

2026 Provider Manual



**CHRISTUS HEALTH PLAN LOUISIANA HEALTH
EXCHANGE COVERS MEMBERS IN THE
FOLLOWING PARISHES:**

- Bossier
- Caddo
- Calcasieu
- Grant
- Natchitoches
- Rapides
- Red River
- Vernon



CHRISTUS HEALTH PLAN PROVIDER MANUAL

Individual and Family Health Plan

Louisiana

2026



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Important Contact Information

Member Services Provider Services Provider Translation Assistance	Tel.: 844-282-3025 Fax: 210-766-8851
Claim Resolution	Fax: 866-416-2840
Utilization Management	Fax: 844-357-7562
Pharmacy Formulary (CVS)	Customer Care: 1-833-844-5350 Help Desk: 1-866-693-4620
Behavioral Health (CHRISTUS Health Plan)	Tel.: 844-282-3025
Family Planning (Conduent)	Member Services: 844.282.3025
Dental (Delta Dental)	Member Services: 833-459-1167 Provider Services: 833-459-1167
Vision (Superior Vision)	Member Services: 800-879-6901 Provider Services: 866-819-4298
24-Hour Nurse Hotline	844-581-3175
Claims Billing Address	P.O. Box 561123 Dallas TX 75356
Report Fraud & Non-Compliance	Hotline: 855-771-8072 CHRISTUSHealthPlanSIU@CHRISTUShealth.org Secure Fax: 210-766-8849
Website	www.CHRISTUShealthplan.org

Welcome to CHRISTUS Health Plan

Welcome to CHRISTUS Health Plan! Thank you for becoming a participating provider with CHRISTUS Health Plan. We view you as our partner in providing high-quality, affordable health care to our members.

CHRISTUS Health Plan, headquartered in Irving, Texas, is a health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach, and wellness for the people we serve across the country.

CHRISTUS Health Plan is positioned to manage the right populations in the right way while reducing the rising healthcare cost trends. Key to this strategy is the engagement of members and their families with a team of providers using population health tools to identify high-risk members and gaps in care for all members that transcends the continuum of care, from the community to primary care to acute care.

Our staff will work collaboratively with you to create a positive experience for you, your members, and CHRISTUS Health Plan. Any time you have a question, please feel free to call your local Provider Engagement Specialist or your Medical Director.

Members of CHRISTUS Health Plan receive services as part of health care benefits managed by their Primary Care Provider (PCP). Benefits are available only through the exclusive use of participating providers, hospitals, medical centers, pharmacies, home health agencies, and other health care providers. No benefits are provided for use of nonparticipating providers (except in the case of emergencies, and when authorized in advance for services not available from participating providers). A list of participating providers is available on the Plan's website at www.CHRISTUShealthplan.org.

This provider manual furnishes participating providers and their office staff with valuable information concerning CHRISTUS Health Plan policies and procedures, claim submission, adjudication requirements, and guidelines used to administer CHRISTUS Health Plan. This manual replaces and supersedes any and all other previous versions and is available at www.CHRISTUShealthplan.org.

Nothing in this provider manual or the CHRISTUS Health Plan Agreement is intended to or shall be interpreted to discourage or prohibit a participating provider from discussing with a member treatment option or providing other medical advice or treatment deemed appropriate by a participating provider.

Please contact your local Provider Relations Representative for specific information in relation to your provider agreement, including but not limited to:

- A listing of all individuals or entities that are party to the written agreement.
- Conditions for participation as a contracted provider.
- Events that may result in the reduction, suspension, or termination of network participation privileges.

- Health care services to be provided and any related restrictions.
- Mechanisms for dispute resolution by participating providers.
- Obligations and responsibilities of the organization and the participating provider, including any obligations for the participating provider to participate in the organization's management, complaint process or other programs.
- Participating provider payment methodology and fees.
- Prohibitions regarding discrimination against consumers.
- Participating provider payment methodology and fees.
- Requirements for claims submission and any restrictions on billing of consumers.
- Requirements with respect to preserving the confidentiality of member health information.
- Term of the contract and procedures for terminating the contract.
- The circumstances under which the network may require access to consumers' medical records as part of the organization's programs or health benefits.

As a provider for CHRISTUS Health Plan, providers have agreed to follow and adhere to "Rules and Regulations," which include, but are not limited to, all quality improvement, utilization management, credentialing, peer review, grievance, and other policies and procedures established and revised by CHRISTUS Health Plan, CMS, and the CHRISTUS Health Plan Provider Manual, as amended from time to time. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by CHRISTUS Health Plan at any time upon notice to the provider.

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied upon as such. The most up-to-date version of the Provider Manual is located on the Plan's website at www.christushealthplan.org. All terms and statements used in this manual will have the meaning ascribed to them by CHRISTUS Health Plan and shall be interpreted by CHRISTUS Health Plan in its sole discretion.

Provider Participation Requirements

CHRISTUS Health Plan contracts and credentials practitioners and certain facilities (hospitals, ambulatory surgery centers, home health agencies and skilled nursing facilities) prior to participation. Practitioners and facilities are re-credentialed, at a minimum, every three (3) years. The credentialing/re-credentialing process consists of the provider application process, verification of credentials with primary sources and a review by the credentialing committee. An executed contract is required prior to plan participation. Credentialing approval is not a guarantee of participation.

To comply with the requirements of accrediting and regulatory agencies, CHRISTUS Health Plan has adopted certain rules for participating providers that are summarized below. This is not a comprehensive, all-inclusive list.

Provider Participation Criteria

- Completed Provider Application.
- Current license to practice medicine or operate facility without limitation, suspension, restriction.
- Current DEA/CDS certificate (if applicable).
- Current malpractice insurance coverage, consistent with the Provider's contract/Agreement.
- Board Certification or completed appropriate training in the requested specialty.
- Ability to meet access and availability standards.
- Must be eligible to become an approved provider.
- No state, Medicare, or Medicaid sanctions.
- Network need.

Facility Participation Criteria

- Completed Facility/Ancillary Application.
- Current operating certificate.
- Current Accreditation (Joint Commission Accreditation if applicable).
- Current malpractice insurance coverage, consistent with the Provider's contract/agreement.
- Ability to meet access and availability standards.
- Must be eligible to become an approved provider.
- No state, Medicare, or Medicaid sanctions.
- Network Development will review the need for adequacy.

Provider, Facility, and Ancillary Contractual Requirements and Expectations

At a minimum, language in the contract includes the following conditions or programs to which the provider agrees to comply:

- Provide continuous 24-hour, 7-day-a-week access to care.
- Have an admission arrangement at an in-network facility (PCPs).

- Utilize CHRISTUS Health Plan participating providers and facilities when services are available and can meet the member's needs.
- Not discriminate based on age, sex, disability, race, color, religion, or national origin.
- Not balance bill a member for providing services that are covered by CHRISTUS Health Plan. Providers may only bill members for applicable deductibles, co-payments, and/or cost-sharing.
- Providers may bill a member for a service or procedure that is not a covered benefit after securing written consent.
- Prepare and complete medical and other related records in a timely fashion and maintain contemporaneous clinical records to substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.
- Provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the member's PCP promptly upon a member's visit with a specialist.
- Maintain medical records for six (6) years from the last date on which service was provided to the member.
- Transfer medical records promptly if requested by a treating provider, after a member change to another Provider.
- Allow access to medical records for review by appropriate committees of the CHRISTUS Health Plan and, upon request, provide the medical records to representatives of the Federal Government and/or their contracted agencies.
- Inform CHRISTUS Health Plan immediately, in writing, of any revocation or suspension of the provider's Drug Enforcement Agency (DEA) number, certificate or other legal credential authorizing the provider to practice in the state of Louisiana or any other state. Failure to comply with the above could result in termination from the Plan.
- Inform the CHRISTUS Health Plan immediately, in writing, of changes in licensure and participating hospital status, loss of liability insurance, and any other change, which would affect a provider practicing status.
- Participate in CHRISTUS Health Plan's quality improvement, utilization management, credentialing, peer review, grievance, other policies, and procedures established and revised by CHRISTUS Health Plan which also includes participation in evidence-based member safety programs.
- Abide by the CHRISTUS Health Plan rules and regulations.

Provider Rights

Providers have certain rights as participating providers of CHRISTUS Health Plan. These rights include:

- Ability to correct erroneous information identified during the credentialing process.
- Ability to review information submitted to support credentialing application.
- Appeal any action taken by CHRISTUS Health Plan that affects their status with the network and/or that is related to professional competency or conduct.
- Ask to have any adjudicated claim reconsidered if they feel the claim was not paid appropriately.

- Opportunity to provide feedback and suggestions on how to improve services for providers and for members through written correspondence, the Health Plan's annual Provider Satisfaction Survey, or via the Physician Advisory Committee.
- Ability to request that CHRISTUS Health Plan remove a member from their care if an acceptable member-provider relationship cannot be established with a CHRISTUS Health Plan member who has selected them as his/her provider.
- Request to serve on the Quality Improvement Committee or other committees that may be formed by CHRISTUS Health Plan.
- Upon request, to be informed of the status of credentialing/re-credentialing applications.

Appointment Availability and Wait Times

CHRISTUS Health Plan follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. CHRISTUS Health Plan monitors participating provider compliance with these standards at least once per year and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability for members. Wait times in any provider's office should not exceed 30-45 minutes for non-emergent visits.

FFE-established Appointment Wait Times

Provider Specialty Type	Appointments must be available within
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-Urgent)	30 business days

Effective January 1, 2026

Louisiana Health Insurance Exchange Appointment Standards

Appointment Type	Access Standards
Urgent Care	Twenty-four (24) hours
Emergency Care	Upon arrival, including at non-network and out-of-area facilities
Pregnant Women – 1 st Trimester 2 nd Trimester 3 rd Trimester	Fourteen (14) days of request Seven (7) days of request Three (3) days of request

Travel Distance and Access Standards

CHRISTUS Health Plan maintains a provider network in accordance with regulations regarding provider to member ratios and monitors the adequacy of the network to ensure provision of quality care and services to its' members. To ensure the network is sufficient to meet the needs of members, the number, type and distribution of practitioners, pharmacies, and ancillary services are continuously monitored.

Evaluations of network availability may include, but are not limited to:

- Analysis of member grievance information.
- Geographic distribution analysis.
- Member and provider satisfaction surveys.
- Member-to-provider ratios.

Providers must offer and provide CHRISTUS Health Plan members appointments and wait times comparable to that offered and provided to other commercial members. CHRISTUS Health Plan routinely monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

Provider Phone Call Protocol

PCPs and specialist providers must:

- Answer member telephone inquiries on a timely basis.
- Schedule appointments in accordance with appointment standards and guidelines set forth in this manual.
- Schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all members.
- Identify and, when possible, reschedule cancelled and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair access, interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments).
- Adhere to the following response times for telephone call-back wait times:
 - After hours for non-emergent, symptomatic issues: within 30 minutes.
 - Same day for all other calls during normal office hours.
- Schedule continuous availability and accessibility for professional, allied, and supportive personnel to provide covered services within normal office hours.
- Have protocols in place to provide coverage in the event of a provider's absence.
- Document after-hours calls in written format in either the member's medical record or an after-hours call log and then transfer to the member's medical record.

Note: If after-hours urgent or emergent care is needed, the PCP, specialist provider or his/her designee should contact the urgent care center or emergency department to notify the facility of the member's impending arrival. CHRISTUS Health Plan does not require prior authorization for emergent care. CHRISTUS Health Plan will monitor appointments and after-hours availability through its Quality Assessment and Performance Improvement (QAPI).

24-Hour Access to Providers

PCPs and specialist providers are required to maintain sufficient access to needed health care services on an ongoing basis and must ensure such services are accessible to members as needed 24-hours-a-day, 365-days-a-year as follows:

- The providers must answer the office phone during normal business hours.

- A member must be able to access his/her provider after normal business hours and on weekends; this may be accomplished through the following:
 - A covering physician.
 - An answering service.
 - A triage service or voicemail message that provides a second phone number that is answered.

If the provider's practice includes a high population of Spanish speaking members, it is recommended that the messages are recorded in both English and Spanish.

Examples of unacceptable after-hours coverage include, but are not limited to:

- Calls received after hours are answered by a recording telling callers to leave a message.
- Calls received after-hours are answered by a recording directing members to go to an emergency room for any services needed.
- Not returning calls or responding to messages left by members after hours within thirty (30) minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCP, specialist providers, or covering providers must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number. CHRISTUS Health Plan will monitor providers' compliance with this provision through scheduled and unscheduled visits and audits conducted by CHRISTUS Health Plan staff.

Covering Providers

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. The provider who engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the CHRISTUS Health Plan fee schedule in such provider's agreement.

Authorizing an Out-of-Network Provider

If it is determined that CHRISTUS Health Plan does not have an in-network provider with the appropriate training and experience needed to treat a member's condition, CHRISTUS Health Plan will approve an out-of-network authorization. An in-network provider may request out-of-network authorization.

Note: Approvals will not be made based on the convenience for either a member or a provider and CHRISTUS Health Plan may not approve the out-of-network provider requested. If CHRISTUS Health Plan approves the authorization, all services performed by the out-of-network provider are subject to a treatment plan approved by CHRISTUS Health Plan in consultation with the member, the member's PCP, and the out-of-network provider. All services rendered by the out-of-network provider will require authorization; however, **this is not a guarantee of payment**. Members are responsible for any applicable in-network cost-sharing and non-covered services. In the event CHRISTUS Health Plan does not approve an authorization, any services rendered by the out-of-network provider will not be covered.

Change in Provider Information

Providers must notify both the CHRISTUS Health Plan Provider Relations Department and CMS, through the CMS-contracted intermediary in writing of any changes in information regarding their practice. Such changes include:

- Name changes.
- Address changes (including changes for satellite offices).
- Phone number.
- Fax number.
- Hours of operation.
- Additions or terminations to a group.
- National provider identification (NPI) number changes.
- Tax ID number changes.

Voluntary Provider Terminations

Providers may terminate their contract with CHRISTUS Health Plan according to the terms of their Provider Agreement. Termination of a Provider Agreement does not release the provider from the obligation to arrange for the provision of services and transition of member care. Providers must continue to provide medical care to assigned members until the effective date of the termination. Please refer to the termination section of the Provider Agreement for termination instructions, continuity of care and notification address.

Transitional Care

CHRISTUS Health Plan understands that when providers leave or are terminated from the Plan, members may require coverage for a period to ensure continuity of treatment. Members being treated by a provider whose contracted status has been terminated may be able to continue ongoing treatment for covered services for up to ninety (90) days after the effective date of the termination. In addition, pregnant members can continue care with a former in-network provider through delivery and any postpartum care related to the delivery.

Note: Members must contact Member Services to request this continuity of care and request authorization prior to service. Former in-network providers must agree to accept the negotiated fee as payment in effect just prior to the termination.

Additionally, the provider must agree to provide CHRISTUS Health Plan with necessary medical information related to the member's care and adhere to CHRISTUS Health Plan's policies and procedures, including those for assuring quality of care, obtaining preauthorization, authorization, and a treatment plan approved by CHRISTUS Health Plan. If a provider was terminated by CHRISTUS Health Plan due to fraud, imminent harm to members, or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with the provider is not available.

Provider Request to Transfer a Member's Care

Members have the right to voluntarily change providers. Likewise, providers have a right to request the transfer of a member to the care of another provider when the provider feels the doctor-member relationship has been compromised due to:

- A pattern of missed appointments.
- Breakdown in member/provider relationship.

- Failure to follow the provider's recommended treatment plan.
- Failure to pay co-payments.
- Fraud.
- Unruly or abusive behavior.

In such situations, the provider is required to resolve the issue through written communication to the member, which includes the following:

- Refers to the specific incident (date).
- Refers to the specific behavior.
- Expresses commitment to work with the member – carbon copy (CC) the CHRISTUS Health Plan Member Service Manager at the following address:

CHRISTUS Health Plan
P.O. Box 169016
Irving | Texas 75016

If the behavior persists, the provider should write a formal letter to the member and carbon copy (CC) to the CHRISTUS Health Plan Member Services Manager to advise of the situation and initiate transfer of the member to another PCP. The Member Services Department will contact members to facilitate the transfer.

Note: Some instances require immediate termination of the provider-member relationship. Providers are encouraged to consult with their Provider Relations Representative for additional assistance as needed.

Non-Discrimination

Participating providers have agreed to provide care to CHRISTUS Health Plan members in the same manner and in accordance with the same standards they follow in providing care to members who are not CHRISTUS Health Plan members. Providers cannot differentiate or discriminate against any CHRISTUS Health Plan member in the delivery of health care services consistent with covered benefits on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Suspected Child or Adult and Elder Abuse or Neglect

During an examination, cases of suspected child or adult and elder abuse or neglect might be uncovered during an examination, and should be reported immediately, by telephone or to a representative of the local Department for Social Services office, local law enforcement agency, or the Louisiana State Police, as appropriate.

Louisiana Revised Statute 15:1503 defines abuse as the infliction of physical or mental injury, or actions which may be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. The statute also describes an adult as any individual eighteen years of age or older, or an emancipated minor who, due to a physical, mental, or developmental disability or the infirmities of aging, is unable to

manage his/her own resources, carry out the activities of daily living, or protect himself or herself from abuse, neglect, or exploitation.

Marketing

The development or use of any material that markets for CHRISTUS Health Plan is prohibited without prior written approval from CHRISTUS Health Plan. Prior to distributing marketing materials, documents, or other information to Medicare beneficiaries, Federal laws require CMS-contracted Marketplace Plans to obtain authorization from the Centers for Medicare and Medicaid Services (CMS).

Medical Records

CHRISTUS Health Plan provider representatives must be permitted access to the provider's office records and operations. This access allows CHRISTUS Health Plan to monitor compliance with regulatory requirements. Each provider's office will maintain complete and accurate medical records for all CHRISTUS Health Plan members receiving medical services in a format and time periods as required by the following:

- Accepted medical practices and standards.
- Applicable federal laws.
- Applicable licensing, accreditation, and reimbursement rules and regulations.

The provider's medical records must be available for quality assessment, utilization, risk management, peer review studies, customer service inquiries, complaint and appeal processing, claims reconsideration, and other initiatives CHRISTUS Health Plan may be required to conduct. To comply with accreditation and regulatory requirements, CHRISTUS Health Plan may periodically perform documentation audits of some provider medical records. If an audit indicates non-compliance in any area, an internal corrective action plan may be initiated with the provider.

Standards

Participating providers must have a system in place for maintaining medical records that conform to regulatory standards. All medical records pertaining to CHRISTUS Health Plan members must be kept the longer of six (6) years or as required by each state, whichever time frame is longer.

Medical records are confidential and are considered Protected Health Information (PHI). Providers must comply with all state and federal laws concerning confidentiality of health and other information about CHRISTUS Health Plan members. Providers must maintain and adhere to policies and procedures regarding use and disclosure of health information that comply with HIPPA and other applicable laws. A complete listing of all compliance policies and procedures can be found on the CHRISTUS Health Plan website at <https://christushealthplan.org/provider-resources/policies-and-procedures>.

Release of Medical Records

CHRISTUS Health Plan members have the right to access their medical records; therefore, each provider must have a mechanism in place to provide this access. Appropriate communication of medical record information between treating providers is essential to promoting continuity and coordination of care.

Transfer of Medical Records

There may be times when a member's medical record needs to be transferred from one PCP to another PCP in the Plan. This may occur when members change PCPs or if a PCP leaves the Plan. All medical records must be transferred to the new PCP within ten (10) business days if requested by the treating provider.

The following information must be included in every individual record:

- Member identification.
- Personal data.
- Alcohol or substance use | abuse.
- Allergies.
- Appropriate use of consultants.
- Chief complaint.
- Chronic | continuing medication list.
- Chronic | significant problem list.
- Date of each visit.
- Date of next visit.
- Diagnosis | impression.
- Growth chart (14 years of age and younger).
- Hospital records, as applicable.
- Immunization history.
- Informed consent.
- Initial relevant history.
- Medical Director review of diagnostic studies.
- Member's signature on file, for insurance purposes.
- Physical examinations.
- Preventive health education.
- Provider signature | name on each entry.
- Results discussed with member.
- Results of consultations.
- Smoking status.
- Treatment | therapy plan.
- Health Education and Wellness promotion services assessed by member.

Risk Adjustment Data Validation

Participation in Risk Adjustment Data Validation is required of all providers, and it is important that providers are aware that medical records may be requested from their office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. The medical record reviews verify the accuracy of Claim and Encounter Data and identify additional conditions not captured through this mechanism.

CHRISTUS Health Plan may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (Health Insurance Privacy and Accountability Act [HIPAA] implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the "general consent" of members. A general consent form should be an integral part of the medical record file. Information on risk adjustment is available at [cms.gov](https://www.cms.gov).

Risk Adjustment Data Validation (RADV) Documentation Requirements

Provider agrees to fully comply with all CMS Risk Adjustment Data Validation (RADV) requirements and the following:

- **Medical Record Submission and Signature Requirements** – Upon request by the Plan or its designated vendor, Provider shall submit complete, legible medical records with valid provider signatures and credentials within the timeframe specified (typically ten (10) to fifteen (15) business days, or sooner if required by CMS).
- **Escalation for non-response**
To ensure timely compliance with CMS audit requirements, the following escalation process will apply if records are not received within the required timeframe:
 - a. Day 15: Second written request and direct outreach to the provider contact.
 - b. Day 20: Escalation to the provider's Medical Director or Practice Administrator.
 - c. Day 25: Escalation to Network Management and Compliance for potential contractual action. Additionally, a referral will be made to CHRISTUS Health Compliance for non-compliance notification to regulatory authorities, including:
 - Department of Health & Human Services (HHS) oversees the Risk Adjustment Data Validation (RADV) program through the Centers for Medicare & Medicaid Services (CMS).
 - Centers for Medicare & Medicaid Services (CMS)

Advance Directives

Advance Directives are written instructions that:

- Are recognized under state law when signed by a competent person.
- Give directions to health care providers as to the provision of care.
- Provide for treatment choices when a person is incapacitated.

There are three types of Advance Directives:

- A durable **Power of Attorney (POA)** for health care allows the member to name a member advocate to act on behalf of the member.
- A **Living Will** allows the member to state his or her wishes in writing but does not name a member advocate.
- A **Declaration for Mental Health Treatment** gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatment described in the declaration with or without conditions and limitations.

CHRISTUS Health Plan directive policies include:

- Respecting the members' right to control decisions relating to his or her own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives. Providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CFR 489 subpart I.

- Advising members of their right to self-determination regarding advance directives by:
 - Encouraging members to request an advance directive form and education from their PCP at their first appointment.
 - Assisting members with questions about an advance directive. No CHRISTUS Health Plan employee may serve as a witness to an advance directive or as a member's authorized agent or representative.
- Allowing a CHRISTUS Health Plan associate, a facility, or a provider to object conscientiously to an advance directive within certain limited circumstances if allowed by state law.
- Having Member Services, Provider Relations, and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regularly.
- Producing member materials containing information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those raised by individual providers.
- The Health Plan issuing a clear and precise written statement of this limitation to CMS and requesting a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
 - Describes the range of medical conditions or procedures affected by the conscience objection.
 - Identifies the state legal authority permitting such objection.
 - Noting the presence of advance directives in the medical records when conducting medical chart audits.

Providers must:

- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive.
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider's office.
- For members who do not have an executed advance directive, ask if he or she would like advance directive information. If the member desires further information, provide the member with advance directive education.
- Comply with the Patient Self-Determination Act requirements.
- Discuss potential medical emergencies with the member, family, significant other and with the referring provider, if applicable.
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate (DNR) directive or the provider and member's discussion and action regarding the execution or non-execution of an advance directive.
- Make an advance directive part of the member's medical record and put it in a prominent place.
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive.

Closing a PCP Panel

CHRISTUS Health Plan and participating providers share the common goal of making medical care available and accessible to members in a timely manner. PCPs whose

practices are nearing capacity typically close their panels to new members regardless of payer. This allows them to handle urgent care for their existing members in a timely manner and to maintain reasonable appointment lead time. PCPs interested in closing their panel should contact their Provider Relations Representative.

Member Eligibility

Eligibility

The Federal Exchange will make eligibility decisions based upon the application submitted by the members. The member is responsible for notifying the Exchange about changes to their family circumstances that could affect eligibility such as adoption, birth, addition of another dependent, or a divorce.

To be eligible for covered benefits in accordance with CHRISTUS Health Plan contracts, members must be enrolled. In this context, the member is the individual who has applied for coverage on behalf of his/herself and his/her dependents, and to whom the contract was issued.

Verifying Eligibility

A provider may confirm member eligibility directly with CHRISTUS Health Plan by visiting the Provider Portal: <https://christushealthprovider.healthtrioconnect.com> or call Member Services at 844-2823025.

Member ID Card

The Member Identification (ID) Card is issued to members upon enrollment and contains information regarding benefit coverage, copayments, and telephone numbers for questions regarding those benefits. Each member receives an ID card when he/she enrolls with CHRISTUS Health Plan. Most providers ask to see the ID card each time the member comes to the office.

The ID card displays information such as:

- Member's Plan Name.
- Member First and Last Name.
- Member ID#.
- Contact Information for Member Services.
- Copayment Amounts.
- Deductible.
- Out-of-Pocket maximum.

Note: A member's eligibility status can change. The member ID card does not guarantee eligibility. Provider office staff must verify eligibility each time a member presents for service. New members may present a copy of an enrollment form or a copy of the sales receipt from

CHRISTUS Health Plan		FULLY INSURED	LA - EX
Member	Medical Plan		
Subscriber Name: JOHN SAMPLE			
Subscriber ID: 000000000			
Group Number: 98780LA012000205			
Effective Date: 01/01/2026			
PCP Name: Jane Doe			
PCP Phone: 555-555-5555			
PCP Effective Date: 01/01/2026			
Dependents:			
JANE SAMPLE	000000001		
JIMMY SAMPLE	000000002		
Pharmacy Plan			
RxBIN: 004336			
RxPCN: ADV			
RxGRP: RX25BA			
www.Caremark.com			
Pharmacy administered by CVS Caremark			
Preferred Generic Drug: \$10			
Generic Drug: \$10			
Brand Drug: \$20			
Non Preferred Brand Drug: Ded/\$60 Copay			
Specialty Drug: Up to \$150			

Provider Services	Member Services
Submit Medical Claims to:	Member Services 1-844-282-3025
P.O. Box 561123	TTY 711
Dallas, TX 75356	Superior Vision 1-800-879-6901
Payor ID: 52106	Delta Dental 1-833-459-1167
Submit Dental Claims to:	Pharmacy for Members 1-833-844-5350
P.O. Box 1809	PHD Pharmacy 1-800-364-6331
Alpharetta, GA 30023-1809	TTY 1-800-231-4403
Submit Vision Claims to:	Assistance 24/7
939 Elkrigde Landing Rd, Ste 200	Nurse Line: 1-844-581-3175
Linthicum, MD 21090	

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

CHRISTUS Health Plan is a licensed HMO in Texas. CHRISTUS Health Plan is also the sole owner of CHRISTUS Health Plan Louisiana, a licensed HMO in Louisiana which operates under the registered trade name of CHRISTUS Health Plan.

Please visit www.christushealthplan.org for more information about your plan and to find information on how to locate an in-network provider.

The ID Card above is shown for illustrative purposes only.

Grace Period

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)

CHRISTUS Health Plan grace period policy is as follows, unless otherwise specified by applicable state or federal law.

For members not receiving advance payments of the tax credit: CHRISTUS Health Plan provides a grace period of thirty-one (31) days to members who are not receiving advance payments of the premium tax credit and who have previously paid at least one full month's premium during the benefit year. During the grace period, the policy will remain active. If any premium is not paid by the end of the grace period, coverage is terminated as of the end of the period for which premium has been paid through.

The provider will refund any payments made to a provider on behalf of a member who loses coverage due to non-payment of premiums to CHRISTUS Health Plan within forty-five (45) days of receipt of written request by CHRISTUS Health Plan. CHRISTUS Health Plan may offset any amounts not paid within forty-five (45) days of receipt of notice from CHRISTUS Health Plan may deny claims that are received and not processed with dates of service beginning on the last day the premium was paid, after CHRISTUS Health Plan has confirmed that the grace period expired without premiums being paid in full.

For members receiving advance payments of the premium tax credit: CHRISTUS Health Plan provides a grace period of three (3) consecutive months to members receiving advance payment of the premium tax credits who have previously paid at least one full month's premium during the benefit year. During the grace period, the CHRISTUS Health Plan will:

- Pay all appropriate claims for services rendered to the member during the first month of the grace period and pend and/or deny claims for services rendered to the enrollee in the second and third months of the grace period.
- Notify providers when the provider confirms the member's eligibility of the possibility for denied claims when a member is in the second and third months of the grace period.
- Request a refund of any payments made in the second or third months of the grace period if the member is terminated.

If a member receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, CHRISTUS Health Plan will terminate the member's coverage on the last day of the first month of the 3-month grace period. The provider will refund any payments made to providers on behalf of members who lose coverage due to non-payment of premium with dates of service beginning after the first month of the 3-month grace period to CHRISTUS Health Plan within forty-five (45) days of receipt of written request by CHRISTUS Health Plan.

CHRISTUS Health Plan may offset any amounts not paid within forty-five (45) days of receipt of notice from CHRISTUS Health Plan from amounts otherwise owed to the provider without any further action.

Provider Complaints and Grievances

All participating providers have agreed to comply with the Plan's dispute resolution process by signing the provider agreement. The provider complaint process is available to any participating provider to resolve disputes with the Plan. The Plan distinguishes disputes by the following categories:

- **Administrative Claim Disputes:** a request for review of claims denied (or underpaid) by the claim's administrator or claims processing entity for technical or medical necessity issues.
- **Utilization Review Disputes:** a request for review of a determination made by the CHRISTUS Health Plan Utilization Review department on request for retro-authorization.
- **Disputes Concerning Professional Competence and Conduct:** a request for review of an action by the Plan that relates to a participating provider's status within the Plan's provider network and any action by the Plan related to a participating provider's professional competency or conduct.

Administrative Claim and Utilization Review Disputes to HMO

CHRISTUS Health Plan will make every effort to resolve provider dispute inquiries using consistent procedures for reviewing and responding to inquiries. Dispute reviews are completed within thirty (30) days of receipt of the request.

A provider dispute must be sent in writing to:

CHRISTUS Health Plan Exchange
Attn: Appeal Processing
P.O. Box 169009
Irving | Texas 75016
Fax: 866-416-2840
ChristusCAG@christushealth.org

All requests must be submitted for review within one hundred eighty (180) days of an action taken or decision made by CHRISTUS Health Plan. For any dispute involving a denied claim, the 180-day period begins on the date of the CHRISTUS Health Plan remittance reflecting the denial. For any dispute related to a claim audit, the 180-day period begins on the date of the notice to the provider.

CHRISTUS Health Plan will forward the provider request to the appropriate area for research and resolution. When appropriate, the Medical Director will review the matter using appropriate peer input.

Providers will receive a payment or written response within thirty (30) calendar days describing how their request was resolved.

Competence or Conduct Dispute and Appeals to HMO

Providers may file a non-administrative dispute that involves actions by the Plan that relate to a participating provider's status within the Plan's provider network and any action by the Plan related to a participating provider's professional competency or conduct.

Competence or conduct provider dispute or appeal with CHRISTUS Health Plan can be requested only in writing.

Participating providers have the right to appeal their dispute to two (2) separate panels above the level of the Plan body involved in the dispute. Each panel consists of at least three (3) qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. In no case will panel members be assigned who have been previously involved with the issue.

A panel will be convened within sixty (60) days of the request and the decision will be returned to the participating provider within thirty (30) days of the panel's closure. It is noted in the Credentialing File and reported, if required by law, when adverse action is taken or if the provider voluntarily relinquishes participation while undergoing investigation and/or peer review.

The following actions are required to be reported to the National Practitioner Data Bank (NPDB):

- Providers who terminate themselves while under investigation.
- Providers who terminate themselves with an action plan in place.
- Terminations resulting from serious quality deficiencies.

Cultural Diversity Resources for Providers

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare

CLAS is a way to improve the quality of services provided to all individuals, which will help reduce health disparities and achieve health equity. CLAS is about Respect and Responsiveness: Respect the whole individual and Respond to the individual's health needs and preferences.

The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services.

<https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>

Best Practices for Working with a Medical Interpreter

Working in the medical field, you have surely seen the need for an interpreter occasionally, if not every day. Fortunately, many clinics now make sure this type of professional is available to help doctors and members communicate. If you are not used to having a medical interpreter in the office with you, here is how to get familiar with this situation so you and your members can benefit from interpreting services right away.

[Working Effectively with an Interpreter](#)

A Physician's Practical Guide to Culturally Competent Care

This e-learning program will equip health care providers with competencies that will enable them to treat the increasingly diverse U.S. population.

[Home - Think Cultural Health](#)

HRSA: Culture, Language, and Health Literacy

Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. <https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy>

<https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy>

American Indian and Alaska Native Culture Card: A Guide to Build Cultural Awareness

Intended to enhance cultural competence when serving American Indian and Alaska Native communities. Covers regional differences, cultural customs, spirituality, communications styles, the role of veterans and the elderly, and health disparities, such as suicide.

<https://store.samhsa.gov/product/American-Indian-and-Alaska-Native-Culture-Card/sma08-4354>

Quality Improvement Program

The goal of CHRISTUS Health Plan's Quality Improvement Program is to ensure that members can receive quality care in a timely and accessible manner, and to provide a process for evaluating the appropriateness of member care. The purpose of the Quality Improvement Program is to ensure timely identification, assessment, and resolution of known or suspected evidence-based opportunities by way of continuously monitoring and evaluating the quality of care and services provided to our members.

The scope of the Quality Improvement Program includes oversight of all aspects of both clinical and administrative services provided to our members, including, but not limited to:

- Assessment of drug utilization for availability, appropriateness, and cost-effectiveness.
- Audits and evaluations of clinical services and processes.
- Benchmarks for disease prevention, chronic disease management, and other appropriate quality of care measures.
- Care Management (to include but not limited to; disease management, health promotion, complex disease management, behavioral health, and care transitions) programs that are member-centric and address the health care needs of members with comprehensive medical, physical, and mental health conditions.
- Credentialing and re-credentialing of physicians, practitioners, and facilities.
- Development and implementation of clinical standards and guidelines.
- Evaluation of accessibility and availability of network providers.
- Evidence-based care delivery.
- Implementation of high-quality customer services standards and process.
- Member appeals and grievances.
- Oversight of health plan delegated activities.
- Potential Quality of Care safety concern processing.
- Program design and structure.
- Quality Improvement activities that comply with Center Medicare and Medicaid Services, Accreditation Association for Ambulatory Health Care, and all other regulatory agencies in which CHRISTUS Health Plan adheres to.
- Utilization Management, which focuses on providing the appropriate level of services to members.

All participating providers are required to comply with CHRISTUS Health Plan's policies and procedures, including complying with, participating in, and implementing quality improvement projects that include member safety programs. This includes – but is not limited to - implementing activities necessary and required to comply with external accreditation by AAAHC or other similar accrediting bodies selected by the Plan. In addition, all participating providers are required to comply with the terms of this Provider Manual, CHRISTUS Health Plan Policies and Procedures, Medical Management, and Quality Improvement programs. Participating providers will allow CHRISTUS Health Plan to use performance data for the purposes of quality improvement initiatives.

Quality Referrals

Any stakeholder may refer a matter for review as a potential quality issue (PQI). The Quality Improvement Clinical Quality Auditor Nurse will investigate and review all potential cases with Chief Medical Officer (CMO) for discussion and recommendations prior to reporting to the Peer Review Committee (PRC). The CMO review may determine that:

- No quality issue exists.
- Potential quality concerns exist.

The CMO will recommend any action as appropriate to the event, in keeping with CHRISTUS Health Plan Policies and Procedures, contractual requirements of the Plan and other relevant federal, state, or local regulatory requirements. All PQIs are reported to the Peer Review Committee, who in turn determines a severity level and action plan.

All participating providers are required to comply with the terms of this Provider Manual as well as Medical Management and Quality Improvement Programs.

Health Care Effectiveness Data Information Set (HEDIS®)

CMS requires Health Exchange Health Plans to report Health Care Effectiveness Data Information Set (HEDIS®) measures annually. HEDIS is a set of standardized Quality Indicators that measure the performance of managed care plans in areas such as preventive screenings and chronic health care, developed by the National Committee for Quality Assurance (NCQA®).

HEDIS rates can be calculated in two ways, administrative data, or hybrid data.

- **Administrative data** consists of claim and encounter data submitted to the health plan.
- **Hybrid data** consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate Current Procedural Terminology, International Classification of Diseases-10 and Healthcare Common Procedure Coding System codes can reduce the necessity of medical record reviews.

Medical Record Reviews (MRR) for HEDIS

CHRISTUS Health Plan may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, if any of your members' medical records are selected for review, you will receive a call from a medical record review representative. Your prompt cooperation with the representative is needed and appreciated.

As a reminder, sharing of Protected Health Information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from members. The MRR vendor will sign a Health Insurance Portability Accountability Act Compliant Business Associate Agreement with CHRISTUS Health Plan, which allows them to collect Protected Health Information (PHI) on our behalf.

How Can Providers Improve Their HEDIS Scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with CHRISTUS Health Plan. Claims and encounter data is the cleanest and most efficient way to report HEDIS.
- Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Keep accurate chart/medical record documentation of each member service and document conversations/services.
- Submit claims and encounter data using CPT 2 codes related to HEDIS measures such as diabetes, eye examinations, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Department at email:

CHP.QualityDepartment@christushealth.org.

CAHPS Enrollee Experience Survey (CAHPS)

The Consumer Assessment of Healthcare Provider and Systems (CAHPS) experience is a member experience survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by Press Ganey an NCQA-certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan meets members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program, including the monitoring of practitioner access and availability.

The survey captures answers to questions such as (but not limited to):

- Did you get an appointment with your doctor as quickly as you thought you needed to?
- Wait time to see provider in relation to actual appointment time?
- Did the provider give you easy-to-understand information about your health concerns?
- Did the provider know valuable information about your medical history?
- Did someone from the office follow up to give you test results?
- Were clerks and receptionists helpful?
- How long did it take for the doctor's office staff to return your call?
- How often did this doctor seem informed about your care with specialists?
- Did the office give you information about what to do if you needed care during the evenings, weekends, or holidays?
- In the last 12 months, how often were you able to obtain care you needed during evenings, weekends, or holidays?

Potential Quality Issues

A **Potential Quality Issue (PQI)** is a suspected deviation from provider performance, clinical care, or outcome of care requiring further investigation to determine if an actual quality of care issue exists.

A Quality of Care (QOC) Issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.

A Clinician or Provider is any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity if licensure or certification is required by State law or regulation.

A Corrective Action Plan (CAP) is a plan approved by the appropriate Quality Improvement Committee to help ensure a related quality issue does not occur in the future. CAPs contain clearly stated goals and timeframes for completion.

CHRISTUS Health Plan has a systematic method for the identification, reporting and processing of Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to CHRISTUS Health Plan members and to direct actions for improvement based upon the frequency and severity of the PQI.

It is CHRISTUS Health Plan's policy to accept a PQI referral through a variety of sources. These include but are not limited to:

- Plan members.
- Plan providers.
- Plan staff members.
- Internal referrals from Grievances and Appeals.

All potential quality issues identified are tracked in the PQI log to monitor patterns to identify any potential trends or any significant sentinel events. All information obtained during and used in a QOC investigation is held in strict confidence, according to the Plans confidentiality policies and in accordance with all relevant State and Federal Peer Review Laws and regulations.

A designated medical professional will review all referred PQIs to identify whether a true QOC issue exists, after which the case will be assigned a severity score. Some cases will be referred to the Peer Review/Credentialing Committee based on CHP's policy.

Based on review by the Credentialing Committee, a provider may be placed on a Performance Improvement Plan (PIP) or may be required to submit a Corrective Plan. The PIP will request follow-up and evidence from the provider in question to demonstrate the corrective actions have been implemented as specified.

All Potential Quality Issues outcomes are trended on a continuous 36-month basis. Any identifiable trends, regardless of outcome to the member, are referred to the Quality Improvement Committee on a quarterly basis for potential action or educational opportunities.

Preventive Health Guidelines

Preventive Health Guidelines

Evidence-based care protocols have been shown to improve member outcomes through clinical research. Care delivery protocol values are evidence-based recommendations for care. CHRISTUS Health Plan recommends the adults and children preventative health guidelines established by U.S. Preventive Services Task Force (USPSTF) of the Agency for Healthcare Research and Quality (AHRQ). These preventative health guidelines include recommendations for screenings, testing, immunizations, and counseling. Full references are available at the following website: [Home page | United States Preventive Services Taskforce](#). Also, for pediatric care we recommend: [Preventive Care/Periodicity Schedule](#).

CHRISTUS Health Plan adopts nationally accepted evidence-based preventive services guidelines for healthy adults and children with normal risks (Grade A and B). Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources.

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy or contact Provider Services at **844-282-3025**.

We review guidelines every two (2) years or more frequently if national guidelines change within the two (2) year period.

Clinical Practice Guidelines

Clinical Practice Guidelines are evidence-based guidelines used to help providers make decisions about specific clinical situations. CHRISTUS Health Plan consults with participating providers practicing in the community to adopt nationally recognized guidelines and standards. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to providers to facilitate improvement of health of our members. Find them online here: [Clinical Practice Guidelines | NCCIH](#)

CHRISTUS Health Plan reviews the Clinical Practice Guidelines at least every two (2) years or more frequently if national guidelines change within the two (2) year time period.

Clinical Practice Guidelines are provided for informational purposes only and are not intended to direct individual treatment decisions. All member care and related decisions are the sole responsibility of their providers. These guidelines do not dictate or control a provider's clinical judgement regarding the appropriate treatment of a member in any given case. Clinical Practice Guidelines that have been formally adopted can be accessed online.

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a hard copy or can reach out to Provider Services at **844-282-3025**.

Claims, Encounters, & EDI Transactions

Claim Submissions Guidelines

Health Exchange Plans are regulated by CMS and therefore claims billed are expected to follow CMS billing practices wherever possible. Providers using electronic submission must submit all claims to CHRISTUS Health Plan using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic formats, or a CMS-1500 and/or UB-04.

Providers are required to submit all claims, encounters, and clinical data to CHRISTUS Health Plan through electronic means that are recognized as industry standard. This may include submission via claims clearinghouses or electronic data interface companies utilized by CHRISTUS Health Plan. Paper submissions are only permitted when allowed by applicable law.

To claim benefits, providers must submit properly completed claim forms that itemize the services or supplies provided and the associated charges. CHRISTUS Health Plan is not liable for payment of benefits if completed claim forms are not received within the applicable timely filing period as outlined in the Claims Filing Deadline section of this document.

Prompt Claim Processing Requirements

A claim is considered processed promptly when it is approved or denied within the timeframe specified by the provider agreement or applicable state regulations governing CHRISTUS Health Plan operations.

To ensure prompt payment, the following criteria must be met:

- Claims must be properly completed and submitted either electronically or on paper and must not require investigation into Coordination of Benefits (COB), member eligibility, subrogation, or similar issues.
- Separate charges must be clearly itemized on individual lines.
- Medical record documentation must support the scope and nature of the services provided and be billed.
- Claims must be submitted in accordance with the timely filing provisions outlined in the provider's contract. CHRISTUS Health Plan is not liable for claims submitted after the timely filing deadline, and members may not be balance billed due to a provider's failure to submit claims on time.
- Claims must include AMA-developed procedural codes.
- Claims must include ICD-10 diagnosis codes, reported to the highest level of specificity, as required by state or federal regulations.
- When submitting paper claims, providers must use original red and white CMS-1500 or UB-04 forms. Black-and-white copies or faxes are not accepted.
- Handwritten claims are not accepted.

Paper Claims Submissions

CHRISTUS Health Plan understands that providers may occasionally need to submit claims in paper format. To ensure proper processing, providers must submit paper claims using the appropriate UB-04 or CMS-1500 claim form. Claims must be submitted using original red and white CMS 1500 or UB-04 forms. The Plan does not accept super-bills or similar substitutes, or handwritten forms as valid claims. To avoid rejection, claims must be submitted to the official paper claims mailing address. Submissions sent to any other address may be returned to the provider. Submit paper claims to:

CHRISTUS Health Plan Exchange

ATTN: Claims Dept.

P.O. Box 561123

Dallas | Texas 75356-1123

EDI Transactions

Electronic Data Interchange (EDI) is the exchange of information using a routine business transaction in a standardized computer format, for example, data interchange between an insurance carrier and a provider. CHRISTUS Health Plan supports the electronic exchange of the Health Insurance Portability Accountability Act (HIPAA) adopted file formats.

- Eligibility inquiry and response (270).
- Health care claims professional (837P).
- Health care claims institutional (837i).
- Claims Inquiry and response (276).

Providers are asked to direct all inquiries regarding electronic file exchange set up for HIPAA-compliant transactions to their local assigned Provider Relations Representative, or they may call Provider Services.

Claims Clearinghouse

The Plan conducts its EDI transactions through the clearinghouse Availity. Providers should coordinate with their own clearinghouse or billing service to confirm they are properly configured to interface with Availity before initiating any EDI transactions with CHRISTUS Health Plan.

Electronic Claims Submissions (837 transaction)

- **Payor ID:** 52106
Providers submitting 837 transactions should use Payor ID **52106**.
- **Plan Name:** CHRISTUS Health Plan Health Exchange
Ensure the correct plan name is used when submitting claims.
- **NPI Requirement:**
Providers must have a valid National Provider Identifier (NPI) on file with CHRISTUS Health Plan to ensure successful claim processing.

Electronic Eligibility Benefit Inquiry (270 transaction)

This transaction is used by healthcare providers to electronically inquire about a patient's insurance eligibility and benefit coverage. Providers do not need to contact CHRISTUS Health Plan to be set up for electronic enrollment status inquiries. To access this service, providers simply need to contact Availity to enroll for the 270-transaction option.

Electronic Claim Status (276 transaction)

Providers can access electronic claims status through Availity using the 276/277 transactions. To ensure accurate claim matching and response, providers should verify that both their Type 1 NPI (individual) and Type 2 NPI (organizational), if applicable, are correctly recorded in CHRISTUS Health Plan's system.

Coordination of Benefits (COB) and Third-Party Liability (TPL)

Coordination of Benefits is a process used to determine payment responsibilities when a member is covered by more than one insurance plan. CHRISTUS Health Plan serves as the primary payor for covered services provided to members. However, it may act as the secondary payor when services are also reimbursable under other medical insurance plans.

In cases where other third parties, such as automobile, liability, or worker's compensation insurers, may be responsible for payment, providers must include the Explanation of Payment (EOP) from the primary carrier when submitting claims to the Plan. If the primary insurer has paid or denied the claim, the timely filing deadline for submitting the claim and EOP to CHRISTUS Health Plan begins on the date the EOP is issued.

Providers are required to indicate the presence of other insurance on the claim form as outlined in claim billing guidelines. (CMS 1500 - Blocks 9 & 10/UB 04 Blocks 50-51 & 58-62)

Claims Filing Deadlines

Providers should consult their individual contracts with CHRISTUS Health Plan to determine applicable timely filing deadlines. If no specific deadline is outlined in the contract, the standard timely filing limits are as follows:

- **Electronic claims:** Must be submitted within 30 days from the last date of service or date of discharge (for inpatient facility claims).
- **Non-electronic claims:** Must be submitted within 45 days from the last date of service or date of discharge.

If a provider initiates a formal dispute resolution process with CHRISTUS Health Plan, they should refer to the Dispute Resolution Section of this manual for applicable timeliness requirements.

Late Payment Penalties

If the Plan does not pay a clean claim within the state-mandated timeframe indicated above, CHRISTUS Health Plan will pay a late payment penalty in accordance with state regulations.

Delinquency Period Payments

For members enrolled through the Health Insurance Marketplace and receiving Advanced Premium Tax Credits (APTC), CHRISTUS Health Plan follows the federally mandated three-month grace period for premium payment delinquency. During this period:

- Claims for services rendered in the first month of the grace period will be processed as usual.
- Claims for services rendered in **the second and third months** may be pended (held for review) if permitted under applicable state law.

- If the member fails to pay all outstanding premiums by the end of the grace period, coverage may be retroactively terminated, and claims for months two and three may be denied.

Providers should verify member eligibility and coverage status prior to rendering services during the grace period.

Good Faith Payments

In certain circumstances, CHRISTUS Health Plan may, at its sole discretion, choose to overturn a claim denial or issue additional payment in the interest of the member, even when the original claim decision was accurate and compliant. These payments are made as a courtesy and are not subject to interest or penalties associated with late payment.

Incomplete Claims

Claims that are incomplete due to missing or incorrect required information, such as invalid CPT codes, will be denied. To have the determination reviewed, providers must correct and resubmit them with the appropriate information.

Claim Corrections and Late Charges

Providers who identify that a previously submitted claim contains incorrect or incomplete information may submit a corrected claim within the applicable timely filing period, as outlined in the **Timely Filing of Claims** section.

- **Facility Claims:** Corrected submissions must include **bill type code XX7** to indicate the claim is a replacement.
- **Professional Claims:** Corrected submissions must include **resubmission code 7** to designate the claim as corrected.

Claims submitted without the appropriate correction indicators may be denied as duplicate submissions and will not be re-adjudicated.

Claim for Emergency Services

Emergency services do not require prior authorization and should be provided without delay to stabilize the member's condition. However, post-stabilization services rendered without prior authorization require notification to CHRISTUS Health Plan. These services may be subject to concurrent or retrospective review to determine medical necessity and coverage eligibility.

Checking the Status of a Claim

Providers may verify the status of submitted claims by logging into the CHRISTUS Health Plan Provider Portal. Access to the portal allows for real-time updates and tracking of claim progress. To register for portal access, please visit CHRISTUShealthplan.org and click Provider Resources at the top right of the page.

For help navigating the portal, refer to the Provider Portal User Guide found on the Provider Resources page under the "Forms" menu.

Claims Explanation of Payment (EOP)

An Explanation of Payment (EOP) is a summary provided to the provider along with the payment, detailing services rendered, amounts billed, denials, adjustments, and payments for one or more claims. CHRISTUS Health Plan uses system-generated message codes on the EOP to communicate claim outcomes. These codes offer additional context regarding payments, adjustments, or denials. For assistance interpreting these codes, providers should contact Provider Services or their Provider Relations Representative.

Collection of Member Copayments and Deductibles

It is the responsibility of the Provider to collect applicable copayments and/or deductible amounts from the Member at the time of service. CHRISTUS Health Plan does not reimburse Providers for copayments or deductible amounts that are not collected directly from the Member during the visit.

If a Provider elects to collect coinsurance and/or deductible amounts prior to rendering services, CHRISTUS Health Plan recommends confirming with the Member whether additional medical or pharmacy services are anticipated on the same date of service. This helps ensure accurate cost-sharing collection and prevents over- or under-collection. In the event that the amount collected upfront exceeds the Member's actual cost share as indicated on the Explanation of Payment (EOP), the Provider is required to issue a refund to the Member within ten (10) business days of receiving the EOP.

Cost-sharing amounts for common services are typically listed on the Member's ID card. Providers may also verify a Member's copayment, coinsurance, or deductible status by contacting CHRISTUS Health Plan Member Services.

Balance Billing

Except for applicable copayments, coinsurance, and deductibles, Providers must not invoice or balance bill CHRISTUS Health Plan Members for the difference between the Provider's billed charges and the reimbursement amount paid by the Plan.

Additionally, Members may not be held financially liable for services if the Provider fails to comply with contractual obligations, requirements outlined in this manual, or applicable state regulations. This includes, but is not limited to, timely filing requirements, pre-authorization protocols, and restrictions on surprise billing.

Reimbursement for Covered Services. Covered Services are reimbursed according to the reimbursement schedule outlined in the Provider's Participating Provider Agreement with CHRISTUS Health Plan. Providers should refer to their Participating Provider Agreement for specific reimbursement details. For additional assistance or clarification, Providers may contact CHRISTUS Health Plan Provider Services.

Important Contact Numbers

Questions about claims transmissions/status reports	Availability: 800-282-4548 (M-F, 8am-8pm) Availability.com
Questions about your claim status (receipt of completion dates)	Provider Services: 844-282-3025
Questions about claims Remittance Advice	Provider Services: 844-282-3025
Need to know a Provider ID Number	Provider Services: 844-282-3025
Update provider, payee, UPIN, Tax ID number, payment address information	Notify your Provider Relations Rep. in writing: CHRISTUS Health Plan Provider Relations P.O. Box 169009 Irving TX 75016 Fax: 210-766-8851
Questions about changing or verifying provider information	

Non-Covered Services

Contracted Providers may bill CHRISTUS Health Plan Members for non-covered services only if both the Provider and the Member sign a written agreement prior to the service being rendered. This agreement must be specific to the service(s) and must clearly include:

- The specific service(s) to be provided.
- A statement indicating the service(s) are not covered by CHRISTUS Health Plan.
- A statement confirming the Member's voluntary decision to receive and pay for the specified service(s).

Members are not financially responsible for any service(s) later determined to be covered by CHRISTUS Health Plan at the time of provision, even if the Plan denies payment due to Provider non-compliance with Plan requirements (e.g., lack of pre-authorization, failure to meet timely filing deadlines).

Billing for Missed Appointment ("No Shows")

Providers may charge Members a reasonable and customary fee for missed appointments when the Member fails to cancel in advance. The missed appointment must be clearly documented in the Member's medical record.

Overpayments and Withholds

In the event CHRISTUS Health Plan determines that a claim has been overpaid, a written refund request will be submitted to the Provider. This request will include:

- Member's name
- Date(s) of service
- Amount of overpayment
- Any applicable interest and/or penalties
- An explanation of how the overpayment was determined

The refund request will be issued within the applicable number of calendar days from the date of payment of the affected claim.

Upon receipt of the refund request, the Provider must either:

- Issue the refund, or
- Submit a clear, written explanation contesting the refund request

This response must be provided within forty-five (45) working days from the date the notice of overpayment was received. If contesting the request, the Provider must identify:

- The portion of the overpayment being contested
- The specific reasons for the contest

Refund checks or written notices contesting the refund request should be sent to:

CHRISTUS Health Plan Exchange

Attn: Claims Recovery Unit

P.O. Box 169001

Irving, Texas 75016-9001

If the Provider fails to respond within forty-five (45) working days, CHRISTUS Health Plan may recover the overpayment by deducting the amount from future claims payments until the Plan has been fully reimbursed. A written explanation will accompany all such deductions.

Product Overview

Metal Tiers

There are many factors that determine into which plan a CHRISTUS Health Plan member is enrolled. The plans vary based on the individual liability limits or cost share expenses to the member. The phrase “Metal Tiers” is used to categorize these limits.

Under the Affordable Care Act (ACA), the Metal Tiers include Gold, Silver, and Bronze.

Essential Health Benefits (EHBs)

EHBs are the same with every plan. This means every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act.

The EHBs outlined in the ACA are as follows:

- Ambulatory member services.
- Emergency services.
- Hospitalization.
- Laboratory services.
- Maternity and newborn care.
- Mental health and substance use services, both inpatient and outpatient.
- Outpatient or ambulatory services.
- Pediatric services including pediatric vision.
- Prescription drugs.
- Preventive and wellness services and chronic disease management.
- Various therapies (such as physical therapy and devices).

CHRISTUS Health Plan covers services described in the Summary of Benefits and Evidence of Coverage document for each CHRISTUS Health Plan type. If there are questions as to a covered service or required prior authorization, please contact CHRISTUS Health Plan Provider Services.

Family Planning

The CHRISTUS Health Plan package of benefits covers family planning services. However, since this benefit is inconsistent with the Ethical and Religious Directives for Catholic Health Care, it is not provided by CHRISTUS Health owned entities. Conduent administers the family planning benefit for CHRISTUS Health Plan members. Conduent is not affiliated with CHRISTUS Health. Family planning services provided are paid for directly through Conduent. Providers who have questions should contact Conduent at the number on the back of the Member ID card.

Transplant Services

CHRISTUS Health Plan requires prior authorization for transplant services. This applies to both solid organ and bone marrow (stem cell) transplant procedures. Prior authorization can be requested by either the provider or the member. For members to obtain the maximum possible benefits, the member must obtain their transplant using health plan contracted

transplant providers: **Optum, Cigna LifeSOURCE, LifeTRAC**. In-network transplant services may be provided outside of the Plan service area if the services are accessible and available to enrollees. For authorization and to initiate the transplant process, please call or fax your request to the CHRISTUS Health Medical Management team at: Phone 844-282-3025, Fax 844-357-7562.

Behavioral Health

CHRISTUS Health Plan is responsible for behavioral health Member Services, provider contracting, credentialing, and claims payment to behavioral health providers. CHRISTUS Health Plan Member Services can be reached at **844-282-3025**.

CHRISTUS Health is responsible for behavioral health pre-authorization, referrals, and medical management of behavioral health services. Behavioral health services, including all Mental Health services, treatment for alcoholism, substance abuse, drug addiction and chemical dependency.

The Behavioral Health Crisis Hotline is available to members 24-hours-per-day, 7-days-per-week at **800-323-0286**. Providers should use this phone number to identify participating behavioral health providers and request pre-authorization for inpatient admissions and outpatient services.

Mental Health and Substance Use Disorder Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care. MHPAEA was expanded to ensure that qualified plans offered on the Health Insurance Marketplace cover many behavioral health treatments and services.

Emergency Care | Urgent Care

What is a Medical Emergency?

A “Medical Emergency” is when a member believes their health is in danger. A medical emergency includes:

- a medical condition that is quickly getting worse.
- bad injury.
- compound fracture.
- seizures or loss of consciousness.
- severe pain.
- sudden illness.

If the member has medical emergency:

- Call 911 for help or go to the nearest emergency room or hospital. The member does not need to get a referral or approval first from their doctor or other network Provider.
- The member should make sure their PCP knows about the emergency as soon as possible, because the PCP will need to be involved in following up on the emergency care. The member or someone else should call to tell the member's PCP about the emergency care, usually within 48 hours. If they need assistance, call CHRISTUS Health Plan.

The PCP will discuss the member's care with the doctors who are providing the emergency care to help manage and follow-up on care. If the emergency care is provided out-of-network, the PCP will assist with arranging for participating providers to take care over as soon as the member's medical condition and circumstances allow.

When the medical emergency is over and the member's condition is stable, the PCP is entitled to follow-up post stabilization care. The follow-up post stabilization care is covered according to applicable guidelines.

Note: Emergency services do not require prior authorization. However, post-stabilization services without prior authorization require notification and may be subject to concurrent or retrospective review and medical necessity determination.

What is Urgent Care?

Urgent care refers to a non-emergency situation, but the condition still requires care within 24 hours. Some examples of urgent care include:

- Accidents and falls.
- Cuts requiring stitches.
- Dehydration.
- Minor broken bones and fractures.
- Sprains and strains.
- Vomiting or diarrhea.

What is the Difference between a Medical Emergency and Urgent Care?

The difference is the severity of the health problem. A medical emergency occurs when the member believes that the condition is life threatening. Urgent care is when the member needs medical attention within 24 hours for an unforeseen illness, injury, or condition, but the condition is not life threatening.

Utilization Management

Care Management

The Care Management program plans and manages the care of members with catastrophic chronic needs and those whose needs are acute, episodic, or short-term in nature. The goals of Complex Care Management are the provision of quality care, enhancement of a member's quality of life and management of health care costs for short term and long term.

Potential participants for Case Management may be identified by the following:

- Case Management criteria per policy.
- Risk Stratification
- Facility admission | Concurrent review process.
- Member request.
- Provider referral.
- Retrospective analysis.
- Health Risk Assessment results.
- Claim review.
- Member self-referral.

Providers can refer members for a complex care management evaluation by calling **800-446-1730, Option 2** or sending an email to caremanagementreferrals@christushealth.org or faxing information to 210-766-8804. Upon referral, members are contacted by the Registered Nurse Case Manager who will complete a telephone health assessment and will work with the members' PCP to develop a Plan of Care.

Disease Management

CHRISTUS Health Plan encourages the use of the Disease Management Program to assist providers, members, and family members in managing members with chronic conditions. The program incorporates a unique personal and collaborative effort between nursing staff, Primary Care Providers (PCPs), and members.

The purpose of Disease Management is to:

- Identify members with chronic conditions.
- Manage chronic conditions more effectively through education, self-management, and care management.
- Prevent or slow the progression of chronic conditions.

Who Qualifies?

All members with the following diagnoses are eligible for Disease Management:

- Asthma.
- Chronic Obstructive Pulmonary Disease (COPD).
- Congestive Heart Failure (CHF).
- Diabetes Mellitus (DM).

Referrals to Disease Management

Providers can refer members for a disease management evaluation by calling **800-446-1730, Option 2** or faxing information to 844-357-7562. Upon referral, members are contacted for enrollment, will be administered a telephonic health assessment, and the Disease Management team will work with PCPs to develop a plan of care.

Referrals to the Disease Management Program are also received and accepted from the following sources:

- Care Management program referral.
- Member Self-Referral.
- Referrals from PCP / Provider, Clinic staff.
- Utilization Management Referrals.
- Risk Stratification
- Other (examples include referrals from mental health benefits coordinator, home health agencies, community resources).

Referral | Authorization Guidelines

CHRISTUS Health Plan Medical Management program is designed to assure that members receive appropriate care at the right time, in the right setting. The Medical Management function is performed in accordance with State guidelines, Federal regulations and NCQA standards.

Providers and CHRISTUS Health Plan staff have no incentives, including compensation, which are based upon the quantity of adverse determinations. Nurses and Medical Directors collaborate with PCPs, specialists, and other providers to assure members get the care they need in a proactive manner.

Role of Primary Care Provider

The Primary Care Provider (PCP) plays a critically important role in the medical care delivery model. The PCP works collaboratively with the member and all other providers to ensure that appropriate care is delivered at the right time in the right setting. Within this provider centric model, the PCP:

- Accesses the health care needs of each member.
- Delivers primary care services.
- Guides the member through the healthcare system by arranging for specialty and ancillary care as needed.
- Provides member education, health screening and prevention services.
- For inpatient hospital and skilled nursing facility (SNF) admissions, the PCP (or assigned hospitalist) is responsible for:
 - Communicating with care management, consulting provider, the member and the member's family.
 - Facilitating approval of all services for discharge and follow-up care.
 - Formulating the member's hospital plan of care and coordinating subspecialty consultation.
 - Obtaining the member's history and physical.
 - Overseeing the discharge plan and arrangements for follow-up care.

Role of Specialist as Primary Care Provider

A specialty provider may assume the responsibilities of a PCP under specific circumstances, such as in the case of a member with a disability or chronic/complex condition. The member's signature is required for a specialist to serve as the member's PCP. By allowing a specialist to act as a PCP, members can draw upon the most appropriate care to meet their needs. In this capacity, the specialist is required to fulfill all the responsibilities of a PCP and the specialist must agree to coordinate all the member's care. Specialists who would like to be the PCP should contact the Medical Management Department for further information and complete the request form.

A determination is made within thirty (30) calendar days from the date the request is received. Member and provider requests for a specialist to be a PCP will be reviewed by a Medical Director. The request will be approved if the specialist meets the criteria for participation as a primary care provider and if there is a medical need for the specialist to act as the member's PCP. The effective date of the designation of the specialist as the PCP may not be applied retroactively.

If this request is denied, a member may appeal the decision through the HMO's established complaint and appeal process. Please refer to the member complaint and appeal section for more information. If the request for special consideration of a non-Primary Care physician specialist to act as a Primary Care physician is approved, the HMO may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

Role of Specialists, Hospitals, and Ancillary Providers

Members are encouraged to utilize their PCP as their guide through the healthcare system. Other providers are also encouraged to work closely with the PCP to coordinate the care of the member. All other providers will report back to the PCP about diagnosis, findings, treatment plans, and treatments in a timely manner.

Except for medical emergencies, all providers are required to call before performing out-of-network services. In addition, providers are required to work closely with Medical Management staff to coordinate the members' health care within the CHRISTUS Health Plan delivery system.

Role of Medical Management Staff

Medical Management, Utilization Management Nurses and Care Managers collaborate with providers to:

- Arrange for psychosocial and/or clinical interventions to improve care management.
- Conduct concurrent review of inpatient stays.
- Coordinate with other providers, including SNF, Home Health, Durable Medical Equipment (DME), and Hospice.
- Facilitate transfer of hospitalized members to alternate levels of care.
- Participate in discharge planning using approved clinical guidelines to prevent readmissions.
- Provide prior authorization for those out-of-network services and procedures if an in-network provider is unavailable.

- Utilize the CHRISTUS Health Plan network of contracted providers where appropriate.

Role of Medical Director

Medical Directors are board-certified/full-time employed physicians who oversee the day-to-day health plan clinical operations. Their functions include:

- Interfacing directly with practicing physicians to resolve clinical issues.
- Making decisions related to the authorization of medically necessary services.
- Providing clinical guidance for the Medical Management staff.

Medical Directors are available for peer-to-peer discussion as needed regarding adverse determinations. Please call Provider Services for a peer-to-peer discussion.

Providers may speak directly to a Medical Director when they have a question about an authorization or clinical issue. Providers are encouraged to contact a Medical Director to provide additional information and to discuss any clinical issues during the authorization/review process.

Peer-to-Peer Availability

Medical Directors conducting medical necessity reviews are available to discuss review determinations with the requesting/ordering provider or attending provider via peer-to-peer conversation. The peer-to-peer conversation allows the treating provider the opportunity to discuss the Medical Management determination before initiating the appeals process. A peer-to-peer conversation is available by calling the Medical Management department.

Peer-to-peer conversations are completed within one (1) business day of request by a treating provider. If the peer-to-peer discussion does not result in authorization of the request, the process includes informing the provider and member of their appeals rights during the notification.

Providers are notified of the opportunity and the availability for a peer-to-peer conversation by fax.

Availability of Medical Management Staff

Medical Management (MM) staff are available on normal business days, Monday through Friday, from 8 a.m. to 5 p.m. Providers can reach the Medical Management department by phone or fax. After normal business hours and on holidays, an on-call Utilization Management RN is available to provide directions.

Member Self-Referrals

Members have direct access to the following services provided by an in-network provider without going through their PCP:

- Annual well woman exam.
- Annual mammogram.
- Behavioral health outpatient services.
- Disease management programs.
- Hearing exam.
- Optometry (annual eye exam and glasses).

- Out-of-area dialysis.

PCP Referrals to Network Specialists

The PCP does not need prior/referral authorization to refer the member to an in-network specialist. Participating providers are listed in the Provider Directory and online www.christushealthplan.org/find-a-provider. Providers may also call Provider Services to verify in-network participation.

Specialists may not refer to other specialists. If a specialist determines that a member needs to be seen by another specialist, the member's PCP is to be contacted for initiation of referral and coordination of care.

Prior Authorization Guidelines

The PCP must complete the CHRISTUS Health Plan Referral/Authorization Form in its entirety and either:

- Fax urgent and emergent requests to 210-766-8841.
- Fax a routine request to Fax: 1-844-357-7562/1-800-277-4926
- Email: CHRISTUS.HP.278@christushealth.org
- [Prior Authorization | CHRISTUS Health Plan](#)
- Please visit our website to access Prior Authorization forms and review the lists outlining provider prior authorization requirements.
- Fax urgent and emergent requests to 210-766-8841.
- Fax routine request to 844-357-7562.

The following information is requested from the provider:

- Provider name, address, and telephone number.
- Member name, ID number, and date of birth.
- Diagnosis/ICD-10.
- Procedure(s), if applicable.
- Procedure code (CPT).
- Name of facility.
- Date of admission/procedure.
- Indications for admission/procedure.
- Request length of stay.
- Pertinent clinical information.

The Medical Management Department will process the completed referrals containing all necessary information and supporting documentation. Please note that authorization is not a guarantee for payment.

Medical Management Components

Preadmission Review is the process of authorizing non-emergency medical and surgical hospitalizations.

Admission notification is when the provider and/or hospital notifies Medical Management that a CHRISTUS Health Plan member has been admitted to the hospital.

Continued Stay Review is a concurrent review process that assures the length of stay in the appropriate for the member's medical condition, whether admitted for non-emergency or emergency treatment.

Discharge Planning is the CHRISTUS Health Plan Utilization Management RN's responsibility for coordinating a member's care and will work with the member and the provider to assist in arranging for the member's discharge needs. The Plan's Utilization Management RN will assist in discharge planning by facilitating any home care services, skilled nursing care, or medical equipment required after leaving the hospital. This process helps assure every member is provided with appropriate care, both in the hospital and post discharge.

Retrospective Review is the process of review that occurs before payment of any claims for which Precertification/Authorization did not occur. The review will consist of assessing the medical necessity of all services not previously approved. Clinical information is reviewed for appropriateness using MCG criteria, plan protocols, and policy coverage.

Ambulatory/Outpatient Review is the process of authorizing non-emergency selected diagnostic and surgical outpatient procedures.

Skilled Nursing, Long Term Acute Care and Rehabilitation Facilities all require prior authorization. Skilled Nursing Facilities (SNF), Long Term Acute Care facilities (LTAC) and Rehabilitation Facilities are specially qualified facilities or designated units in a hospital, which have the staff and equipment to provide acute care, skilled nursing care, or rehabilitation services and other related health services. CHRISTUS Health Plan coverage includes, as a benefit, inpatient care in a participating SNF, LTAC or Rehabilitation Facility. Custodial care is a non-covered benefit.

Home Health Care is performed by a home health agency, a public or private agency that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy in the home. The home health care program provides skilled professional services to members upon receiving prior orders by the attending physician and authorization by the Medical Management department. Requests for continuation of services are reviewed on an ongoing basis to determine medical necessity. Custodial care is a non-covered benefit.

Durable Medical Equipment (DME) is used primarily and customarily for medical purposes rather than primarily for transportation, comfort, or convenience. It can withstand repeated use and improves the function of a malformed, diseased, or injured body part or slows down further deterioration of the member's physical condition. Specific DME items require prior authorization (see Services Requiring Prior Authorization). DME must be obtained through CHRISTUS Health Plan contracted providers.

Utilization Management Notification Requirements

There are specific notification requirements that apply to the services evaluated in each of the review components, to ensure payment. The provider must call the Plan regarding proposed treatment and service within the following notification guidelines:

<u>Treatment Service</u>	<u>Notification Requirement</u>
Urgent admissions observations	Within one (1) business day of admission to the facility.
Elective admissions surgical procedures outpatient procedures	Five (5) business days prior to the requested date of service (DOS).
SNF Inpatient Rehab Hospice	Initiation: Two (2) business days prior to the requested DOS.
Home health	Initiation: Two (2) business days prior to the requested DOS. Continuation: Seven (7) business days prior to requested DOS.
Diagnostic services DME other procedures requiring authorization	Seven (7) business days prior to the requested DOS.

There are specific notification requirements that apply to the services evaluated in each review component, to ensure payment.

Authorization Process

Effective July 1st, 2022, services done in-network, by an in-network provider and/or at an in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost-sharing. Prior authorization is required for out-of-network services, except in the case of emergency or urgently needed care.

For out-of-network services, information received either by phone or electronically will be reviewed for benefit coverage or determination of medical necessity. Appropriateness and medical necessity will be reviewed using Milliman Care Guidelines (MCG), planning clinical protocols and policies, and Medicare benefits and coverage. Upon approval of authorization, the authorization is faxed to the requesting/servicing provider.

Information received either via phone or electronic means is reviewed for benefit coverage or determination of medical necessity. Appropriateness and medical necessity are reviewed using MCG criteria, Plan clinical protocols, benefits, and coverage. Upon approval of authorization, the authorization is faxed to the requesting provider and the servicing provider. An approved authorization notification is made to the member via phone or a mailed letter.

Requests that do not meet the medical necessity criteria or coverage guidelines are sent to the plan's Medical Review Provider for determination of medical necessity or benefit coverage. Peer-to-peer information is provided to the Medical Review Provider to allow additional clinical information to be provided before an adverse determination is made. If the Medical Review Provider determines that medical necessity criteria or benefit coverage is not established, notification is made to the requesting provider, which will include the physician reviewer's determination to deny authorization. A denial letter is sent to the requested provider within two (2) business days of the determination.

Requests to Out-of-Network Providers

Requests for services to non-participating or out-of-network providers may only be made:

- For emergencies experienced in or out of the service area.
- When other medically necessary services are unavailable from participating providers.

All out of network request require prior authorization. Documentation to support the request for OON services should be included in the information for the request.

Medical Management Affirmative Statement

CHRISTUS Health Plan Medical Management decision making is based only on the appropriateness of care and service and the existence of coverage. CHRISTUS Health Plan does not specifically reward providers or other individuals for issuing denials of coverage. Financial incentives for Medical Management decision makers do not encourage decisions that result in underutilization.

Specialty Drugs Authorization Requirements

Specialty Drug coverage may require authorization. Please contact Provider Services.

Provider Obligations – Precertification

Providers are responsible for obtaining precertification from CHRISTUS Health Plan and for submitting the adequate required information before performing certain procedures or when referring members to non-contracted providers. CHRISTUS Health Plan will render a decision on the request within the appropriate period and provide notification of the decision.

Denied requests will generate a notice that includes the denial rationale and applicable appeal rights. Members and providers will also receive a denial letter that includes appeal rights.

Pharmacy Services

CHRISTUS Health Plan includes coverage for prescription drugs. CHRISTUS Health Plan's pharmacy benefit management vendor, CVS processes pharmacy claims.

The formulary includes coverage of generic drugs, as well as many brand-name drugs, non-preferred brands, and specialty drugs. Formularies are reviewed by a Pharmacy and Therapeutics Committee composed of providers and pharmacists.

Some of these drugs have precertification or step-therapy requirements or quantity limits, defined as:

- **Prior Authorization (PA):** CHRISTUS Health Plan requires the provider to get prior authorization before the drug is approved for coverage.
- **Quantity Limits (QL):** For certain drugs, CHRISTUS Health Plan limits the amount of the drug it will cover for a given duration of time (i.e., 30 pills every 30 days).
- **Step Therapy (ST):** In some cases, CHRISTUS Health Plan requires trial and failure of certain drugs to treat a medical condition before it will cover another drug for that condition.

The following chart depicts the pharmacy-related services provided by CHRISTUS Health Plan, as well as the contact information:

Pharmacy-Related Service	Performed By	Notification	Contact Information
Prescription Drugs	CVS	Customer Care: Pharmacy Help Desk:	833-844-5350 800-364-6331
Coverage Determination	CVS	Standard Expedited Coverage Reviews	844-280-5833
Formulary Exceptions	CVS	Coverage Review	833-844-5350

Prescription Drugs by Mail Order

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken regularly for a chronic or long-term medical condition). For mail-order prescriptions, the provider must write on the maintenance drug prescription whether it is for a 30-, 60-, or 90-day supply.

When mailing in a prescription to the mail-order service for the first time, the member must verbally give consent to ship, which includes verifying the shipping address before medications are mailed. Members should allow up to two (2) weeks for the prescription to be processed and mailed. For refills of the same prescription, members should allow up to seven to ten (7-10) days for processing and mailing. If a member runs out of medication before receiving a new supply from the mail-order pharmacy, please call 833-844-5350.

Coverage Determinations for Prescription Drug Benefits

A coverage determination is any decision CHRISTUS Health Plan makes regarding:

- A decision about whether to provide or pay for a drug, including a decision not to pay because:
 - The drug is not on the Plan's formulary.
 - The drug is determined not to be medically necessary.
 - The drug is furnished by an out-of-network pharmacy.
 - We determine the drug is excluded, but the member believes it may be covered by the Plan.
- Failure to provide coverage determination in a timely manner, when a delay would adversely affect the member's health.
- A decision concerning a formulary exception request.
- A decision on the amount of cost sharing for a drug.
- A decision on whether a member has satisfied a precertification or other Medical Management requirement.

Two decisions govern the need for prescription drugs that the member has not yet received:

- A **standard** decision made within the standard seventy-two-hour (72) timeframe.
- An **expedited** decision made within twenty-four (24) hours.

An expedited decision can only be requested if the member or any provider believes waiting for a standard decision could jeopardize the member's life, health, or ability to regain maximum function. This is called the expedited criteria. The member or a provider can request an expedited decision. If a provider requests an expedited decision or supports a member in asking for one and if the provider indicates the situation meets the expedited criteria, CHRISTUS Health Plan will automatically provide an expedited decision within twenty-four (24) hours from the initial request.

Formulary Exceptions

If a prescription drug is not listed in the CHRISTUS Health Plan formulary, please check the updated formulary on the christushealthplan.org website. The website formularies are updated frequently with any changes.

If the drug is not on the formulary, there are two options:

- The prescribing provider can prescribe another drug that is covered on the formulary.
- The member or prescribing provider may ask CHRISTUS Health Plan to make an exception (a type of coverage determination) to cover the non-formulary drug.

If the member pays out-of-pocket for a non-formulary drug and requests an exception that CHRISTUS Health Plan approves, CHRISTUS Health Plan will reimburse the member. If the exception is not approved, the member may appeal the Plan's denial. In some cases, CHRISTUS Health Plan will contact a member taking a drug not on the formulary. CHRISTUS Health Plan will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her provider if any of those drugs would be appropriate options for treatment.

The Health Plan drug formulary is a listing of generic and brand-name prescription medications preferred for use by CHRISTUS Health Plan. CHRISTUS Health Plan may add or

remove drugs from our formulary during the year. To inquire about the status of a drug on the formulary, visit christushealthplan.org.

Member Support Services

New Member Education

Members are encouraged to see their Primary Care Provider (PCP) within the first ninety (90) days of eligibility and to rely on the PCP to guide them through the health care delivery system. PCPs may send a welcome letter to their new members with information such as hours and days of operation, phone numbers, and how to schedule appointments.

24-Hour Nurse Hotline

CHRISTUS Health Plan offers a 24/7 Nurse Hotline. Members can access this service toll free for medical guidance and/or triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace the provider's after-hours coverage commitment. To reach the Nurse Hotline, members should call **844-581-3175**.

Health Management and Education

CHRISTUS Health Plan engages in health education to equip members with tools and resources to stay healthy, improve knowledge about chronic conditions and their treatment, learn behaviors for better self-management, and promote prevention and early detection of illnesses. Educational efforts include telephone outreach, targeted online content, member engagement through the CHRISTUS Health Plan website, and other tactics. CHRISTUS Health Plan evaluates outcomes using several mechanisms, including but not limited to HEDIS measures, utilization statistics, pharmacy data, and program participant surveys.

Cultural Competency

CHRISTUS Health Plan places great emphasis on the wellness of its members. A large part of quality health care delivery is treating the whole member and not just the medical condition. CHRISTUS Health Plan encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).

CHRISTUS Health Plan maintains policies emphasizing the importance of culturally and linguistically competent care to CHRISTUS Health Plan's membership of all cultures, races, languages, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual enrollees while protecting and preserving the dignity of each member. Sensitivity to differing cultural influences, beliefs, and backgrounds, can improve a provider's relationship with members and, eventually, the health and wellness of the members themselves.

Providers must ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act (ADA) including all facilities providing services to members being accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or denied the benefits of services, programs, or activities of a public facility or be subjected to discrimination by any facility.

The following is a list of principles for health care providers including knowledge, skills, and attitudes related to cultural competency in the delivery of health care services of members.

Knowledge

- Provider's self-understanding of health disparities, as related to race, ethnicity or influence and the critical link between quality health care and the clinical encounter.
- Understanding Indigenous healing practices and the role of religion in the treatment of minority members.
- Understanding of cultural factors that can affect decision-making based on cultural beliefs, lack of trust, or other behavior patterns within minority groups.
- Understanding of the cultural differences within racial/ethnic groups and how cultural dynamics influence cross-cultural behaviors.
- Understanding of the difference between culturally acceptable behaviors and psycho-pathological characteristics of different minority groups.
- Understanding of the health service resources for minority members.
- Understanding of the historical factors that impact the health of minority populations, such as racism and immigration patterns, and the importance of building physician/patient-centered relationships.
- Understanding the minority member within a family life cycle, intergenerational conceptual framework, and a personal developmental network.
- Understanding of the particular psycho-social stressors relevant to minority members including war trauma, migration, acculturation stress, and socioeconomic status.
- Understanding of the public health policies and their impact on minority members.

Skills

- Ability to apply treatment methods that enhance clinical assessment processes and adherence.
- Ability to ask for consultation.
- Ability to avoid under diagnosis or over diagnosis.
- Ability to diagnose minority members with an understanding of cultural differences in pathology.
- Ability to enhance member communication effectively with the use of cross-cultural interpreters.
- Ability to facilitate and assess minority members based on a psychological, social, biological, cultural, political, or spiritual model.
- Ability to provide therapeutic and pharmacological interventions with an understanding of the cultural differences in treatment expectations and biological response to medications.
- Ability to utilize community resources (church, community-based organizations, self-help groups).

Attitudes

- Be aware of transference and counter transference issues.
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
- Respect the "survival merits" of immigrants and refugees.
- Respect the holistic view of health and illness.
- Respect the importance of cultural forces.
- Respect the importance of spiritual beliefs.

Member Rights & Responsibilities

Member Rights

Plan members have the following rights:

- A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision to our internal review and the right to request help from the Superintendent.
- All rights afforded by law, rule, or regulation as a member in a licensed Health Care Facility, including the right to be informed about their treatment by their Participating Provider in terms that they understand; to request their consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary under the Plan. The right to consent or agree to treatment by them or their next of kin, guardian, or another authorized person may not be possible in an emergency where their life and health are in danger.
- The right to voice complaints or appeals with the Plan, the Superintendent of Insurance (Superintendent) about the Plan or the coverage the Plan provides. Members also have the right to receive an answer to complaints within a reasonable time and in accordance with existing law and without fear of retaliation.
- The right to available and accessible services for medically necessary and covered services, including 24 hours per day, 7 days per week for Urgent or Emergency Services, and for other health care services as defined in the Summary of Benefits and Coverage.
- The right to be given an explanation of their medical condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by their participating provider in terms the member understands. If the member does not understand the explanation, it must be given to their next of kin, guardian, or another authorized person. This information must be documented in their medical records.
- The right to be promptly notified of termination or changes in benefits, services, or the Provider Network.
- The right to be treated in a prompt, courteous, and responsible manner that respects their dignity and privacy.
- The right to choose a Primary Care Provider within the limits of the covered services, the Plan's network, and as provided by the contract, including the right to refuse care from specific health care professionals. In addition, members have the right to participate with providers in making decisions about their health care.
- The right to confidential handling of all communications, including medical and financial information maintained by the Plan. The privacy of their medical and financial records is maintained by the Plan and participating providers in accordance with existing law.
- The right to know, upon request, of any financial arrangements or provisions between the Plan and participating providers, which may restrict referrals or treatment options or limit the services offered to members.
- The right to receive affordable health care including information regarding out-of-pocket expenses, limitations, the right to seek care from a non-participating provider, and an explanation of their financial responsibility when services are provided by a non-participating provider or without prior authorization.

- The right to receive detailed information about all requirements that must be followed for prior authorization and utilization review.
- The right to receive detailed information about their coverage, benefits and services offered under their contract. This includes any exclusions of specific conditions, ailments, or disorders, including restricted prescription benefits, the Plan's policies and procedures regarding products, services, providers appeal procedures and other information about the Plan and the benefits provided to members. This also includes access to a current list of participating providers in the Plan's network; information about a particular participating provider's education, training, and practice; and the Member Rights and Responsibilities, as well as the right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.
- The right to receive information about how benefits are authorized or denied. Members have the right to know how new technology for covered benefits are evaluated. They can also request and receive information about the Plan's quality assurance plan and utilization review methodology.
- The right to seek care from qualified health care professionals, services, and treatments that are covered benefits near where they live or work within the Plan's service area.

Member Responsibilities

As a member of the Plan, they have the responsibility to:

- Consult their provider before receiving medical care unless their condition is life-threatening.
- Express their opinions, complaints, or concerns in a constructive way to CHRISTUS Health Plan Member Services or to their provider.
- Follow plans and instructions for care that they have agreed to with their provider.
- Follow the Plan's complaint and appeal process when displeased with the Plan or a provider's actions or decisions.
- Inform the Plan of any changes in family size, address, phone number or membership status within thirty (30) calendar days of the change.
- Know the proper use of the services covered by the Plan.
- Make premium payments on time.
- Notify the Plan of other insurance coverage.
- Pay all charges or copay/coinsurance amounts, including those for missed appointments. This also applies to deductibles and any charges for non-covered benefits and services.
- Present their Plan ID card before they receive care.
- Promptly notify their provider if they are delayed or unable to keep an appointment.
- Provide honest and complete information to those providing the care.
- Review and fully understand the information they receive about the Plan.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Refrain from any abusive or noncompliant behavior (verbal or physical) toward staff.

All members are responsible for understanding how the Plan works. They should carefully read and refer to their contract and their Summary of Benefits and Coverage (SBC).

Member Complaints and Appeals

A complaint is defined as any dissatisfaction expressed orally or in writing to CHRISTUS Health Plan with any aspect of the CHRISTUS Health Plan's operations, including but not limited to:

- Dissatisfaction with plan administration.
- Procedures related to review or appeal of an adverse determination, as defined in Louisiana Administrative Code, Title 37, §14113 Subpart B.
- The denial, reduction, or termination of a service for reasons not related to medical necessity.
- The way service is provided.
- Disenrollment decisions expressed by a complainant.

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the member. Members, or a member's designee, can file a complaint with CHRISTUS Health Plan either in writing or verbally by contacting the Appeal and Grievance Representative at:

CHRISTUS Health Plan Exchange
Attn: Appeal and Grievance Department
P.O. Box 169009
Irving | Texas 75016
Phone: **844-282-0380**
Fax: 866-416-2840

Email : Christus.HP.AppealsandGrievances@christushealth.org

Verbal Complaints

The Appeals and Grievance Representative will acknowledge the verbal complaint no later than the fifth day of receipt and send a complaint form that must be returned for prompt resolution of the complaint. The acknowledgement letter will indicate a description of the complaint process and the thirty (30) calendar days for resolution of the complaint. If the complaint form is not returned to the Appeals and Grievance Representative within fifteen (15) calendar days from date on letter, a determination will be made based on information available.

Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case but may not exceed one (1) business day from receipt of the complaint.

Once the complaint has been resolved, the Appeals and Grievance Representative will send a response letter to the member or member's designee with the resolution of the complaint, including the process to appeal the decision when the member or member's designee is not satisfied with CHRISTUS Health Plan's decision.

Member Appeals to HMO

If the member's complaint is not resolved to their satisfaction, members have the right to either:

- Appear in person before a complaint appeal panel in a location where they would normally receive health care services or another agreeable location.
- Address a written appeal to the complaint appeal panel.

CHRISTUS Health Plan will complete the complaint appeal process no later than the thirtieth (30th) calendar day after the date of the request (receipt date) for appeal. If the appeal of a complaint relates to an ongoing emergency or denial of continued hospitalization, the resolution shall be concluded in accordance with the immediacy of the case and not later than one (1) business day after the request for appeal is received. The appeal panel will be composed of an equal number of the Plan staff, physicians or other providers, and Plan enrollees.

CHRISTUS Health Plan will provide the member or the member's designated representative, within five (5) business days, any documentation to be presented to the complaint appeal panel by the Plan staff, the specialization of any physicians or providers consulted during the investigation, and the name and affiliation of each Plan representative on the complaint appeal panel.

The member or the member's designated representative has the right to:

- Appear in person before the complaint appeal panel.
- Present alternative expert testimony.
- Request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.

The Plan's notice of the final decision on an appeal shall include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision, along with the toll-free telephone number and address of the Louisiana Department of Insurance (LDI). A member has the right to request assistance from the Louisiana Department of Insurance during any portion of the Appeal process.

Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge | Louisiana 70804-9214
Phone: 800-259-5300

Online: www.lidi.la.gov/onlineservices/ConsumerComplaintForm

Member Expedited Appeals to HMO

The member or member's designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the member. Requests for an expedited appeal can be made verbally or in writing as indicated in the member complaint to HMO process listed above.

Expedited appeals for emergency care denials and denials of continued hospital stays will be reviewed by a Medical Director that was not involved in the original denial and is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review. The appeal's timeframe is based on the medical immediacy of the condition, procedure, or treatment, but will not exceed seventy-two (72) hours from the date all information necessary to complete the appeal is received.

If the member or member's designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided, they are notified that the appeal review cannot be expedited. If the member or member's designee does not agree with this decision, they may submit a request for an Independent Review Organization as described below.

Members may also file a complaint to the LDI by calling **800-259-5300** or by writing to:

Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge | Louisiana 70804-9214
Online: www.lidi.la.gov/onlineservices/ConsumerComplaintForm

Member Adverse Determination Appeals to HMO

A member, a person acting on behalf of the member, or the member's physician or health care provider may appeal an adverse determination orally or in writing. Any complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of the adverse determination. Appeals must be filed within one hundred eighty (180) days following the Plan's denial notification.

Within five (5) working days from receipt of the appeal, a letter of acknowledgement will be sent to the appealing party. The acknowledgement letter will include:

- The date of receipt of the appeal.
- A description of the appeal procedure and timeframes.
- A list of the documents, such as new, previously unknown information, further reasonable documentation related to the case but not previously received, or medical records that will need to be submitted for review during the appeal process.

The provider will have five (5) business days to submit the additional information requested and a one-page appeal form if the appeal is oral.

As soon as practical, but in no case later than thirty (30) calendar days for pre-service appeals and no later than sixty (60) calendar days for post-service appeals, all available information will be reviewed by a provider who was not involved in making the initial adverse determination, and a written notification of the appeal determination will be sent to the appealing party.

If the appeal is denied, the written notification to the member, the member's designee, and

member's provider shall include a clear and concise statement that includes:

- The clinical basis for the appeal's denial.
- The specialty of the physician making the denial.
- The right of the appealing party to seek review of the denial by an independent review organization and the procedures for obtaining the review.
- The right to an immediate appeal to an independent review organization in circumstances involving a condition that is life-threatening to the member.
- The right of the health care provider to set forth in writing, within ten (10) working days of the appeal denial, good cause for having a particular type of specialty provider reviews the case.

For expedited appeals, members must call **844-282-0380** and fax all related information to 866.416.2840. Standard appeals must be mailed to:

CHRISTUS Health Plan Exchange
Attn: Appeal and Grievance Department
P.O. Box 169009
Irving | Texas 75016
Email: CHRISTUSCAG@christushealth.org

External Review Process by MAXIMUS Federal Services

The member or member's designee may seek a review of CHRISTUS Health Plan's denial of an appeal of an adverse determination by MAXIMUS Federal Services free of charge. Our notice of determination of the appeal will include complete instructions for making a request for an external review by MAXIMUS Federal Services.

Expedited external review may be initiated at the same time as expedited internal appeals. MAXIMUS Federal Services is required to issue an urgent care decision no later than seventy-two (72) hours from receipt of the request for external review and no later than forty-five (45) days for standard request.

Louisiana Health Insurance Exchange Plans

Overview

There are many factors that determine into which plan a CHRISTUS Health Plan member is enrolled. The plans vary based on the individual liability limits or cost share expenses to the member. The phrase “Metal Tiers” is used to categorize these limits.

Under the Affordable Care Act (ACA), the Metal Tiers include Gold, Silver, and Bronze.

Essential Health Benefits (EHBs) are the same with every plan. This means every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act.

The EHBs outlined in the ACA are as follows:

- Emergency services.
- Hospitalization.
- Laboratory services.
- Maternity health and substance use services, both inpatient and outpatient.
- Outpatient or ambulatory services.
- Pediatric services including pediatric vision.
- Prescription drugs.
- Preventive and wellness services and chronic disease management.
- Various therapies (such as physical therapy and devices).

CHRISTUS Health Plan covers services described in the Summary of Benefits and Evidence of Coverage document for each CHRISTUS Health Plan type. If there are questions as to a covered service or required prior authorization, please contact CHRISTUS Health Plan Provider Services.

Louisiana Plans

Plan Variant Marketing Name*
LA Bronze Essential
LA Bronze Essential American Indian Zero
LA Bronze Essential Limited
LA Bronze Essential Plus
LA Bronze Essential Plus American Indian Zero
LA Bronze Essential Plus Limited
LA Gold Essential
LA Gold Essential American Indian Zero
LA Gold Essential Limited
LA Gold Essential Plus
LA Gold Essential Plus American Indian Zero
LA Gold Essential Plus Limited
LA Gold Plus
LA Gold Plus American Indian Zero
LA Gold Plus Limited
LA Value Silver 70%
LA Value Silver 73%
LA Value Silver 87%
LA Value Silver 94%
LA Value Silver American Indian Zero
LA Value Silver Limited
LA Value Silver Plus
LA Value Silver Plus 73%
LA Value Silver Plus 87%
LA Value Silver Plus 94%
LA Value Silver Plus American Indian Zero
LA Value Silver Plus Limited
LA Standard Expanded Bronze
LA Standard Expanded Bronze American Indian Zero
LA Standard Expanded Bronze Limited
LA Standard Gold
LA Standard Gold American Indian Zero
LA Standard Gold Limited
LA Silver Essential
LA Silver Essential 73

LA Silver Essential 73 Plus
LA Silver Essential 87
LA Silver Essential 87 Plus
LA Silver Essential 94
LA Value Bronze
LA Value Bronze American Indian Zero
LA Value Bronze Limited
LA Value Bronze Plus
LA Value Bronze Plus American Indian Zero
LA Value Bronze Plus Limited
LA Silver Essential 94 Plus
LA Silver Essential American Indian Zero
LA Silver Essential Limited
LA Silver Essential Plus
LA Silver Essential Plus American Indian Zero
LA Silver Essential Plus Limited
LA Standard Silver
LA Standard Silver 73
LA Standard Silver 87
LA Standard Silver 94
LA Standard Silver American Indian Zero
LA Standard Silver Limited

Integrity | Compliance

CHRISTUS Health Plan adheres to a corporate strategy that underlines its commitment to health care integrity. CHRISTUS Health Plan is responsible for ensuring that medically necessary services are provided only to eligible beneficiaries by authorized providers under existing law, regulation, and CMS instructions. Furthermore, CHRISTUS Health Plan is responsible for the evaluation of quality care and for ensuring that payment is made for care which is in keeping with accepted standards of medical practice.

CHRISTUS Health Plan is dedicated to the CHRISTUS core values of Dignity, Integrity, Excellence, Compassion and Stewardship, and the Plan holds contracted physicians and providers to the same standards.

As a participating provider in CHRISTUS Health Plan, providers are expected to:

Safety

- Strive to provide a safe, secure, and hazard-free environment consistent with national standards and established federal, state, and local regulations.
- Strictly follow all laws and regulations governing the disposal of hazardous waste and radioactive materials.

Quality Care

- Provide quality care to all members by performing duties to the best of their abilities.
- Attempt to anticipate and understand member needs while meeting their expectations.
- Employ professionals with proper credentials and recognize that members and their personal representatives have the right to access information regarding the identity and licensure of their caregivers.

Accurate Recording and Reporting

- Prepare and maintain all member and organizational data, record, and report accurately and truthfully, and adhere to applicable standards in maintaining all records.
- Strive to maintain complete and accurate medical records of each member and protect this information from breach of confidentiality or loss.

Accurate and Appropriate Claims

- Submit claims for payment or reimbursement only for services rendered and make sure that claims submitted for payment or reimbursement are for medically necessary services.
- Submit claims for payment or reimbursement which are not knowingly false, fraudulent, or otherwise incorrect. Establish an audit function to validate accuracy of claims submission.

- Strive to make sure that all submitted claims are properly coded and documented and filed according to all applicable laws and regulations.

Protection of Privacy

- Protect and maintain the confidentiality of all member records as required by applicable laws and regulations.
- Maintain knowledge of information protection standards affecting job function recognizing that confidential information is valuable, sensitive, and protected by law.
- Maintain the appropriate confidentiality and privacy of all members.

Ethical Practices

- Not mislead members or the public or cause them to request services they do not need.
- Treat all members with dignity, respect, and compassion.
- Respect and support the rights of all members.
- Respect and support the rights of all Health Plan associates by ensuring a zero-tolerance policy toward any potential member abuse (verbal or physical).
- Strive for excellence in quality of care and service provided to all served, regardless of race, color, religion, gender, orientation, disability, age, or national origin.
- Clearly explain care, treatment and services to the member and family, so that the informed consents can be obtained. Explanation of treatment must include:
 - Potential benefits and drawbacks.
 - Potential problems related to recovery.
 - Likelihood of success.
 - Results of non-treatment.
 - Significant alternatives.

Risk Management

CHRISTUS Health Plan maintains a risk management program designed to protect the life and welfare of members and employees. The risk management plan has the following characteristics:

- The risk management plan is approved by the governing body and has coordination between the risk management activities and the quality improvement activities and initiatives.
- The risk management program accounts for member safety and other critical issues.
- Policies and procedures regarding a member being refused care or dismissed from care, and the management of impaired healthcare professionals.
- Procedures to report and analyze member care delivery episodes, such as trauma, death, or any other adverse incidents.
- Periodic review of litigation matters that involve the organization, personnel, or other related health care professionals.
- Review of member complaints and grievances.
- Benefit coverage availability after regular business hours.

- The prevention of unauthorized prescribing, and monitoring to prevent fraud, waste, and abuse.
- Clinical record audits and incorporation of audit results into the re-credentialing process.
- Risk management education and training to all staff and communications of risk management program information to the provider network.

Fraud, Waste, and Abuse

FRAUD, WASTE AND ABUSE (FWA) – Prevention, detection, examples, enforcement and reporting

Special Investigations Unit: Governing agencies and regulatory bodies require CHRISTUS Health Plan (CHP) to staff a Special Investigations Unit (SIU) to detect, investigate, prevent, and deter fraud, waste, and abuse (FWA), involving providers or members within the CHRISTUS Health Plan network, and non-participating providers who submit claims. The SIU uses automated data analysis tools and proactive measures to evaluate pre and post payment of claims, to verify compliance with the CHRISTUS medical management standards, and federal and state laws. To advocate for the highest and best health care for members, CHP endorses treatment that is medically necessary, evidence-based, provided by the proper specialist, at the right time, for the appropriate duration, in the most suitable location, at a reasonable cost. Reasonable cost is determined by fee schedules or by CHRISTUS Health Plan. If these standards are not followed, there is a high likelihood of members experiencing unfavorable impact, payments being incurred for preventable costs, and violations of criminal laws, civil codes, and statutes.

Investigations: The Special Investigations Unit (SIU) promptly and thoroughly investigates all reports of fraud, waste, and abuse (FWA) to detect if non-compliance is occurring and details any findings in a case report. Investigations may include claims data analysis, reviews of medical records, peer-to-peer comparisons, audits, interviews, surveillance, and other activities deemed necessary. When non-compliance is suspected, a referral is sent to all relevant agencies. When non-compliance occurs, CHRISTUS will recoup paid claims revenue.

Examples: Issues and patterns considered non-compliant, which may be considered Fraud, Waste, or Abuse (FWA).

#	ISSUE	DESCRIPTION OF PATTERNS
1)	MEDICAL NECESSITY	Treatment, services, or equipment not medically necessary, or extended duration, etc.
2)	BILLING	Overcharging, double-billing, disguising codes, upcoding, non-covered services, etc.
3)	NON-COMPLIANCE	Not furnishing record requests, inadequate records, suspended license/convictions, etc.

Enforcement

There are several outcomes for providing non-compliance, which include one or more of the following:

- 1) Provider education and counseling.
- 2) Formal written warning.
- 3) Recoupment of overpayments.

- 4) Corrective action plan.
- 5) Temporary suspension from billing and treatment of CHP members.
- 6) Termination of provider contract and from the CHP network.
- 7) Referral to law enforcement, federal, state, and local law enforcement agencies.

Reporting Possible FWA OR Provider Non-Compliance to CHRISTUS

Can be anonymous, if preferred

Please make a report if you suspect non-compliance involving a provider or member. Please contact the Special Investigations Unit (SIU) and describe your observations and experiences, and a representative will contact you to gather more details. If preferred, you may remain anonymous and will not be contacted. The options for reporting are:

- **FWA HOT LINE:** 855-771-8072
- Dedicated email: CHRISUSHealthPlanSIU@CHRISTUSHealth.org
- Secure Fax: 210-766-8849
- Mail: CHRISTUS Health Plan
Attn: Special Investigations Unit
5101 N. O'Connor Blvd
Irving | TX 75039

Federal and State Regulations: A partial list of potential federal and state violations if FWA has occurred:

The False Claims Act

Statute: 31 U.S.C. §§ 3729–3733, 42 C.F.R. §§422.503, 423.504(B)(4)(vi), etc.

The Anti-Kickback Statute

Statute: 42 U.S.C. § 1320a–7b(b)

Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law

Statute: 42 U.S.C. § 1395nn

Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities

Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5

Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law

Statute: 42 U.S.C. § 1320a–7a

Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute

Statute: 18 U.S.C. §§ 1347, 1349

More information on these laws: [Fraud & Abuse Laws | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services](#)

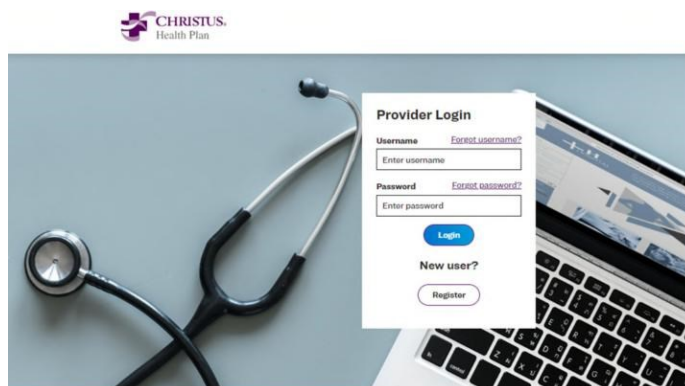
Review OIG enforcement actions: <http://oig.hhs.gov/fraud/enforcementactions.asp>

Provider Resources

Register for the Provider Portal

The CHRISTUS Health Plan Provider Portal can be found online at christushealthprovider.healthtrioconnect.com or from CHRISTUSHealthPlan.org.

Click on register and sign up for the portal.



New User – Administrator Login

The first person that registers is assigned the role of the “Local Administrator” (Office Manager).

The Administrator has access to all features of the provider portal and has access to set up all other users under that tax identification number.

Important note: For each Tax ID number, the Local Administrator or designated user manager must be registered first. If you are not the Local Administrator or the person managing users for your group, kindly contact your Administrator for access or have them register for the portal initially.

The most popular features of the portal include:

- Verifying Eligibility
- Verifying Paid through Dates
- Checking Claim Status
- Authorization Process
- Access to Quick Reference Guides
- Access to Provider Manuals
- Referrals & Authorizations
- Appeals & Grievances

Glossary of Terms

The following terms are intended to provide a brief description of the more important concepts and provisions found in the CHRISTUS Health Plan Provider Manual. They are further intended to provide a point of reference when the terms appear in this manual.

Advance Directive: A statement executed by a person while of sound mind as to that the person's wishes about the use of medical interventions for him or herself in case of the loss of his or her own decision-making capacity.

Administrative Grievance/Complaint: An oral or written complaint submitted by or on behalf of a grievant regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

- Administrative practices of the health care plan that affects the availability, delivery, or quality of health care services.
- Claims payment, handling, or reimbursement for health care services and termination of coverage.

Adverse Determination: A determination by a Health Maintenance Organization (HMO) or a utilization review agent that health care services provided or suggested being provided to an enrollee are not medically necessary or are not appropriate.

Allowable: The monetary amount a provider will receive in exchange for providing health care services, per the terms of the contract.

Annual Out-of-Pocket Maximum (OOP Max): A specified dollar amount of covered services received in a calendar year that is the most a member will pay (cost sharing responsibility) for that calendar year.

Appeal: The type of complaint made by a member when they want CHRISTUS Health Plan to reconsider a decision made about a pre-service (authorization), a post service (claim) or any other cost-sharing dispute.

Application: The forms, including required medical underwriting questionnaires, if any, that each subscriber is required to complete when enrolling for coverage.

Beneficiary: A recipient of insurance benefits.

Calendar Year: The period beginning Jan. 1 and ending Dec. 31 of any given year. The initial calendar year period is from a member's effective date of coverage and ends on Dec. 31, which may be less than 12 months.

Care Management: A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management, and promotes quality and cost-effective interventions and outcomes.

Centers for Medicare and Medicaid Services (CMS): The agency within the Department of Health and Human Services which administers Medicare, Medicaid, and the State Children's Health Insurance Program. Formerly known as HCFA.

Certification: A decision by a health plan that a health care service requested by a provider or grievant has been reviewed and, based upon the information available, meets the Plan's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Claim: A notification to the insurance company that payment is due under the policy provisions; a medical bill.

Claim Turn-Around Time: Claims payment turn-around time is measured from the date received until the disposition date on the check.

Clean Claim: A claim submitted by a physician or provider for medical care or health care services rendered to a member, with the data necessary for the Managed Care Organization (MCO) or subcontracted claims processor to resolve and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837 claim type encounter guides as follows:

- 837 Professional Combined Implementation Guide.
- 837 Institutional Combined Implementation Guide.
- 837 Professional Companion Guide.
- 837 Institutional Companion Guide.
- National Council for Prescription Drug Programs (NCPDP) Companion Guide.

Note: If submitted electronically a claim must be paid within thirty (30) days of receipt and if submitted manually, a claim must be paid within forty-five (45) days of receipt.

Clinical Practice Guidelines: A utilization and quality improvement mechanism designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The development and implementation of parameters for the delivery of health care services to plan members.

Coinsurance: The percentage of allowed charges for covered services for which the member is responsible for payment.

Complaint (Grievance): Any dispute or expressed level of dissatisfaction, either verbally or in writing, by the member or the member's authorized representative with the health plan or a delegated contractor's processes other than an action associated with the disposition of a claim (i.e., adverse determination of a benefit).

Concurrent Review: Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing the care, during the same timeframe that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay.

Condition: A group of related diagnoses dealing with the same organ, system, or disease process.

Continuity of Care: Term used to describe the process that allows an individual to continue to receive medical care from his or her current health care provider if he or she is currently involved in an active, covered treatment plan that if interrupted, could seriously affect the health of the member.

Coordination of Benefits (COB): An insurance claims review process used when a beneficiary is insured by two or more carriers. The process determines the liability of each carrier to eliminate duplication of payments.

Copayment: The amount members are required to pay to a participating provider or other authorized provider in connection with the provision of health care services.

Cost Sharing: Any contribution members make towards the cost of their covered health care services as defined in their policy. This includes deductibles and copayments.

Coverage: Benefits extended under the member's policy, subject to the terms, conditions, limitations, and exclusions of the policy.

Covered Benefit or Covered Service(s): A benefit or service incurred by or on behalf of a member for those services or supplies which are:

- Administered or ordered by a physician or other qualified provider.
- Incurred while the member's coverage is in force under the Policy.
- Medically necessary for the diagnosis and treatment of an injury or illness.
- Not excluded by any provision of the Policy.

Credentialing: Review procedure where a potential or existing provider must meet certain standards to begin or continue participation in each health care plan, on a panel, in a group, or in a hospital medical staff organization.

Cultural Competence: Possession of the knowledge, skills, and attitudes needed to provide effective health care for diverse populations, considering the culture, language, values, and reality of the member and member's community.

Current Procedural Terminology (CPT): A set of codes used for medical services and procedures to standardize claims processing and data analysis.

Custodial Care: Any service primarily for personal comfort or convenience providing general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a member's condition. Custodial care also means those services which do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine drugs, etc.)

and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Denial: Refusal to approve services or payment to a provider for covered or non-covered services under a member's benefit plan. Types of denials include:

- Denial in part of a service, i.e., has been limited, reduced, suspended, or terminated.
- Denial in whole of the service.
- Denial in whole or part of payment for a covered service.

Deductible: Part of the contribution that members make toward the cost of their health care, also known as cost sharing. It is the amount a member is required to pay each calendar year directly to the provider in connection with covered health care services before CHRISTUS Health Plan begins to pay covered benefits.

Diagnosis: The nature of a disease; the identification of an illness, represented on a medical claim by an ICD-10 code.

Diagnosis Related Group (DRG): An inpatient or hospital classification system developed and administered by CMS to pay a hospital or other provider for their services and to categorize illness by diagnosis and treatment.

Diagnostic Service: Procedures ordered by a provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Disenroll or Disenrollment: The process of ending membership in the Plan. Disenrollment may be voluntary (member's own choice) or involuntary (not their own choice).

Drug Formulary: Varying lists of prescription drugs approved by a given health plan for distribution to a covered person through specific pharmacies.

Durable Medical Equipment (DME): Equipment or supplies prescribed by a provider that are medically necessary for the treatment of an illness or accidental injury, or to prevent the member's further deterioration. This equipment is designed for repeated use and is without illness or accidental injury, and includes items such as oxygen equipment, wheelchairs, hospital beds, crutches, and other medical equipment.

Effective Date: 12:01 a.m. of the date on which the member's coverage begins.

Electronic Data Interchange (EDI): The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and authorization.

Eligibility Verification: Confirmation of a member's eligibility status at the time of service.

Emergency Care or Emergency Care Services: Covered services that are furnished by a provider who is qualified to provide Emergency Care Services. The services are needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition: A severe injury or the sudden onset of a medical condition. The injury or medical condition must be one which manifests itself by acute symptoms and in the absence of immediate medical attention, a prudent layperson with an average knowledge of health and medicines would expect that:

- A person's life or health would be in serious jeopardy.
- Bodily functions would be seriously impaired.
- A bodily organ or part would be seriously damaged.
- With respect to a pregnant woman having contractions, there is inadequate time to safely transfer the woman to another hospital for delivery or a transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollee: A person enrolled in the health plan (insured, member, subscriber).

Enrollment: Initial process whereby new individuals apply and are accepted as members of a pre-payment plan. The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

Exception: A type of coverage determination, if approved, allows a member to get a drug not listed on their plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level. Members may also request an exception if their plan sponsor requires them to try another drug before receiving the drug they are requesting, or the Plan limits the quantity or dosage of the drug being requested (a formulary exception).

Exchange: The Health Insurance Exchange Marketplace.

Excluded Services: Health care services that are not covered services and the Plan will not pay for such services.

Expedited Appeals: A request to do a more time sensitive medical necessity review of a denied urgent pre-service or urgent concurrent service when the standard appeal time periods could seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function, or in the opinion of the treating provider member's condition cannot be adequately managed without the urgent care or services. An expedited appeal resolution is made within seventy-two (72) hours, or sooner if the member's condition warrants.

Expedited Authorization: A request to do a more time sensitive medical necessity review of an urgent pre-service or urgent concurrent service when the standard time periods could seriously jeopardize the member's life, health or the ability to attain, maintain or regain maximum function, or in the opinion of the treating provider, the member's condition cannot be adequately managed without the urgent care or services. Expedited authorization is resolved within two (2) working days or sooner if the member's condition warrants.

Experimental, Investigational or Unproven: Any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where the services are provided. In addition, if a federal or other governmental agency approval is

required for use of any items, and such approval was not granted at the time services were administered, or the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies.
- The scientific evidence as published in evidence-based, peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigational settings.

Explanation of Benefits (EOB): A statement sent to covered individuals by a health plan explaining services provided, amount billed, and payments made to the provider and the amount for which the member is responsible.

Explanation of Payment (EOP): A summary statement sent to the provider that lists the services, amounts billed, denials, adjustments, and payment for one or more claims.

Fee Schedule: A list of charges (or allowances) for specific procedures and services.

Fee-For-Service (FFS): A method of paying provider and other health care providers in which each service (i.e., a doctor's office visit or procedure) carries a fee.

Follow-Up Care: The contact with or re-examination of a member at prescribed intervals following diagnosis or during a course of treatment.

Formulary: A listing of covered drug products selected by the Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

Generic Drug: A prescription drug approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. A "generic" drug works the same as a brand name drug and usually costs less.

Grievance: A written complaint submitted by or on behalf of an enrollee regarding any aspect of the member's health care services, including but not limited to the:

- Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
- Administrative practices of the health care plan affecting the availability, delivery, or quality of health care services.
- Claims payment, handling, or reimbursement for health care services.
- Matters pertaining to the contractual relationship between an enrollee or subscriber and a health care plan.

Grievant: Any of the following:

- A policyholder, subscriber, enrollee, or other individual, or the person's authorized representative or provider, acting on behalf of the person with the person's consent, entitled to receive health care benefits provided by the health care plan.
- An individual or the person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan.

Health Benefits Plan: A health plan or a policy, contract, certificate, or agreement offered or issued by a health care plan or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan.

Health Care Facility: An institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory, or imaging center; and a rehabilitation or other therapeutic health setting.

Health Care Plan: A person who has a valid certificate of authority in good standing to act as a health maintenance organization, nonprofit health care plan or prepaid dental plan.

Health Care Professional: A physician or other health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

Health Care Services: Services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Healthcare Effectiveness Data and Information Set (HEDIS): A set of HMO performance measures maintained by the National Committee for Quality Assurance (NCQA). HEDIS data is collected annually and provides an informational resource for the public on issues of health plan quality.

Health Insurance Portability and Accountability Act (HIPAA) : The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes. This act protects privacy and regulates the use of protected health information (PHI).

Health Maintenance Organization (HMO): Any person or entity who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

Health Plan: An organized service to provide stipulated medical, hospital, and related

services to individuals under a prepayment contract.

Health Care Common Procedure Coding System (HCPCS): A set of codes used by Medicare to describe services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment (DME) and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

HHS: The United States Department of Health and Human Services.

Hospitalist: A provider, usually an internist, who specializes in the care of hospitalized members.

ICD-10: The universal coding method used to document the incidence of disease, injury, mortality, and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. This system is used to group members into diagnosis related groups (DRGs), prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

Illness: A sickness or disease, including all related conditions and occurrences, requiring health care services.

In-Area: Services received in the member's health plan-designated service area.

Independent Review Organization (IRO): An entity certified by the Commissioner to conduct reviews. By law, an IRO must not be affiliated with the HMO which has denied a request for authorization for proposed treatment. IROs perform an administrative review of the medical necessity and appropriate health care services being provided or proposed to be provided, which has been denied twice as not medically necessary or not appropriate.

Injury: Bodily injury due to an accident resulting solely, directly, and independently of disease, bodily infirmity, or any other causes.

In-network: Care received from a participating provider.

Inpatient: A member admitted to a hospital requiring at least one overnight stay.

Insurance: A method of providing money to pay for specific types of losses, which may occur. Insurance is a contract between one party and another. The policy states what types of losses are covered, what amounts are paid for each loss and for all losses, and under what conditions.

Limits: Quantity or monetary thresholds associated with a particular benefit.

Living Will (Declaration): A health care directive that tells others how a person would like to be treated if they lose their capacity to make decisions about health care. It contains instructions about the person's choices of medical treatment, and it is prepared in advance, looking ahead to a time when they may no longer be able to make health care decisions for themselves.

Malpractice Liability Coverage: Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the member prove some injury and that the injury was the result of negligence on the part of the professional. A practitioner is liable for damages or injuries caused by malpractice.

Managed Care: A system or technique(s) used by third party payers or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services.
- Contracts with selected health care providers.
- Financial incentives or disincentives for enrollees to use specific providers, services, or service sites.
- Controlled access to and coordination of services by a care manager; and
- Payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost member care.

Medicaid: Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

Medical Management | Quality Improvement Committees: Committees composed of a Provider, the Medical Director, and other health care professionals that provide a mechanism for Provider Participation, communication and development and administration of CHRISTUS Health Plan.

Medically Necessary: A treatment, drug, device, procedure, supply, or service considered necessary and appropriate for the diagnosis or treatment of an illness or injury in accordance with accepted standards of medical practice in the United States at the time it is provided. A treatment, drug, device, procedure, supply, or service shall not be considered medically necessary if it:

- Is experimental, investigational, or unproven or for research purposes.
- Is provided solely for educational purposes or the convenience of the member, the member's family, physician, hospital, or any other provider.
- Exceeds in scope, duration, or intensity, that level of care needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care.
- Could have been omitted without adversely affecting the member's condition or the quality of medical care.
- Does not apply to cancer chemotherapy or other types of therapy that are subjects of on-going phase IV clinical trials.
- Involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA).
- Involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

We may require the provider to furnish peer-reviewed, evidence-based scientific literature

that demonstrates the service required for the health of the member.

Medicare: Title XVIII of the Social Security Act and all amendments thereto.

Member: An individual:

- Who meets each of the enrollment and eligibility requirements described in this Policy.
- Who has been properly enrolled in coverage with the Plan.
- For whom the Plan has received any required premium for the enrolled coverage.

Member ID Card: Identification card issued to members upon enrollment in a health plan.

Member Services: A department within our plan responsible for answering members' questions about their membership, benefits, grievances, and appeals.

Mental Illness | Disorder: Any condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, or current edition), and/or Mental Disorders Section of the International Classification of Disease.

National Accrediting Standards: The Joint Commission Accreditation standards and all accrediting standards that the CHRISTUS Health Plan is required to meet.

National Provider Identifier (NPI): A unique ten-digit number used nationally to identify a provider in standard electronic transactions. It is a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

Network Pharmacy: A network pharmacy is a pharmacy where members of the Plan can get their prescription drug benefits. In most cases, prescriptions are covered only if they are filled at one of the contracted network pharmacies.

Network Provider: Provider is the term used for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. They are network providers when they have an agreement with the Plan to accept plan payment as payment in full, and in some cases to coordinate as well as provide covered services to members of the Plan.

Non-Participating Provider: A provider not contracted with CHRISTUS Health Plan.

Nurse Practitioner: An Advanced Practice Registered Nurse who has additional responsibilities for administering member care than RNs.

Obstetrician/Gynecologist (OB/GYN): A physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

Out-of-Network Services: Health care services obtained from a non-participating provider.

Outpatient: Services that do not necessitate an overnight hospitalization, but visit to a

hospital, clinic, or associated facility for diagnosis or treatment.

Outpatient Hospital: A place to receive covered services while not an inpatient. Services considered outpatient include, but are not limited to, services in an emergency room regardless of whether the member is subsequently admitted as an inpatient in a hospital.

Participating Provider: A physician, provider, hospital, or health care facility has an agreement with CHRISTUS Health Plan to accept the Plan's rates and payments as payment in full when providing health care services to members.

Payor: The entity responsible for funding the payment for covered health services provided through the provider agreement. Sometimes used interchangeably with the word payer.

Physician: One of the following:

- A Doctor of Medicine, surgery, or osteopathy.
- A Doctor of Podiatry or a Doctor of Chiropractic.
- Any other licensed provider who is recognized as a physician by state law and acts within the scope of his/her license to treat an illness or injury.

Physical Therapy: Therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by Illness or Injury that utilizes therapeutic exercise, physical modalities (as massage and electrotherapy), assistive devices, and member education and training.

Physician Assistant: A person who has graduated from a nationally recognized physician assistant or assistant surgeon program; or currently certified by the national commission of physician assistants. A physician assistant must be licensed to practice medicine under the supervision of a licensed physician in the state in which they practice.

Plan: The health benefit plan established by CHRISTUS Health Plan and selected by the member to provide health care services to members, as it exists on the effective date of this policy or as subsequently amended as provided herein.

PPACA: The federal Patient Protection and Affordable Care Act.

Preadmission Review: A function performed by the CHRISTUS Health Plan to review and authorize hospitalizations to determine medical necessity.

Pre-Authorization: A decision by a health care plan that a health care service requested by a practitioner/provider or covered person has been reviewed and, based upon the information available, meets the health care plan's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drugs: Drugs for which sale or legal dispensing requires the order of a provider

with legal authority to prescribe drugs.

Preventive Health Guidelines: Guidelines, order sets and protocols related to maintaining good health, immunizations, or preventing illness or disease development.

Primary Care Provider (PCP): The provider a member sees first for most health problems. The PCP makes sure members get the care they need to keep them healthy. The PCP also may talk with other physicians and providers about the member's care and refer them. PCPs include family practice physicians, general practitioners, internists, pediatricians, obstetricians and/or gynecologists (OB/GYNs). The PCP is responsible for providing primary care services. These include annual examinations, routine immunizations, and treatment of non-emergency acute illnesses and injuries.

Primary Care Services: Services provided by a PCP or primary provider of health care services.

Prior Authorization: A formal process for obtaining approval from a health insurer before a specific treatment, procedure, service, or supply has been provided.

Protected Health Information (PHI): Protected Health Information is any individually identifiable health information that relates to a member's past, present, or future physical or mental health and related health care services. PHI may include, but is not limited to, demographics, documentation of symptoms, examination and test results, diagnoses, and treatments. Personal information is protected by the federal privacy policy.

Provider: An entity that performs or furnishes a medical, behavioral health, and/or dental service/treatment to members AND recognized under Section 1866(e) of the Social Security Act. A duly licensed hospital, physician, or other healing arts practitioner that is authorized to render health care services within the scope of their license.

Provider Agreement: A legal agreement between a payor and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits, and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter.

Provider Directory: A comprehensive listing of all participating providers in a health plan.

Provider Network: A list of the providers that are participating providers.

Qualified Health Plan (QHP): Health care coverage that has been determined to meet the requirements in state and federal law for coverage to be offered through the Exchange.

Qualified Individual: Regarding the Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual or small group Exchange market.

Qualified Medical Child Support Order: An order from a state or federal government agency or court. It requires a person to provide health care coverage for specific dependents.

Quality Improvement (QI) Program: Committees composed of a provider, the Medical Director, and other health care professionals that provide a mechanism for provider participation, communication and development and administration of CHRISTUS Health Plan.

Quality Improvement (QI) Program: A comprehensive system designed to assess and continually improve the processes and outcomes of care and services provided to health plan members.

Quantity Limits: A management tool designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that is covered per prescription or for a defined period.

Rescission of Coverage: A cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the:

- Cancellation or discontinuance of coverage has only a prospective effect.
- Cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Referral: An authorization granted by the participating physician/primary care provider for use of another provider.

Request for Reconsideration: A request to reconsider the initial determination.

Second Opinion: An opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the medical necessity and appropriateness of the initial proposed health service.

Service Area: A geographic area approved by CMS and/or the state Department of Insurance, within which an eligible individual may enroll in a Health Insurance Exchange Plan.

Skilled Nursing Care: Services ordered by a physician which requires the clinical skills and professional personnel of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Skilled care provided directly by or under the supervision of such personnel to a member who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled care does not include custodial care.

Skilled Nursing Facility (SNF): A place that:

- Legally operates as a Skilled Nursing Facility.
- Primarily engages in providing, in addition to room and board accommodations, Skilled Nursing Care under a physician's supervision.
- Provides continuous 24-hour a day nursing service by or under a Licensed Practical Nurse (LPN).
- Maintains a daily medical record on each member.

- Provides Rehabilitation services, such as physical, occupational and speech therapy, and may provide other multidisciplinary services, such as respiratory therapy, dietician/nutrition services, and medical social work.

Specialist: A physician who provides covered services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint, or muscle conditions and psychiatrists who care for patients with behavioral disorders or mental illness/disorders.

Speech Therapy: The treatment and exercises for treating voice and speech and swallowing disorders due to diagnosed illness or injury provided by a qualified provider.

Step Therapy: A utilization tool that requires members to first try another drug to treat the medical condition before the Plan will cover the drug the physician may have initially prescribed.

Subluxation: Misalignment, demonstrable by x-rays or chiropractic examination, which produces pain and is correctible by manual manipulation

Subscriber: An individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the managed health care plan, or in the case of an individual contract, the person in whose name the contract is issued.

Summary of Benefits: A snapshot of a health plan's costs, benefits, covered health care services, and other features that are important to consumers. It also explains health plans' unique features like cost sharing rules and include significant limits and expectations to coverage in easy-to-understand terms.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are different from Social Security benefits.

Tax Identification Number (TIN): A number assigned by the Federal Government in which a business or entity is identified for filing and paying taxes related to the business or entity.

Termination Date: 11:59 p.m. on the last day of the month for which premiums were paid and the date when the member's coverage ends.

Termination of Coverage: The cancellation or non-renewal of coverage provided by a health care plan to a grievant but does not include a voluntary termination by a grievant or termination of a health benefits plan that does not contain a renewal provision.

Third Party Liability: Recovery of the reasonable value of care and treatment furnished or to be furnished by or for the government to persons entitled to such care and treatment when such persons suffer injury or disease under circumstances which create tort or contractual

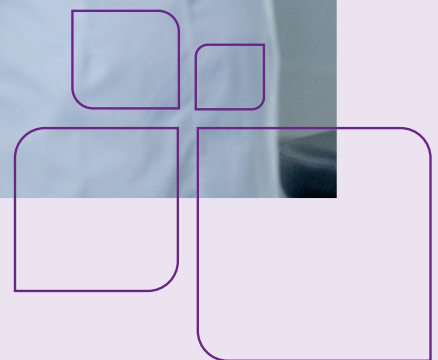
liability on third parties, including insurance companies, to pay damages.

Treatment Plan: A treatment plan is a multidisciplinary care plan for each beneficiary in active care management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals, and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending provider and beneficiary or guardian.

Urgent Care: Medically necessary health care services provided in emergencies or after a PCP's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Urgent Illness: A non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are: sprains, a rising fever despite having taken medication, new ear pain, an asthma attack where medications are not helping, an animal bite, an object in the eye or eye infection, a cut that may need stitches, a child with severe vomiting or diarrhea, a possible broken bone, shortness of breath, a sore throat, flu symptoms, a urinary tract infection, or a migraine headache where medicines are not relieving the pain.

Utilization Management: Set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing member-care decision making through case-by-case assessments of the appropriateness of care based on accepted.



844.282.3025, TTY 711

Monday – Friday, 8 a.m. – 5 p.m., local time

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