2026 US Family Health Plan Provider Manual

800.67.USFHP
USFHPenroll.com

CHRISTUS Health
US Family Health Plan

PROVIDER MANUAL

2026

PC2561

Table of Contents

Important Phone Numbers and Addresses 6
Introduction 7
Beneficiary Rights & Responsibilities 9
  Beneficiary Rights 9
  Beneficiary Responsibilities 10
Primary Care Manager 11
  Provider Credentialing Requirements 11
  Practitioner Participation Criteria 11
  Facility Participation Criteria* 11
  Facility Application Requirements* 12
  Provider, Facility, and Ancillary Contractual Requirements and Expectations 12
  Privacy and Release of Medical Records 13
  Provider Rights 14
  Appointment Wait Time 15
  Covering Providers 15
  Access Standards 16
  Protection of Privacy 16
  24|7 Nurse Line 16
  Patient No Show 16
  Other Provider Information 17
  Beneficiary Grievances and Complaints 17
Benefits and Eligibility 18
  Beneficiary Eligibility 18
  Sample ID Card 18
  Verifying Eligibility 18
  Selecting a PCP 19
  Extended Care Health Options (ECHO) 19
  Autism Care Demonstration (ACD) 20
  Catastrophic Cap Protection 20
  Family Planning 21
  Transplant Services 21

- Behavioral Health and Substance Use Disorder 21
- Partial Hospitalization 22
- Medicare 22
- End-Stage Renal Disease 22
- Coordination of Benefits 22
- Third-Party Liability 22
- Provider Contract Coordination of Benefits section 23
- Services Not Covered Under US Family Health Plan 23
- Informing Beneficiaries about Non-Covered Services 24
- Hold Harmless Policy for Network Providers 24
- Preventive Health Guidelines 25
- Guideline Links 25

Medical Management 25
- Prior Authorization Guidelines 26
- Utilization Management Components 26
- Utilization Management Notification Requirements 26
- Authorization Process 29
- Utilization Management Affirmative Statement 29
- Requests for Case Management 29

Pharmaceutical Management Procedures 31
- Pharmacy Benefit – TRICARE Formulary 32
- Drug Denial Appeals 32
- Specialty Drugs Authorization Requirements 32
- Prescriptions 32
- Mail Order Pharmacy 34
- Smoking Cessation 34
- Pharmacy Benefit Limitations and Exclusions 35

Clinical Quality Management Program 36
- Provider's Role 37
- Quality Referrals 37

Procedure for Investigating Potential Provider Quality Issues 38
President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry 39
Sentinel Event Review Process 39
National Disaster Medical System (NDMS) 40
Healthcare Effectiveness Data Information Set (HEDIS) 40
Medical Record Reviews (MRR) for HEDIS 41
Improving HEDIS Scores 41
Consumer Assessment of Health Plan Providers and Services (CAHPS) Survey 41
Preventive Health Guidelines 43
Clinical Practice Guidelines 43
Claims and Appeals 44
Claim Submissions 44
Claims Filing Deadlines 44
Claims Corrections 45
Claims Overpayments and Withholds 45
Accurate and Appropriate Claims 46
Questions Regarding Claims Payment 46
EDI Transactions 46
Electronic Claims Submissions (837) 46
Electronic Provider Remittance Advice (835) 46
Electronic Enrollment Status (270 | 271) 47
Electronic Claim Status (276 | 277) 47
Encounter Data 48
Provider Grievance, Disputes, and Appeals 49
Grievance 49
Disputes 49
Provider Appeals 49
Reconsideration and Appeals Process 49
Appeal Rights 50
Appeal Process 51
Compliance 52
Safety 52

Quality Care....52
Accurate Recording and Reporting....52
Ethical Practices....52
Risk Management....53
Program Integrity....54
Preventing Identity Theft and Protecting Personal Health Information....54
Enforcement....56
Provider Resources 57
Definitions....59

Important Phone Numbers and Addresses

Billing Address	CHRISTUS Health | US Family Health Plan P.O. Box 561505 Dallas, TX 75356-1505
Electronic Data Interchange (EDI)	CHPIMSupport@CHRISTUShealth.org
Member Services | Provider Relations	Tel: 800-687-7347 Fax: 210-766-8851
Utilization Management | Behavioral Health	Tel: 800-446-1730 Fax: 800-277-4926
TRICARE Formulary	www.express-scripts.com/frontend/open-enrollment/tricare/fst/#/
VytlOne Pharmacy (formerly Maxor)	Tel: 800-687-0707
Family Planning (Conduent)	CHRISTUS Health | US Family Health Plan P.O. Box 561505 Dallas, TX 75356 Tel: 800-687-7347 Payor: 90551
Fraud, Waste, and Abuse	FWA Hot Line: 855-771-8072 FWA Secure Fax: 210-766-8849 Email: CHRISTUShealthplanSIU@CHRISTUShealth.org
Website	www.christushealthplan.org/

Introduction

In 1981, through the Omnibus Reconciliation Act, CHRISTUS Health was designated as a Uniformed Services Treatment Facility (USTF). They served military beneficiaries under a special program called the Uniformed Services Treatment Plan. In 1993, the Uniformed Services Treatment Plan was renamed Uniformed Services Family Health Plan (USFHP) and, along with other programs around the country, they became the first government-sponsored managed care plan.

Through this plan, we serve:

- Active-duty dependents, such as spouses and children.
- Retired military, 64 years and younger, along with their dependents.
- Retired military, over 65 years of age, and their dependents, enrolled on or before Sept. 30, 2012.

Beneficiaries of CHRISTUS Health US Family Health Plan receive services as part of healthcare benefits managed by a Primary Care Provider (PCP). Benefits are available through the exclusive use of participating physicians, hospitals, medical centers, pharmacies, home health agencies, and other health care providers and facilities. A list of participating providers is available on ChristusHealthPlan.org and updated monthly.

The TRICARE benefit provided by CHRISTUS Health US Family Health Plan includes a Point of Service (POS) option that provides limited coverage for unauthorized non-emergent out-of-network services. For POS coverage to apply, the care provided *must be a TRICARE-covered benefit.* While the POS option provides some coverage for unauthorized out-of-network care, beneficiaries out of pocket costs may be significant.

Charges	Individual	Family
Deductible per Plan Year (Jan. 1 – Dec. 31)	$300	$600
Cost Share for Outpatient Care	50% of TRICARE allowable charge, after annual deductible is met	
Cost Share for Inpatient Care	50% of TRICARE allowable charge	
Additional Charges by Non-Network Providers	The beneficiary is fully responsible. Up to 15% above the TRICARE allowable charge is permitted by law	

NOTE: Out-of-pocket costs under the Point of Service option *are not applied* to the catastrophic cap.

CHRISTUS Health US Family Health Plan providers agree to follow and adhere to Rules and Regulations, which include but are not limited to: all quality improvement, utilization management, credentialing, peer review, grievance, National Quality Monitoring Contract (NQMC) program, and other policies and procedures established and revised by CHRISTUS

Health US Family Health Plan, the Department of Defense (DoD), and the CHRISTUS Health US Family Health Plan Provider Manual. Furthermore, the policies and procedures set forth herein may be altered, amended, or discontinued by CHRISTUS Health US Family 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 on as such. All terms and statements used in this manual will have the meaning ascribed to them by CHRISTUS Health US Family Health Plan and CHRISTUS Health Plan and shall be interpreted by CHRISTUS Health US Family Health Plan at their sole discretion. The most up-to-date version of the Provider Manual is located on the Plan's website, CHRISTUSHealthPlan.org/provider/quick-reference-guides-and-manuals.

Beneficiary Rights & Responsibilities

This section is designed to inform providers of the rights and responsibilities for our CHRISTUS Health US Family Health Plan beneficiaries.

Also, as a provider, please be aware that notifications of Beneficiary Rights and Responsibilities are provided to all new beneficiaries as well as maintained on the website at: tricare.mil/PatientResources/RightsResponsibilities.

Beneficiary Rights

CHRISTUS Health US Family Health Plan beneficiaries have the following rights:

- Receive considerate and respectful care with respect for their personal dignity and privacy.
- Receive information about CHRISTUS Health US Family Health Plan, our services, and their rights and responsibilities as our beneficiary.
- Receive information about covered benefits and cost sharing.
- Receive information from CHRISTUS Health US Family Health Plan in a way that works for all beneficiaries. Our plan offers free language interpretation services for non-English speaking beneficiaries that can be accessed by calling Member Services at 800-678-7347.
- Understand an explanation of the diagnosis, treatment, and prognosis of their health condition and participate in decisions involving their health care, including mutually agreed-upon goals to the degree possible. Beneficiaries unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- Receive care and treatment in a safe environment and to be informed of the facility's rules and regulations that relate to beneficiary and visitor conduct.
- Beneficiaries have the right to file grievances and appeals, as outlined in the "Grievance and Appeals Process" section in the Beneficiary Handbook.
- Request that ongoing benefits be continued during appeals (although they may have to pay for the continued benefits if a decision is upheld in the appeal).
- Request and receive a copy of their medical records and request that they be amended or corrected as allowed.
- Receive information about provider and health care facilities, including information about the composition of our network.
- Know the identity and professional status of the health care provider responsible for providing and managing their care and other health care personnel involved in their treatment.
- To participate with a practitioner in making decisions about their health care and question the adequacy of the care being provided.
- To have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Receive a second opinion from another doctor in CHRISTUS Health US Family Health Plan's network if they disagree with their doctor's opinion

about the services needed. Contact us at 1-800-67-USFHP (800-678-7347): TTY 711 for assistance.
- Make recommendations regarding the organization's beneficiary rights and responsibilities policy.

Beneficiary Responsibilities

CHRISTUS Health US Family Health Plan beneficiaries have the following responsibilities:

- Carry their Beneficiary ID card with them and know their eligibility status with CHRISTUS Health US Family Health Plan. Beneficiaries can request a new card if it is lost by calling Member Services at 800-67-USFHP (800-678-7347), (TTY 711).
- Follow the Plan's referral and prior authorization guidelines and policies.
- Become knowledgeable about their Plan coverage and options.
- Provide their CHRISTUS Health US Family Health Plan primary care provider and other health care providers with complete information to provide the needed care, to the best of their knowledge, regarding medical history and other matters relating to their health.
- Comply with medical and nursing treatment, including the follow-up care agreed upon by the beneficiary and the health care provider(s). This includes following all instructions of care provided by their providers, keeping appointments, and notifying providers promptly when an appointment cannot be kept. Beneficiaries also have the responsibility of letting their provider know whether they understand the treatment plan and what is expected of them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the highest degree possible. Becoming involved in specific health care decisions.
- Be considerate of the rights of other beneficiaries, and of CHRISTUS Health US Family Health Plan personnel and network providers.
- Be respectful of the property of other people and facilities.
- Follow provider facility rules and regulations concerning beneficiary conduct.
- Report wrongdoing and fraud to appropriate resources or legal authorities.
- Refrain from any abusive or noncompliant behavior (verbal or physical) toward staff.

Primary Care Manager

A Primary Care Provider (PCP) is a physician or advanced practice provider who manages the primary and preventive care of a CHRISTUS Health US Family Health Plan beneficiary and acts as a coordinator for specialty requests through Utilization Management.

Primary care includes comprehensive health care and support services, which encompass care for acute illness, minor accidents, follow-up care for ongoing medical problems, and enhanced preventive health care. The PCP either provides care directly or refers the beneficiary to the appropriate service or specialist when treatments are outside the scope of the PCP's practice. The PCP's office is responsible for identifying sources of specialty care, making referrals, and coordinating care.

Provider Credentialing Requirements

CHRISTUS Health US Family Health Plan 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 least every three (3) years. The credentialing and re-credentialing process consists of the provider application process, verification of credentials with primary sources and a review by the credentialing committee.

Practitioner Participation Criteria

- Ability to meet CHRISTUS Health US Family Health Plan access and availability standards.
- Board Certification or completed appropriate training in the requested specialty.
- Completed background report.
- Signed and dated CHRISTUS Health US Family Health Plan provider/group agreements.
- Current DEA and CDS certificate (if applicable).
- Current license to practice medicine or operate a facility without limitation, suspension, or restriction.
- Current malpractice insurance coverage per contract requirements.
- Must be eligible to become a TRICARE Authorized Provider.
- No current Medicare and TRICARE sanctions.

Facility Participation Criteria*

- Ability to meet CHRISTUS Health US Family Health Plan access and availability standards.
- Completed CHRISTUS Health US Family Health Plan facility and ancillary application.
- Current accreditation (if applicable).
- Current malpractice insurance coverage per contract requirements.
- Current operating certificate.
- Must be eligible to become a TRICARE authorized provider.

- No Medicare sanctions.
- The Joint Commission or other health care accreditation (if applicable)
- Signed and dated CHRISTUS Health US Family Health Plan agreements.

Facility Application Requirements*

- Copy of current accreditation face sheet.
- Copy of current malpractice coverage sheet (includes effective dates, policy number and amounts of coverage).
- Copy of current operating certificate.
- Detailed explanations to any questions requiring an answer (any professional questions that have been answered YES, i.e., explanation of malpractice history).
- Signed and dated application attestation.
- Signed and dated CHRISTUS Health US Family Health Plan agreements.

*Facility credentialing is limited to hospitals, skilled nursing facilities, home health agencies and ambulatory surgery centers (ASCs).

Provider, Facility and Ancillary Contractual Requirements and Expectations

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

- Abide by CHRISTUS Health US Family Health Plan rules and regulations and by all other lawful standards, policies, rules, and regulations of CHRISTUS Health US Family Health Plan.
- Accept patients transferring from out-of-network care to in-network facilities.
- Allow access to medical records for review by appropriate committees of CHRISTUS Health US Family Health Plan, and upon request, provide the medical records to representatives of the federal government and/or their contracted agencies.
- Arrange for another physician (the "covering physician") to provide patient care or referral services to a beneficiary if a primary care provider is temporarily unavailable.
- Inform CHRISTUS Health US Family Health Plan immediately of changes in license status, tax identification numbers, phone numbers, addresses, status at participating hospitals, loss of liability insurance, and any other change that would affect practicing status in writing.
- Inform CHRISTUS Health US Family Health Plan within twenty-four (24) hours in writing of any revocation or suspension of the physician’s Drug Enforcement Agency (DEA) number, certificate, or other legal credential authorizing the physician to practice in the state of Texas, Louisiana, or any other state. Failure to comply with the above could result in termination from the plan.
- Maintain beneficiaries’ medical records for five (5) years (60 months) from the last date service was provided.
- No balance billing a beneficiary for services covered by CHRISTUS Health US Family Health Plan. You may only bill beneficiaries for applicable deductibles, copayments, and/or cost-sharing amounts.
- No billing for charges that exceed contractually allowed reimbursement rates. May bill a beneficiary for a service or procedure that is not a covered benefit.

- Not discriminate based on age, sex, handicap, race, color, religion, or national origin.
- Participate in CHRISTUS Health US Family Health Plan's Quality Improvement, Utilization Management, credentialing, peer review, grievance, National Quality Monitoring Contract ("NQMC") programs and other policies and procedures established and revised by CHRISTUS Health US Family Health Plan or the Department of Defense (DoD), which also includes participation in evidence-based patient safety programs.
- Prepare and complete medical records in a timely fashion and maintain contemporaneous clinical records that 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 24-hour, 7 day-a-week access to care.
- Provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiaries PCP within ten (10) business days of the beneficiaries visit with the specialist.
- Provide or assist CHRISTUS Health US Family Health Plan in obtaining Coordination of Benefits | Third-Party Liability Information.
- Transfer medical records within ten (10) business days or sooner if requested by a treating physician, after a beneficiary in your panel changes to another PCP.
- Utilize CHRISTUS Health US Family Health Plan's participating physicians and facilities when services are available and can meet the patient's needs.

Note: All subcontractor agreements are subject to the contract requirements above.

Privacy and Release of Medical Records

A provider is expected to maintain policies and procedures within their offices to protect the privacy of all beneficiaries and to prevent unauthorized or inadvertent use and disclosure of confidential information. A provider's policies and procedures must be in accordance with all applicable federal and state laws and regulations and your participating provider agreement.

The privacy and security components of the Health Insurance Portability and Accountability Act (HIPAA) provide broad protection for identifiable health information. The transaction and code set component to HIPAA requires conformity to precise rules in the electronic transmission of financial health information.

The HIPAA Privacy Rule permits providers to disclose Protected Health Information (PHI) to a health plan for health care operations, provided the health plan has a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship.

See 45 CFR 164.506(c)(4) … "Health care operations" includes care management, utilization review activities, and similar activities. See 45 CFR 164.501 (definition of "health care operations"). Thus, a provider may disclose protected health information for care management and/or utilization purposes. A provider may also disclose protected health information to a health plan for the plan's Health Care Effectiveness Data and Information

Set (HEDIS®) purposes, if the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

There may be times when a beneficiary's medical records need to be transferred from one PCP to another PCP in the Plan. This may occur when a beneficiary changes 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 physician.

Medical records for CHRISTUS Health US Family Health Plan beneficiaries must be maintained for five (5) years (60 months) from the last date of service provided.

Federal TRICARE regulations require that the following information should be included in every individual patient record:

- Alcohol or Substance Use | Abuse (12 years and older).
- Allergies.
- Appropriate Use of Consultants.
- Chief Complaint.
- Continuing Medication List.
- Significant Problem List.
- Date of Each Visit.
- Date of Next Visit.
- Impression for Chief Complaint
- Growth Chart (14 years of age and under).
- Hospital Records.
- Immunization History.
- Informed Consent.
- Initial Relevant History.
- MD Review of Diagnostic Studies.
- Patient Identification.
- Patient's Signature on File.
- Personal Data.
- Physical Exam Relevant to Chief Complaint.
- Preventive Health Education.
- Provider Signature for each entry.
- Results Discussed with Patient.
- Results of Consultations.
- Smoking Status (12 years and older).
- Treatment and/or Therapy Plan.
- Health Education and Wellness promotion services assessed by the beneficiary.

Provider Rights

Providers have certain rights as participants of CHRISTUS Health US Family Health Plan.

These rights include:

- Appeal any action taken by CHRISTUS Health US Family Health Plan that affects their status with the network and/or related to professional competency or conduct.
- Request any resolved claim be reconsidered if they feel it was not paid appropriately.
- Request CHRISTUS Health US Family Health Plan removes a beneficiary from their care if an acceptable patient-physician relationship cannot be established with a beneficiary who has selected them as his/her physician.

Appointment Wait Time

Wait times in any provider's office should not exceed 30 minutes for non-emergent visits. Beneficiaries must have access to a PCP within a 30-minute drive time from their residence. Beneficiaries must have access to a specialist within a 60-minute drive from their residence. CHRISTUS Health US Family Health Plan defines access standards as the timelines within which a beneficiary can obtain available services, in accordance with the Department of Defense's access and availability requirements.

When a beneficiary calls to make an appointment, it must be made within the following guidelines:

Emergency Care	Immediate
Urgent | Acute Care	Within 24 hours
Routine Office Visit	Within 1 week
Well | Preventive Health Visit	Within 4 weeks
Specialty Consultation or Procedure	Within 4 weeks
Follow-Up Visit	As required by provider

Covering Providers

Follow-up treatment should always occur with the beneficiary's PCP. It is the responsibility of the contracted PCP to have his/her covering physician provide care according to the benefit and access guidelines outlined in this provider manual, whether or not the covering physician is affiliated with CHRISTUS Health US Family Health Plan.

Access Standards

Service	Definition	Standard
Preventive Care	Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.	30 Days
Routine Care	Non-urgent care for symptomatic conditions.	As soon as possible, no later than 1 week (7 days)
Urgent Care	Medically necessary treatment required for a sudden illness or injury that is not life-threatening but requires immediate professional attention to avoid further complications resulting from non-treatment. Treatment is usually performed outside an Emergency Room (ER) setting.	Immediately
Specialty Care	Specialized medical services provided by a physician specialist.	Within 4 weeks

PCPs see beneficiaries for routine care, preventive, and annual physicals.

Protection of Privacy

CHRISTUS Health US Family Health Plan providers should:

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

24/7 Nurse Line

CHRISTUS Health US Family Health Plan has a 24-hour-a-day, 7-day-a-week nurse line. Beneficiaries can access this service toll-free for medical guidance. Beneficiaries are instructed based on nationally recognized triage protocols. This service does not replace a provider's after-hours coverage commitment.

Patient No Show

The patient's PCP must review each chart for patients who fail to keep their scheduled appointments. A "No Show" patient should be documented in the patient's medical record. Missed appointments are not a billable or reimbursable service by the Health Plan, but a provider may bill a beneficiary directly for recurring missed appointments.

Other Provider Information

National Disaster Medical System (NDMS)
All acute care medical and/or surgical hospitals are encouraged to become beneficiaries of the NDMS. For more information, please visit: aspr/hhs.gov/NDMS/Pages/default.aspx.

Providers and beneficiaries are encouraged to use Medline Plus®, a website developed and maintained by the US National Library of Medicine (NLM) and the National Institutes of Health (NIH). This site provides information on diseases and conditions, clinical trials, drugs, and the latest health information. The use of this site is not intended to be a substitute for health care information but may be used as a resource visit: https://medlineplus.gov/.

Beneficiary Grievances and Complaints

CHRISTUS Health US Family Health Plan encourages beneficiaries to resolve individual inquiries and concerns or problems at the point of service. In the event their request for assistance is not settled at the point of service, beneficiaries should contact Member Services, who will work with beneficiaries to resolve their concerns and issues.

In the event a beneficiary's grievance complaint inquiry has not been settled at the informal level and the beneficiary is dissatisfied, he or she may file a formal grievance. Providers are required to respond in writing to any formal grievance made regarding the provider, the provider’s staff, the provider’s facility/office, or the services provided within ten (10) days of the receipt of the grievance.

CHRISTUS Health Plan
Complaints, Appeals and Grievances Department
P.O. Box 169009
Irving, TX 75016
844-282-0380

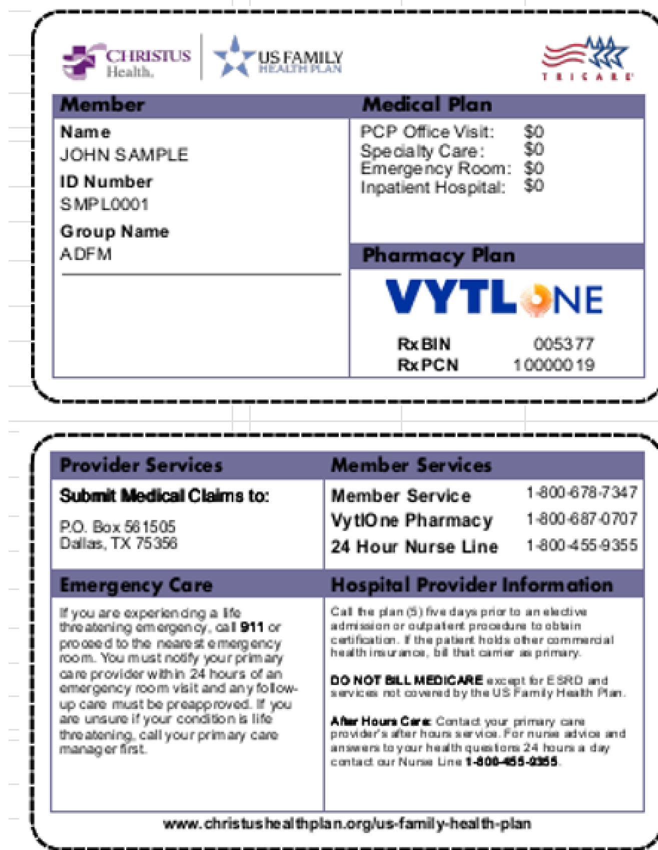
Benefits and Eligibility

Beneficiary Eligibility

CHRISTUS Health US Family Health Plan provides covered medical benefits to its beneficiaries. A copayment may be required for an office visit, hospital admissions, prescribed medications, emergency room visit (if not admitted), purchase or lease Durable Medical Equipment (DME), and other services as indicated. Beneficiaries are responsible for payment of all services determined not to be medically necessary or not authorized by the physician.

Sample ID Card

Below is a sample ID Card your beneficiaries should present at all appointments.



The ID Card above is a sample. The copays shown are examples only.

Verifying Eligibility

A provider may confirm member eligibility directly with USFHP by visiting the Provider Portal: https://christushealthprovider.healthtrioconnect.com or call Member Services at 800-678-7347 to check benefits Mon. – Fri. from 8 a.m. to 5 p.m. local time. Agents can assist in verifying your network status with CHRISTUS Health US Family Health Plan, as well as a beneficiary's

eligibility and benefits. Member Services can check if an authorization is needed for services 2026 CHRISTUS Health Provider Manual – US Family Health Plan or if it has already been initiated. Each time you contact Member Services, you will be given a call reference number that you can use to confirm benefits were provided in your records.

Selecting a PCP

Upon enrollment, the beneficiary and their eligible family members select a Primary Care Physician (PCP). Beneficiaries will only be assigned to PCPs with open panels (those currently accepting new beneficiaries).

Providers may establish a limit on the number of CHRISTUS Health US Family Health Plan beneficiaries accepted into his or her panel. Provider panels can be opened and closed as necessary by the provider via a written notification to the Provider Relations Department.

Extended Care Health Options (ECHO)

Extended Care Health Options (ECHO) provides financial assistance for active-duty family beneficiaries only with specific qualifying mental or physical conditions. Some conditions include, but not limited to:

- Autism spectrum disorder.
- Moderate or severe intellectual disability.
- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (under age 3) that is expected to precede a diagnosis of moderate or severe intellectual disability or serious physical disability.
- Extraordinary physical or psychological condition causing the beneficiary to be homebound.
- Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems).

Children may remain eligible for ECHO benefits beyond the usual TRICARE eligibility age limit (age 21, or age 23 if enrolled in a full-time course of study at an approved institution of higher learning) provided all the following are true:

- The sponsor remains on active duty.
- The child is incapable of self-support because of a mental or physical incapacity occurring prior to the loss of eligibility.
- The sponsor is responsible for over 50 percent of the child’s financial support.

If you believe a qualifying condition exists, call Member Services at 800-678-7347 to determine eligibility for ECHO benefits. For more information, please visit: https://Tricare.mil/echo.

Autism Care Demonstration (ACD)

The TRICARE Comprehensive Autism Care Demonstration covers applied behavior analysis services. Under the ACD, ABA services are authorized to target the core symptoms of autism spectrum disorder.

How the ACD Works:

1. Get diagnosed.
   Your child must be diagnosed by an approved diagnosis provider.

2. Get a referral and pre-authorization.
   You must get a referral to the ACD and a pre-authorization for all ABA services.

3. Complete outcome measures
   The provider team must complete four baseline outcome measures:
    - Pervasive Developmental Disorder Behavior Inventory
    - Vineland Adaptive Behavior Scales
    - Social Responsiveness Scale
    - Parent Stress Index or Stress Index for Parents of Adolescents

You must complete the four outcome measures every 6 months or 12 months. The frequency depends on the measure.

Schedule an appointment

All ABA requests require Prior Authorization.

For more information, please visit:
https://www.tricare.mil/Plans/SpecialPrograms/ACD

Catastrophic Cap Protection

The catastrophic cap is the most beneficiary and his/her family will pay out of pocket for covered TRICARE health care services each calendar year.

Sponsor or Beneficiary Type	Group A	Group B
Active-Duty Family Members	$1,000 per family	$1,324 per family
Retirees, their families, and others	$3,000 per family	$4,635 per family

Copayments are reinstated at the beginning of the next plan year, Jan. 1, as the accrual of catastrophic maximum resets.

The cap does not apply to:

- Services not covered by TRICARE.
- Any amount a non-participating provider may charge above the TRICARE maximum allowable charge for services (The maximum TRICARE pays for each procedure or service. This is tied by law to Medicare's allowable charges).
- TRICARE Point-of-Services charges.

Family Planning

Family planning is included as a covered benefit in the CHRISTUS Health US Family Health Plan benefits. However, because these services do not align with the Ethical and Religious Directives for Catholic Health Care, they are not provided by CHRISTUS Health-owned entities. Instead, Conduent, Inc., an independent company not affiliated with CHRISTUS Health USFHP, administers and pays for family planning services for plan members.

Providers with questions should contact CHRISTUS Health USFHP at 800-678-7347. Claims for family planning services should be submitted to the address listed on page 6 under "Important Phone Numbers and Addresses."

Transplant Services

CHRISTUS Health US Family 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 beneficiary. For beneficiaries to obtain the maximum possible benefits, the beneficiary must obtain their transplant through the use of health plan contracted transplant providers: **Optum, Cigna Life SOURCE, LifeTRAC.** In-network transplant services may be provided outside of the Plan service area if the services are accessible and available to enrollees, and the delivery is consistent with community patterns of care for original Medicare beneficiaries who reside in the same area. For authorization and to initiate the Transplant Process, please call or fax your request to the CHRISTUS Health Medical Management team: Phone 800-446-1730, Fax 800-277-4926.

Behavioral Health and Substance Use Disorder

Outpatient Health

Medically necessary visits to a provider for the treatment of a Behavioral Health or substance use disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis codes.

Inpatient Behavioral Health Services

Inpatient Behavioral Health services are treatments for a Behavioral Health condition as defined by the most recent DSM diagnosis codes. Inpatient admissions and out-of-network admissions to a facility require prior authorization.

Partial Hospitalization

Partial Hospitalization services are visits to a psychiatric facility for a day or partial day without an overnight stay. Outpatient Mental Health Care (to include Partial Hospitalization Programs, Intensive Outpatient Programs, Opioid Treatment Programs, Office-Based Opioid Treatment, and Outpatient Treatment) does not require preauthorization unless out-of-network. Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care.

Medicare

A provider may not bill Medicare for US Family Health Plan-covered benefits provided to a CHRISTUS Health US Family Health Plan beneficiary. Should a provider bill Medicare for USFHP covered services, CHRISTUS Health US Family Health Plan is required to investigate and if appropriate, disenroll the beneficiary from the Plan. Should a beneficiary possessing Medicare benefits disenroll from the plan, their Medicare benefits automatically get reinstated.

End-Stage Renal Disease

Special rules apply for the coverage and payment for maintenance kidney dialysis. Beneficiaries, regardless of age, diagnosed with End-Stage Renal Disease (ESRD) become eligible and must apply for Medicare coverage. CHRISTUS Health US Family Health Plan will provide full coverage for ESRD patients until Medicare coverage is obtained (typically up to the first ninety (90) days of dialysis depending on the method of dialysis).

Once the beneficiary obtains Medicare coverage, it replaces CHRISTUS Health US Family Health Plan as the primary insurance for all health care. USFHP becomes secondary to Medicare thereafter and covers coinsurance charges for which patients would otherwise be responsible.

Claims submitted for services provided to ESRD patients will require the submission of a Medicare EOB in addition to the claim. ESRD patients who do not obtain Part B insurance will lose their USFHP benefit and will be responsible for all charges related to ESRD.

Coordination of Benefits

Coordination of Benefits (COB) applies when beneficiaries are covered by more than one health insurance plan. Providers are to provide or assist CHRISTUS Health US Family Health Plan with obtaining other health insurance information.

CHRISTUS Health US Family Health Plan processes COB claims according to the provider's contract. Providers shall accept payment from CHRISTIS Health US Family Health Plan plus any copayments as payment in full for all covered services provided to beneficiaries and will not attempt to bill any other person, insurer, payer, or other entity for such services.

Third-Party Liability

Third-party liability occurs when a CHRISTUS Health US Family Health Plan beneficiary

suffers from an accident, injury or illness caused by the negligence of or intentional act of a third party. Per the definition, third-party liabilities are automobile insurance, workers' compensation, homeowners' liability, etc.

CHRISTUS Health US Family Health Plan is required to notify DHA when a beneficiary is involved with third-party liability and to collect and forward all claim information to the Uniformed Services Claims Officers.

Provider Contract Coordination of Benefits section

Facility shall accept payment from CHRISTUS Health US Family Health Plan plus any required co-payments as payment in full for all Covered Services provided to Enrollees, and shall not attempt to bill any other person, insurer, payor, or other entity for such services. The facility hereby assigns to CHRISTUS Health US Family Health Plan all its rights to any other benefits payable to an Enrollee. The facility shall use its best efforts to determine the availability of other benefits and to obtain any documentation required to facilitate CHRISTUS Health US Family Health Plan's collection of such other benefits.

Services Not Covered Under US Family Health Plan

The following is a list of services not covered by CHRISTUS Health US Family Health Plan (not all inclusive):

- Acupuncture or acupressure.
- Charges for care and supplies not ordered by a physician.
- Chiropractic or naturopath services.
- Convenience and personal care items billed separately, such as telephone, television, or radio.
- Cosmetic or plastic surgery except as may be necessary to correct a severe disfigurement or to correct the disorder of a normal bodily function.
- Custodial care.
- Experimental or investigational procedures.
- Homemaker services.
- Lodging cost during outpatient dialysis treatment.
- Meals delivered to the home.
- Non-medically necessary transportation cost.
- Organ transplants are considered experimental or investigational.
- Private duty nurses and nursing care on a full-time basis in the home.
- Services for which neither the beneficiary nor another party acting on the beneficiary's behalf has a legal obligation to pay.

NOTE: Under CHRISTUS Health US Family Health Plan, the beneficiary is covered only for services authorized or arranged by their PCP. Care outside of the Plan will not be paid for by the CHRISTUS Health US Family Health Plan, except in emergency situations. Non-preapproved urgently needed care is a covered benefit only when the beneficiary is traveling outside of the 48 contiguous states.

- Services performed by immediate relatives or beneficiaries of the household.
- Services related to education, elective travel, employment, licensing, or other

administrative reasons.
- Services related to the treatment of End Stage Renal Disease (ESRD). Special rules apply for the coverage and payment for maintenance kidney dialysis.
- Wages lost to the caregiver and the dialysis assistant during self-training.

Informing Beneficiaries about Non-Covered Services

As a part of good business practice, providers are expected to notify CHRISTUS Health US Family Health Plan beneficiaries when a service is not covered. TRICARE policy includes a specific “hold harmless” policy for network participating providers and recommends out-of-network providers also follow a similar process to document beneficiary notification.

Hold Harmless Policy for Network Providers

A network provider may not require payment from a beneficiary for any excluded or excludable services the beneficiary received from the participating provider except in the following situations:
- If the beneficiary did not inform the provider that he or she was a CHRISTUS Health US Family Health Plan beneficiary, the provider may bill the beneficiary for services rendered.
- If the beneficiary was told the service was excluded and they agreed in advance to pay for it, the provider may bill it.

CHRISTUS Health US Family Health Plan beneficiaries must be properly informed in advance and in writing of specific services or procedures excluded before the service is provided. If the beneficiary chooses to be financially responsible for the non-covered service, the beneficiary is asked to sign a waiver agreeing to pay for the non-covered service. A beneficiary’s agreement to pay for a non-covered service must be evidenced by written records. Examples of acceptable written records include:
- Provider office or medical record documentation written prior to receipt of the services demonstrating the CHRISTUS Health US Family Health Plan beneficiary was informed the services were excluded or excludable and the beneficiary agreed to pay for them.
- A statement or letter written by the beneficiary prior to receipt of the service, acknowledging the service is excluded or excludable and agreeing to pay.

If the Participating Provider does not obtain a signed waiver, and the service is not authorized by CHRISTUS Health US Family Health Plan, the provider is expected to accept full financial liability for the cost of the care. It is important to note a waiver signed by a beneficiary after the care is rendered is not valid under DoD regulations.

For a CHRISTUS Health US Family Health Plan beneficiary to be considered fully informed, DoD regulations require:
- The agreement is documented prior to the non-covered service being rendered.
- The agreement is in writing – a verbal agreement is not valid under DoD policy.
- The specific service, date of service, and estimated cost of services is documented in writing.

- General agreements to pay, such as those routinely signed by patients, are not evidence the CHRISTUS Health US Family Health Plan beneficiary knew specific services were excluded.

Caution: Providers should be aware that there have been situations when a CHRISTUS Health US Family Health Plan beneficiary has agreed to pay in full for a non-covered service without signing a waiver. The provider rendered the care in good faith without prior written waiver, and the beneficiary was not held financially responsible.

Without a signed advance waiver, the provider could be denied reimbursement and cannot bill the beneficiary.

Preventive Health Guidelines

CHRISTUS Health US Family Health Plan views preventive health as the foundation of services for its beneficiaries. The Plan covers a variety of periodic health examinations and other services such as immunizations, disease-specific screening, cancer screening, annual physicals, school physicals, counseling services, mammograms, cholesterol screenings, blood pressure checks, and health screenings that conform to the recommendations of the TRICARE Policy Manual and the United States Preventive Services Task Force.

There is no specific definition of “periodic” as referenced in the standard for preventive services, so this judgment will be made by the PCP based on each individual case. Each CHRISTUS Health US Family Health Plan beneficiary is entitled to an annual physical, and women are entitled to one self-referring well-woman exam performed by a network Obstetrician and/or Gynecology specialist. CHRISTUS Health US Family Health Plan Active-Duty beneficiary is entitled to an annual eye exam performed by a network Optometrist or Ophthalmologist. Retirees are entitled to an eye exam every two years.

Well-childcare is covered for beneficiaries from birth to age six and includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with the American Academy of Pediatrics (AAP) guidelines.

Note: Preventive health services do not have copays, call to verify eligibility and benefits prior to rendering services.

Guideline Links

Preventive health guidelines followed by TRICARE policy:
Tricare.mil/HealthWellness/preventive

US Preventive Task Force guidelines: uspreventiveservicestaskforce.org

Recommendations for pediatric preventive health care from the American Academy of Pediatrics: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Medical Management

Prior Authorization Guidelines

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

- Contact the Utilization Management (UM) at 800-446-1730 (ext. 1) for prior authorization related inquiries.
- For any urgent or emergent request: fax the request to the urgent fax line at 210-766-8841
- For a routine request, Fax to 800-277-4926 or Email: CHRISTUS.HP.278@christushealth.org
- https://www.christushealthplan.org/provider/prior-authorizationP
  Please visit our website to access Prior Authorization request forms and review the lists outlining provider prior authorization requirements.
- **Note:** If the requirements for prior authorization are not followed, CHRISTUS Health Plan may not pay for the services. In most cases, physicians and other providers will be responsible for getting the prior authorization from the health plan. We have instructions and procedures in place for providers to request prior authorization.

The following information will be requested from the provider:

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

Completed referrals containing all necessary information and supporting documentation will be processed by the UM and/or CM Department.

Utilization Management Components

The Utilization Management reviews consist of assessing the medical necessity of all services not previously approved. Clinical information is reviewed for appropriateness using evidence-based clinical guidelines, plan protocols, and TRICARE benefits and coverage as appropriate.

Prospective Review: Prior assessment of a request for treatment before the treatment is rendered to determine if the treatment is appropriate for the patient. Another term for preauthorization.

Continued Stay Review (Concurrent Review): Evaluation of a patient's continued need for treatment, the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed.

Retrospective Review: The process of review that occurs before payment of any claims for which Precertification and/or Authorization did not occur.

Discharge Planning: The Care Manager is responsible for coordinating a beneficiary's care and will work with the patient and Utilization Management in arranging for the beneficiary's discharge needs. The Care Manager will help in discharge planning by arranging for any home care services, skilled nursing care, or medical equipment required after leaving the hospital. This process helps ensure every beneficiary is provided with appropriate care, both in the hospital and post-discharge.

Preadmission Review: The process of authorizing non-emergency medical and surgical hospitalizations.

Ambulatory | Outpatient Review: The process of authorizing non-emergency selected diagnostic and surgical outpatient procedures.

Skilled Nursing, Long-Term Acute Care, and Rehabilitation Facility Authorization: Skilled nursing facilities (SNF), long-term acute care facilities (LTAC), and rehabilitation facilities are specialty qualified facilities or designated units in a hospital that have the staff and equipment to provide acute care, skilled nursing care, or rehabilitation services and other related health services. CHRISTUS Health US Family Health Plan coverage includes, as a benefit, inpatient care in a participating SNF, LTAC, or rehabilitation facility. Prior authorization is required if done out-of-network.

Home Health Care: A home health agency is 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 beneficiaries upon receiving an order signed by the attending physician and authorization by the UM and/or CM Department. Requests for continuation of services will be reviewed as an ongoing basis to determine medical necessity. Custodial care is a non-covered benefit.

Durable Medical Equipment (DME): 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 improve the function of malformed, diseased, or injured body parts or slows further deterioration of the patient's physical condition. Specific DME items require prior authorization (see Services Requiring Prior Authorization). DME must be obtained through CHRISTUS Health US Family Health Plan-contracted providers.

Utilization Management Notification Requirements

Admission Notification: The provider and/or hospital notifies the Utilization Management department when a CHRISTUS Health US Family Health Plan beneficiary is admitted to the hospital within one business day of the admission to the hospital.

There are specific notification requirements that apply to the services evaluated in each review component, to ensure payment. The provider must submit a completed Notification Form prior to the proposed treatment and service.

Treatment | Service	Notification Requirement
Urgent ED 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 | Long Term Acute | Inpatient Rehab | Hospice	Initiation: Two (2) business days prior to requested DOS.
Home Health	Initiations: Two (2) business days prior to requested DOS. Continuation: Seven (7) business days prior

Authorization Process

Information received either via email or fax will be reviewed for benefit coverage or determination of medical necessity. Appropriateness and medical necessity will be reviewed using Milliman Care Guidelines (MCG) Guideline Criteria, plan clinical protocols and policies, and TRICARE benefits and coverage. Upon approval of authorization, the authorization is faxed to the requesting provider and servicing provider.

Requests that do not meet the medical necessity or coverage guidelines are forwarded to the Medical Director for review and determination of medical necessity or benefit coverage. If CHRISTUS Health Advantage determines medical necessity or benefit coverage is not established, notification is made to the requesting provider will include the physician reviewer’s determination to deny authorization. A denial letter is sent to the requested provider in two (2) business days of the determination.

Utilization Management Affirmative Statement

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

Requests for Care Management

The CHRISTUS Health US Family Health Plan Care Management program plans and supports the care and education of beneficiaries with catastrophic, complex, or chronic conditions (disease management) and those beneficiaries who are undergoing a transition of care (e.g., hospital to home).

The goals of Care Management are the provision of quality care, enhancement of the beneficiary's quality of life, and management of health care costs. Disease Management is health management for beneficiaries with specific chronic diseases. Care management services are also provided to beneficiaries with behavioral health diagnoses.

The following may identify potential participants for Care Management:

- Physician referral.
- Facility admission and concurrent review process.
- Retrospective analysis.
- Beneficiary request.
- Care Management criteria per the risk stratification.
- Claims report
- Pharmacy referral

Providers, members, caregivers, and discharge planners can all refer beneficiaries for care management evaluation by calling 800-446-1730, option 2, or by sending information via email to caremanagementreferrals@christushealth.org.

For Eligibility and Benefits, along with Family Planning Assistance, please contact Member Services, 800-678-7347.

Pharmaceutical Management Procedures

Pharmacy Benefit – TRICARE Formulary
CHRISTUS Health US Family Health Plan covers prescription drugs when ordered by a licensed provider. CHRISTUS Health US Family Health Plan covers medically necessary Food and Drug Administration-approved prescription drugs included on the TRICARE Formulary.

The TRICARE Formulary covers most FDA-approved prescriptions. In general, covered medications under the CHRISTUS Health US Family Health Plan pharmacy benefit must be:

- A prescription medication approved by the FDA.
- Prescribed with good medical practice and established national standards of quality care.
- Medications not medically necessary for diagnosing or treating an illness are not covered by CHRISTUS Health US Family Health Plan.

Formulary: The DoD Pharmacy & Therapeutics (P&T) Committee (a body of military physicians and pharmacists), and the Director of the Defense Health Agency (DHA) establish a uniform formulary, which is a list of approved covered generic and brand-name drugs. This formulary also contains a third tier of drugs that are non-formulary and a fourth tier of drugs that are non-covered. Prescriptions for non-formulary drugs are dispensed at a higher copay. The formulary is updated quarterly.

Use the TRICARE Formulary search tool to see if a specific drug is covered:
tricare.mil/formulary

Some prescription medications may require prior authorization, quantity limitations and/or step therapy requirements as identified by the DoD Pharmacy and Therapeutics (P&T) Committee.

To start a prior authorization, contact VytlOne at 800-687-0707 or fax 844-370-6203.

If a CHRISTUS Health US Family Health Plan beneficiary needs a medication that requires prior authorization or step therapy as determined by the DoD P&T Committee, VytlOne will fax a request for medical information (including diagnosis). This prior authorization form must be filled out entirely and returned by fax to 844-370-6203.

If the request is denied or needs additional information, the clinical department will notify the physician's office by fax.

Step Therapy involves prescribing a safe, cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic that offers the best value in terms of safety, effectiveness, and cost. New prescriptions subject to step therapy will not be covered unless the beneficiary has tried and failed the first-line drug in the past 180 days.

Non-preferred drugs are covered if the preferred medication is ineffective or poorly tolerated. If a brand-name medication has a generic equivalent, it is the Department of Defense policy to dispense the generic equivalent instead of the brand-name medication. The brand-name medication will be dispensed only if the provider fills out a prior authorization form stating the patient-specific clinical reason the generic cannot be tolerated, and it is approved.

For an updated list of drugs requiring prior authorization from the TRICARE Formulary, go to tricare.mil/formulary

DoD quantity limitations are in place for some drugs. TRICARE quantity limits information can be found on the web at: tricare.mil/formulary

Drug Denial Appeals

Administrative and clinical drug denial letters are issued with instructions on the procedure to appeal the decision.

Specialty Drugs Authorization Requirements

Certain specialty drugs are preferred to be dispensed through VytlOne and may require prior authorization.

Prescriptions

Prescriptions can be filled at a local VytlOne Pharmacy (designated provider), a network pharmacy or the VytlOne Mail Order pharmacy.

The local VytlOne Pharmacy location is:

- VytlOne– Clear Lake (Houston).

Nationwide Network Pharmacies include, but are not limited to:

- Brookshire Brothers.
- Costco.
- CVS (freestanding or inside Target).
- H-E-B.
- Kroger.
- Market Basket.
- Sam’s Club.
- Tom Thumb.
- Walmart.

Independent Network Pharmacies include:

- Ed’s Pharmacy – Sugar Land.
- Inwood Pharmacy – 1960 area.
- Katy Pharmacy.
- Kelly Drug - Mineola.
- Scott’s Quitman Pharmacy – Quitman
- Scott’s Pharmacy - Winnsboro

The network pharmacies can be used for the first time and for urgent care fills. Prescriptions filled at a network pharmacy are limited to a maximum of a thirty (30)-day supply. A ninety (90)-day supply can only be obtained by VytlOne Mail Order Pharmacy and walk-in VytlOne Pharmacies.

Beneficiaries are responsible for a copayment to the pharmacy for each prescription filled or refilled. There is no copayment for drugs administered by a healthcare professional. The table below outlines beneficiaries' copayments according to the type of pharmacy and formulary status:

Type of Pharmacy	Formulary Drugs		Non-Formulary	Non- Covered
	Generic Tier 1	Brand Name Tier 2	Tier 3	Tier 4
In-Network (up to a 30-day supply)	$16	$48	$85	Full cost of drug
VytlOne Mail Order & Walk-In VytlOne Pharmacies (up to a 90-day supply)	$14	$44	$85	Not available
Out-of-Network (up to a 30-day supply)	50% of total cost applies after Point of Service (POS) deductible met	50% of total cost applies after POS deductible met	50% of total cost applies after POS deductible met	Full cost of drug

Mail Order Pharmacy
CHRISTUS Health US Family Health Plan requires that maintenance medication prescriptions be routinely filled via mail order through VytlOne Mail Order Pharmacy or VytlOne.

A mail-order pharmacy is a pharmacy that delivers drugs to patients through the mail directly to their homes, rather than requiring patients to show up at the pharmacy to pick up prescriptions.

To facilitate the mail-order process, beneficiaries must use the following process:

- When issuing a first-time prescription for maintenance medication, please write two prescriptions: one for a thirty (30)-day initial supply and one for a ninety (90)-day maintenance supply.
- The initial thirty (30)-day prescription will be filled at any of the affiliated walk-in network pharmacies.
- The ninety (90)-day prescription will be filled through VytlOne Mail Order Pharmacy. Prescriptions can be mailed, faxed, e-prescribed, or called into the pharmacy.
- VytlOne Mail Order Pharmacy is SureScript-enabled for Electronic Prescribing for Controlled Substances

The mail-order pharmacy is limited to filling a thirty (30)-day supply on controlled substances, except ADHD and seizure medications. Controlled substances from Louisiana providers must be filled at a network pharmacy in Louisiana.

VytlOne Mail Order Pharmacy
P.O. Box 32050
Amarillo, TX 79120
Phone: 866-408-2459
Fax: 866-589-7656
(Prescriptions must be faxed directly from the provider's office)

Smoking Cessation

CHRISTUS Health US Family Health Plan is dedicated to helping patients quit smoking and live a healthier life. Smoking cessation drugs are available from VytlOne Mail Order Pharmacy for a $0 copay. Both prescription and over the counter (OTC) products are covered with a prescription.

Pharmacy Benefit Limitations and Exclusions

Due to TRICARE restrictions, the USFHP pharmacy benefit excludes:

- Any prescription refilled before 75% of a previous filling has been used.
- Drugs prescribed for cosmetic purposes, including but not limited to drugs used for hair growth or wrinkle reduction.
- Homeopathic and herbal preparations.
- Multivitamins (except prenatal vitamins for pregnant women).
- OTC products, except when covered by the TRICARE Formulary.
- Any pharmacy product purchased without a prescription.

Clinical Quality Management Program

CHRISTUS Health Uniformed Services Family Health Plan has a comprehensive Clinical Quality Management Program (CQMP). The goal of the CQMP is to ensure every beneficiary can receive quality care in a timely and accessible manner and to provide a mechanism for evaluating the appropriateness of beneficiary care. The purpose of the CQMP is to methodically create processes to partner with beneficiaries and providers to optimize health through promotion of evidence-based care delivery. This involves the process of continuous quality improvement with iterative evaluation of care delivery and service outcomes using all the tools available to advance best care.

The CQMP includes, but is not limited to, the following topics:

- Access and availability of provider services.
- Accreditation and compliance.
- Complaints, grievances and appeals to include timely resolution.
- Complex Case Management.
- Disease Management.
- Engage with beneficiaries and families in their health.
- Ensure adequate privacy and security protection for protected health information.
- Quality Improvement Committee participation and guidance.
- HEDIS (Healthcare Effectiveness Data and Information Set) application to guide quality of care activities.
- Assessment of beneficiary and provider satisfaction to apply continuous improvement processes.
- Medical record review (types of medical record reviews include continuity of care. HEDIS, potential quality of care issues, patient safety indicators, and retrospective studies to apply continuous quality improvement processes in application of evidence-based practice in care delivery, and other focused reviews.
- Oversight of Health Plan committee restructured.
- Oversight of Quality Improvement and Performance Improvement Plans.
- Patient safety assessment and focus on high reliability.
- Effective Pharmacy services.
- Policy and Procedure oversight and training.
- Preventive health services.
- Appropriate utilization of hospital admissions and minimizing unplanned hospital readmissions.
- Timely credentialing of providers and adequacy of the provider network.
- Appropriate Utilization Management (UM).

All participating providers must comply with CHRISTUS Health US Family Health Plan’s policies and procedures, including participating in and implementing Quality Management Projects, and partnering in Patient Safety Programs. This includes, but is not limited to, implementing activities necessary and expected to comply with external accreditation by the National Committee for Quality Assurance (NCQA), 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, as well as Medical Management and Quality Management Programs.

Reviews of the program are conducted periodically by an independent organization contracted by the Department of Defense. These reviews are conducted to ensure that the appropriateness of care, medical necessity, reasonableness of care, and intensity of services occurred. When requests for review are made, all clinical documentation is required. This includes all Utilization Management information as well as facility and physician records.

Provider's Role

Providers are expected to cooperate with CHRISTUS Health US Family Health Plan Quality Improvement, patient safety, and performance improvement activities to improve the quality of care, quality of service, and beneficiary experience. Providers are expected to allow the CHRISTUS Health US Family Health Plan to use performance data for quality improvement initiatives.

Examples of the provider's role in the CHRISTUS Health US Family Health Plan Quality Program include:

- Many providers are invited to participate in Quality Improvement Committees (QIC). Their perspective as participating providers is valuable in evaluating and improving clinical effectiveness, provider satisfaction, and beneficiaries' satisfaction. CHRISTUS Health US Family Health Plan also relies on participating providers to provide feedback on clinical practice guidelines, preventive health guidelines, medical policy, and pharmacy policy.
- Collaborate with the CHRISTUS Health US Family Health Plan to resolve beneficiary complaints regarding access to care, quality of care, provider service, or other issues upon request.
- Collect and share quality and performance data for joint quality initiatives.
- Participate in beneficiary satisfaction initiatives, including improving access to care.
- Provide feedback on the Plan via provider satisfaction surveys.
- Provide medical records as requested for HEDIS®, quality of care investigations, or other medical record audits.
- Review quality reports and act to improve clinical outcomes as measured by HEDIS.

- If you are interested in obtaining additional information about the Quality Improvement Program, including a copy of the full Quality Improvement Program description, please contact your provider network manager or reach out to CHRISTUS Health US Family Health Plan Quality team at USFHPsupport@christushealth.org.

Quality Referrals

Any stakeholder may refer a matter for review as a Potential Quality of Care Issue (PQI). A PQI is any suspected provider quality of care, documentation, or service issue that could impact the level of care provided to the beneficiary/patient. Providers may include independent physicians, medical groups, hospitals, other facilities (Ambulatory Surgery Centers, Inpatient Rehabilitation Facilities, Long Term Acute Care Hospitals, Skilled Nursing

Facilities, Home Health, etc.), nurses, ancillary providers, and their staff, and Health Plan staff.

The Director, USFHP Contract, Quality Program Manager, and/or Patient Safety RN, or designee, may refer cases to the Chief Medical Director for review and recommendation.

The Medical Director's review may result in such determinations as:

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

The Chief Medical Director or Medical Director will recommend action as appropriate to the event, in keeping with CHRISTUS Health US Family Health Plan's Quality Management Program, CHRISTUS Health US Family Health Plan policies and procedures, contractual requirements of the Plan, requirements under the terms of the Plan's contract with the Department of Defense, and other relevant federal, state, or local regulatory requirements.

Procedure for Investigating Potential Provider Quality Issues

Whenever a concern regarding the clinical quality of care and/or services provided is identified/reported, records and related reporting and correspondence are screened by the USFHP Contract/Quality Improvement Department. The concerns are forwarded to the Chief Medical Director or Medical Director for review and determination of any PQIs.

Summarization and review by the Peer Review Committee (PRC) for quality issue (QI) determination at its next regularly scheduled meeting. The PRC may accept the Chief Medical Director's assessment or Medical Director's assessment and follow-up actions, or it may recommend another course of action based upon the information presented.

If the PRC determines a PQI that was reviewed is not a quality issue, it is deemed No Quality Issue (No QI) with no corrective action taken. If upon PRC review, it is determined that the PQI is a confirmed QI, the PRC assigns a severity level of 1-4, with 4 being the most severe. When individual concerns represent a pattern of behavior, the Chief Medical Director or Medical Director informs the Credentialing Committee and Quality Improvement Committee (QIC).

Note: When a situation occurs that is deemed to pose an immediate threat to the health and safety of beneficiaries, the Chief Medical Director may, on behalf of CHRISTUS Health US Family Health Plan, the QIC, PRC, and the Credentialing Committee, act to immediately revoke, limit, or suspend the privileges of a participating provider. The affected provider is immediately notified, as are other affected parties (i.e., Provider Relations, Utilization Management, Quality Management, and Plan Administration). In such an event, the PRC is assembled at the earliest possible time to hear about the situation and support or override the Chief Medical Director's decision.

The sanctioning process of the CHRISTUS Health US Family Health Plan follows the Health Care Quality Improvement Act of 1986. CHRISTUS Health US Family Health Plan has a policy and process for conducting the required due process. The provider may request a copy of the policy at any time by contacting the Chief Medical Director and/or the Director USFHP Contract Quality Department.

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

As part of the contractual obligations to the DoD, CHRISTUS Health US Family Health Plan is committed to the principles contained in a document released on March 13, 1998, entitled "Quality First: Better Health Care for All Americans."

Developed by the Presidential Advisory Commission, this document recommends steps to provide a "national commitment to improving health care quality." The Commission's final report also included its recommendations for a Consumer Bill of Rights and Responsibilities in health care.

The Commission states a Consumer Bill of Rights and Responsibilities can help to establish a stronger relationship of trust among consumers, health care professionals, health care institutions, and health plans by helping sort out the responsibilities of each of these participants in a system promotes quality improvement. Providers desiring more information about the consumer's report, or the Consumer Bill of Rights and Responsibilities can access the documents online from the Commission's website, archive.ahrq.gov/hcqual.

Sentinel Event Review Process

CHRISTUS Health US Family Health Plan complies with the contractual requirements of sentinel event detection and reporting in accordance with the terms of its contract with the Department of Defense. CHRISTUS Health US Family Health Plan has a series of audit processes, screening elements and reporting procedures that facilitate the detection of sentinel events. When a sentinel event is identified to the CHRISTUS Health US Family Health Plan or by CHRISTUS Health US Family Health Plan, it is investigated in accordance with the standards as set forth in the National Quality Forum's Report on Sentinel Events.

A sentinel event is defined as any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Sentinel events are identified to aid in root cause analysis and to help develop preventative measures. CHRISTUS Health US Family Health Plan tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated.

CHRISTUS Health US Family Health Plan conducts its activities to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Quality Improvement Act of 1986. CHRISTUS Health US Family Health Plan retains the privilege of protection and confidentiality afforded under this act. Communication is point-to-point under the auspices of the QIC Committee and Quality Assurance Committee of Medical Staff. CHRISTUS Health US Family Health Plan requires that information provided in compliance with mandatory releases of information is not compromised the protected and privileged nature of the information.

National Disaster Medical System (NDMS)

All participating CHRISTUS Health US Family Health Plan acute-care, medical and/or surgical hospitals are encouraged to become beneficiaries of the National Disaster Medical System (NDMS). NDMS is a cooperative asset-sharing program among federal government agencies, state and local governments and private businesses with civilian volunteers to ensure resources are available to provide medical services following a disaster that overwhelms the local health care resources.

The NDMS is a federally coordinated system that augments the nation's emergency medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting state and local authorities in dealing with the health effects of major peacetime disasters and providing support to the military and Veterans Health Administration (VHA) medical systems in caring for casualties evacuated back to the US from overseas armed conflicts.

All information above is quoted from the National Disaster Medical System website, http://aspr.hhs.gov/NDMS/Pages/default.aspx.

Healthcare Effectiveness Data Information Set (HEDIS)

The Department of Defense requires CHRISTUS Health US Family Health Plan to report Healthcare Effectiveness Data Information Set (HEDIS®) measured annually. HEDIS is a set of standardized Quality Indicators that compare the performance of managed care plans in areas such as preventative screenings and chronic health care, which was 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 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 plan through claims or encounter data. Accurate timely claims encounter data and submission using appropriate CPT, ICD-10 (effective Oct. 1, 2015) and HCPCS codes reduce the necessity of medical record reviews.

Medical Record Reviews (MRR) for HEDIS

CHRISTUS Health US Family 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 patient's 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 the beneficiary. The MRR vendor will sign a HIPAA-compliant Business Associate Agreement with CHRISTUS Health US Family Health Plan, which allows them to collect PHI on our behalf.

Improving HEDIS Scores

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

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the USFHP Contract Quality Improvement Department via email, USFHPsuppport@christushealth.org.

Consumer Assessment of Health Plan Providers and Services (CAHPS) Survey

The CAHPS survey is a beneficiary care experience survey included as part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to beneficiaries by an NCQA certified survey vendor. The survey provides information on the experiences of beneficiaries with health plans and practitioner services. It also gives a general indication of how well CHRISTUS Health US Family Health Plan is meeting the beneficiaries' expectations. Beneficiaries' responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

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

1. In the last twelve (12) months, how often did you get an appointment for a check-up or routine care as soon as you needed?
2. In the last 12 months, how often did your personal doctor spend enough time with you?
3. In the last 12 months, how often did your personal doctor listen carefully to you?
4. In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?
5. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?
6. In the last 12 months, how often did your personal doctor seem informed and up to date about the care you got from these doctors or other health providers?
7. How likely are you to recommend your health plan to your family and friends, if they need health coverage?
8. In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

9. In the last 12 months, when you needed care for a behavioral health problem, how often did you get behavioral care as soon as you needed?

*Please note that changes may occur to NCQA standards during the annual review period.

Preventive Health Guidelines

The health plan uses the most current evidence-based criteria and clinical care guidelines to review all medical necessity requests, including the determination of the plan for discharge from all levels of care.MCG Health (MCG) and other specialty guidelines can be applied in a wide range of clinical settings and are used for making behavioral health and non-behavioral health utilization management determinations.

Process

- The MCG criteria and other evidence-based guidelines are used to assess the appropriateness of:
  - Acute care
  - Acute rehabilitation
  - Behavioral health
  - Long-term acute care
  - Sub-acute and skilled nursing facility
  - Home care
  - Durable medical equipment (DME)
  - Outpatient rehabilitation and chiropractic services
  - Outpatient services
  - Diagnostic imaging
- MCG criteria are an evidence-based first-level screening tool to assist in determining if the proposed services are clinically indicated and provided at the appropriate level of care.
- The medical and behavioral health medical directors, along with community physicians, may participate in the Health Plan's Physician Advisory, Medical Management, and/or Quality Improvement Committees.

Clinical Practice Guidelines

CHRISTUS prioritizes ensuring that beneficiaries receive high-quality care guided by evidence-based practices. To that end, MCG Health Care Guidelines make medical necessity determinations for healthcare services and supplies requested by providers. These guidelines provide decision-making support encompassing the entire care continuum from acute inpatient admission to the home setting for physical and behavioral health care conditions.

Although they are not explicitly used to make prior authorization determinations, CHRISTUS leverages the evidence-based information provided in the VA/DOD Clinical Practice Guidelines in the designing and planning phases of clinical and quality programs and initiatives, such as the Diabetes Depression Screening Initiative, Ambulatory Retrospective Review (Use of Imaging Studies for Low Back Pain (LBP)), and for condition-specific

educational presentations at Member Advisory Committee (MAC) meetings. The VA/DOD Clinical Practice Guidelines are available as an educational resource for beneficiaries and providers via the Member and Provider Resources tabs on the CHRISTUS USFHP website.

Claims and Appeals

Claim Submissions

Providers using electronic submission must submit all claims to CHRISTUS Health US Family Health Plan using the Health Insurance Portability and Accountability Act of 1996 (HIPPA) compliant 837 electronic format, or a CMS-1500 and/or UB-04. Claims must include the provider's NPI and the valid taxonomy code that most accurately describes the services reported on the claim. Providers must submit all claims, encounters, and clinical data to CHRISTUS Health US Family Health Plan by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by CHRISTUS Health US Family Health Plan, unless applicable law provides that submissions may be in a paper format.

Unless indicated otherwise by your agreement, clean claims are to:

- Be submitted electronically or by paper to the correct billing address as directed on the back of the beneficiary ID card.
- Be submitted within 365 days following the original date of service or date of discharge.
- Include AMA-developed procedural coding.
- Include ICD-10 diagnosis coding to the highest specification.
- Have charges listed on separate lines; Charges should always be itemized.
- Be submitted on original red and white CMS 1500 or UB-04 forms when filing paper claims (***Black and white copies or faxes are not accepted***).
- Not to be handwritten.

Claims Filing Deadlines

Providers are encouraged to submit claims immediately after services are rendered; however, unless otherwise stated in the provider participation agreement, all claims must be received within one (1) calendar year of the date of service or date of discharge for Inpatient facility claims. The timely filing deadline is calculated from the date of service to the date the claim is received by CHRISTUS Health US Family Health Plan. All claims received over the weekend or on a holiday are stamped with the date of the following business day.

Providers must claim benefits by sending CHRISTUS Health US Family Health Plan properly completed claim forms, itemizing the services or supplies received and the charges. The Plan is not liable for benefits if they do not receive the completed claim forms prior to the timely filing deadline acceptable.

Claims Corrections

Providers who believe they have submitted an incorrect or incomplete claim may submit an updated claim within the relevant timely filing. Corrected facility claims must include bill type code XX7. Corrected professional claims must include the resubmission code 7. Updated claim submissions that do not have these codes may be denied as duplicate submissions.

Claims Overpayments and Withholds

Should CHRISTUS Health US Family Health Plan determine that it has overpaid a claim, CHRISTUS Health US Family Health Plan will submit a written refund request to the provider.

This request will include the patient's name, date(s) of service, amount of overpayment, all interest and/or penalties associated with the overpayment, and an explanation of how CHRISTUS Health US Family Health Plan determined that an overpayment was made.

Upon receiving this request, the provider must issue the refund or submit a clear, written explanation of why the refund request is being contested within forty-five (45) calendar days of the date displayed on the notice of overpayment. If the provider contests the refund request, the provider must identify the portion of the overpayment that is being contested and the specific reasons for contesting the overpayment.

Providers should send refund checks or written notices contesting refund requests to:

CHRISTUS Health US Family Health Plan
Attn: Claims Recovery Unit
P.O. Box 169001
Irving, Texas 75016-9001

Should the provider fail to issue the refund or notify CHRISTUS Health US Family Health Plan of a contested overpayment within forty-five (45) calendar days, the amount of the overpayment may be deducted from future claim payments until the CHRISTUS Health US Family Health Plan has been fully reimbursed. A written explanation will accompany all deductions made from future claim payments.

The following allied health providers are required to bill under the supervising or employing physician:

- Anesthesiology Assistants (AA).
- Advance Practice Nurse (APN).
- Certified First Assistant (CFA.)
- Certified Surgical Assistants (CSA).
- Licensed Surgical Assistants (LSA).
- Physician Assistant (PA).
- Physician Assistant Certified (PAC).
- Registered Nurse (RN).
- Registered Nurse First Assistant (RNFA).

Accurate and Appropriate Claims

Submit claims for payment or reimbursement only for services rendered and make sure the claims submitted are for medically necessary services.

Submit claims for payment or reimbursement that are not knowingly false, fraudulent, or otherwise incorrect. CHRISTUS Health US Family Health Plan recommends providers establish an audit function to validate accuracy of claims submission.

Ensure all submitted claims are accurately coded, thoroughly documented, and filed in full compliance with applicable laws and regulations.

Questions Regarding Claims Payment

If you have questions regarding the payment of a claim, we can help. Contact Member Services at **800-678-7347**.

EDI Transactions

The Plan's EDI transactions are performed via the following clearinghouse:

- Availity

The following sections provide information regarding each type of transaction and what is required to perform these transactions with CHRISTUS Health US Family Health Plan. Contact your clearinghouse or billing entity to ensure you are set up to interact with Availity prior to performing any EDI transactions involving CHRISTUS Health US Family Health Plan.

Electronic Claims Submissions (837)

For submission of 837s, providers are to use:

Availity:

- Payor ID: 90551.

Providers should ensure they have a valid NPI on file with the Health Plan.

Electronic Provider Remittance Advice (835)

To receive electronic remittance advice (835) from Availity, providers need to contact Availity directly. If the provider is using a billing service or clearinghouse, the billing service or clearinghouse will need to contact Availity directly to set up 835 transactions.

Electronic Enrollment Status (270 | 271)

Providers do not need to contact CHRISTUS Health US Family Health Plan to be set up for this service. Providers only need to contact Availity and choose this transaction.

You will be able to obtain the following information electronically via Availity:

- Beneficiary Name.
- Subscriber ID.
- Address.
- Group | Plan | Product Number.
- Eligibility Time Limit.
- Status (Active or Inactive).
- DOB (Date of Birth).
- Insurance Type.
- Gender.
- Home Phone Number.
- Co-pay (Office and ER)
- Pharmacy (VytlOne) Contact Number.
- PCP Name.
- PCP NPI.
- PCP Contact Number.

Electronic Claim Status (276 | 277)

Providers can obtain electronic claims status (276 | 277) through Availity. Contact the health plan to ensure both NPI 1 and NPI 2 (if applicable) are captured in the plan's system.

You can obtain the following information via Availity:

- Beneficiary Name.
- Subscriber ID.
- Servicing Provider.
- Servicing Provider NPI.
- Date of Service (from and to).
- Claim Number.
- Check Date.
- Check Number.
- Total Claim Charge Amount.
- Total Claim Payment Amount.
- Claim Status (paid, pended, voided, etc.).

Should you have any questions regarding EDI transactions with CHRISTUS Health US Family Health Plan, please feel free to contact Availity directly.

Encounter Data

Participating providers must submit their encounter data monthly. Encounter data should be submitted on an original red and white CMS 1500 or UB-04 form. Faxes and black and white copies *are not permitted*.

Provider Grievance, Disputes, and Appeals

Grievance

A grievance is a written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, the Health Care Finder (HCF), or contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary.

Disputes

Disputes are disagreements between a network provider and the contractor concerning payment for services provided by the network provider and are not appealable per Tricare Operations Manual Chapter 12, section 3 Sub section 1.3.2.4 **Network Provider or Entity/Contractor Disputes**. Disputes include communications regarding TRICARE – determined allowable cost or charge for services or supplies.

All participating providers agree to comply with the plan's dispute resolution process by signing the provider agreement, including a dispute resolution clause. The provider Grievance and Appeal process is available to any participating provider to resolve disputes with CHRISTUS Health US Family Health Plan if they have prior approval from the beneficiary, as indicated by an executed Appointment of Representative (AOR).

Provider Appeals

A request for review of an initial determination is classified as Reconsideration. A request for review of a Reconsideration is considered an Appeal. Network providers, without the beneficiary's consent through the completion of a signed OAR, are not considered proper appealing parties per Tricare Operations Manual Chapter 12, Section 3 § 1.2 and as such are unable to submit requests for Reconsiderations or Appeals.

If a request for reconsideration or appeal is received from a person who is not authorized to participate in the appeal before the expiration of the appeal filing deadline, the request will be treated as routine correspondence. The proper appealing party will be notified in writing, with a copy of the improper appealing party enclosing a blank AOR. CH12 S 3 SS 1.2

Network providers, with beneficiary authorization through an AOR, have the right to request reconsiderations and appeals on behalf of the beneficiary.

Reconsideration and Appeals Process

Reconsideration and Appeals are separated into two categories, Factual Determinations and Medical Necessity Determinations. Factual Determinations are issued in cases involving coverage issues, provider authorization (status) requests, hospice care, and/or foreign claims. Medical Necessity determinations are based on medical necessity, appropriate level of care, custodial care, or other reason relative solely to reasonableness, necessity, or appropriateness. Pharmaceuticals prescribed outside the guidelines issued by the Department of Defense Pharmacy and Therapeutics (DoD P&T) Committee are not considered a medical necessity determination.
If a beneficiary disagrees with an initial Factual or Medical Necessity Determination, the beneficiary or the beneficiary's designee may request a Reconsideration of the initial

determination. Instructions on how and where to submit a request will be provided on the denial (resolution) letter and/or EOB.

- The request must be in writing and must be submitted to CHRISTUS Health US Family Health Plan within ninety (90) calendar days (or 72 hours for concurrent/expedited) of the initial denial or issuance of the EOB. The request should include all necessary supporting documentation. Any costs incurred in providing documentation will not be reimbursed by CHRISTUS Health US Family Health Plan.
- The beneficiary will receive an acknowledgment of receipt of the request for Reconsideration or Appeal.
- Reconsiderations and Appeals will be processed within thirty (30) calendar days, including a resolution letter describing how the appeal was resolved and the basis for the resolution.
- Please note providers cannot appeal to the rules and regulations of the Plan or TRICARE policy but may send a grievance if they think an error in the interpretation of the policy has occurred.
- Grievances are handled similarly to appeals.
- Denials are always communicated in writing.
- Second level medical necessity appeals are reviewed by an independent clinical provider in a similar specialty who has not previously reviewed the case.

Appeal Rights

If the beneficiary or the beneficiary's representative is not satisfied with the Appeal determination, he or she may appeal in writing to TRICARE Quality Monitoring Contractor (TQMC), DHA. The request for appeal review must be filed within ninety (90) calendar days from the date of the determination.

Deloitte
Attn: TQMC Appeals
1919 N Lynn Street
Arlington VA 22209
E-mail: tqmc@deloitte.com
Fax: 1-866-420-2852

Appeal Process

Level 1 Reconsideration of Initial Denial Determination	Written requests for reconsideration may be submitted by the beneficiary or beneficiary's representative within the following time limits: • Concurrent review request for reconsideration must be submitted by noon (12 p.m.) of the day after receipt of the initial denial determination. • Expedited reconsideration of a preadmission | pre-procedure denial must be filed within three (3) calendar days after the date of the receipt of the denial determination. • All other requests for reconsideration must be filed within ninety (90) days after the date of the initial denial determination. All appeals should be in writing.
Level 2 Appeal	The TRICARE Quality Monitoring Contractor (TQMC) is responsible for reviewing requests (Level 2 Appeals) when a contractor upholds an initial determination upon reconsideration. The TQMC will decide of the reconsideration request within the following time limits: • Three (3) working days for expedited appeals by a beneficiary. Thirty (30) days after receipt of the required documentation for review of an appeal not identified as an expedited reconsideration. The TQMC will notify all parties of the determination of appeal of US Family Health Plan's reconsideration.

All appeals for reconsideration of the decisions made by TQMC are final and binding.

All appeals should be sent, in writing, to the following:

By Mail: CHRISTUS Health US Family Health Plan
Attn: Appeals Department
P.O. Box 169009
Irving TX 75016

By Fax: CHRISTUS Health US Family Health Plan
Attn: Medical Appeals
Fax: 866-416-2840

By Email: CHRISTUSCAG@christushealth.org

Compliance

As an affiliate of CHRISTUS Health and as a contracted provider for the Department of Defense (DoD), the US Family Health Plan adheres to a corporate strategy that underlines its commitment to health care integrity. USFHP is responsible for ensuring that medically necessary services are provided only to eligible beneficiaries by authorized providers under existing law, regulation, and Defense Health Agency (DHA) instructions. Furthermore, USFHP is responsible for evaluating quality care and ensuring that payment is made for care in keeping with accepted standards of medical practice.

US Family Health Plan is dedicated to the CHRISTUS Health "Core Values" of Dignity, Integrity, Excellence, Compassion, and Stewardship, and we hold contracted physicians and providers to the same standards. As a participating provider in USFHP, 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 beneficiaries by performing duties to the best of their abilities.
- Attempt to anticipate and understand the beneficiaries' needs while meeting their expectations.
- Employ professionals with proper credentials and recognize beneficiaries 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 beneficiaries and organizational data, records, and reports accurately and truthfully, and adhere to applicable standards in maintaining all records.
- Strive to maintain complete and accurate medical records of each beneficiary and protect this information from breach of confidentiality or loss.

Ethical Practices

- Not mislead beneficiaries or the public or cause them to request services they do not need.
- Treat all beneficiaries with dignity, respect, and compassion.
- Respect and support the rights of all beneficiaries.

Respect and support the rights of all CHRISTUS Health US Family Health Plan associates by ensuring a zero-balance policy toward any potential beneficiary 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 beneficiary and family so that informed consent 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 US Family Health Plan maintains a risk management program designed to protect the life and welfare of beneficiaries 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 beneficiary safety and other critical issues.
- Policies and procedures regarding a beneficiary being refused care or dismissed from care, and the management of impaired healthcare professionals.
- Procedures to report and analyze beneficiary 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 healthcare professionals.
- Review of beneficiary 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.

Program Integrity

Preventing Identity Theft and Protecting Personal Health Information

Follow these "Best Practices" to protect your identity, personal health information, and financial information.

1) Phone Calls: Never share your Personal Health Information, such as your ID number, especially over the phone, unless you are certain the caller is a legitimate healthcare professional. Limit the information you provide, using only the minimum necessary information. Unless you are completely certain, a "Best Practice" is to take down the caller's name, phone number, name of the business, and return the call after you verify the information. Only answer health related questions.

2) Verification of the Caller's Identity: Ask the caller for the address where they are located, which should match a familiar location. Ask the caller for their supervisor's name. The information the caller provides can be verified by a) recognizing the phone number, b) performing a Google search on the phone number and business name, c) calling the main number of the business and then being transferred to the original caller.

3) Ask Questions: Ask Questions before you provide your personal information. Ask the caller to send you an email requesting the information needed, but do not reply. At a minimum, ask the caller to provide you with their email address. The email address should end with a recognizable healthcare business name, such as "@CHRISTUSHealth.org." If a caller is rushing you, sounds agitated, frustrated, or you feel uncomfortable in any way, immediately terminate the call.

4) Payments by Phone: Did you have the treatment for which the caller is requesting payment? If the caller is a bill collector, ask them to mail you full information about the bill, which they are required to do. Call Member Services or the Special Investigations Unit for assistance, to confirm the bill is legitimate. Avoid making payments by phone, giving out a credit card number, or any banking information. Make the payment online via the business website, to confirm legitimacy. If you do make a payment by phone, a credit card is the best way, since most cards have 100% fraud protection, and no funds will be removed from your checking account. Avoid giving out a combination of information so someone can commit identity theft, i.e., Driver's license number, home address, Social Security number, banking information, credit card numbers with the 3-digit code on the back of the card, or family member's name.

5) If Identity Theft Occurs: Call the three credit reporting bureaus and inform them of the identity theft. Transunion, Experian, and Equifax, the three bureaus, will provide protections to prevent unauthorized credit accounts opened in your name. Call your bank and other financial institutions to inform and seek guidance.

***Reporting Unusual Treatment or Billing*:** Please make a report to the Special Investigations Unit, if any unusual or suspicious health care-related activity occurs, i.e., you receive a bill for treatment you did not receive, someone else used your ID to seek treatment, a Provider performs unauthorized treatment, or medically unnecessary equipment. The CHP Special Investigations Unit (SIU) promptly and thoroughly investigates all reports of fraud, waste, and abuse to detect if non-compliance is occurring. Please report any non-compliance. If preferred, you may remain anonymous. The options for reporting are:

- FWA HOT LINE: 855-771-8072
- CHRISTUS Health Plan Main Phone: 469-282-2000
- Dedicated email: CHRISTUSHealthPlanSIU@CHRISTUSHealth.org
- Secure Fax: 210-766-8849
- Mail to: CHRISTUS Health Plan
  Attn: Special Investigations Unit
  5101 N. O'Connor Blvd.
  Irving, TX 75039

Fraud, Waste, and Abuse (FWA) – Detection and Investigation

Detection: Governing agencies and regulatory bodies require that CHP endeavors to detect fraud, waste, and abuse involving Providers or Beneficiaries within the health plan network. The CHP Special Investigations Unit (SIU) monitors, reviews, and analyzes claims activity to verify compliance with regulatory standards. To advocate for the highest and best health care for Beneficiaries, 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. If these standards are not followed, there is a higher likelihood of an unfavorable impact on Beneficiaries, generating preventable health care costs, and the possibility that a report will be made to the Special Investigations Unit.

Special Investigations Unit (SIU): The SIU promptly and thoroughly investigates all reports of fraud, waste, and abuse to detect if non-compliance is occurring by Beneficiaries or Providers. Beneficiaries must never misuse their benefits, such as loaning their Beneficiary ID or card to anyone or receiving medical unnecessary treatment for compensation from a dishonest Provider. When any non-compliance is confirmed, a referral is sent to the law enforcement, governing agencies, regulatory officials. The SIU performs data analysis, medical record reviews, conducts personal interviews, performs audits, collaborates with healthcare Providers to detect Fraud, Waste or Abuse. As required by regulatory agencies, CHRISTUS Health US Family Health Plan makes reports to and cooperates with federal, state, and local law enforcement.

Examples: Below are several examples of non-compliance, which may be considered fraud, waste, or abuse.

Claims For:	Description of Non-Compliance
1) Unnecessary Treatment:	Beneficiary knowingly seeks & receives medically necessary treatment or equipment
2) Cash for Treatment:	Accepting cash, gift cards, or other benefits in exchange for unnecessary treatment
3) Misuse of Beneficiary ID:	Selling, loaning out, or borrowing a Beneficiary ID, for unauthorized use
4) Caravan Care:	Joining a group transported to one or more Providers for unnecessary treatment
5) Over-utilization:	Treatment that is not necessary to the extent rendered
6) Overcharging:	Using an unneeded item or service priced unusually high or unreasonable
7) Non-Covered Services:	Receiving non-covered services and pretending they are covered
8) Non-Cooperation:	Refusal to furnish or allow access to records or being uncooperative
9) Unauthorized Services:	Receiving unnecessary equipment, supplies, and services not specifically prescribed
10) Repetitive Billing:	Receiving ongoing, unnecessary treatment or equipment

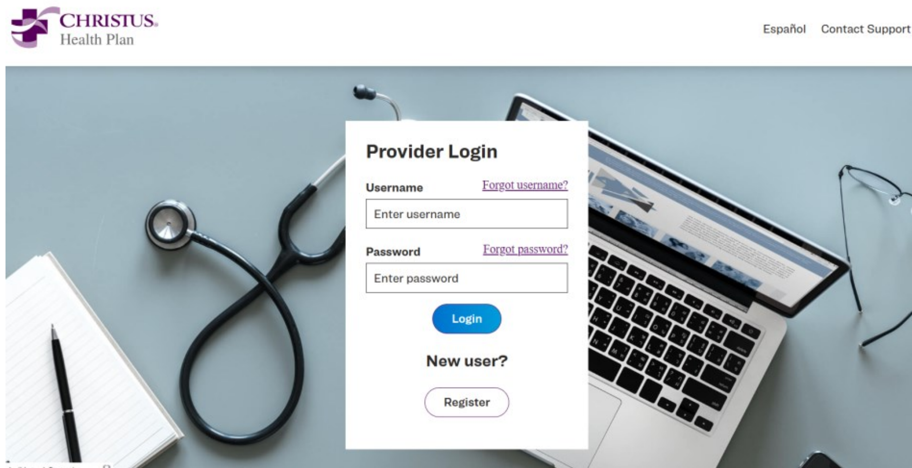
Enforcement

To comply with Federal Agency requirements, all laws, and statutes, CHRISTUS Health US Family Health Plan monitors beneficiary claims activity and reports non-compliance to authorities as appropriate authorities.

Provider Resources

The Provider Portal can be found online at https://christushealthprovider.healthtrioconnect.com

Click on register and sign up for the portal.



New User – Administrator Login

The first person who 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 Guide
- Referrals & Authorizations
- Appeals & Grievances

Definitions

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

Access Standards:
Preferred Provider Networks (PPMs) will have attributes of size composition, mix of providers and geographical distribution so that the networks, coupled with the Military Treatment Facility (MTF) capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander/eMSM Manager (or other authorized person) will ensure that the capabilities of the MTF plus PPN will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

1. Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to the primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

2. The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall not exceed 24 hours.

3. Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers within the service area 24 hours a day, seven days a week.

4. The network shall include enough board-certified specialists to meet the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services. Program.

5. Office waiting times in nonemergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

Advance Directive: A statement executed by a person while of sound mind as to that 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.

Adverse Determination: A determination by a Health Maintenance Organization (HMO) or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate. The adverse determination, i.e., denial of a requested covered service, including type or level of service, which includes:

- Denial in whole for a service.

Denial in part of a service, i.e., has been limited, reduced, suspended, or terminated.

- Denial in whole or in part of payment for a covered service.
- Failure by the health plan to provide a service timely as defined by federal and/or state regulations.
- Failure to act within time limits for the health plan's Prior Authorization review process.

Allowable Charge: The TRICARE determined the level of payment to institutions, physicians, and other categories of individual professional providers based on one of the approved reimbursement methods set forth in 32 CFR 199.14.

Appeal: A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact. See 32 CFR 199.10 and Chapter 12.

Balance Billing: A provider seeking any payment, other than any payment relating to applicable deductible and cost-sharing amounts, from a beneficiary for TRICARE covered services for any amount more than the applicable TRICARE allowable cost of charge.

Beneficiary: An individual affiliated with a Service, either an active-duty member, reserve beneficiary, an active-duty retired beneficiary, or a retired reserve beneficiary. A beneficiary is an individual eligible for benefits. The beneficiary, Sponsor, or representative of the beneficiary, including the parent of a beneficiary under 18 years of age, the beneficiary's attorney, legal guardian, or representative specifically designated by the beneficiary, may on his or her behalf, regarding the benefit at issue. An individual who is subject to the conflict-of-interest provisions of 32 CFR 199.10(a)(2)(i)(B) may not act as the beneficiary's representative under this section.

Beneficiary: An individual:

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

Beneficiary ID Card: Identification card issued to beneficiaries upon enrollment in a health plan.

Beneficiaries: In a retired status, are not former beneficiaries. Also referred to as the sponsor.

Benefit: Services, supplies, payment amounts, cost-shares, and copayments authorized by Public Law (PL) 89-614, 32 CFR 199, and outlined in the TPM and the TRM.

Case Management (Defined in 32 CFR 199.2): A collaborative process which assesses,

plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, including mental health and substance use disorder needs, using communication and available resources to promote quality, cost effective outcomes.

Catastrophic Cap: The National Defense Authorization Act (NDAA) for Fiscal Years (FYs) 1988 and 1989 (Public Law 100-180) amended Title 10, USC, and established catastrophic loss protection for TRICARE beneficiary families on a government fiscal year basis. The law placed fiscal year limits or catastrophic caps on beneficiary liabilities for deductibles and cost-shares under the TRICARE Basic Program. Specific guidance may be found in the TRM, Chapter 2, Section 2. NDAA for FY 2017 amended Title 10, USC to change calculations to a calendar year basis, beginning January 1, 2018. The last quarter of calendar year 2017 was applied to the FY 2017 calculations to bridge the gap.
Claim: Any request for reimbursement for health care services rendered, received from a beneficiary, a beneficiary's representative, or a network or non-network provider, by a contractor on any TRICARE-approved claim for, or approved electronic medium.

Note: If two or more forms for the same beneficiary are submitted together, they shall constitute one claim unless they qualify for separate processing under the claims splitting rules. (It is recognized that services may be provided in situations in which no claims, as defined here, are generated. This does not relieve the contractor from collecting the data necessary to fulfill the requirements of the TED record for all care provided under the contract.)

Note: Any request for reimbursement of a dispensed pharmaceutical agent or diabetic supply item. For electronic media claims, one prescription equals one claim. For paper claims, reimbursement for multiple prescriptions may be requested on a single paper claim.

Clean Claim: A claim submitted by a provider for medical care or health care services rendered to a beneficiary, with the data necessary for the 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 management 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 beneficiaries.

Coinsurance: A percentage of costs for a covered benefit the beneficiary pays after the deductible is met.

Complaint (Grievance): Any dispute or expressed level of dissatisfaction, either verbally or in writing, by a beneficiary or beneficiaries 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.

Continuity of Care: Follow up of health care services from a specific individual professional provider as part of a procedure or service performed within the previous six months to not disrupt therapy or repeat services.

Coordination of Benefits (COB): The coordination, on a primary or secondary payer basis, of the payment of benefits between two or more health care coverage to avoid duplication of benefit payments.

Copayment: An out-of-pocket dollar amount or percentage of charges a beneficiary pays to the provider for specified covered services.

Cost Share: The amount of money for which the beneficiary (or sponsor) is responsible in connection with otherwise covered inpatient and outpatient services (other than the annual deductible or disallowed amounts) as set forth in 32 CFR 199.4(f) and 32 CFR 199.5(b). Cost-sharing may also be referred to as "copayment."

Covered Services: Health care services and items a beneficiary is entitled to receive under their health plan.

Credentials Package: Information required for all clinical personnel supplied by the contractor who will be working in an MTF/eMSM. Similar information may be required for non-clinical personnel. Complete information shall contain the following:

1. All documents required per regulation/directive/instruction/policy are needed to verify that the individual is certified/authorized/qualified to provide the proposed services at the involved facility. This shall include licensure from the jurisdiction in which the individual will be practicing, and a National Practitioner Data Bank (NPDB) query as specified by the facility.

2. A completed Criminal History Background Check (CHBC), for all personnel required by law to have a CHBC prior to awarding of privileges or the delivery of services, within the following considerations:

- If a CHBC has been initiated, but not completed, the MTF Commander/eMSM Manager has the authority to allow awarding of privileges and initiation of services if delivered under clinical supervision.

- The mechanism for accomplishing the CHBC may vary between MTFs/eMSMs and should be determined during phase-in/transition and agreed to by the MTF Commander/eMSM Manager.

Regardless of the mechanism for initiating and completing a CHBC, the cost shall be borne by the contractor.

3. Medicare Provider ID number/National Provider Identifier (NPI) number.

4. Evidence of compliance (or scheduled compliance) with the MTF/eMSM specific requirements, including all local Employee Health Program (EHP), Federal Occupational Safety Act and Health Act (OSHA), and Bloodborne Pathogens Program (BBP) requirements.

Current Procedural Terminology (CPT): A manual that assigns five-digit codes to medical services and procedures to standardize claims processing and data analysis.

Deductible: Payment by the beneficiary of the first $50 of the CHAMPUS determined aggregate payment by two or more beneficiaries who submit claims for the first $100. Effective January 1, 2018.

Defense Enrollment Eligibility Reporting System (DEERS): An automated system maintained by the DoD for the purposes of:

1. Enrolling beneficiaries, former beneficiaries, and their dependents; and

3. Verifying beneficiaries, former beneficiaries, and their dependents' eligibility for health care benefits in the direct facilities and for TRICARE.

Department of Defense (DoD): An executive branch of the federal government charged with coordinating and supervising all agencies and functions of the government concerned directly with national security and the United States Armed Forces.

Dependent: A child or other person claimed by another for a personal tax exemption.

DoD Managed Care Contract: The contract between US Family Health Plan and the Department of Defense (DoD) under which certain covered services are to be provided to or arranged for beneficiaries.

Double Coverage (Denied in 32 CFR 199.2): When a TRICARE beneficiary also is enrolled in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's TRICARE benefits.

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

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 beneficiary's further deterioration. This equipment is designed for repeated use, is not useful in the absence of 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 beneficiary'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 beneficiary'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 Emergency Medical Condition.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his/her condition, sickness, or injury is of such a nature that failure to receive immediate medical attention could result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of pregnant women, serious jeopardy to the health of the fetus.

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

Explanation of Benefits (EOB): An electronic or paper document prepared by insurance carriers, health care organizations, and TRICARE contractors to inform beneficiaries of the actions taken regarding a claim for health care coverage.

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

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

Formulary: A list of prescription drugs chosen and covered by a health plan with prescription drug benefits. The DoD Pharmacy & Therapeutics (P&T) Committee (a body of military physicians and pharmacists) and approved by the Director of the Defense Health Agency (DHA) establishes a uniform formulary, which is a list of covered generic and brand name drugs. This formulary also contains a third tier of drugs that are non-formulary and a fourth tier of drugs that are non-covered. Prescriptions for non-formulary drugs are dispensed at a

higher copay. The formulary is updated quarterly.

Generic Drug: A drug with the same active-ingredient formula as a brand name drug without a trademarked name. Generic drugs usually cost less than brand name drugs.

Grievance: A written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, the Health Care Finder (HCF), or contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary. Health Employer 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 information 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).

Home Health Care: A home health agency is 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 beneficiaries upon receiving prior orders by the attending physician and authorization by the UM and/or CM Department. Requests for continuation of services will be reviewed on an ongoing basis to determine medical necessity. Custodial care is a non-covered benefit.

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

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 patients into diagnosis related groups (DRGs), prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

In-network: Care received from a participating provider.

Inpatient: A patient who is admitted to a hospital that requires 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 will be paid for each loss and for all losses, and under what conditions.

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

Living Will: 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 patient proves 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.

Mail Order Pharmacy: A pharmacy that delivers drugs to patients through the mail directly to their homes, rather than requiring patients to show up at the pharmacy to pick up prescriptions.

Maximum Allowable Prevailing Charge: The TRICARE state prevailing charges adjusted by the Medicare Economic Index (MEI) according to the methodology as set forth in Chapter 16.

Medical Necessity: Services that are sufficient in amount, duration, and scope to achieve their purpose are in accordance with accepted standards of practice in the medical community of the area in which the services are rendered and are furnished in the most appropriate setting. A service is medically necessary when it (1) prevents, diagnoses, or treats a physical or behavioral health injury; (2) is necessary to achieve age-appropriate growth and development; (3) minimizes the progress of disability; or (4) is necessary to attain, maintain, or regain functional capacity. A service is not considered reasonable and medically necessary if it can be omitted without adversely affecting the beneficiary's condition or the quality of medical care rendered.

Medical Management and Quality Improvement Committees: Contemporary practices in areas such as Utilization Management (UM), Case Management (CM), care coordination, chronic care/Disease Management (DM), and the various additional terms and models for managing the clinical and social needs of eligible beneficiaries to achieve the short- and long-term cost-effectiveness of the MHS while achieving the highest level of satisfaction among MHS beneficiaries Health US Family Health Plan.

Medical Review Provider: Medical Director, Chief Medical Officer or delegated provider who determines benefit coverage for requests that do not meet medical necessity criteria.

Medicare: The medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), Medicare Bureau.
Beneficiary: An individual affiliated with a Service, either an active-duty member, reserve member, active-duty retired member, or retired reserve member. Beneficiaries in a retired status are not former beneficiaries. Also referred to as the sponsor.

Beneficiary: An individual:

- Who meets each of the enrollment and eligibility requirements described in this

manual?

- Who has been properly enrolled in coverage with CHRISTUS Health US Family Health Plan?
- for whom CHRISTUS Health US Family Health Plan has received any required premium for the enrolled coverage.

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

National Provider Identifier (NPI): A 10-digit number assigned to all HCPs mandated by HIPPA of 1996. These numbers are to be used for all financial and administrative transactions. The 10-digit number, containing checksum, prevents technical errors during data transmission. The number does not have built-in correlation with any other identifier associated with the provider.

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

Network Provider: An individual or institutional provider that has contracted with a TRICARE contractor to provide care to TRICARE eligible beneficiaries, usually at a discounted rate.

Non-Participating Provider: A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized that furnished medical services or supplies to a TRICARE beneficiary, but who did not agree on the TRICARE claim form to participate or to accept the TRICARE-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider.

Nurse Practitioner: An Advanced Practice Registered Nurse (RN) who has additional responsibilities for administering patient care compared to other 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 Obstetricians and Gynecologists.

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

Outpatient: Services that do not necessitate 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 services in an emergency room regardless of whether the beneficiary is admitted as an Inpatient in a hospital.

Participating Provider: A TRICARE authorized that is required or has agreed by entering into a

TRICARE participation agreement or by an act of indicating “accept assignment” on the TRICARE claim form to accept the TRICARE-allowable amount as the maximum total charge for a service or item rendered to a TRICARE beneficiary, whether the amount is paid for fully by TRICARE or requires cost-sharing by the TRICARE beneficiary.

Note: This is another term for a non-network provider previously defined in this section.

Peer Review Committee: A committee of health care providers, which has the following functions:

- **Evaluates or improves the quality of health care rendered by providers.**
- **Determines whether rendered health care services were performed in compliance with the applicable standards of care.**
- **Determines whether the cost of the health care services performed was following the applicable standards of care.**
- **Determining the cost of the health care services rendered was considered reasonable by the providers of health services in the area.**

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 must be 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 patient education and training.

Physician Assistant: A person who has graduated from a nationally recognized physician assistant or assistant surgeon program; or who is 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 US Family Health Plan and selected by the beneficiary to provide health care services to beneficiaries, as it exists on the effective date of this policy or as subsequently amended as provided herein.

Potential Quality Issue (PQI): Any suspected provider quality of care or service issue that could impact the level of care provided to the enrollee/patient.

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

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

Prescription Drugs: A legal order from an authorized prescriber to dispense pharmaceuticals or other authorized supplies.

Preventive Care (Defined in 32 CFR 199.2): Diagnostic and other medical procedures not related directly to a specific illness, injury or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Care Manager (PCM): An HCP a patient sees first for their health care needs responsible for providing and coordinating the patient's care, maintaining the patient 's health record and when necessary, refers the patient for specialty care.

Protected Health Information (PHI):

1. IIHI that is:
    a. Transmitted by electronic media.
    b. Maintained in electronic medical.
    c. Transmitted or maintained in any other form or medium.

Note: Sometimes referred to as Electronic Protected Health Information (ePHI).

2. PHI excludes IIHI in:
    a. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g;
    b. Records described at 20USC 1232g(a)(4)(B)(iv); and
    c. Employment records held by a covered entity in its role as an employer.
    d. Regarding a person who has been deceased for more than 50 years.

Note: As defined in HIPAA of 1996.

Provider (Defined in 32 CFR 199.2): A hospital or other institutional provider, a physician or other individual professional provider, or other provider of services or supplies in accordance with 32 CFR 199.6.

Provider Agreement: A legal agreement between a payor and a subscribing group or individual, which specifies rates, performance covenants, 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 group of HCPs with which a managed care contractor has made contractual or other arrangements to provide health care at a discounted rate.

Quality Improvement (QI) Program: An approach to quality management that builds upon traditional quality assurance methods by emphasizing:

The organization and systems (rather than individuals).

1. The need for objective data with which to analyze and improve processes.

2. The idea that system and performance can always improve even when high standards appear to have been met.

Sentinel Event: Defined by American health care accreditation organization The Joint Commission (TJC) as any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Sentinel events are identified under TJC accreditation policies to aid in root cause analysis and to help develop preventative measures. The Joint Commission tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated.

Service Area: A geographic area approved by the DoD, within which an eligible individual (and any dependents) may enroll in the US Family Health Plan.

Skilled Nursing Facility (SNF): A place that:

1) Skilled nursing services includes application of professional nursing services and skills by and Registered Nurse (RN), Licensed Practical Nurse (LPRN), or Licensed Vocational Nurse (LVN) that are required to be performed under the general supervision/direction of a TRICARE authorized physician to ensure the safety of the patient and achieve the medically desired result in accordance with accepted standards of practice.

Note: Skilled nursing services are other than those services that provide primarily support for the Activities of Daily Living (ADL) or that could be performed by an untrained adult with minimum instruction or supervision.

Summary Health Information (HIPAA Definition of 1996): Information that may be IIHI and:
1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan.

2. From which the information has been deleted, except that the geographic information may be aggregated to the level of a five-digit zip code.

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 beneficiaries 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 beneficiaries to try another drug to treat the medical condition before the Plan will cover the drug the physician may have initially prescribed.

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: An easy-to-read summary that lets potential beneficiaries make apples-to-apples comparisons of costs and coverage between health plans. Prospective beneficiaries can compare options based on price, benefits, and other features that may be important to them.

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 by which a business or entity is identified for filing and paying taxes related to the business or entity.

Termination: The removal of a provider as an authorized TRICARE provider based on a finding that the provider does not meet the qualifications established by 32 CFR 199.6 to be an authorized TRICARE provider. This includes those categories of providers who have a signed specific participation agreement.

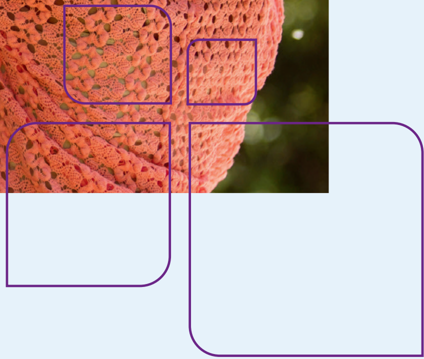
Third-Party Liability: Recovery The recovery by the Government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries of illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third-party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners' insurance) covering the liable third-party. TPL recoveries are made under the authority of the FMCRA (42 USC paragraph 2651 et sec). Other potential sources of recovery in favor of the Government in TPL situations include no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers' compensation plans. Recoveries from such other sources are made under the authority of 10 USC paragraphs 10790, 1086(g), and 1095(b.)

TRICARE: The DoD's managed health care program for Service beneficiaries and their families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's DC system of hospitals and clinics and civilian providers. Through December 31, 2017, TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions in this section and in 32 CFR 199.17). Beginning January 1, 2018, TRICARE offers three options: TRICARE Prime, TRICARE Select, and TRICARE For Life (TFL) (see definitions in this appendix and in 32 CFR 199.2).

Urgent Care: Medically necessary treatment required for a sudden illness or injury, not life-threatening but requiring immediate professional attention to avoid further complications

resulting from non-treatment. Treatment is usually performed outside an Emergency Room (ER) setting.

Utilization Management: A set of techniques used to manage health care costs by influencing patient care decision-making through case-by-case assessment of the appropriateness and medical necessity of care either before, during, or after provision of care. Utilization management also includes the systematic evaluation of individual and group utilization patterns to determine the effectiveness of the employed utilization management techniques and to develop modifications to the utilization management system designed to address aberrancies identified through the evaluation.



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