

US FAMILY
HEALTH PLAN
Caring for our Uniformed Services Family

Provider Manual

Effective January 1, 2011

US Family Health Plan Provider Manual

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Section 1 - US Family Health Plan Resources and Network Facilities

This section is designed to help providers and their office staff contact the appropriate US Family Health Plan resource for assistance. US Family Health Plan recommends that providers and office staff read this manual and reference it as necessary. We hope you find this material helpful. The US Family Health Plan Provider Network Coordinator is available to answer questions and to visit your office at your request.

US Family Health Plan Provider Support Team

Provider Network Coordinator

Phone 617-562-5548

Fax: 617-562-5234

- Conducts new office orientations
- Updates providers on new providers/services
- Enrolls new providers
- Answers general questions
- Answers providers' questions
- Gives referral guidance

Care Coordinator

Phone: 617-562-5583

Fax: 617-562-5244

- Reviews and evaluates all requests for out of plan/out of network referrals
- Communicates plan authorization determinations for health care services to members and providers
- Gives referral guidance

Member Services

Phone: 1-800-818-8589

- Assists members with choice or change of Primary Care Provider (PCP)
- Addresses inquiries from providers and members regarding paid, in-process claims, and Statements of Account (SOA)
- Interprets benefits
- Answers member questions regarding general use of plan
- Addresses member problems or complaints
- Confirms member eligibility

Mental Health Department

Phone: 1-800-208-9565

- Assists with coordination of member's access to inpatient mental health and substance abuse services
- Facilitates discharge planning for members hospitalized at designated facilities
- Monitors quality of care at mental health designated facilities

Network Provider Units

Your hospital affiliation determines your referral circle within the US Family Health Plan. Providers and facilities within your referral circle will provide specialty care except when that care is not available through the referral circle.

Network Hospitals

To assist in locating Specialty Care within or outside of these reference circles please call our Care Coordinator at 617-562-5583

Massachusetts		
St. Elizabeth's Medical Center Boston, MA	617-789-3000	www.caritasstelizabeths.org
Children's Hospital (<i>pediatrics only</i>) Boston, MA	617-355-6000	www.childrenshospital.org
Carney Hospital Boston, MA	617-296-4000	www.caritascarney.org
Good Samaritan Medical Center Brockton, MA	617-427-3000	www.caritasgoodsam.org
Lahey Clinic Burlington, MA	781-744-5100	www.lahey.org
Emerson Hospital Concord, MA	978-369-1400	www.emersonhospital.org
Falmouth Hospital Falmouth, MA	508-548-5300	www.capecodhealth.org
Saint Anne's Hospital Fall River, MA	508-674-5600	www.saintanneshospital.org
Heywood Hospital Gardner, MA	978-632-3420	www.heywood.org
Fairview Hospital Great Barrington, MA	413-528-8600	www.berkshirehealthsystems.com
Baystate Franklin Medical Center Greenfield, MA	413-773-0211	www.baystatehealth.com
Cape Cod Hospital Hyannis, MA	508-771-1800	www.capecodhealth.org
Health Alliance Hospital Leominster, MA	978-466-2000	www.umassmemorial.org
Marlborough Hospital Marlborough, MA	508-481-5000	www.umassmemorial.org
Holy Family Hospital & Medical Center Methuen, MA	978-687-1056	www.caritasholyfamily.org
Milford Regional Medical Center Milford, MA	508-473-1190	www.milfordregional.org
Cooley Dickinson Hospital Northampton, MA	413-582-2000	www.cooley-dickinson.org
Caritas Norwood Hospital Norwood, MA	781-769-2950	www.caritasnorwood.org
Berkshire Medical Center Pittsfield, MA	413-447-2000	www.berkshirehealthsystems.com
Jordan Hospital Plymouth, MA	508-746-2000	www.jordanhospital.org
Baystate Medical Center Springfield, MA	413-794-0000	www.baystatehealth.com/bmc

Network Hospitals - Continued

Massachusetts (continued)		
Mercy Medical Center Springfield, MA	413-748-9000	www.mercycares.com
South Shore Hospital South Weymouth, MA	781-340-8000	www.sshosp.org
UMASS Memorial Medical Center Worcester, MA	508-334-1000	www.umassmemorial.org

Rhode Island		
Newport Hospital Newport, RI	401-846-6400	www.lifespan.org/newport
Our Lady of Fatima Hospital North Providence, RI	401-456-4000	www.fatimahospital.com
Rhode Island Hospital Providence, RI	401-444-4000	www.rhodeislandhospital.org/rih
The Miriam Hospital Providence, RI	401-793-2500	www.lifespan.org/tmh
South County Hospital Wakefield, RI	401-782-8000	www.schospital.com
Kent Hospital Warwick, RI	401-737-7000	www.kenthospital.org
The Westerly Hospital Westerly, RI	401-596-6000	www.westerlyhospital.org
Landmark Medical Center Woonsocket, RI	401-769-4100	www.landmarkmedical.org

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Section 2 – Introduction

What is US Family Health Plan?

The Uniformed Services Family Health Plan (US Family Health Plan) is a Department of Defense (DoD) sponsored managed care plan designed to provide comprehensive medical benefits to enrolled individuals at a low out-of-pocket cost. This government-sponsored managed care plan is an organized system of health care with specific providers and hospitals delivering care to members. US Family Health Plan is part of the military health system but is administered locally and separately from the regional TRICARE® contractor. Eligible beneficiaries are offered a comprehensive benefit package, which includes all services covered by TRICARE plus a set of preventive care services. **Covered benefits are available only from Plan providers except during a medical emergency.** There are no claim forms for the member to complete when Plan approved providers are used.

How the Plan Works

US Family Health Plan follows a managed care approach in caring for its members. Managed care focuses on every aspect of the patient health care. The Primary Care Physician (PCP) is responsible for monitoring the patient's progress and maintaining his or her medical record. This provides a better service to the patient and helps reduce redundant testing and evaluations.

It is the responsibility of the provider to obtain authorization, in advance, for all medical, mental health, substance abuse and hospital care except in life-threatening emergencies. Authorization for in-network specialty services should be obtained by the PCP. Authorization for out-of-network specialty services must be obtained by the Plan

The only time the US Family Health Plan will reimburse care not authorized in advance is for emergency conditions requiring immediate medical attention. It is your responsibility as a Network Provider to call the US Family Health Plan Member Services at **1-800-818-8589 within 24 hours** of a US Family Health Plan patient being hospitalized.

Whenever you need assistance, or need to notify the Plan of services/supplies requiring pre-registration, please call **1-800-818-8589**. A Member Services Representative will guide you through all aspects of the US Family Health Plan benefits, and pre-registration and notification requirements. A listing of the US Family Health Plan Provider Support Team can be found in Section 1 of this manual.

Relationship with Tufts Health Plan

The US Family Health Plan has contracted with Tufts Health Plan to serve as its third party administrator. In this role, Tufts supports US Family Health Plan by providing claims processing, referral management, and customer relations services. This affiliation also allows US Family Health Plan Members access to a selected Tufts network of physicians, hospitals, specialty and ancillary providers. In addition, US Family Health Plan is supported by the Tufts wellness benefits and, other established programs, which include the Diabetes, Congestive Heart Failure, and CAD secondary prevention programs.

Summary of Benefits

This chart presents an overview of the services that are covered by the Plan when they are provided or authorized by the member's primary care provider (PCP).

All specialist visits and hospital admissions must be arranged by the PCP (except for unforeseen medical emergencies). Most co-payments are due at the point of service.

	Active Duty Family Members	Retirees, Survivors & Family Members	Retirees, Survivors & Family Members Enrolled in Medicare Part B ¹
Annual Enrollment Fee	\$0	\$230/individual* \$460/family	\$0 (with proof of Part B enrollment)
COVERED SERVICES	YOUR COST	YOUR COST	YOUR COST
Annual Physical	\$0	\$0	\$0
Outpatient Visits	\$0	\$12	\$0
Home Health Care	\$0	\$12/visit	\$0
Emergency Room Visits	\$0	\$30	\$0
Ambulatory Surgery	\$0	\$25	\$0
Inpatient Hospitalization (general)	\$0	\$11/day \$25/minimum	\$0
Skilled Nursing Facility Care	\$0	\$11/day \$25/minimum	\$0
Ambulance Service	\$0	\$20 per occurrence	\$0
Prescription Drugs			
Retail Pharmacy (30-Day Supply)	Co-payment per prescription	Co-payment per prescription	Co-payment per prescription
Generic Drug	\$3	\$3	\$3
Preferred Formulary Name-Brand Drug	\$9	\$9	\$9
Non-Preferred Formulary Drug	\$22	\$22	\$22
Mail Order Pharmacy (90-day supply)	Co-payment per prescription	Co-payment per prescription	Co-payment per prescription
Generic Drug	\$3	\$3	\$3
Preferred Formulary Name-Brand Drug	\$9	\$9	\$9
Non-Preferred Formulary Drug	\$22	\$22	\$22
Durable Medical Equipment (Prostheses, Supplies)	0%	20% of cost	0%

The summary is not an all-inclusive list. Complete details of the benefit coverage and exclusions are available by calling Member Services at 1-800-818-8589.

*If an individual is paying into Medicare Part B, there is no US Family Health Plan enrollment fee for that person.

¹No co-payments are due for Medicare-covered services.

Summary of Benefits, continued

	Active Duty Family Members	Retirees, Survivors & Family Members	Retirees, Survivors & Family Members Enrolled in Medicare Part B ¹
Physical Therapy	\$0	\$12/visit	\$0
Occupational Therapy	\$0	\$12/visit	\$0
Rehabilitation Therapy (including cardiac)	\$0	\$12/visit	\$0
Radiation Therapy	\$0	\$12/visit	\$0
Routine PAP Smear	\$0	\$0	\$0
Well Child Care & Immunizations (up to 24 months of age)	\$0	\$0	\$0
Maternity (Hospital & Professional Services, pre/pot natal)	\$0	\$ 11/day \$25 minimum	\$0
Eye Exams	\$0	\$12	\$0
Chiropractic Care** (Spinal manipulation only)	\$0	\$ 10/visit	\$0
Mental Illness	\$0	\$ 17/visit	\$0
Outpatient Mental Health Visits, group	\$0	\$ 11/day \$25 minimum	\$0
Inpatient Hospitalization, Mental Health	\$0	\$ 40/day \$25 minimum	\$0
Partial Hospitalization, Mental Health	\$0	\$ 40/day \$25 minimum	\$0
Substance Abuse Treatment (inpatient partial)	\$0	\$ 40/day \$25 minimum	\$0

** Not a DoD Uniform Benefit. Benefit provided as a service of the US Family Health Plan from Brighton Marine.

Catastrophic Cap: Co-payments collections will be subject to a catastrophic cap of \$1,000 per for Active duty families and \$3,000 per year for retiree families. This means you won't have to pay more than that for covered medical services received in a single year. The enrollment fee (if applicable) and all out of pocket co-payments are included in determining the catastrophic cap.

Point of Service Option

The TRICARE benefit provided by US Family Health Plan includes a Point of Service (POS) option that provides limited coverage for unauthorized, non-emergent, out of network services. In order for POS coverage to apply, the care provided must be a TRICARE covered benefit. While the POS option provides some coverage for unauthorized out of network care, there are significant out of pocket costs for members:

Charges	Individual	Family
Deductible per Plan Year (1-Oct through 30-Sept) for outpatient care only	\$300	\$600
Cost Share for outpatient care	50% of TRICARE allowable charge, after annual deductible is met	
Cost Share for inpatient care	50% of TRICARE allowable charge	
Any additional charges by non-network providers	Beneficiary is responsible. Up to 15% above the TRICARE allowable charge is permitted by law	

Important: Out of pocket costs under the POS option are not applied to members' catastrophic cap.

Section 3 - Physicians

Primary Care Providers

Responsibilities

Primary Care Providers (PCPs) are responsible for the total care of their US Family Health Plan members, which includes providing high quality, cost efficient medical management. The PCP must be accessible to members 24 hours a day, seven days a week via direct contact or through PCP arranged alternative coverage. Responsibilities are as follows:

Routine and Preventive Care

Routine preventive care includes physical examinations, immunizations, disease screening and Pap smears (see section on Preventive Care for further details).

Specialty Care

The PCP arranges specialty care for members. For US Family Health Plan members, this care may be arranged within the PCP's referral circle. Any specialty care that cannot be provided within the member's referral circle must be authorized by the US Family Health Plan Care Coordinator or, in certain circumstances, a request must be sent to the US Family Health Plan Appeals Committee.

Urgent/Emergency Care

If a member receives urgent care, follow up should occur with the member's PCP and/or, if needed, a specialist within the member's own referral circle.

When a member notifies you of an admission, you or the member must call US Family Health Plan Member Services, 1-800-818-8589, to report the admission.

Out of Referral Circle Care

PCPs are responsible for transferring members to the appropriate designated hospital for inpatient care. The member should be transferred as soon as he/she is stabilized and the PCP should monitor the member's care closely with the attending physician on a proactive basis.

Healthy People 2010

US Family Health Plan emphasizes achievement of Healthy People 2010 health care indicators. These indicators reflect the health concerns in the United States at the beginning of the 21st century and will be used to measure the health of the Nation over the next 10 years. Each of the 10 indicators has one or more objectives from Healthy People 2010 associated with it. The indicators are:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

For more information on this program, please visit their website at www.healthypeople.gov.

Primary Care Provider Monthly Member List

Once a month, the US Family Health Plan provides each Primary Care Provider (PCP) with a list of all US Family Health Plan members who have selected the physician as their PCP. Among the information included on the monthly member list is the following:

- Monthly additions to and deletions from a Primary Care Provider's Member List
- Member's identification number
- Member's address and telephone number

Important: Providers should call US Family Health Plan Member Services at 1-800-818-8589 with any necessary changes in status to their US Family Health Plan member panel list (i.e., death of a member, incorrect listing on monthly report, etc.)

Closing or Re-opening a Panel

Providers must notify the US Family Health Plan directly of any desired changes to their panel status. Call the US Family Health Plan Provider Network Coordinator at 617-562-5548 in order to close a Primary Care Provider panel, or to re-open a panel that is currently closed.

Removing a US Family Health Plan Member from a Panel

Under rare circumstances, a physician may feel that it is no longer appropriate to act as a Primary Care Provider (PCP) for a US Family Health Plan member. The PCP must send a written notice to the member via registered mail and a copy to US Family Health Plan Member Services, P.O. Box 9195, Watertown, MA 02471-9900, explaining the reason for the decision. Included must be an agreement to provide urgent care for up to thirty days so the member will have time to select a new PCP.

When the Member Services department receives the letter, the member will be contacted so they can be assisted with the selection of a new PCP.

Specialty Care Providers

Specialty care providers are expected to provide quality, cost-efficient health care to US Family Health Plan members within the US Family Health Plan network. The primary responsibility of the specialist is to provide authorized medical treatment to US Family Health Plan members who have a written referral from their Primary Care Provider (PCP). The US Family Health Plan referral form contains the information regarding the medical treatment and number of visits authorized by the PCP.

Members are required to obtain referrals for specialty care from their PCP. Therefore a Specialty Provider *should not* refer a US Family Health Plan member to another provider and/or suggest other treatment *without* discussing the case with the PCP. It is also important for the Specialist to provide only those services authorized by the PCP. For example, if the referral form states: Consultative Opinion only, the Specialty Provider must call the PCP before ordering diagnostic tests or procedures. An additional referral must be written in that circumstance.

Please note: If a specialist feels additional treatment is required and cannot provide these services, the specialist is responsible for contacting the member's PCP, and suggesting that the PCP provide the member with an alternative referral.

On-Call Providers

On-call providers are responsible for urgent/emergency care only. Follow-up treatment should always occur with the member’s PCP.

It is the responsibility of the On-call provider to direct the US Family Health Plan member to the nearest US Family Health Plan hospital whenever possible. If a member is seen at a hospital, which is not within their referral circle, the member must be directed back to their PCP for follow-up care. If admitted, US Family Health Plan members should be transferred to the appropriate US Family Health Plan facility when stabilized.

Credentialing

US Family Health Plan delegates credentialing of the provider network to its third party administrator Tufts Health Plan. US Family Health Plan participating providers are considered credentialed if they have met all the commercial requirements as required by Tufts Health Plan as established from time to time.

Pharmacy Guidelines

Minimum List of Dangerous Abbreviation

Consistent with the national standards for patient safety related to medication orders and prescriptions established by the Joint Commission on Accreditation of Health Care Organizations, US Family Health Plan has established a list of unacceptable abbreviations and symbols, which can no longer be used in any part of the prescription or medical record.

A list of dangerous and prohibited abbreviations, acronyms and symbols has been established by the Plan and must be minimally included in a provider’s own "Do not use" list:

UNACCEPTABLE ABBREVIATIONS AND SYMBOLS

Do not use these dangerous abbreviations or dose designations

Abbreviation/Dose Expression	Potential Problem	Correction
U or u	Mistaken as zero, four or cc.	Write “unit”
IU	Mistaken as IV (intravenous) or 10 (ten).	Write “international unit.”
q.d. or Q.D.	Mistaken for Q.O.D. The period after the Q can be mistaken for an “I”.	Write “daily” or “every day.”
q.o.d. or Q.O.D.	Mistaken for Q.D. The period after the “O” can be mistaken for an “I”.	Write “every other day.”
Trailing zero (X.0 mg).	Decimal point is missed.	Never write a zero by itself after a decimal point (Xmg).
Lack of leading zero (.X mg).	Decimal point is missed.	Always use zero before a decimal point (0.X mg).

MS	Confused for magnesium sulfate.	Write out morphine sulfate.
MSO ₄	Confused for magnesium sulfate.	Write out morphine sulfate.
MgSO ₄	Confused for morphine sulfate	Write out magnesium sulfate.
A.S., A.D., A.U. (Latin abbreviations for left, right, or both ears),	Mistaken for each other.	Write out "left ear," right ear" or both ears."
T.I.W. (for three time a week)	Mistaken for three times a day or twice weekly resulting in an overdose.	Write out "3 times weekly" or "three times weekly"
ss	Mistaken for "55."	Spell out "sliding scale."
R, L	Mistaken for each other.	Spell out Right/Left

Pharmacy Benefits and Forms

You are encouraged to assist the member in realizing the full pharmacy benefits available to them by utilizing the mail order pharmacy at Brighton Marine for all of their maintenance medications. They can receive a 90-day supply of medication through our mail order pharmacy for the same co-pay that is restricted to a 30-day supply at local retail pharmacies. You can initiate prescriptions by calling the Brighton Marine Pharmacy at 1-877-880-7007, faxing them to 617-562-5296, or by electronic prescribing.

The Uniform Formulary and Non-Formulary medications are set up as a tier system: Generics \$3, Preferred Brand \$9, Non-Formulary Brand \$22.

There is a Specialty Pharmacy List that requires the use of our mail order pharmacy for certain medications. In addition, certain medications require you to fill out a Medical Necessity Form, or a Prior Authorization Form.

As the Uniform Formulary, Specialty Pharmacy List, and Medical Necessity/ Prior Authorization Forms go through periodic changes, we encourage you to visit the US Family Health Plan website (www.usfamilyhealth.org) for the most current provider information. You can view all the latest formulary updates and download any forms you may need.

Oral Formula

US Family Health Plan follows Tufts Health Plan's Oral Formula Medical Necessity Guidelines. Please refer to the Tufts Health Plan Provider website Document ID# 1085631 to review the entire document.

Intravenous Immune Globulin (IVIg)

US Family Health Plan follows Tufts Health Plan's Intravenous Immune Globulin Pharmacy Medical Necessity Guidelines. Please refer to the Tufts Health Plan Provider website Document ID# 2098923 to review the entire document.

Section 4 - Referral Management

Important: All non-emergent out-of-network and out-of-referral-circle referrals require the approval and signature of the US Family Health Plan Care Coordinator prior to the member receiving his or her copy. The intact referral form needs to be mailed to the following address:

**US Family Health Plan Care Coordinator
77 Warren Street
Boston, MA 02135**

You may also fax a copy of the referral form to the Care Coordinator at 617-562-5244.

Referral Overview

The referral management process is coordinated by the Primary Care Provider to ensure that appropriate specialty care is provided when medically necessary. A referral form is required for all specialty services except for the following, when performed by a US Family Health Plan provider. Members may not be charged fees for referrals. **Referrals are valid for up to 1 year from the date of the referral or the number of visits, whichever comes first.**

Services Not Requiring Referral:

- Annual eye exam (one per member per enrollment/Plan year when performed by Plan Optometrist)
- Chiropractic (manual manipulation of the spine only – 12 visits/year)
- Dental (2 routine cleanings and exams per year at Brighton Family Dental only). Note - member is responsible for the co-payments.
- Durable medical equipment (members will need prescriptions from PCPs)
- Home health care
- Laboratory (only for services performed at US Family Health Plan facilities)
- Obstetrics (providers need to be in the member's referral circle)
- X-rays

The referral form assures the Specialist that the Primary Care Provider has authorized the member's care and the type of services authorized. It also authorizes the Third Party Administrator to pay the Specialist's claims.

Referral Reporting Requirements for Specialty Care

The PCP must receive clearly-legible specialty care consultation or referral reports, operative reports, and discharge summaries from the referred Specialist within ten working days of the specialty care given. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the PCP within 24 hours by telephone, fax or other means, with a formal written report provided. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the primary care manager within 30 calendar days of member receiving Specialty care. **PCP is responsible for receiving the above reports for all referrals.**

PCPs should take into account the type of services and number of visits the member will need. For example, if a patient is referred to Oncology for chemotherapy or to Renal for dialysis, the PCP may refer for up to 99 visits for one year.

Important: PCPs may not provide US Family Health Plan members referrals for out-of-network or out-of-referral circle referrals without first obtaining approval from the US Family Health Plan Care Coordinator, or in certain circumstances, the US Family Health Plan Appeals Committee.

Limited Network Authorization Web Tool

US Family Health Plan requested Tufts Health Plan to construct a limited network environment to contain provider referrals within the US Family Health Plan network. Active management of select member referrals is one of the primary goals of this project. Tufts Health Plan provided US Family Health Plan tools to steer utilization to specific locations prior to the rendition of service. The purpose of the Limited Network Project is to reduce member liability and increase member and provider satisfaction. The Limited Network Authorization Web tool became effective on November 26, 2008.

In order to administer this request, Tufts Health Plan modified the business logic within the claims system to identify referrals that require US Family Health Plan review and authorization. US Family Health Plan will have access to all referrals that require additional authorization and are less than one year and one week from their entry date. US Family Health Plan will be responsible for ‘approving’ or ‘denying’ these referrals via the Limited Network Authorization Web Tool, which Tufts Health Plan provided for this purpose.

Please note: If a US Family Health Plan member sees a specialist outside of their PCP’s referral circle or a specialist outside of the US Family Health Plan network, both a **PCP referral and US Family Health Plan Reviewer authorization are required.**

The Limited Network Authorization Web tool will display all referrals that require US Family Health Plan Reviewer authorization in the employer portal of US Family Health Plan’s web site. US Family Health Plan will have daily access to referrals that require US Family Health Plan Reviewer authorization. Ex. Referral entered by Tufts Health Plan on 12/01/08 will be accessible to US Family Health Plan on 12/2/08.

US Family Health Plan has the sole authority to determine if the service requested is ‘approved’ or denied’. US Family Health Plan submits authorization decisions to Tufts Health Plan via the Limited Network Authorization Web tool. Once US Family Health Plan submits the decision to Tufts Health Plan, the Web tool automatically creates a service form (one per referral) and sends it to Tufts Health Plan. When the decision is sent to Tufts Health Plan, the IPA Reviewer field in Tufts Health Plan referral screen will auto-populate with either a ‘Y’ or ‘N’ per the submitted disposition. The ‘Y’ code indicates that the referral is ‘approved’ and the ‘N’ code indicates that the referral is ‘denied’.

Please note: **The ‘A’ code indicates that the referral has been pended for further review.**

Please contact Member Services at 1-800-818-8589 if you have additional questions or concerns about the Limited Network Authorization Web Tool.

Mental Health Referrals

For outpatient mental health services, members are not required to obtain prior approval from their PCP and may self-refer to a US Family Health Plan network mental health provider for the first ten visits in a plan year. Although PCP approval is not required, members must call the following number to obtain a current list of authorized network providers and to notify the plan which provider the member intends to visit to ensure that claims will be paid.

Toll-free numbers for Mental Health Self-Referrals: 1-800-208-9565

Surgical Day Care Procedures

Facilities and/or attending physicians' offices are not required to pre-register surgical day care procedures. However, referrals from PCPs will still be required for the claims to pay.

Diabetes Outpatient Self Management Training Services

US Family Health Plan excludes coverage for educational counseling services and nutritional counseling *except* Diabetes Outpatient Self Management Training Services and other medically necessary treatment related to a medical diagnosis.

Prior authorization is required in advance. Each case is reviewed on an individual basis. To request prior authorization, a letter of medical necessity must be written by the referring physician, along with any supporting clinical documentation and a US Family Health Plan 4-ply paper referral completed. This information must be faxed to the Care Coordinator at 617-562-5244 for review. Co-pays may be applicable.

Transcutaneous Electrical Nerve Stimulator (TENS)

A **Certificate of Medical Necessity**, which can be downloaded from our website, and a written prescription must be completed and faxed to US Family Health Plan Medical Director at 617-562-5244.

If Member is approved for a TENS Unit, the Care Coordinator will contact the Member and give him/her instructions on how to order the Unit. This includes explaining to the Member that he/she is responsible for ordering the TENS Unit through our specific vendor. For more information, contact the Care Coordinator at 617-562-5583.

Bariatric Surgery

US Family Health Plan follows Tufts Health Plan's Bariatric Surgery Medical Necessity Guidelines. Please refer to the Tufts Health Plan Provider website Document ID# 2107113 to review the entire document.

US Family Health Plan has a designated network of facilities that are accredited for bariatric surgery. The bariatric surgery must be performed at one of the following facilities in order for the procedure to be covered. These facilities include:

St. Elizabeth's Medical Center
UMASS Memorial Medical Center
Norwood Hospital (*performs Lap Band procedures only*)

Rhode Island Hospital
Baystate Medical Center

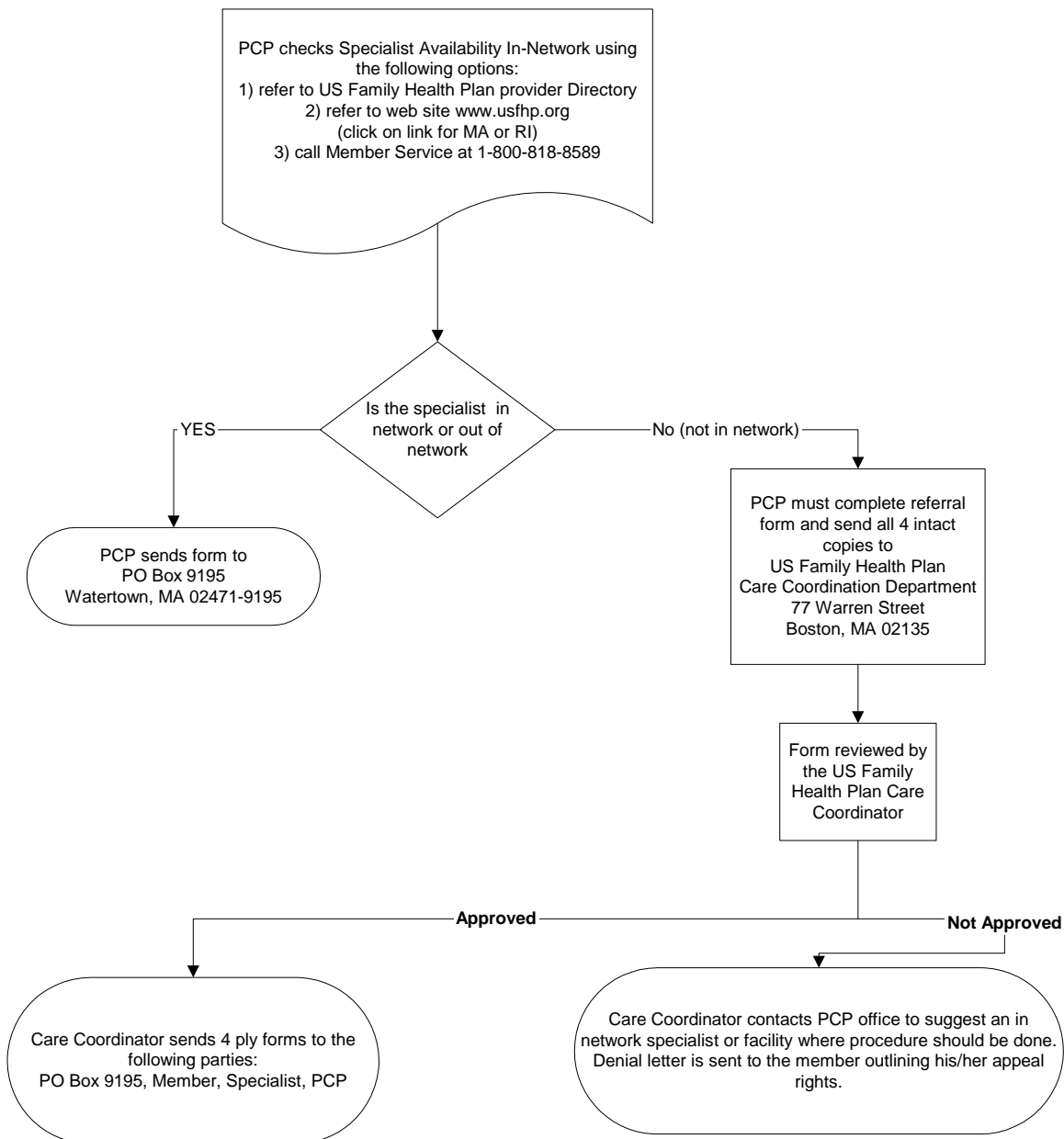
Physical Therapy

Initial evaluation and up to 8 visits (a total of 9) are covered with a referral written by the PCP. Coverage is 3 years of age and older. Services for educational or developmental reasons are not covered. All visits beyond 9 (per Plan year) require prior authorization from the Clinical Review Department. To obtain prior authorization, complete the Physical Therapy Authorization Form and fax to 617-972-9409. The Physical Therapy Authorization Form can be downloaded from our website.

Occupational Therapy

A referral is required. Prior authorization is required for beyond 30 visits. To obtain ongoing coverage beyond the 30 initial visits, complete the Occupational Therapy Authorization Form and fax to Clinical Review at 617-972-9409. The Occupational Therapy Authorization Form can be downloaded from our website. As with Physical Therapy, coverage is 3 years of age and older and services for education or developmental reasons are not covered.

US Family Health Plan Specialty Referral Process



Services not available in the PCP's referral circle require plan authorization.
Referrals are valid for a year. Out-of-Network visits are limited to 3 visits at a time.

In an emergency situation, a member should go to the closest medical facility for treatment. The member is responsible for calling the PCP within 24 hours of arriving at the ER. Upon discharge, the member will be approved for only one (1) follow-up visit to the ER physician if that physician is out of the US Family Health Plan network.

Members do not need a PCP referral for the following services only:

- 1) Obstetrics (must stay within their PCPs referral circle and PU)
- 2) Mental Health (limited to 10 visits; for a list of contracted providers call 1-800-208-9565)
- 3) Emergency Care (Only 1 follow-up visit to an out-of-network provider)
- 4) Yearly eye exam to a THP Optometrist
- 5) Preventive Dental Services (This is a value-added benefit and is only available at the Brighton Marine Health Center.)

Please call the Care Coordinator with any questions at 617-562-5583 or Member Services at 1-800-818-8589

Reviewing the Referral Form (Front side)

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1B 1A

To order additional forms, please contact RR Donnelly Fax (800) 635-9553 or email ncsgeoteam@rrd.com

US FAMILY HEALTH PLAN
PO BOX 9195
WATERTOWN, MA 02471-9900



REFERRAL AUTHORIZATION FORM

FAX OUT OF NETWORK
REFERRALS TO 617.562.5244

REFERRAL NUMBER: **111111 D**

REFERRAL DATE: ___/___/___

SEE BACK OF FORM FOR OUT OF NETWORK
REFERRALS AND OTHER IMPORTANT INFORMATION

①

MEMBER INFORMATION:

Member Name: Last _____ First _____ MI _____ Medical Record Number _____
 Member ID: _____ DOB: ___/___/___
 Phone: (____) _____

②

PRIMARY CARE PROVIDER (PCP):

PCP Name: Last _____ First _____
 NPI Number: _____
 PCP Phone: (____) _____
 Fax: _____

PCP Hospital Affiliation (check one):

<input type="checkbox"/> Baystate Medical Center	<input type="checkbox"/> Heywood Hospital
<input type="checkbox"/> Beverly Hospital	<input type="checkbox"/> Jordan Hospital
<input type="checkbox"/> Cape Cod Hospital	<input type="checkbox"/> Kent County Hospital
<input type="checkbox"/> Caritas Carney Hospital	<input type="checkbox"/> Landmark Medical Center
<input type="checkbox"/> Caritas Holy Family Hospital	<input type="checkbox"/> Marlborough Hospital
<input type="checkbox"/> Caritas Good Samaritan Medical Center	<input type="checkbox"/> Mercy Hospital
<input type="checkbox"/> Caritas Norwood Hospital	<input type="checkbox"/> Milford-Whitinsville Regional Hospital
<input type="checkbox"/> Caritas St. Elizabeth's Medical Center	<input type="checkbox"/> Newport Hospital
<input type="checkbox"/> Children's Hospital (pediatrics only)	<input type="checkbox"/> Our Lady of Fatima Hospital
<input type="checkbox"/> Clinton Hospital	<input type="checkbox"/> Rhode Island Hospital
<input type="checkbox"/> Cooley Dickinson Hospital	<input type="checkbox"/> Saint Anne's Hospital
<input type="checkbox"/> Emerson Hospital	<input type="checkbox"/> St. Joseph's Hospital RI
<input type="checkbox"/> Falmouth Hospital	<input type="checkbox"/> South Shore Hospital
<input type="checkbox"/> Franklin Medical Center	<input type="checkbox"/> UMass Memorial Medical Center
<input type="checkbox"/> HealthAlliance Hospital	<input type="checkbox"/> Lahey

③

REFERRAL INFORMATION:

Specialist Name: Last _____ First _____
 NPI Number: _____
 Specialty: _____
 Phone: (____) _____
 Address: _____
 Fax: _____

Specialist Hospital Affiliation (check one):

<input type="checkbox"/> Baystate Medical Center	<input type="checkbox"/> Heywood Hospital
<input type="checkbox"/> Beverly Hospital	<input type="checkbox"/> Jordan Hospital
<input type="checkbox"/> Cape Cod Hospital	<input type="checkbox"/> Kent County Hospital
<input type="checkbox"/> Caritas Carney Hospital	<input type="checkbox"/> Landmark Medical Center
<input type="checkbox"/> Caritas Holy Family Hospital	<input type="checkbox"/> Marlborough Hospital
<input type="checkbox"/> Caritas Good Samaritan Medical Center	<input type="checkbox"/> Mercy Hospital
<input type="checkbox"/> Caritas Norwood Hospital	<input type="checkbox"/> Milford-Whitinsville Regional Hospital
<input type="checkbox"/> Caritas St. Elizabeth's Medical Center	<input type="checkbox"/> Newport Hospital
<input type="checkbox"/> Children's Hospital (pediatrics only)	<input type="checkbox"/> Our Lady of Fatima Hospital
<input type="checkbox"/> Clinton Hospital	<input type="checkbox"/> Rhode Island Hospital
<input type="checkbox"/> Cooley Dickinson Hospital	<input type="checkbox"/> Saint Anne's Hospital
<input type="checkbox"/> Emerson Hospital	<input type="checkbox"/> St. Joseph's Hospital RI
<input type="checkbox"/> Falmouth Hospital	<input type="checkbox"/> South Shore Hospital
<input type="checkbox"/> Franklin Medical Center	<input type="checkbox"/> UMass Memorial Medical Center
<input type="checkbox"/> HealthAlliance Hospital	<input type="checkbox"/> Lahey
<input type="checkbox"/> Other	<input type="checkbox"/> Anna Jacques, Merrimack Valley

④

Diagnosis/Reason for Referral: If referring to a specialist or facility affiliated with a hospital other than the PCP's hospital, or outside of the US Family Health Plan network, please indicate reason. *Please note: All referrals to providers outside of the PCP's referral circle must receive Plan approval. Contact 800-818-8589 if you have any questions.*

⑤

SERVICES REQUESTED (CHECK ONE):

- Consultative OPINION only. One (1) visit only. Contact PCP prior to initiating treatment or diagnostic studies.
- SECOND OPINION only. (procedures and/or diagnostic are not to be performed by this provider.)
- Consultative OPINION, and necessary DIAGNOSTIC STUDIES only. Number of visits: _____
- Consultative OPINION, necessary DIAGNOSTIC STUDIES, and TREATMENT. Number of visits: _____
- Physical Therapy (Visits: _____) Not to exceed 1 evaluation and 8 treatment visits.
- Occupational Therapy (Visits: _____)
- Speech Therapy (Visits: _____)

⑥

REFERRAL IS VALID FOR TWELVE (12) MONTHS FROM THE REFERRAL DATE OR UNTIL THE NUMBER OF AUTHORIZED VISITS IS EXHAUSTED, WHICHEVER COMES FIRST. AUTHORIZATION MUST BE RECEIVED PRIOR TO OFFICE VISIT.

_____/_____/_____
 SIGNATURE OF PRIMARY CARE PROVIDER AUTHORIZATION DATE

_____/_____/_____
 SIGNATURE FOR PLAN AUTHORIZATION AUTHORIZATION DATE
IPA Signature is Required for Out of Network Prior Authorization

⑦

Distribution: White - US Family Health Plan Canary - Specialist Pink - PCP Goldenrod - Member

⑧

1. **REFERRAL DATE:** Date the Provider is issuing the referral for the patient. (Note the effective date of the referral is when US Family Health Plan referral department receives the referral)

2. **MEMBER INFORMATION:** The member information who will be receiving the treatment from the referral:

- Member's name Last, First, Middle
- Member's Date of Birth
- Member's ID number and suffix
- Member's Medical Record Number (if applicable)
- Member's Phone number

Member information can be obtained from the Member's ID card, calling US Family Health Plan Member Services at 1-800-818-8589, or your Monthly Member List.

3. **PRIMARY CARE PROVIDER (PCP):** General Information about Primary Care Provider and the hospital the provider is affiliated with.

- PCP Name: Last, First
- PCP ID: National Provider Identifier (NPI).
- PCP Phone: Phone number of Provider's primary practice
- PCP Hospital Affiliation: Check off the hospital that provider is affiliated with and where the services and/or procedures will be rendered.

4. **REFERRAL INFORMATION:** Referral information about the Specialist whom the patient will be seen by.

- Specialist Name: Last, First
- Specialist ID: NPI of the Specialist
- Specialty: Description of the Doctors' specialty
- Phone: Main phone number of the Specialist practice
- Address: Address of Specialist main office location
- Specialist Hospital Affiliation: Hospital where the specialist is affiliated with and where the services and/or procedure will be rendered.

5. **Diagnosis / Reason for Referral:** Description of the treatment plan. If referring to a specialist or facility affiliated with a hospital other than the PCP's hospital, or outside of the US Family Health Plan network, please indicate reason. **Please note:** All referrals to providers outside of the PCP's referral circle must receive Plan approval. Please call Member Services at 1-800-818-8589 if you have any questions.

6. **Services Requested (Check one):** The type of services requested by the Primary Care Provider.

7. Obtain the signature of the Primary Care Provider and the date of the signature.

8. Distribute the four copies of the referral authorization form as follows:

- The pink PCP copy is kept as part of patient's chart.
- The canary copy is forwarded to the Specialty Provider.
- The goldenrod copy is mailed to the member.
- The white copy is mailed to the address listed on the referral form promptly so the charges submitted may be paid appropriately.

Understanding the Referral Form (rear side)

The following wording is what you will find on the backside of each of the paper referral forms.

Please Note:

Written referrals are required for all specialty services except:

- Yearly eye exams with a plan optometrist
- Obstetric services within member’s provider unit/referral circle
- Lab services within Plan-contracted facilities
- Diagnostic services (including diagnostic radiological services) within Plan-contracted facilities

Out-of-network referrals are not valid without plan authorization. PCP must send all 4 copies of the out-of-network referral to the US Family Health Plan Care Coordination Department at 77 Warren Street, Brighton, MA 02135. If authorized, the member will receive his or her copy of the referral from the Care Coordination Department. Members may be held financially responsible for out-of-network services provided without first obtaining plan authorization. Out-of-network referrals cannot be authorized retroactively.

If you have questions, please call US Family Health Plan Member Services at 1-800-818-8589. Only those services included as part of the US Family Health Plan benefit package will be covered to the extent the services are provided in accordance with any applicable state law.

Please call Member Services at 1-800-818-8589 to verify eligibility, benefits, and coverage issues.

Services Provided Without Referral Authorization

US Family Health Plan policy dictates that members are responsible for obtaining referrals for specialty services prior to making appointments with Specialists. To confirm a member's understanding of this policy, many offices have patients sign forms similar to the one found below.

Provider Office Provider Address	
As a member of the Uniformed Services Family Health Plan I understand that I have an obligation to obtain a referral for specialty services from my Primary Care Provider prior to making an appointment. I acknowledge that I do not have a referral today, and may be responsible for payment of services received should this be denied by the US Family Health Plan.	
Name:	Date:
Signature:	
Address:	Phone:

Please remember that Plan providers are not allowed to bill Plan members unless the members have signed above waiver form.

Section 5 - Preregistration

Overview

Preregistration is required for members being admitted for inpatient care/surgery. However, **it does not guarantee payment**. When an admission is reported, the preregistration notification process:

- Confirms that the admission is authorized by the PCP if applicable
- Verifies member eligibility
- Screens for coverage/benefits exclusions
- Identifies whether the facility is an US Family Health Plan contracted facility
- Identifies the admission so that the appropriate case manager can begin early identification of potential discharge needs for the member

When the preregistration notification process is completed, a preregistration number is assigned to the admission. This number is used as a reference number for payment of claims associated with that particular hospitalization.

The Tufts Health Plan/US Family Health Plan Case Managers concurrently review inpatient admissions for medical necessity using InterQual criteria. The US Family Health Plan is not obligated to pay preregistered claims under the following circumstances:

- Persons who fail to meet eligibility criteria
- Persons who receive care determined to be not medically necessary
- Persons who have claims that are subject to Coordination of Benefits or Subrogation

Required Notification Time

Admitting physicians and hospital admitting departments are responsible for notifying Tufts Health Plan/US Family Health Plan under the following conditions:

- Within at least five business days prior to elective admissions
- Within one business day following urgent or emergency admissions

General Guidelines

Basic Preregistration Procedure

Contact the Tufts Health Plan/US Family Health Plan Preregistration Department via phone or fax.

Phone: 1-800-672-1515

FAX: 617- 972-9590

Please note: Admissions after business hours are subject to the preregistration guidelines. Messages may be left on the answering machine during non-business hours.

- Business hours are 8:30 a.m. to 5:00 p.m. Monday through Friday.
- Identify the patient as a US Family Health Plan member.

- Provide the member's name, identification number, admitting date, attending physician and complete diagnosis and clinical information.
- The preregistration staff will give you an authorization number.

After-Hours Urgent and Emergency Admissions

Urgent and emergency admissions that occurred after business hours or on the weekends and holidays are subject to the same notification criteria as described above. The phone lines are forwarded to an answering machine during non-business hours; the fax is available 24 hours a day, 7 days a week.

Phone: 1-800-672-1515

Fax: 617-972-9590

On the next business day, the preregistration staff transcribes the admission information. They contact the physician or facility that initiated the preregistration process with the preregistration information or begin the research necessary to resolve a pending case.

Obstetrical and Newborn Preregistration Procedure

In addition to the preceding steps under *Basic Preregistration Procedure*, the following requirements apply to obstetrical and newborn patients

- Pregnant women must be preregistered for delivery by 20 weeks gestation. Completing the MHQP OB Risk Assessment form does this. This will ensure that members receive all maternity benefits and are evaluated for participation in the Tufts Health Plan/ US Family Health Plan Healthy Birthday and MOMS Program. (US Family Health Plan members are eligible to enroll in the Tufts Healthy Birthday Program, which is the Tufts preterm labor and delivery prevention program. MOMS is Tufts Health Plan smoking cessation program for pregnant women.)
- Pregnant women with multiple inpatient admissions must be preregistered for each admittance up to and including actual delivery.
- Well newborns are covered under the mother's preregistration for delivery.
- Sick newborns must be preregistered separately within the reporting time frame guidelines if they will be staying in the hospital beyond the mother's discharge date.

Rescheduled Elective Admissions

If an elective admission is rescheduled, please notify the preregistration staff with the change.

Exclusions

- Emergency room or observation care that is not followed by an inpatient admission or ambulatory day surgery does not require preregistration.
- Surgical day care procedures.

Figure 5.1 Massachusetts Health Quality Partners Risk Assessment Tool Form

Massachusetts Health Quality Partners Obstetrical Risk Assessment Tool

Name _____ Health Plan & Subscriber ID# _____
Last First Middle

Address _____
street Apt.# City State zip

Phone: Home _____ Work: _____ Date of Birth: _____

Obstetrical Clinician's Name: _____ OB Provider ID# _____

Obstetrical Provider's Phone# _____ Fax: _____ EDC: ____/____/____

Planned Hospital for Delivery: _____ 1st Prenatal Visit Date: ____/____/____

Race: White Black Asian/Pacific Islander American Indian Other Ethnicity: Hispanic Non Hispanic

Language spoken at home _____ Needs translation help Y N Support System Y N

Behavioral Risks	Smoking Status	Substance Abuse
	Smokes regularly now, about the same as prior to pregnancy. Y <input type="checkbox"/> N <input type="checkbox"/>	Is the patient currently using alcohol? _____ Y <input type="checkbox"/> N <input type="checkbox"/>
	Smokes regularly now but less than prior to the pregnancy. Y <input type="checkbox"/> N <input type="checkbox"/>	Is the patient currently using street drugs? _____ Y <input type="checkbox"/> N <input type="checkbox"/>
	Smokes every once and a while. Y <input type="checkbox"/> N <input type="checkbox"/>	In the month prior to pregnancy:
	Quit smoking < 3 mo. prior to pregnancy. Y <input type="checkbox"/> N <input type="checkbox"/>	How many drinks did the patient consume in one week? _____
	Quit smoking since becoming pregnant. Y <input type="checkbox"/> N <input type="checkbox"/>	On how many occasions did the patient have more than 3 drinks? _____
	Wasn't smoking when became pregnant and doesn't smoke now. Y <input type="checkbox"/> N <input type="checkbox"/>	On how many occasions did the patient have any drugs? _____
		Occupational Demands Sedentary <input type="checkbox"/> Active <input type="checkbox"/> Hours spent standing _____
	Psychosocial Assessment completed Y <input type="checkbox"/> N <input type="checkbox"/>	
	Psychosocial risk factors identified: (please circle) 1. frequent moves 2. care access 3. hungry 4. education 5. safe 6. violence 7. stress 8. pregnancy planning	

Obstetrical High Risk/ Pre-Term Labor Assessment	Gravida _____ Full Term _____ Pre-term _____ Abs _____ Living _____ Height: _____ Weight: _____
	Previous C/S? Y <input type="checkbox"/> N <input type="checkbox"/> VBAC discussed <input type="checkbox"/> VBAC planned <input type="checkbox"/> VBAC refused <input type="checkbox"/> VBAC medically inappropriate <input type="checkbox"/>
	Risk Factors: Past OB/GYN History Including Past Pregnancies Initial Screen date ____/____/____
	Pre-term labor with previous pregnancy (less than 37 weeks) Y <input type="checkbox"/> N <input type="checkbox"/>
	Pre-term delivery with previous pregnancy (less than 37 weeks) Y <input type="checkbox"/> N <input type="checkbox"/>
	Diagnosis associated with pre-term delivery (narrative) _____
	Incompetent cervix Y <input type="checkbox"/> N <input type="checkbox"/> Cerclage with previous pregnancy Y <input type="checkbox"/> N <input type="checkbox"/>
	DES Exposure Y <input type="checkbox"/> N <input type="checkbox"/>
	Two or more 2 nd trimester abortions Y <input type="checkbox"/> N <input type="checkbox"/>
	Delivery within the past 12 months Y <input type="checkbox"/> N <input type="checkbox"/>
	Prior cone biopsy Y <input type="checkbox"/> N <input type="checkbox"/> Known uterine anomalies Y <input type="checkbox"/> N <input type="checkbox"/>
	Uterine fibroids Y <input type="checkbox"/> N <input type="checkbox"/> Myomectomy Y <input type="checkbox"/> N <input type="checkbox"/>
	Risk Factors: Current Pregnancy 26-28 weeks screening date ____/____/____
	ART this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/> Gonadotropin Y <input type="checkbox"/> N <input type="checkbox"/> Clomophine Y <input type="checkbox"/> N <input type="checkbox"/>
	Multiple gestations Y <input type="checkbox"/> N <input type="checkbox"/> Fetal reduction Y <input type="checkbox"/> N <input type="checkbox"/>
	Presence of Bacterial Vaginosis this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/> Treatment for BV Y <input type="checkbox"/> N <input type="checkbox"/>
	Bleeding after 12 weeks this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/>
	Pre-term labor this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/> Cervical changes Y <input type="checkbox"/> N <input type="checkbox"/> Cerclage Y <input type="checkbox"/> N <input type="checkbox"/>
Placenta previa beyond 26 weeks, this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/>	
Polyhydramnios this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/>	
Pregnancy Induced Hypertension this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/>	
Gestational diabetes this pregnancy Y <input type="checkbox"/> N <input type="checkbox"/>	
Other Risk Factors current or past pregnancy (narrative) _____	

I hereby authorize the Provider indicated herein to release the information on on this from to the named Health Plan

Signature of Member _____ Date _____ Signature of Provider _____ Date _____

Please fax this form to the appropriate office based on patient's health insurance (see information printed on back) Updated 2/02

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Section 6 - Billing Guidelines

General Guidelines

US Family Health Plan will pay “Clean Claims” (see definition below) that meet all of the Conditions of Payment listed below. Submit all claims within a 90-day time frame. This must coincide with the date of service, date of discharge or date of primary carrier's Explanation of Benefits (EOB). Claims received after this time frame will be denied, and the member will not be held responsible for payment.

Send all first submissions to the following address:

US Family Health Plan
P.O. Box 9195
Watertown, MA 02471-9900

Payment of Claims

“Clean Claims” are:

- Submitted on forms with all fields completed accurately, as described later in this section
- With a completed referral form (if required—see Section 5 - Referral Management)
- Not pending or involving Coordination of Benefits (COB)/Third Party Liability, or Workers’ Compensation

The Conditions of Payment are as follows:

1. The services are covered services in accordance with the applicable Benefit Document provided to US Family Health Plan members who meet eligibility criteria.
2. The services were:
 - a.) provided or authorized by the member’s PCP or the PCP’s covering physician in accordance with the applicable benefit document
 - b.) provided or authorized as identified elsewhere in your agreement with the US Family Health Plan
 - c.) authorized by the US Family Health Plan
 - d.) provided in an emergency in accordance with the member’s benefit document
3. The services were medically necessary as defined in the member’s benefit document.
4. The US Family Health Plan received the claim within the timeframe described in the provider’s agreement with the US Family Health Plan or, in the absence of such a timeframe, 90 days from the date of service or the date of discharge if the member is an inpatient provided that US Family Health Plan payment of an untimely invoice shall not constitute a waiver of this requirement for any other invoice
5. For certain imaging services, inpatient admissions, inpatient transfers and hospital-based ambulatory surgery procedures, the services were preregistered in accordance with US Family Health Plan preregistration guidelines

6. The services were billed using the appropriate CPT-4 codes, e.g., no “unbundling,” or other codes assigned by the US Family Health Plan, and
7. In the case of physician services billed by the hospital, services were billed on HCFA 1500 forms with a valid CPT-4 code (level 1 HCPCS code).

Billing Requirements for Hospital Outpatient Services

The HCFA-1500 and the UB-92 forms are the acceptable standard for paper billing. All providers including internal medicine, gynecology and psychiatry should use ICD-9-CM diagnosis codes and the HCPCS/CPT procedure codes. Oral surgeons may use the ADA procedure codes.

To be appropriately reimbursed when your hospital bills for professional services in addition to facility and ancillary services for clinic visits, including Mental Health and Substance Abuse, claims must be submitted on the appropriate form types, as specified below.

Service	Form
Facility/Clinic/Room charge inclusive of professional component (Global Billing)	HCFA-1500
Facility and/or ancillary services	UB-92
Professional physician services	HCFA-1500
Emergency Room professional services	HCFA-1500
Emergency Room facility and ancillary services	UB-92

All claims must be submitted in accordance with the guidelines specified by Tufts Health Plan, the third party administrator for the US Family Health Plan. For a copy of these requirements, please contact your Professional Relations Specialist at 1-888-306-6307.

If you are unable to comply with the billing specifications as outlined above, notify your Professional Relations Specialist.

Electronic Claims Submission

Providers may submit claims electronically by a variety of external clearinghouse sources. Interested providers can contact their Professional Relations Specialist at Tufts.

Statement of Account

The Statement of Account is a weekly report of all claims that have been paid or denied to that provider. Please see sample of Statement of Account (SOA) below:

US FAMILY HEALTH PLAN
 As Administered By: Caritas
 St. Elizabeth's Medical Center of Boston, Inc.
TUFTS Health Plan 333 Wyman Street
 P.O. Box 9203
 Waltham, MA 02454-9203

Statement of Account

Check No: 81-000108832
 Date: 08/11/2003
 Amount: \$64.38
 Page No: 1 of 1
 Payee ID:

SAMPLE PROVIDER UNIT
 ADDRESS
 CITY, STATE ZIP

The amounts shown in the member responsibility column below are billable to the patient.

If you have any questions regarding the disposition of a claim please contact the Provider Services Department at the number listed below:
 1-800-818-8589

THP Provider Services Department hours:
 Monday - Thursday: 8:00 AM - 6:00 PM Eastern Time
 Friday: 10:00 AM - 6:00 PM Eastern Time

If the Provider's payment address and / or practice address has changed, please contact Provider Services.

SERVICE DATE	POS	NO. SVC	PROCEDURE CODE AND DESCRIPTION	AMOUNT BILLED	AMOUNT ALLOWED	MEMBER RESPONSIBILITY	AMOUNT PAID	PAY CODE
Patient Name:				Patient ID:	1 Account:		Claim no.:	
				Provider Name:			Prov.ID:	
03/17/2002	ER	1	99283 EMERGENCY DEPARTMENT VISIT FOR	1,066.00	64.38	0.00	64.38	PD
03/17/2002	ER	1	99285 EMERGENCY DEPT. SERVICES	282.50	0.00	0.00	0.00	EO
CLAIM TOTALS				1,348.50	64.38	0.00	64.38	
SUMMARY:				TOTAL AMOUNT PAID = 64.38				
PAYCODE				EXPLANATION				
EO				REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE PRIMARY PROCEDURE. SEPARATE BILLING FOR THIS SERVICE IS CONSIDERED UNBUNDLING. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT.				
PD				PAID				

US FAMILY HEALTH PLAN
 As Administered By: Caritas
 St. Elizabeth's Medical Center of Boston, Inc.
TUFTS Health Plan 333 Wyman Street
 P.O. Box 9203
 Waltham, MA 02454-9203

5-13
110

CHECK DATE	CHECK NUMBER
08/11/2003	000108832

Sixty four and 38/100 Dollars	*****\$64.38
-------------------------------	--------------

VOID IF NOT PRESENTED FOR PAYMENT
 WITHIN 90 DAYS AFTER DATE OF ISSUE

PAY TO THE
 ORDER OF

TWO SIGNATURES REQUIRED IF OVER \$25,000

AUTHORIZED SIGNATURE

/000108832/ & 011000138 & 38635581/

Field numbers 11, 12, 13 and 14 are displayed on the printed statement. They are not found on a blank statement.

Field	Explanation
1. PATIENT NAME (ID NUMBER)	Patient's name and US Family Health Plan ID number
2. SERVICE DATE	Date of service
3. POS	Place of service
4. NO. SVC	Number of services
5. PROCEDURE AND DESCRIPTION	Procedure code and description (CPT code)
6. AMOUNT BILLED	Amount billed
7. AMOUNT ALLOWED	Amount allowed: reimbursement amount agreed upon by the individual Provider Unit
8. MEMBER RESPONSIBILITY	Co-payment
9. AMOUNT PAID	Amount US Family Health Plan paid provider for services
10. PAY CODE	PD = paid claims Unpaid claims will be identified by a pay code explanation.
11. ACCT	Patient's account number as assigned by the provider
12. CLAIM NO.	US Family Health Plan assigned claim number
13. TOTAL RETENTION	Retention amount held until year-end to protect against incurred deficits.
14. SUMMARY	<ul style="list-style-type: none"> Total amount paid and retained for services rendered. Year-to-date paid and retained for services dating back to the first of the year.

Following Up on Claims

The US Family Health Plan generates a weekly *Summary of Claims in Process* report that shows all claims that have been received to date and are in the payment process. The *Summary of Claims in Process* reports look exactly like the *Statement of Account* reports, except for the following:

- "Summary of Claims in Process" appears at the top of the barred section.
- Pay codes display a pending message rather than a payment or denial message.

All entries on the *Summary of Claims in Process* appear on the *Statement of Account* upon claim adjudication. If a submitted claim has not appeared on either the *Statement of Account* or the *Summary of Claims in Process* reports within 30 to 45 days, submit a Tracer Claim.

Tracer Claims

A tracer is put on a previously submitted claim that has been outstanding for 30-45 days from the date of submission and has not appeared on either the *Statement of Account* or the *Summary of Claims in Process* report. *If a claim was never submitted, and the filing limit is approaching, do not submit a tracer form. Submit the initial claim directly to the Filing Limit Appeal Committee.* Tracer claims may be

submitted by sending a copy of the original claim marked "Tracer" to the following address:

US Family Health Plan
Tracer Unit
P.O. Box 9195
Watertown, MA 02471-9900

Appeals

Filing Deadline Appeals

All claims submitted for the first time after the 90-day filing limit will be denied. However, there are two reasons why an appeal may be requested:

If the claim was submitted within the filing limit but was not received by US Family Health Plan within the appropriate time period:

1. The Provider may appeal the denial by sending a copy of the SOA with proof of the original submission date. This proof may include, but is not limited to, a ledger card showing the original billed date, a print out of the billing history or an EOB from another insurance carrier.
2. If the claim was submitted after the filing limit but the circumstances were beyond the provider's control, such as the following:
 - Incorrect insurance information supplied by the member
 - Computer error that caused a billing delay

The provider may appeal this type of denial by sending a letter documenting the reason(s) why the claim could not be submitted within the appropriate time period. Include a copy of the claim form. This appeal must be submitted within 90 days from the date of the denial in order to be considered.

Send these appeals to the following address:

US Family Health Plan
Attn: Filing Limit Appeals
P.O. Box 9195
Watertown, MA 02471-9900

Preregistration/Provider Appeals

If the admitting physician or the hospital does not notify the US Family Health Plan of an inpatient admission prior to admission, payment will be denied to both the hospital and physician. In this case the member is not responsible for the bill. Preregistration appeals cannot be adjudicated by the Preregistration staff. This appeal must be submitted within 90 days from the date of the denial in order to be considered.

To appeal a preregistration denial, submit a letter stating all pertinent information to the following address:

US Family Health Plan
Provider Appeals Committee
P.O. Box 9195
Watertown, MA 02471-9900

Incorrect Processing Appeals

If a physician or hospital feels that a claim has not been processed correctly, submit a written explanation of charges with highlighted copy of the SOA to the following address:

US Family Health Plan Member Services
P.O. Box 9195
Watertown, MA 02471-9900

This appeal must be submitted within 90 days from the date of the denial in order to be considered.

Referral Appeals

If a provider feels that a claim was inappropriately denied for lack of referral, submit referral with a highlighted copy of the SOA to the following address: (Referral will retroactively match to denied claim.) This appeal must be submitted within 90 days from the date of the denial in order to be considered.

US Family Health Plan
Attn: Referrals
P.O. Box 9195
Watertown, MA 02471-9900

All Other Appeals

If a physician or hospital chooses to appeal the payment or denial for a reason not listed above, submit a letter documenting all pertinent information with a copy of the EOB/Statement of Account to the following address: This appeal must be submitted within 90 days from the date of the denial in order to be considered.

US Family Health Plan
Provider Appeals Committee
P.O. Box 9195
Watertown, MA 02471-9900

The following page is the US Family Health Plan Provider Dispute Form. It can be downloaded from our web site at www.usfamilyhealth.org. Submit the form on the following page for filing a dispute.



Provider Payment Dispute Form

A dispute is any disagreement with the way a claim was processed (paid or denied) that a provider feels should have additional review. Payment disputes include the following:

- Preregistration and prior authorization requirements
- File limits
- Provider reimbursement
- Adjustment requests to previously submitted claims

Please complete this form and attach all appropriate documentation. Detailed descriptions of information required to process a provider dispute are located in the US Family Health Plan Provider Manual. Disputes must be submitted within 90 days from the date of the payment in order to be considered. All disputes must be separated by product and denial code.

All incomplete submissions will be returned.

Today's Date: _____

Provider Name:	
Provider Number:	
Contact Name:	
Telephone Number:	
Email Address:	

Please note: Disputes must be separated by product and denial code

This dispute is for the US Family Health Plan product and should be addressed to the following mailing location:

US Family Health Plan/ Tufts Health Plan Services
 Provider Payment Disputes
 P.O. Box 9195
 Watertown, MA 02471-9900

Message code:	
If no message code, please state action requested:	
Number of claim disputing:	

For more information or assistance filling this form out, please call a provider specialist at 1-800-818-8589

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Section 7 - Coordination of Benefits/Third Party Liability

Coordination of Benefits (COB)

Coordination of Benefits (COB) applies to members who are covered by more than one health insurance plan. US Family Health Plan processes COB claims utilizing a “pend and pursue” methodology. This means that if a provider bills US Family Health Plan and it is determined that US Family Health Plan is not the primary carrier, the claim will be diverted. This claim will show on the provider’s Statement of Account (SOA) with a system-added detail line, which includes the procedure code 41000009.

Throughout this process, please remember that in order to obtain secondary payment from the US Family Health Plan, the provider and the member must follow plan procedure (i.e., obtain referrals, preregister admissions, etc.), the member must be effective on the date of service, and the service must be considered a covered benefit.

Please note that providers are *prohibited* from billing TRICARE or Medicare under *any* circumstances for services covered by the US Family Health Plan.

Also, please remember that *at no time during this process should providers try to seek payment from the member for services covered by the US Family Health Plan.*

Questions regarding coordination of benefits (COB) may be directed to 1-800-818-8589.

US Family Health Plan requests providers’ cooperation in providing us with other insurance information in order to expedite the processing of claims. This information can be communicated to the US Family Health Plan by calling the numbers listed above.

Third Party Liability

Third Party Liability involves members who are claiming against another party for injuries sustained in an accident. The accident may be motor vehicle, slip and fall, product liability, etc. Under the US Family Health Plan contract, we are required to inform the service JAG when an enrollee is involved with third party liability. US Family Health Plan is required to collect all claim information and forward the same to the JAG for disposition. *Under no circumstances can a provider or the US Family Health Plan make collections under third party liability.* **Do not bill the member or the member’s attorney directly.** Should the member and/or attorney request a direct bill, contact US Family Health Plan Member Services.

Please note that US Family Health Plan has contracted with The Rawlings Company to assist in determining whether treatment received by a member is a result of an accident or injury for which another party may be responsible. The criteria used are based on Government guidelines. US Family Health Plan requests providers’ cooperation in providing the other insurance information in order to expedite the processing of claims.

It is important to note that prior to submission of a US Family Health Plan claim, the provider is not precluded from seeking recovery of its billed charges directly from the liable third party or insurer, including auto or home owners insurance, no-fault auto or uninsured motorist coverage.

Section 8 - Mental Health and Substance Abuse Guidelines

Mental Health Services

Outpatient Mental Health

Description: Medically necessary visits to a provider for the treatment of a Mental Health condition as defined by the most recent DSM diagnosis codes for mental health.

Authorization is required after ten outpatient psychotherapy sessions. Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$25 per individual outpatient visit.

Outpatient Family and Group Therapy

Description: Medically necessary visits to a provider for the treatment of a Mental Health condition as defined by the most recent DSM diagnosis codes for mental health.

Authorization is required after ten outpatient psychotherapy sessions. Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$17 per group outpatient visit. This benefit is separate and distinct from the outpatient mental health benefit.

Inpatient Services for Mental Illness

Description: Inpatient Mental Health Services are treatments for a mental health condition, as defined by the most recent DSM diagnosis codes in an inpatient mental health facility.

When provided or authorized by the member's designated facility, up to 30 days per Plan year for adults (age 19+), up to 45 days per Plan year for children under age 19; up to 150 days residential treatment for children and adolescents. Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$40 per day.

Partial Hospitalization

Description: Visits to a psychiatric facility day / partial hospitalization program without an overnight stay.

When provided or authorized by the member's designated facility, up to 60 days per Plan year. The 60 treatment days are not offset by or counted toward the 30-45 day inpatient limit. Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$40 per day.

Substance Abuse Services

Substance Use Treatment (Inpatient, partial)

Description: Inpatient hospital services and partial care are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization, and for treatment of medical complications of substance use disorders.

When provided or authorized by the member's designated facility, up to 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward the statutory day limit, limiting care for adults (age 19 and over) to 30 days in a Plan year or 30 days in an admission and to 45 days for children (age 18 and under).

Note: The beneficiary may have either 21 days of rehabilitation in a residential (inpatient) basis or 21 days of rehabilitation in a partial hospital setting or a combination of both, as long as the 21-day limit for the total rehabilitation period is not exceeded.

Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$40 per day.

Substance Abuse Treatment (Outpatient Care and Family Therapy)

Outpatient Care

Description: Outpatient care is covered when medically necessary for services related to treatment for alcohol and drug abuse.

When provided or authorized by the member's designated facility, up to 60 visits per Plan year. Note: Outpatient care is covered in a group setting only.

Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$17 per group outpatient visit.

Family Therapy

Description: Family Therapy is covered when medically necessary beginning with the completion of the patient's rehabilitative care.

When provided or authorized by the member's designated facility, up to 15 visits per Plan year.

Active Duty Family Members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay \$17 per visit.

Provider Responsibilities

Designated Facilities are authorized to deliver the following inpatient mental health and substance abuse services to the US Family Health Plan members:

- Mental health and substance abuse inpatient care
- Associated inpatient physician services
- Partial hospitalization services, such as day and evening care
- Triage services - emergency evaluation, referral and admission screening

Members are assigned to a Designated Facility based on their age and Primary Care Provider's referral circle. The Designated Facility is responsible for preregistering admissions or coordinating alternatives when appropriate. If a member is hospitalized, a US Family Health Plan Mental Health Case Manager will provide a quality assurance review for that admission. The Case Manager, and Designated Facility facilitates the member's discharge and directs any outpatient care back to the member's Primary Care Provider or contracting mental health provider. Please contact a Mental Health Care Coordinator at 1-800-208-9565 for a listing of participating facilities.

Pediatric Mental Health/Substance Abuse (Inpatient and Outpatient)

All pediatric (under 18 years of age) mental health and substance abuse services are provided by the Tufts Health Plan network of mental health providers. Please contact a Mental Health Care Coordinator at 1-800-208-9565 for more information.

Psychological/Neuropsychological Testing

Written referrals are not required for psychological/neuropsychological testing. Providers should contact a Mental Health Care Coordinator or Mental Health Service Representative at 1-800-208-9565 to request a Psychological/Neuropsychological Testing Request form. This form can also be obtained at usfamilyhealthplan.org – click on Brighton Marine Health Center, then Information for Providers.

Send the form to the following address:

Tufts Health Plan
Mental Health Department
705 Mt. Auburn Street
Watertown, MA 02742
Attn.: Psychological Testing

Or fax to 617-673-0301

The Tufts Health Plan Medical Director or Psychologist Reviewer will review the information and render a determination. Providers will be notified verbally, within one business day, whether the request was approved or denied.

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Section 9 - Selected Benefit Information

Overview

The following is a brief overview of selected benefits. For more detailed information, call US Family Health Plan Member Services at 1-800-818-8589.

Durable Medical Equipment

US Family Health Plan covers the purchase or rental of certain specified pieces of Durable Medical Equipment from vendors affiliated with Tufts Health Plan.

Tufts Health Plan has developed contracts with several organizations that provide Durable Medical Equipment to US Family Health Plan members under beneficial arrangements for service, quality and cost. (Please call US Family Health Plan Member Services at 1-800-818-8589 for a listing of Durable Medical Equipment Providers).

Definition

As defined in the TRICARE Policy 32 CFR 199.2, durable medical equipment is:

- 1. Equipment for which the allowable charge is over \$100.**
2. Medically necessary for the treatment of a covered illness or injury.
3. Improves the function of a malformed, diseased or injured body part or retards further deterioration of the patient's physical condition.
4. Used primarily and customarily to serve a medical purpose, rather than primarily for transportation, comfort or convenience.
5. Can withstand repeated use.
6. Provides the medically appropriate level of performance and quality for the medical condition present (that is, non-luxury and non-deluxe).
7. Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools or other such items.
8. Is other than spectacles, eyeglasses, contact lenses or other optical devices, hearing aids, or other communication devices.

Acquisition

To acquire Durable Medical Equipment, the ordering PCP contacts the Tufts Health Plan contracted DME vendor. The DME vendor will then call the Tufts Health Plan/US Family Health Plan Case Manager to verify coverage and authorize the rental or purchase of DME if over \$100.

Eye Care

Optometry

US Family Health Plan covers members for one eye examination per enrollment period/Plan year by an EyeMed Vision Care participating optometrist. (The member is responsible for any co-payment.) For a list of optometry providers, call 1-866-504-5908.

Ophthalmology

The US Family Health Plan uses a specific network of Tufts Health Plan ophthalmologists. (For a list of the network ophthalmologists in your referral circle, please call 1-800-818-8589). A referral must be completed by the PCP for any and all ophthalmology services.

Home Health Care

US Family Health Plan covers the cost of medically necessary skilled nursing visits and short-term rehabilitative services for the homebound patient. The services must be authorized in advance by a Tufts Health Plan/US Family Health Plan Case Manager. They must also be provided by a contracted Tufts Health Plan Home Health Care Agency.

To receive authorization, PCPs may refer a member for home health services by calling a Tufts Health Plan contracted Home Health Care Agency. For a list of Home Health Care Agencies, call 1-800-818-8589. The agency is responsible for contacting the appropriate Tufts Health Plan/US Family Health Plan Case Manager for authorization.

Outpatient Rehabilitation

US Family Health Plan covers the cost of skilled short-term physical therapy, speech therapy and occupational therapy only when there is a reasonable expectation that there will be significant improvement in the member's condition.

Wellness Benefits

US Family Health Plan members are eligible to participate in certain health promotion programs as part of their Wellness Benefits. Approved programs include topics such as stress management and smoking cessation. They are located at certain network hospitals. Referrals are not required.

For information regarding approved programs, members can contact Member Services at 1-800-818-8589.

Transplants

US Family Health Plan has contracted with a network of qualified facilities for the exclusive provision of specialized organ transplantation services. Network Providers must notify the Plan of potential

candidates for transplant procedures and request an evaluation of the patient for admission into the transplant program. Call the Tufts Health Plan/US Family Health Plan Case Manager at 617-923-5868.

Pharmacy

US Family Health Plan covers all FDA-approved prescription drugs when prescribed by an authorized US Family Health Plan provider.

The primary pharmacies providing the pharmacy benefit to US Family Health Plan members are located at St. Elizabeth's Health Care at Brighton Marine in Boston and St. Elizabeth's Health Care at Hanscom. For urgent, one-time, or family planning prescriptions, members may utilize a retail pharmacy. A listing of network pharmacies can be obtained by calling 1-800-818-8589. For US Family Health Plan members on chronic prescriptions requiring multiple refills, US Family Health Plan offers a mail order pharmacy service. Applicable co-pays for medication(s) will be charged to members; however, members will not be charged for postage. For more information, please call 617- 562-5300.

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, or attempted 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
- Services and drugs not prescribed or authorized by the enrollee's primary care provider (PCP) or a specialist to whom the enrollee was referred
- Services provided by people who ordinarily reside in the enrollee's household, or the household of the enrollee's covered dependent(s), or are related by blood or marriage or legal adoption to the enrollee or the enrollee's covered dependent(s).
- Services provided or received after the date the enrollee's coverage terminated under the Plan.
- Services and medications not considered medically necessary or appropriate for the enrollee's diagnosis and treatment or services that are experimental or of a research nature
- Any mental health or substance-abuse services denied or not preauthorized by the US Family Health Plan (with the exception of the ten authorized self-referral outpatient mental health visits)
- Any services denied or not approved by the US Family Health Plan's Care Coordination department.
- Any services provided for employment, licensing, immigration, elective travel, or other administrative reasons
- Complications due to a treatment or a service not covered by the Plan

Some Specific Exclusions (This is not all-inclusive.)

- Routine abortions
- Acupuncture and acupressure
- Artificial insemination, in vitro fertilization, and other therapies (including drug therapy) to induce pregnancy
- Autopsy and post mortem

- Aversion therapy in connection with alcoholism
- Bed-wetting correctional devices
- Birth control (over the counter). Other types of birth control such as IUDs and birth control pills are covered.
- Cosmetic, plastic or reconstructive surgery, not connected to medical treatment
- Custodial or convalescent care (Nursing Home care)
- Dental X-rays and services other than routine preventive care are not covered under the Plan (US Family Health Plan offers two professional cleanings and exams per year at Brighton Family Dental)
- Education and training (including visual training)
- Electrolysis
- Eyeglasses and contact lenses *
- Food, food substitutes or supplements, and vitamins consumed outside a hospital, except for home parenteral nutrition therapy (PNT)
- Foot care, except in connection with medical treatment
- Hearing aids
- Hearing examinations, except in connection with medical treatment
- Immunizations for elective travel
- Learning disorders (treatment for)
- Massage therapy
- Megavitamins and orthomolecular psychiatric therapy
- Naturopathic services
- Organ transplants considered experimental
- Orthodontia
- Orthopedic shoes and arch supports, except when part of a brace
- Over-the-counter drugs or vitamins or food supplements
- Private hospital rooms, unless ordered by the attending physician for medical reasons, or if a semi-private room is not available
- Radial keratotomy
- Respite care
- Retirement homes
- Sex change procedures
- Sexual dysfunction services
- Smoking cessation programs (but discounts are available)
- Sterilization reversals
- Transportation for convenience
- Treatment for learning disorders
- Weight control or weight reduction services and supplies *

** Call 1-800-818-8589 for value-added benefit information offered by US Family Health Plan through our affiliation with Tufts Health Plan.*

Section 10 – Care Coordination

Care Coordination Guidelines

US Family Health Plan Providers are expected to participate fully with both Reviewers and Plan staff when sharing clinical information concerning Plan members under their care. This includes the following:

- Following Plan notification procedures for preregistration (Refer to Section 5)
- Following Plan policies for services subject to preauthorization review
- Cooperating with hospital and Plan staff concerning case management and discharge planning activities
- Responding promptly to Plan staff regarding outpatient or inpatient utilization concerns raised either concurrently or retrospectively as a consequence of the care coordination process
- Complying with the Plan's confidentiality policy

A quick response is especially important when inpatient care is involved. More cost-effective management of the patient can often avoid the high cost of even one extra inpatient day. To facilitate this, respond to contacts regarding current or pending inpatient stays that same day; respond to contacts regarding completed or more distantly anticipated inpatient stays promptly, recognizing that a same day response is less crucial. **An administrative denial may occur for lack of information.**

Care Coordination Program

The goal of the Care Coordination Program is to monitor the delivery of health care services and ensure that all services meet Plan requirements for coverage under benefit and medical necessity guidelines. This program's scope encompasses all health care delivery activities.

The areas reviewed by the Care Coordination Program include the following:

- Inpatient care
- Outpatient care
- Office care
- Home care
- Extended Care
- Some prescription drugs

To permit the reviews noted above, the Care Coordination Program is responsible for the following:

- Establishing and disseminating criteria that addresses issues of medical necessity
- Monitoring services provided in accordance with the applicable practice guidelines
- Implementing programs designed to improve compliance with the guidelines
- Evaluating program results and providing feedback to US Family Health Plan providers
- Redesigning and implementing further programs as necessary

The Care Coordination Program consists of a number of interdependent and related elements:

- Referral management for outpatient services that require Plan approval
- Outpatient claims review using code review and other utilization reports
- Pre-admission authorization (review prior to inpatient or SDC admission)
- Concurrent review (review during admission)
- Retrospective review (review after discharge)
- High cost case management (review of high cost, exception to benefit cases in all treatment settings)

Each Provider Unit has a designated Physician Reviewer. However, the US Family Health Plan specifically reserves the right to make a final determination on any care coordination decisions.

Referral Management

The Primary Care Provider's authorization is required when a member seeks services. The PCP is the "gatekeeper" and is responsible for planning and managing care in an efficient manner. Specialist claims are paid based on referrals by the PCP. Please see "Section 4 - Referral Management" for more information.

Outpatient Services Review

Outpatient services review is performed in a number of ways. As a gatekeeper model, the Primary Care Provider (PCP) directs and manages member access to most specialty care based on clinical need. Upon written, prior authorization to a specialist, the PCP specifies the maximum number of times that a member may be seen for evaluation, testing and treatment. The specialist is expected to communicate findings to the PCP and seek authorization for further treatment and, if necessary, a second referral.

In addition, certain outpatient services are centrally reviewed and managed. These include the following:

- Home nursing care
- Physical therapy and Occupational Therapy (see page 17)
- Durable medical equipment
- Outpatient MH/SA services
- Transportation services

Retrospectively, outpatient services review is conducted using Code Review and other utilization reports that are routinely produced. These reports identify aberrant patterns of care. Further analysis occurs and action steps taken with the provider of care, as indicated. Broad claims issues are also identified and administratively addressed by the Plan.

Preregistration Notification Process and Prospective Utilization Review

Preregistration notification of all elective, urgent, and emergency admissions is required.

Preregistration notification is a condition of payment for US Family Health Plan facilities. When an admission is reported, the following steps occur:

- Confirm that the member's Primary Care Provider has authorized the care by reviewing referrals
- Verify member eligibility
- Screen for potential coverage/benefits exclusions
- Match the member with his referral circle and reroute members who receive services in an inappropriate setting (i.e., inpatient rather than outpatient) or in a non-authorized, out-of-plan facility
- Identify the admission so that the appropriate case manager can begin early identification of the member's potential discharge needs

Since "managing" care requires continuity and planning, the Preregistration Unit is often the first to recognize that there is a problem with an admission and the first to take steps to correct the problem.

When the preregistration notification process is completed, a preregistration number is assigned to the admission. This number is used as a reference number for payment of claims associated with that particular hospitalization.

Prospective and Concurrent Utilization Review of Inpatient Services

Prospective utilization review for coverage of inpatient services is conducted for selected procedures, diagnoses or facilities. The services that are reviewed are as follows:

- Preoperative inpatient hospital days
- Out-of-plan elective surgeries and medical procedures
- Admission to skilled nursing facility (SNF) or acute rehabilitation hospital
- Mental health, substance abuse, and acute residential treatments requests for admission to all non-designated facilities

In some instances, the Tufts Health Plan or US Family Health Plan medical director may render a concurrent adverse determination of continued coverage for an inpatient hospitalization, acute rehabilitation, or SNF admission. This may occur on a rare basis when an attending physician has written a discharge order and the member disagrees with the treatment plan and refused discharge. This may also occur if a member only qualifies for custodial level of care, which is excluded from benefit coverage. Services will be continued without liability to the member until the member has been notified of the determination.

Inpatient Case Management and Discharge Planning

The Tufts Health Plan /US Family Health Plan case managers work with the continuing care staff in the inpatient facility to identify any special services that a member might require upon discharge. The Tufts Health Plan /US Family Health Plan case managers work closely with the provider unit reviewers and the US Family Health Plan medical director as they help coordinate care for the members throughout the continuum. Case management may be conducted on-site or through telephone review.

These individuals, along with attending physicians, hospital administrators and staff, work to ensure that the care received by each patient is as follow:

- Medically necessary
- Meets quality requirements
- Provided in the setting appropriate to the patient's needs and physical condition
- Referred to contracting providers, agencies and vendors

This requires an on-going evaluation of each patient's medical record and communication with caregivers from the day of admission through discharge. Key terms and concepts incorporated into the medical necessity screening criteria used in case review include items addressing the following:

- Severity of illness - how sick is the patient?
- Intensity of services - what services is the patient receiving?
- Level of care - what type of setting, along with services to be provided, would be safe for the patient, hospital, nursing home, and rehabilitation facility?
- Length of stay - the number of days the patient remains in a facility

General guidelines are available that enable the US Family Health Plan to anticipate the duration of a hospitalization. The actual length of the hospitalization, however, will vary with the patient's speed of

recovery and condition. The Care Coordination process takes these variations into consideration. Extensions in the initially assigned length of stay will be approved or not approved, depending upon the patient's medical progress and needs.

The majority of admissions are authorized as medically necessary. However, there are occasions when all or part of a stay is not approved. In the event that a denial or termination of benefit occurs, an appeal option is available.

Retrospective Review

US Family Health Plan, at times, will retrospectively review treatment to determine whether the treatment provided was medically necessary, and therefore, a covered service. Retrospective utilization review is utilization review of medical necessity of services after they have been provided to a member. Retrospective review may occur on-site in a facility or after a copy of a medical record has been obtained by the US Family Health Plan. It is used primarily as an adjunct to telephone concurrent review of out-of-plan/area admissions or in specific problem cases where concurrent review on-site has already occurred, but a review of the completed medical record is desired. Discussion of a case at the Tufts Health Plan/US Family Health Plan Utilization Review meeting is also a form of Retrospective Review.

Case Management Program

The Tufts Health Plan/US Family Health Plan employ registered specialty nurses who are responsible for home care authorizations, case management and risk management interventions. Case Management provides services for medically complex situations in which the patient is likely to require extensive coordination of services. They also provide services for medically complex cases, including transplant and oncology patients.

The case managers are available to identify obstacles to care, research availability of community resources and maximize services available to US Family Health Plan members. For more information, please call 1-800-818-8589.

Specialty programs and services incorporated in the Case Management Department are as follows:

Specialty Case Management Program

The Specialty Case Management Program provides comprehensive case management services across the health care continuum to members who present with complex medical situations, failed home care plans, high utilization of services, and barriers to care. The specialty case manager is a registered nurse who works with the member and provider to develop, implement, and monitor an individualized cost-effective plan of care which meets the member's medical needs in the most appropriate and least intensive setting.

Transplant Case Manager

The Tufts Health Plan/US Family Health Plan medical director reviews all requests for coverage of a transplant, including solid organ and bone marrow transplant (BMT). The transplant requests need to be submitted to the transplant case manager. The transplant case manager follows the member across

the continuum starting with the pre-authorization process through the discharge to home. The transplant case manager will also follow the member for any future service needs after the transplant case is closed.

Some examples of transplant case management interventions are as follows:

- Coordinating the authorization process and notification of the determination to the member, PCP, and transplant team
- Acting as the US Family Health Plan liaison for the member and transplant team throughout the transplant process
- Serving as a resource for the member regarding available community support groups and benefits related to transplant fund-raising and transportation
- Offering discharge needs support and education to both member and caregiver

High Risk Obstetrical Case Management

The obstetrical (OB) specialty case manager provides case management services through the continuum for members whose pregnancies are complicated by additional medical issues or obstetrical complications. The members at risk for pre-term delivery are followed through the Healthy Birthday Program.

Some examples of OB case management interventions are as follows:

- Assisting with the coordination and coverage certification of complex home care plans for members who fall into high risk status
- Coordinating and facilitating ongoing complex home care services to decrease the risk of complications leading to hospitalization
- Acting as a resource to plan physicians and other US Family Health Plan staff in matters related to services for the high risk OB member

Out-of-network Review and Case Management

A case manager is responsible for concurrent review, discharge planning and assistance with in-plan transfers for all out-of-network inpatient admissions.

Transition-To-Home Program

A case manager facilitates the transition of members from an acute hospitalization to the home setting. They reconcile discharge medications and arrange for appropriate follow-up care for the member.

Provider Appeals Procedures

Purpose

To provide a formal, multi-level mechanism for dissatisfied providers to appeal to the US Family Health Plan for payment of denied services.

Provider Appeals: Standard Level I Procedure

1. The Appealing Party must file reconsideration request within 90 calendar days of the Date of Initial Plan Determination. Written requests from any provider for reconsideration of any payment, benefit or utilization decision made by the US Family Health Plan or by a provider unit are directed to:

Tufts Health Plan
P. O. Box 9193
Watertown, MA 02471-9190
Attn: Appeals and Grievances Department

The objective of a request for consideration is to allow the requester and reviewer an opportunity to discuss the clinical issues in the case and to understand the underlying rationale for each of the clinical opinions. It also ensures that the requester is satisfied that all relevant information has been discussed, reviewed and considered by the reviewer making the final determination.

A copy of the claim(s) in question and any relevant operative and/or therapy notes; and any supporting documentation necessary to support the appeal must accompany letters requesting reconsideration.

2. The Tufts Health Plan /US Family Health Plan Provider Appeals Committee is comprised of representatives from the:
 - Network Medical Services department
 - Clinical Review department
 - Operations
 - Preregistration department
 - Mental Health department
 - Case Management

In addition, ad hoc members attend as needed. For example, legal counsel, medical director or other key person would attend, if circumstances warrant.

1. Within **ten business days** of an appeal's receipt, a letter is sent to the provider acknowledging receipt and that a written response is forthcoming that will outline the Committee's decision.
2. A written response outlining the decision of the Committee is generally sent to the provider within **ten business days of the Committee decision**.

The Provider Appeals Committee meets twice a month or more frequently as the volume of appeals dictates. Typically, an appeal is resolved on average 45 days from receipt but always within 60 days

of receipt. In certain situations, an extension of time may be warranted for information gathering, chart review, and member contact and claims adjudication.

Provider Appeals: Standard Level II Procedure

1. The provider may appeal a Level I determination to Level II—**in writing**—to the US Family Health Plan Appeals Committee at:

Tufts Health Plan
PO Box 9193
Watertown, MA 02471-9190
Attn: Appeals and Grievances Department

The provider may submit issues and any relevant information not presented at the Level I meeting.

2. A committee meeting will make a determination on the case **within 30 business days** of receipt of the appeal. The Committee will review all pertinent information and make a determination. The Committee will notify the **provider within 30 business days** of receipt of the written appeal. The determination of the claim denial shall specify the reason(s) for denial with specific reference to the Plan provisions on which the denial is based, if appropriate.

The provider may appeal a Level II determination to a third and final level of appeal to the TMA Appeals and Hearings Division in Colorado. Third level appeal information, if applicable, will be provided in the Level II decision letter.

3. If special circumstances, such as unavailability of pertinent records, require an extension of time for processing and investigating the claim, written notice will be sent to the provider prior to the termination of the initial 30 day period.

The extension **shall not exceed** a period of 45 working days from the end of the initial period. The extension notice shall inform the provider of the special circumstance requiring an extension of time and the date the Committee expects to make a determination.

4. A written response outlining the decision of the Committee is generally sent to the provider within **10 business days of the Committee decision**.

Provider Appeals: Expedited Appeals

An appeal may be expedited when there is an ongoing service requiring review or a service that the attending MD or other prescribing provider believes that the determination warrants an immediate appeal. A Tufts Health Plan or US Family Health Plan medical director is available by phone to providers to discuss coverage determinations based on medical necessity. In addition, providers have the opportunity to seek reconsideration of an initial or concurrent denial of coverage decision from a board-certified, actively practicing, clinical peer review in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. This reconsideration process occurs within one working day of the receipt of the request and is conducted between the provider rendering the service and the clinical peer reviewer or clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the reconsideration process does not reverse

the denial of coverage determination, the provider may pursue the appeals process on behalf of the member.

A provider requesting an expedited appeal must contact the Case Management Department. Please call Member Services at 1-800-818-8589, and ask for the Case Management Department.

Observation Services

The Observation Program ensures that medically necessary care is provided in the most appropriate setting. Utilization experience has shown that inpatient admissions can be avoided in cases where short-term, intensive outpatient management successfully stabilizes and improves the patient's condition and permits the patient to return home. However, the US Family Health Plan does not expect observation services to be used as a replacement for medically appropriate inpatient admissions.

The following information highlights some important points of this program:

- When medically appropriate, observation care is an option for patients whose problems are reasonably expected to be resolved within 23 hours.
- Up to 48 hours of outpatient observation services may be authorized by the Plan when medical necessity has been clearly demonstrated.
- No referral or preregistration is necessary for observation services.
- Procedures performed on patients in observation status will continue to need a referral (and possibly preregistration) for that procedure.
- Hospitals must follow preregistration procedures for members who are admitted to inpatient status following observation services.
- Facilities must use appropriate CPT codes for observation services. Please reference the CPT coding manual when billing. Observation services will be reimbursed at the contracted rate.
- Mental health and substance abuse observation services must be provided or coordinated by a member's Designated Mental Health Facility.
- US Family Health Plan may retrospectively review observation services for medical necessity to ensure compliance with US Family Health Plan guidelines.
- Hospitals will be reimbursed for both observation care and an inpatient admission when the observation care extends over the midnight census and results in an inpatient admission the following day. If the observation services and admissions commence on the same calendar day, US Family Health Plan will only pay for the admission.

Conditions Appropriate for Observation Services

The Admission Monitoring List includes conditions that are usually appropriate for observation care. Some patients with these diagnoses require inpatient care, and some patients with other diagnoses are clinically appropriate for observation care. The Tufts /US Family Health Plan medical directors reviewed this list annually.

Adult Medical

- Abdominal pain
- Anemia, unspecified
- Angina
- Bronchitis
- Cellulitis
- Chest pain
- Dehydration
- Diabetes Mellitus without electrolyte imbalance
- Dizziness

- Fever of unknown origin
- Gastritis
- Gastroenteritis
- Gastrointestinal bleeding
- Meningitis, rule out viral
- Migraine headaches
- New onset seizures

- Phlebitis, rule out
- Pneumonia
- Pyelonephritis, acute
- Renal/colic/kidney stone
- Renal failure, chronic
- R/O sepsis

- Syncope, questionable etiology
- Upper limb dislocations
- Upper limb closed fractures

Pediatric Medical

- Abdominal pain
- Asthma
- Bronchiolitis
- Cerebral concussion
- Croup

- Gastroenteritis
- Mononucleosis
- New onset seizures
- Otitis Media
- Pharyngitis

- R/O sepsis
- Upper limb dislocations
- Upper limb closed fractures

Obstetrical

- Cerclage procedure for incompetent cervix (Cerclage is generally performed as an outpatient procedure. When complicated by uterine contractions, a trial observation case may precede a decision to admit the inpatient.)
- False labor
- Hyperemesis gravidarum
- Hypertension in pregnancy
- Premature labor
- Prodromal labor
- Spontaneous abortion
- Threatened abortion

Induction of Labor

- Prostin/prepidyl therapy
- Sleep therapy
- Trial of Pitocin

Observation Care with Surgical Day Care

Many facilities now use observation care following some surgical procedures to extend surgical day care (SDC) beyond the date on which the procedure took place. The US Family Health Plan does not reimburse facilities a separate fee for the observation care, but pays only the ambulatory surgery fee for the SDC, if it is authorized in advance.

The facility or attending physician's office must call the preregistration department to report the inpatient admission when the member has a surgical procedure (Day 1) followed by observation care into the following day (Day 2), then requires inpatient admission on Day 2. A record will then be created for the inpatient portion of the care. These records are always pended and given to a Preregistration Clinical Specialist for review and discussion with a Medical Director. Each case is reviewed individually, but the following criteria will be used in most cases to reach a decision.

- If the patient is discharged any time on Day 2, even late in the evening, an inpatient admission is not authorized. The facility receives only the SDC reimbursement.
- If the procedure was such that the patient could reasonably be expected to go home on Day 2, but the patient developed unforeseen complications or recovered more slowly than expected and required acute hospital level of care into Day 3, the inpatient admission is approved.
- If, on the date the surgery is performed the patient requires more extensive surgery than was planned, e.g., laparotomy versus laparoscopy, or the procedure planned is not consistent with SDC, e.g., patient not expected to go home on Day 2, then the case is made inpatient starting on Day 1 and the facility receives per diem rate for each day of the hospitalization, including the date of the surgery.
- Hospitals have the option of admitting patients on the date of the procedure, if an inpatient stay becomes necessary. In this case the entire stay is considered an inpatient stay. The Preregistration Department must be notified of the inpatient admission by the next business day. The Tufts Health Plan/US Family Health Plan case manager and possibly the US Family Health Plan Utilization Review Committee will review the case for medical necessity of the inpatient stay.

Section 11 – Quality Management Guidelines

Quality Management Program Purpose

US Family Health Plan is committed to delivering high-quality, cost-effective health care in a manner that improves the health and quality of life of our uniformed services members. It is policy of US Family Health Plan to require the highest standards of professional performance from its health care providers and support staff. US Family Health Plan actively promotes continuous quality improvement through a comprehensive quality management program. US Family Health Plan defines quality as the degree to which a product or service conforms to the needs, wants, and expectations of the customer.

Medical Care Access Goals for Primary Care Offices

Access to medical care services is a key component of the quality of health care. It is necessary that patients be able to access their physicians, recognizing that in a life-threatening situation, patients are expected to obtain care at the nearest medical facility.

Additionally, the US Family Health Plan is required by the terms of the Department of Defense contract to meet specified administrative standards.

The obligations of the contracted providers as related to clinical practice include the following:

Access Times for Health and Medical Services

The US Family Health Plan requires that members be afforded access to health care services authorized by the Plan within specific maximum time periods contingent upon medical necessity and in a manner which ensures continuity of care. The following defined categories of health care with access times and compliance standards are provided as a standard of access to care. This standard applies to care rendered in the private office as well as the clinic setting.

Definitions

Acute Care is that primary or specialty health care that is required before the next scheduled appointment time and if delayed will cause harm or deterioration in the member's condition.

Routine Care or **Non-Acute Care** is that care which is necessary to maintain and promote the health and well being of the member. The primary care provider provides routine care.

Urgent Care is that care which is required within several hours, and in all cases, within twenty-four hours, after the onset of the illness or injury. The illness or injury is not life threatening.

Emergency Care is that care which is required immediately for the sudden and unexpected onset of a medical condition or acute exacerbation of a chronic condition that is threatening to life, limb, or sight; or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering.

Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and other acute medical conditions.

Specialty Care is that care which is provided by specialized physicians who deal with specific diseases, conditions or systems. Specialty care is provided when a referral is made to the specialist by the primary care provider and when the referral is authorized by the Plan.

Access Times For Member Visits

Emergency	<i>Immediately</i>	Available and accessible 24 hours-a-day, 7 days a week.
Primary Care Well Visit Non-Acute Acute Care	Not to exceed <i>4 weeks</i> Not to exceed <i>1 week</i> Not to exceed <i>1 day</i>	<i>Travel time = 30 minutes</i> from home to delivery site (members must sign waiver if they live further than 30 minutes away).
Specialty	Not to exceed <i>4 weeks</i> . The appropriate waiting time shall be determined by the primary care provider who is making the referral based on the nature of the care required.	<i>Travel time =1 hour</i> (if a longer trip is required, due to an exception for special services not sufficiently available in the area, the member should be informed of the situation).
Office Wait	Not to exceed <i>30 minutes</i> for non-emergency situations.	

Validation Reviews

The Government or National Quality Monitoring Contractor (NQMC) shall conduct validation reviews on a sample of cases selected monthly based upon criteria limited to issues of medical necessity, appropriateness of care, level of care, reasonableness of care, and intensity of services.

Providers have 30 calendar days from the date they receive the case selection notification to provide hard copies of the medical record and all case documentation for each case requested for review. (Note: Providers at St. Elizabeth’s Medical Center, St. Elizabeth’s Health Care at Brighton Marine, and St. Elizabeth’s Health Care at Hanscom have 15 calendar days to submit these materials.)

Government Audits

The government will provide a 30-day notice prior to conducting routine audits relating to services rendered to enrollees of the US Family Health Plan, but reserves the right to conduct unannounced audits if it has information that the beneficiaries’ care is being seriously jeopardized.

Medical Record Standards

Medical Record Confidentiality

The US Family Health Plan considers all medical records to be confidential and requires that all US Family Health Plan physicians accomplish this objective by adhering to the following guidelines:

- Maintaining medical records in a space staffed by office personnel
- Maintaining medical records in a locked office when staff is not present
- Not permitting unauthorized review and/or removal of medical records without a patient's authorization

Medical Record Documentation

A medical record is created for all members receiving services from the US Family Health Plan. This record serves to document the delivery of quality patient care. The medical record must be complete and fully record all aspects of care provided.

All services rendered by Plan providers must be documented in the US Family Health Plan medical record. Documentation of authorized services such as operative procedures must be sent to the respective Medical Records Department within thirty (30) days of the performance of the procedure.

The medical record is the property of the US Family Health Plan. The record is maintained in accordance with the standards of the Joint Commission on Accreditation of Hospitals as well as other regulatory bodies that control the licensing and accreditation status of the health care organization.

The medical record information is considered confidential and is disclosed only upon written authorization from the patient (or legal guardian, if applicable), as required by statute or upon request from the Plan.

Clinical Quality Improvement Program

In collaboration with Tufts Health Plan, US Family Health Plan's comprehensive Quality Improvement Program monitors providers to improve the quality of clinical care and service delivered. This program encompasses a variety of activities that seek to cover many important aspects of health care delivery.

The areas under the direction of the Medical Director and Quality Improvement Program include the following:

- Review of inpatient care
- Review of outpatient care
- Review of home care
- Monitor services provided in accordance with evidence-based guidelines and medical care
- Develop, design, and implement clinical improvement studies and initiatives, HEDIS and Non-HEDIS.
- Monitor, track, trend, and analyze member and provider satisfaction
- Identify, develop, and implement programs designed to promote and improve health care
- Evaluate program results and give feedback to providers

- Redesign and implement future programs as necessary
- Creating and maintaining a system to manage patient complaints and grievances to meet the requirements of the DoD contract.
- Coordinating/conducts medical record review audits, analyzes utilization data, HEDIS indications and other relevant information to assess health care quality.
- Manages annual member satisfaction survey conducted by external vendor.

Patient Safety Program

Potential Quality Indicators / Quality Issues / Patient Safety

As part of its core mission, US Family Health Plan has a process in place for developing and implementing written policies and procedures to identify potential quality issues, and to take steps to resolve identified problems. All US Family Health Plan providers are expected to participate in an evidence-based patient safety program. An essential part of the USFHP patient safety program is the identification and reporting of patient safety and quality issues that affect our members.

At a minimum, as required by our DoD contract, US Family Health Plan must identify, track, trend, and report interventions to resolve the following Potential Quality Indicators and Quality Issues. USFHP providers are required to submit a monthly (see below) **Potential Quality Indicator Report** to Quality Management for US Family Health Plan members. The provider should apply medical judgment and follow the TRICARE criteria for the identification, evaluation and reporting of all patient safety or quality issues. Reports may be sent to the following address:

US Family Health Plan
Quality Management Department
77 Warren St.
Brighton, MA 02135

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 7, SECTION 4

CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)

The contractor shall identify, track, trend, and report interventions to resolve the following PQIs and QIs:

Event	Additional Specifications	No	Actual	I	Patient Safety And/Or Quality Issue (I)			Sentinel Event
					Severity Level 1	Severity Level 2	Severity Level 3	Severity Level 4
Medical, Surgical, Inpatient, Outpatient, Skilled Nursing, Mental Health Facility, Office Visit								
1. SURGICAL EVENTS A. Surgery performed on the wrong body part	Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.							
B. Surgery performed on the wrong patient	Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.							
C. Wrong surgical procedure performed on a patient	Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.							
D. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained							

Event	Additional Specifications	No Actual I	Patient Safety And/Or Quality Issue (I)			Sentinel Event
			Severity Level 1	Severity Level 2	Severity Level 3	Severity Level 4
E. Intra-operative or immediately post-operative death in an ASA Class I patient	Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.					
F. Postoperative sepsis						
2. PRODUCT OR DEVICE EVENTS A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and /or product.					
B. Patient death or serious disability associated with the use or function of a device in patient care in which the device issued or functions other than as intended	Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.					
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility	Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.					
3. PATIENT PROTECTION EVENTS A. Infant discharge to the wrong person						

Event	Additional Specifications	No Actual I	Patient Safety And/Or Quality Issue (I)			Sentinel Event
			Severity Level 1	Severity Level 2	Severity Level 3	Severity Level 4
B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	Excludes events involving competent adults.					
C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility	Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the health care facility					
D. Patient Falls						
4. CARE MANAGEMENT EVENTS A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	Excludes reasonable differences in clinical judgment on drug selection and dose					
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products						
C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility	Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.					

Event	Additional Specifications	No Actual I	Patient Safety And/Or Quality Issue (I)			Sentinel Event
			Severity Level 1	Severity Level 2	Severity Level 3	Severity Level 4
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility						
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	Hyper bilirubinemia is defined as bilirubin levels > 30 mg/dl. Neonates refers to the first 28 days of life.					
F. Stage 3 or 4 pressure ulcers acquired after admission to a health care facility	Excludes progression from Stage2 to Stage 3 if Stage 2 was recognized upon admission					
G. Patient death or serious disability associated due to spinal manipulative therapy						
5. ENVIRONMENTAL EVENTS A. Patient death or serious disability associated with an electric shock while being cared for in a health care facility	Excludes events involving planned treatments such as electric counter shock					
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances						
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility						
D. Patient death associated with a fall while being cared for in a health care facility						

Event	Additional Specifications	No Actual I	Patient Safety And/Or Quality Issue (I)			Sentinel Event
			Severity Level 1	Severity Level 2	Severity Level 3	Severity Level 4
E. Patient death or serious disability associated with the use of restraint or bedrails while being cared for in a health care facility						
6. CRIMINAL EVENTS A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider						
B. Abduction of a patient of any age						
C. Sexual assault on a patient within or on the grounds of a health care facility						
D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care facility						

3.0. PATIENT SAFETY OR QUALITY ISSUE IDENTIFICATION

The contractor shall apply medical judgment and follow the TRICARE criteria for the identification, evaluation and reporting of all patient safety or quality issues.

Department of Defense Quality Monitoring

A monthly Potential Quality Indicator Report will need to be submitted to Quality Management for US Family Health Plan members.

The Department of Defense has also directed us to participate in a quality-monitoring project. Cases are randomly selected for medical record review in order to evaluate the health care that has been provided. Quality Management manages and supports the National Quality Monitoring Contractor medical record audit program.

We are required to provide all information on these cases within thirty (30) calendar days from the date of selection. In order to fulfill our obligation, we ask that you please send us the specified medical record as soon as possible. As a TRICARE provider and a contracted network facility for the US Family Health Plan, you are required to provide such information for the purpose of evaluation of medical care and quality improvement upon request.

Please note that upon joining US Family Health Plan, subscribers sign a release that authorizes providers to share medical information with US Family Health Plan for the purpose of evaluation of medical care and quality improvement. You're providing the specified medical record is in compliance with the HIPAA Privacy Regulations as it is for the use and disclosure of Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO).

Confidentiality of medical record data is strictly upheld. All of the medical records that you send to us will be destroyed upon completion of this project. Again this is a Healthcare Operations purpose, under HIPAA, and as such does not require a signed authorization from the patient(s).

Member Complaint Process

The member complaint process is a mechanism by which members of the US Family Health Plan can express concerns relating to a provider's behavior or treatment. The process was developed as part of the US Family Health Plan Quality Improvement Program to collect and investigate such issues. The US Family Health Plan is committed to investigating and responding to each member's concern within 30 days of receipt.

Administrative Grievances

1. When the US Family Health Plan receives a grievance from a member (verbal or written) by Member Services or Quality Management, consent is obtained to use member name and pursue investigation of issue.
2. US Family Health Plan issues acknowledgement letter to member within 10 calendar days of receipt of grievance.
3. US Family Health Plan investigates complaint.
4. Written response sent to member within 30 calendar days of receipt of grievance. Notification is sent to Quality Management. Quality Management documents and files completed grievance.

Quality of Care Grievances

1. When the US Family Health Plan receives a grievance from a member (verbal or written) by Member Services or Quality Management, a consent is obtained to use member name and pursue investigation of issue.
2. Quality Management issues an acknowledgement letter to member within 10 calendar days of Receipt of grievance.
3. Quality Management investigates grievance.
4. Written response is sent to the member within 30 calendar days of receipt of grievance. Quality Management documents and files completed grievance.

Member Grievance and Appeal Process

The US Family Health Plan is required to provide its members with a grievance and appeals process. This process is designed to reconsider decisions concerning benefits under their US Family Health Plan coverage. Plan members' Member Handbook provides specific information on how to access this system.


Members should be referred to Member Services for any concerns about coverage, Plan policy, etc., where an initial attempt to define and resolve their concerns will be made. If not satisfied, a member may write a letter to initiate the Member Grievance Process. If not resolved at that level, a letter may be written to the US Family Health Plan Appeals Committee to initiate the second level Member Appeals Process. Finally, if not resolved at that level, a member may appeal to the US Family Health Plan Program Office in Washington, D.C.

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Section 12 – US Family Health Plan Card, Information Directory and helpful Web Sites

Member ID Card

(Front)


SAMPLE MEMBER
ID#: 888888888 01
Sex: M **Group ID:** 12001406
Primary Care Provider:
SAMPLE PROVIDER, M.D. (508) 555-5555
Primary Care Site: UMASS MEMORIAL MEDICAL GROUP
Medical Copayments:
OV: \$0
ER: \$0


MH/SA: \$0
Fitness Site: CENTER NOT SPECIFIED
Caremark RXBIN 610415 RXGRP E000-6231

(Back)

www.usfamilyhealth.org
Please refer to your Member Handbook for a full description of your benefits. To verify benefits, view claims, or find a provider, visit our website or call:
Member Services: (800) 818-8589
TDD: (800) 868-5850
Nurse Advice Line: (866) 767-4546

Emergencies: Go to the nearest medical facility or call 911 (or the local number for emergency medical services). Your PCP or Member Services must be contacted within 24 hours for follow up care.
Non Emergencies: Contact your PCP before using medical services. If your PCP is unavailable, call Member Services. Care not authorized by your PCP may not be covered. Please call (800)672-1515 to pre-register for hospital admissions not authorized by your PCP.

Claims Address:
US Family Health Plan
P.O. Box 9195
Watertown, MA 02471-9900


Administrative services for the Uniformed Services Family Health Plan from Brighton Marine are provided by Tufts Health Plan, Inc. US Family Health Plan is a designated provider of the TRICARE Prime Uniform Benefit.

Glossary of Terms and Abbreviations

Acronym	Full Title	Definition
PU	Provider Unit (Independent Physicians Association)	A Grouping of Physicians gathered together under one business entity focused on delivering health care services.
PCP	Primary Care Physician	The members' primary care Doctor who will manage all aspects of members' healthcare needs.
	Referral Circle	Specialists and other PCP providers that are associated with the US Family Health Plan network. PCP can only refer members to doctors within this network. Outside the network referrals, must be approved by contacting US Family Health Plan Care coordinator at 617-562-5583 prior to sending patient.
US Family Health Plan	Uniformed Services Family Health Plan	The US Family Health Plan is a TRICARE Prime option available to families of active duty military, military retirees and their eligible family members, including those age 65 and over, through networks of community-based hospitals and physicians in six areas of the country. US Family Health Plan enrollment is offered throughout Massachusetts, Rhode Island, and portions of southern New Hampshire and northern Connecticut by Brighton Marine Health Center, a not-for-profit health care organization located in Boston.

Helpful Web Sites

Description	URL
US Family Health Plan	www.usfamilyhealth.org
Agency for Healthcare Research and Quality. Evidence Based Patient Safety Practices	http://www.ahrq.gov/
National Patient Safety Foundation	www.npsf.org
Institute of Safe Medication Practices	www.ismp.org
National Quality Forum	www.qualityforum.org/
Joint Commission on Accreditation of Healthcare Organizations	www.jcaho.org
Healthy People 2010	www.healthypeople.gov
Tricare Policies and Regulations	http://manuals.tricare.OSD.mil
Health Information from the National Library of Medicine and the NIH	www.medlineplus.gov
Department of Defense Patient Safety Information	www.DoDpatientsafety.USUHS.mil

Uniformed Services Family Health Plan
PO Box 9195
Watertown, MA 02471-9900

1.800.818.8589
usfamilyhealth.org

