are submitted; any adjustments will be made once the First Recovery Group has completed proper investigation of any third party liability. When FirstCare receives reimbursement from the First Recovery Group for charges paid on a FirstCare member's behalf, claims paid in the system will be adjusted to reflect that a recovery was received by a third party carrier.

## 10.13 – Motor Vehicle Accidents

Members are instructed to seek care within the FirstCare provider network and use their FirstCare benefits as usual. Providers should give any necessary treatment and follow all policies and procedures established by FirstCare as usual.

Physician/provider should bill FirstCare for such services. In the event that a member receives services due to the act or omission of another person or entity, then FirstCare is entitled to receive and will be fully subrogated to all rights of recovery (including, but not limited to, court costs and reasonable attorney fees).

*\*NOTE – If a provider chooses to file his or her own lien, the claim(s) should not be filed with FirstCare as this voids the provider's lien. If the provider withdraws the lien, the provider must observe normal FirstCare filing deadlines.*

## 10.14 – Work Related Injuries

Workers' Compensation is a state-governed system designed to address work-related illnesses and/or injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from the worker's job-related injury or disease, regardless of who is at fault. A work related illness or injury is defined as an illness or injury identified as occurring while on the job, and/or is job related.

Work related injuries are not a FirstCare HMO/PPO covered benefit; however, members are entitled to receive an evaluation by a FirstCare provider to determine if the injury or condition is work related. Providers must make every attempt to determine if the member has a work related illness or injury and to provide that information to FirstCare.

While the issue of whether or not the illness or injury is work-related is still being determined, FirstCare providers may continue to treat the member. FirstCare providers must proceed by following all referral and prior authorization requirements of FirstCare. Those services that do not meet the necessary requirements will not be the responsibility of FirstCare.

In the event services are provided or payments are made by FirstCare for services that are later determined to be work related, FirstCare shall have the right to recover Usual, Customary, and Reasonable Charges for such services so provided. FirstCare will also deny any future claims related to the condition.

If the condition is contested by the workers' compensation carrier and the member is in need of care, FirstCare will provide for the member's care according to FirstCare plan provisions until a determination has been made by the worker's compensation carrier.

FirstCare will request a letter from the workers' compensation carrier stating that the case is contested.

In the event the case is denied, FirstCare will request a letter of denial from the workers' compensation carrier.

## 10.15 – Fraud, Waste, Abuse, and HIPAA

FirstCare is dedicated to maintaining excellence and integrity in all aspects of its operations and its professional and business conduct. FirstCare is committed to high ethical standards and compliance with all applicable governing laws, rules, and regulations, including the prohibition of misleading sales tactics. FirstCare also recognizes that the detection, investigation, and prevention of fraud, waste, and abuse are vital to maintaining an affordable health care system in this state and country.

Accordingly, FirstCare has developed and implemented a Compliance Program and a Fraud, Waste, and Abuse Plan to effectively articulate and demonstrate the organization’s commitment to legal and ethical conduct and to become a function of daily operations. Compliance efforts are designed to establish an organizational culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, federal and state health care program requirements (e.g., the Medicare and Medicaid programs), and FirstCare policies and procedures. These efforts also intend to improve operational quality, to ensure the provision of high quality care, and to reduce fraud, waste, and abuse.

FirstCare has established the following mechanisms for reporting any potential compliance violation, including concerns of suspected fraud, waste and abuse, misleading sales tactics, or inappropriate disclosure of protected health information. Reports of potential violations made by employees, agents, contractors, providers, and enrollees are maintained in a confidential manner. These reporting mechanisms are available 24 hours a day, 7 days a week. Reports may also be made anonymously.

	<b>Compliance Hotline:</b>	<b>1-866-399-8161</b>
	<b>Compliance Hotline website:</b>	<a href="https://www.FirstCare.EthicsPoint.com">FirstCare.EthicsPoint.com</a>
	<b>Compliance email:</b>	<a href="mailto:Compliance@FirstCare.com">Compliance@FirstCare.com</a>
	<b>SIU Email:</b>	<a href="mailto:SIUfraudreports@FirstCare.com">SIUfraudreports@FirstCare.com</a>

You may also contact the Texas Department of Insurance to report your concerns of suspected fraud, waste, or abuse at 1-800-252-3439 or [www.tdi.texas.gov/fraud/index.html](http://www.tdi.texas.gov/fraud/index.html).

For more information about reporting fraud, please visit the FirstCare website and refer to [www.FirstCare.com/en/Important-Information/Identifying-Reporting-Fraud](http://www.FirstCare.com/en/Important-Information/Identifying-Reporting-Fraud).

For more information about how FirstCare maintains the privacy of your health information, please visit the FirstCare website and refer to [www.FirstCare.com/en/Important-Information](http://www.FirstCare.com/en/Important-Information).

*\*NOTE - A provider delegating signature authority for claims preparation to a member of the office staff or to a billing service remains responsible for the accuracy of all information on a claim submitted for payment.*

## 10.16 – Coding

FirstCare requires use of standard CPT, ICD-10, and HCPCS coding, unless otherwise directed by FirstCare as outlined in this manual or participating provider contract.

Diagnosis codes should be billed with the highest degree of specificity. Use fourth and fifth digits whenever applicable. If a diagnosis code requires a fourth or fifth digit, and is not coded as such, the claim will be denied.

### 10.16.1 – New and Deleted Codes

Providers must bill for services using current CPT, ICD-10, and HCPCS codes and modifiers that are appropriate for the service provided. Annually, as CPT and HCPCS codes are added and deleted from the American Medical Association (AMA) and CMS listing of valid codes, FirstCare’s policy will be the following:

- New codes are accepted by FirstCare the beginning of the year on which they become effective
- Services coded with deleted codes will be denied if they are submitted for any date(s) of service of the year the code(s) is deleted from the CPT or HCPCS manual
- FirstCare will only accept HIPAA approved code sets

### 10.16.2 – Unlisted Codes

FirstCare will accept a provider’s use of an unlisted code only when no valid CPT or HCPCS code is available, or when the provider’s contract with FirstCare specifically requires use of the unlisted code. Except as noted above, any claim submitted for a service that is CPT coded as an “unlisted” procedure or service must be filed with a detailed description of the procedure or service being billed. Failure to provide a description will result in the claim being denied. Additional documentation may be requested if the description provided is not sufficient.

For unlisted supplies (e.g. HCPCS code E1399), the claim should include a detailed description of the supply. The description can be written in detail on the claim form or provided as an attachment (i.e. copy of the supply invoice).

If billing for an unlisted drug, physician/provider must include a National Drug Code (NDC) number, a detailed description, and the dosage given.

If a claim is filed using an unlisted code and a valid code is available, unless specifically allowed by physician/provider contract, FirstCare will deny the service or supply and the claim for that service or supply will need to be re-filed by the physician/provider.

### 10.16.3 – Service Location Codes

FirstCare accepts valid CMS place of service codes, with one addition, location code 98, which is a FirstCare “homegrown” code used to specify a free-standing physical therapy provider. Consultations and professional services rendered in a hospital setting will be processed according to the level of care authorized.

Improper coding, including procedure and location coding may result in denial of the claim. Refer to location code matrix below:

Place of Service	Description
3	School
4	Homeless Shelter
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care
21	Inpatient Hospital
22	Outpatient
23	Emergency Room
25	Ambulatory Surgery Center/ Day Surgery Unit (DSU)
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Intermediate Care Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
49	Independent Clinic
Place of Service	Description
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility/Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Lab
98	Physical Therapy Facility
99	Other Unlisted Facility

## 10.17 – Modifiers

Physicians/Providers should use modifiers to indicate that a service provided to the member has been altered by some special circumstance(s) while the code description itself has not changed.

FirstCare requires providers to bill with appropriate American Medical Association (AMA) and/or Medicare two digit numeric or alphanumeric character modifiers.

When processing claims, FirstCare will evaluate the appropriateness of the modifiers used based on the coding review logic of the iCES™ software. The iCES™ software evaluates the modifier used applying various AMA, CMS, and medical board guidelines. If the iCES™ software determines that a modifier was used inappropriately, the specific service or services may be denied by FirstCare.

For additional information, review the requirements specified in this section and under iCES™ (Ingenix Claim Editing Systems).

The use of a modifier alone does not ensure payment if other FirstCare criteria are not met. Some services that are identified by modifiers also require prior authorization and/or supporting documentation. See Modifier Requirements Table in the ATTACHMENTS section for further information on modifiers.

The following information outlines FirstCare guidelines and/or requirements when using any of the following modifiers:

Modifier(s)	Guidelines
25	Required for significant E&M service by same physician (post-operative)
26, TC	26, TC Certain procedures have both technical and professional components (x-ray, pathology, etc.) as defined by CMS. FirstCare requires a provider performing only one (1) of the two (2) components to use the appropriate modifier
50	FirstCare will only accept Medicare standard coding for bilateral surgical procedures (100xx to 69999). Please bill bilateral surgeries as specified below to ensure correct reimbursement: On a single line with a quantity of one (1) and modifier 50, or On two (2) separate lines with a quantity of one (1) for each line, and a modifier RT on one service line and modifier LT on the other line
51	This modifier should not be used to indicate procedures that are considered components of or are incidental to the primary procedure
LT, RT	Required by FirstCare when billing hearing aids. May also be used to bill for bilateral procedures
P1-P6	Required when submitting anesthesia codes
KR	When billing only partial month for DME rentals. The count should indicate the number of rental days.
80, 81, 82	Assistant surgeons (MD, DO, or DDS) must file with one of these modifiers
81, AS	Required for Nurse Practitioners (NP), Physician Assistants (PA), or Certified Registered Nurse First Assistants (RNFA) acting as an Assistant Surgeon.

## 10.18 – Special Billing Situations

### 10.18.1 – Accidental Dental

Access FirstCare’s website at [FirstCare.com](http://FirstCare.com) to verify benefits, or contact the Customer Service Department at the phone number shown on the Important Contact Information guide located in the INTRODUCTION section of this manual. Providers may also refer to the member’s Evidence of Coverage (EOC) to verify covered service and for the applicable office visit copayment amount.

### 10.18.2 – After-Hours Care

After-hours charges are payable when services are rendered after posted hours in the office setting only. The provider must bill using CPT 99050 and location code 11 or 72. Use of any location code other than those specified will result in denial of the charge.

### 10.18.3 – Assistant Surgeon Billings

FirstCare has adopted guidelines for determining when an assistant is appropriate to use for surgery. Approved procedures are included in our Assistant Surgeons List and do not require specific authorization of the assistant surgeon. Procedures not listed will require specific authorization of the assistant surgeon.

A list of the procedures (called “Assistant Surgeons List”) approved by FirstCare can be viewed on the FirstCare website at [FirstCare.com](http://FirstCare.com). A copy of the list may also be obtained by calling your Provider Relations representative.

The only providers approved for reimbursement by FirstCare as Assistant Surgeons are:

- Assistant Physician Surgeons
- Advanced Practitioners, including Physician Assistants (PAs), Nurse Practitioners (NPs), Registered Nurse First Assistants (RNFAs), and Licensed Surgical Assistants (LSAs).

*\*NOTE – Certified Surgical Assistants are not authorized for reimbursement as Assistant Surgeons by FirstCare*

A separate claim form must be filed by assistant surgeons. When processing claims for assistant surgeon a copy of the operative report and fees may be requested by FirstCare. Assistant surgeons must bill with the appropriate modifier (Refer to Modifiers in this section of the manual). If the mid-level practitioner’s services are specifically contracted for under the terms of the physician employer’s agreement with FirstCare or if the mid-level practitioner or physician assistant surgeon is independently contracted, they will be assigned a unique Provider ID number by FirstCare and should bill using that number or NPI. Otherwise, bill under the primary surgeon’s name and tax ID.

### 10.18.4 – Bilateral Procedures

FirstCare will only accept Medicare standard coding for bilateral surgical procedures (100xx to 69999). Please bill bilateral surgeries on a single line with a quantity of one (1) and modifier 50 to ensure correct reimbursement or on two (2) separate lines with a quantity of one (1) for each line, and modifier RT on one service line and a modifier LT on the other line.

Bilateral procedures are reimbursed at 100% of the maximum allowable for the first side and 75% of the maximum allowable for the second side. If the bilateral procedure is the primary surgical procedure, then subsequent bilateral procedures will pay at 50% per side. If it is not the primary surgical procedure, the first side is reimbursed at 75% and the second side is reimbursed at 50%, subsequent bilateral procedures will reimburse at 50% per side.



### 10.18.5 – Durable Medical Equipment

When billing for Durable Medical Equipment (DME), the HCPCS code must be specifically authorized to be payable. DME rental items should be billed with the modifier “RR”. Used items should be billed with the modifier “UE”. Providers billing for partial month rental should bill with a “KR” modifier. The count should indicate the number of rental days.

Charges for unlisted items should be billed with the applicable unlisted code and a complete description of the item. The charges will be denied if there is no description with the claim (Refer to MEDICAL SERVICES section for additional information).

### 10.18.6 – Emergency Room

Hospital based Emergency Room (ER) physician services should bill in accordance to the Hospital contract and will be reimbursed as such. Re-admission to the ER on the same day for a different diagnosis should be billed as separate ER visit.

### 10.18.7 – Global Fees

There may be some instances where a global fee for a surgery or other service (i.e. maternity care) has been established. The claim should be billed using the applicable code when services are rendered under these circumstances.

### 10.18.8 – Injections

Providers should access the provider web portal at [FirstCare.com](http://FirstCare.com) or consult FirstCare’s Customer Service Department to confirm which injections are covered under the member’s health benefit design (Evidence of Coverage/EOC). Some injections require authorization prior to administration. Physicians/ Providers must bill using current year and age specific HCPCS/ CPT codes (i.e. influenza vaccine).

Specify the units according to the HCPCS code description for “J” code drugs.

If seeking reimbursement for both, drug/immunization (i.e. pneumonia vaccine, 90732, and Administration, G0009). Providers should bill using the appropriate administration code along with the current year/age specific HCPCS/CPT code for the drug/immunization. Reimbursement for the administration code does not include payment for the drug/ immunization being administered. An administration code is typically NOT payable when billed in addition to an Evaluation & Management code. However, immunization administration for vaccines, CPT codes 90471 – 90474 and 90465 – 90465, are payable when billed in addition to an Evaluation & Management code.

FirstCare does not accept use of generic or unlisted codes (i.e. 90799) unless no valid HCPCS/ CPT code exists. FirstCare requires unlisted codes to be billed with a detailed description and the dosage amount. Failure to do so will result in denial of payment.

### 10.18.9 – Multiple Surgery Billing

When billing for multiple surgical procedures performed on the same date of service FirstCare classifies the procedure with the greatest allowable as primary. With the exception of bilateral procedures, modifier 51 is not required when billing for multiple surgeries. Allowed amounts for additional procedures will be reduced based on CMS guidelines or rates specified in the contract.

*\*NOTE – FirstCare’s iCES™ software may re-bundle services which are considered bundled or included in another procedure.*

### 10.18.10 – Physician Extender Billing

If a physician extender is individually contracted with FirstCare or if their services are specifically contracted for under the terms of the physician employer's agreement with FirstCare, they will be assigned a unique Provider ID number by FirstCare and should bill using that number or their NPI. Otherwise, the physician extender must bill under the supervising physician/provider name and tax ID.

Services rendered by physician extenders using the tax ID number and name of the supervising physician must list that physician or Medical Director in Box 31 of CMS-1500. If using UB-04, include the physician's name in Box 76 (attending) or Box 77 (operating). The physician extender's name may appear elsewhere on the claim form.

### 10.18.11 – Same Day Services

Services cannot be listed as a separate line item for members required to return to the office the same day for the same type of treatment. Such services must be billed on one line using the appropriate number of units, or using the appropriate coding/modifiers as per CPT coding guidelines. Only one office visit should appear for the same diagnosis and treatment.

Providers visiting their members more than one time in the hospital may only bill one code per day as per CPT guidelines. If two unrelated services must be billed for the same day of service, the claim must indicate different diagnoses to support each service and the appropriate modifier must be used.

### 10.18.12 – Supplies

Supplies must be coded using appropriate HCPCS codes. FirstCare will accept use of code 99070 only when there is no HCPCS code available. A detailed description of the supply is required if code 99070 is billed. An attachment (i.e. copy of the invoice) may be used to supplement the description if it is not possible to adequately describe the item on the actual CMS-1500 (08-05) form.

If a claim is filed using the code 99070 and a valid HCPCS code is available, FirstCare will deny the claim service line, with or without a description.

### 10.18.13 – Technical vs. Professional Services

Certain procedures include both technical and professional components. It is necessary to define the components with the appropriate modifier when a provider performs only one of the components. The provider performing the technical aspect of the test should bill using the modifier "TC" following the code. The provider who reads the test should bill using the modifier "26" following the code. The provider performing both aspects should bill using the code and no modifier.

Professional fees for radiology readings (26 modifier) of films not taken in the physician's office will be paid only to radiologists. Non-radiologist physicians who perform radiology services in their office when allowed by regional policies and procedures, may charge global fees if they read their own films. Only one reading will be reimbursed per procedure.

## 10.19 – OB/GYN Services for HMO Members Only

Each female member may designate an Obstetrician/Gynecologist (OB/GYN) Plan Provider in addition to her Primary Care Physician (PCP). These providers are known as the "designated OB/GYN". Female members may go directly to their designated OB/GYN for the following health care services:

- One (1) well-woman exam per contract year;
- Care related to pregnancy;
- Care for all active gynecological conditions; and
- Diagnosis, treatment, and referral for a gender related disease or condition within the scope of the professional practice of the OB/GYN, including treatment of medical conditions concerning the breasts.

### 10.19.1 – Copayments

Because copayment amounts and the rules under which they should be taken can vary, copayments should always be verified with FirstCare’s Customer Service Department. Some members may have a lower copayment for services performed by their PCP or “designated OB/GYN”, but higher copayment for those services performed by a “non-designated OB/GYN” to whom the member has been referred to obstetrical services. IN addition, certain outpatient diagnostic radiology services may require a copayment.

### 10.19.2 – Claims Submission

OB Services: Billing for OB services should occur after the date of delivery and within 95 days of delivery.

GYN Services: FirstCare requires provider to file claims within 95 days from the date of service

### 10.19.3 – Billing for Partial Prenatal Care

If seen for only part of the antepartum care (e.g. one trimester only) bill within 95 days after the last office visit and use appropriate CPT codes corresponding to the number of antepartum visits.

If prenatal care was rendered only in the second or last trimester and included the delivery (e.g. for new members), bill using the stand-alone delivery and postnatal CPT code with the appropriate CPT codes corresponding to the number of antepartum visits.

### 10.19.4 – High Risk Maternity Care

The global maternity code should be used to bill for the pregnancy care. Additional E&M visits required for high-risk pregnancies should be billed with the applicable E&M code and high-risk diagnosis. If the diagnosis does not support a high-risk status, FirstCare may request additional supporting documentation from the provider.

## 10.20 – Allergy Services

Allergy testing and evaluation services, including injections and serum, are covered benefits. FirstCare recommends that benefits be verified with Customer Service or plan document prior to administering services. These services are reported using CPT codes 95004-95199.

Copayments apply to allergy services in various amounts depending on the nature of service provided (i.e. allergy testing and evaluation, office visit, number of vials of serum, and/or injection). Therefore, a full office visit copayment may not always apply if a member comes in just for immunotherapy injections. When in doubt, copayments should be verified with FirstCare’s web portal at [FirstCare.com](http://FirstCare.com) or our Customer Service Department prior to administration.

Provider must bill using current year CPT codes. The codes below are subject to change.

Allergy Testing: CPT codes 95004 – 95075 are used for allergy testing. Each procedure should

be billed with the number of tests performed in the “units” field. One (1) copayment should be taken for each series of tests.

Allergy Injections: CPT codes 95115 – 95117 are allergen immunotherapy codes that do not include the provision of allergenic extracts. These codes are used when the member supplies the allergenic extracts and the service performed is only the injection and monitoring.

Allergy Serum, Single Dose Vials: CPT code 95144 describes the supervision and provision of single or multiple antigens using single dose vials. This code does not include the injection(s). The number of vials should be specified.

Allergy Serum, Insect Venom: CPT codes 95145 – 95149 describe the supervision and provision of allergen immunotherapy using single or multiple dose vials. These codes are used for insect venom and do not include the injection(s). The number of doses should be specified.

Allergy Serum, Multiple Dose Vials: CPT code 95165 describes the supervision and provision of single or multiple antigens using multiple dose vials. CPT code 95170 is for whole body extracts of biting insects or other arthropods. The number of doses should be specified in the “units” field of the claim form. FirstCare should be billed only for the actual number of doses used out of the multiple dose vials.

Unlisted Procedures: CPT code 95199 should be used only for unlisted allergy/clinical immunological services or procedures. FirstCare requires this code to be billed with a complete description. If no description of the unlisted service or procedure is attached or indicated, the claim will be denied.

## 10.21 – Anesthesia Services

Anesthesia services should be billed to FirstCare according to the following guidelines:

- Use standard ASA and Medicare coding guidelines. Copayment may be applicable to services provided pertaining to infertility. Verify benefits.
- Use the five-digit anesthesia codes (00100 – 01999), not surgical codes.
- Use appropriate modifiers specifying the level of service provided according to standard Medicare modifiers (“anesthesiologist” modifiers vs. “CRNA” modifiers);
- Follow ASA standards for all other appropriate modifiers (i.e. physical status modifier);

P1	A normal healthy member
P2	A member with mild systemic disease
P3	A member with severe systemic disease
P4	A member with severe systemic disease that is a constant threat to life
P5	A moribund member who is not expected to survive without the operation
P6	A declared brain dead member whose organs are being removed for donor purposes

- Indicate the time in minutes in the following format (0000 to 9999)
- Unit field should always equal 1. FirstCare has assigned ASA unit value to specific procedure code. Reimbursement formula is determined by the following formula: (base units + time units) x conversion factor.

### 10.22.1 – Time Reporting

Anesthesia time begins when the Anesthesiologist begins to prepare the member to receive

anesthesia and ends when the Anesthesiologist is no longer in personal attendance of the member.

### 10.21.2 – Qualifying Circumstance

Anesthesia services provided under difficult circumstances are billed with qualifying circumstance codes. These codes are not billed alone, but in addition to an anesthesia procedure. When billing for these codes, always submit an operative report or anesthesia report for consideration of the additional payment.

99116 – Anesthesia complicated by utilization of total body hypothermia

99135 – Anesthesia complicated by utilization of controlled hypotension

99140 – Anesthesia complicated by emergency conditions

*\*NOTE – The operative report is not required for 99100.*

### 10.22.3 – CRNA Services

CRNAs billing must comply with anesthesia services billing requirements, and one of the following medical direction modifiers:

- QX – CRNA medically directed by the anesthesiologist
- QZ – CRNA not supervised by the anesthesiologist; the surgeon is directing

If a CRNA is independently contracted with FirstCare or if their services are specifically contracted for under another agreement with FirstCare, they will be assigned a unique Provider ID number by FirstCare and should bill using that number. Otherwise, the CRNA must bill under the supervising physician's name and Tax ID.

### 10.21.4 – Pain Management Services

Use standard ASA and Medicare coding guidelines. Copay may be applicable to services; verify benefits.

Providers must also follow the guidelines established in the “Prior Authorization Requirements Matrix” under focused review services pertaining to pain management procedures.

## 10.22 – FirstCare’s Explanation of Payment

The FirstCare’s Explanation of Payment (EOP) is the statement sent to the physician or provider which lists the services provided, the amount billed, and the payment made. The EOP will accompany the reimbursement check.

A provider may designate that he/she would like the check generated either to an individual provider or to a provider group.

The FirstCare EOP will provide:

- A summary of finalized claims for a particular check run showing claim payment, denials, and adjustments
- A summary per claim, per individual provider

Providers may also access their EOP on the provider web portal at [FirstCare.com](https://www.firstcare.com). Just click on Explanation of Payment.

A sample of the EOP and a table of EOP field descriptions immediately follow:

Field #	Field Name	Description
1	FirstCare Name and Address	
2	Claim appeal information	Claim appeal address and provider portal info
3	Provider to whom payment is generated	Payment will go to this provider's address
4	Payment Information	Payment amount, check #, and effective date of check
5	Provider Information	Provider Unique #, NPI, and Tax ID information
6	Member Name	
7	Control Number	Claim Number
8	Age	Member's (member's) Age
9	DRG#	DRG # (if applicable)
10	Member ID#	
11	Account	Account Number as listed on the claim
12	Auth#	Authorization Number (if applicable)
13	Serv	Service Line Number
14	Dates	Dates of Service
15	Diag#	Diagnosis Code
16	Proc#	Procedure Code
17	Days/Cnt	Number of Days or Unit Count
18	Charged	Charged Amount for Service Line
19	Adjusted Amount	
20	Allowed	Allowed Amount for specific Procedure Code
21	Explain Codes	Explanation Code (EX code) An EX code service as a message to the provider to provide a reason for claim payment or denial at a service line level
22	Denied	Denied Amount of Service Line
23	Member Responsibility	Amount Member is responsible for (i.e. copayment, coinsurance, deductible)
24	Discount	Discount Amount
25	TPP	Third Party Payment
26	Payment	Payment Amount of Service Line
27	Claim Summary	Gives amount paid on claim including the Negative Balance amount (if applicable)
28	Negative Balance (Neg Bal) Summary	Negative Balance Amount (if applicable) - The summary will show any negative advances or prepayments against the provider (i.e. a refund was set up to recoup out of the next check, or once money has been accrued).
29	Refund Applied	Amount refunded to provider (if applicable)
30	EX Code Description	Gives description of what the EX Code stands for
31	Fraud Notice	Information pertaining to Fraud, Waste, and Abuse

Forwarding Service Requested

MIXED AADC 79D



Provider Name (3)  
 Provider Address  
 CITY, STATE, ZIP

Submit Claim appeals using the Provider Portal at  
 (2) www.firstcare.com  
 or by mail to:  
 PO BOX 853935 Richardson, TX 75085-3935

PAYMENT AMT:  
 CHECK / EFT DATE: (4)  
 CHECK NO:  
 835 TRACE#:  
 PROVIDER ID:  
 IRS#: (5)  
 NPI#:

### Remittance Advice and Explanation of Payment

Patient Name: (6)		Control No: (7)		Member ID#: (10)		Acct #: (11)							
Patient Control No: (8)		Age: (9)		DRG#: (12)		Auth #:							
Serv	Dates	Diag#	Proc#	Days/ Cat	Charged	Adjusted Amount	Allowed	Explain Codes	Denied	Member Resp	Discount	TPP	Payment

Sub-tot

Patient Name:		Control No:		Member ID#:		Acct #:							
Patient Control No:		Age:		DRG#:		Auth #:							
Serv	Dates	Diag#	Proc#	Days/ Cat	Charged	Adjusted Amount	Allowed	Explain Codes	Denied	Member Resp	Discount	TPP	Payment
(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)

Sub-total:

TOTAL

Check Summary:

Claim/Penalty Amount: (27)  
 - Applied to Neg Bal:  
 - New Neg Bal:  
 = Check Amount:

Negative Balance (Neg Bal) Summary:

Opening Neg Bal:  
 + Applied to Neg Bal: (28)  
 + New Neg Bal:

+ Refund Applied:  
 + Adjustments: (29)  
 - Closing Neg Bal:

### Remittance Advice and Explanation of Payment

Code Description (Mail appeals to PO BOX 853935, Richardson, TX 75085-3935)

(30)

Why wait for payment? Get paid electronically - for free! Enrollment available for EFT payment with Emdeon at  
 www.emdeonpayment.com or call 1-866-506-2830.

Fraud Notice (31)

Any person who knowingly presents false or fraudulent claims for payment may be subject to fines and confinement. If you suspect any fraudulent activity, please call our toll-free Fraud Hotline, 1-800-714-5205.

## 10.23 – Hold Harmless

Provider agrees that in no event, including, but not limited to, non-payment by SWHP or SWHP's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any other recourse against any Covered Persons or persons acting on their behalf other than SWHP for Covered Services provided under this Agreement. This provision shall not prohibit collection of Copayments or supplemental charges on SWHP's behalf made in accordance with the terms of the applicable Plan. Provider further agrees that the terms of this Section shall: (1) survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Covered Persons; and (2) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and Covered Persons or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this Section shall be effective on a date no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such proposed change. Provider shall cooperate with SWHP to ensure that any payments received from Covered Persons by Provider in violation of this provision are reimbursed to the Covered Person. Repeated violation of this provision may result in the termination of this Agreement.



# SECTION 11

## Complaints and Appeals Procedures

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FirstCare is committed to providing a high quality of healthcare service and a high level of member/provider satisfaction within our HMO and PPO programs. If a member or provider is dissatisfied with FirstCare policies, procedures, coverage of benefit decisions, or with any aspect of a member's treatment by physicians or other providers, they have the legal right to initiate a complaint and if not satisfied with the resolution of the complaint, they may request a decision by a Complaint Appeal Panel. Complainants are encouraged to communicate their dissatisfaction as soon as possible. To assist in this communication, FirstCare has developed the following complaint and appeal procedure.

“Complaint” means any dissatisfaction expressed by a member, anyone action on behalf of a member, or any provider orally or in writing to us with any aspect of our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an adverse determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the way a service is provided or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the member or provider. A complaint also does not include a plan provider's or member's oral or written dissatisfaction or disagreement with an adverse determination. A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an “appeal of an adverse determination: and is discussed under a separate heading later in this section.

### 11.1 – Complaint Procedure

FirstCare will forward a confirmation letter within five (5) days of receipt of an oral or written complaint and will enclose a one-page complaint form. Please complete the form and return to FirstCare as soon as possible.

Direct all oral complaints to the Customer Service Department at the phone number shown for the member eligibility and benefits on the Important Contact Information guide in the INTRODUCTION section of this manual; written complaints should be directed to:

SHA, L.L.C. dba FirstCare  
Complaints and Appeal Department  
12940 N Hwy 183  
Austin, TX 78750

Following receipt of a written complaint or completion of the complaint form, FirstCare will investigate the complaint and provide a resolution letter. FirstCare has 30-calendar days after we receive your written complaint to recognize, research, and resolve your complaint.

#### 11.1.1 – Complaint Appeal Procedure – For HMO Only

If your complaint is not resolved to your satisfaction, you have the right either to appear in person before a Complaint Appeal Panel where you normally render health care services, unless

another site is agreed to by you, or you may elect to forward a written appeal to the Complaint Appeal Panel rather than appear in person. FirstCare will forward an acknowledgment letter to you not later than the fifth (5th) business day after the date of receipt of the request for appeal.

FirstCare shall appoint members to the Complaint Appeal Panel to discuss and deliberate the appeal and render a decision. The Complaint Appeal Panel is composed of an equal number of our staff, (not involved in any previous review of the issue being disputed) physicians or other providers, (who were not involved in any previous review of the issue being disputed and who are independent of any physician/provider involved in any previous review) and members (who are not FirstCare employees). The physician/provider representative will be of the same/similar specialty to which the appeal is relating unless the member's Evidence of Coverage specifically excludes the issue as a non-covered benefit.

No later than the fifth (5th) business day before the scheduled meeting of the Panel, unless you agree otherwise, FirstCare shall provide to you or your designated representative:

- Any documentation to be presented to the Panel by our staff;
- The specialization of physicians/Providers consulted during the investigation; and
- The name and affiliation of each of our representatives on the Panel.

You or a designated representative is entitled to:

- Appear in person before the Complaint Appeal Panel,
- Present alternative expert testimony, and
- Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Written notification of FirstCare's final decision on the appeal will be provided no later than the 30th calendar day after the date we received the appeal. The notice of final decision will address the specific medical determination, clinical basis and/or contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and address of the Texas Department of Insurance.

The Complaint Appeal Panel decision is only a recommendation to FirstCare. FirstCare is not bound by the recommendation of the Complaint Appeal Panel. FirstCare is solely responsible for the final decision regarding the appeal, factoring in the recommendation of the Complaint Appeal Panel.

*\*NOTE - Some physician contracts provide additional procedures for resolving complaints. Physicians may contact their regional Provider Relations representative to determine available options.*

## 11.2 - Adverse Determinations Appeal Procedure

FirstCare has in place processes by which a member, someone acting on behalf of the member, or the physician or other health care provider of the enrollee/member can file an appeal of an adverse determination. FirstCare will ensure that all appeals of an adverse determination are processed in a timely manner and are consistent with all regulatory requirements.

An adverse determination is a denial of a requested authorization or service which FirstCare denies based on the requested services do not meet established medical criteria, are not medically necessary, level of care (inpatient vs. outpatient) is not appropriate, or any days of a hospital confinement denied as not medically necessary or does not meet criteria.

If you notify us orally or in writing of an appeal to an adverse determination, no later than the fifth (5th) business day after the date of the receipt of the appeal, we will send to you a letter acknowledging:

- The date the appeal of the adverse determination was received;
- The format of the appeal (oral or written);
- A reasonable list of the documents to be submitted by the appellant for review by the physician;
- Statement indicating the appeal will be reviewed by a physician or dentist not previously involved in the original adverse determination;
- The date the appeal review will be completed; and
- If the appeal was received orally, a one-page appeal form for your use.

Oral appeals should be directed to the Customer Service Department at the phone number shown for member eligibility and benefits on the Important Contact Information guide in the INTRODUCTION section of this manual. Written appeals should be directed to the Complaints and Appeals Department at:

SHA, L.L.C. dba FirstCare  
Complaints and Appeals Department  
12940 N Hwy 183  
Austin, TX 78750

Following the review by the physician or dentist not previously involved in the original adverse determination, the Regional Medical Department will notify the appellant in writing of the appeal resolution within 30 days of FirstCare's receipt of the oral or written appeal.

If the appeal is denied, the appeal resolution letter will include:

- A statement of specific medical, dental, or contractual reason or the resolution
- The clinical basis for the decision
- The specialty of the physician or other health care provider consulted
- Notice of the appellant's right to seek review of the denial by an independent review organization (IRO) and the procedures for obtaining that review; and
- The right of the appellant to contact the Texas Department of Insurance.

If the appeal is denied, the health care provider within ten working days sets forth in writing good cause for having a particular type of specialty provider review the case. The adverse determination will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review of the adverse determination. The specialty review will be completed within 15 working days of the receipt of the request.

### **11.2.1 - Expedited Appeals**

Expedited Appeals will be available for emergency care denials, denials of care for life-threatening conditions, and denials of continued stay for hospitalized members. Elements of an expedited appeal include:

- The review will be performed by a health care provider who has not previously reviewed the case and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review; and
- The time the appeal review is to be completed will be based on the medical or dental immediacy of the condition, procedure, or treatment, but will in no event exceed one working day from the date all information necessary to complete the appeal is received.

In a circumstance involving a member's life-threatening condition, the member is entitled to an immediate appeal to an independent review organization (IRO) of FirstCare's adverse determination.

### **11.2.2 – Filing Complaints with the Texas Department of Insurance**

Any person, including persons who have attempted to resolve complaints/appeals and appeals of an adverse determination through our procedures as outlined above and who are dissatisfied with the resolution, may file a complaint with the Texas Department of Insurance.

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
(800) 252-3439

## **11.3 – Appeals to an Independent Review Organization (IRO)**

In a circumstance involving a life-threatening condition, you are entitled to an immediate appeal to an Independent Review Organization (IRO) and are not required to comply with procedures for an internal review or our Adverse Determination.

Any party whose appeal of an Adverse Determination is denied by us is entitled to seek review of that determination by an IRO assigned to the appeal as follows:

- You or your designated representative will be provided with information on how to appeal the denial of an Adverse Determination to an IRO and will be provided this information at the time of the denial of the appeal.
- You or your designated representative will be provided a prescribed form which you must complete and return to us to begin the independent review process.
- In life-threatening situations, you or your designated representative may contact us by telephone to request the review and provide the required information.
- Retroactive reviews of adverse determinations are not subject to an IRO appeal process.

The appeal process does not prohibit you from pursuing other appropriate remedies including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the member's health in serious jeopardy.

FirstCare will not take any retaliatory action against you or your group because you, the group, or any person acting on your or your group's behalf, have filed a complaint against FirstCare or appealed a decision.

# SECTION 12

## Attachments

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Provider Portal Handbook  
Prior Authorization Requirements Matrix  
Prior Authorization Request Form  
Drug Coverage List Modification Request Form  
Modifier Requirements Table  
Clean Claim Requirements (1500)  
Health Insurance Claim Form (1500)  
Clean Claim Requirements (UB04)  
Health Insurance Claim Form (UB04)  
Sample Clearinghouse Report  
Sample FirstCare Report  
Return Receipt Request  
Claim Shuttle Handbook  
Request for Claim Status Form  
Appeal Submission Form  
Recoupment Letter Sample  
Refund Submission Form

# Provider Portal Reference Guide



## Registration & Access

To access the FirstCare Provider Self-Service Portal, complete the self-directed registration process:

- 1 Go to the login page at [my.firstcare.com](http://my.firstcare.com) and select the **Create an account today!** link or **Create an Account** button and choose **Provider** from the popup selector.
- 2 Follow the instructions to register using a recently-processed Claim ID and Member ID for the claim. That's all you'll need to proceed with your self-guided registration.
- 3 **If you do not have a claim, an activation code is required.** To obtain an activation code, you will need to click the **here** link and call your Provider Relations Representative.

Please have the following information on hand:

- First and last name
- Billing address
- Group NPI
- Name of organization
- Job title
- Group tax ID number
- Email address
- Phone Number
- Name of group

- 4 Click the **Use Activation Code** checkbox, and enter your code in the **Activation Code** field to proceed with your registration. Your entire group will be added automatically; once inside your account you can un-hide those you want to see.

**Note:** *If you already have access to the Provider Portal and need to add new users, simply follow the same steps above once logged into your account at **View/Edit My Info** and **Registered Providers**.*



## Getting Help

Our Provider Relations Team is here for you. Please contact us at [prsupport@bswhealth.org](mailto:prsupport@bswhealth.org) or by calling one of the numbers below:

- FirstCare Amarillo area: 1-806-321-7947
- FirstCare Lubbock, Waco and all other areas: 1-806-784-4380



# Navigation

Simply select the activity/function you wish to access from the left navigation bar. For example, to access claims-related information, click on **Claims**.

**NOTE:** This example shows all of the navigation bar options open for display purposes only. These will not display unless you click on the section header.

The screenshot displays the myFirstCare Self-Service portal interface. On the left is a vertical navigation bar with the following options: Home, Members, Claims, Claim Search, Electronic Claims Status, Claim Submission, Payments, Payment Negative Balance, Authorizations, Auth. Requirements, Auth. Code Search Tool, Auth. Request, Auth. Search, Reports, Panel Reports, Texas Health Steps, Important Documents, All Documents, Appeals and Complaints, Manuals, Provider News, Training, HEDIS, View/Edit My Info, My Account, Registered Providers, Message Center, My Messages, Send a Message, Contact Us, and Log Out. The main content area is titled 'Home' and includes a 'Provider' dropdown menu and a 'Date Range' dropdown menu set to 'one month'. Below these are two donut charts: 'Claims' and 'Authorizations'. The 'Claims' chart shows 0 Pending (blue), 0 Denied (grey), and 0 Processed (green). The 'Authorizations' chart shows 2 Approved (green), 1 Partially Approved (blue), 1 Not Approved (grey), and 0 Pending (orange). Below the charts are sections for 'Announcements' and 'Quick References'. The 'Announcements' section features a notice about concurrent review fax number updates for hospitals. The 'Quick References' section lists links for Provider News, STAR & CHIP Provider Information, Authorization Information, Case Management/Disease Management Referrals, Important Forms, and Electronic (EFT) Payments. The footer contains the copyright notice: © 2019 FirstCare Health Plans. All rights reserved. [Legal Notices & Privacy](#) | [FirstCare.com](#)



## Requesting an Authorization

- 1 Select Authorizations and then choose Auth. Request from the options.
- 2 Enter the member ID number and ordering provider, along with the date of service, authorization type and service code.
- 3 Click **Validate Information** and then **Continue** to fill out the contact information related to the authorization.
- 4 Once the **Contact Information** has been added, click **Continue** to provide all necessary details regarding the authorization.
- 5 Click **Submit**.

The screenshot shows the 'Authorization Request' page in the myFirstCare Self-Service portal. The page has a dark blue header with the FirstCare logo and 'myFirstCare Self-Service' text. A left sidebar contains navigation options like Home, Members, Claims, Authorizations, and Reports. The main content area is titled 'Authorization Request' and features three steps: 1. Start Request (highlighted in green), 2. Contact Details, and 3. Authorization Details. The form includes fields for Member ID\*, Authorization Type\* (a dropdown menu), Service Code\*, Date of Service\* (with a calendar icon), and Ordering Provider\* (a dropdown menu). There is also a search field for practitioners with a magnifying glass icon and the text 'Search for Practitioners\*'. A 'Validate Information' button is located at the bottom of the form. A note at the bottom of the form states: 'Please note: We now allow the selection of all in-network FirstCare providers as ordering providers instead of groups. If the ordering Provider cannot be located, please fax your request to 800-248-1852 (Medical), 800-431-7738 (DME), or 512-233-5949 (Behavioral Health).' The footer of the page contains copyright information: '© 2019 FirstCare Health Plans. All rights reserved. Legal Notices & Privacy | FirstCare.com'.



## Appealing a Claim

- 1 Perform a claim search to find the claim or claim line to be appealed.
- 2 Click on **Appeal**.
- 3 Enter the information on the **Reason for Appeal** tab and attach any supporting files (*optional, except for Reasons with an asterisk.*).
- 4 Click the **Claim Lines** tab to view/edit the lines for a claim.
- 5 Return to the **Reason for Appeal** tab to summarize the appeal.
- 6 Click **Submit Appeal**.





# Appealing a Claim (cont.)

See below for screen image of **Claim Appeal** window.

**FirstCare**  
HEALTH PLANS  
PART OF BAYLOR SCOTT & WHITE HEALTH

myFirstCare Self-Service

**Claim Appeal**

Member Name: Member ID: Start Date: Paid Date:  
 Provider NPI: Patient Control #: End Date: Paid Amount:  
 Charge: Network:  
 Provider Name: Date of Birth:  
 Claim Number: Status:

**Reason for Appeal** | Claim Lines

Indicate the reason for Appeal:

- Provider information updated
- Member eligibility updated
- Authorization updated
- Denied in error
- EOB Attached (COB Claim)\*
- Corrected/Replaced Claim
- Resubmission with Proof of Authorization/Referral\*
- Resubmission with Proof of Timely Filing\*
- Other (specify reason below)

\*Requires an attachment be submitted

Attachments (File Types: WORD DOCUMENT, PDF, TXT, or EXCEL. Maximum file size 20 MB)  
 or Drop file here

Please provide a summary of this appeal. You may also include any additional supporting information that you believe is useful for the claim's appeal.

An Appeal Reason is required to appeal a Claim. If you want to review or edit Claim Lines, please do so BEFORE clicking the "Submit Appeal" button. Select the "Claim Lines" tab above.

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After your submission is complete, a reference number will be provided to track your appeal. Notation of the appeal will also be documented in the **Message Center**.



# Texas Standard Prior Authorization Request Form for Health Care Services

HOFR001 | 0415

Texas Department of Insurance

**Please read all instructions below before completing this form.**

**Please send this request to the issuer from whom you are seeking authorization. Do not send this form to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.**

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

**Intended Use:** Use this form to request authorization by fax or mail when an issuer requires prior authorization of a health care service. An issuer may also provide an electronic version of this form on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

**Do not use this form to:** 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

## **Additional Information and Instructions:**

### **Section I – Submission:**

An issuer may have already entered this information on the copy of this form posted on its website.

### **Section III – General Information:**

**Urgent reviews:** Request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

### **Section IV – Provider Information:**

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

### **Section VI – Clinical Documentation:**

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

**Note:** Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.

**Note:** If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

# TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form
Print

## SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
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## SECTION II — GENERAL INFORMATION

Review Type:	<input type="checkbox"/> Non-Urgent	<input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

## SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
			<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:		

## SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

## SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description [ICD version ____]	Code

Inpatient  
  Outpatient  
  Provider Office  
  Observation  
  Home  
  Day Surgery  
  Other: \_\_\_\_\_

Physical Therapy  
  Occupational Therapy  
  Speech Therapy  
  Cardiac Rehab  
  Mental Health/Substance Abuse

Number of Sessions: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_ Other: \_\_\_\_\_

Home Health (MD Signed Order Attached?  Yes  No)  
 [Nursing Assessment Attached?  Yes  No]

Number of Visits: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_ Other: \_\_\_\_\_

DME (MD Signed Order Attached?  Yes  No)  
 [Medicaid Only: Title 19 Certification Attached?  Yes  No]

Equipment/Supplies (include any HCPCS Codes): \_\_\_\_\_ Duration: \_\_\_\_\_

## SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

**An issuer needing more information may call the requesting provider directly at: \_\_\_\_\_**



**Drug Coverage List  
Modification Request Form**

**Instructions:**

FirstCare welcomes the participation of in-plan practitioners in suggesting changes to the Drug Coverage List (DCL). This form should be used to request medication additions or modifications. Please fax or mail the completed form to FirstCare, 12940 N. Highway 183, Austin, TX 78750, Attn: PNT Committee

**Review Criteria:**

The following criteria are used in the evaluation of product selection for the Drug Coverage List:

1. The drug product must demonstrate acceptable safety for medical use.
2. The drug must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of a covered medical condition.
3. The drug product must be accepted for use by the medical community and have appropriate Federal and State approvals.
4. The drug product must demonstrate a satisfactory therapeutic outcome.
5. The drug product must have an equitable cost ratio for the treatment of a covered medical condition.
6. The drug product must demonstrate significant documented advantages over drugs currently on the Preferred Drug List.

<b>Date:</b> _____		<b>Physician Specialty:</b> _____	
<b>Physician Name:</b> _____		<b>Physician Phone #:</b> _____	
<b>Modification Request: (check one)</b>			
<input type="checkbox"/> Addition	<input type="checkbox"/> Deletion	<input type="checkbox"/> Modification	
<b>Drug Requested:</b> _____			
<b>Strength:</b> _____		<b>Dosage Form:</b> _____	
<b>Reason for Modification Request:</b> _____ _____			
<b>References to Support Request:</b> _____ _____			

\_\_\_\_\_  
Physician Signature

## Modifier Requirements Table

Modifier	Description
25	Significant, E&M Service (same physician) post operative
27	Multiple Outpatient Hospital E & M Encounters on the same day
50	Bilateral Procedure
52	Reduced Services
58	Staged or related procedure
59	Distinct Procedural Services
73	Discontinued Out-Patient Procedure prior to Anesthesia Administration
74	Discontinued Out-Patient after Anesthesia Administration
76	Repeat procedure by same physician
77	Repeat procedure by another physician
78	Return to OR for related procedure post-op
79	Unrelated procedure by same physician during post-op
91	Repeat Clinical Diagnostic Laboratory Test

## Clean Claim Requirements

Claims must meet specific criteria in order to be considered a clean claim. If a provider submits an unclear claim, FirstCare may either deny, toll, or send the claim back to the provider for correction, depending upon the scenario.

<b>Elements of Non-Electronic Clean Claim: CMS 1500 (08/05)</b>			
Field #	HB 610: Required as indicated unless otherwise agreed by contract	SB 418: Emergency Rules as Indicated. No change, even if indicated by contract.	SB 418: Final Rules as Indicated. No change, even if indicated by contract.
1a	R	R	R
2	R	R	R
3	R	R	R
4	R	R	R - If shown on patient ID card
5	R	R	R
6	R	R	R
7	R	R - Enter "Same" if - patient address, field 5	R - Enter "Same" if - patient address, field 5
9	R - If field 11d is "yes"	R - If field 11d is "yes"	R - If field 11d is "yes"
9a	R - If field 11d is "yes"	R - If field 11d is "yes"	R - If field 11d is "yes"
9b	R - If field 11d is "yes"	R - If field 11d is "yes"	R - If field 11d is "yes"
9c	R - If field 11d is "yes"	R - If field 11d is "yes". Facility based: radiological, pathological, or anesthesiological can enter NA.	R - If field 11d is "yes". Facility based: radiological, pathological, anesthesiological can enter NA.
9d	R - If field 11d is "yes"	R - If field 11d is "yes"	R - If field 11d is "yes"
10	R	R - Facility based radiological, pathological, anesthesiological, enter "N" if answer is "No" or into unknown.	R - Facility based radiological, pathological, anesthesiological, enter "N" if answer is "No" or into unknown.
10d	Not required	R - If duplicate, enter "D", or if corrected, enter "C".	R - If duplicate, enter "D", or if corrected, enter "C".
11	R	R	R
11a	R	Not required	Not required
11b	R - If health plan is a group plan	Not required	Not required
11c	R	R	R
11d	R - If answer is "no", prov must have on file patient signature with last 12 mos. indicating no other coverage.	R - If answer is "no", prov must have patient statement on file signed with last 12 mos. indicating no other coverage.	R - If answer is "no", prov must have patient statement on file signed with last 12 mos. indicating no other coverage.
12	R	R	R
13	R	R	R
14	R	R - only if due to accident	R - only if due to accident
15	R	Not required	Not required
17	Not required	R - Primary care and specialty physicians and hospitals, if no referral, enter "self-referral" / "none".	R - Primary care and specialty physicians & hospitals, if no referral, enter "self-referral" or "none".
17a	Not required	R - Primary care and specialty physicians and hospitals, if no referral, enter "self-referral" / "none".	R - Primary care and specialty physicians & hospitals, if no referral, enter "self-referral" or "none".

## Clean Claim Requirements

Claims must meet specific criteria in order to be considered a clean claim. If a provider submits an unclear claim, FirstCare may either deny, toll, or send the claim back to the provider for correction, depending upon the scenario.

<b>Elements of Non-Electronic Clean Claim: CMS 1500 (08/05)</b>			
Field #	HB 610: Required as indicated unless otherwise agreed by contract	SB 418: Emergency Rules as Indicated. No change, even if indicated by contract.	SB 418: Final Rules as Indicated. No change, even if indicated by contract.
19	Not required	RL - If Physician/provider uses an unclassified or not classified PROC or NDC code for unclassified drugs.	RL - If Physician/provider uses an unclassified or not classified PROC or NDC code for drugs.
21	R	RL - May enter up to 4 Dx codes. At least 1 is required and primary diagnosis must be entered first.	RL - Enter up to 4 Dx codes. At least 1 is required. Enter primary diagnosis first.
23	R - When prior auth is required	RL - If services have been verified. Otherwise, a prior auth number is required when prior auth is.	RL - If services have been verified. Otherwise, a prior auth number is required when prior auth is required.
24a	R	RL	RL
24b	R	RL	RL
24c	R	Not Required	Not Required
24d	R	RL	RL
24e	R	RL - with first code listed in the applicable diagnosis code for that service in Field 21	RL - with first code listed in the applicable diagnosis code for that service in Field 21
24f	R	RL	RL
24g	R	RL	RL
25	R	RL	RL
27	R - when assignment under Medicare has been accepted	RL - when assignment under Medicare has been accepted	RL - when assignment under Medicare has been accepted
28	R	RL	RL
29	R - if amount has been paid by or on behalf of patient or subscriber by a primary plan.	RL - if amount has been paid by or on behalf of patient or subscriber by a primary plan.	RL - if amount has been paid by or on behalf of patient or subscriber by a primary plan.
30	R - if amount has been paid by or on behalf of patient or subscriber	Not required	Not required
31	R	RL	RL
32	R	RL	RL
33	R	RL - In addition to telephone #: Provider number is required if center required provider numbers and gave notice of requirement to physician/provider.	RL - In addition to telephone #: Provider number is required if center required provider numbers and gave notice of requirement to physician/provider.





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## Clean Claim Requirements

Claims must meet specific criteria in order to be considered a clean claim. If a provider submits an unclean claim, FirstCare may either deny, toll, or send the claim back to the provider for correction, depending upon the scenario.

### Elements of Non-Electronic Clean Claim: UB04

Field #	HB 610: Required as indicated unless otherwise agreed by contract	SB 418: Emergency Rules as indicated. No change, even if indicated by contract.	SB 418: Final Rules as indicated. No change, even if indicated by contract.
1	R	R	R
3	R	R	R
4	R	R - shall include a "7" in the 3rd position if claim is a duplicate	R - shall include a "7" in the 3rd position if claim is a duplicate
5	R	R	R
6	R	R	R
7	R - if Medicare is primary or secondary	R - if Medicare is primary or secondary	R - if Medicare is primary or secondary
8	R - if Medicare is primary or secondary	R - if Medicare is primary or secondary	R - if Medicare is primary or secondary
9	R - if Medicare is primary or secondary	R - if Medicare is primary or secondary	R - if Medicare is primary or secondary
10	R - if Medicare is primary or secondary & was inpatient admit	R - if Medicare is primary or secondary & was inpatient admit	R - if Medicare is primary or secondary & was inpatient admit
12	R	R	R
13	R	R	R
14	R	R	R
15	R	R	R
16	R	R	R
17	R	R - for inpatient admissions, obs stays, & emergency room care	R - for inpatient admissions, obs stays & emergency room care
18	R	R - for inpatient admissions, obs stays, & emergency room care	R - for inpatient admissions, obs stays & emergency room care
19	R	R - for inpatient admissions	R - for inpatient admissions
20	R	R - for inpatient admissions R - for inpatient admissions, outpatient surgeries or obs stays	R - for admissions, outpatient surgeries or obs stays
21	R - if patient was inpatient or admitted for outpatient obs	R - for inpatient admissions, outpatient surgeries or obs stays	R - for admissions, outpatient surgeries or obs stays
22	R	R - for inpatient admissions, obs stays, and emergency room care	R - for admissions, obs stays and emergency room care
24-30	R - if there is condition code applicable to patient's condition	R - if there is condition code applicable to patient's condition	R - if there is condition code applicable to patient's condition
32-35	R - if there is condition code applicable to patient's condition	R - if there is condition code applicable to patient's condition	R - if there is condition code applicable to patient's condition
36	R - if there is condition code applicable to patient's condition	R - if there is condition code applicable to patient's condition	R - if there is condition code applicable to patient's condition
39-41	R	R - for inpatient admission. If n/a enter "01".	R - for inpatient admission. If n/a, enter "01".

## Clean Claim Requirements

Claims must meet specific criteria in order to be considered a clean claim. If a provider submits an unclean claim, FirstCare may either deny, toll, or send the claim back to the provider for correction, depending upon the scenario.

### Elements of Non-Electronic Clean Claim: UB04

Field #	HB 610: Required as indicated unless otherwise agreed by contract	SB 418: Emergency Rules as indicated. No change, even if indicated by contract.	SB 418: Final Rules as indicated. No change, even if indicated by contract.
42	R	RL	R
43	R	RL	R
44	R - if Medicare is primary or secondary	RL - if Medicare is primary or secondary	R - if Medicare is primary or secondary
45	Not required	RL - if claim is for outpatient services	R - if for outpatient services
46	R	RL	R
47	R	RL	R
50	R	RL	R
51	Not required	RL - if required by carrier and notice given to provider	R - if required by carrier and notice given to provider
54	R - if payments made to provider by or on behalf of patient/ subscriber by primary plan	RL - if payments made to provider by or on behalf of patient / subscriber by primary plan	R - if payments made to prov by or on behalf of patient / subscriber by primary plan
58	R	RL - if shown on patient ID card	R - if shown on patient ID card
59	R	RL	R
60	R	RL	R - if shown on patient ID card
62	Not Required	RL - if shown on patient ID card	R - if shown on patient ID card
63	Not Required	RL - if services have been verified. Otherwise, treatment auth codes are required when auth is required.	R - if services have been verified. Otherwise, treatment auth codes req when auth is required.
67	R	RL	R
68-75	R - if there are diagnoses other than the principal Dx code	RL - if there are diagnoses other than the principal diagnosis	R - if there are diagnoses other than the principal diagnosis
76	Not required	RL	R
79	R - if CMS UB manual indicates a procedural coding method	RL - if CMS UB manual indicates a procedural coding method	R - if CMS UB manual indicates a procedural coding method
80	R - if patient has undergone inpatient or outpatient surgical procedure	RL - if patient has undergone inpatient or outpatient surgical procedure	R if patient has undergone inpatient or outpatient surgical procedure
81	R - as extension of Field 80 if there were additional surgical procedures	RL - as extension of Field 80 if there were additional surgical procedures	R - as extension of Field 80 if there were additional surgical procedures
82	R	RL	R
85	R	RL	R
86	R	RL	R

1	2	30 PUL ORL #	31	4 TYPE OF BILL
		30 MCD REC #		
		31 PUL REC #		
		32 FROM THE NO.	33 STATEMENT COVERS PERIOD FROM	34 THROUGH
3 PATIENT NAME	a	3 PATIENT ADDRESS	a	
b		c	d	e
35 INVOICE DATE	36 PLACE	37 DATE	38 ADMISSION	39
10 HR	11 TYPE	12 SRC	13 ICD9	14 ICD9
15	16	17	18	19
20	21	22	23	24
25	26	27	28	29
30	31	32	33	34
35	36	37	38	39
40	41	42	43	44
45	46	47	48	49
50	51	52	53	54
55	56	57	58	59
60	61	62	63	64
65	66	67	68	69
70	71	72	73	74
75	76	77	78	79
80	81	82	83	84
85	86	87	88	89
90	91	92	93	94
95	96	97	98	99
100	101	102	103	104
105	106	107	108	109
110	111	112	113	114
115	116	117	118	119
120	121	122	123	124
125	126	127	128	129
130	131	132	133	134
135	136	137	138	139
140	141	142	143	144
145	146	147	148	149
150	151	152	153	154
155	156	157	158	159
160	161	162	163	164
165	166	167	168	169
170	171	172	173	174
175	176	177	178	179
180	181	182	183	184
185	186	187	188	189
190	191	192	193	194
195	196	197	198	199
200	201	202	203	204
205	206	207	208	209
210	211	212	213	214
215	216	217	218	219
220	221	222	223	224
225	226	227	228	229
230	231	232	233	234
235	236	237	238	239
240	241	242	243	244
245	246	247	248	249
250	251	252	253	254
255	256	257	258	259
260	261	262	263	264
265	266	267	268	269
270	271	272	273	274
275	276	277	278	279
280	281	282	283	284
285	286	287	288	289
290	291	292	293	294
295	296	297	298	299
300	301	302	303	304
305	306	307	308	309
310	311	312	313	314
315	316	317	318	319
320	321	322	323	324
325	326	327	328	329
330	331	332	333	334
335	336	337	338	339
340	341	342	343	344
345	346	347	348	349
350	351	352	353	354
355	356	357	358	359
360	361	362	363	364
365	366	367	368	369
370	371	372	373	374
375	376	377	378	379
380	381	382	383	384
385	386	387	388	389
390	391	392	393	394
395	396	397	398	399
400	401	402	403	404
405	406	407	408	409
410	411	412	413	414
415	416	417	418	419
420	421	422	423	424
425	426	427	428	429
430	431	432	433	434
435	436	437	438	439
440	441	442	443	444
445	446	447	448	449
450	451	452	453	454
455	456	457	458	459
460	461	462	463	464
465	466	467	468	469
470	471	472	473	474
475	476	477	478	479
480	481	482	483	484
485	486	487	488	489
490	491	492	493	494
495	496	497	498	499
500	501	502	503	504
505	506	507	508	509
510	511	512	513	514
515	516	517	518	519
520	521	522	523	524
525	526	527	528	529
530	531	532	533	534
535	536	537	538	539
540	541	542	543	544
545	546	547	548	549
550	551	552	553	554
555	556	557	558	559
560	561	562	563	564
565	566	567	568	569
570	571	572	573	574
575	576	577	578	579
580	581	582	583	584
585	586	587	588	589
590	591	592	593	594
595	596	597	598	599
600	601	602	603	604
605	606	607	608	609
610	611	612	613	614
615	616	617	618	619
620	621	622	623	624
625	626	627	628	629
630	631	632	633	634
635	636	637	638	639
640	641	642	643	644
645	646	647	648	649
650	651	652	653	654
655	656	657	658	659
660	661	662	663	664
665	666	667	668	669
670	671	672	673	674
675	676	677	678	679
680	681	682	683	684
685	686	687	688	689
690	691	692	693	694
695	696	697	698	699
700	701	702	703	704
705	706	707	708	709
710	711	712	713	714
715	716	717	718	719
720	721	722	723	724
725	726	727	728	729
730	731	732	733	734
735	736	737	738	739
740	741	742	743	744
745	746	747	748	749
750	751	752	753	754
755	756	757	758	759
760	761	762	763	764
765	766	767	768	769
770	771	772	773	774
775	776	777	778	779
780	781	782	783	784
785	786	787	788	789
790	791	792	793	794
795	796	797	798	799
800	801	802	803	804
805	806	807	808	809
810	811	812	813	814
815	816	817	818	819
820	821	822	823	824
825	826	827	828	829
830	831	832	833	834
835	836	837	838	839
840	841	842	843	844
845	846	847	848	849
850	851	852	853	854
855	856	857	858	859
860	861	862	863	864
865	866	867	868	869
870	871	872	873	874
875	876	877	878	879
880	881	882	883	884
885	886	887	888	889
890	891	892	893	894
895	896	897	898	899
900	901	902	903	904
9				



**APPEAL SUBMISSION FORM**

Date: \_\_\_\_\_ Provider Contact Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Contact Phone Number: \_\_\_\_\_

Provider ID Number: \_\_\_\_\_ Provider Contact E-Mail: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

Control/Claim Number: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

**Reason for Review:**

- † Provider Information Updated
- † Member Eligibility Updated
- † Authorization Updated
- † Additional Payment Requested
- † Denied in Error
- † EOB Attached (COB claim)
- † Corrected/Replacement Claim
- † Resubmission with Proof of Authorization/Referral
- † Resubmission with Proof of Timely Filing
- † OTHER: \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To expedite processing, return this form, along with the any information to the following address:

**FirstCare  
Attn: Adjustment Unit  
12940 N. Highway 183  
Austin, Texas 78750**



## REFUND SUBMISSION FORM

This form or a similar form should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

Date: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Provider Contact Name: \_\_\_\_\_

Provider Contact Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

Check Number: \_\_\_\_\_ Check Amount: \_\_\_\_\_ Check Date: \_\_\_\_\_

### Reason for Refund:

- Not our member
- Billed in error
- Wrong provider and/or affiliation
- Services not rendered
- Third party liability determined
- Other coverage paid as primary (refund entire amount and re-submit claim with primary EOB)
- OTHER: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To expedite processing, return this form, along with information to the following address:

**FIRSTCARE**  
Attn: Recovery Department  
PO Box 853935  
Richardson, TX 75085-3935

**FIRSTCARE • FIRSTCARE Star • FIRSTCARE Chip • FIRSTCARE Administrative Services • FIRSTCARE Direct • FIRSTCARE Advantage**  
12940 N. Highway 183 • Austin, Texas 78750 • (512) 257-6000 • (800) 431-7737

**FIRSTCARE is a registered service mark of SHA, L.L.C.**

Southwest Life & Health Insurance Company is a subsidiary of SHA, L.L.C.

# SECTION 13

## Glossary of Terms

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### 13.1 - Glossary of Terms

**Adverse Determination** - a determination made by plan that the health care services furnished or proposed to be furnished are not medically necessary

**After-Hours** - anytime not included in the realm of normal business hours

**Agreement** - a contract and application completed by the provider to become a participating provider

**ASC Rate** - per case rate of payment to hospital for covered health services furnished to a member in connection with outpatient surgical procedures performed in any attached or free-standing ambulatory surgical suite or center-owned or operated by hospital

**Assistant Surgeon Procedure** - a surgical procedure determined to require the presence of a second surgeon based on the complexity of the procedure

**Authorization** - having received the plan's agreement for a service to be delivered based on evaluation of medical necessity before the time the service is rendered

**Bed Day** - each 24-hour period of admission of a member as an inpatient in hospital

**Case Management** - a method of managing the provision of health care to members with high-cost medical conditions; the goal is to coordinate the care to improve both continuity and quality of care and to lower costs

**Concurrent Review** - part of the FirstCare Utilization Management Program in which provider services are monitored for appropriateness of setting and progress of discharge plans

**Copayment** - the amount required to be paid by or on behalf of a member by the applicable plan document of such member to a participating provider or other FirstCare approved provider in connection with the payment of covered health services rendered by such provider.

**Covered Health Services** - those medical/health care services and supplies specified and defined as covered benefits in the applicable plan document of a member

**Duplicate Claim** - any claim submitted by provider for the same covered health service provided to a member on a particular date of service that was included in a previously submitted claim. This term does not include corrected claims

**Declination** - a response to a request for verification in which an HMO or PPO carrier does not issue a verification for proposed medical care or health care services

**Emergency Care** - health care services provided in a hospital emergency facility to evaluate and



stabilize medical conditions of a recent onset and severity that would lead a prudent layperson possessing an average knowledge of medicine to believe that the condition, sickness, or injury was such a nature that failure to obtain immediate medical care could result in:

- Placing the member's health in serious jeopardy;
- Serious impairment to bodily functions;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus;
- Serious dysfunction of any bodily organ or part; and/or
- Serious disfigurement

**Enrollee** - an individual who is enrolled in a health plan, and who is eligible to receive covered health services in accordance with the Evidence of Coverage applicable to such individual

**Estimated Length of Stay (ELOS)** - the number of inpatient days authorized by the prior authorization department or concurrent review staff based on average days for the same diagnoses.

**Evidence of Coverage** - an agreement between FirstCare and an employer group, association, government entity, or an individual, the form of which has been approved by the Texas Department of Insurance (TDI), specifying the terms and conditions, under which covered health services are to be provided to enrollees; hereinafter referred to as Plan Document

**Expedited Appeal** - the appeal of a medical director decision regarding emergency care, a life threatening condition, or continued hospital stay that requires review by a physician not previously involved in reviewing the case, and who is of the same or similar specialty as typically manages the condition, procedure, or treatment under review. The review must be completed in a timeframe based on the immediacy of the situation, but in no event will the decision exceed one working day

**Explanation of Payment (EOP)** - refers to FirstCare's documentation, which accompanies and explains providers' reimbursement for covered health services

**Global Guideline** - the number of visits and/or length of time allotted for the treatment of a specific medical condition established by the plan based on Medicare or Texas Law

**Health Plan** - means SHA, L.L.C. dba FirstCare, a Texas limited liability company, authorized by the Texas Department of Insurance to operate a health maintenance organization and a preferred provider organization within the service area

**Hospital** - an acute care institution licensed by the State of Texas as a hospital, that is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, under supervision of a staff of physicians and with 24-hour a day nursing and physician services. It does not include a nursing home, or any part used principally as a custodial facility

**InterQual** - a nationally recognized resource used to determine appropriateness of care setting, ELOS/LOS, ambulatory care standards and the need for Assistant Surgeons

**Length of Stay (LOS)** - number given to identify the projected or actual length of an inpatient stay

**Medical Director** – physician licensed in the State of Texas and designated by FirstCare who is responsible for monitoring the provision of covered health services to enrollees

**Medically Necessary** – those services and supplies covered by the plan document which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a member’s medical condition, sickness, disease, injury, or bodily malfunction;
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States;
- Not primarily for the convenience of the enrollee, a participating physician, participating hospital, participating provider, or other health care provider; and
- Economical supplies or levels or service as may be specified in the plan document that is appropriate for the safe and effective treatment of the member. When applied to hospitalization, this further means that the member requires acute care as a bed member due to the nature of the services rendered or the member’s condition, and the member cannot reasonably receive safe or adequate care as an outpatient

**Medicare** – Title XVIII of the Social Security Act and amendments thereto

**Member** – a person who has enrolled in FirstCare as a subscriber or dependent and is eligible to receive covered health care services

**Newborn** – a recently born infant; neonate

**Notification** – process of informing FirstCare of the delivery of an emergency service and/or admission

**Office-based Procedure** – a procedure performed in an office setting that has been determined to be safe for performance in an office setting. A procedure that does not require authorization when performed in the office, but does require authorization if performed in a setting other than the office.

**Participating Hospital** – an acute care facility licensed as a hospital by the State of Texas and under contract with FirstCare to provide covered health services to members

**Participating Physician** – a duly licensed physician who has entered into an agreement with FirstCare, to provide an arrange for the provision of covered health services to members

**Participating Provider** – physician, hospital, health care facility, or other health care provider who has agreed to provide covered health services to members

**Payor** – the entity ultimately responsible for funding the payment for the covered health services provided through the provider agreement with FirstCare. FirstCare will be the payor for the insured plans of FirstCare. FirstCare will be the administrator, not the payor, of self-funded plans.

**Per Case Rate** – an all-inclusive payment to be made to the hospital for covered health services provided to a member as specified in the provider agreement and its accompanying schedules and/or amendments. A per case rate shall be considered payment in full for all covered health services provided to a member typically including, but not limited to, facility fees (emergency services, operating rooms, recovery rooms, etc.), nursing care, radiology, laboratory, and pathology charges, supplies and medications unless otherwise specified in the provider agreement.

**Per Diem** – that all-inclusive payment to be made to a hospital for covered health services provided to a member as specified in the provider agreement or its accompanying schedules and/or amendments. A per diem payment shall be made for each bed day of stay of the member, including the day of admission, but not the day of discharge unless otherwise specified in the provider agreement

**Physical/Annual Examination** – a preventive health care intervention consisting of a history, physical, and necessary laboratory examinations performed on a yearly basis and which should be scheduled within two (2) months of receiving the member's request.

**Physician** – (1) an individual licensed to practice medicine in the State of Texas as either a medical doctor or a doctor of osteopathy; (2) a professional association organized under the Texas Professional Association Act or a nonprofit health corporation certified under Section 5.01, Texas Medical Practice Act; or (3) any entity wholly owned by physicians

**Plan** – alternative term for FirstCare HMO and/or FirstCare PPO

**Post-Natal Care** – the period from delivery to six weeks after delivery in a normal uncomplicated delivery

**Post-Stabilization** – the need for continued medical attention following an emergency condition becoming stable and usually provided in a hospital setting; requires authorization.

**Prior Authorization** – having received the plan's agreement for a service to be delivered based on evaluation of medical necessity before the time the service is rendered

**Prior Authorization Department** – a part of the Medical Services Department that screens referrals and requests for HMO health care services against specific criteria, and either authorizes the care, suggests an alternative when appropriate, consults the Medical Director when indicated, and initiates the Concurrent Review process

**Prenatal** – prior to birth; refers to both the care of the woman during pregnancy and the growth and development of the fetus

**Primary Care Physician (PCP)** - a General/Family Practice, Internal Medicine, or Pediatric Physician, selected by or assigned to the care of a FirstCare Enrollee with responsibility for providing, arranging, and coordinating all aspects of the enrollee's health care

**Prior Authorization** – FirstCare's issuance of a written or verbal notice, in accordance with its policies, procedures and medical guidelines, that covered health services ordered by a provider, including but not limited to inpatient admissions, outpatient surgical procedures, provision of post-stabilization care or ordering of certain ancillary services, prescription of certain medications, and referral to non-participating providers, based on the information provided to FirstCare, are determined to be medically necessary and appropriate

**Provider** – any practitioner, institution, organization or person that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician

**Quality Improvement** – a comprehensive system designed to assess and continually improve the process of provider care and services to our enrollees

**Quality Improvement/Utilization Review Committee and Program** – a program for daily or frequent review and monitoring of covered health services being provided by a provider.

This review may include phone monitoring as well as nurse visits directly to the facility where covered health services are being rendered

**Referral** - recommendation by a participating provider that the member be seen by another participating provider or physician

**Routine Care** - health care need requiring medical attention within 2 weeks

**Specialist** - a non-primary care physician who has obtained specialty training

**State** - HHSC or an agency within the executive or legislative branch of Texas State Government other than HHSC, as appropriate

**TDI** - Texas Department of Insurance

**Urgent Care** - health care need that requires medical attention within 24 hours and/or to prevent the possibility of the condition advancing to emergent status

**Utilization Management** - the process of monitoring the delivery of health care for appropriateness of setting, provider, over and/or under-utilization of services, and length of stay

**Verification** - a guarantee of payment for health care or medical care services if the services are rendered within the required timeframe to the member for whom the services are proposed



**FirstCare**<sup>TM</sup>  
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PART OF BAYLOR SCOTT & WHITE HEALTH



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