

US FAMILY HEALTH PLAN PROVIDER MANUAL



US Family Health Plan at Pacific Medical Centers

1200 12th Ave S

Seattle, WA 98144

(800) 585-5883 (option 2)

(206) 621-4090

www.usfhpnw.org

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INTRODUCTION

The *US Family Health Plan Provider Manual* is for provider groups who have contracted with US Family Health Plan (USFHP) in the Puget Sound region of Washington State. This handbook aims to help those providers and their staff implement common USFHP policies and procedures.

This handbook answers common questions about:

- Referrals
- Billing and claims
- Provider reimbursement
- Provider rights and responsibilities

The most current version of this handbook, along with any network updates, is available on the USFHP website, www.usfhpnw.org.

We hope this handbook proves useful. If you have suggestions or questions, please contact our Provider Relations team at (206) 621-4090 or 1 (800) 585-5883 (option 2).

The provider handbook will be updated annually with interim updates as needed.

MISSION STATEMENT

US Family Health Plan is a TRICARE Prime option administered by Pacific Medical Centers (PacMed). PacMed offers excellent health care coverage built on a sound mission and our unsurpassed commitment to plan members. This commitment is displayed every day through high-quality service and strong physician-patient relationships.

The mission of PacMed is to “advocate, educate and provide extraordinary care” for each person and the communities we serve.

REFERRAL POLICY

Our referral policy aims to meet patients' needs through the most efficient and cost-effective use of resources. The overriding goal is to provide high-quality care to USFHP members. Please follow this policy when making referral decisions.

Role of Primary Care Provider

Primary care providers in the USFHP network include family medicine practitioners, internal medicine practitioners, pediatricians, nurse practitioners and physician assistants. Each USFHP member must designate a primary care provider (PCP). The PCP coordinates all medical services required by his or her patients. This includes:

- Management of referrals to specialists
- Continued management of referrals to non-network providers
- Ongoing coordination of patient care

External Referrals

An external referral is made by a USFHP network provider for services and tests to be provided outside the USFHP network. A USFHP network provider (primary or specialty care) must coordinate external referrals.

When a USFHP network provider refers a USFHP member to a non-network provider, the services requested are generally limited in scope, quantity and duration, as deemed appropriate by the ordering physician.

Referrals to non-network providers are used when:

- A USFHP network provider does not offer the needed service.
- The needed service is offered within the USFHP network but is not available in a medically necessary time frame.
- Distance is a barrier. (This may relate to patient mobility or some other issue of concern.)

Authorization Requirements

All services by network providers must be referred by a USFHP network provider and **authorized in advance**. Note: Emergent services do not require preauthorization.

Appointment Requirements

USFHP is a Department of Defense–sponsored health plan. As a USFHP-contracted provider, it is important that you meet these contractual obligations required of USFHP by the Department of Defense.

When a USFHP member is referred to you, you must:

- See all elective referrals within 10 business days of the request for an appointment.
- See all urgent referrals within 24 hours of the request for an appointment.

Prior-Authorization Form (for Referral Requests)

USFHP network providers use the Prior-Authorization Form for all referrals (see sample in [Appendix](#)). This form details the information needed to process the referral request. In some cases, additional supporting documentation will be needed to support the request. The form is available at www.usfhpnw.org on the [Provider Resources](#) menu.

Note: The Prior-Authorization Form does **not** constitute referral authorization—unless an authorization number is noted on the form.

Referral Authorization Form

When the requested services on the Prior-Authorization Form are approved, a Referral Authorization form is automatically generated. Copies of the Referral Authorization form are then mailed to you and the patient.

The Referral Authorization form confirms the scope of services being authorized.

Importance of the Authorization Number

The authorization number is your assurance that the referral request has been approved.

If a USFHP member presents for care without an authorization number, call either the referring provider office or Member Services at USFHP to determine if the services are authorized. Member Services can be reached at (206) 621-4090 or 1 (800) 585-5883 (option 2).

Without authorization, your claim may be denied, and the patient cannot be held financially responsible.

If you believe the patient needs to receive more treatment than what is authorized, contact the USFHP network referring physician for additional referral and authorization. If you feel that the patient needs to be referred to another provider, you must contact the patient's USFHP network referring physician for further referral.

Diagnostic Testing

Routine lab and X-ray are included in the authorization for office visits. All other diagnostic tests or procedures require separate authorization.

For routine lab work, refer the patient to a TRICARE-authorized lab.

Communication with the USFHP Network Referring Provider

After you have treated our USFHP patient, mail a summary of the services provided within 30 days to

the patient’s USFHP network referring provider. The information in your summary should include at least the following:

- Summary of the services rendered
- Progress notes
- Any surgical, pathology or laboratory reports describing your examination, diagnosis or treatment plan

If you prefer, you may send a copy of your medical record for the patient instead of a summary. The medical record must be legible, signed and dated, and clearly identified with the patient’s name and authorization number.

When providing care to a referred USFHP member, it is important that you follow the specifications on the Referral Authorization form. Please note:

- Services not authorized in advance by USFHP will be denied payment.
- Any services not indicated on the form or provided in a quantity greater than authorized will not be paid.
- The patient may not be billed for unauthorized services unless the patient signs a financial responsibility agreement for non-covered services in advance of services being rendered.
- Payment for authorized services is always subject to the patient’s eligibility in and benefit limitations of USFHP.

Referral Checklist

What to do:	Reminders:
Ask to see USFHP ID card	If no card, verify eligibility by calling USFHP Member Services at (206) 621-4090 or 1 (800) 585-5883 (option 2).
Review Prior-Authorization Form	Pay attention to the number of visits authorized and the date the authorization expires.
Request appropriate copay amount	Copays are on the USFHP member’s ID card, as well as in the Network Quick Reference Guide located at www.usfhpnw.org/provider-resources .
Provide service	Only the service authorized is eligible for reimbursement.
Keep USFHP referring provider informed	Send summary or report.
Request additional referrals?	Contact USFHP referring provider if you wish to provide additional service or make a referral to another specialist.
Questions?	Any questions should be directed to USFHP Member Services at (206) 621-4090 or 1 (800) 585-5883 (option 2).

REFERRAL PROCEDURES

Admissions to Hospitals and Skilled Nursing Facilities

USFHP policy is that all hospital and skilled nursing facility admissions must be coordinated with a USFHP network provider. Within 24 hours of admission, contact USFHP Care Coordination at (206) 326-2453, option 1.

- **With planned admissions, preauthorization is required.** Contact the patient's primary care provider (PCP) prior to admission. USFHP Care Coordination will make a benefit determination and specify a target length of stay.
- **For Emergency Department admissions,** make a concerted effort to contact the patient's PCP for coordination of care only. There is no referral requirement. For ED visits that result in admission, contact USFHP Care Coordination at (206) 326-2453, option 1, within 24 hours of admission.

BILLING PROCEDURES

How to Bill

- Submit charges on standard billing forms such as the CMS 1500 or UB 04.
- Use standard CPT, ICD-10, HCPCS and UB codes unless otherwise specified in your contract.
- Do not adjust charges for any copayments, capitation or fee discounts.

If more than one insurance plan: As a benefit program, USFHP is considered the primary manager of care but the secondary payor when commercial insurance is involved.

1. Submit claims to the primary payor first. (See note below.)
2. After the primary payor issues payment, bill USFHP and include the Explanation of Benefits from the primary payor.
3. Payment will be based on the amount the patient is responsible for, as indicated by the primary payor. Payment will be made only up to the contract/CMAC allowed amount. Our member cannot be billed for any remaining balance.

Note: Always submit a claim—even if the balance is zero. As stipulated by the Department of Defense, USFHP must report all insurance reimbursement amounts collected by any provider.

Send claims to:

USFHP
Attn: Claims Department
1200 12th Ave S, Quarters 3/4
Seattle, WA 98144-2712

US Family Health Plan and Medicare

When our members join USFHP, they agree to not use Medicare. Use of Medicare benefits can result in a member being disenrolled from USFHP.

Providers may not bill or accept payment from Medicare for services rendered to USFHP members—except for services not covered by USFHP-contracted medical groups.

Exceptions

USFHP members *can* use Medicare for:

- Chiropractic care
- Routine foot care for non-diabetics
- Orthotic shoe inserts
- Most custodial care

If you send any bills to Medicare, those bills must be clearly marked as Medicare Secondary Payor (MSP), which is informational billing only and results in no payment to you or our member.

If you receive payment from Medicare, you will be required to return the payment, **whether or not** USFHP is paying the claim.

Billing USFHP Members

- Providers may bill members for applicable copayments; they may not bill for charges that exceed contractually allowed reimbursement rates.
- The provider may not collect for any non-covered service unless the enrollee has been properly informed and has agreed in advance and in writing to pay for such a service.
- Services not authorized in advance by USFHP will be denied payment. Our member may not be billed for any unauthorized service.
- Commercial insurance is always the primary plan. So if a member has commercial insurance, there is no USFHP copay. While USFHP is the primary plan for benefits and the primary manager of care, it becomes a secondary payor when commercial insurance is involved.
- Copays are based on member status, so please check the member's USFHP ID card.

Understanding Our Explanation of Benefits

A. VENDOR NUMBER	Number assigned to your Master Vendor.
B. CHECK NUMBER	Numerical identification of the payment made to the Master Vendor.
C. MASTER VENDOR	Name and address where payment was sent.
D. NAME	Name of the patient who received services.
E. MEMBER #	The patient's USFHP number.
F. REFERRAL #	Assigned authorizing number for requested services.
G. CLAIM #	Number assigned to your claim submission.
H. ACCOUNT #	Patient's account number found on the claim.
I. PLAN #	USFHP identification number.
J. PLAN TYPE B	Mnemonic for US Family Health Plan.
K. CLAIM VENDOR	Name of actual service provider. Does not appear if provider and Master Vendor are identical.
L. PROCEDURE CODE	CPT, UB or HCPCS codes from the claim.
M. DESCRIPTION	Description of the procedure code used.
N. SERVICE DATES	Date span attached to the procedure code.
O. S/F	For internal use only.
P. AMOUNT BILLED	Amount billed by the provider.
Q. CONTRACT ADJUST	Amount above the contractual allowance.
R. DEDUCT AMOUNT	Amount applied to patient's deductible.
S. COPAY AMOUNT	Patient's copay to be collected by provider.
T. AMOUNT APPROVED	Amount to be paid by USFHP.
U. AMOUNT WITHHELD	(Field not in use at this time.)
V. NET AMOUNT	Same as Amount Approved.
W. CLAIM TOTAL	Sum total of all charges for that claim.
X. VENDOR REMITTANCE CLAIMS SUBTOTAL	Subtotals for Master Vendor and alternate payees.
Y. VENDOR SUMMARY	Totals for Master Vendor and alternate payees.

APPEAL PROCESS

If a provider disagrees with a Plan decision regarding medical necessity or claim payment, the decision may be appealed.

- The appeal must be in writing and must be submitted to USFHP within ninety (90) calendar days of the initial denial. The appeal should include all documentation that supports your position. Any cost incurred in providing documentation will not be reimbursed by the Plan.
- You will receive a written response generally within thirty (30) calendar 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 manner similar to appeals.

Please send your claim appeals to:

USFHP
Attn: Coding and Audit Program Manager
1200 12th Ave S, Quarters 3/4
Seattle, WA 98144

PROVIDER DISPUTE PROCESS

According to the PacMed Provider Agreement:

The parties hereto encourage the prompt and equitable settlement of all disputes, controversies, or claims (“Disputes”) between or among them, including those arising out of the provider agreement or the Payor addenda. At any time, any party may give the other written notice that it desires to settle a Dispute. Within ten (10) days of delivery of such notice, the parties agree to meet in good faith to resolve such Dispute. If such Dispute cannot be resolved within a reasonable amount of time, the parties agree to resolve such Dispute in accordance with PacMed’s written dispute resolution policies and procedures, as set forth in the Provider Manual. Such dispute resolution policies and procedures shall include, but not be limited to, policies and procedures to resolve Disputes relating to Provider’s status as Participating Provider or Provider’s professional competency or conduct.

Administrative Disputes

The dispute process is available to any participating provider. The provider has the right to submit administrative dispute for reconsideration by a USFHP-authorized representative who was not involved in the initial decision of the subject of the dispute.

Other administrative disputes not listed above should be forwarded to USFHP Member Services/Provider Relations.

Administrative disputes are the following:

- Claim disputes
- Factual determination by utilization management

USFHP will make every attempt to provide a written determination to the provider within 30 days. However, if the plan requires additional time for review, the provider will be notified by the plan with an expected turnaround for the resolution.

Non-administrative Disputes

Non-administrative disputes concern professional competence or conduct that relates to a participating provider within the plan network. An appeal request should be submitted in writing, addressed to the USFHP Medical Director. See page 17.

PROVIDER EDUCATION

USFHP's active provider education program enhances awareness of USFHP requirements. Integral to this program is an emphasis on achieving the leading health care indicators of "Healthy People 2020." Additional information can be found at www.healthypeople.gov. As part of this orientation, network providers will be given information about Healthy People 2020 and encouraged to participate. Providers will also receive regular updates and ongoing access to assistance with provider-related concerns.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

You are encouraged to let USFHP know if you are interested in serving as a member of the USFHP Clinical Quality Management Committee or other committees that may be formed by USFHP.

USFHP welcomes your feedback and suggestions on how service may be improved for provider and health plan member. Please contact USFHP Member Services to submit your feedback and suggestions.

You may appeal a claim submission that you feel was not paid appropriately.

You may appeal any action taken by USFHP that affects your network participation and is related to professional competency or conduct.

Provider Responsibilities

1. You will treat USFHP patients the same as all patients, regardless of type and amount of reimbursement.
2. In the event that a participating provider is unavailable to treat a USFHP member, you must arrange for another physician (the covering physician) to provide such services on your behalf.
3. In the event that a network provider arranges for a non-network provider to deliver covered services to a member for any reason, the network provider shall ensure the following:
 - a) The network provider submits a thirty-day (30-day) advance written request to USFHP to utilize a non-network provider.
 - b) The network provider receives written consent from the plan prior to the provision of services by the non-network provider.
 - c) The non-network provider provides services to the member under the terms and all provisions of the participating provider agreement with USFHP, the USFHP Provider Manual and the rules and regulations.
 - d) The network provider compensates the non-network provider for all services rendered.
4. In the event that the network provider arranges for a non-network provider to provide covered services to a member for any reason, the network provider shall assure the following:
 - a) The non-network provider provides services to member under the terms and all provisions of the participating provider agreement with USFHP, the USFHP Provider Manual and the Rules and Regulations.
 - b) USFHP consents in advance to the provision of services by a non-network provider.
 - c) Provider provides USFHP with a thirty-day (30-day) advanced written notice of Provider's request to utilize a non-network provider and must receive written consent prior to utilizing a sub-contractor provider. Provider is responsible for compensating the sub-contracted provider for all services rendered.
5. You will provide comprehensive health services to the member in accordance with the TRICARE policy.
6. You will not discriminate on the basis of age, sex, handicap, race, color, religion or national origin.
7. You will allow access to the medical records of USFHP members by the appropriate USFHP designee. If requested, you must provide the medical records to the federal government and/or contracted agency representative.
8. You agree to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) with respect to preserving the confidentiality of patient health information.
9. You will provide continuing care to participating members.
10. You will abide by the USFHP at PacMed rules and regulations.

11. You may not balance bill a member for provider services that are covered by US Family Health. You may bill members only for applicable deductibles, copayments and cost share amounts. You may not bill for charges that exceed the allowable charge.
12. You will provide to USFHP or help it to obtain coordination of benefits/third-party liability information. If you receive payment from other insurance, you are required to do the following:
 - a) Refund the amount received from the other insurance to USFHP; or
 - b) Return the payment to the other insurance with a letter stating that the incorrect insurance was billed and then submit the claim to USFHP.
13. You may not balance bill a member for services you provide and are covered by USFHP. You may bill only for deductibles, copayments and cost share amounts. You may not bill for charges that exceed the allowable charge.
14. You may bill a member for services that are not a covered benefit if the member was informed that the services were not covered and agreed in advance to pay for such services.
15. You agree to the terms of the written agreement that renews annually unless either party chooses to review, renegotiate or terminate. Written notice of such review or termination must be provided at least ninety (90) days prior to the renewal date.
16. You agree to participate in the USFHP quality improvement, utilization management, credentialing, peer review, grievance and TRICARE Quality Monitoring Contract (TQMC) program. You agree to participate in any evidence-based patient safety programs.
17. You agree that participating providers' written agreements do not include:
 - a) Any clauses or language that could restrict providers from discussing matters relevant to members' health care.
 - b) A definition of "medical necessity" that emphasizes cost over quality.

Credentialing and Recredentialing

18. All network providers are required to meet the credentialing and recredentialing requirements of USFHP at PacMed. The requirements include but are not limited to the following:
 - a) All network providers must hold a current, valid license or certificate to practice their profession in Washington State.
 - b) Licensure or certification must be at the full clinical practice level, and the services must be provided within the scope of the license or certification.
19. A list of the locations that are party to your agreement with USFHP is found in the Exhibits of your contract.
20. All network providers must be certified Medicare providers.
21. If a provider does not participate in the recredentialing process, the provider will be subject to a corrective action plan or a termination of participation.
22. All network providers must be credentialed by the PacMed Credentialing department.

Grievance and Appeal Process

23. Practitioners may appeal decisions of the Credentials Committee and/or USFHP Medical Director.
24. Any participating provider that is denied, limited, suspended or terminated for cause by USFHP shall receive written notice of the decision that includes the reason for the denial, limitation, suspension or termination by the USFHP Medical Director. This includes all events that may result in the denial, limitation, suspension or termination of network participation privileges.
25. Right to Appeal: Following a denial, limitation, suspension or termination of appointments or privileges, a practitioner may request a formal hearing to respond to the proposed action.
 - a) Written Request: Petitioner must request an appeal hearing in writing to the chair of the Credentials Committee no later than thirty (30) calendar days after receipt of the notification of adverse decision.
 - b) Failure to request an appeal hearing within thirty (30) days of receipt of the notification of adverse decision shall be deemed a waiver of the right to an appeal hearing.
26. Appeal Hearing: Appeal hearings are set forth herein to assure that the affected practitioner is afforded all rights to which the practitioner is entitled.
 - a) If the decision is unfavorable to the practitioner, the practitioner may request a second appeal of the decision by the first appeal panel.
 - b) The Level II Appeals Committee has sole discretion over the appeal decision. The Level II Committee decision will be final.
 - c) The petitioner will receive the written decision of the Level II Appeals Committee including a statement of the basis for the decision.

REIMBURSEMENT METHODOLOGIES

Fee-for-Service (Professional Services)

Professional services provided under a fee-for-service contract are reimbursed based on the contract rates.

For services for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the Medicare fee schedule is used.

Institutional Services

USFHP reimburses facility-based care at the TRICARE/CHAMPUS DRG or contracted rate. TRICARE rates are updated annually, and claims are processed by date of service.

Note: Any changes to fee schedule or contract provisions are sent to the participating provider's office at least 30 days prior to the effective date.

QUALITY ASSURANCE

Monitoring

According to our contract with the Department of Defense, PacMed is required to monitor the following:

- Serious occurrence events and catastrophic events
- Unusual prescribing practices, which may include communication with the prescribing physician
- Unusual, non-standard or unapproved therapies
- Claims to identify utilization patterns for investigation of potential quality issues

Provider Reviews

Member satisfaction questionnaires and incident/complaint reports are maintained on each provider for review.

UNDERSTANDING THE US FAMILY HEALTH PLAN ID CARD

A sample US Family Health Plan ID card

Member's name.

(Middle initial and designations such as "Jr." may not appear on card)

Member's ID

Group Number indicates

member's copay level. For a legend of USFHP Group Numbers and associated copays, see the Network Quick Reference Guide at: <https://www.usfhpnw.org/provider-resources>



Pharmacy Benefit Manager information

Office Visit/Consult Copayments

Card is for ID purposes only; it does not guarantee coverage or benefits. Preauthorization is required for care received outside PacMed.

Call Member Services at (206) 621-4090 or 1 (800) 585-5883 (option 2) to verify eligibility, benefits and coverage. Reimbursement will be reduced by the applicable copay amount.

Enrollees who are Medicare beneficiaries have waived their use of Medicare. Do not bill Medicare for care provided to this enrollee.

Send claim(s) to:

USFHP
1200 12th Ave S, Quarters 3/4
Seattle, WA 98144-2712

PROVIDER CONTACTS

Provider Appeals:

USFHP
Attn: Provider Appeals
1200 12th Ave S, Quarters 3/4
Seattle, WA 98144-2712
(send certified mail)

USFHP Medical Director:

US Family Health Plan
1200 12th Ave S, Quarters 5
Seattle, WA 98144-2712

Provider Relations and Network Provider Questions:

(206) 621-4090 or 1 (800) 585-5883 (option 2)

Member Services:

For eligibility, benefits, formulary and appeal information
(206) 621-4090 or 1 (800) 585-5883

Website:

www.usfhpnw.org

Please contact
US Family Health Plan Member Services
for additional provider information
or an updated provider manual.

APPENDIX: PRIOR-AUTHORIZATION FORM (REFERRAL REQUEST)

Attn: UM Department-Referral Coordinator — Phone: (206) 326-2453 option 1; Fax: (206) 621-4026



Prior-Authorization Form



Patient Name:		Date:	
Insurance ID #:		DOB:	
Patient's PCP:			
REFERRAL/SERVICES REQUESTED			
Inpatient: <input type="checkbox"/> Surgical procedures <input type="checkbox"/> Inpatient Admits <input type="checkbox"/> Rehab	Outpatient: <input type="checkbox"/> Surgical procedures <input type="checkbox"/> PT, OT & ST <input type="checkbox"/> Imaging <input type="checkbox"/> Wound Care	Other Services: <input type="checkbox"/> Home Health <input type="checkbox"/> Home Infusion <input type="checkbox"/> Skilled Services (SN/PT/OT/ST)	<input type="checkbox"/> Consultation <input type="checkbox"/> Office Visit Follow-up <input type="checkbox"/> DME: <i>Please fax Prior-Auth Form & Rx to 206-621-4026</i>
Service is: <input type="checkbox"/> Elective/Routine <input type="checkbox"/> Expedited/Urgent*	*Definition of Expedited/Urgent: <i>The delay of treatment could jeopardize the life and health of patient, jeopardize patient's ability to regain maximum function or subject patient to severe pain that cannot be adequately managed without the care or treatment requested.</i>		
Behavioral Health: <input type="checkbox"/> Inpatient: <i>If patient requires inpatient hospital treatment for mental health needs, please send to nearest ED for evaluation</i>			
<input type="checkbox"/> Chemical Dependency (CD): <i>If patient requires CD treatment, they must be assessed by a CD professional to determine appropriate level of care as part of their admission process</i>		<input type="checkbox"/> Eating Disorder/Residential Treatment: <i>Coordination for these services managed by Behavioral Health Case Manager</i>	
PROCEDURE INFORMATION			
ICD-10 Code and Description:			
CPT/HCPCS Code and Description:			
Number of visits requested:		Date of Service:	
REFERRED FROM: ORDERING/REFERRING PHYSICIAN INFORMATION			
Name:		Contact Name:	
Address:		Specialty Department:	
TIN:	NPI:	Phone:	Fax:
REFERRED TO: REFERRING FACILITY/ PHYSICIAN INFORMATION			
Name:		Contact Name:	
Address:		Specialty Department:	
TIN:	NPI:	Phone:	Fax:
SUPPORTING DOCUMENTATION IS REQUIRED! If not received within 48 hrs, referral may be denied for missing information			
FOR INTERNAL USE ONLY			
Date:	Auth. #:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Valid date from:	Valid date to:	Number of visits:	
Notes/Comments:			
Processed by _____			

UM Prior-Authorization Form revised 8.2.18