Provider Manual

Revised 12/22/2010

www.fchn.com

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Introduction

Welcome to the First Choice Health PPO Network! The purpose of this manual is to provide you with the basic information that you and your office staff need when seeing our PPO Network patients. This manual provides you with direction and clarification regarding your obligations as a PPO Network provider. This information is also available on our web site at: http://www.fchn.com/ppo/providers/ProviderManual.aspx. Please check the web site periodically to ensure that your manual information is up-to-date. Notifications of manual updates are published in our quarterly newsletter.

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 well over one million 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 State and has a growing regional presence in Oregon, Idaho, Montana and Alaska. Our network offers over 42,000 directly contracted and credentialed providers and 220 hospitals used by a wide variety of insurance companies, third party administrators, and plan sponsors. In addition to our PPO Network, First Choice Health offers Medical Management Services, an Employee Assistance Program (EAP), a Physician Assistance Program (PAP), and Third Party Administration (TPA).
How to Contact us

Provider Relations can be contacted directly at (800) 231-6935 extension 2103. We can also be contacted via email at ProviderRelations@fchn.com. Any information that a provider needs about working with First Choice Health Network can be found on the provider web page at www.fchn.com.

Business Profile

<table>
<thead>
<tr>
<th>Management</th>
<th>Shareholder Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenneth A. Hamm, President &amp; CEO</td>
<td>Evergreen Health System, Kirkland</td>
</tr>
<tr>
<td>Curtis Taylor, V.P. &amp; Chief Marketing Officer</td>
<td>Good Samaritan Community Healthcare, Puyallup</td>
</tr>
<tr>
<td>Jacque Brainard, V.P. of Operations</td>
<td>MultiCare Health System, Tacoma</td>
</tr>
<tr>
<td>Jeff Robertson, M.D., V.P. &amp; Chief Medical Officer</td>
<td>Northwest Hospital, Seattle</td>
</tr>
<tr>
<td>Sara Kasper, V.P. of TPA Operations</td>
<td>Overlake Hospital Medical Center, Bellevue</td>
</tr>
<tr>
<td>Warren Maxwell, V.P. of Finance</td>
<td>Providence Health System, Seattle</td>
</tr>
<tr>
<td></td>
<td>Spokane Washington Hospital Co., LLC Spokane</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board of Directors</th>
<th>Shareholder Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathryn D. Beattie, M.D., CEO Valley Medical Center</td>
<td>Associated Emergency Physicians, Inc.</td>
</tr>
<tr>
<td>Diane E. Cecchettini, R.N., CEO MultiCare System</td>
<td>Colville Medical Center, P. S.</td>
</tr>
<tr>
<td>Gerald A. Cufley, M.D., Board Vice Chairman</td>
<td>Covington Primary Care</td>
</tr>
<tr>
<td>Paul M. Elliott, Board Chairman</td>
<td>Eastside Gastroenterology Consultants</td>
</tr>
<tr>
<td>John V. Fletcher, V.P. Providence Health System</td>
<td></td>
</tr>
<tr>
<td>William Gilbert, CEO, Deaconess Medical Center</td>
<td></td>
</tr>
<tr>
<td>Dan Greening, Consultant</td>
<td></td>
</tr>
<tr>
<td>Craig Hendrickson, CEO Overlake Hospital Medical Center</td>
<td></td>
</tr>
<tr>
<td>William F. Johnston, M.D., Northwest Hospital</td>
<td></td>
</tr>
<tr>
<td>Calvin K. Knight, CEO, Swedish Health Services</td>
<td>Edmonds Emergency Medicine</td>
</tr>
<tr>
<td>Scott F. Kronlund, M.D., Physician Consultant</td>
<td>Evergreen Medical Group</td>
</tr>
<tr>
<td>Barbara L. Mitchell, Employer Representative</td>
<td>Minor &amp; James Medical, P.L.L.C.</td>
</tr>
<tr>
<td>Erica V. Peavy, M.D., The Everett Clinic</td>
<td>North Seattle Women’s Group</td>
</tr>
<tr>
<td>Richard A. McGee, M.D., US Oncology</td>
<td>Northwest Emergency Physicians</td>
</tr>
<tr>
<td>Richard E. Rust, M.D., Emeritus</td>
<td>Proliance Surgeons, Inc. P. S.</td>
</tr>
<tr>
<td>Peter Rutherford, M.D., Board Chair Wenatchee Valley Clinic</td>
<td>Puget Sound Family Physicians</td>
</tr>
<tr>
<td>Johnese Spisso, COO, University of WA Medicine</td>
<td>Summit View Clinic</td>
</tr>
<tr>
<td>Clyde D. Walker, Sr. V.P., Continental Mills</td>
<td>Tacoma Emergency Care Physicians</td>
</tr>
<tr>
<td>Mitchell B. Weinberg, M.D., Evergreen Healthcare</td>
<td>Tacoma Radiology Associates</td>
</tr>
<tr>
<td><strong>Book of Business by Class</strong></td>
<td>The Everett Clinic</td>
</tr>
<tr>
<td>35%</td>
<td>Insurance Companies</td>
</tr>
<tr>
<td>18%</td>
<td>Union Trusts</td>
</tr>
<tr>
<td>28%</td>
<td>Self-Insured Groups/TPA’s</td>
</tr>
<tr>
<td>15%</td>
<td>National Networks</td>
</tr>
<tr>
<td>3%</td>
<td>Employer</td>
</tr>
<tr>
<td>1%</td>
<td>Other</td>
</tr>
</tbody>
</table>

**PPO Network Membership** - Total eligible employees and dependents: 970,000
Chapter two: Web Page

Provider Web pages

The Provider Web pages have been substantially updated in order to serve as a functional tool and help our providers understand the First Choice Health Network business model and how to operate within it. Several new areas of the web have been added over the past year. To get to the provider web pages, follow this link: http://www.fchn.com/ppo/providers/default.aspx

The navigational bar on the left lists out the tools available to all Providers. The following tools are the most frequently used.
Payor / Employer Group Search:

This is a “real time” search tool where Providers have access to view the most current First Choice Health Network payor and employer group information. Providers can search by Payor Name, Employer/Group Name or Employer/Group Number.

Providers can also upload the most current copy of our List of Payors (Yellow Pages) in this section. The Employer Group List (Blue Pages) can be found in this section as well. This file is run on a monthly basis as a pdf file, however, and may not have the most current information. Your preferred tool should be the “real time” Payor and Employer Group Search.
Publications:

Providers can view Newsletters and Provider Bulletins that have been sent to all contracted providers. The on-line version of the Provider Manual is located in this section also. We post all publications here and list the most current copies along with archived copies.

Reference Materials:

Providers can reference the most up-to-date information regarding billing and claims tools including Sample Id cards and Sample EOP/EOB (Explanation of Payment/Explanation of benefits) in this section.

Contracted Network Providers:

We offer two secured options to providers through OneHealthPort (OHP). Priced claims status inquiry and Claims activity reports.

Priced Claims Status Inquiry:

If you submit a claim directly (paper or electronically), you can view the priced status of that claim. First Choice Health Network will provide you with information on when the claim was priced and when it was forwarded to the appropriate payor. Paper claims can be submitted to:

First Choice Health Network
PO Box 2289
Seattle, WA 98111-2289
Claims Activity Reports:

If you are a provider that has been set up to receive claims activity reports, you can now download them online.

If you are a provider or hospital group submitting 100 claims or more per week and are not currently receiving this report, you can contact Provider Relations at 1.800.231.6935 extension 2103 or via email at ProviderRelations@fchn.com.
Chapter Three: Claims and Billing

First Choice Health Network contracts with over 100 payors. This means that to you, the provider, billing your claims with the Employer group information (name and number on the ID card) is essential so that we are able to direct your claims to the correct administrator for processing.

Claim form:

Whether you use an electronic or paper form, a CMS 1500 or UB04, a complete claim includes the following information:

- Patient’s name, address, gender, date of birth and relationship to subscriber
- Subscriber’s name and ID number
- Subscriber’s employer group name in box 11b and group number in box 11 on the CMS 1500 form. Please see FCH Web page for assistance when ID card is not available [http://www.fchn.com/ppo/providers/payorSearch.aspx](http://www.fchn.com/ppo/providers/payorSearch.aspx)
- Name of payor in box 11c on the CMS 1500 form (i.e.: Principal, KPS, etc.)
- Name and address where service was rendered, “remit to” address, and phone number of physician or health care provider performing the service; provide this information in a manner consistent with how that information is presented in your agreement
- Physician’s or health care provider’s federal tax ID number
- Physician’s or health care provider’s National Provider Identifier (NPI)
- Date of service(s), place of service(s) and units rendered
- Current CPT and HCPC procedure codes with modifiers where appropriate
- Current ICD-9 diagnostic codes by specific service code to the highest level of specificity
- Charges per service and total charges
- Information about other insurance coverage, including job-related, auto or accident information, if available

Additional information needed for a complete UB-04 form:

- Date and hour of admission and discharge as well as customer status at discharge code
- Type of bill code
- Type of admission
- Current revenue code
- Current principal diagnosis code (highest level of specificity)
- Current other diagnosis code if applicable (highest level of specificity)
• Current ICD-9-CM procedure codes when applicable
• Bill all procedures with the appropriate revenue and CPT or HCPCS codes

**Reporting requirements for Anesthesia claims:**

• One of the CMS required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting
• For CMS 1500 paper claims, report the start and stop time on the claim form
• For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV104 with an “MJ” qualifier in loop 2400 SV103.
• When reporting obstetrical anesthesia services, it is recommended that add-on codes 01968 or 01969 be reported on the same claim as the primary procedure 01967.
• When reporting qualifying circumstance qualifier codes 99110, 99116, 99135 and/or 99140, it is recommended that the qualifier be reported on the same claim with the anesthesia service

**Modifiers:**

Please refer to chapter four (Payment Overview) to learn more about modifiers.

**National Provider Identification (NPI):**

In compliance with HIPAA, all “covered” health care professionals and organizations must obtain NPI enumeration to identify themselves in HIPAA standard transactions. You can submit your NPI to First Choice Health Network via fax to the attention of Provider File Maintenance at 206.268.2940. You can also submit this on link by following this link: [https://www.fchn.com/ppo/providers/submitNPI.aspx](https://www.fchn.com/ppo/providers/submitNPI.aspx).

**Where to send claims:**

The List of Payors (Yellow Pages) contains all necessary claims mailing information for each of our payors. It is mailed quarterly to all providers and can also be found on our web site at: [http://www.fchn.com/ppo/providers/payorSearch.aspx](http://www.fchn.com/ppo/providers/payorSearch.aspx). If you require further assistance identifying a payor, please contact Provider Relations at 800.231.6935 ext. 2103 or via email at ProviderRelations@fchn.com.

**Payment of claims:**

First Choice Health Network does not process or adjudicate claims. Please refer to the patient’s ID card or the List of Payors for the correct Payor information which will include the phone number to call to check the status of your claim.
Claims Pricing Status:

If claims are sent directly to First Choice Health Network for pricing (PO Box 2289, Seattle, WA, 98111 or via payor ID 91131), providers have the capability to view the status of their priced claim. This status will include information such as when the claim was received, priced, the allowable and where the claim was sent for processing. Please see our web site for more at: [http://www.fchn.com/ppo/Providers/PPOProviderContractedProviders/default.aspx](http://www.fchn.com/ppo/Providers/PPOProviderContractedProviders/default.aspx)

Sample ID Cards:

First Choice Health Network has obtained sample ID cards from our top payors by patient volume. To access these sample ID cards, please follow this link to the provider web page: [http://www.fchn.com/ppo/providers/sampleIdCard.aspx](http://www.fchn.com/ppo/providers/sampleIdCard.aspx).

Eligibility and Benefits:

First Choice Health Network does not have information regarding patient’s eligibility and benefits therefore we recommend that you contact the payor directly to verify eligibility of the patient, coverage limitations and whether or not pre-authorization or certification is required. Contact information for all of our payors is located in our List of Payors which can be found on our web site: [http://www.fchn.com/ppo/providers/payorSearch.aspx](http://www.fchn.com/ppo/providers/payorSearch.aspx).

This contact information is also listed on the group level search found on the same page on the provider web page.

Prior Authorization:

Many of the plans that use First Choice Health Network are PPO plans and do not require referrals or prior authorization to see another provider. Some plans may require a referral or prior authorization from the member’s Primary Care Provider (PCP) for certain services.

To determine whether or not a member’s plan requires a referral or prior authorization, call the number listed on the back of the member ID card listed under Benefits and Eligibility. This contact information can also be found at the payor level in our List of Payors on line at: [http://www.fchn.com/ppo/providers/payorSearch.aspx](http://www.fchn.com/ppo/providers/payorSearch.aspx).

Claims Appeals:

If you disagree with a claim adjustment regarding a claim edit or benefit level determination, please contact the Payor directly using the contact information on the EOP/EOB or identification card from the patient.

If you disagree with a claim adjustment regarding your First Choice Health Network contractual allowance, please send the claim form and explanation of payment (EOP/EOB) along with your expected allowable amount to the attention of Provider Relations via fax at 206.268.2940. We will review your appeal and let you know the outcome.
Coordination of Benefits (COB):
Coordination of benefits is administered according to the member’s benefit plan and/or in accordance with applicable statutes and regulations depending on whether the plan is self-insured and therefore regulated by ERISA, or insured and therefore regulated by applicable state or industry statutes and regulations.

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 participant’s insurance company and not to balance bill the participant.

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 will be indicated on the participant’s ID card or can be verified by contacting the payor directly. Deductibles need to be verified before the participant’s visit directly with the Payor. 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.

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

- For CMS 1500 paper claims, report the start and stop time on the claim form
- One of the CMS required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV104 with an “MJ” qualifier in loop 2400 SV103.
- When First Choice Health Network prices for Anesthesiology services, claims are calculated using base plus time units. All claims for anesthesia services require the total time of the procedure. The time is then converted into “time units”. Time units are calculated in fifteen (15) minute increments or four (4) time units per hour. The allowed amount is then calculated by adding the time units to the base anesthesia units. The total anesthesia units are then multiplied by the appropriate conversion amount.
- Please note that First Choice Health Network applies a seven (7) minute rule when rounding minutes to apply time units. On the second and all subsequent time unit calculations, the first seven minutes reported will be rounded down to the previous fifteen minute increment, any time reported after seven minutes will be rounded up to the next fifteen minute increment.
- Please note that this methodology applies to First Choice Health Network priced claims only. If the payor performs pricing in their own system, we allow them discretion as to how they apply rounding methodology.
- See additional information regarding reporting requirements for Anesthesia claims in Chapter three: Claims and Billing.

Modifiers:

To ensure correct claims payment by Payors accessing First Choice Health Network, the standard CPT/HCPCS modifiers mentioned below should be used when appropriate. When a modifier is billed that will effect a First Choice Health Network negotiated allowable, do not bill the charge at a reduced rate. This will result in additional discounts within the First Choice Health Network claims pricing system.

It is the policy of First Choice Health Network to recognize all valid CPT/HCPCS modifier codes, however, not every modifier code will impact the First Choice Health Network negotiated allowable. There may be modifiers noted that do not impact First Choice Health Network pricing, however, payment adjustment may be made based the individual payor’s medical payment policy.
Please note that this list is not inclusive of all modifiers that may warrant additional or decreased payment.

<table>
<thead>
<tr>
<th>#</th>
<th>Modifier Denotes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA/AD</td>
<td>Anesthesia Component</td>
<td>The allowable amount is based on the starting and end times of the procedure, and is calculated in conjunction with the predetermined base units.</td>
</tr>
<tr>
<td>AS</td>
<td>PA Services for Assistant at surgery</td>
<td>Reduces the base code allowable amount by 80%.</td>
</tr>
<tr>
<td>NU</td>
<td>New DME</td>
<td>The allowable amount is contractually predetermined.</td>
</tr>
<tr>
<td>P1</td>
<td>A normal healthy patient.</td>
<td>Zero base units will be added.</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>Zero base units will be added.</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>One base unit will be added.</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Two base units will be added.</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Three base units will be added.</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>Zero base units will be added.</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.</td>
<td>Reduce the base code allowable by 50%</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>Reduces the base code allowable amount by 50%.</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
<td>Reduces the base code allowable amount by 50%.</td>
</tr>
<tr>
<td>RR</td>
<td>Rental DME</td>
<td>The allowable amount is contractually predetermined.</td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component</td>
<td>The allowable amount is contractually predetermined.</td>
</tr>
<tr>
<td>UE</td>
<td>Used DME</td>
<td>The allowable amount is contractually predetermined.</td>
</tr>
<tr>
<td>22</td>
<td>Unusual Procedural Services</td>
<td>Upon medical review by Payor, if determined appropriate, recommended reimbursement is to increase to 125% of allowable.</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>25</td>
<td>Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>26</td>
<td>Professional Component</td>
<td>The allowable amount is contractually predetermined.</td>
</tr>
<tr>
<td>#</td>
<td>Modifier Denotes</td>
<td>Description</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>50</td>
<td><strong>Bilateral Procedure</strong></td>
<td><em>150% of allowable.</em>&lt;br&gt;<em>Bill CPT code on one line with modifier 50.</em></td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedure</td>
<td>Reduces according to the following sequence: 100/50/50/50.</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>Reduces the base code allowable by 20%</td>
</tr>
<tr>
<td>55</td>
<td>Post Operative Management Only</td>
<td>Reduces the base code allowable by 90%</td>
</tr>
<tr>
<td>56</td>
<td>Pre-Operative Management Only</td>
<td>Reduces the base code allowable by 90%</td>
</tr>
<tr>
<td>57</td>
<td>Surgical Care Only</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>58</td>
<td>Staged or Related Procedure or Service by the Same Physician During the Postoperative Period</td>
<td>Upon review by the payor, recommended reductions should be according to the following sequence: 100/50/50/50.</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>Upon review by the payor, recommended reductions should be according to the following sequence: 100/50/50/50.</td>
</tr>
<tr>
<td>62</td>
<td>Two Surgeons</td>
<td>Reduces the base code allowable by 37.5% for a surgical procedure.</td>
</tr>
<tr>
<td>76</td>
<td>Repeat Procedure by Same Physician</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>77</td>
<td>Repeat Procedure by Another Physician</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>78</td>
<td>Return to the Operating Room for a Related Procedure During the Postoperative Period</td>
<td>Reduces the base code allowable by 20% for a surgical procedure.</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated Procedure or Service by the Same Physician During the Postoperative Period</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td>Reduces the base code allowable amount by 80%.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td>Reduces the base code allowable amount by 80%.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon (when qualified resident surgeon not available)</td>
<td>Reduces the base code allowable amount by 80%.</td>
</tr>
<tr>
<td>90</td>
<td>Reference (Outside) Laboratory</td>
<td>100% of allowable.</td>
</tr>
<tr>
<td>91</td>
<td>Repeat Clinical Diagnostic Laboratory Test</td>
<td>100% of allowable.</td>
</tr>
</tbody>
</table>

**Code Editing Software:**

Claims may be subject to standard claims editing software by Payors to detect bundling and unbundling as well as incorrect billing.
Supplies for immunization Injections:

First Choice Health Network reimbursement for injectable drugs, including immunizations, is based on your current First Choice Health Network reimbursement agreement. Reference your fee schedule for the applicable allowable. If you require assistance with your fee schedule, please contact Provider Relations at 1.800.231.6935 extension 2103 or via email at ProviderRelations@fchn.com.

Supplied Vaccine Program:

Washington State Department of Health has an excellent Immunization program which provides “universal distribution” for all recommended childhood vaccines at no cost to providers. First Choice Health Network providers in Washington State should obtain their vaccines for children through this program. For more information regarding this program, please contact your local county Department of Health.

Providers in states other than Washington are encouraged to contact your local county Department of Health to inquire about similar programs.
Chapter Five: Payor Information

Eligibility and Benefits
To determine if a patient is eligible for coverage, please contact the payor directly. The payor can also provide you with information regarding the level of coverage or benefits offered. The patient’s ID card lists the payor’s telephone number. If the patient does not have their ID card, refer to our website at [http://www.fchn.com/ppo/providers/payorSearch.aspx](http://www.fchn.com/ppo/providers/payorSearch.aspx) for any information regarding our payors.

You can search for the payor by both group number as well as employer name. Refer to the List of Payors (Yellow Pages) on our website (same link as above) for the telephone number. Next to the payor’s name is the telephone number for “eligibility, coverage, and claims information.”

After seeing a First Choice Health Network patient, send the bill or “claim” for the services provided to the payor or First Choice Health Network.

- The patient’s ID card lists the payor. If the patient does not have their ID card, refer to our website ([http://www.fchn.com/ppo/providers/payorSearch.aspx](http://www.fchn.com/ppo/providers/payorSearch.aspx)). Search for the patient or subscriber’s payor by Employer name or Employer group number. Refer to the Yellow Pages for the claim forwarding address.
- Submit the claim on the CMS 1500 form or UB-04 form.

Patient Identification Cards
To identify a First Choice Health Network patient, look for the First Choice Health Network name or logo on the patient’s medical ID card. The ID card typically contains the following information:

- Subscriber name (employee).
- 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 eligibility, benefits and claim status.

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

We have comprised sample ID card examples on our web site for our top volume payors: [http://www.fchn.com/ppo/providers/sampleIdCard.aspx](http://www.fchn.com/ppo/providers/sampleIdCard.aspx)
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 Benefit (EOB) or Remittance Advice (RA). The EOP will provide you with details on how to apply the reimbursement, if any, to your billed charges. It will also contain other valuable information such as:

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

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

We have comprised sample EOP examples on our web site for our top volume payors:

http://www.fchn.com/ppo/providers/sampleEOB.aspx
Chapter Six: Credentialing

Credentialing and Re-credentialing

First Choice Health Network gratefully acknowledges the valued service that you provide to over 900,000 members of our community. Based on American Accreditation Healthcare Commission (URAC) Guidelines, First Choice Health Network credentials all providers with whom we sign contracts, and we re-credential them every three years to ensure ongoing compliance.

Confidentiality

First Choice Health Network views all records submitted or obtained during the credentialing and recredentialing process as protected by the peer review privilege as defined by Washington State Law. Therefore, release of any records will occur only pursuant to court order or written release by the subject in review.

Non Discrimination

The First Choice Health Network Credentialing Program prohibits discrimination on the basis of race, color, religion, gender, national original, sexual orientation, marital status, age, types of procedures or types of patients the provider specializes in, or any other protected classification.

Provider’s Right to Communication about their Credentialing Status

All initial applicants are informed within 30 business days (in writing) of receipt of the application submitted for network participation. At any time, applicants may request the status of the credentialing applications by contacting the Credentialing Department.

Provider Effective Date Assignment

The First Choice Health Network (FCHN) Credentialing Committee will assign all effective dates for providers that are non-delegated, through the Credentialing process. FCHN must enter the assigned effective date assigned by FCHN Credentialing Dept. Credentialing effective dates are based on the approved committee date for initial applications. Providers credentialled through FCHN will be assigned an effective date for the 1st of the following month after committee approval date. (Exception: Providers approved by committee, but FCHN contract is not received or signed. Provider effective date will be based on contract received date and the 1st of the following month rule will still apply.)

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

Provider profiles, rosters, or provider updates, received by FCHN between the 1st and the 15th of the month, will receive an effective date of the 1st day of the month received, unless the provider/clinic requests the effective date in the future. In which case, it will be assigned to the 1st day of the requested month given by the provider.
Provider profiles, rosters, or provider updates received by FCHN between the 16th and the last day of the month, will receive an effective date of the 1st of the following month, unless the provider/clinic requests the effective date in the future. In this case, they will be assigned to the 1st day of the requested month given by the provider.

**Rules for Retroactive Effective Date**

Retroactive effective date assignment (backdating) is not permitted. Any requests for a retroactive effective date assignment are an exception process. The PPO Retroactive Date Request Committee (includes: Provider Relations, Provider File, Contracting, Account Management, Credentialing, PPO Operations, and Payor Operations Department) will review exception requests for approval or denial at the following scheduled committee meeting provided that all required information is presented to make a final decision.

If an exception is granted, the retroactive effective date will not exceed a 90 day period, unless specifically approved by the PPO Retroactive Date Request Committee & VP of Operations.

**Locum Tenens**

A locum tenens provider is a provider who is sponsored by or otherwise retained by a First Choice Health Network contracted provider on a temporary basis to provide services to the contracted provider’s patients. First Choice Health Network 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 name and the tax identification numbers of the providers they are replacing.

If a practitioner and/or group requests that a locum tenens practitioner be added to either the network or the health plan, it is First Choice Health Network’s policy to explain to the interested party that bills are required to be submitted on behalf of the locum tenens practitioner under the name and the tax identification number of the practitioner they are replacing.

**Provider’s Right to Review**

A provider has the right to review information obtained by First Choice Health Network to evaluate his/her application. The provider must schedule the review through the Credentialing Department in advance. If, during the review process, the provider identifies information that is no longer applicable or is incorrect, a written addendum may be attached to the application.

If information documented on the provider application is inconsistent with information obtained via primary source verification during the credentialing or recredentialing process, the Credentialing Department will notify the provider (in writing) that First Choice Health Network has obtained inconsistent information.

Providers have the right to correct erroneous information submitted by another party (i.e., actions on a license, malpractice claims history, suspension or termination of hospital privileges or board certification status).
Providers are informed (in writing) of any discrepancies found during the credentialing process within 30 business days of the discovery. Providers will be given 15 calendar days from receipt of the notification to respond to the Credentialing Department. In the event that no response is received, a second/final request for information will be sent. The provider will be given an additional 15 calendar days to respond.

Criteria for Denial of Credentialing or Recredentialing Application or Termination

The First Choice Health Network Credentialing Committee shall approve, deny or terminate participation. Denial or termination based upon quality of care is a reportable issue. The criteria for denying or terminating participation may include, but are not limited to:

1. Submission of inaccurate or misleading information on the application, or failure to disclose relevant information.

2. Inability of First Choice Health Network to complete the credentialing/re-credentialing process due to the applicant’s failure to provide relevant information or the necessary release.

3. Failure to notify First Choice Health Network of any changes in clinical privileges, any changes in hospital staff privileges, any changes in practice scope; any sanctions or restrictions or any medical or mental health problems that could effect the care of patients.

4. Any current or previous loss of, or revocation, or restrictions to, or limitations, or sanctions, or actions to professional license, certification/registration or authorization to practice, including but not limited to, probationary status, monitoring requirements, chaperone requirements or related requirements (i.e., monitoring, open doors, etc), prescribing limitations, required supervision, or restricted hospital privileges.

5. History of practicing without valid license, registration/certification or authorization.

6. Current or previous loss of, or revocation, or restrictions to, DEA certificate.

7. Current or previous loss of or restrictions to hospital, clinic, facility, surgical center, network or other healthcare privileges or scope of practice.

8. Criminal record affecting professional practice.

9. Current or history of a felony conviction.

10. Currently or previously censured or excluded or sanctioned by Medicare/Medicaid and/or by Labor and Industry (L&I).

11. Current or history of chemical dependency or substance abuse.

12. Notification from a confidential program for chemically impaired providers (i.e., 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.
13. Current physical or mental health condition that may significantly impair the provider’s ability to practice within the full scope of licensure and qualifications or may impose a risk of harm to patients.

14. Loss of, or insufficient, or inadequate malpractice insurance coverage.

15. 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 judgement against the provider.

16. History of providing patient care outside of the scope of license, registration/certification or authorization.

17. Renders or has rendered any services outside the scope of license, registration/certification, or other authorization.

18. History of practice trends that raise concerns regarding provider’s ethics, quality of care and/or practice standards.

19. Practice inconsistent with professional standards of care.

20. History of significant patient complaints documented by licensing authority, healthcare facility, health plan, or network administrator.

21. Lack of local hospital admitting privileges or inpatient coverage plan (if applicable).

22. Loss of local hospital admitting privileges or inadequate inpatient coverage plan (if applicable).

23. Failure to become board certified in practice specialty within five years of completion of residency (if applicable).

24. Failure to maintain Board certification in practice specialty for specialties that require periodic recertification (if applicable).

25. Quality issues as reported by National Provider Data Bank (NPDB)/Healthcare Integrity Data Bank (HIPDB), licensing boards or prior work/training sites.

26. Refusal, revocation, suspension or restrictions of hospital staff privileges at any hospital.

27. Failure to comply with procedures implemented in connection with the administration of utilization review or failure to cooperate with the quality management activities.

28. 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.

29. Voluntary relinquishment or withdrawal of clinical privileges in order to avoid an adverse action, or to preclude an investigation, or while under investigation relating to professional competence or conduct.
30. Unethical conduct in violation of laws or standards governing the practice of health care.

31. History of unethical conduct in violation of laws or standards governing the practice of health care.


33. History of acts of fraud, deceit, dishonesty or moral turpitude.

34. Practice inconsistent with the professional standard of care.

35. Evidence of compromised quality of care.

36. Submission of erroneous, improper, or incomplete claims for payment.

37. Inadequate medical record practices or inappropriate billing practices (i.e., upcoding, failure of adequate chart documentation to support submitted claims, etc).

38. History of or current non-compliance with First Choice Health Network Provider Contract.

39. Lack of Network and/or membership needs.

**Termination**

All providers must meet the credentialing and re-credentialing requirements of First Choice Health Network. Failure to meet established standards or guidelines can result in termination.

- Termination of a provider contract must be in accordance with the specific terms of the provider’s contract.

- A participating provider may be terminated without cause with 90 days written notice. Criteria considered by First Choice Health Network 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 (e.g., license revocation/suspension, sexual abuse, notification from a confidential program for chemically impaired providers 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).

Where a provider’s application to become a contracted provider participating in First Choice Health Network’s lines of business is denied, or when a provider’s FCH contract for participation is terminated, the provider shall not be eligible to reapply for participation for a period of at least two (2) years, or until any specified terms of such denial or termination have been satisfied, whichever occurs first.
Appeals Process

If First Choice Health Network denies a provider, places a provider on suspension, imposes a corrective action plan or terminates the provider for failure to meet participation criteria, the provider has the right to appeal the decision and the right to legal representation. Appeal hearings are set forth herein to assure that the affected provider is afforded all rights to which he/she is entitled.

Level One Appeal

1. The provider will be notified of termination, suspension, imposition of corrective action plan, or denial within 10 days of the action and/or approval of minutes. The notification will be forwarded via registered certified return receipt 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 provider's issues with the decision or the decision making process.

4. The appeal must be received within 30 days of the date of receipt of the written notice of termination, suspension, imposition of corrective action plan, or denial.

5. Within 10 business days of receipt of the providers appeal, the provider will be notified in writing (via certified mail) of receipt of appeal and of the anticipated Credentialing Committee review date.

6. The appeal will be reviewed by the Credentialing Committee within 60 business days of receipt of appeal, unless First Choice Health Network and appealing Provider 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 provider will be notified of the outcome within 10 business days of approval of the associated Credentialing Committee minutes.

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

Level Two Appeal

1. Provider may request in writing a hearing with the Level II Appeals Committee. The request must be received by First Choice Health Network within 30 days of receipt by the provider of the Level One Appeal decision.

2. Within 10 business days of receipt of the providers appeal, the provider will be notified in writing (via certified mail) of receipt of appeal and of the anticipated Appeals Committee review date.
3. Provider will receive a summary of his/her rights and a description of the Level II Appeals process within 10 business days of receipt of request for a Level II Appeal.

4. The appeal will be reviewed by the Appeals Committee within 60 business days of receipt of appeal, unless First Choice Health Network and appealing Provider both agree to a different timeline.

5. Provider will have the right to legal representation. Any costs related to such representation are the provider’s responsibility.

6. Provider 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.

7. Provider will have the right to present information and other documentation determined to be relevant by the hearing officer.

8. Provider will have the right to submit a written statement at the close of the hearing.

9. The voting members of the Level II Appeals Committee are appointed by the President & CEO or his/her designee. Voting members will be selected from the First Choice Health Network Board of Directors, the First Choice Health Network Quality Improvement Council the First Choice Health Network Medical Advisory Committee, and/or community health care providers. Prior participation in the credentialing process of the appellant disqualifies a candidate from participating in the Level II Appeals Committee.

10. The Level II Appeals Committee will consist of not less than two actively practicing health care providers, with at least one of them being in the same practice category (i.e., MD/DO, Naturopath, Chiropractor, etc).

11. Decisions of the Appeals Committee are reached by majority vote. A quorum consists of three voting members, to include at least two (2) health care providers.

12. The First Choice Health Network President and CEO or his/her designee will serve as the hearing officer.

13. 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.

14. Formal minutes will be taken at the meeting.

15. The Appeals Committee will have access to all written materials and documentation that were reviewed by the Credentialing Committee.

16. Decisions regarding the appeal will be determined by majority vote of the voting members constituting the Level II Appeals Committee.

17. The written notification of the decision will be sent to the provider within ten (10) business days of the meeting.
18. The written notification will be sent via registered mail, and the notice will be deemed received and final upon signature and date of the receipt.

19. The decision of the Level II Appeals Committee will be final and binding for all involved parties.
Chapter Seven: Quality

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

PPO services 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 include:

- Customer Service & Provider Relations Call statistics
  - Average answer time
  - Abandonment rates
- Claims processing metrics
  - Claims pricing turn-around times
  - Days on hand
- Payor pricing
- Active providers
- Provider files

Receiving and Tracking Complaints

First Choice Health Network has a process for tracking any written or verbal concerns from any customer who access care and services through First Choice Health Network participating providers.

Complaints are defined as:

- **Complaints regarding providers:** Any issue, verbal or written, regarding the care, administrative service, or office environment of a FCHN provider
- **Quality of care:** Any verbal or written objection about the quality of care provided or the actions of a healthcare provider. Either the participant or another provider can lodge a quality of care concern.

When a perceived quality of care concern is identified, the concern is reviewed by a medical director. As a part of this review, patient medical records may be requested. All perceived quality of care concerns are submitted to the credentialing department.
Chapter Eight: Frequently Asked Questions

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

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

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

Refer to the member’s ID card to verify the First Choice Health Network logo is found on the card. If the patient does not have an ID card, refer to the First Choice Health Network provider web page under Payor/Employer group search at http://www.fchn.com/ppo/providers/payorSearch.aspx and search by the Payor name, Employer/Group name or Employer/Group number.

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 web page to verify by following the link. http://www.fchn.com/ppo/providers/payorSearch.aspx

More information can be found in chapter three of this manual under claims and billing – section titled “where to send claims”.

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 web page to verify by following the link. http://www.fchn.com/ppo/providers/payorSearch.aspx

More information can be found in chapter three of this manual under claims and billing – section titled “collecting money at time of service”.


What are my member’s benefits?

To check benefits and eligibility, please refer to the member’s ID card for the phone number to call or use the List of Payors on the provider web page following this link:  

More information can be found in chapter three of this manual under claims and billing – section titled “eligibility and benefits”.

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

Not all First Choice Health Network 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 referencing the List of Payors on line at:  

How will I know if my reimbursement rate is correct?

All claims for First Choice Health Network patients 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 EOP/EOB (Explanation of payment/Explanation of benefit) advising how the benefits were applied. Please review the EOP/EOB closely to ensure the amount declared as “allowed amount” corresponds with your expected contractual allowance. The EOP/EOE will also indicate what, if any, portion should be considered member responsibility. This is expanded upon further in this manual under chapter five payor information – section titled “explanation of payment”. You can also view sample EOP/EOP copies on the web site at:  
http://www.fchn.com/ppo/providers/sampleEOB.aspx

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, contact provider relations at 800.231.6935 extension 2103 or via email at ProviderRelations@fchn.com.