



US FAMILY
HEALTH PLAN
Caring for our Uniformed Services Family

Provider Manual

US Family Health Plan

The US Family Health Plan (the Plan) is a congressionally legislated health care program for the Military Health System. The program is a full risk, HMO-like benefit plan that arranges for the provision of medical care for military beneficiaries. Providers who participate with the Plan receive excellent customer and health care management service, as well as the satisfaction of providing health care to America's military families.

About this manual

This manual describes in detail the Plan policies and procedures, provides information on verifying member eligibility, filing claims, obtaining referrals and authorizations, and whom to contact with questions. We are pleased that you have joined the US Family Health Plan network of providers and look forward to working with you. If your questions are not answered in this document, please visit our website at www.usfhp.net, or call Customer Service, 800-241-4848 so that we can assist you further.

Plan History

Since inception, the US Family Health Plan has a strong history of partnering with the medical community to provide service to the military. The Plan began in the former US Public Health Hospital on Staten Island, New York (now Bayley Seton Hospital) as a Uniformed Services Treatment Facility in 1981. In 1993 was authorized by the Department of Defense (DoD) as the Uniformed Services Family Health Plan, the first DoD sponsored full-risk managed health care plan and the first to serve military beneficiaries age 65 and over. Following the success of the Plan, Congress made it a permanent part of the military health care system in 1997.

The US Family Health Plan is a health care option under TRICARE, the national military health care program. The Plan is a TRICARE Prime, or HMO-style, option. Members receive a comprehensive benefit package that includes all services covered by TRICARE Prime, plus preventive and educational services offered only to Plan members. People eligible for membership include the family members of active duty military personnel, and retired military personnel and their eligible family members under the age 65.

US Family Health Plan Across the Country

There are six organizations that sponsor the US Family Health Plan in different regions throughout the United States. Members may transfer from one region to another and/or into a military treatment facility or major contractor (e.g. HealthNet) Prime program without an interruption in benefits (portability). In the metropolitan New York area, Eastern Pennsylvania, New Jersey and a small portion of Connecticut, the sponsoring administrator of the USFHP is Saint Vincent Catholic Medical Centers. The other five US Family Health Plan sponsoring organizations and covered regions are:

BRIGHTON MARINE HEALTH CENTER- Serving eastern Massachusetts, including Cape Cod, and Rhode Island

CHRISTUS HEALTH - Serving southeast Texas and southwest Louisiana

JOHNS HOPKINS COMMUNITY PHYSICIANS -Serving central Maryland and parts of Pennsylvania, Virginia and West Virginia

MARTIN'S POINT HEALTH CARE-Serving Maine and New Hampshire

PACMED CLINICS – Serving the Puget Sound area of Washington State

ADDRESS & TELEPHONE DIRECTORY

Medical Claims Paper:

Mail claim forms to: U.S. Family Health Plan
P.O. Box 830745
Birmingham, AL 35283-0745

Electronic:

Emdeon Payor ID 13407

Medical/Behavioral Health/Radiology Authorizations/UM

To inform us of an authorization request and to obtain approval, please call 800-241-4848 and select the appropriate prompt. If you prefer, you may call our utilization review department directly at 866-390-0933 or fax your authorization request to 866-813-1722.

Physical/Occupational Therapy Outpatient Authorizations/UM

Call 800-241-4848 and select the appropriate prompt or contact OrthoNet at 800-401-0062.

DME

Contact Apria Healthcare directly at 800-294-2275. Apria is our preferred provider for most DME. Visit our website or contact Customer Service to identify a DME vendor for DME that Apria does not supply.

Verify Member Eligibility/Check Claims Status:

Visit our website at www.usfhp.net and click on the Provider Portal Link to verify member eligibility and/or check a claim's status via the internet or via our USFHP Fax Recall System by contacting 800-241-4848 and using the appropriate prompt.

Laboratory Testing:

For questions regarding lab work and where to send lab tests, call LabCorp, the US Family Health Plan's preferred lab company, at 800-788-9091 or via the Labcorp website at www.labcorp.com. Members may also have routine laboratory testing done at any hospital based outpatient lab or independent lab without authorization.

Pharmacy:

For any pharmacy related questions, use 800-241-4848 with the appropriate prompt or call Maxor National Pharmacy, US Family Health Plan's partner pharmacy manager direct at:

Mail Order: 866-408-2459 (phone) or 866-222-3274 (fax)

Maxor Plus for TRICARE Uniform Formulary or any pharmacist questions:
800-687-0707 or 866-208-9930 (fax)

General Questions:

E-mail us at: usfamily@svcmcnyc.org

Call us at: 800-241-4848

Write to us at: US Family Health Plan
5 Penn Plaza, 9th Floor
New York, NY 10001

Online/Electronic Access:

To verify member eligibility or check on the status of a claim visit our website at www.usfhp.net and click on the Provider Portal link. If you do not have online access, you may call 800-241-4848 to access the USFHP Fax Recall System for member eligibility, authorization or claims status.

MEMBER ELIGIBILITY

Verifying Member Eligibility

The provider's office is responsible for verifying US Family Health Plan members' eligibility before rendering services.

It's easy to verify that the patient is a member of the US Family Health Plan. Please ask to see the member's US Family Health Plan Identification Card. If the member does not have the card, eligibility may also be verified on line by accessing our website at www.usfhp.net and clicking on the **Provider Portal** link to verify member eligibility via the internet, or by accessing USFHP Fax Recall at 800-241-4848. Lastly, you may call Customer Service at 800-241-4848 to verify eligibility or get information. Payment for services provided during lapses of coverage, or after plan termination, is the responsibility of the patient.

Membership Identification Card

Each member is issued an Identification Card. This card should be requested when the member first comes to your office and at each subsequent visit.

The ID card is printed with Plan information, including:

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

If you need information about member eligibility, please call or visit our website at www.usfhp.net or call Customer Service at 800-241-4848. Sample of a US Family Health Plan Member Identification Card:



Member Enrollment

Members may enroll in US Family Health Plan at any time throughout the year. Once enrolled, membership is automatically renewed every twelve months unless the member voluntarily disenrolls, or is disenrolled due to loss of eligibility, or moves out of our service area. Members wishing to voluntarily disenroll must request disenrollment in writing. Members who disenroll are responsible for informing your office that they have changed health insurance plans prior to their next visit.

CO-PAYMENTS

Co-payments – Office Visits

Members are responsible for making all applicable co-payments. Some members have no co-payments (except pharmacy) while others are responsible for making a small co-payment. The co-payment amount per office visit is as follows:

Active Duty Dependents	No co-payment
Retirees and their family members with Medicare Part B	No co-payment
Retirees and their family members without Medicare Part B	\$12

A co-payment should not be charged by the Primary Care Physician if a member is picking up a referral from the office or for the copy exceptions below.

A full summary of all co-payments is listed below under the “Summary of Benefits” schedule on page 8.

Co-payment Exceptions – No charges for:

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

Co-payments – Prescriptions

Maxor Retail Pharmacy located at Mitchell Field Health Center and Fort Wadsworth Health Center:	up to 90 day supply
Maxor Network Pharmacy:	up to 30 day supply
Maxor Pharmacy Mail Order:	up to 90 day supply
Generic:	\$0 co-payment
Brand Name:	\$16 co-payment
Tier 3:	\$46 co-payment

US Family Health Plan members save money and time with the convenience of the Maxor Pharmacy Mail Order program. Members **must** use a Maxor Retail Pharmacy or the Mail Order Program for maintenance medications. The Mail Order program allows patients to obtain a 90-day supply of maintenance medications, and therefore, patients may ask for a 90-day prescription. Urgent medications such as antibiotics may be filled at a Maxor Network Pharmacy. For first time fills of maintenance medications, please give the patient a 30-day prescription to fill at the local walk-in pharmacy and a 90-day prescription to fill through mail.

Summary of Benefits and Co-Payments

<i>Covered Services</i>	Active Duty Family Members	Retirees with Medicare Part B	Retirees without Medicare Part B
<i>Outpatient Services</i>			
Office Visits	\$0	\$0	\$12 per visit
Maternity Care (prenatal, postnatal)	\$0	\$0	\$0
Well-baby care (up to age 6)	\$0	\$0	\$0
Annual well-child care (age 6 and older)	\$0	\$0	\$0
Annual physical examination	\$0	\$0	\$0
Ambulatory surgery and procedures (including anesthesia)	\$0	\$0	\$25
Physical, occupational, speech therapy	\$0	\$0	\$12 per visit
<i>Inpatient Services</i>			
Semi-private room and board	\$0	\$0	\$11 per day/\$25 minimum charge per admission
Physicians services	\$0	\$0	\$0
General nursing services	\$0	\$0	\$0
Diagnostic tests, including lab and x-ray	\$0	\$0	\$0
Operating room, anesthesia and supplies	\$0	\$0	\$0
Medically necessary supplies and services	\$0	\$0	\$0
Physical therapy	\$0	\$0	\$0
<i>Mental Health Service</i>			
Outpatient care: individual 1	\$0	\$0	\$25 per visit
Outpatient care: group 1	\$0	\$0	\$17 per visit
Partial hospitalization mental health (up to 60 days per enrollment year)	\$0	\$0	\$25 per visit – individual \$17 per visit – group
Inpatient hospital psychiatric care (subject to medical review) 2	\$0	\$0	\$40 per day
<i>Substance Abuse Treatment</i>			
Outpatient – group therapy	\$0	\$0	\$17 per visit
Inpatient service (up to 7 days for detoxification per year) 3	\$0	\$0	\$40 per day
Inpatient rehabilitation (up to 21 days per year) 3	\$0	\$0	\$40 per day
<i>Other Services</i>			
Medical Transportation service (when medically necessary)	\$0	\$0	\$20 per occurrence
Durable medical equipment (including orthotics and prosthetics) and medical supplies	\$0	\$0	20%
Emergency room services 4	\$0	\$0	\$30 per visit
Eye examinations (1 per enrollment period)	\$0	\$0	\$0
Radiation/chemotherapy office visits	\$0	\$0	\$0
Skilled nursing facility care (when medically necessary)	\$0	\$0	\$11 per day/\$25 minimum per admission
Home health care (part time skilled nursing care)	\$0	\$0	\$0 per visit
Out of area (emergency room)	\$0	\$0	\$30 per visit
<i>Pharmacy (over the counter medications are not covered)</i>			
Prescriptions drugs (up to 30 day supply) 5	\$8 generic/\$20 brand/\$47 third tier	\$8 generic/\$20 brand/\$47 third tier	\$8 generic/\$20 brand/\$47 third tier
Mail order pharmacy drugs (up to 90 day supply) 5	\$0 generic/\$16 brand/\$46 third tier	\$0 generic/\$16 brand/\$46 third tier	\$0 generic/\$16 brand/\$46 third tier
<i>Yearly Enrollment Fee</i>	\$0	\$0	\$277.92 per individual \$555.84 per family

- 1 One hour of therapy, no more than two times per week, when medically necessary.
- 2 With authorization, up to 30 days per enrollment year for adults (age 19+); up to 45 days per enrollment year for children under age 19; up to 150 days residential treatment for children and adolescents.
- 3 Maximum of one rehabilitation program per year, three per lifetime. Detoxification and rehabilitation days count toward the limit for mental health benefits.
- 4 Unless you are admitted to the hospital, in which case only the inpatient co-pay applies.
- 5 Prescription drug availability is limited to those prescribed by a licensed provider and covered as a Plan benefit. Availability of non-emergency prescriptions when out of area is also limited. Over the counter medications and supplies are not covered.

EXCLUSIONS

General Exclusions

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

Service Exclusions

- Abortion, elective (except in specific situations approved by TRICARE)
- Acupuncture and acupressure
- Alterations to living space
- Arch supports (except diabetic orthotics)
- Artificial insemination, in vitro fertilization, and other therapies (including drug therapy and testing) intended for non-coital methods of pregnancy)Note: infertility evaluations are covered)
- Aversion therapy (e.g. in connection with alcoholism)
- Bed-wetting correctional devices
- Body piercing
- Botulinum toxin (Botox) injections for palmar hyperhidrosis, urinary urge incontinence, lower back pain, lumbago, migraine headache and other primary headache disorders and strabismus in patients under age 12
- Contraceptives, over the counter
- Convalescent care
- Cosmetic, plastic or reconstructive surgery, that is not medically necessary (TRICARE exceptions exist)
- Court ordered care
- Cranial orthosis (Dynamic Orthotic Cranioplasty Band) and cranial molding helmets
- CT scan for acute ischemic stroke
- CT for intracerebral aneurysm, subarachnoid hemorrhage
- CT scan heart without contrast
- Custodial care
- Chiropractic services
- Complementary and alternative medicine (CAM)
- Dental care
- Dental X-rays and services (TRICARE exceptions exist)
- Dermoscopy
- Domiciliary care
- Education and training
- Electrolysis
- Exercise equipment
- Exercise programs

- Experimental/investigational treatments/ procedures (except NCI phase I, II & III trials)
- Food, food substitutes or supplements, and vitamins consumed outside a hospital, except for home parenteral/enteral nutrition therapy
- Foot care, routine preventive, except in connection with medical treatment of a peripheral vascular disease
- Hair analysis to identify mineral deficiencies – hair analysis testing may be covered when medically necessary to determine lead poisoning
- Hair removal
- Hair transplant
- Hypnosis
- Hyperthermia, whole body or hyperthermia for recurrent breast cancer
- Hearing Aids (except in specific situations)
- Immunizations for elective travel
- Intelligence testing
- Internal infusion pump (IIP) for treatment of thromboembolic, IIP for treatment of diabetes; any IIPs and related services for non-FDA approved specifications
- In-vitro Fertilization (and any treatment/testing for non-coital methods to achieve pregnancy)
- Intersex surgery
- Laser surgery for pain relief/biostimulation; non-covered surgical services (i.e., tattoo removal), arthritis or low back pain, corneal sculpting, and body sculpting
- Learning disorders (treatment for)
- Mandibular staple implants
- Massage therapy
- Megavitamins and orthomolecular psychiatric therapy
- MRI to screen for breast cancer
- MRI to evaluate suspicious lesions to avoid biopsy
- MRI to differentiate cysts from solid lesions
- MRI to assess implant integrity or confirm implant rupture
- Naturopathic services
- Neuropsychological testing for education, employment, or if court-ordered
- Nutritional counseling (limited medical necessity exceptions – pre/post bariatric surgery)
- Occlusal equilibration and restorative occlusal rehabilitation
- Organ transplants considered investigational/experimental
- Orthodontia
- Orthopedic shoes and arch supports, except when an integral part of a brace or custom molded shoes for a diabetic or other individual diagnosed with peripheral vascular disease
- Over-the-counter drugs, vitamins or food supplements
- Patient Convenience Items (examples include, but are not limited to, adult diapers, incontinence pads, admission packets, telephone rental, television rental)
- PET scan for diagnosis and monitoring of Alzheimer's disease or any form of dementia
- Physician assisted suicide
- Podiatry, routine (i.e., removal of corns, calluses, trimming of toenails and other routine podiatry services are excluded unless the patient has a diagnosed systemic medical disease affecting the lower limbs)
- Private duty nursing
- Private hospital rooms, unless ordered by the attending Physician for medical reasons, or a semi-private room is not available
- Psychological testing and assessment as part of an assessment for academic placement

- Psychological testing related to child custody disputes
- Psychological testing for job placement
- Psychological testing for general screening, in the absence of specific symptoms of a covered mental disorder, to determine if individuals being tested are suffering from a mental disorder
- Psychological testing, teacher/parent referrals
- Reitan-Indiana battery when administered to a patient under age 5 and for self-administered tests to patients under age 13
- Reproductive tissue, cryopreservation/thawing
- Reversal of sterilization
- Radial keratotomy
- Respite care (except as part of pre approved home hospice program)
- Retirement homes, assisted living facility, custodial care facility
- Sex change procedures
- Smoking cessation programs unless part of a special Plan program
- Sterilization reversals
- Surgical preparation of the mouth for dentures
- TMJ syndrome, treatment of
- Topical application of oxygen
- Topographic brain mapping (brain electrical activity mapping, quantitative EEG, digital EEG, topographic EEG, brain mapping EEG)
- Transportation for convenience
- Vestibuloplasty or surgical preparation of the mouth for dentures Virtual colonoscopy for screening
- Weight control or weight reduction services and supplies (except bariatric surgery)
- 3D rendering to monitor coronary artery stenosis activity
- 3D rendering for evaluating graft patency in individual who has undergone revascularization procedures

Note:

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

CLAIMS SUBMISSION PROCESS

- All claims should be submitted within sixty (60) days from the date of service on a HCFA 1500 claim form. Claims not submitted within this time frame may be denied for timely filing. Members may not be held financially responsible even when the claim is administratively denied.
- Submit claims electronically via Emdeon Payor ID 13407.
- Capitated providers are required to submit encounter data each time a US Family Health Plan member receives services. Encounter data is to be submitted within sixty (60) days and reflect all services received that day. This information should be submitted on a HCFA 1500 form or UB92 form.
- Members should not be billed for any service, treatment or procedure covered under the Plan except for applicable co-payments and coinsurance.
- Members are not financially liable for non-covered services unless a prior written acknowledgement that the services will be the member’s responsibility is obtained.

- Medicare/Medicaid or any other TRICARE Program contractor should not be billed; the US Family Health Plan is the primary insurer. Exceptions – 1) ESRD (diagnosis of ICD-9 code 585.6 and with Medicare Parts A/B), many healthcare services are covered by Medicare are primary; 2) Medicare and/or Medicaid may be billed for those services not covered by US Family Health Plan but that are covered by Medicare and/or Medicaid.
- USFHP is always the secondary payor to other commercial health insurance **except for Medicare and Medicaid.**
- USFHP is always the primary payor to Federal Employee Health Benefits Program (FEHBP).

Instructions for Submitting US Family Health Plan Paper Claims

Optical Character Recognition (OCR) technology allows for a more automated process of capturing information from paper documents. To ensure the best results, please follow the specifications on page 12. OCR technology enables us to process paper forms electronically, resulting in shorter claim turn-around and improved quality.

Please use the guidelines listed in the "Do" section below. Following the items in the "Don't" section will not necessarily cause your claim to be rejected or returned; however, it will require manual intervention to process claim, which will cause delays in payments.

Send Claims to:

Medical and Surgical Claims

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

Behavioral Health Claims

Health Integrated
10008 N Dale Mabry Suite 214
Tampa, FL 33618

Check medical and surgical claims status on line via the Internet by accessing our website at www.usfhp.net and click on the **Provider Portal** link or by accessing USFHP Fax Recall at 800-241-4848. Check behavioral health claims status by calling 866-390-0933.

Electronic Claims

Submit Electronic Claims via Emdeon: Use Payor I.D. number 13407

IMPORTANT CLAIMS PROCESSING REMINDERS

- Claims must be filed using the current Procedural and Diagnosis coding developed by the AMA.
- DO NOT handwrite the form.
- Claims will be rejected for not filing with the most recent codes and proper number of digits. Should your claims be rejected for not filing with the most recent Procedural or Diagnosis coding, USFHP members may not be billed. Please resubmit your claims with the correct and up to date coding. In addition, when submitting claims, be sure to include all diagnosis codes on the claim forms.
- Do not balance bill USFHP members for any amounts in excess of the allowed amount, other than for co-payments and coinsurance.
- Do not bill Medicare. USFHP is always primary to Medicare, except if the member has End Stage Renal Disease. USFHP is secondary to commercial insurance.
- Claims must be filed within sixty (60) days from the date the service is rendered to the member. Claims filed after sixty (60) days may be denied for timely filing. Members cannot be billed for these services.
- Submit claims electronically via Emdeon, Payor ID 13407.
- Check claims status and member eligibility at www.usfhp.net or by dialing 800-241-4848 and accessing our USFHP Fax Recall system.
- Remember ALL out of network care requires pre-authorization (exceptions – routine outpatient diagnostic radiology and routine outpatient laboratory services). **Referrals are not pre-authorizations.** Call 800-241-4848 to request an Out of Network Authorization or to obtain authorization for any healthcare service that requires authorization.
- If a claim is denied, please pay close attention to the reason for the denial. Do not resubmit the claim without correcting the reason for the denial; the claim will be denied again. Send an appeal to the Plan when you disagree with the non-payment reason. Resubmitting the same claim without correction will result in a 2nd denial.

COORDINATION OF BENEFITS

US Family Health Plan is the **primary** payor to Federal Employee Health Benefit Program (FEHBP), Medicare, Medicaid and Medicare supplement plans, except:

- If the patient has a diagnosis of End State Renal Disease (ESRD, ICD-9 585.6, and eligible for the Medicare ESRD Program), or
- If the injury or condition is due to an accident that would be covered by other insurance, such as workers' compensation or no-fault automobile insurance, in which case the other insurance will be primary or
- If a service is not covered by TRICARE but is covered by Medicare.

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

PRIMARY CARE PROVIDER

Primary Care Physician

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

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

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

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

To obtain a list of US Family Health Plan network specialists for patient referrals, please call 800-241-4848 or visit www.usfhp.net

ACCESS AND AVAILABILITY

Access Standards

Primary Care Physician:

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

Specialty Care Provider or Ancillary Provider:

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

Wait Times for Office Visits Appointments:

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

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

Office Waiting Time for Non-Emergency Care

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

Appointment Wait Time for Urgent Care

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

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

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

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

24/7 Nurse Triage Line

The Plan has a 24/7 Nurse Triage line 866-390-0933. Members can access this service toll free for medical guidance/triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace your commitment to providing coverage after hours.

REFERRALS

In-Network Referrals

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

Guidelines for In-Network Referrals

- All US Family Health Plan referrals should be issued **only** to Plan participating providers. Please refer to the Plan Physician/Provider Directory, access the Provider Locator on our website at www.usfhp.net, or contact Customer Service at 800-241-4848 to verify if a provider is participating with the Plan. **Referrals to non-participating providers require prior approval and a specific authorization by the Plan.** Please call 800-241-4848 for inquires about referrals to non-participating providers. See the section below on Out of Network referral requirements.

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

Point of Service

The Point of Service (POS) benefit option allows members to seek services from a non-network provider without an authorization from the USFHP. The POS option applies to office, hospital based clinics, and ambulatory surgery facilities; however, using this option comes at a price. TRICARE regulations require that if a member uses this POS option, the USFHP will not deny payment, but will pay the provider 50% of the TRICARE allowable charges, after member meets an initial deductible. This deductible will only be applied for care received under the POS option. If member obtains a referral and uses of a network provider there remains no deductible. The deductible is \$300 per enrollment year for an individual, and \$600 for a family, just like TRICARE standard. After paying the deductible member would also be responsible for up to 65% of the TRICARE allowable charge.

Out-of-Network Referrals

Unless specifically authorized through the process outlined below, referrals must be made only to participating US Family Health Plan providers. Please check your Plan Physician/Provider Directory, access the Provider Locator on our website at www.usfhp.net or contact Customer Service at 800-241-4848 to determine the participating status of a health care provider.

A referral to an out-of-network provider may be issued when the Plan determines that a member's particular health care needs cannot be met by a participating provider with appropriate training and experience. In most situations, members will be treated by participating Plan providers. Out of network treatment must be pre-approved by US Family Health Plan in consultation with the member's PCP and the non-participating physician.

Reason why an Out of Network Referral may be approved:

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

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

A referral is NOT the same as an authorization.

Referral Tracking and Reporting Requirements

Network specialists must provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the enrollee's primary care physician within thirty (30) 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 physician within 24 hours by telephone, fax or other means with a formal written report provided within ten (10) working days.

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

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

INFORMING MEMBERS ABOUT NON – COVERED SERVICES

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

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

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

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

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

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

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

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

Example of a proper waiver is provided below for your information:

SAMPLE REQUEST FOR NON – COVERED SERVICE

I am hereby requesting that that the following medical service(s) be provided to me by _____ .
(Provider name)

Service: Frequency limitation:

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

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

Print Member Full Name:

Member ID #:

Member Signature:

Print Sponsor Full Name:

Date:

Patient Self-Determination Act

The Federal Patient Self-Determination Act requires certain health care facilities to document whether or not a member has executed an “advance directive.” An “advance directive” is a written set of instructions recognized under state law relating to the provision of health care when the member is unable to communicate his or her own wishes regarding medical treatment. To ensure compliance with the provisions of the Patient Self-Determination Act, we strongly recommend that the following language be added to or used with your standard intake sheet:

Have you executed an Advance Directive or Health Care Proxy? YES___ NO___

To be completed by Office Staff:

Advance Directive/Health Care Proxy on file? YES___ NO___

Healthcare Agent named in Advance Directive/Health Care Proxy:

Name _____
Address _____
Phone _____

PROVIDER PARTICIPATION REQUIREMENTS

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

PRACTITIONER PARTICIPATION CRITERIA

- Completed US Family Health Plan Provider/Group Application.
- Current license to practice medicine or operate facility without limitation, suspension, restriction
- Current DEA/CDS certificate (if applicable)
- Current malpractice insurance coverage: minimum \$1,000,000/3,000,000
- Board Certification or completed appropriate training in the requested specialty
- Ability to meet USFHP Access and Availability standards
- Must be eligible to become a TRICARE Authorized Provider
- No current Medicare/TRICARE sanctions

PRACTITIONER APPLICATION REQUIREMENTS

- Copy of current license/operating certificate
- Copy of current DEA/CDS if applicable
- Copy of current malpractice coverage sheet (includes effective dates, policy number, and amounts of coverage)
- Copy of board certification if applicable
- Copy of accreditation face sheets if applicable
- Curriculum vitae or documentation of education and training
- Detailed explanations to any questions which require an answer (any professional questions that have been answered YES, i.e.; Explanation to malpractice history)
- Signed and dated application attestation
- Signed and dated USFHP provider agreements

FACILITY PARTICIPATION CRITERIA**

- Completed US Family Health Plan Facility/Ancillary Application
- Current operating certificate
- Current Accreditation (if applicable)
- Current malpractice insurance coverage: minimum 1,000,000/3,000,000 or consistent with state minimum standards
- Ability to meet USFHP Access and Availability standards
- Must be eligible to become a TRICARE Authorized Provider
- No Medicare sanctions
- JCAHO Accreditation (if applicable)

FACILITY APPLICATION REQUIREMENTS**

- Copy of current operating certificate
- Copy of current accreditation face sheet
- Copy of current malpractice coverage sheet (includes effective dates, policy number, and amounts of coverage)
- Detailed explanations to any questions that require an answer (any professional questions that have been answered YES, i.e.; Explanation to malpractice history)
- Signed and dated application attestation
- Signed and dated USFHP agreements

** Facility credentialing is limited to hospitals, skilled nursing facilities, home health agencies, and ambulatory surgery centers.

PROVIDER, FACILITY AND ANCILLARY CONTRACTUAL REQUIREMENTS

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

- Meet the certification requirements of TRICARE
- Comply with access and availability standards

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

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

NETWORK DISPUTE RESOLUTION

Network Affiliation Issues

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

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

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

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

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

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

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

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

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

APPEAL PROCESS

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

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

- You will receive a payment or written response generally within thirty (30) calendar days (can take up to 90 days), describing how your appeal was resolved and the basis for the resolution.
- Please note that you cannot appeal the rules and regulations of the Plan or TRICARE policy, but you may send a grievance if you think an error in the interpretation of the policy has occurred. Grievances are handled in a like manner to appeals.
- Denials are always communicated in writing
- 2nd Level medical necessity appeals are reviewed by an independent clinical provider in the like specialty who has not previously reviewed the case.

US FAMILY HEALTH PLAN COMPLIANCE PROGRAM

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

Whistleblower – Sarbanes/Oxley Act

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

False Claims

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

Criminal Investigation of Health Care Offenses

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

Mail and Wire Fraud

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

Social Security Act

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

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

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

Federal Anti-Referral Law (Stark Laws)

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

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

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

Sherman Antitrust Act-prohibits any ventures which result in a monopoly or combination in restraint of interstate trade.

Emergency Medical Treatment and Active Labor Act-(EMTALA)

Hospitals that receive Medicare funds are prohibited from transferring out patients in their ER's based solely on their inability to pay for services.

Civil Rights Act of 1964

Prohibits any federally funded program from discriminating on the basis of race, creed, color, or national origin.

Rehabilitation Act of 1973

Prohibits qualified handicapped individuals from being discriminated against in any program or activity receiving federal funds Individuals protected are those with:

- Physical or mental impairment which substantially limits one or more major activities of daily living
- Has a record of such an impairment or has it currently
- Blind/visual impairment or deaf/hearing impairment
- Cerebral Palsy, epilepsy or seizure disorder
- Drug/Alcohol addiction
- Mental retardation and Psychiatric disorders
- Orthopedic handicap, spinal cord/traumatic brain injury
- Specific learning disability, and certain speech disorders
- Chronic diseases including AIDS, arthritis, cancer and diabetes

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This act mandates that security and confidentiality of individually identifiable protected health information (PHI) must be stored and transmitted securely, patients must be notified of their rights, and where to submit complaints, and patients must have access to their medical records.

Alcohol Drug Abuse and Mental Health Administration Reorganization Act

This act specifies that alcohol and drug abuse records are kept confidential and requires certain court orders.

Confidentiality and Disclosure Requirements Table 10

This requires that quality assurance documentation is kept confidential in DoD programs.

The Freedom of Information Act

This was enacted to reach a balance between the right of the public to know, and the needs of government to keep information private. The DoD has specific procedures by which information is made available to the public that requires a written request.

QUALITY MANAGEMENT PROGRAM

US Family Health Plan has a comprehensive Quality Management Program.

The purpose of the Quality Management Program is to assess, measure, oversee and assist with the improvement of services rendered to members. The activities are data driven. The scope and content of the program is designed to monitor, evaluate, and improve the clinical and non-clinical services and member/provider satisfaction. The Quality Improvement Program includes, but is not limited to, the following topics:

- Preventative Health Services
- Disease Management
- Access and availability of provider/services
- Timely Credentialing of providers and adequacy of the provider network
- Improvement of member and provider satisfaction
- Timely resolution of complaints and Appeals
- Improved patient safety, and error reduction
- Pharmacy Services Effectiveness
- Credentialing
- Utilization Management
- Complaints and Grievances
- Appeals
- Patient Safety
- Accreditation and Compliance

All participating providers are required to comply with US Family Health Plan's policies and procedures including complying with, participating in, and implementing Quality Management Projects including Patient Safety Programs. This includes but is not limited to implementing activities necessary required to comply with external accreditation by the NMC, JCAHO, URAC or other similar accrediting bodies selected by the Plan. In addition, all participating providers are required to comply with the terms of this Provider Manual as well as Medical Management and Quality Management Programs.

UTILIZATION MANAGEMENT PROGRAM

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

This Utilization Management Program has several major components:

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

Utilization Management Notification Requirements

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

<u>Treatment/Service</u>	<u>Notification Requirement</u> Call: 800-241-4848 or 866-390-0933 Fax: 866-813-1722
<u>An overnight hospital stay:</u> <ul style="list-style-type: none"> • Non-emergency admission • Urgent Admission • Emergency admission* 	At least seven (7) business days before admission Within 48 hours following admission Within 48 hours following admission
<u>Skilled Nursing Facility (SNF), Acute or Subacute Inpatient Rehab</u>	At least three (3) business days before services commence
<u>Outpatient Procedures</u>	At least seven (7) business days before the procedure
<u>Home Health Care</u>	At least seven (7) business day before services commence
<u>Durable Medical Equipment</u> (if the purchase price or combined monthly rental charges exceed \$2,000 and is not available from Apria Healthcare)	At least one (1) business day before ordering the equipment

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

PRE- AUTHORIZATION PROCESSES

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

Initiation of Authorization - Primary Care Physician

When a PCP determines that a patient requires consultation from a specialist, the PCP must complete a US Family Health Plan Referral Form or other written format (ie script). A note in the patient’s chart is

required. The PCP should give the designated copy to the patient to bring to the specialist and retain the designated copy.

The referral form must include the following information:

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

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

Pre-Authorization and Notification Process

To obtain authorization for the procedures and services listed in the next section, call 800-241-4848 or 866-390-0933 or fax 866-813-1722. Please provide the following information:

- Patient Name
- Patient Date of Birth
- Identification Number
- Procedure(s) to be performed, including CPT/HCPCS code(s)
- Planned date of procedure
- Diagnosis, including ICD-9 code(s)
- Provider Name/Facility Name

SERVICES THAT REQUIRE PRE AUTHORIZATION

Providers must obtain authorization or provide notification for the following:

Inpatient Elective Admissions:

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

Emergent or Urgent Admissions:

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

Other Services

- DME over \$2,000 and not available from Apria Healthcare
- Home Health Care Services
- Hospice Services
- Inpatient Days at any type of facility
- Prosthetics and Orthotics
 - L0100-L2999 & L3650-L9900, \$1000 or greater each item; L3000-L3649 at any price point. All diabetic shoes & inserts require authorization (A5500, A5501, A5503, A5504, A5506, A5507, A5510, A5512, A5513)
- High Tech Radiology (non-emergent MRI, MRA, PET)
- All Out of Network Care (exceptions include: emergent care, urgent care provided at a hospital based or free standing urgent care center, routine diagnostic lab, routine radiology)

Procedures & Outpatient Services:

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

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • adjunctive dental • arthroscopy • augmentative communication device (ACD) • behavioral health services (after the 7th visit) • biofeedback • cardiac rehabilitation • carpal tunnel surgery • carotid angiography • chelation therapy • coronary angiogram • cosmetic/plastic surgical procedures • CT angiography • dental anesthesia and related institutional services • diabetic education • dialysis • gamma knife radiosurgery • hearing aid and hearing aid services (benefit limited to active duty dependents) • home birth • home infusion therapy | <ul style="list-style-type: none"> • Hyperbaric Oxygen Therapy • Indium Pentetate (Octreoscan) Scintigraphy • Injectibles, select and covered under medical benefit • laminectomy/microdiscectomy • laparoscopic abdominal vaginal hysterectomy (LAVH) • laparoscopic procedures, select • Lithotripsy (except renal lithotripsy) • Magnetic Resonance Angiography (MRA) • Magnetic Resonance Imaging (MRI) • Medical transport, non-emergent • Meniscectomy • Mental health/behavioral health (except first 8 visits with PAR BH provider) • mental health/behavioral health (except 1st 8 visits) • NCI trial participation (phase II and III) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

- Neuropsychological testing
- Nutritional therapy infusion
- pain management services
- PET scans
- pulmonary rehabilitation
- psychological testing
- septoplasty/rhinoplasty
- single Photon emission
Computer Tomography (SPECT)
- speech therapy
- stereotactic radiosurgery
- vertebroplasty
- virtual colonoscopy (CT
colonoscopy)

This list is not all inclusive and is subject to change. If your office is unsure about the necessity to obtain authorization, we suggest that one is requested.

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

Completion of the authorization process will result in notification to the requesting provider.

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

INPATIENT HOSPITAL REVIEW

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

Pre-Admission Testing

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

Pre-Admissions

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

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

Elective/Urgent Admissions to Hospitals

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

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

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

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

Emergency Admissions to Hospitals

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

Concurrent Hospital Review

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

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

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

Discharge Planning

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

CASE MANAGEMENT AND DISEASE MANAGEMENT PROGRAMS

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

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

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

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

The overall objective of the Plan's disease management program is to empower members diagnosed with selected chronic diseases through education in self-management techniques. Interventions are based on nationally accepted clinical guidelines for each disease and specially trained registered nurses deliver education telephonically through our Care Management Program. Participation in either program is voluntary and free of charge. You can refer members for an evaluation by calling our utilization management department at 866-390-0933.

SKILLED NURSING FACILITY, INPATIENT REHABILITATION AND INPATIENT HOSPICE SERVICES REVIEW

Skilled nursing facility, inpatient acute and subacute rehabilitation, long term acute care and inpatient respite hospice as part of a pre approved hospice program admissions also require preauthorization by the Plan. Preauthorization should be requested 7 days prior to the admission to the SNF, rehab or

hospice facility. The same preauthorization, concurrent review, discharge planning and case management process described above applies to SNF, inpatient rehab and inpatient hospice respite services. General inpatient hospice is not a covered benefit; exceptions may be made based on medical necessity.

ANCILLARY SERVICES REVIEW

Skilled Home Health Care Review

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

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

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

Durable Medical Equipment and Prosthetics/Orthotics Review

Apria Healthcare is our preferred provider for most DME (i.e. hospital beds, non-custom wheelchairs, patient lifts, and other ambulatory assistive devices), respiratory equipment and oxygen. Apria may also be able to provide other medically necessary DME and medical supply items. Apria will perform the medical necessity review for all equipment they provide. All other DME medical necessity review will be conducted by the plan's UR department.

The review process evaluates the medical necessity and appropriateness of the rental and/or purchase of durable medical equipment exceeding \$2,000 and all Prosthetics and Orthotics \$1,000 and greater, and orthotics at certain price points.

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

Notification of Review Determinations

Initial determinations are communicated in writing to the participating provider. After the initial notification letter, written communications will only be issued when the medical necessity and appropriateness no longer support an authorization. All denials are communicated by telephone to the

participating providers on the day the review decision is made and are followed by a notification letter. Appeal rights will be included with all notifications of denial.

Managed Care Reconsideration Process

When an initial denial occurs before or during the period of time services are being provided, and the participating provider believes that the determination warrants an immediate reconsideration, the participating provider has the opportunity to request a reconsideration of that determination, over the telephone, on an expedited basis.

- The participating provider must call the Plan at 800-241-4848 to request the reconsideration within 24 hours of the initial notification of denial.
- All supporting information must be received by the Plan within three (3) business days of the initial notification of denial. Within one (1) business day of the request or receipt of documentation, the reconsideration process will be completed and decisions will be communicated, in writing, to the participating provider. This notification will include standard appeal rights.
- Use of the reconsideration process does not affect standard appeal rights.

LABORATORY

Labcorp is our preferred outpatient laboratory services providers. All lab work should be referred to a Labcorp Service Center or if necessary a hospital based outpatient laboratory or other independent laboratory. To locate a Labcorp Service Center, visit their website at www.labcorp or call LabCorp at 800-788-9091. Only the STAT laboratory procedures should be performed in the office.

BEHAVIORAL HEALTH

US Family Health Plan has contracted with **Health Integrated** to manage behavioral health services. Health Integrated behavioral health staff is available 24 hours per day/7 days per week at 800-241-4848 with the appropriate prompt or directly at 866-390-0933. Please use this number to identify participating behavioral health providers, request pre authorization for inpatient admissions and outpatient services after the initial 8 visits and continued stay reviews. Members may self-refer for the initial 8 visits to a participating behavioral health provider.

RADIOLOGY

All outpatient elective High Tech imaging studies require pre authorization. High tech imaging services include PET, MRIs, and MRAs. Please contact our Utilization Review department at 866-390-0933.

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

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

US Family Health Plan has contracted with Orthonet to manage Outpatient Physical Therapy and Occupational Therapy Services. Referrals must be to a participating Orthonet provider. Initial Outpatient PT/OT evaluations do not require pre authorization. The PT/OT provider is responsible for obtaining authorization from Orthonet for care subsequent to the initial evaluation. Claims should be submitted to Orthonet. Contact Orthonet at 800-401-0063 (or through 800-241-4848) with any questions related to Outpatient PT/OT.

DURABLE MEDICAL EQUIPMENT

Apria Healthcare is our preferred provider for many DME items including hospital beds, respiratory equipments, oxygen, patient lifts, non-custom wheelchairs and other ambulatory assistance devices. Contact Apria Healthcare directly at: 800-294-2275 (or through 800-241-4848).

PHARMACY

Pharmacy Benefit – TRICARE Uniform Formulary

Prescription drugs are covered by USFHP when ordered by a licensed provider. USFHP pays for medically necessary FDA-approved prescription drugs that are included on the TRICARE Uniform Formulary. The TRICARE Uniform Formulary covers most US Food and Drug Administration (FDA) approved prescriptions. In general, for a medication to be covered under the TRICARE (USFHP) pharmacy benefit it must:

- Be a prescription medication approved by the FDA;
- Not be part of a procedure covered under the medical benefit; and
- Be prescribed in consistent with good medical practice and established national standards of quality care.

Medications that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness are not covered by USFHP (TRICARE). Some prescription medications may have TRICARE mandated pre-authorization, quantity limitations and step therapy requirements. If a brand name medication has a generic equivalent, it is DoD policy to dispense the generic equivalent instead of the brand name medication. The brand name medication will be dispensed only if the pharmacy determines that it is clinically required after careful review of clinical information provided by the prescriber.

Visit the TRICARE Pharmacy website (<http://www.tricare.osd.mil>) for the most current listing and quarterly updates. Maxor Plus Pharmacy is also able to assist with TRICARE Uniform Formulary questions.

Medications with Age Limitations

Pre-authorization required if age limit exceeded

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

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

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

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

Category	Specific Drugs with Quantity Limits (generic/brand)
Antiemetics	Aprepitant (Emend), Granisetron (Kytril), Granisetron transdermal (Sancuso), Ondansetron (Zofran), Dolasetron (Anzemet), Palonosetron
Antimigraine	Almotriptan (Axert), Dihydroergotamine (Migranal); Eletriptan (Relpax), Frovatriptan (Frova), Naratriptan (Amerge), Rizatriptan (Maxalt or Maxalt MLT), Sumatriptan (Imitrex), Zolmitriptan nasal spray, Zolmitriptan (Zorning or Zornig-ZMT)
Controlled Substances	Fentanyl buccal tabs (Fentora), Fentanyl oral transmucosal lozenges (Actiq), all Schedule II drugs (no refills per federal law/state law may impose additional restrictions), all Schedule III and IV drugs (per Federal law prescriptions may not be filled or refilled for more than 6 months after the date of the prescription or refilled more than 5 times/state law may impose additional restrictions)
Erectile Dysfunction	Alprostadil injection (Caverject or Edex), Alprostadil intraurethral pellet (Muse), all PDE-5 inhibitors (Sildenafil/ and Viagra, Tadalafil (Cialis), Vardenafil (Levitra)

Fertility Agents	Follitropin alpha injection (Gonal-F), Follitropin beta injection (Follistirn), Menotropins inject (Humegron, Menopur, Pergonal, Repronex), Urofollitropin inject (Fertinex or Bravelle)
Glucose test strips	Includes all blood and urine test strips
Miscellaneous	Adalimumab (Humira), Anakinra (Kineret), Erlotinib (Tarceva), Medroxyprogesterone (Depo-Provera), Butorphanol (Stadol), Dasatinib (Sprycel), Enfuvirtide (Fuzeon), Etanercept (Enbrel), Fluoxetine (Prozac Weekly), Gefitinib (Iressa), Gemifloxacin (Factive), Imatinib (Gleevec), Ketorolac (Toradol), Lapatinib (Tykerb), methylNaltrexone (Relistor injectable), PEG-filgrastim (Neulasta), Sunitinib (Sutenet), Sorafenib Tosylate (Nexavar), Tramadol (Ultram, Ultram ER), tramadol/acetaminophen (Ultracet), Vorinostat (Zolinza)
Nasal Inhalers	Astelin, Astepro, Azelastine, Beclomethasone, Beclomethasone AQ, Budesonide, Combivent, Dudesonide AQ, Flunisolide, Fluticasone, Fluticasone furoate, Ipratropium bromide, Mornetasone, Triamcinolone, Triamcinolone AQ
Oral inhalers and inhalant solutions	Albuterol (AccuNeb, Proventil), Albuterol HFA, Albuterol sulfate 3mg/Ipratropiu, bromide 0.5mg per 3ml, Arformoterol, Beclomethasone, Bitolterol(Tornalate), Budesonide (Pulmicort,Pulmicort reputles, Symbicort), Cromolyn sodium, Flunisolide (Aerobid, Aerobid-M), Fluticasone (Flovent or Flovent HFA), Fluticasone/salmeterol (Advair), Formoterol fumarate (Foradil), Formoterol furoate (Perforomist), Ipratropium (Atrovent), Levalbuterol (Xopenex), Metaproterenol (Alupent), Mornestason furoate (Asamanex), Nedocromil (Tilade), Pirbuterol (Maxair), Salmeterol (Serevent), Tiotropium bromide (Spiriva), Triamcinolone (Azmacort)
Syringes	All syringes, needles and lancets
Topicals	Calcipotriene(Dovonex), Alitretinoin (Panretin), Becaplermin (Regranex), Tazarotene (Tazorac)

Any questions regarding the TRICARE Uniform Formulary or any other pharmacy question can be directed to Maxor Plus at 800-687-0707. Clinical justification, if required, may be faxed to Maxor Plus at 866-208-9930. Download the brand name override or quantity limit override form at www.usfhp.net

Tier 3, Non-formulary Brand Name Medications

This list is not all-inclusive and is subject to change. Visit the TRICARE Pharmacy website (<http://www.tricare.osd.mil>) for the most current listing of Tier 3 medications, formulary (generic and brand) alternatives, and medical necessity criteria. Maxor Plus Pharmacy is also able to assist with TRICARE Uniform Formulary questions. Contact Maxor Plus Pharmacy at 800-867-0707 (phone) or 866-208-9930 (fax).

TRICARE requires a \$47 (\$46 for mail order) co-pay for medications on the 3rd tier that do not meet medical necessity criteria. Tier 3 medications that do meet medical necessity will continue with the usual co-pay. Medical necessity criteria include but are not limited to: allergic reaction, therapeutic failure (did not obtain desired effect) of all similar medications in Tier 1 (generic) or Tier 2 (brand name,

formulary), or no formulary alternative. The 3rd tier was established by the DoD to encourage beneficiaries to use the most clinically appropriate, safe, and cost-effective medications.

The following drugs are currently on the DoD 3rd tier:

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

Injectible Drugs

Maxor Mail Order can provide the injectable medications listed below which can be delivered to the member or the provider. However, if the provider will be administering the injectable medication, it is not mandatory that the provider accepts Maxor Mail Order stock. If the cost is greater than \$300 per prescription, prior authorization is required.

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

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

Pharmacy Clinical Review forms (name brand or quantity limit override) can be called or faxed to Maxor Plus at 800-687-0707 (phone) or 866-208-9930 (fax). In general Department of Defense regulations prevent payment for the use of drugs for non-FDA approved indications; exceptions exist. Contact Maxor Plus or the Plan's utilization review department.

Drug Denial Appeals

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

Mail Order Information

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

When issuing a first-time prescription for a maintenance medication, please write two prescriptions: one for a 30-day initial supply and one for a 90-day maintenance supply. The initial 30-day prescription will be filled at any of their affiliated walk-in Plan pharmacies. The 90-day prescription will be filled through Maxor Mail Order.

Pharmacy Benefit limitations and Exclusions

Due to TRICARE restrictions, the USFHP pharmacy benefit excludes:

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

MEDICAL/SURGICAL RECORD CRITERIA

Federal/TRICARE regulations require that the following information should be included in every individual patient record:

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

HEALTHY PEOPLE 2020

Healthy People 2020 is a set of health objectives for the nation to achieve over the first decade of the new century. US Family Health Plan encourages all participating providers to undertake activities to further the health of all members of our health plan. Health care providers can motivate their patients to pursue healthier lifestyles and to participate in community-based programs.

Each objective represents an important public health area and has a target for improvements to be accomplished by the year 2010. The Leading Health Indicators are a limited set of objectives designed to encourage wide participation in improving health in the next decade. They represent the major health concerns in the United States.

The Leading Health 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 please contact the Healthy People Information line at 800-367-4725 or visit www.healthypeople.gov.

National Disaster Medical System (NDMS)

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

What is NDMS?

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

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

Visit the NDMS website at <http://ndms.dhhs.gov/NDMS/ndms.html>.

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