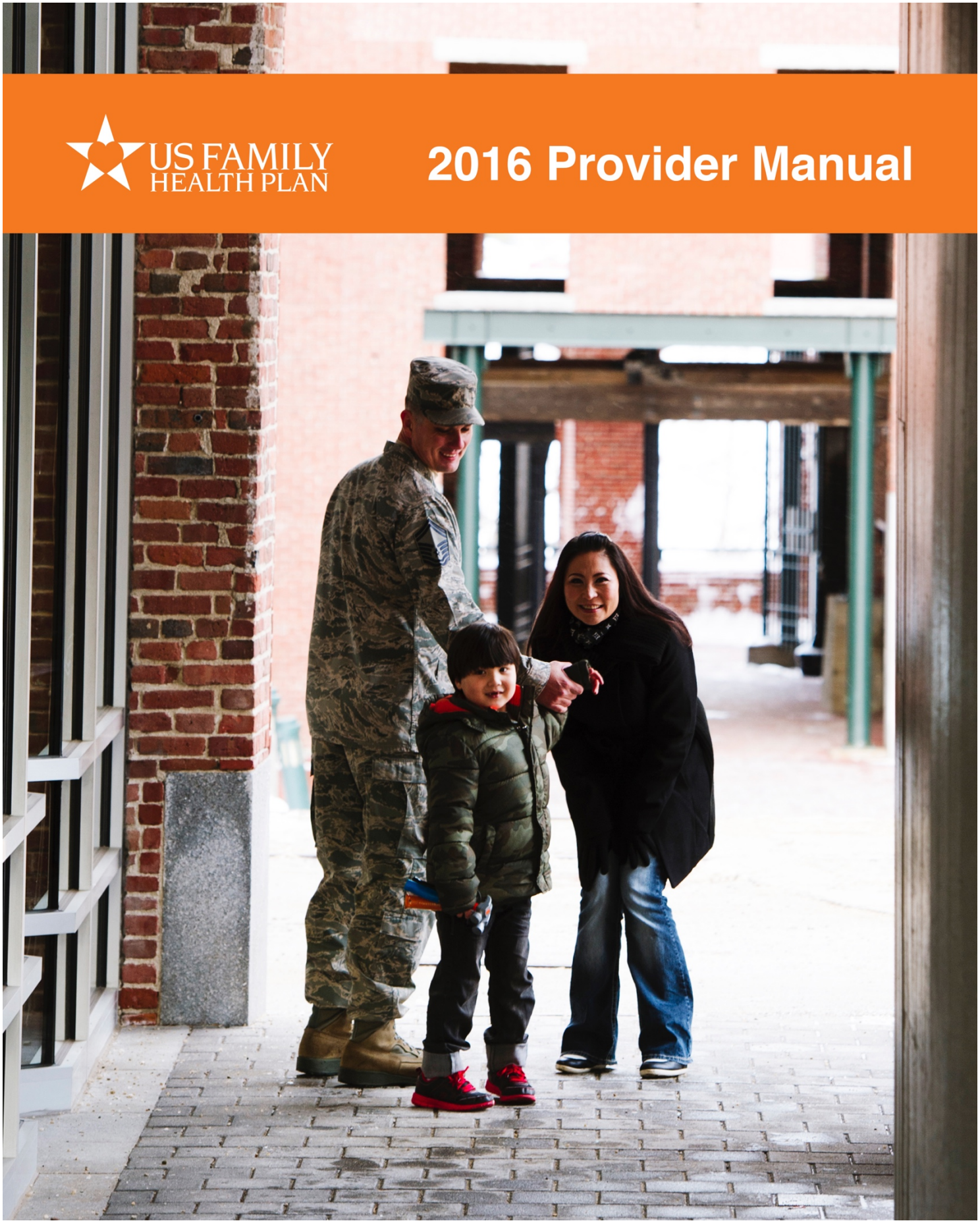
US FAMILY HEALTH PLAN

2016 Provider Manual



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US Family Health Plan
77 Warren Street
Boston, MA 02135
usfamilyhealth.org

Provider Relations and Contracting Manager
Billy Partain, RN
Tel: **617.562.5548**
Cell: **617.992.1882**
Fax: **855.273.5736**
billypartain@usfamilyhealth.org

Provider Relations Representative
Stephanie Shapiro
Tel: **617.562.5254**
Cell: **617.992.1883**
stephanie.shapiro@usfamilyhealth.org

Care Coordinator
Requests for plan authorizations, initial benefit requests
Lexi Lew-Murphy
Tel: **617.562.5583**
Fax: **855.270.5470**
lexi.lew-murphy@steward.org

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

Home Delivery Pharmacy
Tel: **1.877.880.7007**
Fax: **617.562.5296**

Member services
Tel: **1.800.818.8589**

Mental health
Members self refer using this Tufts number for a list of network providers.
Tel: **1.800.208.9565**

Pre-registration
Please identify patient as a US Family Health Plan member.
Tel: **1.800.672.1515**

2 • Network hospitals

Eastern Massachusetts

Greater Boston / North Shore

Anna Jaques Hospital
Beverly Hospital
Boston Children's Hospital
Carney Hospital
Emerson Hospital
Holy Family Hospital
Holy Family Hospital at Merrimack Valley
Lahey Hospital and Medical Centers (2)
Norwood Hospital
St. Elizabeth's Medical Center
Winchester Hospital

South Shore / South of Boston

Good Samaritan Medical Center
Beth Israel Deaconess Hospital – Plymouth
Morton Hospital
New England Sinai Hospital
Saint Anne's Hospital
South Shore Hospital

Cape Cod

Cape Cod Hospital
Falmouth Hospital

Western Massachusetts

Springfield area

Baystate Mary Lane Hospital
Baystate Medical Center
Baystate Franklin Medical Center
Baystate Wing Hospital
Cooley Dickinson Hospital
Holyoke Medical Center
Mercy Medical Center
Noble Hospital

Berkshire County

Berkshire Medical Center
Fairview Hospital

Worcester area

Athol Memorial Hospital
Clinton Hospital
HealthAlliance Hospital
Heywood Hospital
Marlborough Hospital
Milford Regional Medical Center
Nashoba Valley Medical Center
UMASS Memorial Medical Center

Rhode Island

Hasbro Children's Hospital
(pediatric specialty care only)
Kent Hospital
Landmark Medical Centers
Memorial Hospital of Rhode Island
The Miriam Hospital
Newport Hospital
Our Lady of Fatima Hospital
Rhode Island Hospital
Roger Williams Medical Center
South County Hospital
The Westerly Hospital
Women and Infants Hospital

3 • About US Family Health Plan

What is US Family Health Plan?

US Family Health Plan (the Plan) is a TRICARE Prime option, funded by the Department of Defense (DoD), available to families of active-duty service members and to retired service members and their families. The Plan is a managed care plan designed to provide comprehensive medical benefits to members at low out-of-pocket cost. We serve thousands of members in southern New England.

US Family Health Plan provides the full TRICARE Prime benefit, including doctor visits, hospitalizations, emergency care, and prescription drugs. We are different from TRICARE Prime in that instead of being restricted to military hospitals or clinics, our members choose from a network of civilian doctors and hospitals. Covered benefits are available only from Plan providers and hospitals except during a medical emergency.

We require referrals, but strive to make the referral process efficient and easy to use (see pages 12-14 for details).

Relationship with Tufts Health Plan

Tufts Health Plan serves as the Plan's third-party administrator, providing claims processing, referral management, and member-relations services. This affiliation provides US Family Health Plan members with access to a selected Tufts network of physicians and hospitals, as well as to specialty and ancillary providers. In addition, US Family Health Plan is supported by the Tufts wellness benefits and other established programs, which include Complex Care Management programs.

Summary of benefits

	Active-Duty Family Members and/or those with Medicare Part B	Retirees and Family Members Without Medicare Part B
Annual Enrollment Fee	$0	$282.60/individual $565.20/family
Covered Services	**When provided or authorized by a network provider**	
Annual physical (all ages)	$0	$0
Annual comprehensive GYN exam	$0	$0
Other doctor visits, including specialists	$0	$12
Emergency room visits (network or non-network)	$0	$30
Inpatient hospitalization (including maternity)	$0	$11/day ($25 minimum)
Outpatient surgery	$0	$25
Eye exams	$0	$12
Prenatal and postnatal visits	$0	$0
Well-child visits / immunizations (up to 24 mos.)	$0	$0
Lab work and diagnostic radiology	$0	$0
Physical / occupational / rehabilitation therapy	$0	$12/visit
Radiation therapy and chemotherapy	$0	$12/visit
Ambulance	$0	$20/occurrence
Chiropractic (spinal manipulation) Not covered under other TRICARE options	$0	$10/visit
Home health care	$0	$12/visit
Skilled nursing facility care	$0	$11/day ($25 minimum)
Durable medical equipment (supplies, prostheses)	$0	20% of cost

Mental Health	When provided or authorized by a network provider	
Outpatient visits	$0	$25/individual $17/group
Inpatient hospitalization (partial or full)	$0	$40/day ($25 minimum)
Inpatient substance-abuse treatment (partial)	$0	$40/day ($25 minimum)

Prescription Coverage Home Delivery Maintenance medications (90-day supply)	Copayment (per prescription)	
Generic	$0	$0
Brand-name	$20	$20
Non-formulary	$49	$49
Retail Pharmacy One-time or urgent medications (30-day supply)	Copayment (per prescription)	
Generic	$10	$10
Brand-name	$24	$24
Non-formulary	$50	$50

Catastrophic cap. Your copayment expenses are limited to $1,000 per year for active-duty families and $3,000 per year for retiree families. The enrollment fee (if applicable) and all out-of-pocket copayments are included when determining the catastrophic cap.

Deductibles. Covered services provided by or authorized by network providers are not subject to a deductible amount.

This summary is not all-inclusive. Call Member Services at **1.800.818.8589** for complete details of benefit coverage and exclusions. The benefits and costs described here are accurate as of February 1, 2016, but are subject to change by the government.

Point of Service option

The TRICARE benefit provided by US Family Health Plan includes a Point of Service option that provides limited coverage for unauthorized, non-emergent, out-of-network services.

In order for Point of Service coverage to apply, the care provided must be a TRICARE-covered benefit. While the Point of Service option provides some coverage for unauthorized out-of-network care, members must pay significant out-of-pocket costs.

Charges	Individual	Family
Deductible per Plan Year (October 1 through September 30) for outpatient care only	$300	$600
Cost share for outpatient care	50 percent of TRICARE allowable charge, after annual deductible is met	
Cost share for inpatient care	50 percent of TRICARE allowable charge	
Additional charges by non-network providers	Beneficiary is fully responsible. Up to 15 percent above the TRICARE allowable charge is permitted by law.	

Note: Out-of-pocket costs under the Point of Service option are not applied to the catastrophic cap.

4 • Physicians

Primary Care Providers

Responsibilities

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

Routine and preventive care

Routine and preventive care includes physical examinations, immunizations, disease screening, and Pap smears (see page 5 for details).

Specialty care

The PCP arranges specialty care for members. For US Family Health Plan members, this care must be arranged within the US Family Health Plan network. **Visit usfamilyhealth.org/find-a-doctor** to search for a participating provider or hospital. Any specialty care that cannot be provided within the US Family Health Plan network must be authorized by the US Family Health Plan Care Coordinator. In certain circumstances, a request must be sent to the US Family Health Plan Appeals Committee.

Urgent/Emergency care

Urgent or emergency care includes the coordination of emergency services and inpatient and outpatient care. If members receive urgent care, follow up should always occur with the PCP and/or, if needed, a specialist within the US Family Health Plan network. A referral is required for urgent care.

When a member notifies you of an admission, instruct him or her to call US Family Health Plan Member Services at **1.800.818.8589** to report the admission.

Out of network care

PCPs are responsible for transferring members to the appropriate US Family Health Plan network hospital, which you can find at **www.usfamilyhealth.org/wp-content/uploads/2015/08/Hospitals.pdf**. The member should be transferred as soon as he or she is stabilized, and the PCP should monitor the member's care closely with the attending physician on a pro-active basis.

Healthy People 2020

We also encourage our providers to participate in the federal government's Healthy People 2020 program. Go to **healthypeople.gov** to learn more about the program and the government's important Leading Health Care Indicators.

Primary Care Provider monthly member list

Once a month, US Family Health Plan provides each PCP with a list of all US Family Health Plan members who have selected the physician as their PCP. The information on the monthly member list includes:

- Monthly additions to and deletions from the PCP's member list
- Member's identification number
- Member's address and telephone number

Note: Providers should call US Family Health Plan Member Services at **1.800.818.8589** with any necessary changes in status to their US Family Health Plan member list (for example, death of a member or incorrect listing on monthly report).

Closing or re-opening a panel

Providers must notify the US Family Health Plan Provider Relations Representative directly of any changes they would like to make to their panel status.

Removing a US Family Health Plan member from a panel

Under rare circumstances, a physician may feel that it is no longer appropriate to act as a PCP for a US Family Health Plan member. The PCP must send a written notice to the member by registered mail and a copy to US Family Health Plan, attn: Member Services, P.O. Box 9195, Watertown, MA 02471-9900, explaining the reason for the decision. The PCP must include an agreement to provide urgent care for up to 30 days so that the member will have time to select a new PCP.

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

Specialty Providers

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

A Specialty Provider *should not* refer a US Family Health Plan member to another provider and/or suggest other treatment without discussing the case with the PCP. Many members assume that if their PCP refers them to a Specialty Provider, all care is covered. It is also important for the Specialty Provider to provide only those services authorized by the PCP.

For example, if the referral form states "Consultative Opinion Only," the Specialty Provider must call the PCP before ordering diagnostic tests or procedures. An additional referral must be written in that circumstance.

Note: If a Specialty Provider feels additional treatment is required and cannot provide these services, the Specialty Provider is responsible for contacting the member's PCP and suggesting that the PCP provide the member with an alternative referral.
There are two exceptions to this rule:

- Urology may refer to Oncology/Radiation Services (a written referral from the urologist must be issued).
- Orthopedics may refer to Physical Therapy (a written referral from the orthopedist must be issued).

On-Call Providers

On-Call Providers are responsible for urgent/emergency care only. Follow-up treatment should always occur with the member's PCP.

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

Credentialing

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

5 • Pharmacy

Home Delivery Pharmacy program

US Family Health Plan members are required to receive maintenance medications through our mail-order pharmacy program, called "Home Delivery."

Home Delivery saves members money. They receive a 90-day supply of maintenance medication for considerably less than they would pay for a 30-day supply at a local pharmacy. Because generic medications are free to our members through Home Delivery, please prescribe them whenever possible.

Maintenance medications

Write all prescriptions for maintenance medications for 90-day supplies and submit the prescriptions to our Home Delivery service one of these ways:

- **Online**. Submit the member's prescription electronically to the Brighton Marine Health Center at 77 Warren Street, Brighton, MA 02135.
- **Fax**. Send the member's prescription by fax to our pharmacy at **1.617.562.5296**.
- **Phone**. Call the member's prescription in to our pharmacy at **1.877.880.7007**.

Urgent and one-time prescriptions

US Family Health Plan members may pick up urgent and one-time medications at a retail pharmacy. Please submit these prescriptions to the retail pharmacy in your usual way.

Refills

Members obtain refills of maintenance medications online at **usfamilyhealth.org/refill** or by phone at **1.877.880.7007**.

Refills are not automatic. Members call our pharmacy at **1.877.880.7007** if they run out of refills, and we ask the primary care provider to provide a new prescription.

Exclusions

Oral contraceptives. Because of certain restrictions, we are not allowed to dispense oral contraceptives. Members should obtain these prescriptions at their local pharmacy.

US Family Health Plan as secondary insurer. If a member has another insurance plan where US Family Health Plan is the secondary insurance, we do not accept those plans at our pharmacy.

If you have any questions about the service, please call a Home Delivery representative at **1.877.880.7007**. You can also learn more at **usfamilyhealth.org/pharmacy**.

Oral formula

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

Intravenous Immune Globulin (IVIg)

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

Minimum list of dangerous and prohibited abbreviations

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

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

Unacceptable Abbreviations and Symbols

Do not use these dangerous abbreviations or dose designations.

Abbreviation/Dose Expression	Potential Problem	Correction
U or u	Mistaken as zero, four or cc.	Write "unit"
IU	Mistaken as IV (intravenous) or 10 (ten).	Write "international unit."
q.d. or Q.D.	Mistaken for Q.O.D. The period after the Q can be mistaken for an "I".	Write "daily" or "every day."
q.o.d. or Q.O.D.	Mistaken for Q.D. The period after the "O" can be mistaken for an "I".	Write "every other day."
Trailing zero (X.0 mg).	Decimal point is missed.	Never write a zero by itself after a decimal point (Xmg).
Lack of leading zero (.X mg).	Decimal point is missed.	Always use zero before a decimal point (0.X mg).
MS	Confused for magnesium sulfate.	Write out morphine sulfate.
MSO_4	Confused for magnesium sulfate.	Write out morphine sulfate.
$MgSO_4$	Confused for morphine sulfate	Write out magnesium sulfate.
A.S., A.D., A.U. (Latin abbreviations for left, right, or both ears),	Mistaken for each other.	Write out "left ear," right ear," or both ears."
T.I.W. (for three times a week)	Mistaken for three times a day or twice weekly resulting in an overdose.	Write out "3 times weekly" or "three times weekly."
ss	Mistaken for "55."	Spell out "sliding scale."
R, L	Mistaken for each other.	Spell out "Right" or "Left"

6 • Referral Management

	USFHP referral form needed?	Plan authorization needed?	Number of visits	Referral expires
In-network specialist — referrals are always required.				
Medical services with limited benefit, such as oral surgery	✓	✓	PCP indicates	**1 year** or number of visits indicated, whichever comes first
Nutritional counseling related to diabetes	✓	✗	**First year: 10 visits** to certified diabetes educator; **3 visits** to registered dietician	**1 year** or number of visits indicated, whichever comes first
Nutritional counseling related to medical condition (not just being overweight)	✓	✓	**3 visits in 1 year (maximum)**	**1 year** or number of visits indicated, whichever comes first
Outpatient physical therapy	✓	✗	**9 visits** (after first 9, PT facility must contact Tufts Health Plan pre-certifi-cation department for additional authorization)	PCP must **make new referral at start of every Plan year** (Oct 1 through Sept 30)
Outpatient occupational therapy and speech therapy	✓	Depends on diagnosis	**30 visits**	PCP must **make new referral at start of every Plan year** (Oct 1 through Sept 30)
Ophthalmology when medically necessary, such as eye exam for patient with glaucoma or diabetes. (Optometry services are rendered through EyeMed.)	✓	✗	PCP indicates	**1 year** or number of visits indicated, whichever comes first
Radiation, chemotherapy, dialysis	✓	✗	**99 visits**	**1 year** or number of visits indicated, whichever comes first

Referrals to in-network specialists

To see a specialist in the US Family Health Plan network (which isn't identical to the Tufts Health Plan network), a member needs a referral from his PCP. Find out whether a specialist is in our network at **usfamilyhealth.org** or by calling Member Services at **1.800.818.8589**. Sometimes Plan authorization is also required (see above). Referrals ordinarily last for one year or the number of visits indicated, whichever comes first. Submit the US Family Health Plan referral form one of these ways:

- Electronically using Tufts Health Plan's secure website, NEHEN, NEHENNet, or Emdeon.
- Or mail to PO Box 9195, Watertown, MA 02471-9195.

If Plan authorization is needed, submit the referral form and documentation one of these ways:

- Electronically using Tufts Health Plan's secure website, NEHEN, NEHENNet, or Emdeon. Always accompany by fax/e-fax transmittal of documentation and clinical notes with the member ID and referral number. Out-of-network referrals will be denied unless accompanied by this information.
- Fax/e-fax the referral form to **855.270.5470**, including documentation and clinical notes.
- Or mail to US Family Health Plan, Care Coordinator, 77 Warren Street, Boston, MA 02135, including documentation and clinical notes.

Our Care Coordinator responds in two to three business days.

	USFHP referral form needed?	Plan authorization needed?	Number of visits	Referral expires
Out-of-network specialist If both a referral and Plan authorization are not obtained, the patient bears significant extra cost.				
All services	✓	✓	PCP indicates	**1 year** or number of visits indicated, whichever comes first
Other care Referral not required.				
Laboratory, diagnostic, and radiology diagnostic services rendered at a network facility.	✗	✗	NA	NA
Mental health (members self-refer to in-network provider)	✗	✗	**8 visits** per calendar year	NA
Chiropractic (for members over age 12, spinal manipulation only)	✗	✗	**12 visits** per calendar year	NA
Optometrist (routine eye exams, medical/non-routine eye care through EyeMed network)	✗	✗	**3 visits** per calendar year (for visits beyond 3, PCP's referral and authorization are required)	NA

Referrals to out-of-network specialists

To see a specialist not in the US Family Health Plan network, a member needs a referral from her PCP *and* authorization from US Family Health Plan. If a member is seen by an out-of-network specialist without a referral and a US Family Health Plan authorization, the member must pay significant out-of-pocket costs under the Plan's point of service policy. For out-of-network authorization, submit the referral form and documentation one of these ways:

- Electronically using Tufts Health Plan's secure website, NEHEN, NEHENNet, or Emdeon. Always accompany by fax/e-fax transmittal of documentation and clinical notes with member ID and referral number. Out-of-network referrals will be denied unless accompanied by this information.
- Fax/e-fax the referral form to **855.270.5470**, including documentation and clinical notes.
- Or mail to US Family Health Plan, Care Coordinator, 77 Warren Street, Boston, MA 02135, including documentation and clinical notes.

Our Care Coordinator responds in two to three business days.

Surgical day care procedures

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

Diabetes outpatient self-management training services

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

Authorization is required in advance. Each case is reviewed on an individual basis. To request prior authorization, a letter of medical necessity must be written by the referring physician, along with any supporting clinical documentation and a US Family Health Plan referral completed. This information must be faxed to the Care Coordinator at **617.562.5244** for review. Co-pays may apply.

Transcutaneous Electrical Nerve Stimulator (TENS)

A Certificate of Medical Necessity, which can be downloaded from our website, and a written prescription must be completed and faxed to the US Family Health Plan Medical Director at **617.562.5244**.

If member is approved for a TENS Unit, the Care Coordinator will contact the member and explain how to order the Unit. This includes explaining to the member that he or she is responsible for ordering the TENS Unit through our specific vendor. For more information, contact the Care Coordinator at **617.562.5244**.

Bariatric surgery

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

US Family Health Plan has a designated network of facilities that are accredited for bariatric surgery.

Services provided without referral authorization (waivers)

Under US Family Health Plan policy, members are responsible for obtaining referrals for specialty services before making appointments with Specialty Providers. To confirm a member's understanding of this policy, many offices have patients sign a waiver form similar to this:

Provider Office
Provider Address

As a member of US Family Health Plan I understand that I must obtain a referral for specialty services from my Primary Care Provider before making an appointment. I acknowledge that I do not have a referral today, and may be responsible for payment of services received should this be denied by the US Family Health Plan.

Name: Date:

Signature:

Address: Phone:

Note: Please remember that Plan providers are not allowed to bill Plan members unless the members have signed the waiver form above or a similar form.

7 • Pre-registration

Overview

Pre-registration is required for members being admitted for inpatient care or surgery. However, it does not guarantee payment. When an admission is reported, the pre-registration notification process does the following:

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

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

The Tufts Health Plan/US Family Health Plan care managers concurrently review inpatient admissions for medical necessity using InterQual criteria. US Family Health Plan is not obligated to pay pre-registered claims under the following circumstances:

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

Required notification time

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

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

Pre-registration procedure

Contact the Tufts Health Plan/US Family Health Plan Pre-registration Department by phone or fax.

Phone: **1.800.672.1515**
Fax: **617.972.9590**

Admissions after business hours are subject to the pre-registration guidelines. Messages may be left on the answering machine during non-business hours. Business hours are 8:30 am to 5:00 pm, Monday through Friday. When you call, please:

- Identify the patient as a US Family Health Plan member.
- Provide the member's name, identification number, admitting date, attending physician, and complete diagnosis and clinical information.

The pre-registration staff will give you an authorization number.

After-hours urgent and emergency admissions

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

Phone: **1.800.672.1515**
Fax: **617.972.9590**

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

Obstetrical and newborn pre-registration procedure

In addition to the preceding steps, the following requirements apply to obstetrical and newborn patients:

- Pregnant women must be pre-registered for delivery by 20 weeks gestation through completion of the MHQP OB Risk Assessment form. This will ensure that members receive all maternity benefits and are evaluated for participation in the Tufts Health Plan / US Family Health Plan Healthy Birthday program. The Healthy Birthday Program is the Tufts preterm labor and delivery prevention program.
- Pregnant women with multiple inpatient admissions must be preregistered for each admission up to and including actual delivery.
- Well newborns are covered under the mother's pre-registration for delivery.
- Sick newborns must be pre-registered separately within the reporting time-frame guidelines if they will be staying in the hospital beyond the mother's discharge date.

Rescheduled elective admissions

If an elective admission is rescheduled, please notify the pre-registration staff of the change.

Exclusions

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

MHQP OB Risk Assessment

Figure 5.1 Massachusetts Health Quality Partners Risk Assessment Tool Form

Massachusetts Health Quality Partners Obstetrical Risk Assessment Tool

Name _____ (Last / First / Middle) Health Plan & Subscriber ID#_____

Address _____ (street / Apt.# / City / State / zip)

Phone: Home_____ Work:_____ Date of Birth:_____

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

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

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

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

Language spoken at home_____ Needs translation help Y ❑ N ❑ Support System Y ❑ N ❑

Behavioral Risks

Smoking Status

Smokes regularly now, about the same as prior to pregnancy. Y ❑ N ❑

Smokes regularly now but less than prior to the pregnancy. Y ❑ N ❑

Smokes every once and a while. Y ❑ N ❑

Quit smoking < 3 mo. prior to pregnancy Y ❑ N ❑

Quit smoking since becoming pregnant. Y ❑ N ❑

Wasn't smoking when became pregnant and doesn't smoke now. Y ❑ N ❑

Substance Abuse

Is the patient currently using alcohol?_____ Y ❑ N ❑

Is the patient currently using street drugs?_____ Y ❑ N ❑

In the month prior to pregnancy:

How many drinks did the patient consume in one week? _____

On how many occasions did the patient have more than 3 drinks? _____

On how many occasions did the patient have any drugs? _____

Occupational Demands Sedentary ❑ Active ❑ Hours spent standing_____

Psychosocial Assessment completed Y ❑ N ❑

Psychosocial risk factors identified: (please circle) 1. frequent moves 2. care access 3. hungry 4. education 5. safe 6. violence 7. stress 8. pregnancy planning

Obstetrical High Risk/ Pre-Term Labor Assessment

Gravida_____ Full Term_____ Pre-term_____ Abs_____ Living_____ Height:_____ Weight:_____

Previous C/S? Y ❑ N ❑ VBAC discussed ❑ VBAC planned ❑ VBAC refused ❑ VBAC medically inappropriate ❑

Risk Factors: Past OB/GYN History Including Past Pregnancies **Initial Screen** date ___/___/___

Pre-term labor with previous pregnancy (less than 37 weeks) ..... Y ❑ N ❑

Pre-term delivery with previous pregnancy (less than 37 weeks) ..... Y ❑ N ❑

Diagnosis associated with pre-term delivery (narrative)_____

Incompetent cervix Y ❑ N ❑ Cerclage with previous pregnancy Y ❑ N ❑

DES Exposure ..... Y ❑ N ❑

Two or more 2nd trimester abortions ..... Y ❑ N ❑

Delivery within the past 12 months ..... Y ❑ N ❑

Prior cone biopsy Y ❑ N ❑ Known uterine anomalies Y ❑ N ❑

Uterine fibroids Y ❑ N ❑ Myomectomy Y ❑ N ❑

Risk Factors: Current Pregnancy **26-28 weeks screening date** ___/___/___

ART this pregnancy Y ❑ N ❑ Gonadotropin Y ❑ N ❑ Clomophine Y ❑ N ❑

Multiple gestations Y ❑ N ❑ Fetal reduction Y ❑ N ❑

Presence of Bacterial Vaginosis this pregnancy Y ❑ N ❑ Treatment for BV Y ❑ N ❑

Bleeding after 12 weeks this pregnancy ..... Y ❑ N ❑

Pre-term labor this pregnancy Y ❑ N ❑ Cervical changes Y ❑ N ❑ Cerclage Y ❑ N ❑

Placenta previa beyond 26 weeks, this pregnancy ..... Y ❑ N ❑

Polyhydramnios this pregnancy ..... Y ❑ N ❑

Pregnancy Induced Hypertension this pregnancy..... Y ❑ N ❑

Gestational diabetes this pregnancy ..... Y ❑ N ❑

Other Risk Factors current or past pregnancy (narrative)_____

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

Signature of Member Date Signature of Provider Date

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

8 • Billing

General guidelines

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

Send all first submissions to this address:

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

Payment of claims

"Clean Claims" are:

- Submitted on forms with all fields completed accurately, as described later in this section.
- Accompanied by a completed referral form, if required (see pages 12-14 for details).
- Not pended or involving Coordination of Benefits (COB)/Third-Party Liability, or Workers' Compensation

The conditions of payment are as follows:

1. The services are covered services in accordance with the applicable benefit document provided to US Family Health Plan members who meet eligibility criteria.

2. The services were:
   - Provided or authorized by the member's PCP or the PCP's covering physician in accordance with the applicable benefit document.
   - Provided or authorized as identified elsewhere in your agreement with the US Family Health Plan.
   - Authorized by US Family Health Plan.
   - Provided in an emergency in accordance with the member's benefit document.
   - Medically necessary as defined in the member's benefit document.

3. US Family Health Plan received the claim within the time frame described in the provider's agreement with US Family Health Plan or, in the absence of such a time frame, 90 days from the date of service or the date of discharge if the member is an inpatient, provided that US Family Health Plan payment of an untimely invoice shall not constitute a waiver of this requirement for any other invoice.

4. For certain imaging services, inpatient admissions, inpatient transfers, and hospital-based ambulatory surgery procedures, the services were pre-registered in accordance with US Family Health Plan pre-registration guidelines.

5. The services were billed using the appropriate CPT-4 codes (e.g., no "unbundling," or other codes assigned by US Family Health Plan), and

6. In the case of physician services billed by the hospital, services were billed on CMS-1500 forms with a valid CPT-4 code (level 1 HCPCS code).

Billing requirements for hospital outpatient services

The CMS-1500 and the UB-04 forms are the acceptable standard for paper billing. All providers, including internal medicine, gynecology, and psychiatry should use ICD-9-CM diagnosis codes and the HCPCS/CPT procedure codes. Oral surgeons may use the ADA procedure codes.

To be appropriately reimbursed when your hospital bills for professional services in addition to facility and ancillary services for clinic visits (including mental health and substance abuse), claims must be submitted on the appropriate form types, as specified here:

Service	Form
Facility/Clinic/Room charge inclusive of professional component (global billing)	CMS-1500
Facility and/or ancillary services	UB-04
Professional physician services	CMS-1500
Emergency room professional services	CMS-1500
Emergency room facility and ancillary services	UB-04

All claims must be submitted in accordance with the guidelines specified by Tufts Health Plan, the third-party administrator for US Family Health Plan. For a copy of these requirements, please contact your Provider Relations Representative.

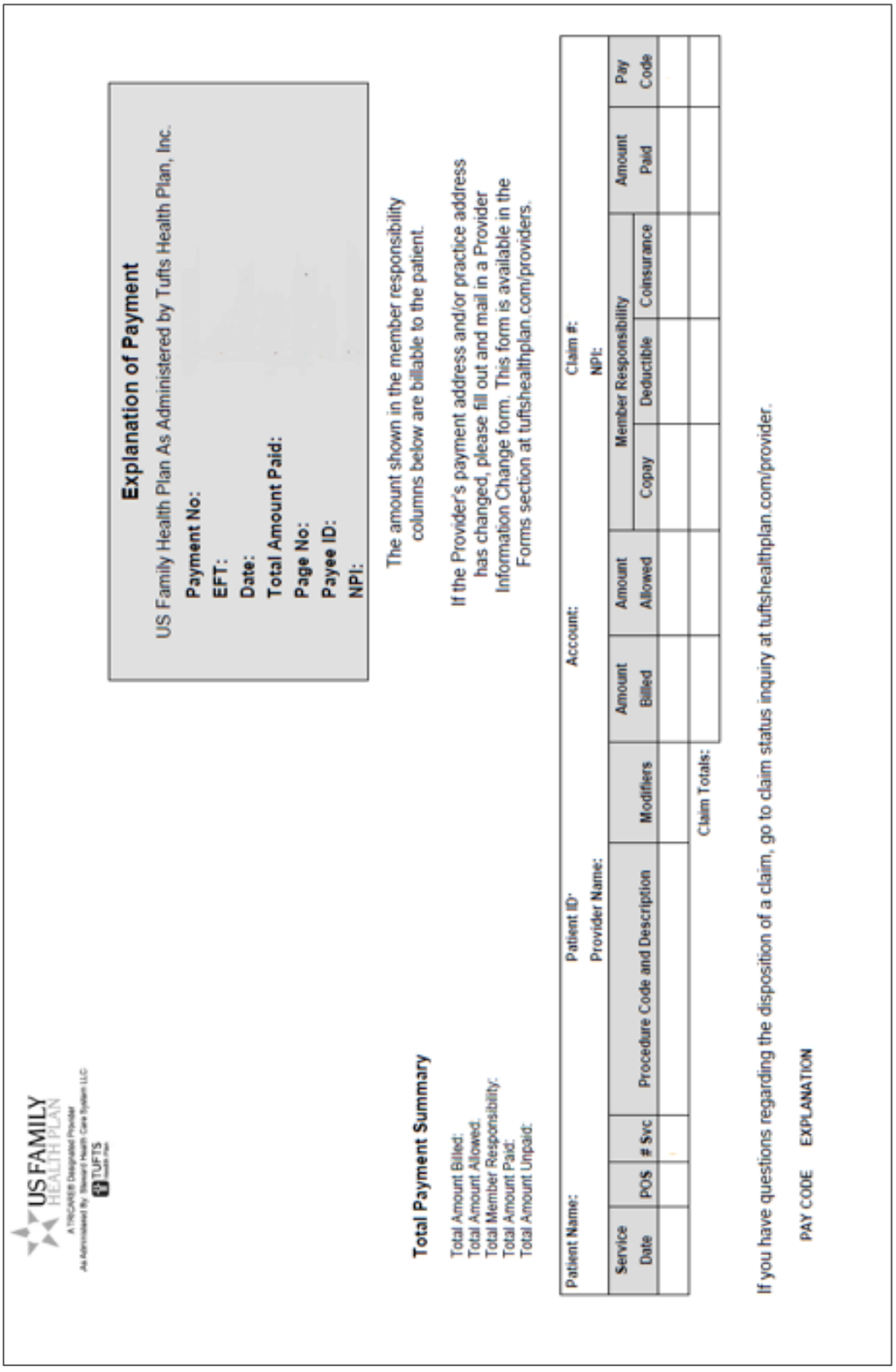
If you are unable to comply with the billing specifications described above, notify your Provider Relations Representative.

Electronic claims submission

Providers may submit claims electronically by means of a variety of external clearinghouse sources. Interested providers can contact their Provider Relations Representative.

Explanation of Payment (EOP)

The Explanation of Payment (EOP) is a weekly report of all claims that have been paid or denied to that provider. Please see the sample EOP below.



US FAMILY HEALTH PLAN

A TRICARE® Designated Provider

As Administered By: Network Health Care System LLC

TUFTS Health Plan

Explanation of Payment

US Family Health Plan As Administered by Tufts Health Plan, Inc.

Payment No:
EFT:
Date:
Total Amount Paid:
Page No:
Payee ID:
NPI:

The amount shown in the member responsibility columns below are billable to the patient.

If the Provider's payment address and/or practice address has changed, please fill out and mail in a Provider Information Change form. This form is available in the Forms section at tuftshealthplan.com/providers.

Total Payment Summary

Total Amount Billed:
Total Amount Allowed:
Total Member Responsibility:
Total Amount Paid:
Total Amount Unpaid:

Patient Name: Patient ID: Account: Claim #:
Provider Name: NPI:

Service Date	POS	# Svc	Procedure Code and Description	Modifiers	Amount Billed	Amount Allowed	Member Responsibility			Amount Paid	Pay Code
							Copay	Deductible	Coinsurance		
			Claim Totals:								

If you have questions regarding the disposition of a claim, go to claim status inquiry at tuftshealthplan.com/provider.

PAY CODE EXPLANATION

US FAMILY HEALTH PLAN
A TRICARE® Designated Provider
As Administered By: Steward Health Care System LLC
TUFTS Health Plan

Payment Date:
Payment Amount:
Payment #:

Tufts Health Plan Go-Green is NOW LIVE!

Tufts Health Plan is no longer printing and mailing Explanations of Payment (EOPs) to providers. In order to access your EOPs you must register with PaySpan Health®. If you are already registered with PaySpan for electronic EOPs, no action is required.

If you are not yet registered, visit the PaySpan Health website at payspanhealth.com and use the Registration Code and PIN below.

Would you like to receive your claims payments faster? Activate your existing account for EFT and have payments deposited directly into the provider's bank account.

To activate for EFT, please visit www.payspanhealth.com and login to your account. You will need the bank routing and account number.

If you need assistance, please contact PaySpan Provider Services at 877.331.7154, Option 1

PIN:

US FAMILY HEALTH PLAN
A TRICARE® Designated Provider
As Administered By: Steward Health Care System LLC
TUFTS Health Plan

Bank of America
Boston, MA

Payment Number:
Payment Date:

Field	Explanation
PATIENT NAME (ID NUMBER)	Patient's name and US Family Health Plan ID number
SERVICE DATE	Date of service
POS	Place of service
NO. SVC	Number of services
PROCEDURE AND DESCRIPTION	Procedure code and description (CPT code)
AMOUNT BILLED	Amount billed
AMOUNT ALLOWED	Amount allowed: reimbursement amount agreed upon by the individual Provider Unit
MEMBER RESPONSIBILITY	Co-payment
AMOUNT PAID	Amount US Family Health Plan paid provider for services
PAY CODE	PD = paid claims Unpaid claims will be identified by a pay code explanation.
ACCT	Patient's account number as assigned by the provider
CLAIM NO.	US Family Health Plan assigned claim number
SUMMARY	Total amounts billed, allowed, paid, and unpaid

Following up on claims

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

- "Summary of Claims in Process" appears at the top of the barred section.
- Pay codes display a pending message rather than a payment or denial message.
- All entries on the Summary of Claims in Process appear on the Explanation of Payments upon claim adjudication.

If a submitted claim has not appeared on either the Explanation of Payments or the Summary of Claims in Process reports within 30 to 45 days, then verify if the claim was received by logging on to the Tufts Health Plan's website or by contacting the Member Services department. If the website or the Members Services department confirms that US Family Health Plan has not received the claim, resubmit another claim electronically or on paper to the US Family Health Plan claims address.

Electronic Claims Follow-Up — 999 and 277CA Reports

Direct submission: Reports are posted online within 24 hours of transmission to US Family Health Plan. The reports must be reviewed for error messages daily and stored for future reference. If a claim is rejected, it must be corrected and submitted before the 90-day filing limit. If the claim has not appeared on your Explanation of Payments or electronic remittance, review the original transmission report.

Appeals

If a provider disagrees with US Family Health Plan's decision regarding the denial of a claim that was not allowed due to the lack of prior authorization or inpatient notification, the provider can file a request for reconsideration using the online claim adjustment process. This appeal must be submitted within 90 days from the date of the denial in order to be considered.

Note: When submitting a paper request for reconsideration (appeal) of a denied claim, you must include a completed Request for Claim Review Form. Go to **hcasma.org/attach/Interactive-appeal-form-final-aug-2013.pdf** for the form and follow the process outlined below.

Filing deadline appeals

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

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

   The provider may appeal the denial by sending a copy of the EOB with proof of the original submission date. This proof may include, but is not limited to, a ledger card showing the original billed date, a print-out of the billing history, or an EOB from another insurance carrier.

2. If the claim was submitted after the filing limit but the circumstances were beyond the provider's control, such as the following:

   - Incorrect insurance information supplied by the member
   - Computer error that caused a billing delay

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

Send these appeals to the following address:

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

Pre-registration/Provider appeals

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

To appeal a pre-registration denial, submit a letter stating all pertinent information to:

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

Incorrect processing appeals

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

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

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

Referral appeals

If a provider feels that a claim was inappropriately denied for lack of referral, submit the referral with a highlighted copy of the EOP to (referral will retroactively match to denied claim):

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

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

All other appeals

If a physician or hospital chooses to appeal the payment or denial for a reason not listed above, submit a letter documenting all pertinent information with a copy of the EOB/EOP to:

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

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

9 • Coordination of Benefits/Third-Party Liability

Coordination of Benefits

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

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

- **Providers are prohibited from billing TRICARE or Medicare under any circumstances for services covered by US Family Health Plan.**
- **At no time during this process should providers attempt to seek payment from the member for services covered by US Family Health Plan.**

US Family Health Plan is secondary to all commercial health plans. Federally sponsored health plans (Federal Blue Cross and Mail Handlers) are primary to US Family Health Plan. If you have questions about COB, please call **1.800.818.8589**.

We ask for your cooperation in providing us with other insurance information in order to expedite the processing of claims. You can communicate this information to US Family Health Plan by calling **1.800.818.8589.**

Third-party liability

Third-party liability involves members who are claiming against another party for injuries sustained in an accident. These accidents might include motor vehicle accidents, slip and fall accidents, product liability situations, and so on. Under the US Family Health Plan contract, we are required to inform the service Judge Advocate General (JAG) when an enrollee is involved with third-party liability and to collect and forward all claim information to the JAG for disposition.

Under no circumstances can a provider or US Family Health Plan make collections under third-party liability. **Do not bill the member or the member's attorney directly.** Should the member and/or attorney request a direct bill, contact US Family Health Plan Member Services at **1.800.818.8589**.

Please note that US Family Health Plan has contracted with The Rawlings Company to assist in determining whether treatment received by a member is a result of an accident or injury for which another party may be responsible. The criteria used are based on government guidelines.

Note: Prior to submission of a US Family Health Plan claim, the provider is not precluded from seeking recovery of its billed charges directly from the liable third party or insurer, including auto or homeowners insurance, no-fault auto, or uninsured motorist coverage.

10 • Mental Health and Substance Abuse

Mental health services

Outpatient mental health

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

Authorization is required after 10 outpatient psychotherapy sessions. Active-duty family members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay $25 per individual outpatient visit.

Outpatient family and group therapy

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

Authorization is required after 10 outpatient psychotherapy sessions. Active-duty family members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay $17 per group outpatient visit. This benefit is separate and distinct from the outpatient mental health benefit.

Inpatient services for mental illness

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

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

Partial hospitalization

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

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

Substance abuse services

Substance use treatment (Inpatient, partial)

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

When provided or authorized by the member's Designated Facility, up to 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward the

statutory day limit, limiting care for adults (age 19 and over) to 30 days in a Plan year or 30 days in an admission and to 45 days for children (age 18 and under).

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

Active-duty family members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay $40 per day.

Substance abuse treatment (outpatient care and family therapy)

Outpatient care

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

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

Active-duty family members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay $17 per group outpatient visit.

Family therapy

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

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

Active-duty family members have no co-payments. Retirees and their families who are not enrolled in Medicare Part B pay $17 per visit.

Pediatric mental health/substance abuse (inpatient and outpatient)

All pediatric (under 18 years of age) mental health and substance abuse services are provided by the Tufts Health Plan network of mental health providers. Please contact a Mental Health Care Coordinator at **1.800.208.9565** for more information.

Psychological/Neuropsychological testing

Written referrals are not required for psychological/neuropsychological testing. Providers should contact a Mental Health Care Coordinator or Mental Health Service Representative at **1.800.208.9565** to request a Psychological/Neuropsychological Testing Request form. This form can also be obtained at **usfamilyhealth.org** (click on Information for Providers).

Send the form to this address:

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

Or fax to **617.673.0301**

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

Provider responsibilities

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

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

Members are assigned to a Designated Facility based on the member's age and location. The Designated Facility is responsible for pre-registering admissions or coordinating alternatives when appropriate. If a member is hospitalized, a US Family Health Plan Mental Health Care Manager will provide a quality assurance review for that admission.

The Care Manager and Designated Facility facilitate the member's discharge and direct any outpatient care back to the member's PCP or contracting mental health provider. Please contact a Mental Health Care Coordinator at **1.800.208.9565** for a list of participating facilities.

11 • Selected Benefit Information

This is a brief overview of selected benefits. For more detailed information, call US Family Health Plan Member Services at **1.800.818.8589**.

Durable Medical Equipment

US Family Health Plan covers the purchase or rental of certain specified pieces of Durable Medical Equipment (DME) from vendors affiliated with Tufts Health Plan. Tufts Health Plan has developed contracts with several organizations that provide DME to US Family Health Plan members under arrangements for service, quality, and cost. Please call US Family Health Plan Member Services at **1.800.818.8589** for a list of DME providers.

Definition

As defined in TRICARE Policy 32 CFR 199.2, DME is:

1) Equipment for which the allowable charge is over $100.

2) Medically necessary for the treatment of a covered illness or injury.

3) Improves the function of a malformed, diseased, or injured body part or retards further deterioration of the patient's physical condition.

4) Is used primarily and customarily to serve a medical purpose, rather than primarily for transportation, comfort, or convenience.

5) Can withstand repeated use.

6) Provides the medically appropriate level of performance and quality for the medical condition present (that is, non-luxury and non-deluxe).

7) Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools, or other such items.

8) Is other than eyeglasses, contact lenses, or other optical devices; hearing aids or other communication devices.

Acquisition

To acquire DME, the ordering PCP (or any TRICARE authorized provider, including podiatrists, nurse practitioners, and physician assistants) contacts the Tufts Health Plan-contracted DME vendor. The DME vendor then calls the Tufts Health Plan/US Family Health Plan Care Manager to verify coverage and authorize the rental or purchase of DME (if over $100).

Eye care

Optometry

US Family Health Plan covers members for one eye examination per enrollment period/Plan year by an EyeMed Vision Care participating optometrist. The member is responsible for any co-payment. For a list of optometry providers, call **1.866.504.5908**. A referral is not required.

Ophthalmology

US Family Health Plan uses a specific network of Tufts Health Plan ophthalmologists. For a list of the network ophthalmologists, call **1.800.818.8589**. The PCP must complete a referral for any and all ophthalmology services.

Home health care

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

To receive authorization, PCPs may refer a member for home health services by calling a Tufts Health Plan-contracted home health care agency. For a list of home health care agencies, call **1.800.818.8589**. The agency is responsible for contacting the appropriate Tufts Health Plan/US Family Health Plan Care Manager for authorization.

Outpatient rehabilitation

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

Wellness benefits

US Family Health Plan members are eligible to participate in certain health-promotion programs at certain network hospitals as part of their wellness benefits. Approved programs cover topics such as stress management and smoking cessation. Referrals are not required. For information about approved programs, members can contact Member Services at **1.800.818.8589.**

Transplants

US Family Health Plan has contracted with a network of qualified facilities for the exclusive provision of specialized organ-transplantation services. Network providers must notify the Plan of potential candidates for transplant procedures and request an evaluation of the patient for admission into the transplant program by calling the US Family Health Plan Care Manager at **617.923.5868**.

Exclusions
General exclusions

The Plan does not provide coverage for:

- Services provided or charges incurred prior to the effective date of coverage under the Plan
- Services not specifically included as covered services in this handbook
- Care or treatment as a result of being engaged in an illegal occupation or commission of, or attempted commission of, a felony or assault
- Charges or services for which you or your covered dependent are not legally required to pay, or that would not have been made if coverage had not existed
- Services and drugs not prescribed or authorized by your primary care provider (PCP) or a specialist to whom you were referred
- Services provided or received after the date your coverage terminated under the Plan
- Services and supplies that are not medically or psychologically necessary for your diagnosis and treatment, or services that are experimental or of a research nature
- Any mental-health or substance-abuse services denied or not preauthorized by the Plan's Care Coordination Department (with the exception of the eight authorized self-referral outpatient mental health visits)
- Any services provided for employment, licensing, immigration, elective travel, or other administrative reasons
- Complications due to a treatment or a service not covered by the Plan
- Services and supplies provided by an unauthorized provider

Some specific exclusions

(This list is not all-inclusive.)

- Routine abortions, specifically, when the mother's well-being/life is not in jeopardy (US Family Health Plan does cover abortions in the cases of pregnancies resulting from incest or rape.)
- Acupuncture and acupressure. (However, the Plan does offer discounts for self-pay with participating providers.)
- Alterations to living space. (However, you may qualify for benefits from the Department of Veterans Affairs (VA).) The VA provides up to $4,100 lifetime benefit for veterans with service-connected injuries and up to $1,200 for veterans with non-service-connected injuries to make home improvements necessary for:
  - Continuation of treatment
  - Disability access to the home, and
  - Essential lavatory and sanitary facilities

  To learn more or see if you qualify, please contact Veterans Affairs at **va.gov** or **1.800.827.1000**.
- Alternative treatments
- Artificial insemination or any form of artificial conception. This non-coverage includes in vitro fertilization and gamete intrafallopian transfer, as well as all other non-coital reproductive methods and all services, supplies, and drugs related to them.

- Assisted living facility care. The Plan does not cover assisted living facility care or routine personal care associated with assisted living. Assisted living is a housing arrangement where people can live independently but can find help with tasks and have some services provided for them. These services may include meals, medication administration, personal care, housekeeping, medical services, recreational activities, and more.
- Augmentation mammoplasty. US Family Health Plan does not cover augmentation mammoplasty or breast-enhancement procedures. However, the Plan does cover post-mastectomy reconstructive breast surgery.
- Autopsy services and postmortem examinations
- Aversion therapy in connection with alcoholism
- Birth control (over the counter). Other types of birth control, such as IUDs and birth control pills, are covered.
- Blood-pressure monitoring devices
- Bone-marrow transplants for treatment of ovarian cancer
- Camps — for example, camps for diabetics or obese people
- Charges for missed appointments
- Computerized Dynamic Posturography (CDP)
- Cosmetic drugs
- Cosmetic, plastic, or reconstructive surgery not connected to medical treatment, such as skin tag removal
- Counseling services — for example, nutritional counseling, stress management, life-style modifications, or marriage counseling
- Custodial or convalescent care (nursing homes). US Family Health Plan does not cover custodial care in an institution or at home. Custodial care is defined as taking care of someone's daily needs, such as eating, dressing, or providing a place to sleep.

  Some aspects of the care may be covered, such as:
  - Limited specific skilled nursing services (one hour per day)
  - Prescription medicines and up to 12 physician visits per calendar year
  - Medically necessary care for inpatient care in an acute-care hospital
- Dental X-rays and services
- Diagnostic admissions
- Domiciliary care (care provided in an institution or home-like environment)
- Dynamic posturography
- Dyslexia treatment
- Elective psychotherapy and mind expansion psychotherapy such as Ehrhard seminar training, transcendental meditation, and Z-therapy. US Family Health Plan does not cover psychotherapy for mental disorders involving sexual dysfunctions.
- Elective services or supplies that are not medically and/or psychologically necessary
- Electrolysis
- Elevators and/or chair lifts
- Employment-requested physical examinations
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, or other such charges or items
- Exercise programs
- Experimental or unproven procedures
- Fluoride preparations

- Foot care, except in connection with medical treatment (routine foot care is covered only for enrollees with specific medical conditions, such as diabetes) and foot orthotics
- Gym membership (See fitness centers on page 30)
- Hair removal (including laser hair removal).
- Homeopathic and herbal drugs
- Hospitalization for medical or surgical error. US Family Health Plan does not cover services or hospitalization as a result of medical or surgical error.
- Immunizations for elective travel
- Inpatient stays directed or agreed to by a court or other governmental agency unless medically necessary
- Inpatient stays for the following: 1) to control or detain a runaway child, whether or not admission is to an authorized institution, 2) to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis, 3) in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care, 4) for rest or rest cures
- Investigational drugs
- LASIK surgery
- Learning disorders. US Family Health Plan does not cover diagnostic, evaluation, treatment, services or supplies (including special education services) for learning disorders, such as dyslexia.
- Long-term care. Long-term care is often used as an umbrella phrase to refer to all kinds of assistance to the aging, the elderly, or the disabled, whether that care is given in a patient's home or in a nursing home. It includes a wide range of support services for patients with a degenerative condition, prolonged illness or cognitive disorder. Also known as "custodial care," long-term care primarily involves assistance with daily living (walking, personal hygiene, dressing, etc.) or supervision of someone who is cognitively impaired.

  You may qualify to purchase long-term care insurance through commercial insurance programs or through the Federal Long Term Care Insurance Program (FLTCIP).
  - Eligible beneficiaries include active duty and National Guard members activated for more than 30 days, retired uniformed service members, and members of the Selected Reserve.
  - Eligibility and enrollment requirements are complex. Not everyone who applies for this insurance will be approved for it.
  - For complete details, please visit the FLTCIP website at **opm.gov**
- Magnetic resonance neurography
- Massage therapy
- Medical care from a family member. The Plan does not cover care or supplies that an immediate family member provides or prescribes.
- Medical marijuana
- Medications: drugs prescribed for cosmetic purposes, fluoride preparations, food supplements, homeopathic and herbal preparations, multivitamins
- Megavitamins
- Naturopathic service
- Neurofeedback
- Non-surgical treatment of obesity or morbid obesity
- Nursing homes

- Nutritional counseling. Nutritional counseling is not covered except for certain diagnosed conditions.
- Orthodontia (Coverage exists only if related to surgical correction of a cleft palate.)
- Orthomolecular psychiatric therapy
- Orthoptics. US Family Health Plan does not cover orthoptics, which includes:
  - Vision therapy
  - Eye exercises
  - Visual training
- Over-the-counter drugs, vitamins, or food supplements. The Plan will cover alcohol swabs, needles, and syringes for home use; injectable drugs; glucose test strips; insulin and insulin syringes; and spacers for inhalers.
- Paternity tests
- Personal, comfort, luxury, or convenience items, such as beauty and barber services, radio, television, and telephone
- Postpartum inpatient stay for a mother to stay with a newborn infant (usually primarily for the purpose of breastfeeding the infant) when the infant (but not the mother) requires the extended stay, or continued inpatient stay of a newborn infant primarily for the purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.
- Private hospital rooms
- Psychiatric treatment for sexual dysfunction
- Psychogenic surgery. The Plan does not cover surgery performed for psychological reasons.
- Respite care (except as part of the hospice benefit)
- Rest cure
- Retirement homes or nursing homes
- Safety medical supplies. US Family Health Plan does not cover safety medical supplies, such as bath or toilet rails, sleep safe beds, helmets, and childproof locks.
- Sensory integration therapy
- Services and supplies that are 1) provided under a scientific or medical study, grant, or research program, or 2) furnished or prescribed by an immediate family member for which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE eligible
- Sex change procedures
- Sexual dysfunction or inadequacy treatment services. The Plan may cover some erectile dysfunction medications if such have been determined by a patient's provider to be medically necessary for treatment of a Plan-covered medical problem.
- Speech therapy. The Plan will cover speech therapy when prescribed and provided or supervised by a physician to treat speech, language, and voice dysfunctions resulting from birth defects, disease, injury, hearing loss, and pervasive developmental disorders. The Plan does not cover services for:
  - Disorders resulting from occupational or educational deficits
  - Myofunctional or tongue-thrust therapy
  - Videofluoroscopy evaluation
  - Maintenance therapy that does not require a skilled level after a therapy program has been designed
  - Special educational services from a public educational agency to beneficiaries age 3 – 21
- Surgical sterilization reversals
- Temporalmandibular joint syndrome treatment (TMJ)

- Therapeutic absences from inpatient facility. The Plan does not cover therapeutic absences from an inpatient facility. The exception is when the Plan approves these absences specifically in a treatment plan.
- Transportation for convenience
- Treatment for learning disorders
- Uncovered services and supplies. The Plan does not cover services and supplies:
  - From a scientific or medical study, grant or research program,
  - Provided for free,
  - That would be free if you or your sponsor were not eligible for the Plan,
  - Like inpatient stays directed or agreed to by a court or other government agency, unless medically necessary,
  - Needed for an occupational disease or injury when worker's compensation or a similar law can pay for them. The exception is if you have exhausted those benefits.
  - That any other health insurance can pay for. The Plan will be the secondary payer for any remaining charges.
- Unnecessary Diagnostic Tests. The Plan does not cover tests that are unnecessary. They must be related to a specific illness, injury, or defined set of symptoms.
- Vestibular rehabilitation
- Vision therapy
- Vitamins — except for formulations of folic acid, niacin, and vitamins D, K, and B12 (injection)
- Weight-control or weight-reduction services and supplies.
- Workers' Compensation

12 • Care Coordination

Care coordination guidelines

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

- Following Plan notification procedures for pre-registration (see page 15-17 for details)
- Following Plan policies for services subject to preauthorization review
- Cooperating with hospital and Plan staff concerning case management and discharge-planning activities
- Responding promptly to Plan staff regarding outpatient or inpatient utilization concerns raised either concurrently or retrospectively as a consequence of the care coordination process
- Complying with the Plan's confidentiality policy

A quick response is especially important when inpatient care is involved. More cost-effective management of the patient can often prevent the high cost of even one extra inpatient day. To facilitate this, please respond to inquiries regarding current or pending inpatient stays the same day. Please respond to inquiries regarding completed or more distantly anticipated inpatient stays promptly, a same-day response being less crucial.

Note: An administrative denial may occur for lack of information.

Care Coordination program

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

The areas reviewed by the Care Coordination program include:

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

To permit the reviews described above, the Care Coordination program is responsible for:

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

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

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

US Family Health Plan reserves the right to make a final determination on any care coordination decisions.

Referral management

The PCP's authorization is required when a member seeks services. As the "gatekeeper," the PCP is responsible for planning and managing care efficiently. Specialist claims are paid based on referrals by the PCP (see pages 12-14 for details).

Outpatient services review

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

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

- Home nursing care
- Physical therapy and occupational therapy
- Durable medical equipment
- Outpatient MH/SA services
- Transportation services

Pre-registration notification process and prospective utilization review

Pre-registration notification of all elective, urgent, and emergency admissions is required and is a condition of payment for US Family Health Plan facilities. When an admission is reported, the following steps occur:

- By reviewing referrals, confirmation that the member's PCP has authorized the care
- Verification of member eligibility
- Screening for potential coverage/benefits exclusions
- Matching of the member with his or her provider and rerouting of members who receive services in an inappropriate setting (for example, inpatient rather than outpatient) or in a non-authorized, out-of-plan facility
- Identification of the admission so that the appropriate care manager can begin early identification of the member's potential discharge needs

Since managing care requires continuity and planning, the Preregistration Unit is often the first to recognize that there is a problem with an admission and the first to take steps to correct the problem. When the pre-registration notification process is completed, a preregistration number is assigned to the admission. This number is used as a reference number for payment of claims associated with that particular hospitalization.

Prospective and concurrent utilization review of inpatient services

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

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

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

Inpatient case management and discharge planning

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

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

- Is medically necessary
- Meets quality requirements
- Is provided in the setting appropriate to the patient's needs and physical condition
- Is referred to contracting providers, agencies, and vendors

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

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

General guidelines are available that allow US Family Health Plan to anticipate the duration of a hospitalization. The actual length of the hospitalization, however, will vary with the patient's speed of recovery and condition. The Care Coordination process takes these variations into consideration. Extensions in the initially assigned length of stay will be approved or not approved, depending upon the patient's medical progress and needs.

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

Retrospective review

At times, US Family Health Plan will conduct retrospective reviews to determine whether the treatment provided was medically necessary and, therefore, a covered service. Retrospective review is utilization review of the medical necessity of services after they have been provided to a member.

Retrospective review may occur on-site in a facility or after a copy of a medical record has been obtained by the US Family Health Plan. It is used primarily as an adjunct to telephone concurrent review of out-of-plan/area admissions or in specific problem cases where concurrent review on-site has already occurred, but a review of the completed medical record is desired. Discussion of a case at the US Family Health Plan Utilization Review meeting is also a form of Retrospective Review.

Complex Care Management programs

Depending on their medical needs, our members may voluntarily participate in special complex care management programs that provide extra, individualized support. The programs are provided through Tufts Health Plan, our third-party administrator. They encourage collaboration among our members, nurse care managers, and, with your involvement, support the care the member receives from you. With these programs, members receive telephone support from care managers familiar with their medical treatment plan and needs.

How to refer a member to one of the programs

Call Tufts Health Plan at **1.888.766.9818**, **x3532** and leave this information:

Member name
US Family Health Plan ID number
Member telephone and/or e-mail
Reason for the referral
Your (the provider's) name and contact information

After you submit a referral, a care manager will contact the member and let you know whether the member has decided to participate. If the member agrees to participate, the care manager will also call you to discuss member health goals and how the program can support your plan of care.

Tufts Health Priority Care program (adult and pediatric)

Who may participate

Members with complex medical conditions, including cancer, stroke, multiple comorbid illnesses, atrial fibrillation, coronary artery disease, spinal cord injuries, congenital illnesses, rare diseases, diabetes with complications, and transplant; or members with complex medical conditions discharged from a facility.

How the program works

By telephone, a nurse care manager helps the member navigate his or her health care, addressing medication and care compliance, self-management, barriers to care, caregiver support, and community resources, supporting the provider's prescribed plan of care.

Healthy Birthday program (high-risk maternity)

Who may participate

Pregnant members with conditions including diabetes, cancer, multiple sclerosis, and cardiac disease; and conditions that increase the risk of pre-term labor. Early referral by obstetricians is the optimal and primary member-identification process.

How the program works

By telephone, the obstetrical care manager works with the member and her provider to support treatment plans, address compliance issues, and make sure that the member knows how to obtain community and other resources.

Tufts Health Priority Newborn program

Who may participate

This program supports parents with babies who have been in the Neonatal Intensive Care Unit for at least 72 hours.

How the program works

A nurse care manager supports the family by telephone while the baby is in the NICU, while they prepare to return home with the baby, and after the baby is home. The nurse care manager helps the family understand the NICU, the doctor's plan for the baby's care, and ways to communicate effectively with the medical team; and helps them locate resources.

Transition to Home program (non-behavioral)

Who may participate

Outreach is to selected members at risk for readmission, within 48 hours of hospital discharge.

How the program works

Nurse care managers focus on medication and discharge-plan compliance, symptom identification, recovery and stabilization education, and depression screening. The program lasts for 30 to 45 days. The member will be transferred to Priority Care, a higher-intensity program, as the need is identified.

Behavioral programs

US Family Health Plan members may also take part in behavioral care management programs. You can refer a member by calling the behavioral health department at **1.800.208.9565**.

Behavioral Transition to Home program

Who may participate

This program supports adults, adolescents, and children who have been hospitalized for a psychiatric admission and are at risk for readmission. Risk factors may include a history of noncompliance with outpatient services or with taking medication as prescribed, poor social supports, low motivation, psychosocial issues, and co-morbid conditions that can make self-management more challenging.

How the program works

A mental-health care manager contacts identified members directly and provides care management services by telephone, working with the member or the member's designee to help make certain that they understand the discharge plan, can attend after-care appointments, and can fill and take prescribed medications. When barriers to compliance are identified, the care manager helps find ways to support the member's plan of care. The goal is to help members overcome barriers to managing their mental-health condition while promoting high-quality, cost-effective treatment; safety; and stabilization in the community.

This is a short-term (60 days or less) intervention. For members who will benefit from more intensive monitoring and coordination of care over a longer period of time, we provide a Behavioral Care Management program.

Behavioral Care Management program

Who may participate

This program is designed for adults, adolescents, and children who are at high risk for, or make frequent use of, acute care. Members eligible for the program have been diagnosed with a psychiatric disorder, have had admissions to an acute or intermediate level of care within 30 days, and/or have a documented history of failing to follow up with treatment recommendations.

How the program works

A mental-health care manager works closely with the member, the member's family (when appropriate), and the member's providers to ensure access and appropriate use of mental-health services. The goal is to improve the member's functioning, increase community support, promote integrated care among caregivers, and create a plan in the event of a crisis.

Observation services

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

Here are some important aspects of this program:

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

13 • Provider Appeals Procedures

Purpose

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

Provider Appeals: Standard Level I Procedure

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

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

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

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

The Tufts Health Plan/US Family Health Plan Provider Appeals Committee comprises representatives from the:

- Network Medical Services department
- Clinical Review department
- Operations department
- Preregistration department
- Mental Health department
- Care Management department

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

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

3. A written response outlining the decision of the Committee is generally sent to the provider within ten business days of the Committee's decision.

   The Provider Appeals Committee meets twice a month or more frequently as the volume of appeals dictates. Typically, an appeal is resolved, on average, 45 days from receipt but always within 60 days of receipt. In certain situations, an extension of time may be warranted for information gathering, chart review, and member contact and claims adjudication.

Provider Appeals: Standard Level II Procedure

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

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

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

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

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

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

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

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

Provider Appeals: Expedited Appeals

An appeal may be expedited when there is an ongoing service requiring review or a service for which the attending physician or other prescribing provider believes that the determination warrants an immediate appeal. A Tufts Health Plan or US Family Health Plan medical director is available by phone to providers to discuss coverage determinations based on medical necessity.

In addition, providers have the opportunity to seek reconsideration of an initial or concurrent denial of coverage decision from a board-certified, actively practicing, clinical peer review in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. This reconsideration process occurs within one working day of the receipt of the request and is conducted between the provider rendering the service and the clinical peer reviewer or clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the reconsideration process does not reverse the denial of coverage determination, the provider may pursue the appeals process on behalf of the member.

A provider requesting an expedited appeal must contact the Care Management department. Please call Member Services at **1.800.818.8589** and ask for the Care Management department.

14 • Quality Management

Purpose of the Quality Management program

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

Medical care access goals for primary care offices

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

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

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

Access times for health and medical services

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

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

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

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

Emergency Care is care that is required immediately for the sudden and unexpected onset of a medical condition or acute exacerbation of a chronic condition that is threatening to life, limb, or sight, or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and other acute medical conditions.

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

Access times for member visits

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

Validation reviews

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

Providers have 30 calendar days from the date they receive the case selection notification to provide hard copies of the medical record and all case documentation for each case requested for review.

Note: Providers at St. Elizabeth's Medical Center, St. Elizabeth's Health Care at Brighton Marine, and St. Elizabeth's Health Care at Hanscom AFB have 15 calendar days to submit these materials.

Government audits

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

Medical record standards

Medical record confidentiality

US Family Health Plan considers all medical records to be confidential and requires all US Family Health Plan physicians to accomplish this objective by:

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

Medical record documentation

A medical record is created for all members receiving services from US Family Health Plan. This record documents the delivery of quality patient care. The medical record must be complete and fully record all aspects of care provided.
All services rendered by Plan providers must be documented in the US Family Health Plan medical record. Documentation of authorized services such as operative procedures must be sent to the respective medical records department within 30 days of the performance of the procedure.

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

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

Clinical Quality Improvement program

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

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

- Review of inpatient care
- Review of outpatient care
- Review of home care
- Monitoring of services provided in accordance with evidence-based guidelines and medical care
- Development, design, and implementation of clinical improvement studies and initiatives, HEDIS and non-HEDIS
- Monitoring, tracking, trending, and analyzing member and provider satisfaction
- Identification, development, and implementation of programs designed to promote and improve health care
- Evaluation of program results and provision of feedback to providers
- Redesign and implementation of future programs as necessary
- Creation and maintenance of a system to manage patient complaints and grievances to meet the requirements of the DoD contract
- Coordination and conducting of medical record review audits, analysis of utilization data, HEDIS indications, and other relevant information to assess health care quality
- Management of annual member satisfaction survey conducted by external vendor

Patient safety program

Potential quality indicators/quality issues/patient safety

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

At a minimum, as required by our DoD contract, US Family Health Plan must identify, track, trend, and report interventions to resolve Serious Reportable Events (SREs) and Quality Issues. Using the current National Quality Forum SREs and Agency for Healthcare Research and Quality (AHRQ) patient safety indications, US Family Health Plan providers will submit any confirmed or potential SREs for US Family Health Plan members to the Quality Management Department.

The provider should apply medical judgment and follow the TRICARE criteria for the identification, evaluation, and reporting of all patient safety or quality issues. Reports may be sent to this address:

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

Department of Defense quality monitoring

The Department of Defense may at times direct US Family Health Plan to participate in ongoing quality-monitoring activities. Cases are selected for medical record review in order to evaluate the health care that has been provided. The US Family Health Plan Quality Management Department supports the National Quality Monitoring Contractor medical record audit program.

In order to fulfill our obligation, we ask that you please send any specified medical records as soon as possible. As a contracted network provider and a contracted network facility for US Family Heath Plan, you are required to provide such information for the purpose of evaluation of medical care and quality improvement upon request.

Note: Upon joining US Family Health Plan, subscribers sign a release that authorizes providers to share medical information with US Family Health Plan for the purpose of evaluation of medical care and quality improvement. HIPAA privacy regulations allow for the use and disclosure of Protected Health Information (PHI) to carry out Treatment, Payment, and Health Plan Operations (TPO).

Member complaint/grievance process

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

Administrative grievances

1. When US Family Health Plan receives a grievance from a member (verbal or written), consent is obtained to use the member's name and pursue investigation of the issue.

2. US Family Health Plan issues an acknowledgement letter to the member within 10 calendar days of receipt of the grievance.

3. US Family Health Plan investigates complaint.

4. Written response is sent to the member within 30 calendar days of receipt of the grievance.

5. Notification is sent to Quality Management.

6. Quality Management documents and files completed grievance.

Quality of care grievances

1. When the US Family Health Plan receives a grievance from a member (verbal or written), consent is obtained to use the member's name and pursue investigation of issue.

2. Quality Management issues an acknowledgement letter to the member within 10 calendar days of receipt of grievance.

3. Quality Management investigates grievance.

4. Written response is sent to the member within 30 calendar days of receipt of the grievance.

5. Quality Management documents the completed grievance.

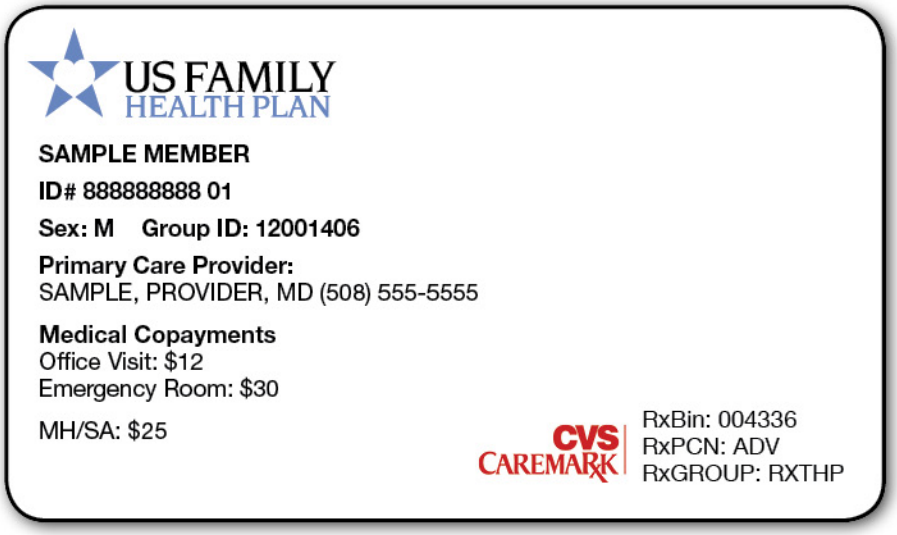
Member appeal process

US Family Health Plan is required to provide members with a comprehensive appeals process designed to reconsider decisions regarding benefits under their US Family Health Plan coverage. The US Family Health Plan *Member Handbook* provides specific information on how to access the appeals process.

Members should be referred to Member Services for any concerns about coverage, Plan policy, etc., where an initial attempt to define and resolve their concerns will be made. If the concern is not resolved at that level, a letter may be written to the US Family Health Plan Appeals Committee to initiate the first-level Member Appeals Process. A second level of appeal may be available to an external review body if the denial is based on a medical necessity determination.

Member ID Card

Front



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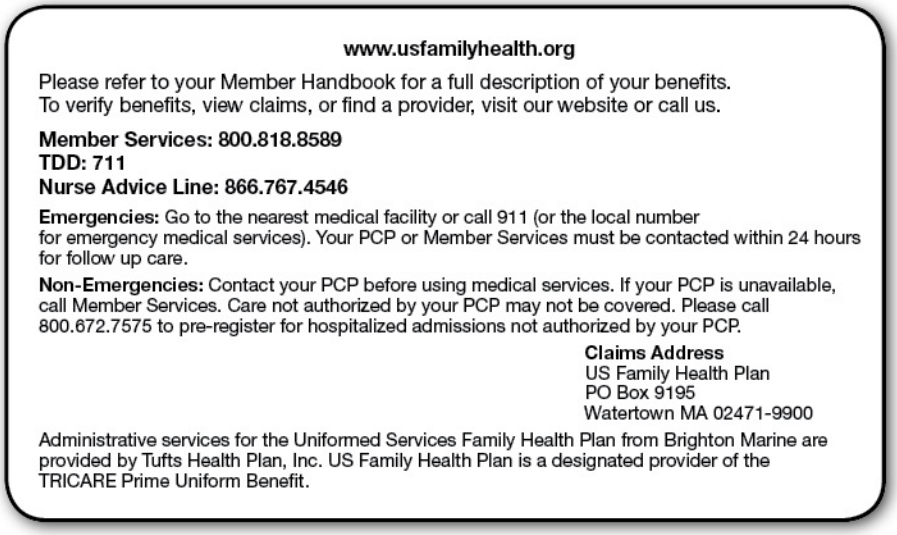

Helpful Websites

US Family Health Plan
usfamilyhealth.org

Agency for Healthcare Research and Quality. Evidence Based Patient Safety Practices
ahrq.gov/

National Patient Safety Foundation
npsf.org

Institute of Safe Medication Practices
ismp.org

National Quality Forum
qualityforum.org/

The Joint Commission
jcaho.org

Healthy People 2020
healthypeople.gov

TRICARE Policies and Regulations
manuals.tricare.OSD.mil

Health Information from the National Library of Medicine and the NIH
medlineplus.gov

77 Warren Street
Boston, MA 02135

1.800.818.8589
usfamilyhealth.org