



CONTRACTED PROVIDER HANDBOOK

Prepared by:
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Information contained in this manual is confidential and must not be disclosed to any third party without prior written consent of US Family Health Plan at Pacific Medical Centers

Introduction

The US Family Health Plan at Pacific Medical Center Contracted Provider Handbook is designed to provide participating providers and their office personnel with information regarding the US Family Health Plan.

This handbook answers common provider questions including:

- Who to contact in the US Family Health Plan office at PacMed Clinics
- Referral policies and procedures
- Billing policies and procedures
- Participating Provider Rights and Responsibilities.

We hope the information contained in this handbook proves useful. If participating providers or staff has suggestions or network issues, please contact the US Family Health Member Services Dept. Provider Relations at (206) 621-4090 or 1-800-585-5883.

This Handbook includes information regarding referral management, claim processing, provider reimbursement, provider rights and responsibilities. In order to provide the most current version of the Provider Handbook, the handbook and any network updates will be available on the US Family website at www.usfamilyhealthplan.org. The provider handbook will be updated annually unless there is a need to update arises.

The Mission of Pacific Medical Centers is

- To provide respectful, high quality, patient-focused healthcare to each person and to the communities we serve.

Introduction

Pacific Medical Centers USFHP referral policy is intended to meet the needs of the patient through the most efficient and cost-effective use of resources. This policy is a tool used by providers in making referral decisions to provide high quality care to our US Family Health Plan members.

Role of Primary**Care Provider**

Pacific Medical Centers Primary Care Providers include family practice, internal medicine, pediatricians, nurse practitioners, and physician assistants. The Primary Care Provider (PCP) coordinates all medical services required by his/her patients. This includes:

- Management of referrals to specialists
- Continued case management of referrals to non-PacMed providers
- On-going coordination of patient care

Pacific Medical Centers***External Referral Policy***

An external referral is made by a Pacific Medical Center provider for services and tests to be provided within the Pacific Medical Center USFHP network. A Pacific Medical Centers Primary Care Provider or a Pacific Medical Centers specialist must coordinate external referrals.

When a Pacific Medical Centers provider refers a US Family Health Plan patient to a contracted or network provider, the services requested are generally limited in scope, quantity, and duration as deemed appropriate by the ordering physician.

Referrals to network providers are utilized under the following conditions

- A Pacific Medical Center provider does not offer the needed service.
- The needed service is offered at Pacific Medical Center but is not available in a medically necessary time frame.
- Distance is a barrier because of urgency, patient mobility, or the type of medical care required.

Authorization Requirements

All services by contracted providers must be referred by a Pacific Medical Center provider and **authorized in advance**. A noted exception would be emergent services.

Appointment Requirements

It is important that as a contracted provider you meet contractual obligations required of Pacific Medical Centers by the Department of Defense. As a provider in USFHP network, you are required to:

- See all emergency referrals no later than 3 hours after receiving the request.
- See all elective referrals within 10 business days of the request for an appointment.
- See all urgent referrals within 24 hours of the request for an appointment.

Referral Request Form

Pacific Medical Centers providers use a Referral Request form for all referrals (see sample). This form is designed to give any provider, internal or external, all of the information necessary to treat the referred patient.

REFERRAL POLICIES

You may receive a copy of this form; however, it **does not** constitute referral authorization unless an authorization number is noted on the form.

Referral Authorization Form

When the requested services on the Referral Request form are approved, the Referral Authorization form is system generated. Copies of this form are then mailed to you and to the patient.

The Referral Authorization form is your confirmation of the scope of services being authorized.

Importance of the Authorization Number

The authorization number is your assurance that the referral request has been approved.

If a US Family Health Plan member presents for care without an authorization number, please call either the referring Pacific Medical Centers Clinic or Member Services at US Family Health Plan (USFHP) to determine if the services are authorized. *Without authorization, your claim will be denied and the patient cannot be held financially responsible.*

If you believe the patient needs to receive more treatment from you than is authorized, please contact the Pacific Medical Centers referring physician for additional authorization. If you feel that the patient needs to be referred to another provider, you must contact the patient's Pacific Medical Centers referring physician for further authorization.

Diagnostic Testing

If routine lab work is needed, please refer the patient to Dynacare. A list of Dynacare draw stations is included later in this handbook.

If simple x-rays or labs are needed, routine lab and X ray is included on the referral authorization form.

The PacMed Clinics referring physician must authorize all other diagnostic tests.

REFERRAL POLICIES

Communication with

Pacific Medical Centers Referring Provider

After you have treated our US Family Health Plan patient, a summary of the services you provided should be mailed within 10 days to the patient's PacMed referring provider. The information in your summary should include at least the following:

- Summary of the services rendered
- Progress notes
- Any surgical, pathology, or laboratory reports describing your examination, diagnosis, or treatment plan

If you prefer, you may send a copy of your medical record instead of a summary. The medical record must be legible, signed and dated, and clearly identified with the patient's name and referral authorization number.

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When you received authorization from US Family Health Plan at PacMed Clinics to provide care for our patient, it is important that you follow the specifications listed on the Referral Authorization form.

- Services not authorized in advance by PacMed will be denied for payment.
- Any services that are not listed or indicated on the form or provided in a quantity greater than authorized will not be paid.
- The patient may not be billed for unauthorized services unless the patient signs a financial responsibility agreement

for non-covered services.

- Payment for authorized services is always subject to the patient's eligibility in and benefit limitations of the US Family Health Plan.

REFERRAL POLICIES

Referral Checklist

What to do:	Reminders:
Ask to see US Family Health Plan ID card	If no card, verify eligibility by calling Member Services
Review referral form	Pay attention to the number of visits authorized and the date the authorization expires
Request appropriate copay amount	NAD-ALL members have \$12 copays, while NAD-RXonly members have zero copays
Provide service	Only the service authorized is eligible for reimbursement
Keep PacMed provider informed	Send summary or report
Request additional referrals?	Contact PacMed if you wish to provide additional service or make a referral to another specialist
	Any questions should be directed to PacMed Member Services

REFERRAL PROCEDURE

Admissions to Hospitals and Skilled Nursing Facilities

<i>Policy</i>	All hospital and skilled nursing facility admissions must be coordinated with a Pacific Medical Center provider.
<i>Preauthorization</i>	Required for all non-emergent admissions.
<i>Notification</i>	Required within 24 hours of emergent admissions. Contact the Quality & Care Coordination Department at (206) 326-2453 option #1.
<i>Procedure</i>	Admission to the Emergency Department: <ul style="list-style-type: none">• Best efforts will be made to contact patients PCP for coordination of care only.• There is no requirement for referral for Emergency Department visits.• ED visits resulting in admission will be treated as above.
<i>Planned Admissions:</i>	<ul style="list-style-type: none">• Contact with the PCP must be made prior to admission as <u>preauthorization is required</u>.• The Quality & Care Coordination department will make a benefit determination and specify a target length of stay.
<i>How to contact the PCP or Pacific Medical Center referring provider</i>	<p>During normal office hours, find the number from the phone directory listed in the back of this manual.</p> <p>After hours, call the same phone number and select from the options given.</p>

How to Bill

- Submit charges on standard billing forms such as the HCFA 1500 or UB 04.
- Use standard CPT, ICD-9, HCPCS, and UB codes unless otherwise specified in your contract.
- Do not adjust charges for any copayments, capitation, or fee discounts.

As a benefit program, the US Family Health Plan is considered the primary manager of care but the secondary payor when commercial insurance is involved.

- Submit claims to the primary payor first.
- After the primary payor issues payment, bill US Family Health Plan at PacMed Clinics and include the Explanation of Benefits from the primary payor.
- Payment will be issued only if the primary payor's payment is less than our agreed contract rate. *If the primary payor's payment is greater than our contract rate, our reimbursement will be zero. Our member cannot be billed for any remaining balance.*
- As stipulated by the Department of Defense (DoD), PacMed Clinics must report all insurance reimbursement amounts collected by any provider. Therefore, please always submit a claim – even if the balance is zero.

US Family Health Plan

And Medicare

- Providers may not bill or accept payment from Medicare for services rendered to our enrollees except for those services not covered by the US Family Health Plan at PacMed Clinics. *Upon joining the US Family Health Plan at Pacific Medical Centers, our enrollees agreed not to use their Medicare benefits. Use of Medicare benefits can result in the disenrollment of our member.*

Exceptions:

- Chiropractic care
 - Routine foot care for non-diabetics
 - Orthotic shoe inserts
 - Most custodial care
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- If you send any bills to Medicare, those bills must be clearly marked as Medicare Secondary Payor (MSP), which is informational billing only and results in no payment to you or our member.
 - If you receive payment from Medicare, you will be required to return the payment, **whether or not** the US Family Health Plan at Pacific Medical Centers is paying the claim.

Billing our Member

- Providers may bill enrollees for applicable copayments and may not bill for charges which exceed contractually allowed reimbursement rates.
- The provider may not collect for any noncovered service unless the enrollee has been properly informed and has agreed in advance and in writing to pay for such a service.
- Services not authorized in advance by US Family Health Plan at Pacific Medical Centers will be denied for payment. Our member may not be billed for any unauthorized service.
- If our enrollee has commercial coverage, only the US Family Health Plan copay is applicable. That copay amount will be deducted from your reimbursement. *Starting 12/1/02 date of service, copayments will be waived for those enrollees with commercial coverage.*
- Copays are based on member status so please check the member's card.

Understanding our Explanation of Benefits

A.	VENDOR NUMBER:	Number assigned to your Master Vendor.
B.	CHECK NUMBER:	Numerical identification of the payment made to the Master Vendor.
C.	MASTER VENDOR:	Name and address where payment was sent.
D.	NAME:	Name of the patient who received services.
E.	MEMBER #:	The patient's US Family Health Plan number.
F.	REFERRAL #:	Assigned authorizing number for requested services.
G.	CLAIM#:	Number assigned to your claim submission.
H.	ACCOUNT #:	Patient's account number found on the claim
I.	PLAN #:	US Family Health Plan identification number.
J.	PLAN TYPE B:	Mnemonic for US Family Health Plan.
K.	CLAIM VENDOR:	Name of actual service provider. Does not appear if provider and Master Vendor are identical.
L.	PROCEDURE CODE:	CPT, UB, or HCPCS codes from the claim.
M.	DESCRIPTION:	Description of the procedure code used.
N.	SERVICE DATES:	Date span attached to the procedure code.
O.	S/F:	<i>For internal use only.</i>
P.	AMOUNT BILLED:	Amount billed by the provider.
Q.	CONTRACT ADJUST:	Amount above the contractual allowance.
R.	DEDUCT AMOUNT:	Amount applied to patient's deductible.
S.	COPAY AMOUNT:	Patient's copay to be collected by provider.
T.	AMOUNT APPROVED:	Amount to be paid by Pacific Medical.
U.	AMOUNT WITHHELD:	<i>Not in use at this time.</i>
V.	NET AMOUNT:	Same as Amount Approved.
W.	CLAIM TOTAL:	Sum total of all charges for that claim.
X.	VENDOR REMITTANCE CLAIMS SUBTOTAL:	Subtotals for Master Vendor and alternate payees.
Y.	VENDOR SUMMARY:	Totals for Master Vendor and alternate payees.

APPEAL PROCESS

If a provider disagrees with a Plan decision regarding medical necessity or claim payment, the decision may be appealed.

- The appeal must be in writing and must be submitted to the US Family Health Plan within (90) calendar of the initial denial. The appeal should include all documentation that supports your position. Any cost incurred in providing documentation will not be reimbursed by the Plan.
- You will receive a written response generally within thirty (30) calendar days, describing how your appeal was resolved and the basis for the resolution.
- Please note that you cannot appeal the rules and regulations of the Plan or TRICARE policy, but you may send a grievance if you think an error in the interpretation of the policy has occurred. Grievances are handled in a like manner to appeals.

Please send your Claim Appeals to:

US Family Health Plan @ Pacific Medical Centers
1200 12th Ave So. Qrts 8/9
Seattle, WA 98144
Attn: Appeals

PROVIDER DISPUTE PROCESS

According to the Pacific Medical Center Provider Agreement: The parties hereto encourage the prompt and equitable settlement of all disputes, controversies, or claims ("Disputes") between or among them, including those arising out of the provider agreement or the Payor addenda. At any time, any party may give the other written notice that it desires to settle a Dispute. Within ten (10) days of delivery of such notice, the parties agree to meet in good faith to resolve such Dispute. If such Dispute cannot be resolved within a reasonable amount of time, the parties agree to resolve such Dispute in accordance with Pacific Medical Center's written dispute resolution policies and procedures, as set forth in the Provider Manual. Such dispute resolution policies and procedures shall include, but not be limited to, policies and procedures to resolve disputes relating to Provider's status as Participating Provider or Provider's professional competency or conduct.

Administrative Disputes:

The dispute process is available to any participating providers. Participating providers have the right to submit administrative dispute reconsideration by the USFHP authorized representative who was not involved in the initial decision of the subject of the dispute. Other administrative disputes not listed below should be forwarded to US Family Health Plan Member Services / Provider Relations.

Administrative disputes are the following:

Claim Disputes

Factual Determination by Utilization Management

US Family Health Plan will make every attempt to provide a written determination to the provider within 30 days. However, if the plan requires additional time for review, the provider will be notified by the plan with an expected turnaround for the resolution.

Non Administrative Disputes:

These are disputes concerning professional competence or conduct that relate to a participating provider within the plan network. An appeal request should be submitted in writing, addressed to the USFHP Medical Director. See pgs 18-19

PROVIDER RIGHTS AND RESPONSIBILITIES

PROVIDER RIGHTS

You are encouraged to let the US Family Health plan know if you are interested in serving as a member of the US Family Health Plan Clinical Quality Management Committees or other committees that may be formed by the US Family Health Plan.

The US Family Health plan welcome your feedback and suggestions on how service may be improved for provider and health plan member. Please contact the US Family Health Plan Member Services to submit your feedback and suggestions.

You may appeal a claim submission which you feel was not paid appropriately.

You may appeal any action taken by the US Family Health Plan that affects your network participation and is related to professions competency or conduct.

PROVIDER RESPONSIBILITIES

- You have agreed to treat US Family Health Plan patients the same as all patients, regardless of type and amount of reimbursement.
- In the event that a participating provider is unavailable to treat a US Family Health plan member, you must arrange for another physician (the covering physician) to provide such services on your behalf.
- If a provider arranges for a sub contracted provider to provide covered services to a member for any reason. Provider shall assure the following:

The Sub-Contracted Provider provides services to member under the terms and all provisions of the participating provider agreement with USFHP, the USFHP Provider Manual and the Rules and Regulations.

- USFHP must consent in advance to the provision of services by a subcontractor. Provider must provide USFHP with a thirty day (30) advanced written notice of Provider's request to utilize a sub-contracted provider and must received Suhl's written consent prior to utilizing a sub-contractor provider. Provider is responsible for compensating the sub-contracted provider for all services rendered.
- You have agreed to provide comprehensive health services to the member depending on the needs of the US Family Health Plan.
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- You have agreed to inform patients about the care they require, including various treatment options and whether such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the Member's contract with the contracted plan. PMC also agrees not to prohibit, discourage or penalize Provider's otherwise in compliance with the law from advocating with PMC on behalf of a Member.
- You have agreed not to discriminate on the basis of aged, sex, handicap, race, color, religion or national origin.
- You have agreed to allow access to the medical records for US Family Health Plan members by the appropriate USFHP designee. If requested, you must provide the medical records to the Federal Government and or contracted agency representative.
- You agree to the confidential and HIPAA requirements with respect to preserve the confidentiality of patient health information.
- USFHP may at any time, with or without cause, to immediately withdraw its consent to any subcontracted provider upon notice to Provider.
- You have agreed to provide continuing care to participating members.
- You have agreed to abide by the USFHP and Pacific Medical Centers rules and regulations.
- You may not balance bill a member for provider services that are covered by the US Family Health. You may only bill members for applicable deductibles, co-payments, and cost sharing amounts. You may not bill for charges which exceed the allowable charge.
- You have agreed to provide or assist the US Family Health Plan to obtain Coordination of Benefits / Third Party Liability information. If you receive payment from other insurance, you are required to do the following:
 - a) Refund the amount received from the other insurance to the US Family Health Plan; or
 - b) Return the payment to the other insurance with a letter stating the incorrect Insurance was billed and then submit the claim to the US Family Health Plan.
- You may bill a member for services that is not a covered benefit if the member was informed that services were not covered and has agreed to pay in advance for such services

- You have agreed to the terms of the written agreement that renews annually unless either party chooses to review / renegotiate or terminate. Written notice of such review or termination must be provided at least ninety (90) days prior to the renewal date.
- You have agreed to participate in the USFHP quality improvement, utilization management, credentialing, peer review, grievance, and National Quality Monitoring Contract (NQMC) program. You have agreed to participate in any evidence-based patient safety programs.

CREDENTIALING AND RECREDENTIALING

- All participating providers are required to meet the credentialing and recredentialing requirements of Pacific Medical Centers and the US Family Health Plan. The requirements include but not limited to the following:
- All participating providers must hold a current, valid license or certificate to practice his or his profession in Washington State.
- Licensure or certification must be at the full clinical practice level and the services must be provided within the scope of the license or certification.
- All participating providers must be certified Medicare providers.
- If the provider does not participate in the recredentialing process, the provider will be subject to a corrective action plan or a termination of participation.
- Participating provider must be credentialing by the Pacific Medical Centers Credentialing Dept.

GRIEVANCE AND APPEAL PROCESS

- Practitioners / providers may appeal decision of the Credentials Committee and or Medical Director.
- Any participating provider that is denied suspended or terminated for cause by the US Family Health Plan shall receive written notice of the decision that includes the reason for the rejection, suspension or termination by the US Family Health Plan Medical Director.
- Right to Appeal: Following a denial, limitations, suspension or terminations of appointments or privileges, a Practitioner may request a formal hearing to respond to a proposed action.

- a) Written Request: Petitioner must request an appeal hearing in writing to the chair of the Credentials Committee no later than thirty (30) calendar days after receipt of the notification of adverse decision.
 - b) Failure to request an appeal hearing within thirty (30) days of receipt of the notification of adverse decision shall be deemed a waiver of the right to an appeal hearing.
- Appeal Hearing: Appeal hearings are set forth herein to assure that the effected practitioner is afforded all rights to which he/she is entitled.

If the decision is unfavorable to practitioner, practitioner may request a second appeal of the decision by the first appeal panel.

The Level II Appeals Committee has sole discretion over the appeal decision. The Level II Committee decision will be final.

a) The Petitioner will receive the written decision of the Level II Appeals Committee including a statement of the basis for the decision.

REIMBURSEMENT METHODOLOGIES

CAPITATION

Capitation reimbursement varies according to an actual calculation of service requirements based on age and sex of the member.

FEE-FOR-SERVICES (PROFESSIONAL SERVICES)

Professional services provided under a fee for service contracted agreement are reimbursed based on the contract rates.

Medicare fee schedule is utilized for DMEPOS services.

INSTITUTIONAL SERVICES

The US Family Health Plan reimburses facility based care at the TRICARE / CHAMPUS DRG or contracted rate. TRICARE rates are updated annually and claims are processed by date of service.

Note: Any fee schedule changes or contract provisions are sent to the participating provider office

Monitoring

According to our contract with the Department of Defense, PacMed is required to monitor the following:

- Serious occurrence events and catastrophic events.
- Prescribing practices. Unusual prescribing practices are reviewed which may include communication with the prescribing physician.
- Utilization of unusual, non-standard, or unapproved therapies.
- Claims review to identify utilization patterns for investigation of potential quality issues.

Provider Reviews

- Patient satisfaction questionnaires and incident/complaint reports are maintained on each provider for review.

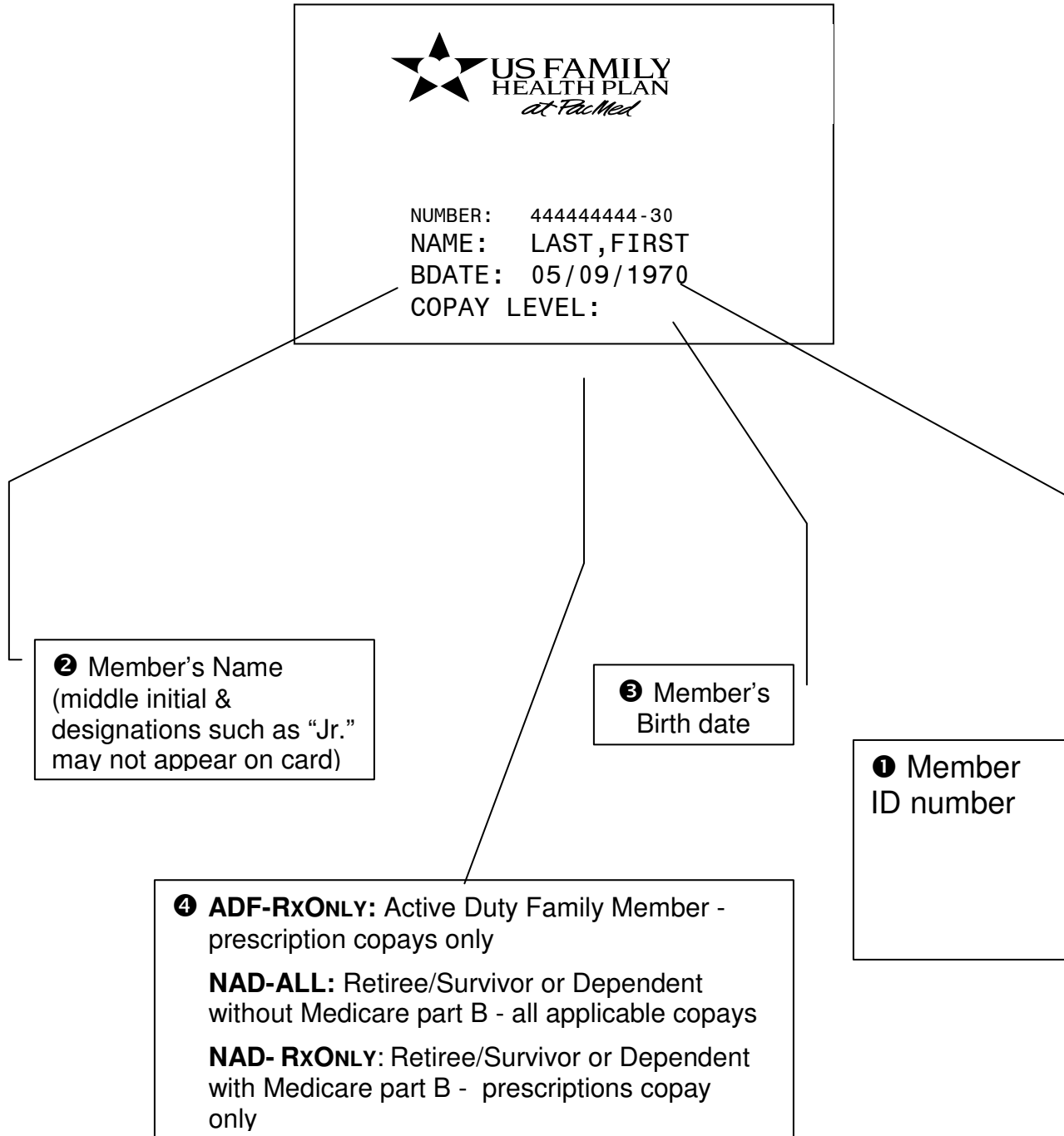
DYNACARE LAB*Collection Sites*

Ballard:	Medical Plaza Building 1801 NW Market, #106 Seattle, WA 98107 (206) 706-8549 <i>hours: 7am – 7pm</i>
Bellevue:	1200 116 th NE Suite G Bellevue, WA 98004 (425) 688-1600 <i>hours: M-F 7:15am – 5pm; Sat 7:30am – 11:30am</i>
Issaquah:	450 NW Gilman Blvd, #305 Issaquah, WA 98027 (425) 391-8633 <i>hours: 8:30am – 5 pm</i>
Kirkland:	Stat Lab 12911 120 th NE, D-20 Kirkland, WA 98034 (425) 814-6156 <i>hours: M-Th 7am – 5:30pm; F 8am – 5pm</i>
Lakeview:	3216 NE 45 th Place #210 Seattle, WA 98105 (206) 527-2598 <i>hours: 8:30am – 5:30pm</i>
Main Lab:	Nordstrom Tower 1229 Madison #500 Seattle, WA 98104 (206) 386-2672 <i>hours: 24 hours/day</i>
Olympia:	Lacy 200 Lily Road, Bldg B Olympia, WA 98506 (360) 438-3760 <i>hours: 8:30am – 5pm</i>
Renton:	920 N 1 st Street Renton, WA (425) 228-2018 <i>hours: 8:30am – 5pm</i>

The sites listed above are in addition to the Dynacare sites within each of the PacMed Clinics.

Understanding the US Family Health Plan ID Card

Sample Card



Office Visit/Consult Copayments:

ADF-RxOnly = ZERO dollars.

NAD-ALL = \$12.00 per visit

NAD-RxOnly = ZERO dollars.

Card for ID purposes only. Does not guarantee coverage or benefits. Pre-authorization required for care received outside PacMed Clinics. Call Member Services at (206) 621-4090 or 1-800-585-5883 to verify eligibility, benefits, and coverage. Reimbursement will be reduced by the applicable copay amount. Enrollees who are Medicare beneficiaries have waived their use of Medicare. Do not bill Medicare for care provided to this enrollee. Send claim(s) to:

US Family Health Plan at PacMed Clinics, 1200 12th Avenue South, Seattle, WA 981

Provider Quick Reference Guide

Provider Appeals – (206) 621-4090 or 1-800-585-5883

Provider Relations & Network Provider Questions:

(206) 621-4090 or 1 800-585-5883

Member Services: (206) 621-4090 or 1 800-585-5883

For eligibility, benefits, formulary and appeal information

Website – [USFHP@ Pacmed.org](mailto:USFHP@Pacmed.org)

Please contact the US Family Health Plan Member Services for additional provider information or an updated provider manual