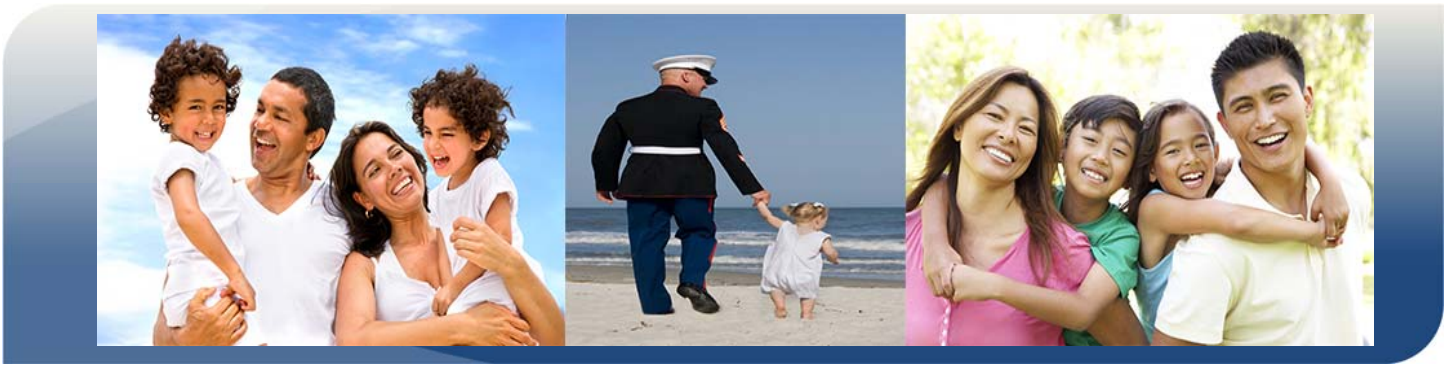
2021

US FAMILY HEALTH PLAN

PROVIDER MANUAL

2021 EDITION

PROVIDER SERVICES



A message from the Executive Director

US Family Health Plan @ Saint Vincents is a Department of Defense Designated Provider of the TRICARE Prime Health Program, and has been providing care to the military community for over 30 years. Health care is offered to active duty family members, retirees and their family members, including active and retired National Guard and Reservist who reside in New Jersey, NYC, Westchester, Orange, Rockland, Suffolk and Nassau counties, Eastern Pennsylvania and Western Connecticut.

We are dedicated to providing our military beneficiaries with the highest level of healthcare services available. Beyond our breadth of benefits, the keystone of our program is our extensive network of caring, quality and professional providers and facilities. Your participation in the plan allows our members to have easy access to healthcare services and support. Our combined commitment to their health and wellness, continuity of care, and our policy of individual care management programs has been recognized year after year by our USFHP members as one of the best health plans in the country! We take pride in working with you in delivering exceptional health care to all our members and so should all of you!

Let me take this opportunity to thank each and every one of our providers and facilities for extending excellence in healthcare services to our members. You have made it possible for US Family Health Plan to deliver on the promise to provide our members with the very best in healthcare.

Sincerely,

Jeffrey M. Bloom

urac ACCREDITED HEALTH NETWORK

TRICARE

THE 5-STAR HEALTH PLAN

Provider Manual
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Plan Overview

US Family Health Plan @ Saint Vincent's is a Department of Defense Designated Provider of the TRICARE Prime Health Program, a managed health care program providing care to the military community for over 30 years. Health care is offered to active duty family members, retirees and their family members, including active and retired National Guard and Reservist who reside in New Jersey, NYC, Westchester, Orange, Rockland, Suffolk and Nassau counties, Eastern Pennsylvania and Western Connecticut.

The DOD's objective in launching the Plan was to provide enhanced primary and preventive services by expanding access to health care providers and facilities. Under this model, the plan requires members to select a primary care provider (PCP) as their medical provider.

The PCP works with the member to oversee their entire health care needs. US Family Health Plan @ Saint Vincent's provides members access to our own medical clinics, primary care providers, specialists, and facilities in addition to a large contracted network of community providers throughout the region.

The US Family Health Plan @ St. Vincent's goes beyond traditional TRICARE Prime benefits to offer excellent customer service, and value-added benefits including vision benefits, hearing aids, fitness memberships, and more. This plan has consistently earned high ratings for quality and member satisfaction

Excellence in primary care management combined with strong case and disease management programs ensure that the Plan provides best value health care services in support of the Military Health System.

USFHP @ St. Vincent's has been providing health care services to members of all ages, including Medicare-eligible members since 1981. And, we continue our long history of service and commitment to caring for members.

USFHP offers the following:

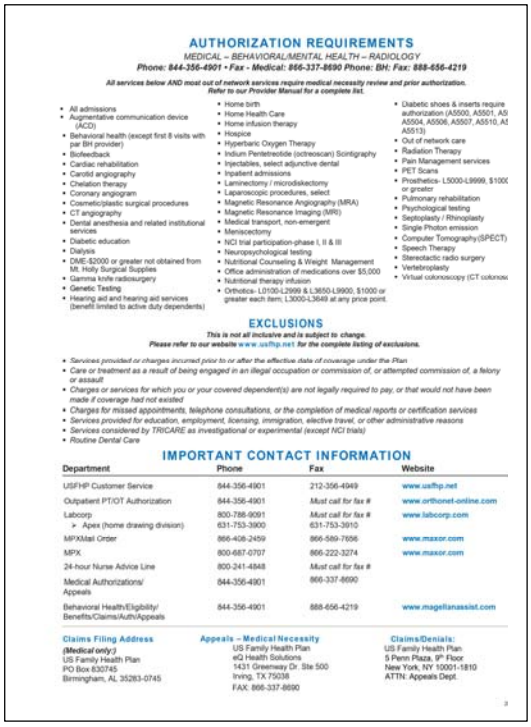
- No enrollment fee for active duty dependents
- Nominal copays per office visit (retirees/dependents)
- No copay per office visit (active duty family members or retirees w/Medicare)
- Guaranteed appointments (access standards)
- PCP supervised and coordinated care coverage when away from home

Part 1 - Directory of Resources and Contacts

The US Family Health Plan "**Provider Quick Reference Guide"** is available on the provider page at www.USFHP.net. The Quick Reference Guide is a two (2) page concise summary of essential information about the plan. You can get helpful details about submitting claims, learn about special programs we offer, and receive answers to information to assist our providers in accessing necessary information.


US FAMILY HEALTH PLAN

PROVIDER QUICK REFERENCE GUIDE


AUTHORIZATION REQUIREMENTS

MEDICAL – BEHAVIORAL/MENTAL HEALTH – RADIOLOGY

Phone: 844-356-4901 • Fax - Medical: 866-337-8690 Phone: BH: Fax: 888-656-4219

All services below AND most out of network services require medical necessity review and prior authorization. Refer to our Provider Manual for a complete list.

- All admissions
- Augmentative communication device (ACD)
- Behavioral health (except first 8 visits with par BH provider)
- Biofeedback
- Cardiac rehabilitation
- Carotid angiography
- Chelation therapy
- Coronary angiogram
- Cosmetic/plastic surgical procedures
- CT angiography
- Dental anesthesia and related institutional services
- Diabetic education
- Dialysis
- DME-$2000 or greater not obtained from Mt. Holly Surgical Supplies
- Gamma knife radiosurgery
- Genetic Testing
- Hearing aid and hearing aid services (benefit limited to active duty dependents)
- Home birth
- Home Health Care
- Home infusion therapy
- Hospice
- Hyperbaric Oxygen Therapy
- Indium Pentetreotide (octreoscan) Scintigraphy
- Injectables, select adjunctive dental
- Inpatient admissions
- Laminectomy / microdiskectomy
- Laparoscopic procedures, select
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Medical transport, non-emergent
- Meniscectomy
- NCI trial participation-phase I, II & III
- Neuropsychological testing
- Nutritional Counseling & Weight Management
- Office administration of medications over $5,000
- Nutritional therapy infusion
- Orthotics- L0100-L2999 & L3650-L9900, $1000 or greater each item; L3000-L3649 at any price point.
- Diabetic shoes & inserts require authorization (A5500, A5501, A5504, A5506, A5507, A5510, A5513)
- Out of network care
- Radiation Therapy
- Pain Management services
- PET Scans
- Prosthetics- L5000-L9999, $100 or greater
- Pulmonary rehabilitation
- Psychological testing
- Septoplasty / Rhinoplasty
- Single Photon emission
- Computer Tomography(SPECT)
- Speech Therapy
- Stereotactic radio surgery
- Vertebroplasty
- Virtual colonoscopy (CT colonog

EXCLUSIONS

This is not all inclusive and is subject to change.

Please refer to our website www.usfhp.net for the complete listing of exclusions.

- Services provided or charges incurred prior to or after the effective date of coverage under the Plan
- Care or treatment as a result of being engaged in an illegal occupation or commission of, or attempted commission of, a felony or assault
- Charges or services for which you or your covered dependent(s) are not legally required to pay, or that would not have been made if coverage had not existed
- Charges for missed appointments, telephone consultations, or the completion of medical reports or certification services
- Services provided for education, employment, licensing, immigration, elective travel, or other administrative reasons
- Services considered by TRICARE as investigational or experimental (except NCI trials)
- Routine Dental Care

IMPORTANT CONTACT INFORMATION

Department	Phone	Fax	Website
USFHP Customer Service	844-356-4901	212-356-4949	www.usfhp.net
Outpatient PT/OT Authorization	844-356-4901	Must call for fax #	www.orthonet-online.com
Labcorp	800-788-9091	Must call for fax #	www.labcorp.com
➢ Apex (home drawing division)	631-753-3900	631-753-3910	
MPXMail Order	866-408-2459	866-589-7656	www.maxor.com
MPX	800-687-0707	866-222-3274	www.maxor.com
24-hour Nurse Advice Line	800-241-4848	Must call for fax #	
Medical Authorizations/ Appeals	844-356-4901	866-337-8690	
Behavioral Health/Eligibility/ Benefits/Claims/Auth/Appeals	844-356-4901	888-656-4219	www.magellanassist.com

Claims Filing Address (Medical only):
US Family Health Plan
PO Box 630745
Birmingham, AL 35283-0745

Appeals – Medical Necessity
US Family Health Plan
eQ Health Solutions
1431 Greenway Dr. Ste 500
Irving, TX 75038
FAX: 866-337-8690

Claims/Denials:
US Family Health Plan
5 Penn Plaza, 9th Floor
New York, NY 10001-1810
ATTN: Appeals Dept.

Provider Portal	•**Enroll in our Provider Portal – usfhp.net** •Check member eligibility, claim status inquiries, demographic updates and much more •**Call 844-356-4901 and Press #1 for Eligibility** •Check member eligibility & claim status inquiries
DME	• **Mount Holly Surgical Supply** •Ambulatory assistive devices, home oxygen and home respiratory equipment •Call 844-356-4901 and Press #5 for DME
Laboratory Testing	•**Labcorp is the Plan's preferred outpatient lab vendor** •For locations call 800-788-9091 • or visit their website awww.labcorp.com
Authorization Review Process and Appeals	•**eQ Health** •Fax all requests to: 866-337-8690 •Fax appeals to: 866-337-8690

Part 2 - Directorv of Resources and Contacts

24 Hour Nurse Line

- **Nurse Line**
  - Call : 800-241-4848
  - Fax: Must call for fax #

Behavioral Health

- **Magellan:**
  - Contact Magellan to pre-certify services or to obtain a listing of providers
  - Call 844-356-4901; Press #2 for Behavioral Health
  - Or visit their website at www.magellanassist.com

Physical & Occupational Therapy

- **Orthonet:**
  - To pre-certify OT/PT services contact Orthonet
  - Call 844-356-4901; Press #4 for PT/OT
  - Or visit their website at www.orthonet-online .com

Pharmacy

- **MPX**
- MPX Customer Service can be reached on 800-687-0707
  - Submit and order: Phone 866-408-2459 or Fax 866-222-3274
  - Mail Order: P.O. Box 32050,Amarillo, Texas 79120-2050

Davis Vision

- **Eye Glasses/Exams**
  - Member Services 800-999-5431
  - Provider Recruitement 800-584-3140
  - www.davisvision.com

Medical Claims Office

- **Medical and Surgical**
  - US Family Health Plan
  - P.O. Box 830745
  - Birmingham, AL 35283-0745
  - ELECTRONIC: Change Health Care Payor ID 13407

Magellan Claims Address

- **Magellan Mailing Address**
  - PO Box 1099
  - Maryland Heights, MO 63043

Claims Denials

- **US Family Health Plan**
  - 5 Penn Plaza, 9th Floor
  - New York, NY 10001
  - ATTN: USFHP Appeals Department

USFHP Customer Service

- **US Family Health Plan**
  - Attn: Customer Service
  - 5 Penn Plz, 9th Fl
  - New York, NY 10001
  - Provider Line - 844-356-4901

Membership Eligibility

Members must meet one of the following criteria:

- Be an active-duty family member, including a spouse or unmarried dependent (until the 21st birthday, or, if a full-time student, the 26th birthday)
- Be a military retiree from the active/reserve component, a spouse or unmarried dependent (until the 21st birthday, or, if a full- time student, the 26th birthday)
    - Military retirees who were enrolled in the plan on or before 9/30/12 are allowed to stay enrolled after their 65th birthday as long as they maintain continuous enrollment. If a member leaves the plan and returns, he or she loses "grandfathered" status.
    - Military retirees who became a member of the plan on or after 10/1/2012 will be automatically dis-enrolled when they turn 65 and moved to TRICARE for Life (TFL).
- Be a family member of a deceased active-duty military member or retiree

Eligibility Verification

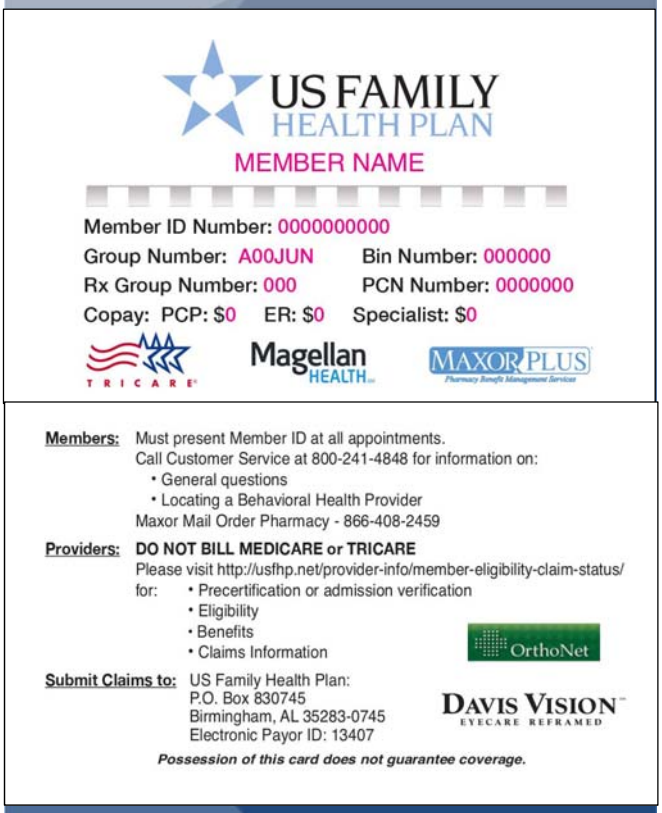
Members must present their USFHP identification card whenever they request services. Providers are responsible for verifying members' eligibility before rendering services.

For our provider's convenience, verification of member's eligibility can be obtained by using E-power from our on-line Provider Portal. Verification of eligibility is not a guarantee of claims payment. Payment for services provided during lapses of coverage, or after plan termination, is the responsibility of the patient.

Provider Portal Registration

Providers are required to register for the provider portal via ePower to verify member eligibility. In order to access ePower you will need to register as a first-time user. You will have the opportunity to select your User ID name and password. To register please go to: https://epower.dsthealthsolutions.com/STV_provider/login.jsp

Membership Card



- Member ID Number
- Member's Name
- Co-payment amount for outpatient, emergency and pharmacy applicable to the enrollee at the time of his/her enrollment effective date; there are differing co-payments for ambulatory surgery, inpatient admissions, behavioral health, and DME.
- Member group number
- Pharmacy Group number

Co-Payments

Co-payments – Office Visits

Members are responsible for making all applicable co-payments. Please check the members ID card for exact amounts. Some members have no co-payments (except pharmacy) while others are responsible for making a small co-payment.

Examples:

Active Duty Dependents	No co-payment
Retirees /family members **with Medicare Part B**	No co-payment
Retirees /family members **without Medicare Part B**	Primary Care Visit $21
	Specialist Care Visit $31

The Primary Care Providers should not charge a co-payment if a member is picking up a referral from the office or for the co-pay exceptions listed below. A full plan summary and co-payments can be found on our website USFHP.net. See "Summary of Benefits" schedule on page 8.

Co-payment Exceptions – No co-payment is required

- Annual physical examination/preventive health visit
- Annual eye examination /eyeglasses
- Annual gynecology exam
- Pediatric well-child visits to age 6 years
- Obstetrical care
- Radiation Therapy
- Radiology, Laboratory, or Immunizations
- Chemotherapy
- Hospice and Home Care

Co-payments – Prescriptions

A Maxor Retail Pharmacy is conveniently located at both of our Family Health Centers: Mitchel Field Health Center and Fort Wadsworth Health Center.

Maxor Pharmacy Mail Order Schedule:

GENERIC	$13	Co-Payment
BRAND	$33	Co-Payment
TIER 3	$60	Co-Payment

Members **MUST** use a Maxor retail pharmacy or the mail order program for maintenance medications. The mail order program allows patients to obtain a 90-day supply of maintenance medications. Urgent medications such as antibiotics may be filled at a Maxor Network Pharmacy.
For first time fills of maintenance medications, please give the patient a 30-day prescription to fill at the local walk-in pharmacy and a 90-day prescription to fill through mail.

Summary of Payments – Outpatient

COVERED SERVICES	Active Duty Family Members	Retirees with Medicare Part B	Retirees without Medicare Part B
OUTPATIENT SERVICES			
Office Visits	$0	$0	$21 per visit Primary Care $31 per visit Specialist Care
Maternity Care (prenatal, postnatal)	$0	$0	$0
Well-baby care (up to age 6)	$0	$0	$0
Annual well-childcare (age 6 and older)	$0	$0	$0
Annual physical examination	$0	$0	$0
Ambulatory surgery and procedures (including anesthesia)	$0	$0	$63
Physical, occupational, speech therapy	$0	$0	$31 per visit
Inpatient Services			
Semi-private room and board	$0	$0	$158 per admission with authorization
Physicians services	$0	$0	$0
General nursing services	$0	$0	$0
Diagnostic tests, including lab and x-ray	$0	$0	$0
Operating room, anesthesia and supplies	$0	$0	$0
Medically necessary supplies and services	$0	$0	$0
Physical therapy	$0	$0	$0
Mental Health Service			
Outpatient care: individual [1]	$0	$0	$31 per visit
Outpatient care: group [1]	$0	$0	$31 per visit
Partial hospitalization mental health (up to 60 days per enrollment year)	$0	$0	$31 per visit – Individual $31 per visit – Group
Inpatient hospital psychiatric care (subject to medical review) [2]	$0	$0	$158 per admission
Substance Abuse Treatment			
Outpatient – group therapy	$0	$0	$31 per visit
Inpatient service (up to 7 days for detoxification per year) [3]	$0	$0	$158 per admission
Inpatient rehabilitation (up to 21 days per year) [3]	$0	$0	$158 per admission
Other Services			
Medical Transportation service (when medically necessary)	$0	$0	$42 per occurrence
Durable medical equipment (including orthotics and prosthetics) and medical supplies	$0	$0	20% of purchase price or monthly rental rate
Emergency room services [4]	$0	$0	$63 per visit
Eye examinations (1 per enrollment period)	$0	$0	$31
Radiation/chemotherapy office visits	$0	$0	$31
Skilled nursing facility care (when medically necessary)	$0	$0	$31 per day/$25 minimum per admission
Home health care (part time skilled nursing care)	$0	$0	$0 per visit
Out of area (emergency room)	$0	$0	$63 per visit
Pharmacy (over the counter medications are not covered)			
Prescriptions drugs (up to 30-day supply) [5]	$13 generic/$33 brand/$60 third tier	$13 generic/$33 brand/$56 third tier	$13 generic/$33 brand/ $60third tier
Mail order pharmacy drugs (up to 90-day supply) [5]	$10 generic/$29 brand/$60 third tier	$10 generic/$29 brand/$60 third tier	$10 generic/$29 brand/$60 third tier
Yearly Enrollment Fee	$0	$0	$303 per individual $606 per family $459/Month TRICARE Young adult

SUMMARY OF PAYMENTS AND CO-PAYMENTS

[1] **One hour of therapy, no more than two times per week, when medically necessary.**

[2] **With authorization, up to 30 days per enrollment year for adults (age 19+); up to 45 days per enrollment year for children under age 19; up to 150 days residential treatment for children.**

Exclusions

General Exclusions

- Services provided or charges incurred prior to the effective date of coverage under the Plan.
- Care or treatment as a result of being engaged in an illegal occupation or commission of a felony or assault.
- Charges or services for which the enrollee, or the enrollee's covered dependent(s), is not legally required to pay, or that would not have been made if no coverage had existed.
- Charges for missed appointments.
- Charges for telephone calls and other types of indirect communication (e.g. EMT supervision).
- Services not specifically included as covered services in the TRICARE Policy Manual/Member Handbook.
- Services provided by people who ordinarily reside in the enrollee's household, or the household of the enrollee or the enrollee's covered dependent or are related by blood or marriage or legal adoption to the enrollee or the enrollee's covered dependent.
- Services provided or received after the date the enrollee's coverage terminated under the Plan.
- Services not considered medically necessary for the enrollee's diagnosis and treatment.
- Services which are investigational/experimental or of a research nature as defined by TRICARE (exception - participation in NCI Phase I, II and III trials).
- Any services denied by the Plan's Utilization Management Program.
- Complications due to the treatment of a non-covered service.
- Non-medically necessary services ordered by a court.
- Custodial care as defined by TRICARE

Part 1. Service Exclusions

- Abortion, elective (except in specific situations approved by TRICARE)
- Acupuncture and acupressure
- Alterations to living space
- Arch supports (except diabetic orthotics)
- Artificial insemination, in vitro fertilization, and other therapies (including drug therapy and testing) intended for non-coital methods of pregnancy (Note: infertility evaluations are covered)
- Aversion therapy (e.g. in connection with alcoholism)
- Bed-wetting correctional devices
- Body piercing
- Botulinum toxin (Botox) injections for palmar hyperhidrosis, urinary urge incontinence, lower back pain, lumbago, migraine headache and other primary headache disorders and strabismus in patients under age 12
- Contraceptives, over the counter
- Convalescent care
- Cosmetic, plastic or reconstructive surgery, that is not medically necessary (TRICARE exceptions exist)
- Court ordered care
- Cranial orthosis (Dynamic Orthotic Cranioplasty Band) and cranial molding helmets
- CT scan for acute ischemic stroke
- CT for intracerebral aneurysm, subarachnoid hemorrhage
- CT scan heart without contrast
- Custodial care
- Chiropractic services
- Complementary and alternative medicine (CAM)
- Dental care
- Dental X-rays and services (TRICARE exceptions exist)
- Dermoscopy
- Domiciliary care
- Education and training
- Electrolysis
- Exercise equipment
- Exercise programs
- Experimental/investigational treatments/ procedures (except NCI phase I, II & III trials)
- Food, food substitutes or supplements, and vitamins consumed outside a hospital, except for home parenteral/enteral nutrition therapy
- Foot care, routine preventive, except in connection with medical treatment of a peripheral vascular disease
- Hair analysis to identify mineral deficiencies – hair analysis testing may be covered when medically necessary to determine lead poisoning
- Hair removal
- Hair transplant
- Hypnosis
- Hyperthermia, whole body or hyperthermia for recurrent breast cancer
- Hearing Aids (except in specific situations)
- Immunizations for elective travel
- Intelligence testing
- Internal infusion pump (IIP) for treatment of thromboembolic, IIP for treatment of diabetes; any IIPs and related services for non-FDA approved specifications
- In-vitro Fertilization (and any treatment/testing for non-coital methods to achieve pregnancy

Part 2. Service Exclusions

- Intersex surgery
- Laser surgery for pain relief/biostimulation; non-covered surgical services (i.e., tattoo removal), arthritis or low back pain, corneal sculpting, and body sculpting
- Learning disorders (treatment for)
- Mandibular staple implants
- Massage therapy
- Megavitamins and orthomolecular psychiatric therapy
- MRI to screen for breast cancer
- MRI to evaluate suspicious lesions to avoid biopsy
- MRI to differentiate cysts from solid lesions
- MRI to assess implant integrity or confirm implant rupture
- Naturopathic services
- Neuropsychological testing for education, employment, or if court-ordered
- Occulusal equilibration and restorative occlusal rehabilitation
- Organ transplants considered investigational/experimental
- Orthodontia
- Orthopedic shoes and arch supports, except when an integral part of a brace or custom molded shoes for a diabetic or other individual diagnosed with peripheral vascular disease
- Over-the-counter drugs, vitamins or food supplements
- Patient Convenience Items (examples include, but are not limited to, adult diapers, incontinence pads, admission packets, telephone rental, television rental)
- PET scan for diagnosis and monitoring of Alzheimer's disease or any form of dementia
- Physician assisted suicide
- Podiatry, routine (i.e., removal of corns,

NOTE: This list is not all-inclusive and is subject to change. Additionally, although not all-inclusive, real time TRICARE "No Pay Codes" are available at http://www.tricare.osd.mil/nogovernmentpay.

- Private hospital rooms, unless ordered by the attending Physician for medical reasons, or a semi-private room is not available
- Psychological testing and assessment as part of an assessment for academic placement
- Psychological testing related to child custody disputes
- Psychological testing for job placement
- Psychological testing for general screening, in the absence of specific symptoms of a covered mental disorder, to determine if individuals being tested are suffering from a mental disorder
- Psychological testing, teacher/parent referrals
- Reitan-Indiana battery when administered to a patient under age 5 and for self-administered tests to patients under age 13
- Reproductive tissue, cryopreservation/ thawing
- Reversal of sterilization
- Radial keratotomy
- Respite care (except as part of pre-approved home hospice program)
- Retirement homes, assisted living facility, custodial care facility
- Sex change procedures
- Smoking cessation programs unless part of a special Plan program
- Sterilization reversals
- Surgical preparation of the mouth for dentures
- TMJ syndrome, treatment of
- Topical application of oxygen
- Topographic brain mapping (brain electrical activity mapping, quantitative EEG, digital EEG, topographic EEG, brain mapping EEG)
- Transportation for convenience
- Vestibuloplasty or surgical preparation of the mouth for dentures
- Virtual colonoscopy for screening

- Weight control or weight reduction

CLAIMS

Listed below are some hints and tips for successful claims submission:

- Complete all required information on a CMS 1500 (formerly known as HCFA 1500) or UB04/CMS 1450 form
- Check for accuracy and please DO NOT handwrite the form
- Claims must be filed using the current Procedural and Diagnosis coding developed by the AMA.
- Double check CPT/ICD10 codes; Claims will be rejected for not filing with the most recent codes and proper number of digits
- Claims MUST be submitted within 60 days from the date of service (claims not submitted timely will be denied) and members cannot be billed for these claims
- Submit claims electronically via Emdeon Payor ID 13407
- Members should not be balanced billed for covered services
- Do not balance bill USFHP members for any amounts in excess of the allowed amount, other than for co-payments and coinsurance
- Members are not financially liable for non-covered services unless a prior written acknowledgement that the services will be the member's responsibility is obtained
- Medicare/Medicaid or any other TRICARE Program contractor should not be billed; the US Family Health Plan is the primary insurer.
    - Exception 1. ESRD (diagnosis of ICD-10 code N18.6 and with Medicare Parts A/B), many healthcare services are covered by Medicare are primary;
    - Exception 2. Medicare and/or Medicaid may be billed for those services not covered by US Family Health Plan, but that Medicare and/or Medicaid covers.
- USFHP is always the secondary payor to other commercial health insurance **except for Medicare and Medicaid.**
- Federal employees with the Federal Employee Health Benefits Program (FEHBP) is primary to USFHP.
- All out of network care requires pre-authorization (exceptions – routine out-patient radiology and routine out-patient laboratory services)
- **Referrals are not pre-authorizations**. Call 844-356-4901 to request an Out of Network Authorization or to obtain authorization for any healthcare service that requires authorization
- If a claim is denied, please pay close attention to the reason for the denial. Do not resubmit the claim without correcting the reason for the denial; the claim will be denied again. Send an appeal to the Plan when you disagree with the non-payment reason. Resubmitting the same claim without correction will result in a 2nd denial.
- Check claim status on the provider portal USFHP.net or on our provider automated system (IVR) 844-356-4901) and press 1. Behavioral Health claim status: 800-921-2273

Where to Send Claims

Claims must be sent to the appropriate address listed below:

CLAIMS ADDRESSES

Medical & Surgical:

U.S. Family Health Plan
P.O. Box 830745
Birmingham, AL 35283 - 0745

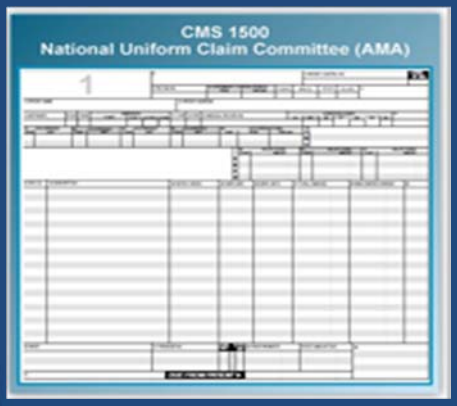
Electronic:

Change Health Care Payor ID 13407

Behavioral Health

Magellan
PO Box 1099
Maryland Heights, MO 63043

NOTE: Paper forms are now processed electronically using Optical Character Recognition (OCR) technology resulting in shorter claim turn-around and improved



Claims

Coordination of Benefits

US Family Health Plan is the **primary** payor to Medicare, Medicaid and Medicare supplement plans, except:

- If the patient has a diagnosis of End State Renal Disease (ESRD, ICD-10 N18.6, and eligible for the Medicare ESRD Program), or
- If the injury or condition is due to an accident that would be covered by other insurance, such as workers' compensation or no-fault automobile insurance, in which case the other insurance will be primary or
- If a service is not covered by TRICARE but is covered by Medicare.

US Family Health Plan is the secondary payor to all commercial plans.

Third Party Liability

The US Family Health Plan will coordinate benefits for those provided services, which are also, covered by Workers' Compensation or other third-party carriers. Third Party Liability occurs when a US Family Health Plan patient suffers injury or illness that was caused by the negligence of or intentional act of a third party. Examples of third-party liabilities are automobile insurance, workers' compensation, homeowners' liability, etc. Benefits will also be coordinated with a "no-fault" auto insurance carrier if allowable under the specific state law. It is the responsibility of the physician to provide or assist the US Family Health Plan in obtaining Coordination of Benefits/Third Party Liability information.

Provider shall accept payment from US Family Health Plan, plus any copayments as payment in full for all covered services provided to members, and will not attempt to bill any other person, insurer, payor, or other entity for such services. Providers must provide to US Family Health Plan information upon request about a member's other insurance coverage(s). Providers assign to US Family Health Plan all of provider's rights to any other benefits that may be payable in respect to a member and agrees to use their best efforts to determine other benefit coverage assisting US Family Health Plan's collection of other such benefits. Providers will be required to provide patient information updates upon request to allow US Family Health Plan to update records or other information.

Primary Care Provider

Primary Care Providers

US Family Health Plan members are required to select a Primary Care Provider (PCP). A PCP specializes in the practice of one or more of the following:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- Geriatrics

The PCP is responsible for providing and/or coordinating all health care for all covered family members who have selected him/her as their Primary Care Provider.

- PCPs refer members to US Family Health Plan network specialists.
- PCPs arrange for hospitalization and authorize urgent care, X-rays, lab work and other medical services when necessary.
- PCPs see members for routine care, preventive and annual physicals.
- PCPs initiate and coordinate authorization requests.

To obtain a list of US Family Health Plan network specialists for patient referrals, visit www.usfhp.net

Access, Availability, and Standards

Primary Care Provider:

Members must have access to a primary care provider within a 30-minute drive time from their residence.

Specialty Care Provider or Ancillary Provider:

Members must have access to a specialist provider within a 60 minutes' drive time from their residence.

Wait Times for Office Visits Appointments:

In accordance with the Department of Defense's access and availability requirements, when a member calls to make an appointment, it must be made within the following guidelines:

Emergency Care	Immediate
Urgent/Acute Care	Appointment within 24 hours
Routine office Visit	Appointment within 1 week
Well/Preventive Health Visit	Appointment within 4 weeks
Specialty Consultation or Procedure	Appointment within 4 weeks
Follow-up Visit	As required by provider

Primary Care Provider

Office Waiting Time for Non-Emergency Care

Members' waiting time for non-emergency care should not be longer than thirty (30) minutes in the office setting. However, we realize that your office is busy and that you are treating many patients and only expect you to do your best to keep member' waiting time to within that timeframe.

Appointment Wait Time for Urgent Care

For urgent care matters, members need to have access to the Primary Care Provider on a same-day basis. In order to ensure that primary care coverage is available 24-hours a day, seven days per week, all PCPs are required to provide US Family Health Plan with the name, address and phone number of physician(s) covering their medical practice.

Covering physicians should submit claims to US Family Health Plan and should not bill members.

Covering physicians will be reimbursed according to the contracted provider's reimbursement rates.

Covering physicians are responsible for urgent care only. Follow up treatment should always occur with the member's PCP. It is the responsibility of the contracted PCP to have his/her covering physician provide care according to the benefit and access guidelines outlined in this Provider Manual, whether or not the covering physician is affiliated with US Family Health Plan. A covering physician may not make routine referrals.

24/7 Nurse Advice Line

The Plan has a 24/7 Nurse Advice line 800-241-4848. Members can access this service toll free for medical guidance/triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace your commitment to providing coverage after hours.

Referrals

In-Network Referrals

PCPs are responsible for providing or arranging for the provision of health care services for their members. The management of the member's health care by the PCP is essential for effective and quality health care under the US Family Health Plan benefits programs. An integral component of this process is the Referral.

Guidelines for In-Network Referrals

- All US Family Health Plan referrals should be issued **only** to Plan participating providers. Please refer to our Provider Directory at www.usfhp.net. **Referrals to non-participating providers require prior authorization.** See the "Out of Network Referral" requirements detailed in this section of the manual.
- The Referral Form has space for PCPs to provide a brief explanation of the reason for the referral, which will be sent to the specialty physician. Please be as specific as possible, (i.e., include the symptoms or diagnosis and list any procedures that the specialist might perform). Although the USFHP referral form is preferred, any other written format is acceptable (e.g. script).
- Referrals must be noted by the PCPs in the member's medical record.
- Referrals are valid for six (6) months. The first visit should occur within sixty (60) days from the date the referral was issued.
- If the specialist feels additional treatment is required, the specialist is responsible for contacting the PCP and discussing the need for additional treatment and requesting a referral from the PCP.
- The PCP must refer all non-emergency services using the US Family Health Plan referral form, a prescription form or other written form, all non-emergency specialty and hospital services. Non-emergency services obtained without a proper referral may not be covered.
- Do not send a copy of the referral form to the plan. Give one copy to the member and keep one copy for your records.

Point of Service

The Point of Service (POS) benefit option allows members to seek services from a non-network provider without an authorization from the Plan. The POS option applies to office, hospital-based clinics, and ambulatory surgery facilities; however, **using this option comes at a price**. TRICARE regulations require that if a member uses this POS option, the USFHP will not deny payment, but will pay the provider 50% of the TRICARE allowable charges, after the member has met an initial deductible. This deductible will only be applied for care received under the POS option. The deductible is $300 per enrollment year for an individual, and $600 for a family. Only the TRICARE allowable is applied to the deductible. After paying the deductible the member would also be responsible for up to 65% of the TRICARE allowable charge.

Referrals

Out-of-Network Referrals

Referrals must be made only to participating US Family Health Plan providers. Please refer to our Provider Directory at www.usfhp.net to determine the participating status of a health care provider.

A referral to an out-of-network provider may be issued when the Plan determines that a member has health care needs that cannot be met by a participating provider with appropriate training and experience. Out of network treatment MUST be pre-approved by US Family Health Plan in consultation with the member's PCP and the non-participating physician. A referral is NOT the same as an authorization.

Reasons why an "Out of Network Referral" may be approved:

- Continuity of Care
- Specialist/Subspecialist not available in network
- Specialist/Subspecialist in network cannot provide appointment within USFHP access standards.
- Second opinion not available in network

Please remember that if you wish to refer a US Family Health Plan patient to an out-of-network provider, the referral must be pre-authorized by the Plan, otherwise, the member may be responsible for the charges.

Referral Tracking and Reporting Requirements

Network specialists must provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the enrollee's primary care provider within 30 (thirty) working days of the specialty encounter. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the enrollee's primary care provider within 24 hours by telephone, fax or other means with a formal written report provided within 10 (ten) working days.

The Provider Relations staff conducts audits to ensure compliance with this standard. Provider offices are informed of the audit results and educated on the need and importance of referral tracking as well as methods and tools for tracking. Corrective action plans are developed to address non-compliance. Failure to comply may result in termination from the provider network.

The details of this process are outlined in the Appeals Policies (9.60 & 9.61 series). Briefly, all appeals must be made in writing and be submitted within 90 days of the medical necessity denial from UM. A 2-stage process is then available by following the appeal rights outlined on the denial letters. The final decision for network providers rests with the Plan's Leadership/Appeals Committee.

Informing Members About Non-Covered Services

As part of your usual good business practice, providers are expected to notify USFHP (TRICARE) beneficiaries when a service is not covered. TRICARE policy includes a specific "hold harmless" policy for network providers and recommends that out of network provider also follow a similar process to document beneficiary notification.

Hold Harmless Policy for Network Providers: A network provider may not require payment from a beneficiary for any excluded or excludable services that the beneficiary received from the PAR provider except in the following situations:

- If the member did not inform the provider that he or she was a USFHP member, the provider may bill the beneficiary for services rendered.
- If the member was informed that the service was excluded or excludable and he or she agreed in advance to pay for that service, the provider may bill the member.

USFHP members must be properly informed in advance and in writing of specific services or procedures that are excluded under TRCARE before the service is provided. If the member chooses to be financially responsible for the non-covered service, the member should be asked to sign a waiver agreeing to pay for TRICARE non-covered service. A member's agreement to pay for a TRICARE non-covered service must be evidenced by written records. Examples of acceptable written records include:

- Provider office or medical record documentation written prior to receipt of the services demonstrating that the USFHP member was informed that the services were excluded or excludable and the beneficiary agreed to pay for them.
- A statement or letter written by the beneficiary prior to receipt of the service, acknowledging that the service is excluded or excludable and agreeing to pay.

If the PAR provider does not obtain a signed waiver, and the service is not authorized by USFHP, the provider is expected to accept full financial liability for the cost of the care. It is important to note that a waiver signed by a member after the care is rendered is not valid under TRICARE regulations. For a USFHP member to be considered fully informed, TRICARE regulations require that:

- The agreement is documented prior to the non-covered service being rendered.
- The agreement is in writing – a verbal agreement is not valid under TRICARE policy.
- The specific service, date of service and estimated cost of service is documented in writing.
- General agreements to pay, such as those routinely signed by patients, are not evidence that the USFHP member knew specific services were excluded.

Caution: *Providers should be aware that there have been situations when a USFHP member has agreed to pay in full for non-covered services without signing a waiver. The provider rendered the care in good faith without prior written waiver and the beneficiary was not held financially responsible. Without a signed advance waiver, the provider was denied reimbursement and could not bill the member.*

Example of a proper waiver is provided on page 20 for your information and convenience.

Sample **Request For Non-Covered Service**

I am hereby requesting that that the following medical service(s) is provided to me by (Provider Name).

Service: _____ Frequency limitation: _____

Proposed date(s) of service: _____
Estimated cost of service: _____

In making this request, I acknowledge that this service is not a covered benefit under US Family Health Plan, and I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. I also understand that if US Family Health Plan has denied authorization for this care, or if reimbursement is denied upon submittal of a claim, I may appeal the written notification of the denial issued. Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment in full of the billed charges for these services.

Print Member Full Name: _____ Member ID #: _____

Member Signature: _____

Members Full Name – Printed: _____

Sponsor Full Name – Printed: _____

Date: _____

TRICARE HOLD HARMLESS POLICY:

A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the Services are excluded or excludable and has agreed in advance in writing to pay for the services.

Provider Participations Requirements

The US Family Health Plan credentials practitioners and certain facilities (hospitals, ambulatory surgery centers, home health agencies, skilled nursing facilities) prior to participation. Practitioners and facilities are re-credentialed, at a minimum, every three (3) years. The credentialing /re-credentialing process consists of the provider application process, verification of credentials with primary sources (and review by the credentials committee. New providers must meet the business needs of the Plan (e.g. required to improve an access goal or be requested by a member or USFHP staff member).

Practitioner Application and Participation Criteria

- Completed and signed CAQH or USFHP application; including detailed explanations to any questions if needed.
- Copy of current malpractice coverage sheet (includes effective dates, policy number, and amounts of coverage)
- Have a Current license to practice medicine without limitation, suspension, restriction
- Current DEA/CDS certificate (if applicable)
- Board Certification or completed appropriate training in the requested specialty
- Ability to meet USFHP Access and Availability standards
- Must be eligible to become a TRICARE Authorized Provider
- No current Medicare/TRICARE sanctions
- Curriculum vitae or documentation of education and training
- Signed and dated USFHP provider agreement and W-9
- Provider listing in USFHP provider directory is limited to primary location. Additional locations considered subject to confirmation of provider scheduled service hours at additional locations

Facility Application and Participation Criteria

- Completed US Family Health Plan Facility Application
- Current license, registration or operating certificate
- Current professional liability face sheet, including amount and dates of coverage
- Accreditation documentation (i.e., JCAHO) if applicable
- Current Medicare participation certificate (CMS) along with CCN number
- State approved Plan of Correction (if applicable in the last 3 years)
- Determination of Compliance letter (if applicable in the last 3 years)
- Ability to meet USFHP Access and Availability standards
- Must be eligible to become a TRICARE Authorized Provider
- No Medicare sanctions
- Signed and dated USFHP agreement and W-9

Provider, Facility, and Ancillary Contractual Requirement

At a minimum, language in the contract includes the following conditions or programs to which the provider agrees to comply:

- Meet the certification requirements of TRICARE
- Comply with access and availability standards
- Comply with the Provider Manual
- Comply with Utilization Management Policies and Procedures
- Agree to participate in evidence based safety programs as defined by USFHP
- Provide for primary care coverage 24 hours/day, 7days/week
- Not balance bill members/hold members harmless
- Comply with claims filing and processing policies
- Agree to participate in plan quality management and utilization review programs
- Provider requested medical records within 30 days
- Events that may result in the reduction, suspension or termination of network participation privileges
- The specific circumstances under which the network may require access to consumers' medical records as part of the organization programs or health benefits
- Health care services to be provided and any related restrictions
- Requirements for claims submission and any restrictions on billing of consumers
- Participating provider payment methodology and fees
- Mechanisms for dispute resolution by participating providers
- Term of the contract and procedures for termination the contract
- Requirements with respect to preserving the confidentiality and security of patient health information
- Prohibitions regarding discrimination against consumers
- Continuing participation with the Federal Medicare Program, (i.e., are Medicare participating providers unless waived due to extraordinary circumstances
- US Family Health Plan referral consultation report process
- Maintenance and provision of copies of appropriate medical records for Quality Assessment and UM monitoring and evaluation
- Maintaining non-limited privileges at a hospital unless the provider has no need to admit US Family Health Plan
- Comply with access and availability standards
- Comply with Provider Manual
- Provide primary care coverage 24 hours/day, 7days/week
- Not balance bill members/hold members harmless
- Comply with claims filing and processing policies

Note: All subcontractor agreements are subject to the contract requirements above.

Network Dispute Resolutions

Network Affiliation Issues

The provider dispute resolution process is incorporated into this Credentials Program Description and is reviewed annually and includes the involvement of participating providers including the Credentials Review Committee members. All participating providers have agreed to comply with the plan's dispute resolution process by signing the provider agreement, which includes a dispute resolution clause.

This process is available to any participating provider to resolve disputes with the Plan regarding actions that relate to either: their status within the provider network, or any action taken by Plan related to a provider's professional competency or conduct.

Participating providers have the right to appeal their dispute to two (2) separate panels above the level of the Plan body involved in the dispute, each consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. In no case will panel members be assigned who have been previously involved with the issue.

At each level, the provider has the right submit relevant information.

- When appropriate, the Medical Director will review the matter first, using appropriate peer input; if not satisfactorily resolved, the dispute will be referred to the first level panel.
- The first level panel will discuss the dispute and make a decision. The decision will be forwarded in writing, return receipt required, to the disputing provider; and when necessary, the second level appeal rights, procedures, and timeframes will be provided.
- The provider has the right to challenge the findings of decision.
- The decision of the second level panel is final. Its decision will also be transmitted in writing.

In order to maintain the right to use the dispute resolution process a signed written appeal from the participating provider must be received within 30 calendar days from the date the letter was received. Unless otherwise indicated delivery will be assumed to have occurred 5 days after mailing.

The provider has the right to challenge the findings of the decision and to present relevant documentation and information in support of his/her dispute or appeal.

A panel will be convened within 60 days of the request and the decision will be returned to the participating provider within 3 days of the closure of the panel. When an adverse action is taken or if the provider voluntarily relinquishes participation while undergoing investigation and/or peer review it is noted in the Credentials File and reported if required by law.

The following actions are required to be reported to the National Practitioner Data Bank (NPDB):
Terminations resulting from serious quality deficiencies, providers who terminate themselves while under investigation and providers who terminate themselves with an action plan in place.

Network Dispute Resolutions

Appeal Process and Resolution

If a provider disagrees with a Plan decision regarding medical necessity or claim payment, the decision or payment may be appealed. Instructions on how and where to submit an appeal will be provided on the denial letter and/or EOB.

- The appeal must be in writing and must be submitted to the Plan within 90 (ninety) calendar days of the initial denial or issuance of the EOB. The appeal should include all documentation that supports your position. Any costs incurred in providing documentation will not be reimbursed by the Plan.

- You will receive a payment or written response generally within 30 (thirty) calendar days (can take up to 90 days), describing how your appeal was resolved and the basis for the resolution.

- Please note that you cannot appeal the rules and regulations of the Plan or TRICARE policy, but you may send a grievance if you think an error in the interpretation of the policy has occurred. Grievances are handled in a like manner to appeals.

- Denials are always communicated in writing.

- An independent clinical provider reviews 2nd Level medical necessity appeals in the like specialty that has not previously reviewed the case.

US Family Health Plan Compliance Program

All US Family Health Plan participating providers are required to comply with all relevant laws, regulations, and DoD contract requirements. The following is a listing and brief description of the applicable laws participating providers are required to comply with:

Whistleblower – Sarbanes/Oxley Act

Employees have the right to report an employer's illegal conduct without being fired.

False Claims

National Disaster Medical System (NDMS

The False Claims Act imposes civil liability on any person/entity submitting false claims to the US government.

Criminal Investigation of Health Care Offenses

Imposes criminal penalties for any person willfully obstructing such investigation(s), for example withholding medical records.

Mail and Wire Fraud

Imposes criminal penalties for any scheme to defraud another of money or property by using mail, private courier, telephone, fax or computer. Notably each offense is considered a separate crime**.**

Social Security Act

A broad statute with civil and criminal penalties that covers many fraudulent and abusive activities including:

- Upcoding
- Providing services not medically necessary
- Unlicensed providers
- Offering kickbacks/bribes/rebates to influence the beneficiary to seek services from a provider excluded from participation with the Federal government

There are a limited number of exceptions to the Social Security law known as "safe harbors" which provide immunity from criminal prosecution.

Federal Anti-Referral Law (Stark Laws)

Named after Pete Stark, Congressman from California. Providers are prohibited from referring patients to health entities. In which they have an ownership relationship. Any health service receiving a "prohibited referral" is prohibited from billing for it. Health services include:

- Lab and radiology
- Physical Therapy and Occupational Therapy
- DME equipment and supplies
- Intravenous and enteral (tube feeding) nutrients and supplies
- Orthotic and Prosthetic devices and supplies
- Home Health services, inpatient and outpatient hospital services
- Outpatient prescription drugs

There are specific exceptions to the Stark laws; some related to Stocks and Bonds, certain physician services.

Quality Management Program

US Family Health Plan has a comprehensive Quality Management Program. Overall goals are to ensure that all member services, both clinical and administrative, are high quality, comprehensible, integrated, accessible, safe, state of the art and medically sound, continuously improving HIPAA compliant and compliant with all pertinent Federal law and TRICARE policy requirements. Equally important is the commitment to provider and ancillary provider satisfaction. The scope of the QM program includes complaints, grievances, clinical quality of care events (potential and actual), provider credentialing, peer review, and preventative health.

Governing Law & Policy

US Family Health Plan's QM Program is governed by Federal law and TRICARE policy, Reference:

- TRICARE Operations Manual, 2015 Chapter 7, Section 4, Clinical Quality Management Program
- Title 32 CFR Part 99, Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS)

QM Program Components

The QM Program encompasses the continuum of care delivery for all age groups in all healthcare service areas including, but not limited to acute inpatient services skilled home care, hospice, inpatient skilled nursing/rehabilitation, emergency department, urgent care, pharmacy and all levels of behavioral health.
Important components of the US Family Health Plan QM Program include, but are not limited to:

- Compliant/Grievance Investigation/Resolution
- Identification and investigation of potential and actual quality issues and serious reportable event
- Clinical Care Delivery Focus Studies
- Credentials
- Public Scorecard Analysis and Reporting (i.e., Medicare.gov Compare programs and Leapfrog)
- Health promotion and HEDIS Reporting
- Peer Review
- Quality Improvement Projects

Continuous Quality Improvement (CQI

US Family Health Plan uses Continuous Quality Improvement (CQI) techniques and tools. This approach views all work as part of a process, each with variations. All processes are measurable and link together to form systems. Our QM program emphasizes process analysis and system improvement. Those processes having the greatest impact on patient outcome and customer satisfaction are given the Highest Priority.

All potential clinical quality and/or safety issues identified by any means are fully investigated, Issues May be identified by members, providers staff and claims analysis using Agency for Healthcare Research and Quality (AHRQ) Patient Safety indicator software and Hospital Acquired Conditions (HACs). If a quality issue is determined to be present a severity level is assigned, any potential quality issue or actual quality issue deemed to be a Sentinel Event as defined by the National Quality Forum (NQF) shall receive immediate attention and must be reported to TRICARE within 48 hours of discovery. Any event determined to be a QI is presented to the Plans Peer Review Committee for review and confirmation.

Quality Management Program

Provider Role

As a US Family Health Plan network provider you are an important part of the Plan's QM program. As such you may be asked to participate in any of the following ways.

- Participate in investigation and resolution of complaints/grievances
- Participate in on-site visits as part of credentials and/or complaint/grievance investigations
- Submit medical records for quality if care reviews or clinical care delivery focus studies, quality improvement projects (QIP), HEDIS reporting or as requested by TRICARE for any medical record review request
- Submit documentation on quality information reported on Medicare.gov Hospital Compare, Nursing Home Compare, Home Health Compare or Physician Compare or Leapfrog Hospital Safety Grade.
- Respond to satisfaction Survey

Subject to applicable Federal law and TRICARE policy, IS Family Health Plan shall have the right to inspect, make copies and prepare abstracts of members medical records during regular business hours upon prior written notice to provider, except that prior notice shall not be required of regulators. Provider shall make available complete, legible copies of member's medical records or quality review data involving medical records within thirty (30) calendar days of receipt if written request from US Family Health Plan for the purpose of quality review or audit. In addition, all provider types are required to respond to any request for medical records from the TRICARE Quality Monitoring Contractor (TQMC).

Providers are encouraged to contact their assigned Provider Relations Representative if they experience dissatisfaction or have recommendations for the Plan. If the problem is a clinical issue, the provider will be referred to the Medical Director or senior clinical nurse on duty (in the absence of the Medical Director). The Medical Director/designee and assigned Provider Representative will work with provider to resolve the complaint/grievance.

Important Terms

Complaints: Complaints are defined as any expressed dissatisfaction with the Plan or its services. Oral complaints will be addressed within 30 days and resolved within 60 days.

Grievances: A written complaint of dissatisfaction. Grievances will be addressed within 30 days and resolved within 60 days.

Hospital Acquired Conditions (HACs): As defined by CMS, HACs are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines. Examples of HACs include foreign object retained after surgery, air embolism, blood incompatibility, Stage III and IV pressure ulcers, falls/traumas, and manifestations of poor glycemic control, catheter associated UTI, vascular catheter-associated infection surgical site infection mediastinitis, following coronary artery bypass graft (CABG), surgical site infection following bariatric surgery for obesity, surgical site infection following certain orthopedic procedures, surgical site infection following cardiac implantable electronic device, DVT/PE following certain orthopedic procedures, and iatrogenic pneumothorax with venous catheterization.

Important Terms - Continued

Patient Safety Indicators (PSIs): As defined by the agency for Healthcare Research and Quality (AHRQ). Measures that screen for adverse events that patients experience as a result of exposure to the health care system. These events are likely amenable to prevention by changes at the system or provider level.

Potential Quality Issue (PQI): A clinical or system variance that warrants further review and investigation for determination if the presence of an actual QI.

Quality Improvement Project (QIP): A clinical or system variance warranting further review and investigation for determination of the presence of an actual QI.

Quality Issue (QI): A verified deviation, as determined by a qualified reviewer, from an acceptable standard of care as a result of some process, individual or institutional component of the health care system.

Sentinal Event (SE): Defined by TRICARE utilizing the most current definition as published by The Joint Commission. The current Joint Commission definition: A sentinel event is a Patient Safety Event that reaches a patient and results I any of the following: death, permanent harm, or severe temporary harm and intervention is required to sustain life.

Serious Reportable Event (SRE): As defined by NQF, SREs are largely preventable, and harmful events. The current list of SREs is designed to help the healthcare field assess, measure, and report performance in providing safe care. Categories of events included in the list of SREs are surgeries and other invasive procedures, product/device, patient protection, care management, environmental, radiologic and potential crime.

Utilization Management Program

The US Family Health Plan maintains a comprehensive Utilization Management Program. The Utilization Management Program staff works with the PCP and specialists to ensure that providers receive timely and excellent customer service, and that members receive quality health care and services that are both medically necessary and appropriate.

This Utilization Management Program has several major components:

- Authorization Referral Process for services from specialists
- Focused Procedure Review
- Inpatient Facility Review
- Selected Ancillary Services Review

Utilization Management Notification Requirements

There are specific notification requirements that apply to the services evaluated in each of the review components, in order to ensure payment. The provider must fax the pre-authorization form to the Plan regarding proposed treatment and service.

Treatment/Service	Notification Requirement Pre-Authorization form **Fax: 866-337-8690**
An overnight hospital stay: **Non-emergency admission** **Urgent Admission** **Emergency admission***	At least seven (7) business days before admission Within 48 hours following admission Within 48 hours following admission
Skilled Nursing Facility (SNF), Acute, Sub-Acute Inpatient Rehab	At least three (3) business days before services commence
Outpatient Procedures	At least seven (7) business days before the procedure
Home Health Care	At least seven (7) business day before services commence
Durable Medical Equipment (If the purchase price or combined monthly rental charges exceed $2,000 and is not available from Mount Holly Surgical Supplies)	At least one (1) business day before ordering the equipment

**This Plan is provided by the Department of Defense (DoD) and governed by contracts between DoD and US Family Health Plan. The DoD contract defines an emergency admission as one in which a delay in instituting appropriate treatment could result in serious impairment of the patient's health. The service(s) is then subject to a review process to determine if it is eligible under the Plan.*

Pre-Authorization Process

Each US Family Health Plan member has an assigned Primary Care Provider (PCP). The PCP coordinates the member's health care and is responsible for managing all specialty services that a member may require. Patients are required to obtain referrals from their PCP before obtaining care from a specialty physician.

Initiation of Authorization - Primary Care Provider

When a PCP determines that a patient requires consultation from a specialist, the PCP must complete a US Family Health Plan Referral Form or other written format (i.e. script). A note in the patient's chart is required. The PCP should give the designated copy to the patient to bring to the specialist and retain the designated copy.

The referral form must include the following information:

- Patient Name
- Patient Date of Birth
- Patient I.D. Number
- Referring Physician
- Specialty type to whom referral is being made. **Unless an OON authorization is obtained from the plan, ALL referrals should be made to participating USFHP provider.**
- Reason for referral (it is very important that this section is used as a tool to communicate clinical information to the specialty provider)
- Number of visits recommended with the specialty physician
- Urgency of consultation

Referrals to specialty physicians who are not part of the Plan network are not permitted except in unusual situations and must be reviewed and pre-authorized by the Plan.

Pre-Authorization and Notification Process

To obtain authorization for the procedures and services listed in the next section, fax the pre-authorization form to:

Fax number: 866-337-8690

Please provide the following information:

- Patient Name
- Patient Date of Birth
- Identification Number
- Procedure(s) to be performed, including CPT/HCPCS code(s)
- Planned date of procedure
- Diagnosis, including ICD-10 code(s)
- Provider Name/Facility Name

Pre-Authorization Process

Services Requiring Pre-Authorization

Providers must obtain authorization or provide notification for the following:

Inpatient Elective Admissions

Request authorization seven (7) days prior to admission, including acute hospital, acute or sub-acute rehabilitation, skilled nursing facility, or inpatient respite care as part of a pre-approved home hospice program. General inpatient hospice is not a covered benefit and will be evaluated on a case-by-case basis

Emergent or Urgent Admissions

Notify the Plan within forty-eight (48) hours of admission.

Other Services

- DME over $2,000 or greater not obtained from Mt. Holly Surgical Supply
- Home Health Care Services
- Hospice Services
- Inpatient Days at any type of facility
- Prosthetics and Orthotics
    - L0100-L2999 & L3650-L9900, $1000 or greater each item; L3000-L3649 at any price point. All diabetic shoes & inserts require authorization (A5500, A5501, A5503, A5504, A5506, A5507, A5510, A5512, A5513)
- High Tech Radiology (non-emergent MRI, MRA, PET)
- All Out of Network Care (exceptions include emergent care, urgent

Pre-Authorization Process

Procedures & Outpatient Services

Request authorization seven (7) days prior for the specific procedures and services listed below:

- adjunctive dental
- arthroscopy
- augmentative communication device (ACD)
- biofeedback
- cardiac rehabilitation
- carpal tunnel surgery
- carotid angiography
- chelation therapy
- coronary angiogram
- cosmetic/plastic surgical procedures
- CT angiography
- dental anesthesia and related institutional services
- diabetic education
- dialysis
- gamma knife radiosurgery
- genetic testing
- hearing aid and hearing aid services (benefit limited to active duty dependents)
- home birth
- home infusion therapy
- Hyperbaric Oxygen Therapy
- Indium Penetrative (ControlScan) Scintigraphy
- Injectables, select and covered under medical benefit
- laminectomy/microdiscectomy
- laparoscopic abdominal vaginal hysterectomy (LAVH)
- laparoscopic procedures, select
- Lithotripsy (except renal lithotripsy)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Medical transport, non-emergent
- Meniscectomy
- Mental health/behavioral health (except first 8 visits with PAR BH provider)
- mental health/behavioral health (except 1st 8 visits)
- NCI trial participation (phase II and III)
- Neuropsychological testing
- Nutritional therapy infusion
- pain management services
- PET scans
- pulmonary rehabilitation
- psychological testing
- septoplasty/rhinoplasty
- single Photon emission Computer Tomography (SPECT)
- speech therapy
- stereotactic radiosurgery
- vertebroplasty
- virtual colonoscopy (CT colonoscopy)

NOTICE: This list is not all-inclusive and is subject to change. If your office is unsure about the necessity to obtain authorization, we suggest that one is requested. Completion of the authorization process will result in notification to the requesting provider.

All requests received by the Plan will be reviewed for approval according to Utilization Management program requirements. Some requests may require additional information from the specialty physician before an authorization determination can be completed. In that case, a nurse reviewer will contact the specialist to obtain the required information.

The Participating Provider must notify the Plan, by fax, at least seven (7) days before the anticipated date of the Inpatient Elective Admission or Outpatient or Ambulatory Surgery. Urgent and Emergent Admissions require notification within forty-eight hours of admission. Failure to notify the Plan within the required time frame may result in a denial of reimbursement.

In Patient Hospital Review

The inpatient hospital review process evaluates the medical necessity and appropriateness of the inpatient hospital setting. This review is required for all admissions to acute medical/surgical, acute rehabilitation and acute psychiatric hospitals.

Pre-Admission

Pre-Admission Testing

All pre-operative testing and screening must be performed on an outpatient basis.

Pre-Admissions Pre-Operative

Pre-operative days will not routinely be authorized in advance of scheduled surgery.

IMPORTANT: All calls concerning a service are provided a reference number. The reference number is NOT an authorization until specifically approved. The approval is always communicated to the requestor of the service.

Elective/Urgent Admissions to Hospitals

All elective admissions (including maternity admissions) to any hospital must be pre-authorized. It is the hospital's responsibility to notify the Plan, by telephone, at least forty-eight (48) hours prior to the anticipated admission. Urgent admissions require notification one (1) day prior to admission. Failure to notify the Plan within the required time frame may result in a denial of reimbursement.

After admission notification is received, US Family Health Plan UR Coordinator will contact the provider/facility to obtain clinical information needed to assess the appropriateness of the admission. The US Family Health Plan uses InterQual criteria when available. It is the admitting physician's and/or the hospital's responsibility to confer with the reviewer and to provide the required clinical information.

If the clinical information supports the inpatient admission, the UR coordinator reviewer will inform the admitting physician or the hospital of the number of days initially authorized and the scheduled date for concurrent review.

If the clinical information fails to meet the established criteria, a US Family Health Plan physician from Utilization Review will review the case. The Plan physician will make the determination regarding the medical necessity and appropriateness for the hospitalization. The review determination will be communicated to the admitting physician, the member, and/or the hospital by the Plan UR coordinator. Appeal rights will always accompany notifications of denial.

In Patient Hospital Review

Emergency Admissions to Hospitals

All emergency admissions to hospitals require Plan notification and are subject to Utilization Management review. It is the hospital's responsibility to notify the Plan, by telephone, within forty-eight (48) hours or by the next business day of the emergency admission. An admission will not be approved if the service could have been provided at a lower level of care (e.g. observation).

Concurrent Hospital Review

Once the patient is admitted into the hospital and the initial review process has been completed, a Plan UR coordinator will conduct periodic concurrent hospital review with the participating provider or the hospital. It is always the facility's responsibility to provide continued stay medical necessity prior to the authorized days expiring. Each concurrent review will be scheduled as needed. The Plan UR coordinator will assess the appropriateness of continued hospitalization using established criteria.

If the information supports continued hospitalization, the Plan UR coordinator reviewer will inform the participating provider and/or the hospital of the additional days authorized and will schedule a date for the next concurrent review. This process will continue throughout the hospitalization.

If the clinical information fails to meet the criteria, a Plan physician will be available to review the case with the admitting physician. The Plan physician will make the final determination regarding the medical necessity and the appropriateness for continued hospitalization. The review determination will be communicated by telephone to the hospital and/or the admitting physician by the Plan UM coordinator. Appeal rights will accompany all notifications of denial.

Discharge Planning

Discharge planning ideally begins prior to admission with an assessment of the patient's potential needs, community and family resources, and benefits available under the Plan. The Plan UR Coordinator will assist the provider(s) in identifying appropriate alternatives to the acute hospital setting. Alternatives covered by the Plan include home care, home infusion therapy, outpatient care, as well as care provided by a rehabilitation or skilled nursing facility.

Case Management and Disease Management Programs

Case Management

The goals of the case management program are to improve or maintain the quality of care provided, to improve or maintain the quality of life, and to minimize the health care expenses of Plan members who become catastrophically ill or who suffer severe traumatic injury. The Plan focuses on providing quality health care services to improve the health status of members.

The case management goals are accomplished in collaboration with the participating physicians by developing a plan that best meets the health care needs of the individual patient. US Family Health Plan will work with participating physicians to develop a health care plan within the Plan benefits. Extra contractual arrangements will be considered in situations where the quality of care and overall management would benefit the patient.

Criteria used to identify possible members for the Plan's Case Management Program include (but are not limited to):

- Hospital Stay greater than 30 days
- Repeat hospitalizations for the same diagnosis (i.e., more than 3 hospitalizations in a 12-month period for the same diagnosis)
- Traumatic injuries
- Degenerative neurological diseases (e.g., Guillain Barre, Muscular Dystrophy, Amyotrophic Lateral Sclerosis, Parkinson's Disease)
- Cerebral vascular accident, new
- Premature or low birth weight infants
- Major congenital defects
- HIV/AIDS
- Organ and Bone Marrow Transplants
- Major obstetrical complications
- Ventilator dependence
- TPN dependence/continuous home IV infusions or antibiotic therapy
- Third degree burns
- End Stage Renal Disease
- Multiple diagnosis and multiple providers
- Bariatric Surgery candidates
- New Cancer
- New amputation
- New Spinal cord injuries
- Frequent ER utilization (i.e., 3 ER visits for the same diagnosis in a 3-month period)
- Multiple medications (i.e., prescribed for 12 or more meds)

Disease Management

The overall objective of the Plan's disease management program is to empower members diagnosed with selected chronic diseases through written education in self-management techniques. Interventions are based on nationally accepted clinical guidelines for each disease. Participation in either program is voluntary and free of charge. Members are selected for participation using claims data to identify members with the selected chronic diseases. There is no self or provider referrals necessary. Members who need special assistance may need to refer for case management.

Skilled Nursing Facility, Inpatient Rehabilitation and Inpatient Hospice Review

Skilled nursing facility, inpatient acute and subacute rehabilitation, long term acute care and inpatient respite hospice as part of a pre-approved hospice program admissions also require preauthorization by the Plan. Preauthorization should be requested 7 days prior to the admission to the SNF, rehab or hospice facility. The same preauthorization, concurrent review, discharge planning and case management process described above applies to SNF, inpatient rehab and inpatient hospice respite services. General inpatient hospice is not a covered benefit; exceptions may be made based on medical necessity.

Skilled Home Health Care Review

Skilled Home Health Care is a covered benefit. Requests for skilled home healthcare will be initially authorized for up to five (5) visits (evaluation and 4 re-visits for each skilled service). Authorizations are valid for thirty (30) days. Additional services must meet medical necessity criteria. A home health aide may be authorized after medical necessity review of the initial skilled nursing visit documentation (i.e. OASIS).

The Home Health Care review process evaluates the medical necessity and appropriateness for home care services. It is the responsibility of the participating provider to notify the Plan at least one day before initiating services for the following:

- Home Health Care provided by a participating home health agency or visiting nurse association includes Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Occupational Therapy, and Social Work
- Home Infusion Therapy
- Home Laboratory
- Home Physician Visits

Durable Medical Equipment &Prosthetics/Orthotics Review

Mount Holly Surgical Supplies is our preferred provider for most DME (i.e. hospital beds, non-custom wheelchairs, patient lifts, and other ambulatory assistive devices), respiratory equipment and oxygen. Mount Holly may also be able to provide other medically necessary DME and medical supply items. Mount Holly will perform the medical necessity review for all equipment they provide
The review process evaluates the medical necessity and appropriateness of the rental and/or purchase of durable medical equipment exceeding $2,000 and all Prosthetics and Orthotics $1,000 and greater, and orthotics at certain price points.

It is the responsibility of the participating provider to notify the Plan, with clinical indicators, at least seven (7) business days before providing this equipment.

Skilled Nursing Facility, Inpatient Rehabilitation and Inpatient Hospice Review

Notification of Review Determinations

Initial determinations are communicated in writing to the participating provider. After the initial notification letter, written communications will only be issued when the medical necessity and appropriateness no longer support an authorization All denials are communicated by telephone and/or fax to the participating / requesting providers on the day the review decision is made and are followed by a notification letter, Appeal rights will be included with all notifications of denial.

Managed Care Reconsideration / Appeals Process When an initial denial occurs before or during the period of time services are being provided, and the participating provider believes that the determination warrants an immediate reconsideration, the participating provider has the opportunity to request a reconsideration of that determination, by calling 844-356-4901 and requesting a **Peer to Peer** review.

Alternatively, you or your patient may request an **Expedited Appeal** in writing (mail or fax) by noon of the next business day after you receive the denial notification if your patient is currently hospitalized and receiving the health care that has been denied, or in writing (mail or fax) within 3 business days of the date of the denial notification for outpatient services or inpatient services that have not yet been rendered.

Standard Appeals must be requested in writing (mail or fax) and must be received by the health plan no later than 90 days from the date of the denial notification. Requests for reconsiderations or appeals must include the reason(s) for disagreeing with our determination as well as any new, pertinent information.

The details of this process are outlined in the Appeals Policies series. A 2-stage process is then available by following the appeal rights outlined on the denial notification letters. Our Medical Director or a physician consultant who was not involved in the original decision will review your record. In cases where the original determination remains unchanged, we will give you information about your right to request further appeal. On request, and at no additional charge, you may obtain reasonable access to, and copies of all documents, records and information relevant to your appeal by sending a written request to: US Family Health Plan/eQ Health 1431 Greenway Dr. Ste 500 Irving, TX 75038

Upon receipt of all requisite information, we will contact you with the Plan's decision within the following time frames:

Expedited: By telephone and/or fax within 2 business days or 72 hours (whichever is sooner) from the time we receive all pertinent information concerning your request for appeal followed by a written confirmation within 24 hours of rendering a determination.

Pre-Service: By letter within 30 calendar days after receipt of your appeal and all requisite information.

Post-Service: By letter no later than 30 calendar days after the plan receives your request for appeal.

Submit Requests for Appeal by fax *only* to: *US Family Health Plan*
c/o eQ Health
Fax: 866-337-8690

Ancillary Services

Laboratory

LabCorp and BioReference are our preferred outpatient laboratory services providers. All lab work should be referred to these providers or if necessary, a hospital-based outpatient laboratory or other independent laboratory**.** To locate laboratory Service Center, visit their website:
LabCorp at 800-788-9091 or visit www.labcorp.com
BioReference at 800-229-5227, option 1 or visit www.biorefrence.com
Only the STAT laboratory procedures should be performed in the office.

Behavioral Health

US Family Health Plan has contracted with **Magellan** to manage behavioral health services. Magellan behavioral health staff is available 24 hours per day/7 days per week at 844-356-4901, press # 2 at the prompt. Please use this number to identify participating behavioral health providers, request pre authorization for inpatient admissions and for psychoanalysis and outpatient therapy for substance use disorder provided by a substance use disorder rehabilitation facility.

Radiology

All outpatient elective High-Tech imaging studies require pre authorization. High tech imaging services include PET, MRIs, and MRAs. Please contact our Utilization Review department.

All services should be performed by a participating US Family Health Plan facility. If necessary, members may be referred to a hospital-based radiology department or any free-standing radiology facility for plain x-rays, CT, nuclear scans, sonograms, ultrasounds, dopplers, and mammography.

Physical Therapy/Occupational Therapy

US Family Health Plan has contracted with OrthoNet to manage Outpatient Physical and Occupational Therapy Services. Referrals must be to a participating OrthoNet provider. Initial Outpatient PT/OT evaluations do not require pre authorization. The PT/OT provider is responsible for obtaining authorization from OrthoNet for care subsequent to the initial evaluation. Claims should be submitted to OrthoNet. Contact OrthoNet at with any questions related to Outpatient PT/OT.

Pharmacy Services
Ancillary Services

Medications with Age Limitations

Pre-authorization required if age limit exceeded.

The following medications have **age limitations and pre-authorization requirements** if age limit exceeded as identified by the DoD P&T Committee. This list is not all-inclusive and is subject to change. Visit the TRICARE Pharmacy website (http://www.tricare.osd.mil) for the most current listing. MPX Pharmacy is also able to assist with TRICARE Uniform Formulary questions.

Medication	Limitations
Topical Tretinoin Products (i.e., Retin-A)	If age 36 years or older, prior authorization required to document that use of topical tretinoin is clinically required to treat a condition other than winkles, age spots, or other cosmetic conditions related to the normal aging process. Authorization is good for as long as the medication is needed.
Prenatal Vitamins	If a female age 46 years or older authorization is required to document that use of prenatal vitamins is clinically required du to pregnancy. Prenatal vitamins are not covered for men of any age. Authorization is good for as long as the medication is needed.

Quantity Limitations

The following medications have **quantity limitations** as identified by the DpD P&T Committee. This list is not all-inclusive and is subject to change. Visit the TRICARE Pharmacy website (http://www.tricare.osd.mil) for the most current listing. MPX Pharmacy is also able to assist with TRICARE Uniform Formulary questions.

Quantity limitations required to address the issue of overuse of medications that can be unsafe for the patient and costly to the government. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity.

Pharmacy

Quantity Limitations

Category	Specific Drugs with Quantity Limits (generic/brand)
Antiemetics	Aprepitant (Emend), Granisetron (Kytril), Granisetron transdermal (Sancuso), Ondansetron (Zofran), Dolasetron (Anzemet), Palonosetron
Antimigraine	Almotriptain (Axert), Dihydroergotamine (Migranal); Eletriptan (Relpax), Frovatriptan (Frova), Naratriptain (Amerge), Rizatriptain (Maxalt or Maxalt MLT), Surnatriptain (Imitrex), Zolmitriptain nasal spray, Zolmitriptain (Zorning or Zornig-ZMT)
Controlled Substances	Fentayl buccal tabs (Fentora), Fentanyl oral transmucosal lozenges (Actiq), all Schedule II drugs (no refills per federal law/state law may impose additional restrictions), all Schedule III and IV drugs (per Federal law prescriptions may not be filled or refilled for more than 6 months after the date of the prescription or refilld more than 5 times/state law may impose additional restrictions)
Erectile Dysfunction	Alprostadil injection (Caverject or Edex), Alprostadil intraurethral pellet (Muse), all PDE-5 inhibitors (Sildenafil/ and Viagra, Tadalafil (Cialis), Vardenafil (Levitra)
Fertility Agents	Follitroprin alpha injection (Gonal-F), Follitropin beta injection (Follistirn), Menotropins inject (Humegron, Menopur, Pergonal, Repronex) , Urofollitropin inject (Fertinex or Bravelle)
Glucose test strips	Includes all blood and urine test strips
Miscellaneous	Adalimumab (Humira), Anakinra (Kineret), Erlotinib (Tarceva), Medroxyprogesterone (Depo-Provera), Butorphanol (Stadol), Dasatinib (Sprycel), Enfuvirtide (Fuzeon), Etanercept (Enbrel), Fluoxetine (Prozac Weekly), Gefitinib (Iressa), Gemifloxacin (Factive), Imitinab (Gleevec), Ketorolac (Toradol), Lapatinib (Tykerb), methylnaltrexone (Relistor injectable), PEG-filgrastim (Neulasta), Sunitinib (Sutenet), Sorafenib Tosylate (Nexavar), Tramadol (Ultram, Ultram ER), tramadol/acetaminophen (Ultracet), Vorinostat (Zolinza)
Nasal Inhalers	Astelin, Astepro, Azelastine, Beclomethasone, Beclomethasone AQ, Budesonide, Combivent, Dudesonide AQ, Flunisolide, Fluticasone, Fluticasone furoate, Ipratropium bromide, Mornetasone, Triamcinolone, Triamicinolone AQ
Oral inhalers and inhalant solutions	Albuterol (AccuNeb, Proventil), Albuterol HFA, Albuterol sulfate 3mg/Ipratropiu, bromide 0.5mg per 3ml, Arformoterol, Beclomethasone, Bitolterol(Tornalate), Budesonide (Pulmicort,Pulmicort reputles, Symbicort), Cromolyn sodium, Flunisolide (Aerobid, Aerobid-M), Fluticasone (Flovent or Flovent HFA), Fluticasone/salmeterol (Advair), Formoterol fumarate (Foradil), Formoterol furoate (Perforomist), Ipratropium (Atrovent), Levalbuterol (Xopenex), Metaproterenol (Alupent), Mornestasone furoate (Asamanex), Nedocromil (Tilade), Pirbuterol (Maxair), Salmeterol (Serevent), Tiotropium bromide (Spiriva), Triamcinolone (Azmacort)
Syringes	All syringes, needles and lancets
Topicals	Calcipotriene(Dovonex), Alitretinoin (Panretin), Becaplermin (Regranex), Tazarotene (Tazorac)

Pharmacy Service

Current DOD 3rd Tier

TRICARE requires a $60 co-pay for medications on the 3rd tier that do not meet medical necessity criteria. Tier 3 medications that do meet medical necessity will continue with the usual co-pay. Medical necessity criteria include but are not limited to: allergic reaction, therapeutic failure (did not obtain desired effect) of all similar medications in Tier 1 (generic) or Tier 2 (brand name, formulary), or no formulary alternative. The 3rd tier was established by the DoD to encourage beneficiaries to use the most clinically appropriate, safe, and cost-effective medications.

Aceon	Ertaczo	Pristiq
Aerobid	Estrostep Fe	Prozac Weekly
Alvesco	Exelderm	Pulmicort Flexhaler
Amerge	Exforge	QVar
Antara	Flomax	Rhonocort Aqua
Anzemet	Focalin	Sanctura
Astepro	Focalin XR	Sancuso
Avodart	Frova	Sarafem
Azmacort	Istalol	Seasonale
Azopt	Kapidex	Seasonique
Axert	Ketek	Spectazole
Beconase AQ	Lexapro	Sular
Betimol	Lexxel	Tarka
Buproprion XL	Loestrin 24 Fe	Toviaz
Bystolic	Loprox	Travatan
Cardene	Lovaza (Omacor)	Travatan Z
Cardene SR	Lybrel	Tricor
Cardizem LA	Lyrica	Trilipix
Ciclopirox	Maxair Inhaler	Ultram ER
Clarinex	Metaproterenol Inhaler	Uniretic
Clarinex D	Miacalcin	Univasc
Cognex	Moexipril	Veramyst
Covera HS	Moexipril HCTZ	Verelan
Cymbalta	Nasacort AQ	Verelan PM
Daytrana	Omnaris	Vusion
Detrol	Ovcom 35	Vyvanse
Diovan	Ovcon 50	Welchol
Diovan HCT	Oxistat	Wellbutrin XL
DynaCirc	Oxytrol	Xyzal
DynaCirc CR	Patanase	Zmax
Econazole	Paxil CR	Zyflo
Emsam	Perforomist	Zyflo CR

Pharmacy Service

Injectable Medications

Adriamycin	Epogen	Neulasta
Ana-Kit (anaphylaxis)	Euflexxa	Neupogen
Aranesp	Fludarabine	Ondansetron Inj
Avastin	Fluorouracil	Ortho-visc
Betaseron Kit	Forteo	Pegasys
Boniva inj	Fragmin	Peg-Intron Kit
Byetta	Gemzar	Procrit
Camptosar	Glucagon Kit	Remicade
Carboplatin	Herceptin	Sandostatin
Caverject	Humira	Symlin Inj
Copaxone Kit	Hyalgan	Synagis Inj
Cyanocobalamin	Imitrex	Synvisc
Cytoxan	Kineret	Trelstar Depot
Depo-provera 150mg/ml	Kytril	Vectibix
Dexamethasone Inj	Leucovorin Inj	Velcade
Eligard	Lovenox	Venofer
Enbrel	Lupron	Zemplar
Engerix-B	Methotrexate	Zoladex
Epi-pen/Epi-pen Jr.	Navelbine	Zometa

Prescriptions can be called or faxed to the MPX Mail Order Pharmacy: 866-408-2459 (phone) or 866-222-3274 (fax). Calls and faxes are only accepted from provider offices.

Pharmacy Clinical Review forms (name brand or quantity limit override) can be called or faxed to MPX at 800-687-0707 (phone) or 866-222-3274(fax). In general Department of Defense regulations prevent payment for the use of drugs for Non-FDA approved indications; exceptions exist. Contact MPX or the Plan's utilization review department.

Pharmacy Services

Drug Denial Appeals

Administrative and Clinical Drug denial letters are issued along with the instructions on the procedure to appeal the decision.

Mail Order Information

US Family Health Plan requires that maintenance medication prescriptions routinely be filled via mail order through MPX Mail Order. In order to facilitate the mail order process, the following process must be used:

When issuing a first-time prescription for a maintenance medication, you may write two prescriptions: one for a 30-day initial supply and one for a 90-day maintenance supply. The initial 30-day prescription can be filled at any of their affiliated walk-in Plan pharmacies. The 90-day prescription will be filled through MPX Mail Order. It is not necessary to order a 30-day prescription through a commercial pharmacy prior to ordering through mail order. The MPX pharmacies at the USFHP Family Health Centers at Mitchel Field and Fort Wadsworth may fill prescriptions with the same cost and numbers as mail order.

Pharmacy Benefit Limitations and Exclusions

Due to TRICARE restrictions, the USFHP pharmacy benefit excludes:

- Drugs prescribed for cosmetic purposes including but not limited to drugs used for hair growth or wrinkle reduction
- Food supplements
- Homeopathic and herbal preparations
- Multivitamins (except prenatal vitamins for pregnant women)
- Over –the-counter (OTC) products or any pharmacy product purchased without a prescription except insulin and related diabetic supplies
- Smoking cessation products (approved only if member is participating in a program)
- Weight reduction products
- Any prescription refilled before 75% of a previous filling has been used

Medical and Surgical Records Criteria

Member Records Requirements

Requested medical records are required to be submitted to USFHP within 30 days. Abstracted medica records are not permitted. The preferred transmittal method is electronic (email, fax or CD). Paper copies may be submitted and reimbursed at standard TRICARE rates. Facilities or individual providers that are contracted with USFHP and/or reimbursed for this service are required to comply with this request. Failure to provide the requested medical record in a timely manner could lead to 100% pre-payment review. Federal/TRICARE regulations require that the following information should be included in every individual patient record:

- Patient Identification
- Personal Data
- Allergies
- Chronic/Significant Problem List
- Medication reconciliation
- Immunization History
- Chart Legible
- Informed Consent
- Provider Signature/Name, Each Entry
- Patient's Signature on File
- Growth Chart (14 years of age and under)
- Initial Relevant History
- Smoking Status (12 years and older)
- Alcohol or Substance Use/Abuse (12 years and older)
- Date of Each Visit
- Chief Complaint
- Physical Exam Relevant to Chief Complaint
- Diagnosis/Impression for Chief Complaint
- Appropriate Use of Consultants
- Treatment/Therapy Plan
- Results discussed with Patient
- MD Review of Diagnostic Studies
- Results of Consultations
- Date of Next Visit
- Hospital Records
- Preventive Health Education
- Advance directives (all provider types)
- Discharge planning (facility)

National Disaster Medical System (NDMS)

All participating US Family Health Plan acute-care, medical/surgical hospitals are encouraged to become members of NDMS.

What is NDMS?
The National Disaster Medical System (NDMS) is a cooperative asset-sharing program among Federal government agencies, state and local governments, and the private businesses and civilian volunteers to ensure resources are available to provide medical services following a disaster that overwhelms the local health care resources.

The National Disaster Medical System (NDMS) is a federally coordinated system that augments the Nation's emergency medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting state and local authorities in dealing with the medical and health effects of major peacetime disasters and providing support to the military and Veterans Health Administration medical systems in caring for casualties evacuated back to the U.S. from overseas armed conflicts.

Visit the NDMS website at http://ndms.dhhs.gov/NDMS/ndms.html.
All information above is quoted from the National Disaster Medical System website at http://ndms.dhhs.gov/NDMS/ndms.html.

US Family Health Plan Manual Disclaimer

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied upon as such. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by US Family Health Plan at any time upon notice to the physician. The most current version of the Provider Manual is located on the Plan's website at www.usfhp.net. All terms and statements used in this manual will have the meaning ascribed to them by the US Family Health Plan ad shall be interpreted by US Family Health Plan in its sole discretion.

US FAMILY HEALTH PLAN

urac ACCREDITED HEALTH NETWORK

TRICARE®

THE 5-STAR HEALTH PLAN

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