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Ready to Serve

A Newsletter for USFHP Network Providers

Guiding Your USFHP Patients to After-Hours Care

When patients have an unexpected health issue arise after your office is closed, they may be confused about where to go for care. We've developed the following guidelines, which we hope is helpful as you develop relationships with your US Family Health Plan patients.

Where to Go When You Need Care

➤ Primary Care Clinic

Your primary care provider (PCP) helps you manage your health by providing preventive care, general care and chronic-condition care. Your provider also coordinates care when a specialist is needed.

- Call your primary care provider's office to make an appointment.
- Know your clinic's hours and keep them on hand, and take note of any evening or weekend hours.
- Ask your PCP if an on-call provider is available for phone consultation after hours. Ask for the phone number.

➤ After Hours

- Use urgent care clinics for minor injuries or illnesses that do not require hospitalization.
- If your clinic has an on-call provider after hours, talk with the provider and ask for help in determining if you need urgent care. The provider also may be able to help you locate an urgent care clinic when you call.

➤ Emergency Care

- Call 911 or go to the nearest hospital for severe or life-threatening events.

In this Issue

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US FAMILY HEALTH PLAN at PacMed

Initial vs. Subsequent Diagnosing for Fractures

Most people would presume *initial encounter* means the very first visit, where a patient sees a physician for the first time about a new issue. Therefore, *subsequent visits* would be any visit thereafter, correct? The simple answer is no—especially when it comes to fracture coding for US Family Health Plan members.

Coding for fractures can be confusing and often leads to errors in reporting the correct diagnosis. Although *initial* and *subsequent* were used with fracture coding in ICD-9, they are interpreted differently in ICD-10.

ICD-10 defines initial encounters as those "that occur while the patient is receiving active treatment." Active treatment includes surgical treatment, emergency department encounter, and evaluation and continuing (ongoing) treatment by the same or a different physician.

ICD-10 defines subsequent encounters as those "that occur after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase."

So, for example, these are initial encounters:

- Patient John Doe presents with hand pain, and X-rays reveal a hand fracture. The physician feels the fracture may heal routinely without surgical repair. The physician gives John Doe a brace and instructs him to follow up in a week. This is coded as an Initial Visit.

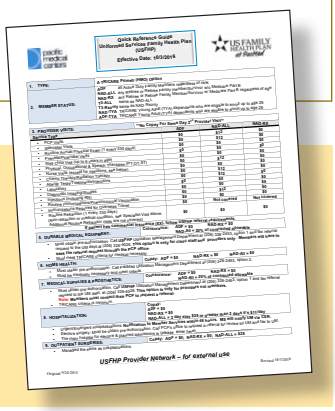
- The next week, John Doe returns and gets another X-ray. Because healing is not routine, the same physician decides that surgery is needed. The decision for surgery is considered active care, and the visit is still coded as an Initial Visit.

This is a subsequent encounter:

- John Doe had surgery with the original diagnosing physician. A month later, the patient is supposed to follow up, but the physician is out of town. John Doe follows up with a different physician, who takes new X-rays to check the healing post-op. No recommendations are made other than to follow the original plan of care. As this is aftercare for the fracture, this is considered a Subsequent Visit.

Did you receive a new USFHP Quick Reference Guide?

An updated guide that reflects these changes was mailed in September. If you did not receive an updated guide and would like one, it can be downloaded at www.usfhpnw.org/index.cfm/provider-resources/



Self-Referrals for Annual Eye Exams and Mammograms

US Family Health Plan members may self-refer to participating TRICARE providers for annual mammograms and routine annual eye exams. If a medical issue is identified during the course of the exam, the provider must obtain authorization for any additional treatments or tests. As a managed care organization, USFHP directs all referral authorizations to in-network providers.

Clinical Quality and Patient Experience Report

US Family Health Plan at PacMed annually assesses the quality of care of our members across a variety of measures using the Healthcare Effectiveness Data and Information Set (HEDIS®). We compare our scores to national benchmarks from the National Committee for Quality Assurance (NCQA), with a goal that our rates are at or above the 75th percentile. We track 35 measures every year, of which a selection is shown below. We provide opportunity and enrollment reports to assist you in identifying members for outreach, and we send reminders to members who are overdue for physical exams.

CY 2016 US Family Health Plan HEDIS Rates

HEDIS Measure	Rate	75th Percentile	90th Percentile
Adolescent Well Care Visits	37.4%	53.1%	61.6%
Well Child Visits 3 to 6 Years of Age	71.7%	83.0%	87.8%
Breast Cancer Screening	80.0%	77.4%	81.6%
Cervical Cancer Screening	71.4%	79.1%	82.6%
Colorectal Cancer Screening	71.2%	69.9%	74.3%
Chlamydia Screening in Women	35.2%	54.7%	63.4%
Diabetic Hemoglobin A1C Testing	92.8%	93.2%	94.9%
Diabetic Blood Pressure Control	62.4%	72.5%	78.8%
Diabetic Eye Exams	78.2%	63.6%	71.5%
Adolescent Immunization – Tdap/Td	90.2%	92.6%	94.3%
Adolescent Immunization – Meningococcal	72.0%	84.7%	89.4%

2016 Patient Experience Survey Results

We use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to measure our members' experience of care and their satisfaction with their providers and US Family Health Plan. We survey 1,100 members and typically have a response rate of around 60%. Selected responses for composites and individual questions are below. Our member scores usually place us above the 90th percentile (NCQA national benchmark) for most questions and composites. We use this tool and other internal monitoring mechanisms to determine where to focus our improvement efforts.

2016 CAHPS Survey

Patient Experience Survey Composites and Questions	2017 Rates	2016 Rates	2016 Benchmark*
Getting Needed Care	91.4%	92.5%	86.4%
Getting Care Quickly	93.2%	91.7%	84.7%
How Well Doctors Communicate	97.9%	97.0%	95.1%
Customer Service	93.8%	90.9%	87.5%
Shared Decision Making	82.2%	81.4%	81.3%
Health Promotion and Education	80.2%	80.1%	75.1%
Coordination of Care	93.1%	91.6%	82.6%
Rating Items (Summary Rate = 8 + 9 + 10)			
Rating of Health Care	87.7%	89.0%	77.4%
Rating of Personal Doctor	90.3%	91.5%	84.5%
Rating of Specialist	92.4%	91.2%	83.8%
Rating of Health Plan	91.3%	90.0%	63.9%

* 2016 Public Report benchmark is derived from NCQA's Quality Compass benchmark.

PRESCRIBE THIS... NOT THAT!

KEY: Prices per 30-day supply

$$	=	$150–500
$$$	=	$500–$1,000
$$$$	=	> $1,000

GENERAL TIPS

- √ Generic medications
- √ Medications with long-term evidence of effectiveness and minimal harm
- √ Highest pill strength available: 1 pill per dose, or ½ tabs if amenable
- √ Generic combination meds (if stable on dose)
  - Branded or newest medications with limited evidence
  - Lower pill strength when patient has to take 2+ pills per dose
  - Same medication in two different strengths (unless titrating or tapering)
  - Brand-only combination products (when separate meds are available as generics)
  - Combinations in general are more expensive

GLUCOSE-LOWERING AGENTS IN TYPE 2 DIABETES MELLITUS

Always assess for adherence and optimize doses of current medications before adding additional therapy. Increased medication burden may worsen adherence and outcomes.

- √ Referral to Certified Diabetes Educator for all newly diagnosed patients
- √ Generic metformin ER (Glucophage XR®); metformin can be used at reduced doses with eGFR 30-44
- √ Glimepiride or glipizide
- √ A1C > 10 % on metformin: Start basal insulin with patient self-titration if appropriate
- √ NPH can be considered a reasonable option for some patients with Type 2 DM starting on insulin
  - Metformin ER MOD 500-1000 mg (Glumetza®) – **$$$$**
  - Fortamet – **$$$**
  - Glyburide
  - DPP4 or DPP4-GLP1 combo – **$$**
  - Caution > 2-3 non-insulin glucose-lowering agents, to minimize polypharmacy, improve adherence

OPIATES

General principles: < 50 MEDs, limit use for chronic pain treatment; non-pharmacologic therapy and non-opiates preferred. Avoid concomitant benzodiazepine use.

- √ Limit short-acting agents
- √ If prefer long-acting agents, choose morphine sulfate CR
- √ Can add APAP to opiate to augment pain relief effect
- √ Non-opiates: APAP, NSAIDs, TCA, gabapentin
- √ Don't forget: naloxone when appropriate
  - OxyContin (oxycodone CR) – **$$**
  - Opana ER (oxymorphone CR) – **$$**
  - Long-acting hydrocodone products: Zohydro ER – **$$**
  - Hysingla ER – **$$**

CLAIMS CORNER

Patients have the option to seek certain care from providers who are outside the US Family Health Plan network. Here are some pointers on how the Point of Service benefit works.

The Point of Service (POS) feature in US Family Health Plan gives our members the option, at added cost, to receive:

- Nonemergency, medically necessary, TRICARE-covered medical services
- From any non-network, TRICARE-authorized specialty or inpatient care provider
- Without a referral from the patient's USFHP primary care provider

POS does not apply to urgent or emergency services.

PRE-AUTHORIZATION

Please note that some covered services still require prior medical review for authorization by USFHP prior to receiving services. Examples include a gastric bypass, etc.

If the service does *not* require prior authorization, the services will be applied to the POS benefit option. The patient will be responsible for the applicable POS deductible and cost-share.

HIGHER OUT-OF-POCKET COSTS AND DEDUCTIBLES

Deductibles per enrollment/calendar year:

- Individual – **$300, Family – $600**
- Beneficiary's incur POS deductibles for outpatient and inpatient care

Cost Shares, after deductible is met:

- Outpatient claims – 50% of TRICARE allowable charge
- Inpatient Claims – 50% of TRICARE allowable charge

After POS deductible is met, patient may also be subject to balance billing (up to an additional 15 percent of the TRICARE allowable charge).

REMINDER Although US Family Health Plan and UnitedHealthcare (UHC) 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 UHC (or vice versa). This will avoid complication and undue frustration for our beneficiaries, you and for us.

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.

Contact Us

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

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