

PROVIDER MANUAL

Provider Policies and Procedures

www.fchn.com

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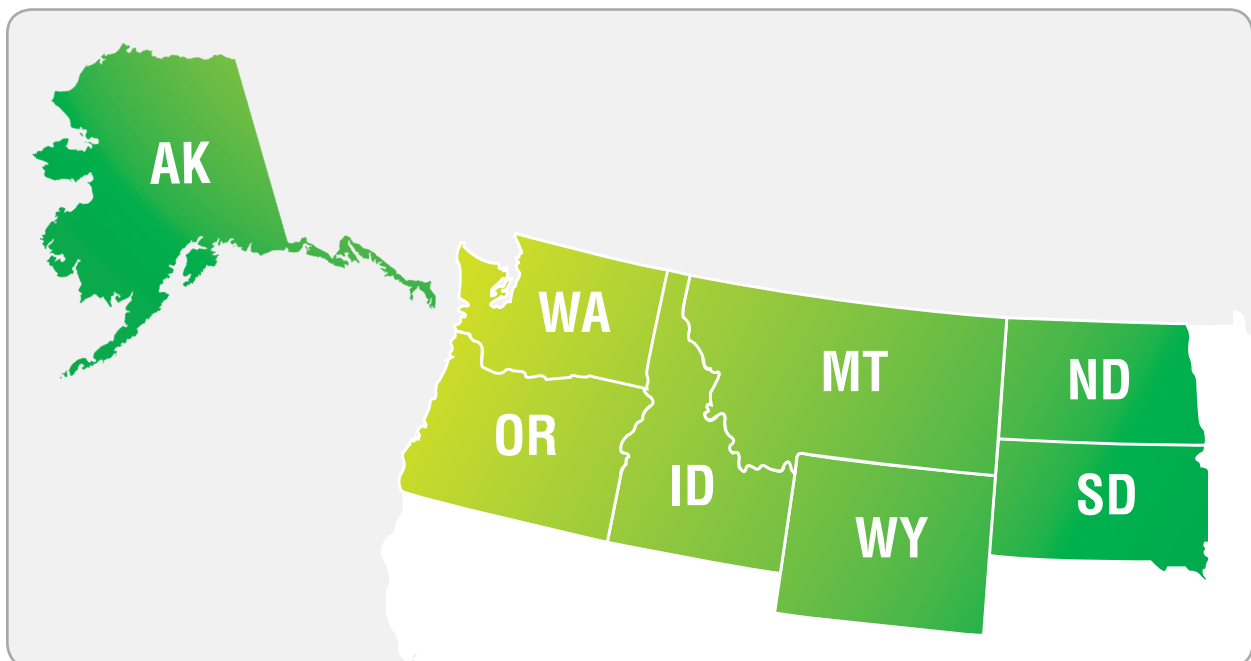
Chapter One: First Choice Health Information

Introduction

Welcome to the First Choice Health PPO Network! The purpose of this manual is to provide you with the basic information you and your office staff need when seeing First Choice Health patients. This manual provides you with direction and clarification regarding your obligations as a First Choice Health provider. This information is also available on our website (<http://www.fchn.com/ppo/providers/ProviderManual.aspx>). Please check the website periodically to ensure that your manual information is up to date.

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 just under 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, North Dakota, South Dakota, Wyoming, and Alaska. Our network offers over 69,000 contracted and credentialed providers and 320 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 (Assistance Services) and Third Party Administration (TPA), First Choice Health Administrators (FCHA).



How to Contact Us

Provider Relations can be contacted directly at (800) 231-6935, Ext. 2103. We can also be contacted via e-mail at ProviderRelations@fchn.com. Any information that a provider needs about working with First Choice Health can be found on the provider webpage at www.fchn.com.

Business Profile

Management	Shareholder Hospitals
Kenneth A. Hamm, President & CEO	EvergreenHealth, Kirkland
Curtis Taylor, Chief Marketing Officer	MultiCare Health System, Tacoma
Jacque Brainard, V.P. of Operations	Northwest Hospital, Seattle
Warren Maxwell, V.P. of Finance	Overlake Hospital Medical Center, Bellevue
John Robinson, M.D., Chief Medical Officer	Providence Health System, Seattle
Board of Directors	Spokane Washington Hospital Co., LLC Spokane
Kathryn D. Beattie, M.D. CMO, UW-Valley Medical Center	Swedish Edmonds, Edmonds
Gerald A. Cufley, M.D., Board Vice Chairman	Swedish Health Services, Seattle
Paul M. Elliott, Board Chairman	Valley Medical Center, Renton
Todd Hofheins, S.V.P./CFO, Providence Health & Services	University of Washington Medical Center, Seattle
Dan Greening, Consultant	Shareholder Physicians
Dan Harris, CFO, Swedish	Associated Emergency Physicians, Inc.
William F. Johnston, M.D., Medical Director, Northwest Hospital	Colville Medical Center, P. S.
Scott F. Kronlund, M.D., CMO, Northwest Physicians Network	Covington Primary Care
Bob Malte, CEO, Evergreen Healthcare	Eastside Gastroenterology Consultants
J. Michael Marsh CEO, Overlake Hospital Medical Center	Edmonds Emergency Medicine

Board of Directors	
Meredith Mathews, M.D., Consultant	
Richard A. McGee, M.D., President, Puget Sound Cancer Center	
Erica V. Peavy, M.D., Medical Director, The Everett Clinic	
William G. "Bill" Robertson, CEO, MultiCare System	
Richard E. Rust, M.D., Emeritus	
Peter Rutherford, M.D., CEO, Confluence Health	
Johnese Spisso, COO, University of WA Medicine	
Clyde D. Walker, Sr. V.P., Continental Mills	
Mitchell B. Weinberg, M.D., Woodinville Pediatrics	
Book of Business by Class	
38%	Insurance Companies
22%	Union Trusts
29%	Self-Insured Groups/TPAs
6%	National Networks
5%	Other
PPO Network Membership - Total eligible employees and dependents: 770,000	

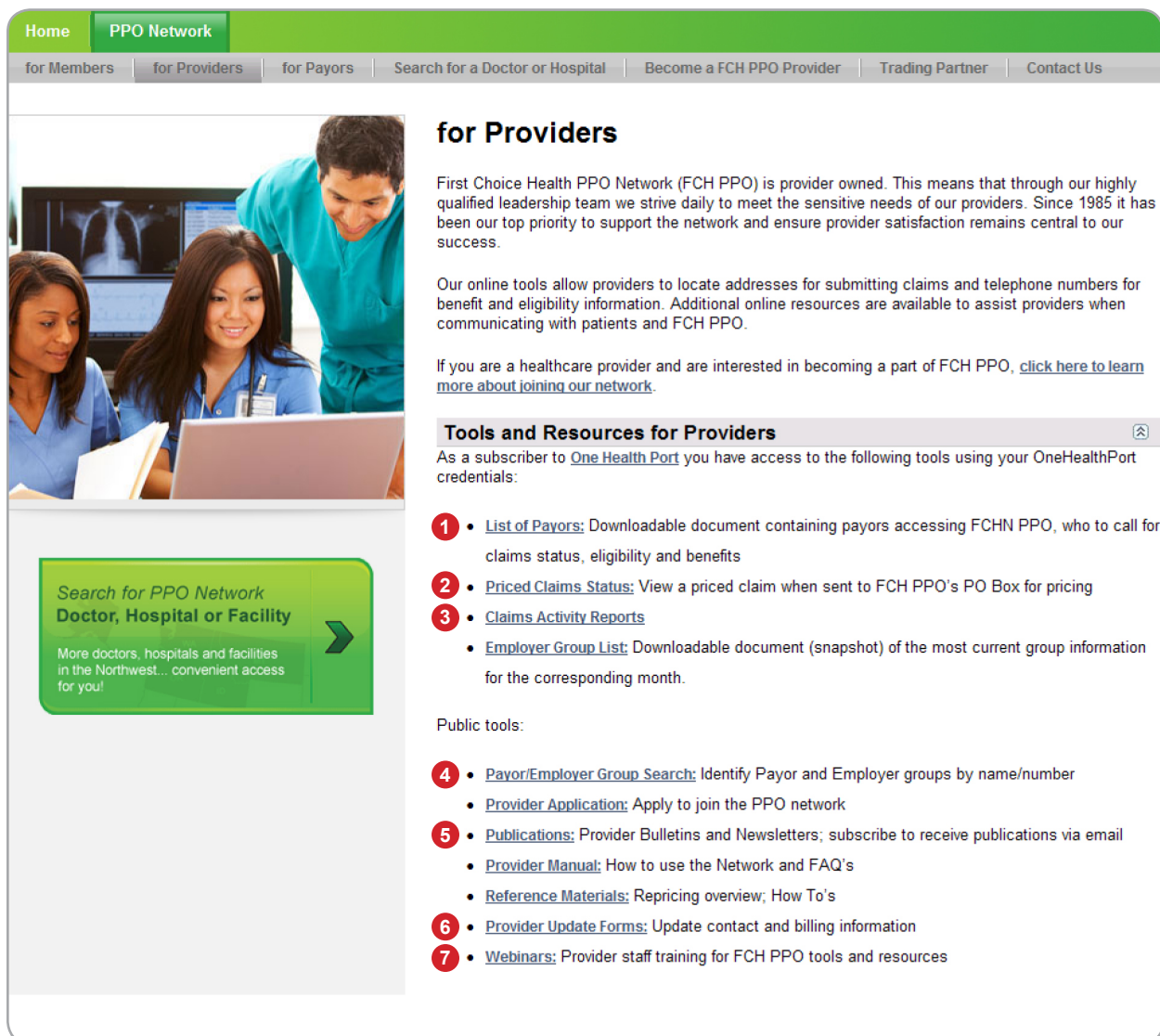
Shareholder Physicians
Evergreen Medical Group
Minor & James Medical, P.L.L.C.
North Seattle Women's Group
Northwest Emergency Physicians
Proliance Surgeons, Inc. P. S.
Puget Sound Family Physicians
Summit View Clinic
Tacoma Emergency Care Physicians
Tacoma Radiology Associates
The Everett Clinic
Valley Anesthesia Associates
Valley Internal Medicine
Valley Radiologists, Inc.
Washington Sports Medicine
Wenatchee Valley Medical Center
Western Radiology Associates

Chapter Two: Webpage

Provider Webpage

Provider Relations uses the provider webpage to help educate and communicate with our providers. It explains the First Choice Health business model and how to operate within it. To access the provider webpage, follow this link: <http://www.fchn.com/ppo/providers/default.aspx>.

There are both secure and public tools available to all providers. We have called out some of the most widely-used tools on the web below (numbered in red).



The screenshot shows the provider webpage for the FCH PPO Network. The page has a green header with 'Home' and 'PPO Network' tabs. Below the header is a navigation bar with links: 'for Members', 'for Providers', 'for Payors', 'Search for a Doctor or Hospital', 'Become a FCH PPO Provider', 'Trading Partner', and 'Contact Us'. The main content area is titled 'for Providers' and includes an image of healthcare professionals. The text describes the FCH PPO as provider-owned and lists online tools for providers. A section titled 'Tools and Resources for Providers' lists seven numbered items: 1. List of Payors, 2. Priced Claims Status, 3. Claims Activity Reports, 4. Employer Group List, 5. Payor/Employer Group Search, 6. Provider Application, 7. Publications, 8. Provider Manual, 9. Reference Materials, 10. Provider Update Forms, and 11. Webinars. A sidebar on the left contains a search button for PPO Network Doctor, Hospital or Facility.

Home PPO Network

for Members for Providers for Payors Search for a Doctor or Hospital Become a FCH PPO Provider Trading Partner Contact Us

for Providers

First Choice Health PPO Network (FCH PPO) is provider owned. This means that through our highly qualified leadership team we strive daily to meet the sensitive needs of our providers. Since 1985 it has been our top priority to support the network and ensure provider satisfaction remains central to our success.

Our online tools allow providers to locate addresses for submitting claims and telephone numbers for benefit and eligibility information. Additional online resources are available to assist providers when communicating with patients and FCH PPO.

If you are a healthcare provider and are interested in becoming a part of FCH PPO, [click here to learn more about joining our network](#).

Tools and Resources for Providers

As a subscriber to [One Health Port](#) you have access to the following tools using your OneHealthPort credentials:

- 1 • [List of Payors](#): Downloadable document containing payors accessing FCHN PPO, who to call for claims status, eligibility and benefits
- 2 • [Priced Claims Status](#): View a priced claim when sent to FCH PPO's PO Box for pricing
- 3 • [Claims Activity Reports](#)
 - [Employer Group List](#): Downloadable document (snapshot) of the most current group information for the corresponding month.

Public tools:

- 4 • [Payor/Employer Group Search](#): Identify Payor and Employer groups by name/number
- [Provider Application](#): Apply to join the PPO network
- 5 • [Publications](#): Provider Bulletins and Newsletters; subscribe to receive publications via email
- [Provider Manual](#): How to use the Network and FAQ's
- [Reference Materials](#): Repricing overview; How To's
- 6 • [Provider Update Forms](#): Update contact and billing information
- 7 • [Webinars](#): Provider staff training for FCH PPO tools and resources

Search for PPO Network Doctor, Hospital or Facility

More doctors, hospitals and facilities in the Northwest... convenient access for you!

As a subscriber to [OneHealthPort](#), the secure tools available to you are as follows:

- 1. List of Payors:** This is published on a quarterly basis and is available for download on the web. The List of Payors is a PDF that supplies providers with the names of all the payors that access the FCH PPO network (including FCHA), the addresses where claims can be submitted via mail or electronically, and how to contact the payors for claims status. The best way to access this information is by utilizing the Payor/Employer group search under the Public Tools. Please be sure to sign up to receive notice electronically when the List of Payors has been updated.
- 2. Priced Claims Status:** When you are looking to check the status of how your claim was priced (not processed), you will access this tool. If your claim was sent to FCH for pricing (PO Box 2289, Seattle, WA 98101 or EDI submitter #91131), you should be able to recreate the re-pricing worksheet here for verification and submit to payors if necessary. To make it easier for you to check the status, you can also find the payor's contact information on the pricing worksheet.
- 3. Provider Claims Activity Reports:** We offer the Provider Claims Activity Report (PCAR) to track priced claims status. The PCAR allows providers to visit our website to check status of all claims submitted to FCHN for pricing. This report is run on a weekly basis and can be checked at anytime. Any claim that has an error will be reflected on the report and available for providers to correct and resubmit.

Public Tools available to you as a Preferred FCH Provider:

- 4. Payor/Employer Group Search:** This is the most widely-used tool on the provider webpage. It is a real-time search for payor information. You will also find payor weblinks (if available) and access to the groups related to each payor.
- 5. Publications:** All provider bulletins, provider newsletters, and the list of payors can be found here. We strongly encourage website utilization to obtain the most accurate and current information available regarding priced claims status, payor and group information and industry news. FCHN has discontinued mailing provider bulletins to our contracted providers as of the second quarter of 2013. All provider bulletins are posted on our website for viewing. Sign up online to begin receiving electronic publications (<http://www.fchn.com/ppo/providers/ListServ.aspx>).
- 6. Provider Update Forms:** See [Chapter Four](#) for detailed information regarding this form.
- 7. Webinar:** A short, pre-recorded webinar that covers the FCHN PPO business model.

Chapter Three: Claims and Billing

First Choice Health contracts with over 100 payors. This means billing your claims with the Employer group information is essential so that we are able to direct your claims to the correct administrator for processing.

Where to Send Claims

The List of Payors contains all necessary claims mailing information for each of our payors. It is published quarterly and can be found on our website (<http://www.fchn.com/ppo/providers/default.aspx>). In addition, the Payor/Employer Group Search contains real-time data.

Providers must [sign up online](#) to receive an e-mail when the quarterly List of Payors has been published.

If you require further assistance identifying a payor, please contact the First Choice Health PPO Customer Service Department at (800) 231-6935, Ext. 2102. If you disagree with a claim adjustment regarding your First Choice Health contractual allowance, please send the claim form and explanation of payment (EOP/EOB) along with your expected allowable amount via fax to (206) 268-6150, Attention: Provider Relations. We will review your appeal and let you know the outcome.

When submitting EDI claims to FCH for pricing, please use EDI submitter # 91131. For additional individual payor EDI submitter numbers, you can reference the [List of Payors](#). FCH can receive EDI claims for all payors at EDI submitter # 91131.

Payment of Claims

First Choice Health 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. Providers who bill claims electronically and want payments to be sent to PO boxes or lock boxes, 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 FCH for pricing (PO Box 2289, Seattle, WA, 98111 or EDI submitter # 91131), providers have the ability to view the status of their priced claim and print a re-pricing worksheet. This status will include information such as when the claim was received, priced, allowable and where the claim was sent for processing. It will also include the phone number to call for claims status. Please see our [website](#) for more information.

Eligibility and Benefits

First Choice Health does not have information regarding a patient's eligibility and benefits. It is recommended 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 [website](#).

This information is also repeated at the group level search found on the same page as the website link noted above.

Electronic (EDI) Claims

5010

Under the Health Insurance Portability and Accountability Act (HIPAA) all physicians and healthcare providers submitting claims electronically were required to transition to Version 5010 EDI transactions by January 1, 2012.

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).

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.

To assist FCH PPO with effectively pricing your network claims, we recommend that providers also submit the "Payor Name" (name other than "First Choice Health") in the "NM103" field under EDI segment loop "2010BB," in addition to submitting valid Group ID or Group Name information (not both) in the "SBR03" under EDI segment loop "2000B."

Without the presence of valid group information, FCH PPO will be unable to accurately reference 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, please refer to our online "Payor – Employer Group Search" tool (<http://www.fchn.com/ppo/providers/payorsearch/PayorSearch.aspx>).

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 provider claims that are submitted with a post office box in the billing provider address field for EDI claims transactions to comply with HIPAA. Providers sending claims with post office boxes or lock box addresses in the billing provider address field will result in rejected claims for pricing. **Providers who want payments to be sent to PO boxes or lock boxes need to report this address in the “pay-to” address field on the EDI transaction (Loop 2010AB).**

In addition, HIPAA requires that all 5010 transactions are billed with extended zip codes (ZIP+4) in the billing provider loop (2010AA N403). FCH 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).

Paper Claims

FCH does not accept handwritten claims. Claims should be submitted electronically or, if on paper, must be “typewritten” in order for FCH to be able to properly price the claim and forward it on to our payors for claims adjudication. All handwritten claims will be rejected and sent back to the submitter.

For providers still submitting claims to First Choice Health PPO Network on paper, we have several options that can assist you in making the transition from paper to EDI. Electronic transactions are a very efficient way to submit claims to FCH. By sending your claims electronically, you speed up your revenue cycle.

Below are some alternative ways to send your claims electronically to FCH at little to no cost to you:

- Office Ally: www.onehealthport.com/services/administrative_ally.php
- MD Online: www.mdon-line.com/mdonline/index.asp

When submitting paper claims (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 webpage](#) for assistance when ID card is not available.
- Name of payor in box 11c on the CMS 1500 form (i.e. KPS, GHO, etc.)
- Name and address where service was rendered (box 32)
- The pay-to address in box 33 on the CMS 1500 form (i.e. KPS, GHO, etc.)
- Billing provider information and phone number of physician or health care provider performing the service (provide this information in a manner consistent with how the information is presented in your agreement); 5010 HIPAA compliant claims require this to be a physical street address (not a PO Box) and the zip code needs the +4 extension
- 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 (See Chapter 4 for modifier list)
- 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)
- Present on Admission (POA) indicator (unless POA exempt facility)
- Current ICD-9-CM procedure codes when applicable
- Bill all procedures with the appropriate revenue and CPT or HCPCS codes
- Baby’s birth weight (Newborn Claims) should contain 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 “Value Code” field, enter the weight in grams then decimal point 00. E.g., 2499.00)

These are examples and this list is not all inclusive. Please refer to the National Uniform Claim Committee (NUCC) for CMS 1500 and the National Uniform Billing Committee (NUBC) for UB04 as well as the electronic equivalent companion guides for standard requirements.

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 FCHN to price.

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 directly with the payor before the participant'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 participant fails to provide proof of insurance at the time of service, the 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: Updating Provider Information

When to Notify FCHN regarding Demographic Changes

Goal: The PPO Pricing system relies on the most current, updated information. Our goal is to price claims accurately and efficiently. This requires you to keep information up to date and accurate.

Please notify First Choice Health PPO Network when you make changes to your demographic information such as:

- Tax name changes including “Doing Business As” (DBA) names
- Practitioner name changes or practice location name changes including clinics, hospitals, and facilities
- Changes in practice locations that you are affiliated with
- Mailing address for routine business correspondence, including contract information and provider bulletins
- Physical billing address as required by 5010 (this must be a “physical street address”)
- Practice address (the physical address where the practice(s) are located)
- Clinic NPI (this is an organizational NPI and should match the CMS website)
- Practitioner NPI (this is the individual rendering practitioner NPI and should match the CMS website)
- Notice of new clinics (additional clinics that the practitioner is associated with and/or new practice locations for an existing clinic)
- Notice of new practitioners (additional practitioners that are associated with a medical group, clinic or hospital); Please note that they must be credentialed or joining an entity that has a “delegated credentialing” relationship.
- Notice of practitioners no longer with clinic

This information can be submitted to FCHN two ways:

1. Use the **FCHN Provider Update form** available online (<http://www.fchn.com/ppo/providers/ProviderUpdateForms.aspx>). You can submit the form via e-mail to PPOFileMaintenance@fchn.com or via fax to (206) 268-2940, Attention: Provider Information Management. The average time for demographic changes to be entered into the FCHN system is 10 business days from date of receipt.
2. Use [ProviderSource](#) to indicate what demographic changes you wish to make. You must indicate that you want FCHN to be notified that you are making the changes, otherwise, we will not know that the changes are there to be picked up.

First Choice Health Form W-9

A payor, union trust, third party administrator, or self-funded group, who 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, a Third Party Administrator (TPA).

For clarification and instruction, please refer to the IRS website (www.irs.gov/instructions/iw9/ar02.html) and (www.irs.gov/pub/irs-pdf/iw9.pdf).

A W-9 is required when you have a Tax ID (TIN) change or name change. To obtain a blank W-9 form, please visit the IRS website (www.irs.gov/pub/irs-pdf/fw9.pdf).

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 FCH is as follows:

- All claims for anesthesia services require the total time of the procedure, with the exception of codes 01953 and 01966, 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.
- 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.
- FCH will not accept CPT codes billed with time units for contracted anesthesia providers.
- Only bill appropriate CPT anesthesia codes (00100-01999).

Baby's Birth Weight

When billing Newborn Inpatient claims on the UB04, please 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).

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 FCH PPO re-pricing. However, 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 FCH 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/AD	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.
AS	PA Services for Assistant at Surgery	Reduce the base code allowable amount by 80%.
LT	Procedure done on the left side of the body	100% of allowable
NU	New DME	The allowable amount is contractually predetermined.
P1	A normal healthy patient	Zero base units will be added.
P2	A patient with mild systemic disease	Zero base units will be added.
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.
P6	A declared brain-dead patient whose organs are being removed for donor purposes	Zero base units will be added.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Reduce the base code allowable by 50%.
QX	CRNA service: with medical direction by a physician	Reduce the base code allowable amount by 50%.
QY	Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	Reduce the base code 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
TC	Technical component	The allowable amount is contractually predetermined.
UE	Used DME	The allowable amount is contractually predetermined.

Modifier #	Modifier Denotes	Description
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 according to the following sequence: 100/50/50/50.
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	Upon medical review by payor, reduce the base code allowable by 20%.
55	Post-operative management only	Reduce the base code allowable by 80%.
56	Pre-operative management only	Reduce the base code allowable by 90%.
57	Decision for surgery	100% of allowable
58	Staged or related procedure or service by the same physician during the post-operative period	Upon review by payor, recommended reductions should be according to the following sequence: 100/50/50/50.
59	Distinct procedural service	It may be appropriate to review supporting documentation for this distinct procedural service.
62	Two surgeons	Reduce the base code allowable by 37.5% for a surgical procedure.
76	Repeat procedure by same physician	100% of allowable
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%.
77	Repeat procedure by another physician	100% of allowable
78	Return to the operating room for a related procedure during the post-operative period	Reduce the base code allowable by 20% for a surgical procedure.

Modifier #	Modifier Denotes	Description
79	Unrelated procedure or service by the same physician during the post-operative period	100% of allowable
80	Assistant surgeon	Reduce the base code allowable amount by 80%.
81	Minimum assistant surgeon	Reduce the base code allowable amount by 80%.
82	Assistant surgeon (when qualified resident surgeon not available)	Reduce the base code allowable amount by 80%.
90	Reference (outside) laboratory	100% of allowable

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.

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

See below for information regarding the Washington Vaccine Association (WVA). All information has been relayed from the WVA website (www.wavaccine.org). For the most up-to-date and current information, please be sure to visit this website.

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: Payor Information

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

As a PPO, First Choice Health (FCH) contracts with health care providers and facilities. Payors contract with FCH 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 a self-insured employer.

Eligibility, Benefits and Claims Status

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. The number to call for claims status can also be found on the pricing worksheets. If the patient does not have their ID card, refer to our [website](#).

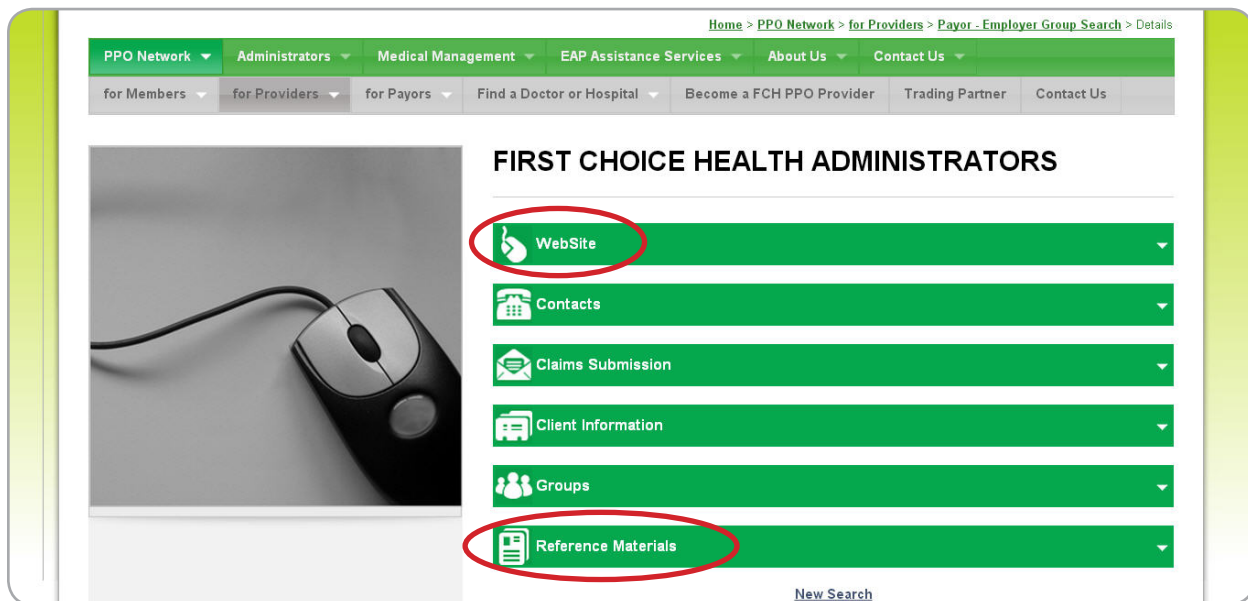
You can search for the payor by payor name, employer group or employer name. Information on where to submit the claim as well as where to call for claim status can be found using this search. Please see the below information regarding payor websites--many of these websites contain eligibility, benefit information and claim status.

After seeing a First Choice Health patient, submit the claim for services provided to...

- The address listed on the patient's ID card. If the patient does not have their ID card, refer to our website (<http://www.fchn.com/ppo/providers/payorSearch.aspx>). Search for the patient or subscriber's payor by payor name, employer name or employer group number.
- Submit the claim (refer to [Chapter Three](#) for further information).

Payor Websites

We have several payors that have websites to help providers obtain claims status and/or benefits and eligibility. When we have a link to a payors website, it can be found at the top of the page when searching at the payor level. If you do not see a tab titled "WebSite" then that means we have not been informed that the payor has a website. Please see the illustration on the following page for an example of what this looks like on the provider webpage.



Patient Identification Cards

To identify a First Choice Health patient, look for the First Choice Health name or logo on the patient's medical ID card. The ID card typically contains 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 eligibility, benefits and claim status.

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

We have several sample ID card examples available on our provider webpage. When searching at the payor level, if there is a sample ID card it will be shown under the Reference Materials tab. Please see the illustration on the prior page to see a sample of what this looks like on the provider webpage.

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 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/EOB carefully to ensure proper reimbursement for services according to your contractual agreement with FCHN. If you feel there has been a discrepancy with your contractual allowance, please contact Provider Relations for assistance.

Chapter Seven: Credentialing

Credentialing and Recredentialing

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 American Accreditation Healthcare Commission (URAC) Guidelines.

Every practitioner must submit a completed, signed and dated application to FCH. The application must be signed and dated within 180 days of Credentialing Committee review and approval.

FCH formally recredentials 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.

First Choice Health is currently accepting applications through OneHealthPort for both initial credentialing and also recredentialing. For those providers outside the State of Washington, you can use the [FCHN website](#) to complete credentialing or return recredentialing directly to the network. Please allow standard turnaround time of 90 days.

Confidentiality

FCH's Credentialing Committee is a regularly constituted review committee. The Committee is involved in credentialing, recredentialing, ongoing monitoring and peer review of practitioners who contract with or otherwise participate in FCH's network. The Committee may also be involved in the evaluation and improvement of care rendered by those practitioners. FCH 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 FCH'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 (e-mail, 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, e-mail, 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 First Choice Health (FCH) Credentialing Committee will assign all effective dates for providers that are non-delegated through the Credentialing process. Provider File Maintenance (PFM) must enter the effective date assigned by the FCH Credentialing Department. Effective dates are based on the approved committee date for initial applications. Providers credentialed through FCH will be assigned an effective date for the first day of the current month if the Committee approved the application between the first and the fifteenth of the month. Providers credentialed through FCH will be assigned an effective date for the first day of the following month if the Committee approved the application between the sixteenth and the end of the month.

Exception: Providers, approved by Committee, but FCH contract is not received or signed. The effective date will be based on the contract received date and the first day of the current month rule will apply.

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:

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

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 60 days per 12-month period, to provide services to the contracted provider's patients. The contracted provider must be currently employed at that location. FCH 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 his/her 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 FCHN 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 recredentialing 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/rec 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. Failure to become Board certified in practice specialty when applicable
12. Failure to become Board certified in practice specialty within five years of completion of residency (if applicable)
13. Failure to maintain Board certification for specialties that require periodic recertification
14. Loss of Board certification status based on a adverse event
15. Current or previous loss of or insufficient/inadequate malpractice insurance coverage
16. 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
17. Current or previous sanctions by Medicare/Medicaid (including censure or exclusions)
18. 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
19. 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
20. History of practicing without valid license, registration/certification or authorization
21. History of significant patient complaints documented by licensing authority, health care facility, health plan, or network administrator
22. Current or previous revocation or loss of, or restrictions to, DEA registration
23. History of concerns about quality of care or evidence of compromised quality of care
24. Current or history of chemical dependency/substance abuse
25. Current physical or mental health problem(s) which significantly impair practitioner's ability to perform within the scope of his/her professional duties
26. 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
27. 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

28. History of providing patient care outside of the scope of license, registration/certification or authorization
29. Practice inconsistent with professional standards of care
30. Criminal record affecting professional practice
31. Current or history of a felony conviction
32. Unethical conduct or history of unethical conduct, in violation of laws or standards governing the practice of health care
33. Acts of, or history of, fraud, deceit, dishonesty or moral turpitude
34. Practice trends, or history of, practice trends that raise concerns regarding provider's ethics, quality of care and/or practice standards
35. 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.)
36. Submission of erroneous, improper or incomplete claims
37. Failure to comply with procedures implemented in connection with the administration of utilization review or failure to cooperate with the quality management activities
38. 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 provider who is not currently credentialed and/or contracted with FCH PPO.

Providers 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.

Providers 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 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 effected provider is afforded all rights to which he/she is entitled.

Level I Appeal

1. The provider 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 and a summary of FCH appeal rights and the appeals process. 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 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 provider's 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 sixty (60) days of receipt of appeal, unless FCH 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 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 registered certified return receipt 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. Provider may request in writing a hearing with the Level II Appeals Committee. Level II appeals have an administrative fee of \$1,500. 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 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 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 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. The provider 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 provider 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. 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. Documents will be forwarded (via carrier) to the members, the provider, and/or legal representative ten (10) business days prior to the hearing.
10. Provider will have the right to present information and other documentation determined to be relevant by the hearing officer.
11. Provider 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 not less than two (2) actively practicing health care providers, 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 provider 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 registered mail, and the notice will be deemed received and final upon signature and date of the receipt.
22. The decision of the Level II Appeals Committee will be final and binding for all involved parties.

Chapter Eight: Quality

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

FCH 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 turnaround times
- Days on hand
- Payor pricing
- Active providers
- Provider files

Receiving and Tracking Complaints

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

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 a medical director. As part of the review, patient medical records may be requested. The final review of the complaint is submitted to the Credentialing Department.

Chapter Nine: Frequently Asked Questions

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

As a PPO, First Choice Health (FCH) contracts with health care providers and facilities. Payors contract with FCH 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 a 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 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 on the [provider webpage](#) 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 FCHN website to look up your practice. Look for the large green arrow on our homepage or go to <http://www.fchn.com/ppo/providers/payorSearch.aspx>.

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 [provider webpage](#) to verify.

More information can be found in [Chapter Three](#) of this manual under Claims and Billing – section titled “Where to Send Claims.”

How do I obtain claims status?

Refer to the members' ID card for the payor number to obtain claims processing status. If the member does not have an ID card, you can use the [provider webpage](#) to verify. You can search by employer group name or number or you can search by the payor name. The number will be listed under the “Contacts” tab.

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 [webpage](#) to verify.

More information can be found in [Chapter Three](#) of this manual under Claims and Billing – section titled “Collecting Funds at Time of Service.”

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?

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 webpage](#). More information can be found in [Chapter Three](#) of this manual under Claims and Billing—section titled “Eligibility and Benefits.”

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 referencing the [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 FCHN first for pricing, however, there are some variations in the instructions as to where to mail claims. As a Preferred Provider in the FCHN 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 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 Explanation of Payment/Explanation of Benefit (EOP/EOB) 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/EOB will also indicate what, if any, portion should be considered member responsibility. This is expanded upon further in this manual in [Chapter Five](#) under Payor Information—section titled “Explanation of Payment.”

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 webpage](#) 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, Ext. 2103, or via e-mail 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. FCHN does not pay claims, we only price the claims based on the your contractual allowance. Please 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 FCHN is up to date with all federally mandated rules?

FCHN makes every effort to stay in compliance with all federally mandated rules. Please check our Newsletters and Bulletins for any upcoming federally mandated changes, such as ICD-10.

How do I verify credentialing or recredentialing status?

The credentialing process is complex and we at First Choice Health aim to be as accurate and comprehensive as possible. As a result the process will take some time, please feel free to call Provider Relations after 60 days to check on your status.

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

There is an online form we ask providers to use. Please refer to [Chapter Four](#) of this manual for further instruction.

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

- FCHN 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.