



Provider Manual

Provider Policies & Procedures

v.2022.1

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Chapter One: First Choice Health Information

Introduction

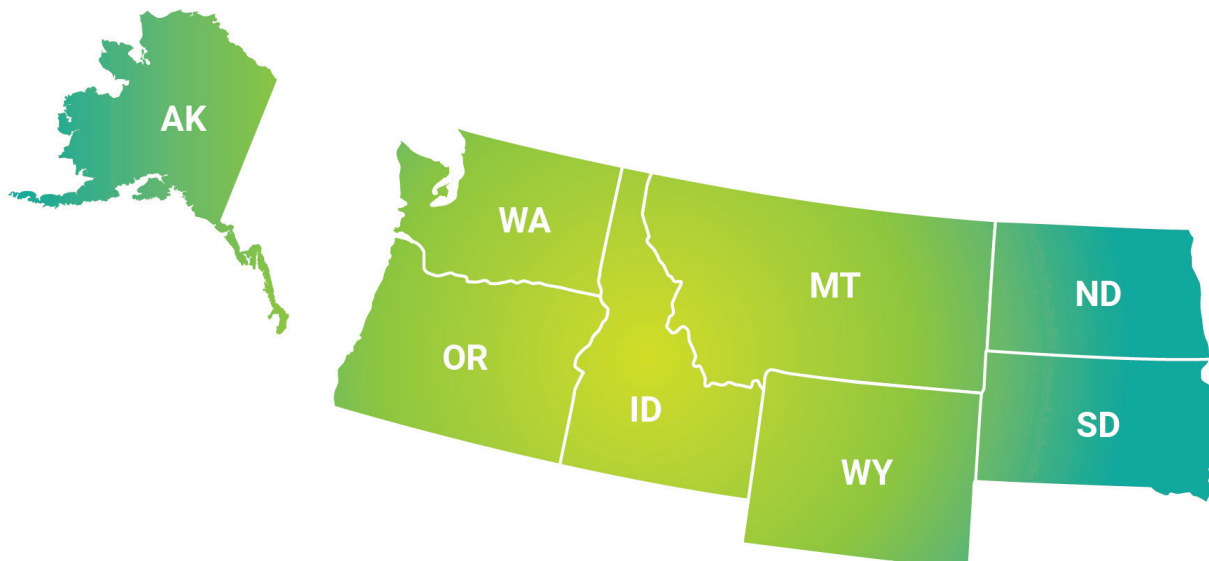
Welcome to the First Choice Health PPO Network! The purpose of this manual is to provide the basic information you and your office staff need when you see First Choice Health members. This manual provides direction and clarification regarding your obligations as a First Choice Health provider. This information is also available on our website: www.fchn.com. Check the website periodically to ensure that you are viewing the most recent version of the manual.

General Information

First Choice Health is a Seattle-based, physician and hospital owned company that has served Washington and the Northwest since 1985. We now serve approximately 1,030,000 people with our array of products and services. First Choice Health's Preferred Provider Organization (PPO Network) is recognized as the leading independent PPO Network in Washington and Oregon and has a growing regional presence in Idaho, Montana, North Dakota, South Dakota, Wyoming, and Alaska. Our network offers approximately 120,000 contracted and credentialed providers, 2,592 facilities, and 369 hospitals used by a wide variety of insurance companies, third party administrators, and plan sponsors. In addition to the PPO Network, First Choice Health offers Medical Management services, an Employee Assistance Program (EAP), and Health Plan Administration (HPA).

How to Contact Us

You can contact Provider Relations at (800) 231-6935 or via email at ProviderRelations@fchn.com. Any information that a provider needs about working with First Choice Health can be found at www.fchn.com.

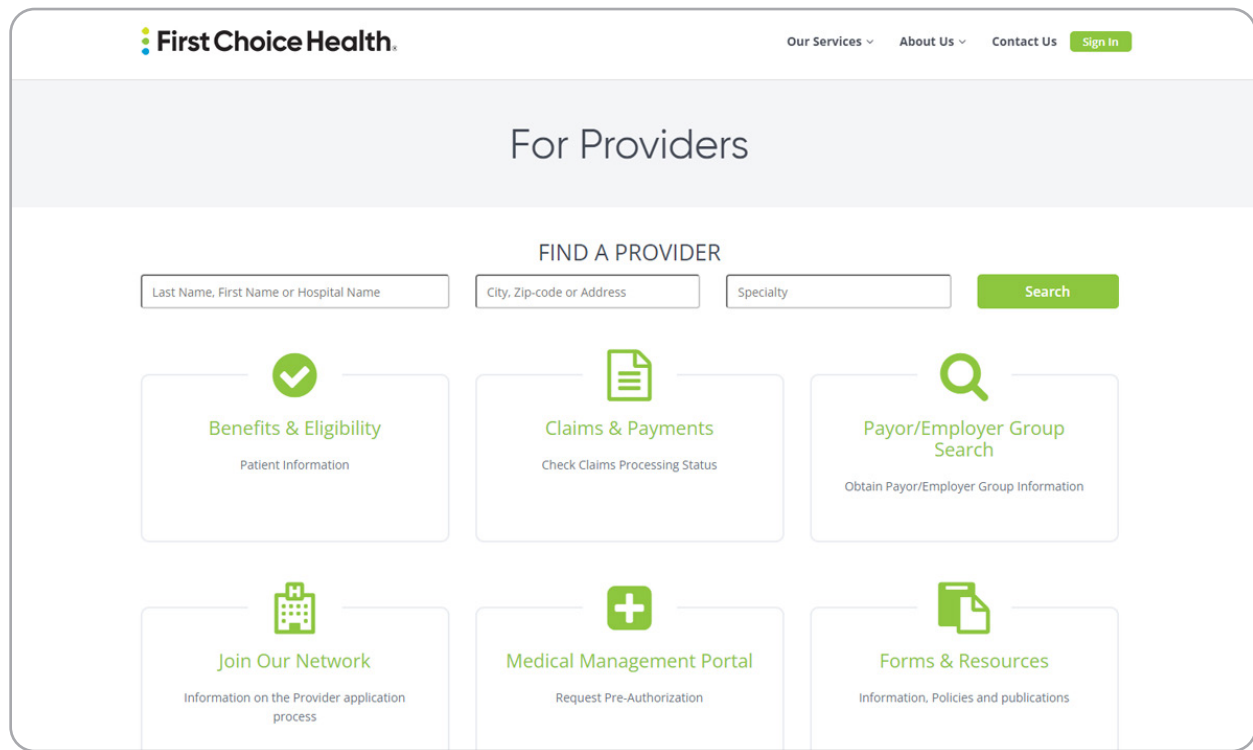


Chapter Two: Web Page

Provider Web Page

Provider Relations uses the [provider web page](#) to help educate and communicate with our providers. It explains the First Choice Health business model and how to operate within it.

We have listed some of the most widely-used tools on the web (displayed below).



- 1. Benefits and Eligibility:** This area is very similar to the Claims and Payment tool. We regularly inquire about our payors' websites/tools and we have increased visibility to their websites. We believe this will save your office time and money by eliminating phone queue wait times, increasing efficiencies, and streamlining day-to-day processes.
- 2. Claims and Payments:** All tools related to claims can be found here, including a tool which provides the websites listed in our [Payor/Employer Group Search](#) to increase visibility for providers seeking claims processing status for our PPO Payors. Providers can also view First Choice Health pricing worksheets to verify how their claim was priced and print the worksheet if necessary. Lastly, this is where providers can access their Claims Activity reports.
- 3. Payor/Employer Group Search:** This is one of the most widely used tools and offers providers a real-time lookup using group name, group number, or payor name.
- 4. Forms & Resources:** This area provides forms and publications such as the List of Payors, Provider Bulletins, and Newsletters. Providers can sign up to receive email notifications when publications are posted on the web. In addition, there are webinars that further explain the provider tools we offer and the FCH PPO business model.

Chapter Three: Claims and Billing

First Choice Health contracts with a large number of payors. This means billing claims with the employer group information is essential so we are able to direct the claims to the correct administrator for processing.

Where to Send Claims

Always refer to the member's ID card to get the most accurate information regarding where to send claims for processing. If you do not have access to the ID card, we recommend using the [Payor/Employer Group Search](#). It contains real-time data and users can look up where to send claims by searching by employer group name, group number, or payor name.

We also offer the List of Payors (under the [Forms & Resources page](#)), which is published monthly and contains all necessary claims mailing information for each of our payors. Providers should [sign up online](#) to receive an email when the List of Payors has been published.

For website assistance identifying a payor, contact the First Choice Health PPO Customer Service Department at (800) 231-6935.

The preferred method of claims receipt is EDI (electronic data interchange). The [Payor/Employer Group Search](#) and the List of Payors will provide users with the appropriate EDI submission number.

Payment of Claims

First Choice Health does not process or adjudicate claims. We offer website links for those First Choice Health Payors that offer online claims status under the 'Claims and Payments' section of the [provider web page](#). If a payor is not listed, refer to the member ID card or utilize the [Payor/Employer Group Search](#), which will provide the phone number to call to check the status of a claim. Providers who bill claims electronically and want payments to be sent to PO boxes or lockboxes will need to report this address in the "pay-to" address field on the EDI transaction (Loop 2010AB).

Claims Pricing Status

If claims are sent to First Choice Health for pricing electronically or on paper, providers have the ability to view the status of their priced claim and print a re-pricing worksheet. The status will include information such as when the claim was received, priced, allowed amount, and where it was sent for processing. It will also include the phone number to call for claims status. For more information, visit the [provider web page](#).

Benefits and Eligibility

First Choice Health does not have information regarding a member's benefits or eligibility. Contact the payor directly to verify eligibility of the member, coverage limitations, and whether or not pre-authorization or certification is required. We offer website links for the First Choice Health Payors that offer online Benefits and Eligibility on the [provider web page](#). If a payor is not listed, refer to the member ID card or utilize the [Payor/Employer Group Search](#), which will provide the phone number to call to check Benefits and Eligibility.

Group Information

Billing requirements for both Professional and Institutional claims under version 5010 include the option to submit either the insurance member's "Group ID" or "Group Name" within the 837 claim transaction, specifically, within the 5010 "SBR03" claim transaction field under segment Loop "2000B" (Subscriber Group or Policy Number).

To assist us with effectively pricing your network claims, we recommend providers also submit the "Payor Name" (name other than "First Choice Health") in the "NM103" field under EDI segment Loop "201088," in addition to submitting valid Group ID or Group Name information (not both) in the "SBR03" under EDI segment Loop "20008."

First Choice Health PPO Network may use both Group ID and Group Name information to match a claim to the specific payor. Group information is required for pricing and assists FCH PPO in accurately submitting claims to the appropriate payor for adjudication.

Without the presence of valid group information, we will be unable to accurately associate the claim to a specific payor and will have no other choice but to return/reject those claims to the provider for the required valid group information.

To conduct a search of group information by payor name or payor information by group ID or group name, use the [Payor/Employer Group Search](#).

Billing (Physical) Address and Zip+4

Physicians and healthcare providers are required to use only a street address as the billing provider address under the Version 5010 transactions. The billing provider address is reported in the billing provider loop (2010AA, N3S01, and N302) of the 837 claim transaction.

Pay-To (Remittance) Address

First Choice Health PPO Network rejects EDI claims transactions that are submitted with a post office box in the billing provider address field to comply with HIPAA. **Providers who want payments to be sent to PO boxes or lockboxes need to report this address in the “pay-to” address field on the EDI transaction (Loop 2010AB).**

HIPAA requires that all 5010 transactions are billed with extended zip codes (ZIP+4) in the billing provider Loop (2010AA N403). First Choice Health requires all transactions to include a *complete address* (a complete address is defined as including the full 9-digit ZIP code—the traditional five digits plus the extra four digits for localized mail delivery).

Interim Claims

First Choice Health does not have the ability to price interim claims. If an interim claim is received, it will be rejected and returned to the submitter. The rejection code 'C12' (*interim bills cannot be processed*) can be found on the pricing worksheet. The claim must be submitted as final for First Choice Health to price. The exception to this pricing rule is if your contract is based on a percentage of billed charges.

Collecting Funds at the Time of Service

Provider agrees upon execution of the contract with First Choice Health Network to submit a claim to the patient's insurance company and not to balance bill the patient.

Providers are permitted to collect office co-payments or co-insurance, deductibles and non-covered services at the time of service. Co-payments and co-insurance may be indicated on the member ID card or can be verified by contacting the payor directly. Deductibles need to be verified directly with the payor before the patient's visit. Non-covered services can be collected for up front if the providers verify services with the payor. There should be no contractual write-off for non-covered services. Maximum benefits of a service are considered non-covered services.

If the patient fails to provide proof of insurance at the time of service, the provider can bill up front for services. If, at some point, the patient is identified as a First Choice Health Network member, the difference between the contractual allowance and the amount collected should be refunded.

Chapter Four: Updating Provider Information

Effective January 1, 2022 Congress passed the No Surprises Act (NSA) which is changing the landscape for how health plans (fully-insured health plans, insurance carriers, and self-funded medical plans) and Provider Organizations communicate and share data.

Regardless of the state you live or practice in, you must have an active provider application with either Provider Source or CAQH, and have attested to that application between April 1st, 2022, and June 30th, 2022, or you will be removed from our Provider Directory per the NSA.

1. Attestation every 90 days is required

Applications must be attested to every 90 days to ensure your provider demographic information is current and accurate. This is an NSA requirement.

a. For CAQH, you must have global access selected or you must give FCH access to your application.

b. All provider demographic updates will be submitted to us via these attestations.

c. If adding a new Tax Identification Number, we require a W9 separate from the attestation. Send the W9 to ppofilemaintenance@fchn.com with an indication you have attested to your update via Provider Source or CAQH.

2. Removal from our Provider Directory until in compliance

If a provider has not attested to their application at least once every 90 days, we are required by the NSA to remove them from our Provider Directory. The provider will remain an in-network provider but will not be visible on our Provider Directory. If your application has not been attested in the 90 days prior to July 1st, 2022, we will deactivate your listing in our directory on that date until you have attested to your information.

How to Notify First Choice Health of Demographic Changes

- **Terminating an existing practice address:** Send an email to ppofilemaintenance@fchn.com indicating you wish termination of a specific practice address. Include your NPI and Tax Identification numbers so we can find you in our system.
- **Changing/adding a billing address:** A billing address equals pay to address or where the checks need to be sent. It should match what is being sent in box 33 on the CMS 1500 or EDI form locator 2010AA (street address) or 2010AB (PO Box). To update this address type, send an email to ppofilemaintenance@fchn.com indicating you wish to change your billing address. Include your NPI and Tax Identification numbers so we can find you in our system.
- **Tax Identifier Number changes:** Your new Tax ID information must be reflected on your online application. Once you have added it to your application and attested, email a W9 to ppofilemaintenance@fchn.com along with messaging indicating that you have added a new TIN or are changing to a different TIN. Please indicate if you are terminating an existing TIN with the effective date of the termination.

- **All other changes not listed above (new practice address, name change, specialty change, etc):** Ensure your demographics are correct and accurate on either the ProviderSource application (WA state) or CAQH application (outside WA state). Once all your information has been updated and attested to, we will automatically get the updates and make the change in our system within 2 business days.

First Choice Health Form W-9

A payor, union trust, third party administrator, or self-funded group, that is required to file an information return with the Internal Revenue Service (IRS) must obtain your correct taxpayer identification number (TIN) to report income paid to you.

Payors, union trusts, third party administrators, or self-funded groups that utilize the First Choice Health PPO Network may request a current Form W-9 from you. Without this information, payments to you may be subject to backup withholding.

First Choice Health collects W-9 forms on behalf of First Choice Health Administrators, an HPA.

A W-9 is required when you have a Tax ID (TIN) change or name change. For clarification and instruction or to obtain a blank W-9 form, visit the [IRS website](#).

Chapter Five: Payment Overview

This section of the provider manual covers any type of service where the provider’s contractual allowance is affected by certain billing methodologies.

Anesthesia Claims

Anesthesiology services are calculated using base units plus time units. The procedure for re-pricing anesthesia claims by First Choice Health is as follows:

- All claims for anesthesia services require the total time of the procedure, with the exception of codes 01953, 01995, and 01996, which do not require time units. The time billed is then converted into “time units.” Time units are calculated in fifteen (15) minute increments or four (4) time units per hour.
- All claims for maternity related anesthesia claims billed with CPT code 01967 are calculated at 15 minute increments for the first hour (4 units) and 60 minute increments for subsequent hours (1 unit).
- Any value of time up to the first 15 minutes is considered one time unit. For time billed beyond the initial time unit, FCH PPO applies a seven (7) minute rule when calculating time units. The first seven minutes reported after the first time unit will be rounded down to the previous 15-minute increment. Any time reported after seven minutes will be rounded up to the next 15-minute increment.
- All applicable codes are assigned base units on each fee schedule. Total anesthesia units are calculated by adding the calculated time units to the specific base anesthesia units that are listed on the fee schedule for the CPT code billed.
- CPT codes ranging from 0019T-0042T are Category III codes and are considered temporary (anesthesia logic does not apply). These codes will be priced at the Default Discount for each fee schedule when payable.
- First Choice Health will not accept CPT codes billed with time units for contracted anesthesia providers.
- Only bill appropriate CPT anesthesia codes (00100-01999).
- Every anesthesia procedure billed must include one of the following anesthesia HCPCS modifiers:

Modifier	Modifier Denotes
AA	Anesthesia services performed personally by anesthesiologist or when an anesthesiologist assists a physician in the care of a single patient
QY	Medical direction of one qualified non-physician
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
QX	Qualified non-physician anesthesiologist service: with medical direction by a physician
QZ	Qualified non-physician anesthesiologist service: without medical direction by a physician

Baby's Birth Weight

When billing Newborn Inpatient claims on the UB04, use Value Code 54 - Enter this code in the code field with the newborn birth weight in grams in the amount field (no decimals). Right justify the weight in grams to the left of the dollars/cents delimiter. (If billing software requires the decimal in the "Value Code" field, enter the weight in grams then decimal point 00 e.g., 2499.00). Baby's birth weight should be billed in EDI Loop 2300.

Modifiers

FCH PPO recognizes all valid CPT/HCPCS modifier codes, although not every modifier code will affect a FCH PPO negotiated allowable. There may be modifiers billed that do not impact pricing. Payment adjustment may be necessary based on the payor's medical payment policy. The following modifier table is not inclusive of all modifiers that may or may not warrant a change in reimbursement. The modifiers on the following pages are only applied to professional claims unless otherwise noted in your contract. Adjustments applied to codes billed with modifiers will be limited to the charge line in which the code and modifier were billed.

Modifier Pricing Hierarchy

The following guidelines will be used by First Choice Health to ensure correctly priced modifiers:

- Modifiers that alter the contract allowed amount due to the provider agreement should always be priced according to that agreement first.
- Modifiers that result in an allowed amount greater than the contract allowed amount are priced next.
- Modifiers that result in an allowed amount less than the contract allowed amount are priced next.
- Modifiers that do not alter the contract allowed amount are informational only.

Additional Modifier Information

Modifier	Modifier Denotes	Description
AA	Anesthesia component	The allowable amount is based on the start and end times of the procedure, and is calculated in conjunction with the predetermined base units.
AD	Anesthesia component	Reduce allowable by 50%.
AS	PA services for assistant at surgery	Reduce allowable by 80%.
NU	New DME	The allowable amount is contractually predetermined.
P3	A patient with severe systemic disease	One base unit will be added.
P4	A patient with severe systemic disease that is a constant threat to life	Two base units will be added.
P5	A moribund patient who is not expected to survive without the operation	Three base units will be added.

Modifier	Modifier Denotes	Description
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Reduce allowable by 50%.
QX	CRNA service: with medical direction by a physician	Reduce allowable amount by 50%.
QY	Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	Reduce allowable amount by 50%.
RR	Rental DME	The allowable amount is contractually predetermined.
RT	Procedure done on the right side of the body	100% of allowable
LT	Procedure done on the left side of the body	100% of allowable
TC	Technical component	The allowable amount is contractually predetermined.
UE	Used DME	The allowable amount is contractually predetermined.
22	Unusual procedural services	Upon medical review by payor, if determined appropriate, recommended reimbursement is to increase to 125% of allowable.
24	Unrelated evaluation and management service by the same physician during a post-operative period	100% of allowable
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	100% of allowable
26	Professional component	The allowable amount is contractually predetermined.
50	Bilateral procedure	150% of allowable
51	Multiple procedure	Reduce allowable by 50%.
52	Reduced services	Upon medical review by payor, if determined appropriate, recommended reimbursement is to reduce allowable by 25%.
53	Discontinued procedure	Upon medical review by payor if determined appropriate, recommended reimbursement is to reduce allowable by 50%.
54	Surgical care only	Reduce the contract allowed by 20% per applicable charge line.
55	Post-operative management only	Reduce allowable by 80%.
56	Pre-operative management only	Reduce allowable by 90%.
58	Staged or related procedure or service by the same physician during the post-operative period	100% of allowable

Modifier	Modifier Denotes	Description
59	Distinct procedural service	It may be appropriate to review supporting documentation for this distinct procedural service.
62	Two surgeons	Reduce allowable by 37.5% for a surgical procedure.
73	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	Upon medical review by payor, a determination is made on how much of the procedure was not done. It is then reduced by 25%, 50%, or 75%.
74	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure after the administration of anesthesia	Upon medical review by payor, a determination is made on how much of the procedure was not done. It is then reduced by 25%, 50%, or 75%.
78	Return to the operating room for a related procedure during the post-operative period	Reduce allowable by 20% for a surgical procedure.
80	Assistant surgeon	Reduce allowable by 80%.
81	Minimum assistant surgeon	Reduce allowable by 80%.
82	Assistant surgeon (when qualified resident surgeon not available)	Reduce allowable by 80%.

Bilateral Procedures

A valid bilateral adjustment as indicated by CMS, should be billed on one line with modifier 50. These are procedures with a Medicare Physician Fee Schedule Database (MPFSDB) bilateral indicator of one (1). If a bilateral procedure is eligible for bilateral adjustment, it should be processed with one (1) unit of service and reimbursed at 150% of allowed charges, not to exceed billed charges.

For ASCs, bilateral procedures billed on one line with modifier 50 and one (1) unit, will be reimbursed at 150% of allowed charges. Bilateral procedures may also be billed on two lines with RT and LT modifiers on each and will be reimbursed for the first line at 100% of allowed charges, and for the second line at 50% of allowed charges.

Observation and Inpatient Admission Policy

A patient admitted to observation and then admitted to inpatient status on the same day should be billed using inpatient admission codes only.

A patient admitted to observation and then admitted to inpatient status on a different day may be billed with both the initial observation codes and also hospital admission codes on the subsequent day. Any observation hours exceeding 48 hours should be billed in the non-covered column.

Claims Editing

Claims may be subject to standard claims editing software by payors to detect bundling and unbundling as well as incorrect billing.

Sales Tax

HCPCS code S9999, which bills for sales tax, will appear on FCH PPO re-pricing worksheets with an allowed amount of \$0.00 as FCH PPO does not have the authority to dictate payment on sales tax. This rule applies to all active FCH PPO fee schedules. Sales tax is reimbursable at the payor's discretion.

Supplied Vaccine Program

For current information regarding the Supplied Vaccine program, visit the WVA website (www.wavaccine.org). See below for an excerpt from the WVA website regarding the Washington Vaccine Association (WVA).

In May 2010, funding for state-supplied vaccines for privately insured children was scheduled to end. Through the WVA's work as an independent, nonprofit organization, the state has been able to continue universal purchase of state-supplied vaccines for all children under the age of 19.

What this Means for Providers

- You can continue to receive vaccines at no charge from the Washington State Department of Health *and* give your patients easy access to critical vaccinations.
- You avoid the financial and staffing burden required to purchase vaccines on your own.
- You don't need to store vaccines separately for privately and federally-covered children.

How State-Supplied Vaccines are Funded

Health plans, insurers, and other payors now pay for administered vaccines based on a per dosage assessment. The WVA collects these payments and transfers the funds to the state.

Through its Childhood Vaccine Program, the Washington State Department of Health buys the vaccines at federal contract rates and distributes them to physicians, clinics, hospitals, and other providers at no charge.

Chapter Six: FCH Network Standards of Access to Care (WA)

FCHN Participating Hospitals, Practitioners, and Facilities in Washington State shall provide timely access to adequate and appropriate care based on industry acceptable accessibility standards, contractual requirements, or as defined by [WAC 284-43-9970](#).

Accessibility Standards

FCHN shall require all contracted practitioners meet the following access to care standards:

1. Provide, or arrange for services on a timely basis, without regard to health status or medical condition, and in accordance with generally accepted medical practice guidelines and standards.
2. Furnish services to each Participant on the same basis as such services are made available to individuals who are not Participants, and without regard to the Participant's enrollment in FCHN as a private purchaser or as a participant in publicly financed programs of health care services.
3. Arrange for services to Participants during normal business hours at the usual places of business of Provider. Provider shall ensure that Provider arranges for and maintains call schedules that provide appropriate call coverage to Participants in the event Participants are unable to contact their Participating Providers.
4. Answering service (or equivalent system) availability during all non-business hours.
5. Provide access to an appointment, for other than preventative services, made available from the PCP or another provider within 10 calendar days.
6. Provide access to an appointment, for all specialists' services, with provider within 15 calendar days.
7. Provide routine, preventive care and/or periodic follow-up care appointment accessibility no greater than 45 calendar days.
8. Emergency care accessibility 24 hours per day, 7 days per week.
9. Urgent care appointments available within 48 hours.

Procedure

FCHN tracks all Participant complaints regarding accessibility standards through PPO Customer Service, HPA Customer Service, and website feedback. Upon the receipt of a Participant complaint, FCHN will address the deficiencies with the applicable contracted hospital, providers, and/or facility.

Chapter Seven: Credentialing

Credentialing and Re-credentialing

Our goal is to demonstrate to the payor community that we maintain high standards of provider credentialing, based upon national criteria. First Choice Health PPO Network reappoints all contracted providers every three years based on National Committee for Quality Assurance (NCQA) Guidelines.

Every practitioner must submit a completed, signed, and dated application to First Choice Health.

The application must be signed and dated within 180 days of Credentialing Committee review and approval.

First Choice Health formally re-credentials its practitioners at least every three years.

As of January 2011, Washington State now requires a centralized collection of provider credentialing data to simplify the provider's experience. OneHealthPort (OHP) hosts the [ProviderSource](#) application as a single source to enter your provider data for credentialing. This service is free to providers entering their data.

As of March 1, 2022, First Choice Health no longer accepts paper applications; Provider Source or CAQH application is required. All providers whose credentialing is not delegated to another organization will be required to have an active Provider Source or CAQH application. We will utilize Provider Source and CAQH applications for credentialing new providers, recredentialing existing providers, and for provider demographic updates. Please allow a standard turnaround time of 90 days.

Confidentiality

First Choice Health's Credentialing Committee is a regularly constituted review committee. The Committee is involved in credentialing, re-credentialing, ongoing monitoring and peer review of practitioners who contract with or otherwise participate in First Choice Health's PPO Network. The Committee may also be involved in the evaluation and improvement of care rendered by those practitioners. First Choice Health recognizes that confidentiality is vital to the free and candid discussions necessary for effective credential reviews, peer review, and quality evaluation and improvement activities.

Every Credentialing Committee member/participant will sign a Confidentiality Statement annually. Each committee member/participant agrees to respect and maintain the confidentiality of all discussions, deliberations, proceedings, records, complaints, reports, and all other information and documents created, collected, and/or maintained in connection with these activities. Each committee member/participant agrees not to disclose such information except to persons authorized to receive it in the conduct of First Choice Health's business.

Non-Discrimination

The FCH Credentialing Program prohibits discrimination on the basis of race, color, religion, gender, national origin, sexual orientation, marital status, age, types of procedures, or types of patients the practitioner specializes in, or any other protected classification. The Credentialing Committee members must sign a statement attesting to perform their duties in a consistent and non-discriminatory manner.

Practitioners Right of Communication about their Credentialing Status

- An applicant may request the status of their credentialing application by contacting the Credentialing Department. The request may be forwarded via telephone or written correspondence (email, facsimile and/or US mail).
- All initial applicants are informed within 30 business days (in writing) of receipt of an application submitted for network participation.
- Within one business day, a representative from the Credentialing Department will respond to the request for information (via telephone, email, facsimile and/or US mail).
- FCH is not required to reveal the source of the information if the disclosure is prohibited by state law and/or peer review protected information.
- Prior to Credentialing Committee review, the FCH Credentialing Department will accept additional information from providers to correct incomplete, inaccurate, or conflicting information.
- Prior to making a decision, the FCH Credentialing Committee may request and accept additional information from providers requesting network participation.
- Practitioners are informed of this process in the FCH Credentialing Application Packet, the FCH Provider Manual, the FCH Provider Newsletter, and/or the FCH website.

Provider Effective Date Assignment

The FCH Credentialing Committee will assign all effective dates for non-delegated providers during the Credentialing process. Effective dates are equal to the approved committee date for initial and re-credentialing applications, if you have a FCH Contract on file. If signing a new contract, your effective date will be equal to the date the contract was signed.

For providers that do not have dates assigned by the FCH credentialing Committee (e.g. Delegated Entities or Hospital Based Groups), the following rules apply:

- Hospital based profiles and rosters will be given an effective date equal to when the information is received by FCH.
- Delegated Updates and rosters will utilize the effective date provided by the delegated entity. If no effective date provided, we will assign an effective date equal to when the update was received by FCH.

Rules for Retroactive Effective Date Assignment

Retroactive effective date assignment (backdating) is not permitted.

Locum Tenens

A locum tenens provider is a provider who is sponsored by or otherwise retained by a FCH contracted provider on a temporary basis, not to exceed 180 days per 12-month period, to provide services to the contracted provider's patients. The contracted provider must be currently employed at that location. First Choice Health does not credential, contract with, or make any representation with regard to a locum tenens provider's qualifications or competency. All liability for the acts or omissions of a locum tenens provider rests with the provider or organization retaining the services of the locum tenens. Locum tenens providers must bill for their services under the name and tax identification numbers of the providers they are replacing.

Locum tenens providers must be licensed in the state in which they are practicing and must only perform services within the scope of their professional license and certification.

The locum tenens must be the same type of provider as the authorizing provider (e.g., an MD/DO can only authorize another MD/DO as a locum tenens, a DC can only authorize another DC, an ARNP can only authorize another ARNP, etc.). To be considered for locum tenens status, the temporary provider must be one of the following provider types:

- Doctor of Medicine (MD)
- Physician Assistant (PA)
- Doctor of Podiatry (DPM)
- Doctor of Optometry (OD)
- Doctor of Osteopathy (DO)
- Doctor of Chiropractic (DC)
- Doctor of Naturopathy (ND)
- Advanced Registered Nurse Practitioner (ARNP)
- Physical Therapist (PT)

Registered Nurse First Surgical Assistant (RNFA)

RNFAs must obtain certification by the Certification Board of Preoperative Nursing (CNOR). In addition, FCH requires documentation of a written formal agreement to practice in collaboration with and under the on-site supervision and direction of a FCH contracted physician.

Practitioners Right to Review (Information Submitted in Support of their Credentialing Application)

The practitioner has the right to review information obtained by FCH to evaluate their application.

The practitioner must schedule the review through the Credentialing Department in advance. If, during the review process, the practitioner identifies information that is no longer applicable or is incorrect, a written addendum may be attached to the application. Only responses to the practitioner application may be modified.

The addendum will become a part of the credentialing file. The practitioner must sign and date the addendum to certify the accuracy of the information provided.

A Credentialing Specialist must be present during the file review and will determine whether the addendum triggers review by the Credentialing Committee. The practitioner may request copies to be made of the documents in their file that were supplied by the practitioner.

Practitioners are informed of the right to this process in the FCH Credentialing Application Packet, the FCH Provider Manual, the FCH Provider Newsletter, and/or the FCH website.

FCH Criteria for Provider Denial or Termination

The FCH PPO Credentialing Committee shall approve or deny network participation. Denial or termination based upon quality of care is a reportable action.

All providers must meet credentialing and re-credentialing requirements of FCH. Failure to meet established standards or guidelines can result in the denial or termination of a provider.

- Termination of a provider contract must comply with the specific terms of the provider contract.
- A participating provider may be terminated without cause with 90 days written notice. Criteria considered by FCH PPO in making the decision to terminate without cause include but are not limited to administrative reasons.
- A participating provider may be terminated immediately with cause when charges are serious enough to warrant urgent action and/or members are at immediate risk of harm or imminent danger.

Criteria considered by FCH PPO in making the decision to deny or terminate network participation include, but are not limited to the following criteria:

1. Lack of network and/or membership needs
2. Inability of FCH PPO to complete credentialing/re-credentialing due to the applicant's failure to provide relevant information or the necessary release
3. Submission of inaccurate or misleading information on the application, or failure to disclose relevant information
4. Voluntary relinquishment, withdrawal or failure to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional competence or conduct
5. Failure to notify FCH PPO of any changes in clinical privileges, hospital staff privileges, practice scope; sanctions/restrictions or of any medical or mental health problems that could affect the care of patients
6. Lack of local hospital admitting privileges or an inpatient coverage plan (if applicable)
7. History of restrictions on hospital privileges or scope of practice
8. Inadequate inpatient coverage plan (if applicable)
9. Current or previous loss of, or restrictions to, hospital, clinic, facility, surgical center, network, or other healthcare privileges
10. Refusal, revocation, suspension or restrictions of hospital staff privileges at any hospital
11. Loss of Board certification status based on a adverse event

12. Current or previous loss of or insufficient/inadequate malpractice insurance coverage
13. History of malpractice claims judged excessive by the Credentialing Committee. Professional liability claims history is defined as cases that are settled and have resulted in an adverse judgment against the provider
14. Current or previous sanctions by Medicare/Medicaid (including censure or exclusions)
15. Current or previous quality issues as reported by National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Data Bank (HIPDB), licensing boards or prior work/training sites
16. Current or previous loss of, restriction to or sanctions on professional licensure, certification/ registration or authorization to practice, including, but not limited to, probationary status, chaperone or related requirements (i.e., monitoring, open doors, etc.), or prescribing limitations, required supervision or restricted hospital privileges
17. History of practicing without valid license, registration/certification or authorization
18. History of significant patient complaints documented by licensing authority, healthcare facility, health plan, or network administrator
19. Current or previous revocation or loss of, or restrictions to, DEA registration
20. History of concerns about quality of care or evidence of compromised quality of care
21. Current or history of chemical dependency/substance abuse
22. Current physical or mental health problem(s) which significantly impair practitioner's ability to perform within the scope of his/her professional duties
23. Physical or mental health condition that may impair the provider's ability to practice within the full scope of licensure and qualifications or may impose a risk of harm to patients
24. Notification from a confidential program for chemically impaired providers e.g., Washington Physicians Health Program, documenting that they can no longer provide advocacy for the provider because of instability in his/her recovery and/or for non-compliance with the Program/Contract
25. History of providing patient care outside of the scope of license, registration/certification or authorization
26. Practice inconsistent with professional standards of care
27. Criminal record affecting professional practice
28. Current or history of a felony conviction
29. Unethical conduct or history of unethical conduct, in violation of laws or standards governing the practice of health care
30. Acts of, or history of, fraud, deceit, dishonesty or moral turpitude
31. Practice trends, or history of, practice trends that raise concerns regarding provider's ethics, quality of care, and/or practice standards
32. Current or history of inadequate medical record practices or inappropriate billing practices (i.e., upcoding, failure of adequate chart documentation to support submitted claims, etc.)

33. Submission of erroneous, improper, or incomplete claims
34. Failure to comply with procedures implemented in connection with the administration of utilization review or failure to cooperate with the quality management activities
35. Non-compliance with or history of non-compliance with FCH PPO Provider Contract

Appeals Process

First Choice Health PPO Network's (FCH PPO) decision to deny an Initial Application for network participation is not appealable.

An Initial Application is defined as an application submitted by a practitioner who is not currently credentialed and/or contracted with FCH PPO.

Practitioners denied initial network participation are not eligible to reapply for at least one year from the date of the denial or until any specified terms for reapplication have been satisfied.

Practitioners denied initial network participation more than once are not eligible to reapply for network participation for at least five (5) years from the most recent date of denial.

If FCH PPO places a practitioner on suspension, imposes a corrective action plan, or terminates the provider for failure to meet participation criteria that was based on a "quality of care" concern, the practitioner has the right to appeal the decision and the right to have their legal representation participate. Appeal hearings are set forth herein to assure that the affected practitioner is afforded all rights to which he/she is entitled.

Decisions that are administrative in nature and do NOT involve a patient "quality of care" concern, are NOT appealable and are the final decision of the credentialing committee or Chief Medical Officer, where appropriate. Practitioners that are terminated are NOT eligible to reapply for at least two years from the date of the termination or until any specified terms have been satisfied. The application will be treated as an initial application.

Level I Appeal

1. The practitioner will be notified of termination, suspension, imposition of corrective action plan, or denial, in writing, within ten (10) business days of the action and/or approval of minutes. The notification will include the reason(s) for the action, a summary of FCH appeal rights, and the appeals process. The notification will be forwarded via standard mail.
2. Upon receipt of notification of termination, suspension, imposition of corrective action plan, or denial, the provider may submit a request for appeal.
3. The appeal must be in writing and must contain details of the practitioner's issues with the decision or the decision making process.
4. The appeal must be received within thirty (30) days of the date of receipt of the written notice of termination, suspension, imposition of corrective action plan, or denial.
5. Within ten (10) business days of receipt of the practitioner's appeal, the practitioner will be notified in writing (via standard mail) of receipt of appeal and of the anticipated Credentialing Committee review date.
6. The appeal will be reviewed by the Credentialing Committee within sixty (60) days of receipt of appeal, unless FCH and appealing practitioner both agree to a different timeline.
7. The Credentialing Committee will review the appeal and move to uphold or not uphold the original decision by a majority vote.
8. The practitioner will be notified of the outcome within ten (10) business days of approval of the associated Credentialing Committee minutes. The notification will include the reason(s) for the action and a summary of FCH appeal rights and the appeals process. The notification

will be forwarded via standard mail.

9. If the decision of the Credentialing Committee is to uphold the original decision, the provider may then request a Level II Appeal.

Level II Appeal

1. Practitioner may request in writing a hearing with the Level II Appeals Committee. Level II appeals have an administrative fee of \$5,000. The request and administrative fee must be received by FCH within thirty (30) days of receipt by the provider of the Level I Appeal decision.
2. Within ten (10) business days of receipt of the provider's appeal, the practitioner will be notified in writing (via standard mail) of receipt of appeal and of the anticipated Appeals Committee review date.
3. Practitioner will receive a summary of his/her rights and a description of the Level II Appeals process within ten (10) business days of receipt of request for a Level II Appeal.
4. The appeal will be reviewed by the Appeals Committee within sixty (60) days of receipt of appeal, unless FCH and appealing practitioner both agree to a different timeline.
5. Practitioner will have the right to legal representation. Any costs related to such representation are the practitioner's responsibility.
6. The practitioner and/or Legal Representative will be notified thirty (30) days in advance of the scheduled hearing.
7. If the hearing date is not acceptable to the provider and/or Legal Representative, a one-time written request to reschedule the hearing may be submitted to FCH. FCH will move the provider's hearing date.
8. Additional requests for rescheduling the hearing will not be honored unless extenuating circumstances exist. If extenuating circumstances do not exist, the final determination of the Level I Appeals Committee will be considered binding. Extenuating circumstances include, but are not limited to, health issues verified by a licensed physician who certifies in writing that the practitioner is unable to participate in the hearing, and/or natural disasters. The Credentialing Manager will forward second requests to the FCH Legal Representative and/or the Credentialing Committee Chair for a final decision.
9. Practitioner will have a right to receive a full set of all written materials and documentation considered by the Credentialing Committee in making its decision with regard to provider. Documents will be forwarded (via standard mail) to the members, the provider, and/or Legal Representative ten (10) business days prior to the hearing.
10. Practitioner will have the right to present information and other documentation determined to be relevant by the hearing officer.
11. Practitioner will have the right to submit a written statement at the close of the hearing.
12. The voting members of the Level II Appeals Committee are appointed by the FCH President and CEO or his/her designee. Voting members will be selected from the FCH Board of Directors, the FCH Quality Improvement Council, the FCH Medical Advisory Committee, and/or community health care practitioners. Prior participation in the credentialing process of the appellant disqualifies a candidate from participating in the Level II Appeals Committee.
13. The Level II Appeals Committee will consist of no less than two (2) actively practicing health

care practitioners, with at least one (1) of them being in the same practice category (i.e., MD/DO, Naturopath, Chiropractor, etc.).

14. Decisions of the Appeals Committee are reached by majority vote. A quorum consists of three (3) voting members, to include at least two (2) health care practitioners.
15. The FCH President and CEO or his/her designee will serve as the hearing officer.
16. At the discretion of the Credentialing Committee, a representative may be appointed to act as a liaison to the Level II Appeals Committee to provide pertinent history summarizing the Credentialing Committee's decision, if desired by the Level II Appeals Committee.
17. Formal minutes will be taken at the meeting.
18. The Appeals Committee will have access to all written materials and documentation that were reviewed by the Credentialing Committee.
19. Decisions regarding the appeal will be determined by majority vote of the voting members constituting the Level II Appeals Committee.
20. The written notification of the decision will be sent to the practitioner within ten (10) business days of the meeting. The notification will include the reason(s) for the decision.
21. The written notification will be sent via standard mail.
22. The decision of the Level II Appeals Committee will be final and binding for all involved parties.

Chapter Eight: Payor Information

What is the relationship between First Choice Health and its payors?

As a PPO, First Choice Health contracts with health care providers and facilities. Payors contract with First Choice Health to gain access to the network of providers for the employees (and their dependents) of these groups. The payor will offer benefit incentives for the covered members to obtain services from First Choice Health providers. Payors can be an insurance company, third party administrator (TPA), union trust, or a self-insured employer.

Benefits, Eligibility, and Claims Status

To determine if a patient is eligible for coverage or for information regarding the level of coverage or benefits offered, contact the payor directly. The payor's telephone number can be found on the member ID card. In addition, the number to call for claims status can be found on the pricing worksheets. If the patient does not have their ID card, refer to [provider web page](#).

We offer website links for the First Choice Health Payors that offer online Benefits and Eligibility and Claims Status on the [provider web page](#). If a payor is not listed, refer to the member ID card or utilize the [Payor/Employer Group Search](#) which will provide the phone number to call and check on Benefits and Eligibility or Claims Status.

After seeing a First Choice Health patient, submit the claim for services to the address listed on the member ID card. If the patient does not have their ID card, use the [Payor/Employer Group Search](#) to search for the patient or subscriber's payor by payor name, employer name, or employer group number (for more information, refer to [Chapter Three](#)).

The screenshot shows the First Choice Health website interface for the Payor/Employer Group Search. At the top, the First Choice Health logo is on the left, and navigation links for 'Our Services', 'About Us', 'Contact Us', and 'Sign In' are on the right. The main heading is 'Payor/Employer Group Search'. Below this, a descriptive text states: 'Search for First Choice Health PPO Network Payors/Employers Groups. This section will enable you to locate addresses for submitting claims and telephone contact numbers for benefits and eligibility information.' A search input field is provided with the placeholder text 'Search by Payor/Employer Name or Group Number...' and a green 'Search' button. Below the search field, a result is displayed for 'Aetna - Montana, Wyoming and Western South Dakota' with a sub-note: 'First Choice Health is the network for Aetna in Montana, Wyoming and Western South Dakota. Please refer to the member's ID card for more information.' The footer contains the First Choice Health logo, 'HIPAA Statement Forms & Resources', 'Press Careers', and 'Feedback Sitemap'.

Member Identification Cards

To identify a First Choice Health patient, look for the First Choice Health name or logo on the member ID card. The ID card typically includes the following information:

- Subscriber (employee) name
- Subscriber social security number or other applicable ID number
- Any group, plan, or account number
- Employer group name
- Payor name and logo
- Address to send claims
- Co-payment amount due at time of service
- Telephone number to verify benefits, eligibility, and claim status.

Use the above information when filling out the claim form for billing.

We have several sample ID cards available on the [Payor/Employer Group Search](#). When searching at the payor level, if there is a sample ID card it will be shown under the Reference Materials tab.

Explanation of Payment (EOP/EOB)

Payment received from one of our payors will include an Explanation of Payment (EOP), also referred to as an Explanation of Benefits (EOB). The EOP/EOB will provide you with details on how to apply the reimbursement, if any, to your billed charges. It will also contain other information such as:

- Contractual allowance
- Contractual write-off amount
- Patient responsibility (co-pays, deductible amount, etc.)
- Any other details regarding coding, bundling, etc.

Review the EOP/EOB carefully to ensure proper reimbursement for services according to your contractual agreement with First Choice Health. If you feel there has been a discrepancy with your contractual allowance, contact Provider Relations for assistance.

Chapter Nine: Quality

First Choice Health product performance is measured by identifying and implementing a set of organizational quality standards designed to meet and exceed customer and regulatory requirements.

First Choice Health tracks, trends, and looks for opportunities to improve services across all divisions and departments. Measures are tracked daily and reported weekly, monthly, and quarterly to appropriate corporate and quality committees.

Metrics Monitored at a Corporate Level

- Customer Service and Provider Relations call statistics
- Average answer time
- Abandonment rates
- Claims processing metrics
- Claims pricing turnaround times
- Days on hand
- Payor pricing
- Active providers
- Provider files

Receiving and Tracking Complaints

First Choice Health has a process for tracking any written or verbal concerns from any customer who accesses care and services through a participating FCH provider.

Complaints regarding providers: Any issue, verbal, or written statements, regarding perceptions of sub-standard care, administrative service, or office environment of a provider. Complaints fall under two categories:

1. Perceived Service Quality Concern: Any non-clinical issue, raised verbally or in writing, regarding the administrative service or office environment of a participating FCH provider. Service quality includes perceived friendliness and courtesy of staff.
2. Perceived Quality of Care (PQOC) Concern: Any verbal or written concern about the perceived quality of clinical care provided or actions taken by a healthcare provider. Either the participant or his/her designated representative, a provider, FCH Medical Management staff, or a client may submit a perceived quality of care concern.

Perceived quality of care concerns are initially reviewed by the Chief Medical Officer or medical director designee. As part of the review, patient medical records may be requested. The final review of the complaint may be submitted to the Credentialing Department.

Chapter Ten:

Frequently Asked Questions

What is the relationship between First Choice Health and its payors?

As a PPO, First Choice Health contracts with health care providers and facilities. Payors contract with First Choice Health to gain access to the network for the employees (and their dependents) of those groups. The payor will offer benefit incentives for the covered members to obtain services of FCH providers. Payors can be an insurance company, third party administrator (TPA), union trust, or self-insured employer.

How will I know if my patient has access to First Choice Health providers?

Refer to the member's ID card to verify that the First Choice Health logo appears on the card. If the patient does not have an ID card, refer to the [Payor/Employer Group Search](#) and search by the payor name, employer/group name, or employer/group number.

How do I make sure my provider demographic information is current with the network?

Utilize the First Choice Health website to look up your practice. Look for the Provider Search tool in the center of the [home page](#).

Where do I submit claims?

Refer to the member's ID card for claims address verification. If the member does not have an ID card, you can use the [Payor/Employer Group Search](#) to verify a payor's claim address.

For more information, see the Claims and Billing section titled "Where to Send Claims" in [Chapter Three](#).

How do I obtain claims status?

Refer to the member's ID card for the payor number to obtain claims processing status. We offer website links for those FCH Payors that offer online claims status under the "Claims and Payments" section of the [provider web page](#). If the payor you are looking for is not listed, utilize the [Payor/Employer Group Search](#), which will provide the phone number to call to check the status of your claim.

How will I know if a co-payment or co-insurance is due?

Refer to the member's ID card for co-payment and/or co-insurance amounts. If the member does not have an ID card, you can use the [provider web page](#) to verify patient responsibility. For more information, see the Claims and Billing section titled "Collecting Funds at Time of Service" in [Chapter Three](#).

How do I obtain allowables for my practice?

You can contact Provider Relations to get allowables for individual CPT codes or you can request a copy of your current fee schedule.

What are my members' benefits?

Refer to the phone number listed on the member's ID card. We provide links for those FCH Payors that offer online Benefits and Eligibility on the [provider web page](#). For more information, see the Claims and Billing section titled "Benefits and Eligibility" in [Chapter Three](#).

Do First Choice Health patients need a referral or prior authorization to see me?

Not all First Choice Health payors require referrals or prior authorizations for in-network specialty care services. Providers should contact the member's insurance carrier to determine if any referral or prior authorization is required. This can be achieved by referring to the member's ID card or [List of Payors](#).

Do I need to obtain a patient's insurance card with each visit?

Beyond the insured's name and policy number, cards contain instructions about billing, obtaining benefits/eligibility, or pre-certification/prior authorization for services. It is important to note that each payor has its own requirements, so carefully review the information on the card with each visit as information does change often. For most cases the claims will be sent to First Choice Health first for pricing, however, there are some variations in the instructions as to where to mail claims. As a Preferred Provider in the FCH PPO Network you are contractually obligated to accept the agreed allowable reimbursement amounts and collect only the patient's co-pay, deductible and out-of-pocket expenses.

How will I know if my reimbursement rate is correct?

All claims for First Choice Health members should be priced and adjudicated by the payors according to your contract allowable or fee schedule allowable. The payor will apply the member's benefits using this allowed amount and remit a check (if payment is allowed) along with an Explanation of Payment/Explanation of Benefit (EOP/EOB) advising how the benefits were applied. Review the EOP/EOB closely to ensure the amount declared as "allowed amount" corresponds with your expected contractual allowance. The EOP/EOB will also indicate what, if any, portion should be considered member responsibility. This is expanded upon further in the Payor Information section titled "Explanation of Payment" in [Chapter Five](#).

Where do I find information regarding Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA/835)?

To receive payments electronically from our Payors, contact the EFT vendor associated with each Payor. When notified, the EFT vendors are displayed under the "Submit Claims to" column in our [List of Payors](#).

What should I do if my reimbursement rate is incorrect?

If the EOP/EOB indicates that you were not reimbursed at the correct allowed amount or if you aren't certain what the allowable amount should be, you may reference the repricing worksheet on the website if the claim was sent to FCH for pricing (EDI# 91131 or PO Box 2289, Seattle, WA 98101). Go to the [provider web page](#) and under 'Tools and Resources,' select "Priced claims status" to view and print the pricing worksheet if needed. If the claim was not priced by FCH, contact Provider Relations at (800) 231-6935 or via email at ProviderRelations@fchn.com for assistance.

How do I appeal a claim?

The appeal of a payor's payment claim should be done directly with the payor. First Choice Health PPO Network does not pay claims, we only price the claims based on the your contractual allowance. Send all appeals to the address on the EOB, not to the claims pricing address (since that is typically the FCHN PO Box).

How do I know that First Choice Health is up to date with all federally mandated rules?

We make every effort to stay in compliance with all federally mandated rules. Check our Newsletters and Bulletins for any upcoming federally mandated changes.

How do I verify credentialing or re-credentialing status?

The credentialing process is complex and we aim to be as accurate and comprehensive as possible. As a result, the process may take up to 90 days. If after 90 days you do not receive your welcome or reappointment letter, contact Credentialing at credentialingapp@fchn.com.

How do I update my demographic information (e.g., tax ID number, add a practitioner, or update my address)?

Please refer to [Chapter Four](#).

What role does the Provider Rep play with my practice or facility?

- FCH Provider Reps are advocates for you and the network.
- We're focused on helping providers understand the PPO Network business model.
- We're here to help contracted providers decrease pricing turnaround times.
- We're able to conduct provider training in person or by webinar.
- We're available to assist providers with pricing discrepancies.