

# **PAYOR MANUAL**

**Payor Information & Procedures**

**[www.fchn.com](http://www.fchn.com)**

**v.2020.1**

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# Introduction

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## About the Payor Manual

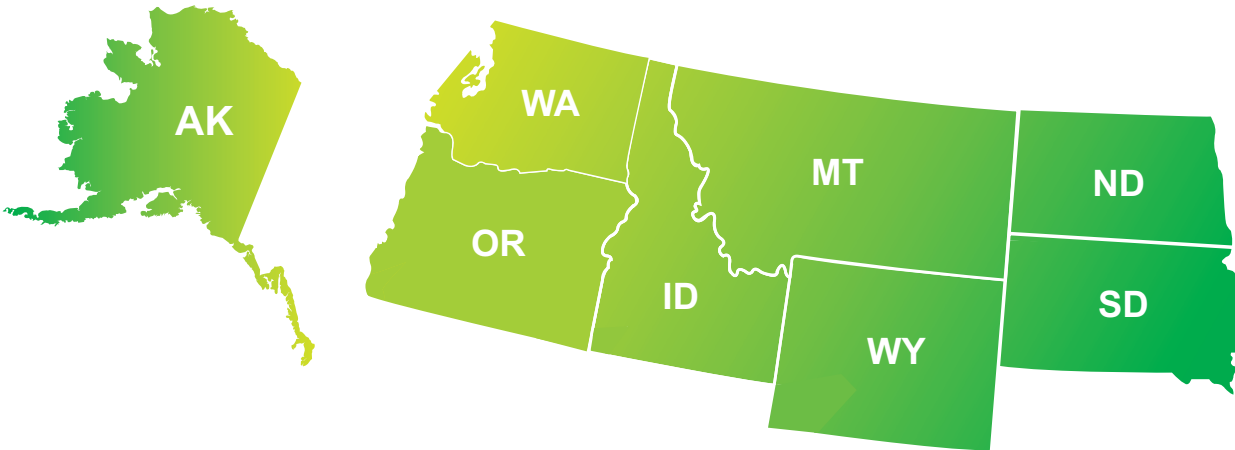
This manual is a guide to help you better understand the role that First Choice Health plays in our relationship with your company and to provide answers to frequently asked questions about FCH's PPO Network. This information is also available on our website: [www.fchn.com](http://www.fchn.com). Check 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 96,000 contracted and credentialed providers, 2,400 facilities, and 362 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 PPO Account Management at (800) 231-6935 or via email at [ppoaccountmanagement@fchn.com](mailto:ppoaccountmanagement@fchn.com). Visit the payor website at [www.fchn.com/PayorPortal](http://www.fchn.com/PayorPortal) to find tools, forms, reports, and the latest payor communications (see page 8 for more information).



# Departments Overview

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## Account Management

The Account Management department acts as a liaison and primary point of contact for all contract holders in order to address questions, concerns, and other needs as they may arise. This department can answer questions regarding your Contract Holder (Payor) Agreement, assist with Requests for Information (RFI's), facilitate the addition of groups, and assist with escalated issues involving your account.

The Account Managers strive to provide optimum assistance and communication to our contract holders and their subsidiaries. Each Account Manager is assigned specific clients, enabling each client to have a familiar point of contact they can count on to be available to them on a regular basis. They research and manage any concern regarding their assigned clients. If they cannot resolve the concern directly, they will contact those parties either internally or externally needed in order to reach a resolution.

The Account Management staff is available from 8 am to 5 pm PST, Monday through Friday, with the exception of holidays and meetings that require the attendance of all Account Management personnel. The Account Management email address is [ppoaccountmanagement@fchn.com](mailto:ppoaccountmanagement@fchn.com).

## Customer Service

The Customer Service department is available to assist plan members with any network related questions or concerns. This would include, but is not limited to, locating participating providers, ordering directories, assistance with website navigation, or addressing provider directed member complaints.

The Customer Service department is available 8 am to 5 pm PST, Monday through Friday, with the exception of holidays. You can contact the Customer Service department at (800) 231-6935, Ext. 2102.

## Reimbursement

The Reimbursement department determines the appropriate reimbursement methodology and calculates reimbursement allowances based upon information billed on claims received by First Choice Health.

Claims billed by an FCH contracted provider can be priced:

- Automatically if they are transmitted from the provider via EDI.
- Automatically if they are transmitted from the payor or contract holder via EDI.
- At FCH by the Reimbursement department.

## Medical Management

The Medical Management department performs many functions for those contract holders that choose to subscribe to their services. Examples of some of those services would be case management, utilization review, and pre-authorization. These services are provided to all subscribing clients with the utmost discretion. The Medical Management department is available 8am to 5pm PST, Monday through Friday, with the exception of holidays, and can be reached at (800) 808-0450.

## Employee Assistance Program

The Employee Assistance Program (EAP) is a stand-alone benefit, sold separately from insurance by brokers to employers. Its purpose is to supplement an employee's mental health benefits, as well as to offer numerous other offerings to the employees of such companies. The EAP representatives can assist with setting up counseling appointments, coordinating legal referrals and financial referrals, childcare and eldercare referrals, identity theft assistance, and directing the member to assistance with buying and selling a home. Each benefit is offered ala carte and some groups may pick and choose various services for their employees. The EAP customer service department is always available 24 hours a day, 7 days a week at (800) 777-4114.

## Health Plan Administration

First Choice Health offers Health Plan Administration (HPA) to provide outstanding customer care, timely and accurate claims administration, and online access to claims and benefits information. Our offerings include custom networks and benefit plan designs for self-funded plans. The full suite of integrated solutions is electronic, highly efficient, and flexible in order to meet the needs of their clients. Our experienced staff is dedicated to service excellence on all levels.

HPA services provided include:

- Eligibility and Enrollment
- Claims Processing
- Integrated Medical Management
- Comprehensive Case Management
- Health Savings Accounts and Health Reimbursement Accounts
- Flexible Spending Accounts (Medical and Dependent Care)
- Web based Consumer Decision Support Tools
- Comprehensive Reporting Package
- Regulatory and Compliance Consultation
- Pharmacy Program Administration
- Stop-loss Administration
- COBRA Administration
- Health Risk Assessments
- Debit Benefit Cards

The HPA department also utilizes First Choice Health's PPO Network. Our PPO Network serves members in Alaska, Idaho, Montana, North Dakota, Oregon, South Dakota, Washington, and Wyoming.

The HPA Customer Service team is available at (800) 450-3818 from 8 am to 5 pm PST, Monday through Friday, with the exception of holidays.

## Network Coverage Outside the Northwest

For coverage outside the Northwest, both First Choice Health PPO Network and First Choice Health HPA members have access to Multiplan PPO Network ([www.multiplan.com](http://www.multiplan.com)) and First Health PPO Network ([firsthealth.coventryhealthcare.com](http://firsthealth.coventryhealthcare.com)).

# HIPAA

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The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996. This legislation improves the portability and continuity of health benefits, ensures greater accountability regarding healthcare fraud, and simplifies health insurance administration. In Title II of the Act, a subsection entitled “Administrative Simplification” mandates compliance with a wide range of health information management and privacy standards. Additionally, First Choice Health’s PPO Network is a member of the Association of Washington Health Plans Administration Simplification Collaborative.

First Choice Health takes the utmost care to be compliant with all applicable regulations. This statement provides a summary of FCH’s HIPAA position and implementation plan.

## Covered Entity/Business Associate

First Choice Health recognizes that, according to the HIPAA regulations, each specific trading partner relationship will determine whether we are functioning as a covered entity or a business associate. Employers and clients who sponsor group health plans, their payors (insurers), and providers who conduct one of the designated transactions electronically are defined as covered entities per §164.501. FCH’s PPO Network will typically function as a business associate to client payors and employers.

FCH makes no warranty or representation on behalf of other covered entities that they will comply with the HIPAA regulations. Covered entities, as defined by §164.501, are solely responsible for HIPAA compliance for their own purposes regardless of their business relationship with the PPO Network.

The information provided in this document does not constitute, and is no substitute for, legal or other professional advice. Users should consult their own legal or other professional advisors for individual guidance regarding the application of HIPAA law to their particular situations and in connection with other compliance related concerns.

## Privacy Standard

The purpose of the HIPAA Privacy Rule is to protect the rights of individuals with respect to their individually identifiable protected health information (PHI). Compliance with this rule is required.

### The Privacy Rule:

1. Identifies health information that is covered.
2. Defines the acceptable use and disclosure of such health information.
3. Establishes individual rights.



We are required to adopt policies and procedures to safeguard all individually identifiable health information. FCH has established and is continually updating policies and procedures that address all relevant HIPAA regulations.

## Security Standard

The HIPAA Security Rule improves the effectiveness and efficiency of the healthcare industry by establishing protection levels for certain electronic health information. The Security Rule was the final rule to be implemented by health plans, healthcare clearinghouses, and certain healthcare providers. It adopts standards for electronically protected health information (ePHI).

The Security Rule assures the protection of the integrity, confidentiality, and availability of collected, maintained, used, and transmitted ePHI.

First Choice Health is required to adopt policies and procedures to safeguard all individually identifiable health information. FCH continually establishes policies and procedures that address all relevant HIPAA regulations.

## Electronic Transactions Standard

First Choice Health supports and encourages fully compliant HIPAA claims transactions. We support our current clearinghouse proprietary format, as well as, the HIPAA ANSI X12 format for exchanging claims transactions (837 P and I) with our clearinghouse.

We continue to support accepting claims from our clearinghouse as well as being able to accept claims transactions directly using the ANSI X12 format. If you are interested in direct claim submission with FCH, please contact us at [ediservices@fchn.com](mailto:ediservices@fchn.com).

## Collaborative Effort

First Choice Health voluntarily participates in meetings with various groups (health plans, providers, and vendor organizations) to address the implementation of standardized electronic transactions, the use of secure internet-based technology, and the aspects of Administrative Simplification.

## HIPAA Contact

If you have any further questions on our HIPAA compliance efforts, please contact your PPO Account Manager, or the FCH Compliance Officer at [compliance@fchn.com](mailto:compliance@fchn.com).

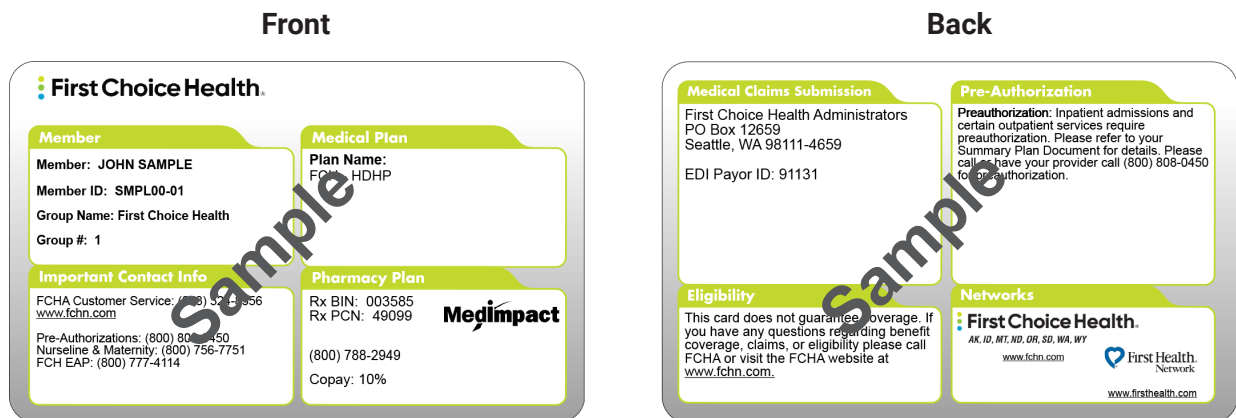
# First Choice Health Name and Logo

## Member Identification Cards

The contract holder or their payors will issue identification cards to plan participants which indicate, at a minimum, the items set forth in Exhibit C of the contract holder agreement including:

- The First Choice Health name and/or logo
- Participant name
- Any group name/logo
- Contract holder name/logo
- Claims submission address
- Co-payment due at time of service
- Telephone number to verify eligibility, benefits, and claims status
- Utilization review/medical management vendor

PPO Network providers may refuse the benefit of PPO Network's preferred rates to the contract holder, or its payor, if the member's card does not display the minimum data elements and the First Choice Health name or logo.



# Payor Website and Communications

## Online Secure Payor Portal

First Choice Health provides an [Online Secure Payor Portal](#) to efficiently communicate and allow 24/7 access to tools and reports. You can use this portal as a “network tool kit” for finding released publications, training communications, forms, and reports that you use most frequently. To access this website, contact your Account Manager for your log-in credentials.

**First Choice Health.** Our Services ▾ About Us ▾ Contact Us [Sign In](#)

### For Clients

FIND A PROVIDER

Last Name, First Name or Hospital Name City, Zip-code or Address Specialty [Search](#)

- Employers**  
For Self-Funded Employer Groups  
Analytics and Reporting Tools
- Payors**  
For TPAs, Unions, & Trusts  
Secure Payor Portal
- Producers**  
For Strategic Partners & Affiliates  
Analytics and Reporting Tools
- Request for Proposal**  
Complete the RFP Form to request a quote on our services.
- GeoAccess Reports and Provider Directories**  
Report Request Form
- Forms & Resources**  
Online Forms, FAQs, and Marketing Collateral

**First Choice Health.** Our Services ▾ About Us ▾ Contact Us [Sign Out](#)

### Payor Portal

- Home
- Claims Management
- Payor Bulletins
- Repricing Instructions
- Remote Access Guidelines
- Monthly Provider Files
- Washington OIC Report
- View Print Queue

The Contracted Payors Portal is designed to provide our clients with quick and easy access to resources that will assist you in managing the information provided by First Choice Health PPO Network.

By selecting the appropriate link on the navigation bar located on the left of this page, you can search for pricing worksheets, print priced claim batches, review important Payor Bulletins, pick up files that are posted for your company and more.

Information available on the portal includes:

- Claims Activity Reports and Priced Claims Batches
- Credentialing Status Report
- EDI Trading Partner Setup Information
- Payor Bulletins and Newsletters
- Remote Pricing System Access (for those payors with remote pricing capabilities)
- Provider and Hospital Directories
- Other Reports, Tools, and Resources

## Payor Bulletins

Urgent updates, announcements, and other system information are available for download from the [Online Payor Portal](#). Payor Bulletin notifications will be emailed to the contact information on file. You may unsubscribe at any time. (When referring to a payor bulletin please use the control number and subject line from the email).

# Contracted FCH Providers

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## NCQA Accredited Credentialing

First Choice Health's credentialing process is accredited through the [National Committee for Quality Assurance \(NCQA\)](#). Through its accreditation and certification programs, this independent and non-profit organization is the leader in promoting healthcare quality. NCQA offers wide-ranging quality benchmark programs and services that keep pace with the rapidly changing healthcare system.

NCQA provides a symbol of excellence to organizations validating their commitment to accountability and quality. Their broad based governance structure and inclusive standards-development process ensures complete stakeholder representation in establishing meaningful quality measures for the entire healthcare industry.

## W-9 Forms

The form W-9, Request for Taxpayer Identification Number and Certification, certifies under perjury penalties by the IRS that your Tax Identification Number is correct and you are not subject to backup withholding. Failing to certify on a Form W-9 (or similar statement) may cause the IRS to initiate:

- Immediate backup withholding on your account
- Withholding of twenty-eight percent of the interest or payments paid on your account for income tax

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](#).

## How to Request a Credentialing Application be sent to a Non-PPO Provider

Contact First Choice Health with the desired provider's contact information and we will send a credentialing application. Providers can also submit an application online at [www.fchn.com/Providers/NetworkParticipation](http://www.fchn.com/Providers/NetworkParticipation).

# Claim Pricing

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Pricing of a claim through First Choice Health is done either by the First Choice Health Reimbursement department or by payors with remote access.

## Remote Access Payors

Remote access payors are able to log in to the First Choice Health pricing system via remote connection. By accessing the pricing system remotely, the payor is able to price the claims themselves but they do not need to maintain the full provider file nor the fee schedule required by a rate load payor. Another advantage to this type of pricing is the ability for users to log in and price claims 24/7 at their convenience.

## Pricing Instructions

The pricing instructions contain critical information on how First Choice Health prices a claim. Some of the critical pieces found in the pricing instructions are default discounts, the minimum 10% rule, how to price anesthesia claims, and modifier descriptions. A complete copy of the current pricing instructions is available on the [Online Payor Portal](#).

## FCH's Reimbursement Department Pricing

As described on page 3 of this manual, claims can also be submitted to the First Choice Health Reimbursement department for pricing. Depending upon the payor's business needs, the claims can be submitted either via fax, mail, or electronically. Once priced, the FCH pricing sheets are forwarded to the payor electronically or posted to the [Online Payor Portal](#).

# Payment Processing

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## Explanation of Benefits (EOBs)

Following the processing of a clean claim, each EOB issued by the contract holder, or its payor, must identify at a minimum:

- The First Choice Health name and/or logo.
- The total billed charges.
- The allowed amount in accordance with the FCH PPO fee schedules.
- The amount the payor is responsible to pay.
- The amount the patient is responsible to pay.
- An explanation for non-payment of a particular code or service.

PPO Network providers may refuse the benefit of the PPO Network's preferred rates to the contract holder or its payor if the EOB does not display the minimum data elements and the First Choice Health name or logo.

## Bundling/Unbundling Software

We understand that some Payors rely on bundling software. This is allowed as long as it is used within community standards. We would also ask that the payor identify the specific software being used to First Choice Health for reporting purposes. If the bundling software detects an error on the claim, the payor should produce an explanation of benefits or statement to the provider with an informational message clarifying what has been identified as an error.

## 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

*This methodology applies to professional claims and applicable ASCs only.*

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.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Reduce allowable by 50%.

Modifier	Modifier Denotes	Description
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
59	Distinct procedural service	It may be appropriate to review supporting documentation for this distinct procedural service.

Modifier	Modifier Denotes	Description
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%.
82	Assistant surgeon (when qualified resident surgeon not available)	Reduce the base code allowable amount 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.

## 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](http://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.