HEART *to* HEART
Provider Update

US FAMILY HEALTH PLAN

Fall 2025

Get to Know US Family Health Plan (USFHP)

As the seasons shift and we welcome the cooler days of fall, we are reminded of the importance of resilience, adaptability, and community – values deeply rooted in our mission to support military families. This season brings opportunities to reflect on the progress we've made together and to look ahead to continued collaboration in delivering exceptional care to our beneficiaries. We thank you for your partnership.

In this edition, you'll find updates on new provider resources, highlights from ongoing initiatives, and reminders designed to strengthen your partnership with US Family Health Plan. We remain committed to ensuring you have the tools, information, and support you need to care for those who have served and current active duty families.

Provider Relations Team Actively Engaging with Practices

Over the next few weeks, our Provider Relations team will be reaching out to practices more actively. As part of our ongoing commitment to support providers and ensure accurate information to our members, your practice may receive calls, emails, or in-person visits from our Provider Relations team as we work together to confirm practice details, including rosters and demographic information. We encourage your staff to engage with our representatives during these outreach efforts. Your partnership helps us deliver reliable information, reduce administrative issues, and enhance the overall experience for providers and members alike.

HEART *to* HEART
Provider Update

US FAMILY HEALTH PLAN

Billing for Our Over-65 Members

Have you seen this card presented at your office before?

USFHP beneficiaries who enrolled with the plan prior to October 1, 2012, are grandfathered in for participation after they turn 65. They **do not** need to disenroll from US Family Health Plan.

If you have a patient who presents this card, **DO NOT BILL MEDICARE** for services that are covered by USFHP. If you bill Medicare, you will need to reimburse Medicare before you can bill USFHP.

Provider Spotlight Opportunity

We want to highlight you!

US Family Health Plan of Southern New England is kicking off a series sharing a glimpse into our member and provider community. We are looking for providers who have a connection to the military community, and in return, you will have access to pictures, interviews, and videos taken by our marketing team. This is a great way to feature your practice and show how you give back to our beneficiaries.

Email ProviderRelations@usfamilyhealth.org for more information.

HEART *to* HEART
Provider Update

US FAMILY HEALTH PLAN

Clinical Corner

Policy Update: Gender Dysphoria

A recent change to TRICARE policy excludes certain treatment for gender dysphoria, including, but not limited to, puberty blockers (to delay the onset or progression of normally timed puberty in an individual who does not identify as his or her sex) and sex-hormones (to align an individual's physical appearance with an identity that differs from his or her) for beneficiaries under the age of 19.
Gender Dysphoria Services | TRICARE

Pharmacy Updates

Reminder to go to our website for the pharmacy prior authorizations, due to the frequency in which prior authorization forms are updated. This will ensure the most up-to-date form is being utilized.
Pre-Authorization Forms | US Family Health Plan

Military Cultural Competency: Acute Stress Disorder

What Is Acute Stress Disorder (ASD)?

Acute stress disorder, or ASD, was introduced into the DSM-IV in 1994. In DSM-5 (2013), ASD was reclassified in the Trauma- and Stressor-Related Disorders[1]. A diagnosis of ASD has been integral in helping facilitate access to health care after trauma exposure. Debate continues regarding ASD as a predictor of posttraumatic stress disorder (PTSD)[2].

- The diagnosis of ASD can only be considered from 3 days to one month following a traumatic event (commonly referred to as the acute phase). If posttraumatic symptoms persist beyond a month, the clinician would assess for the presence of PTSD. The ASD diagnosis would no longer apply.
- ASD requires meeting criteria for at least 9 of the 14 symptoms[3].

Continued

1. Bryant, R. A. (2016). *Acute stress disorder: What it is and how to treat it.* New York, NY: The Guilford Press.

2. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author. Bryant, R. A. (2011).

3. Bryant, R. A. (2016). *Acute stress disorder: What it is and how to treat it.* New York, NY: The Guilford Press.

Military Cultural Competency: Acute Stress Disorder (continued)

How Do PTSD and ASD Differ?

ASD and PTSD share the same requirement for exposure to a traumatic event (Criterion A). Many of the ASD symptoms are similar to those for PTSD. Yet, ASD and PTSD differ in several important ways:

- PTSD diagnosis requires meeting a certain number of symptoms within established clusters. For ASD, symptoms are not classified within clusters; therefore an individual meets diagnosis based upon expression of symptoms in total.
- PTSD includes non-fear based symptoms (i.e., risky or destructive behavior, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feeling isolated), whereas ASD does not.
- PTSD includes a <dissociative subtype>, whereas in ASD, depersonalization and derealization are included as symptoms under the dissociative heading.

How Common Is ASD Following Trauma Exposure?

ASD prevalence rates vary in trauma exposed populations across studies and across different trauma types, with an average of 19%[1]. Some trauma types are associated with higher rates of ASD than others. For example, prevalence estimates of ASD range from 13 - 21% following motor vehicle accidents and 14% after brain injury[2]; to 24% following assault[3] and 59% following rape[4]. Of note, these rates are based on DSM-IV ASD criteria. Currently, there are no prevalence estimates of ASD in adults using DSM-5 criteria.

1. Bryant, R. A. (2016). *Acute stress disorder: What it is and how to treat it*. New York, NY: The Guilford Press.

2. Harvey, A. G., & Bryant, R. A. (1998). Acute stress disorder after mild traumatic brain injury. *Journal of Nervous and Mental Disease*, 186, 333-337. doi:10.1097/00005053-199806000-00002

3. Elklit, A., & Brink, O. (2004). Acute stress disorder as a predictor of post-traumatic stress disorder in physical assault victims. *Journal of Interpersonal Violence*, 19, 709-726. doi:10.1177/0886260504263872

4. Elklit, A., & Christiansen, D. M. (2010). ASD and PTSD in rape victims. *Journal of Interpersonal Violence*, 25, 1470-1488. doi:10.1177/0886260509354587

HEART *to* HEART
Provider Update

US FAMILY HEALTH PLAN

Access to Care Standards

Type of Care	Access to Care Standards for Participating Provider
Emergency Care	Immediate Access
Urgent Care	Within 24 Hours (1 Day)
Routine Care	Within 1 Week (7 Days)
Specialty Care	Within 4 Weeks (28 Days)
Office Wait Time	Less than 30 Minutes

Stay current with all your US Family Health Plan communications.

Sign up to day to receive digital updates!