US FAMILY HEALTH PLAN
A TRICARE Prime® Option

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The Beat

A Quarterly Supplement to the Provider Pulse Beat from USFHP

Contents

POA Indicator

- UB claims require a “present on admission” indicator for the ICD-10 codes.
- Some ICD-10 codes are exempt and do NOT require an indicator on an electronic claim.
- Exempt ICD-10 codes filed on a paper claim require an indicator of “1”.
- Due to the Change Healthcare outage, large amounts of claims are being filed on paper. Multiple claims are being denied due to the exempt ICD-10 codes NOT having an indicator of 1.
- Providers MUST file a corrected claim with a POAI of 1 on a paper form or submit a corrected claim with NO POAI via electronic submission for claims to be reprocessed.

Clean Claim

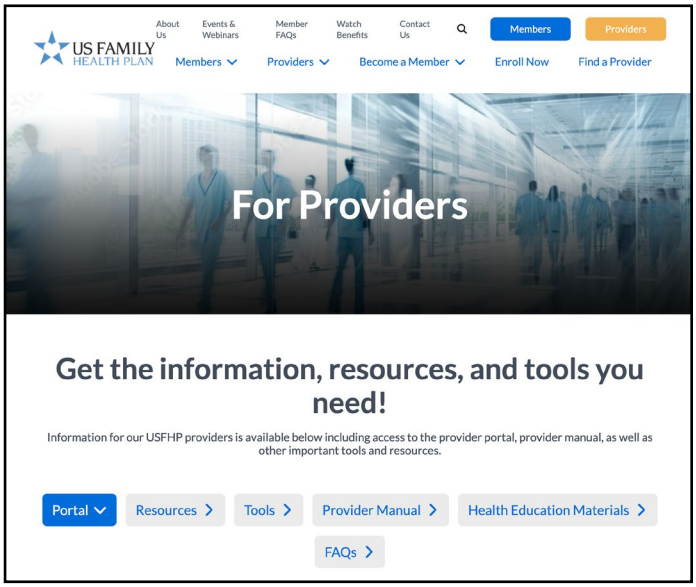
The term clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Modifier 51

Historically, USFHP denied claims, which should have been filed with a 51 modifier but it was not on the claim. This is no longer accurate.

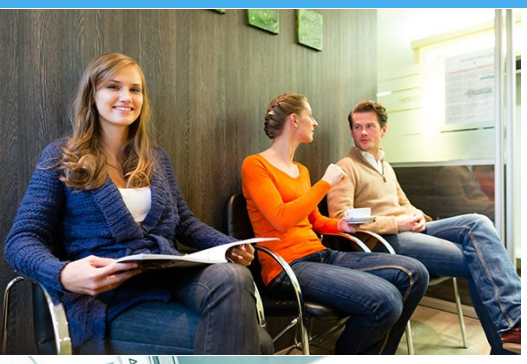
Currently, when a claim processes and is impacted by the modifier 51 edit, our claims processor will append an informational remark code to the EOP indicating the service reimbursement has been altered due coding requirements for the 51 modifier. All service lines impacted by the automated application of the requirements of the 51 modifier are auto-reduced by 50% and payment is made based on the reduction of the allowable.

New and Improved Provider Website



Our Provider Website has gone through major updates with more resources and forms added to make it easier to keep your provider demographics up-to-date and accurate.

https://usfhp.net/for-providers/



USFHP Access and Availability Standards

TYPE OF VISIT	TIME
Emergency Care	Immediate
Urgent/Acute Care	Appointment within 24 hours
Routine Office Visit	Appointment within 1 week
Well/Preventive Health Visit	Appointment within 4 weeks
Specialty Consultation or Procedure	Appointment within 4 weeks
Follow-up Visit	As required by Provider
Office Visit Wait Time	Less than 30 min

Referral Tracking and Reporting Requirements

All network specialists must provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the enrollee's primary care provider within 30 (thirty) working days of the specialty encounter. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the enrollee's primary care provider within 24 hours by telephone, fax, upload to the EMR or a formal written report provided within 10 (ten) working days. If your practice is chosen to participate in our random consult report audit, please respond in the requested turn around time.

Interested in partnering with HEDIS and Population Health at USFHP?

Our Population Health Team would love to hear from you!

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