Volume 5 • July 2018

Ready to Serve

A Newsletter for USFHP Network Providers

Tips on the Referrals Process

We receive many questions about referrals. Here is a refresher on the USFHP referrals process.

- USFHP at PacMed is a TRICARE Prime benefit and a managed care plan, so all referrals must be authorized in advance.
- The primary care provider within the USFHP network coordinates all medical services required by his or her patients and manages referrals to specialists. As often as possible, members will be directed to providers/facilities within the USFHP network.
- Patients do not need a referral for these services:
  - Emergency care
  - Office-based, outpatient behavioral health visits (to a TRICARE-authorized provider)
  - Routine annual mammography (to a TRICARE-authorized provider)
  - Routine annual eye exam (to a TRICARE-authorized provider)

  As often as possible, members will be directed to facilities within the USFHP network.
- To request a referral, use a *Referral Request form*. USFHP receiving the form does not constitute authorization. You must have an authorization number, usually provided in an automatically generated *Referral Authorization form*. Once a referral is authorized by USFHP, the patient can call the specialist for an appointment.
- No authorization number when a patient arrives? Call the referring provider office or USFHP Member Services. Without authorization, your claim will be denied, and the patient will not be held financially responsible.
- If patients receive services without a referral, they will be covered under the Point of Service option, which carries higher cost shares (emergency services are an exception). Providers cannot charge patients more than the TRICARE allowable for such services.

More information about referrals, including admissions to hospitals and skilled nursing facilities, are in the Provider Manual. It can be found at www.USFHPnw.org under the Provider Resources tab.

SEE REFERRALS CHECKLIST ON PAGE 2 ▶

In this Issue

URAC ACCREDITED HEALTH NETWORK

TRICARE®

US FAMILY HEALTH PLAN at PacMed

Referrals Checklist:

1. Ask to see the USFHP member ID card. If no card is available, verify eligibility by calling USFHP Member Services.

2. Request the appropriate copay amount. See *Copays Quick Reference Guide* in this newsletter.

3. Review the referral form. Ensure the form includes the authorization number, number of visits and expiration date.

4. Provide only the services authorized. Services not authorized, not indicated on the referral form or provided in greater quantity than authorized will be denied payment.

5. Keep USFHP referring provider informed. Send a summary/report with patient name and referral authorization number clearly indicated to the referring provider within 30 days.

6. Get new authorization for services beyond the scope of the original referral. Contact the USFHP referring provider for authorization of additional services or to make a new referral.

3-D Breast Tomography Not Covered for USFHP Members

The Washington State Senate recently passed legislation that requires all private insurance companies to cover breast tomosynthesis, also called three-dimensional (3-D) mammography or digital breast tomosynthesis (DBT).

This legislation does not apply to federal programs, and USFHP is a federal program. USFHP members seeking this service are required to sign a "Waiver of Non-Covered Services" form, and USFHP network providers must inform beneficiaries in advance that 3-D mammography is not covered by USFHP. PacMed's contract with the Department of Defense will not permit it to reimburse network providers for non-covered services. The signed waiver confirms that the beneficiary has agreed in advance to be financially responsible for any portion of the encounter/service that is not covered. Providers must keep copies of all signed beneficiary waivers.

The Department of Defense may establish 3-D mammography coverage at some point, but we have received no indication this will happen in the near future.

If you need assistance, please contact USFHP Member Services at 1 (800) 585-5883.

Introducing Lisa Velotta, CPCS

Manager, Provider Credentialing

Please welcome Lisa Velotta as the new Credentialing Manager for US Family Health Plan and Pacific Medical Centers clinics. A Certified Provider Credentialing Specialist, Lisa comes to us with over 20 years of credentialing and enrollment experience. Provider credentialing is a verification process to ensure that practitioners have the training and experience required to see USFHP patients.

You may contact Lisa at lisave@pacmed.org or (206) 621-4316. We hope you enjoy working with Lisa as we serve our USFHP beneficiaries.

Post-payment Audits

To ensure the proper allocation of health care resources, US Family Health Plan (USFHP) regularly audits claim compliance. Reviews of completeness, accuracy and necessity are conducted on a random selection of claims submitted by providers for services rendered. Any provider who submits a claim for payment may receive a request for records from USFHP to ensure that minimum medical record requirements were met for verification of services that were billed.

HIPAA Guidelines

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes a foundation of federal protection for protected health information (PHI), which is carefully balanced to avoid creating unnecessary barriers to the delivery of quality health care. As such, the Privacy Rule generally prohibits a covered entity from using or disclosing PHI unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities. Ready access to treatment and efficient payment for health care, both of which require the use and disclosure of PHI, are essential to the effective operation of the health care system.

In addition, certain health care operations—such as administrative, financial, legal and quality improvement activities—conducted by or for health care providers and health plans are essential to support treatment and payment. Many individuals expect that their PHI will be used and disclosed as necessary to treat them, bill for treatment and, to some extent, operate the covered entity's health care business. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose PHI, with certain limits and protections, for treatment, payment and health care operations activities.

Timely Response to a USFHP Review

When a provider receives a written request for records from USFHP, the request will include guidance on exactly how, when and where to respond and/or appeal decisions that are made. The request also provides timely response requirements that are expected to be followed for such requests. *Failing to respond to a request within the stated timeframe could result in the payment made on the claim being recouped in full.*

These claim-compliance reviews focus on maintaining the integrity of the USFHP network as well as our reimbursement practices. We actively monitor activity that may include, but is not limited to, fraud, waste and abuse. As a TRICARE Designated Provider, US Family Health Plan is committed to coordinating, evaluating and improving activities that support and use the health care resources needed to improve the health of all individuals under our care.

Copays Quick Reference Guide

Increases in copayments for some military beneficiaries became effective on January 1, 2018, with the passage of the National Defense Authorization Act (NDAA) of 2017. These increases affect military retirees who are not entitled to Medicare. (Retirees with Medicare and active-duty family members do not have copays for medical services.)

The NDAA established different levels of copays for certain categories of medical services. For instance, retirees who are not entitled Medicare now have a $20 copay for a primary care visit and a $30 copay for a specialty care visit.

The US Family Health Plan membership card has been changed to reflect the current copay levels for the most frequently used services: primary care, specialty care, urgent care and emergency care. (The membership card for active-duty family members and retirees with Medicare will show $0 copay for these services.)

COPAYS FOR MEDICAL SERVICES AS OF JAN. 1, 2018

Service Type	Active-Duty Family Member & Retiree WITH Medicare B	Retiree WITHOUT Medicare B
Primary Care Provider Visits	$ 0	**$ 20**
Specialist Visits	$ 0	**$ 30**
Routine Annual Physical Exam (1 every 330 days)	$ 0	$ 0
Urgent Care Clinic Visits	$ 0	**$ 30**
Prenatal Visits	$ 0	$ 0
Well-Child Visits (up to 6 years in age)	$ 0	$ 0
Physical, Occupational & Speech Therapies	$ 0	**$ 30**
Nurse Visits (except for injections; see below)	$ 0	$ 0
Chemo/Radiation Therapy	$ 0	**$ 30**
Allergy Tests, Treatments, Injections in Specialist Office	$ 0	**$ 30**
Laboratory	$ 0	$ 0
Diagnostic Imaging/Studies	$ 0	$ 0
Injections (including RN) in Specialist Office	$ 0	**$ 30**
Routine Immunizations/Pneumococcal Vaccination	$ 0	$ 0
Immunizations Required for Overseas Travel	Not covered*	Not covered*
Vision: Routine Refraction (1 every 330 days) (For non-refraction or medical condition, see Specialist Visit. Additional routine refraction visits are not covered.)	$ 0	$ 0

*Covered in full for active duty members when traveling as a result of an active duty member's duty assignment while under orders issued by a Uniformed Service.

Pharmacy Copay Increases

On February 1, 2018, copayments for prescription drugs covered under US Family Health Plan increased. These increases affect most USFHP beneficiaries. (Increases do not apply to dependent survivors of active-duty service members nor to medically retired service members and their dependents.)

PHARMACY COPAYS AS OF FEB. 1, 2018

Copay Tier	Pharmacy	Cost Rx Per Fill	Average Cost Per Year
Tier 1 Formulary Generics	Mail Order Local Pharmacy	$ 7 $ 11	$ 28 $ 132
Tier 2 Formulary Brands	Mail Order Local Pharmacy	$ 24 $ 28	$ 96 $ 336
Tier 3 Non-formulary	Mail Order Local Pharmacy	$ 53 $ 53	$ 212 $ 636

Both charts can be found in the Network Quick Reference Guide, which also provides useful Utilization Management information. The guide can be downloaded from the USFHP website at http://www.usfhpnw.org/provider-resources.

Contact Us

We are here to answer your questions, and we welcome your suggestions or feedback.

Member Services
1 (800) 585-5833, option 2
(206) 621-4090, option 2

Lisa Velotta
Credentialing Manager
(206) 621-4316
lisave@pacmed.org

Elizabeth Maltos
Network/Provider Relations
(206) 621-4531
elizabethma@pacmed.org

www.usfhpnw.org

US Family Health Plan

A health plan sponsored by the Department of Defense (DoD) that offers the TRICARE Prime benefit to uniformed services beneficiaries in the Puget Sound region. The plan is administered by Pacific Medical Centers, which has performed this role for over 30 years.

Mission

To provide quality health care for uniformed services family members, retirees and their family members; to have extremely satisfied members; to demonstrate quality, value and operational effectiveness; and to be an integral and respected health care partner in the DoD's Military Health System.

Reminder

Although US Family Health Plan and Health Net Federal Services, LLC are both TRICARE Prime providers and serve the same population — we're not the same organization! Please make sure that bills/claims/referrals or anything else intended for USFHP does not go to HNFS (or vice versa). This will avoid complication and undue frustration for our beneficiaries, you and for us.