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# **CHRISTUS Health Plan**

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**2018**

**TEXAS**  
**Health Insurance Exchange**  
**PROVIDER MANUAL**

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## CHRISTUS HEALTH PLAN IMPORTANT PHONE NUMBERS AND ADDRESSES TEXAS EXCHANGE

MEMBER SERVICES	1-844- 282-3025 Fax: 1-210-766-8851
PROVIDER SERVICES	1-844-282-3025 Fax: 1-210-766-8851
CLAIM RESOLUTION	1-844-282-3100
UTILIZATION MANAGEMENT	1-844-282-3025 Fax: 1-800- 277-4926
PHARMACY/FORMULARY	ESI: Helpdesk: 1-844-470-1531
BEHAVIORAL HEALTH	CHRISTUS Health 1-800-323-0208
FAMILY PLANNING	HealthSmart 1-855-596-6740
DENTAL	DentaQuest Member Services: 1-855-343-7343 Provider Services: 1-855-343-4276
VISION	Superior Block Member Services: 1-800-879-6901 Provider Services: 1-866-819-4298
24 HOUR NURSE LINE	1-844-581-3175
CLAIMS BILLING ADDRESS	Refer to: P.O. Box 981654 El Paso, TX 79998
WEBSITE	<a href="http://www.christushealthplan.org">http://www.christushealthplan.org</a>

# WELCOME TO CHRISTUS HEALTH PLAN

Welcome to CHRISTUS Health Plan!

We are delighted you have chosen to become a participating provider with CHRISTUS Health Plan. We view you as our partner in providing high quality, affordable healthcare to our Members.

CHRISTUS Health Plan, headquartered in Irving, Texas, is a health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. CHRISTUS Health is taking its experience and success in the military plan and Medicaid plan and is expanding its product services and creating a footprint in the Healthcare Insurance Exchange in the state of Texas. Central to its business model is the movement to population based care.

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

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

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

This provider manual furnishes participating Providers and their office staff with important information concerning CHRISTUS Health Plan policies and procedures, claim submission, adjudication requirements, and guidelines used to administer CHRISTUS Health Plans. This manual replaces and supersedes any and all other previous versions and is available at <http://www.christushealthplan.org>.

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

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

- A listing of all individuals or entities that are party to the written agreement
- Conditions for participation as a contracted provider
- Obligations and responsibilities of the organization and the participating provider, including any obligations for the participating provider to participate in the organization's management, complaint process, or other programs
- Events that may result in the reduction, suspension, or termination of network participation privileges
- The circumstances under which the network may require access to consumers' medical records as part of the organization's programs or health benefits
- Health care services to be provided and any related restrictions
- Requirements for claims submission and any restrictions on billing of consumers
- Participating provider payment methodology and fees
- Mechanisms for dispute resolution by participating providers
- Term of the contract and procedures for terminating the contract
- Requirements with respect to preserving the confidentiality of patient health information
- Prohibitions regarding discrimination against consumers

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

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied upon as such. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by CHRISTUS Health Plan at any time upon notice to the provider. The most up-to-date version of the Provider Manual is located on the Plan's website at <http://www.christushealthplan.org>. All terms and statements used in this manual will have the meaning ascribed to them by CHRISTUS Health Plan and shall be interpreted by CHRISTUS Health Plan in its sole discretion.



# PROVIDER PARTICIPATING REQUIREMENTS

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

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

## PRACTITIONER PARTICIPATION CRITERIA

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

## FACILITY PARTICIPATION CRITERIA\*\*

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

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

## PROVIDER, FACILITY AND ANCILLARY CONTRACTUAL REQUIREMENTS

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

- Provide continuous 24-hour, 7 day a week access to care
- Utilize CHRISTUS Health Plan participating providers and facilities when services are available and can meet the patient's needs
- Not discriminate on the basis of age, sex, handicap, race, color, religion or national origin
- Accept patients transferring from out-of-network care to in-network facilities
- Not balance bill a member for providing services that are covered by CHRISTUS Health Plan. Providers may only bill members for applicable deductibles, co-payments, and/or cost-sharing amounts
- Providers may bill a member for a service or procedure that is not a covered benefit after securing written consent.
- Prepare and complete medical and other related records in a timely fashion and maintain contemporaneous clinical records 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 clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the member's PCP promptly upon a members visit with a specialist.
- Maintain medical records for six (6) years from the last date in which service was provided to the member.
- Transfer medical records promptly if requested by a treating provider, after a member changes to another Provider.
- Allow access to medical records for review by appropriate committees of the CHRISTUS Health Plan and, upon request, provide the medical records to representatives of the Federal Government and/or their contracted agencies
- Inform the CHRISTUS Health Plan immediately, in writing, of any revocation or suspension of the provider's Drug Enforcement Agency (DEA) number, certificate or other legal credential authorizing the provider to practice in the state of New Mexico, or any other state. Failure to comply with the above could result in termination from the Plan.
- Inform the CHRISTUS Health Plan immediately, in writing, of changes in licensure and participating hospital status, loss of liability insurance, and any other change, which would affect a provider's practicing status.
- Participate in CHRISTUS Health Plan's quality improvement, utilization management, credentialing, peer review, grievance, other policies and procedures established and revised by CHRISTUS Health Plan which also includes participation in evidence-based patient safety programs
- Abide by the CHRISTUS Health Plan rules and regulations.

## PROVIDER RIGHTS

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

- Ask to have any adjudicated claim reconsidered if they feel it was not paid appropriately
- Appeal any action taken by CHRISTUS Health Plan that affects their status with the network and/or that is related to professional competency or conduct
- Request that the CHRISTUS Health Plan remove a member from their care if an acceptable patient-provider relationship cannot be established with a CHRISTUS Health Plan member who has selected them as his/her provider
- Request to serve on the Quality Improvement Committee or other committees that may be formed by CHRISTUS Health Plan
- Provide feedback and suggestions on how service may be improved for providers and for members through written correspondence, the Health Plan's annual Provider Satisfaction Survey, or via the Physician Advisory Committee

## PROVIDER RESPONSIBILITIES

### Appointment Availability and Wait Times

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

## TEXAS HEALTHCARE INSURANCE EXCHANGE APPOINTMENT STANDARDS

Appointment Type	Access Standard
PCPs – Routine visits	Three weeks
Preventive Care or Periodic Health Evaluation	4 months
Behavioral Health – Routine visits Specialist	10 business days Routine Specialty care referral within three weeks
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	24 hours
Emergency Providers	Upon arrival, including at non-network and out-of-area facilities
Behavioral Health Non-Life Threatening Emergency	Within six hours

## TRAVEL DISTANCE and ACCESS STANDARDS

CHP maintains a provider network in accordance with regulations regarding provider ratios and monitors the adequacy of the network to ensure provision of quality care and services to its members. The number, type and distribution of practitioners, pharmacies, and ancillary services are monitored on an ongoing basis to ensure the network is sufficient to meet the needs of members. Evaluations of network availability may include but, are not limited to, geographic distribution analysis, member-to-provider ratios, member and provider satisfaction surveys, and analysis of member grievance information. Providers must offer and provide CHP members appointments and wait times comparable to that offered and provided to other commercial members. CHP routinely monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

## Authorizing an Out-of-Network Provider

If it is determined that CHP does not have an in-network provider with the appropriate training and experience needed to treat a member's condition, CHP will approve an out-of-network authorization. Requests for out-of-network authorizations may be made by an in-network provider.

Please note: approvals will not be made on the basis of convenience for either a member or a provider, and CHP may not approve the particular out-of-network provider requested. If CHP approves the authorization, all services performed by the out-of-network provider are subject to a treatment plan approved by CHP in consultation with the member, the member's PCP, and the out-of-network provider. All services rendered by the out-of-network provider will be paid as if they were provided by an in-network provider, and members are responsible for any applicable in-network cost-sharing. In the event that CHP does not approve an authorization, any services rendered by the out-of-network provider will not be covered.

## COVERING PROVIDERS

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. In the event of unscheduled time off, the provider must notify the Provider Services department of coverage arrangements as soon as possible. For scheduled time off, the provider must notify the Provider Services department prior to the scheduled time off. The provider who engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the CHP fee schedule in such provider's agreement.

## Transitional Care

CHP understands that when providers leave or are terminated from the plan, members may require coverage for a period of time to ensure continuity of treatment. As such, members who are being treated by a provider whose contracted status has been terminated may be able to continue ongoing treatment for covered services for up to 90 days after the effective date of termination. In addition, pregnant members in their second or third trimester may be able to continue care with a former in-network provider through delivery and any postpartum care directly related to the delivery. Please note, members must contact Member Services to request this continuity of care and it must be authorized prior to service. Formerly in-network providers must agree to accept as payment the negotiated fee that was in effect just prior to the termination. Additionally, the provider must agree to provide CHP with necessary medical information related to the member's care and adhere to CHP's policies and procedures, including those for assuring quality of care, obtaining preauthorization, authorization, and a treatment plan approved by CHP. If a provider was terminated by CHP due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

## Provider Phone Call Protocol

PCPs and specialist providers must:

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

Please note: If after-hours urgent or emergent care is needed, the PCP, specialist provider or his/her designee should contact the urgent care center or emergency department in order to notify the facility of the patient's impending arrival. CHP does not require prior-authorization for emergent care. CHP will monitor appointment and after-hours availability on an on-going basis through its Quality Assessment and Performance Improvement (QAPI).

## 24-Hour Access to Providers

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

- A provider's office phone must be answered during normal business hours.
- A member must be able to access his/her provider after normal business hours and on weekends; this may be accomplished through the following:
  - A covering physician
  - An answering service
  - A triage service or voicemail message that provides a second phone number that is answered
  - If the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish
- Examples of unacceptable after-hours coverage include, but are not limited to:
  - Calls received after-hours are answered by a recording telling callers to leave a message
  - Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed
  - Not returning calls or responding to messages left by patients after-hours within 30 minutes

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

## MEDICAL RECORDS

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

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

The provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, complaint and appeal processing, claims reconsideration, and other initiatives CHRISTUS Health Plan may be required to conduct. To comply with accreditation and regulatory requirements, CHRISTUS Health Plan may periodically perform documentation audits of some Provider medical records.

### Standards

Participating providers must have a system in place for maintaining medical records that conform to regulatory standards. All medical records pertaining to CHRISTUS Health Plan members must be kept the longer of ten (10) years or as required by each state. On a periodic basis, the Plan may require access to medical records for the purpose of quality assessment, investigating complaints and appeals, credentialing, and peer review.

Medical records are considered confidential and protected health information. Providers must comply with all state and federal laws concerning confidentiality of health and other information about CHRISTUS Health Plan members. Providers must maintain and adhere to policies and procedures regarding use and disclosure of health information that comply with HIPAA and other applicable laws.

### Release of Medical Records

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

### Transfer of Medical Records

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

The following information must be included in every individual record.

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>• Patient identification</li><li>• Personal data</li><li>• Allergies</li><li>• Chronic/significant problem list</li><li>• Chronic/continuing medication list</li><li>• Immunization history</li><li>• Informed consent</li><li>• Provider signature/name, on each entry</li><li>• Patient's signature on file, for insurance purposes</li><li>• Growth chart (14 years of age and under)</li><li>• Initial relevant history</li><li>• Smoking status</li></ul> | <ul style="list-style-type: none"><li>• Alcohol or substance use/abuse</li><li>• Date of each visit</li><li>• Chief complaint</li><li>• Physical exam</li><li>• Diagnosis/impression</li><li>• Appropriate use of consultants</li><li>• Treatment/therapy plan</li><li>• Results discussed with patient</li><li>• MD Review of diagnostic studies</li><li>• Results of consultations</li><li>• Date of next visit</li><li>• Hospital records, as applicable</li><li>• Preventive health education</li></ul> |
|--|---|

## Advance Directives

Advance directives are written instructions that:

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

**There are three types of advance directives:**

- A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member
- A living will allows the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations.

**CHRISTUS Health Plan directive policies include:**

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

**Advising members of their right to self-determination regarding advance directives by:**

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

**Providers must:**

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

## NON-DISCRIMINATION

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

## CLOSING A PCP PANEL

CHRISTUS Health Plan and participating providers share the common goal of making medical care available and accessible to members in a timely manner. PCPs whose practices are nearing capacity typically close their panels to all new patients regardless of payer. This allows them to handle urgent care for their existing patients in a timely manner and to maintain reasonable appointment lead times. PCPs interested in closing their panel should contact their Provider Relations Representative.

## PROVIDER REQUEST TO TRANSFER A MEMBER'S CARE

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

- Unruly or abusive behavior
- Failure to follow the provider's recommended treatment plan
- Breakdown in patient/provider relationship
- A pattern of missed appointments
- Fraud
- Failure to pay co-payments

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

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

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

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

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



## **VOLUNTARY PROVIDER TERMINATIONS**

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

## MEMBER ELIGIBILITY

### ELIGIBILITY

The Federal Exchange (Exchange) will make eligibility decisions based upon the Application submitted by the Member. The Member is responsible for notifying the Exchange about changes to their family circumstances that could affect eligibility such as an adoption, a birth, addition of another dependent, or a divorce. To be eligible for Covered Benefits in accordance with CHRISTUS Health Plan Contracts, Members must be enrolled. In this context, the Member is the individual who has applied for coverage on behalf of his/herself and his/her Dependents, and to whom the Contract was issued.

To enroll in CHRISTUS Health Plan, a Member must be a Qualified Individual eligible for coverage through the Exchange, under the age of 65 and not be eligible for coverage under Medicare due to age, illness or disability, and must reside, live, or work in the CHRISTUS Health Plan Service Area, and the legal residence of any enrolled Dependents must be the same as the subscriber, or the subscriber must reside, live or work in the Service Area and the residence of any enrolled dependents must be in the:

- Service Area with the person having temporary or permanent conservatorship or guardianship of the Dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the for the health care of such Dependents;
- Service Area under other circumstances where the subscriber is legally responsible for the health care of the Dependents;
- Service area with the subscriber's spouse; or
- Anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

Members may add newborn and other Dependents to the Plan by completing an enrollment form for the Dependent and submitting it to the Federal Exchange. Members must notify CHRISTUS Health Plan within 31 days after the birth of a child they wish to add as a Dependent and pay any premium required to continue the coverage. In addition, grandchildren living with and in the household of the subscriber may also qualify as a Dependent. Unless special circumstances apply, coverage of such Dependents is limited to those under the age of twenty-six (26). Dependent children, age 26 or older, may qualify for continued dependent coverage while the child is incapable of self-sustaining employment due to a mental retardation or physical disability, which existed prior to attaining and chiefly dependent upon the subscriber for support and maintenance.

**To be eligible as a Dependent, the Dependent must:**

- Be enrolled at the same time as the Member;
- Be a Dependent of a Qualified Individual eligible for coverage through the Exchange under Texas law;
- Be enrolled within 31 days of a Qualifying Event as described under the Special Enrollment Period for Dependents.

## MEMBER ID CARD

The Member identification (ID) card is issued to Members upon enrollment and contains information regarding benefit coverage, copayments, and telephone numbers for questions regarding those benefits. Each member receives an ID card when they enroll with CHRISTUS Health Plan. Most providers ask to see the ID card each time the member comes to the office. The ID card displays information such as:

- Member's Plan Name
- Member First and Last Name
- Member ID #
- Contact Information for Member Services
- Co-payment Amounts

CHRISTUS Health Plan TX - EX	
<b>Member</b> Subscriber Name: CHRISTUS member Subscriber ID: 0002 Group Number: 11112222 Effective Date: 01/01/2017 PCP Name: PCP Phone: PCP Effective Date: 3/13/2018 <b>Dependents:</b> Member 1 000111111 Member 2 000222222 Member 3 000333333	<b>Medical Plan Co-Pay</b> PCP Office Visit: \$10 Specialist Office Visit: \$35 Emergency Room: \$250 Urgent Care: \$35 QHP/DI/HMO <b>Pharmacy Plan</b> RxBIN: 003858 RxPCN: A4 RxGRP: CHPHCRE EXPRESS SCRIPTS <a href="http://www.express-scripts.com">www.express-scripts.com</a> Pharmacy administered by Express Scripts Holding Company

Provider Services	Member Services
<b>Submit Medical Claims to:</b> P. O. Box 981654 El Paso, TX 79998-1636 Payor ID: 52106  <b>Submit Dental Claims to:</b> 12121 N Corporate Pkwy, Mequon, WI 53092  <b>Submit Vision Claims to:</b> 939 Elkridge Landing Rd, Ste 200 Linthicum, MD 21090	<b>Member Services:</b> TTY TX 1-844-282-3025 Superior Vision 1-800-735-2989 DentaQuest 1-800-879-6901 Pharmacy for Members 1-855-343-7343 TDD Pharmacy 1-800-282-2881 Pharmacy Use Only 1-800-759-1089 1-800-922-1557  <b>Assistance 24/7</b> Nurse Line: 1-844-581-3175 Behavioral Health Crisis Helpline: 1-800-323-0286

[www.christushealthplan.org](http://www.christushealthplan.org)

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

## VERIFYING ELIGIBILITY

A provider may confirm member eligibility directly with CHRISTUS Health Plan by calling Member Services at 1-844-282-3025.

## Grace Period

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

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

For members not receiving advance payments of the tax credit: CHP provides a grace period of 31 days

to members who are not receiving advance payments of the premium tax credit and who have previously paid at least one full month's premium during the benefit year. During the grace period, the policy will remain active. If any premium is not paid by the end of the grace period, coverage will be terminated as of the end of the period for which premium has been paid.

Any payments made to a provider on behalf of a member who ultimately loses coverage due to non-payment of premiums will be refunded to CHP by the provider within forty five (45) days of receipt of written request by CHP. Any amounts not paid within forty five (45) days of receipt of notice from CHP may be offset by CHP from amounts otherwise owed to the provider without any further action required.

CHP will deny claims that are received and not processed with dates of service beginning on the last day the premium was paid after CHP has confirmed that the grace period expired without premiums being paid in full.

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

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

If a member receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, CHP will terminate the member's coverage on the last day of the first month of the 3-month grace period and deny claims incurred during months two and three of the 3-month grace period. Any payments made to providers on behalf of members who ultimately lose coverage due to non-payment of premium with dates of service beginning after the first month of the 3-month grace period will be refunded to CHP by the provider within forty five (45) days of receipt of written request by CHP. Any amounts not paid within forty five (45) days of receipt of notice from CHP may be offset by CHP from amounts otherwise owed to the provider without any further action required. CHP will deny claims that are received and not processed with dates of service beginning after the last day of the first month of the 3-month grace period after CHP has confirmed that the Chas expired without premiums being paid in full. If the member pays in full during the 3-month grace period, claims will be processed as usual.

## Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCS)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
2. All members associated with the subscriber will inherit the enrollment status of the subscriber.
3. After the initial premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium.
4. Coverage will remain in force during the grace period.
5. If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period. The member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium.

## Premium Grace Period for Members NOT Receiving Advanced Premium Tax Credits (APTCS)

1. Premium payments are due in advance on a calendar month basis.
2. Monthly payments are due on or before the first day of each month for coverage effective during such month.
3. There is a one-month grace period. If any required premium is not paid before the date it is due, it may be paid during the grace period.
4. During the grace period, coverage will remain in force.

## COLLECTION OF CO-PAYMENTS AND CO-INSURANCE

It is the provider's responsibility to collect co-payments and co-insurance directly from the member at the time services are rendered. Co-payments are required for professional services and cannot be waived by the provider. Providers must not bill or collect any amount in excess of the CHRISTUS Health Plan payment except for the applicable co-payments and co-insurance.

## MEMBER PAYMENT FOR NON-COVERED SERVICES

Providers may charge CHRISTUS Health Plan members for non-covered services. However, such charges must be the usual and customary fee the provider would charge all other patients. The CHRISTUS Health Plan member must agree in writing to accept payment responsibility for the non-covered service prior to receiving that service.

# MEMBER RIGHTS AND RESPONSIBILITIES

## MEMBER RIGHTS

Plan Members have the right to:

- Available and accessible services for Medically Necessary and Covered Services, including 24 hours per day, 7 days per week for Urgent or Emergency Services, and for other Health Care Services as defined in the Summary of Benefits and Coverage
- Be treated in a prompt, courteous and responsible manner that respects their dignity and privacy
- Receive detailed information about their coverage, benefits and services offered under their Contract. This includes any Exclusions of specific Conditions, ailments or disorders, including restricted prescription benefits; the Plan's policies and procedures regarding products, services, Providers appeal procedures and other information about the Plan and the benefits provided to Members. This also includes access to a current list of Participating Providers in the Plan's network; information about a particular Participating Provider's education, training, and practice; and the Member Rights and Responsibilities, as well as the right to make recommendations regarding the Plan's Member Rights and Responsibilities policies
- Receive affordable health care including information regarding out-of-pocket expenses; limitations; the right to seek care from a Non-Participating Provider; and an explanation of their financial responsibility when services are provided by a Non-Participating Provider or without Prior Authorization
- Choose a Primary Care Provider within the limits of the Covered Services, the Plan's network, and as provided by the Contract, including the right to refuse care of specific Health Care Professionals. In addition, Members have the right to participate with Providers in making decisions about their health care
- Be given an explanation of their medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by their Participating Provider in terms that they understand. If they are unable to understand the information, an explanation must be given to their next of kin, guardian or another authorized person. This information shall be documented in their medical records
- All rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to be informed about their treatment by their Participating Provider in terms that they understand; to request their consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary under the Plan. The right to consent or agree to treatment by them or their next of kin, guardian, or another authorized person may not be possible in an emergency where their life and health are in serious danger
- Voice Complaints, Complaints or Appeals with the Plan or the Superintendent of Insurance (Superintendent) about the Plan or the coverage the Plan provides. Members also have the right to receive an answer within a reasonable time and in accordance with existing law and without fear of retaliation
- Be promptly notified of termination or changes in benefits, services or the Provider Network
- Confidential handling of all communications, including medical and financial information maintained by the Plan. Privacy of their medical and financial records will be maintained by the Plan and Participating Providers in accordance with existing law
- A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision, to our internal review and the right to request help from the Superintendent.
- Know, upon request, of any financial arrangements or provisions between the Plan and Participating Providers, which may restrict referrals or treatment options or limit the services offered to Members
- Seek from qualified Health Care Professionals services and treatments that are Covered Benefits near where they live or work within the Plan's Service Area
- Receive information about how benefits are authorized or denied. Members have the right to know how new technology for Covered Benefits are evaluated. They can also request and receive information about the Plan's quality assurance plan and Utilization Review methodology
- Receive detailed information about all requirements that must be followed for Prior Authorization and Utilization Review

## MEMBER RESPONSIBILITIES

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

- Provide honest and complete information to those providing the care
- Review and fully understand the information they receive about the Plan
- Know the proper use of the services covered by the Plan
- Present their Plan ID card before they receive care
- Consult their Provider before receiving medical care, unless their Condition is life threatening
- Promptly notify their Provider if they will be delayed or unable to keep an appointment
- Pay all charges or Copay/Coinsurance amounts, including those for missed appointments This also applies to Deductibles and any charges for non-Covered Benefits and Services
- Express their opinions, Complaints or Concerns in a constructive way to CHRISTUS Health Plan Member Services or to their Provider
- Inform the Plan of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change
- Make Premium payments on time
- Notify the Plan of other insurance coverage
- Follow the Plan's Complaint and Appeal process when displeased with the Plan or a Providers' actions or decisions
- Understand their health problems and participate in developing treatment goals that they agree to with their Providers
- Follow plans and instructions for care that they have agreed to with their Provider

All Members are responsible for understanding how the Plan works. They should carefully read and refer to their Contract and their *Summary of Benefits and Coverage*.

## MEMBER SUPPORT SERVICES

### NEW MEMBER EDUCATION

When a member joins CHRISTUS Health Plan, Member Services Representatives will call to welcome the new members and answer any questions they have. Members are encouraged to see their Primary Care Provider (PCP) within the first 90 days of eligibility and to rely on the PCP to guide them through the health care delivery system.

PCPs may send a welcome letter to their new members with information such as hours and days of operation, phone numbers, and appointment scheduling.

### 24/7 NURSE LINE

CHRISTUS Health Plan has a 24/7 Nurse Line. Members can access this service toll free for medical guidance/triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace the provider's after-hours coverage commitment. To reach the Nurse Line, members should call 1-800-455-9355.

## CASE MANAGEMENT

The Case management program plans and manages the care of members with catastrophic, chronic needs and those whose needs

are acute, episodic or short term in nature. The goals of case management are the provision of quality care, enhancement of a member's quality of life and management of health care costs for short term and long term. Disease Management is Case Management for members with Specific chronic diseases.

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

- Provider referral
- Facility admission/ Concurrent review process
- Retrospective analysis
- Member request
- Case Management criteria per policy.

Providers can refer members for a case management evaluation by calling 1-844-282-3025 or faxing information to 1-800-277-4926.

## DISEASE MANAGEMENT

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

The purpose of **Disease Management** is to:

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

### Who Qualifies

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

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

### Referrals to Disease Management

Provider may refer potential candidates to Disease Management by calling 1-844-282-3025 or faxing information to 1-800-277-4926.

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

- Case management program referral
- Referrals from PCP / Provider, Clinic staff
- UM Referrals
- Member Self-Referral
- Other (examples include referrals from mental health benefits coordinator, home health agencies, community resources)

Upon referral, members will be contacted for enrollment and will be administered a telephonic health assessment. The Disease Management team members will work with the PCPs to develop a Plan of Care.

### Health Management and Education

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



## CULTURAL COMPETENCY

CHP places great emphasis on the wellness of its members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. CHP encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS). CHP maintains policies which emphasize the importance of culturally and linguistically competent care to CHP's membership of all cultures, races, languages, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual enrollees while protecting and preserving the dignity of each member. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with patients and, in the long run, the health and wellness of the patients themselves.

Providers must ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility or be subjected to discrimination by any such facility. The following is a list of principles for health care providers to include knowledge, skills and attitudes related to cultural competency in the delivery of health care services to Superior members.

### Knowledge

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

### Skills

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

### Attitudes

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

## Cultural Diversity Resources for Providers

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

CLAS is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. CLAS is about respect and responsiveness: Respect the whole individual and Respond to the individual’s health needs and preferences. The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. <https://www.thinkculturalhealth.hhs.gov/clas>

### **Best Practices for Working with a Medical Interpreter**

Working in the medical field, you’ve surely seen the need for an interpreter at least once in a while, if not every day. Fortunately, many clinics now make sure this type of professional is available to help doctors and patients communicate. If you’re not yet used to having a medical interpreter in the office with you, here’s how to get familiar with this situation so you and your patients can benefit from interpreting services right away. <https://www.accreditedlanguage.com/2017/01/09/best-practices-for-working-with-a-medical-interpreter/>

### **A Physician's Practical Guide to Culturally Competent Care**

This e-learning program will equip health care providers with competencies that will enable them to better treat the increasingly diverse U.S. population. <https://cccm.thinkculturalhealth.hhs.gov/>

### **HRSA: Culture, Language, and Health Literacy**

Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. <http://www.hrsa.gov/culturalcompetence/index.html>

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

Intended to enhance cultural competence when serving American Indian and Alaska Native communities. Covers regional differences, cultural customs, spirituality, communications styles, the role of veterans and the elderly, and health disparities, such as suicide. <http://store.samhsa.gov/shin/content//SMA08-4354/SMA08-4354.pdf>

### **Multicultural Health Care: A Quality Improvement Guide**

[Culturally and Linguistically Appropriate Services \(CLAS\) Toolkit](#)

## TEXAS NON-COVERED BENEFITS (Exclusions)

### NON-COVERED BENEFITS (Exclusions)

The Member's Contract only covers certain Medically Necessary healthcare benefits. This EXCLUSIONS Section lists services that are specifically excluded from coverage under the Contract. All other benefits and services not specifically listed in the COVERED BENEFITS section of the Contract are also Excluded Services. Refer to the member's evidence of coverage for excluded services.

Abortion	Direct abortions are not a covered benefit. See Covered Benefits for more exceptions.
Accident and Emergency Care Services	Use of an emergency facility for non-emergent services (including without limitation, Urgent Care or observation).
Autopsies and Ambulance Services	<ul style="list-style-type: none"> <li>Autopsy costs for deceased Members.</li> <li>Ambulance services to the coroner's office or to a mortuary, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.</li> </ul>
Before or After Coverage Period	Services received, items purchased, prescriptions filled or expenses incurred before the date of coverage or after the effective date of termination of Coverage under the Policy.
Cancer Clinical Trials	<ul style="list-style-type: none"> <li>Any Cancer Clinical Trials provided outside of New Mexico, as well as those that do not meet the requirements of the COVERED BENEFITS section of the Policy.</li> <li>Costs of Cancer Clinical Trials that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.</li> <li>Services from non-Participating Providers, unless services are not available from a Participating Provider. Pre-authorization is required for any Out-of-Network Services, which must be provided in New Mexico.</li> <li>Costs of a non-FDA approved Investigational drug, device or procedure.</li> <li>Costs associated with managing the research associate with the Cancer Clinical Trial.</li> <li>Costs of tests necessary for the research of the Cancer Clinical Trial</li> <li>Costs paid for or not charged by the Cancer Clinical Trial Providers</li> </ul>
Certified Hospital Care Benefits	<ul style="list-style-type: none"> <li>Food, housing and delivered meals.</li> <li>Volunteer services.</li> <li>Personal or comfort items.</li> <li>Homemaker or housekeeping services.</li> <li>Private duty nursing.</li> <li>Bereavement counseling.</li> </ul>
Clothing or Protective Devices	Clothing or other protective devices, including photo protective clothing, windshield tinting, lighting fixtures or other items or devices whether prescribed or not.
Complementary Therapies	Acupuncture, except as specified in COVERED BENEFITS.
Cosmetic Surgery	<ul style="list-style-type: none"> <li>Cosmetic therapy, drugs or medications, or procedures for the purpose of changing appearance.</li> <li>Any surgical or non-surgical procedures that are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from injury, congenital defects or disease.</li> <li>Reconstructive surgery following a mastectomy will be covered.</li> </ul>
Circumcisions	Performed other than for newborn stays, unless Medically Necessary
Dental Services	
Durable Medical Equipment	<ul style="list-style-type: none"> <li>Upgraded or deluxe Durable Medical Equipment</li> <li>Convenience items, including items for comfort and ease and not primarily medical in nature, such as shower seats, bath grab bars, shades for wheelchairs, pillows, fans, special beds and chairs, and other items.</li> <li>Duplicate Durable Medical Equipment items</li> <li>Repair or replacement of Durable Medical Equipment due to loss, neglect, misused, abuse to, or to improve appearance or convenience.</li> </ul>

	<ul style="list-style-type: none"> <li>• Repair or replacement of items under the manufacturer or supplier's warranty</li> <li>• Additional wheelchairs, if the Member has a functional wheelchair.</li> </ul>
Excessive Charges	Charges or costs in excess of Usual, Customary and Reasonable Charges.
Exercise Equipment and Services	Exercise equipment, videos, personal trainers, club memberships and weight reduction programs.
Experimental, Investigational or Unproven Drugs, Medicines, Treatments, Procedures, Devices or Services, Extracorporeal shock wave therapy, Foot Care	Routine foot care, such as treatment of flat feet or other structural misalignments of the removal of corns, and calluses, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.
Genetic Inborn Errors of Metabolism	<ul style="list-style-type: none"> <li>• Food substitutes for lactose intolerance or other carbohydrate intolerances</li> <li>• Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM.</li> <li>• Special Medical Foods for Conditions that are not present at birth.</li> <li>• Dietary supplements and items for Conditions including diabetes, hypertension, hyperlipidemia, obesity, autism spectrum disorder, celiac disease, and food allergies.</li> </ul>
Hair Loss	Hair loss or baldness treatments, medications, supplies and devices, regardless of medical cause of hair loss or baldness.
Home Health Care Services	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Custodial Care needs that can be performed by non-licensed medical personnel to meet normal activities of daily living.</li> <li>• Custodial Care needs that can be performed by non-licensed medical personnel to meet normal activities of daily living.</li> </ul>
Hospital Services	<ul style="list-style-type: none"> <li>• Acute medical detoxification in a residential treatment center.</li> <li>• Rehabilitation as part of acute medical detoxification</li> </ul>
Infertility Services	<ul style="list-style-type: none"> <li>• Prescription Drugs and injections.</li> <li>• Reversal of voluntary sterilization.</li> <li>• Donor sperm.</li> <li>• In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization.</li> <li>• Storage or banking of sperm, ova (human eggs), embryos, zygotes, or other human tissue.</li> </ul>
Male Health Care	<ul style="list-style-type: none"> <li>• Contraceptive Coverage</li> <li>• Family planning services</li> <li>• Sterilization procedures</li> </ul>
Mental Health and Alcoholism and Substance Abuse	<ul style="list-style-type: none"> <li>• Codependency treatment.</li> <li>• Bereavement and sexual counseling.</li> <li>• Psychological testing when not Medically Necessary.</li> <li>• Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems.</li> <li>• Court ordered evaluation or treatment, or a treatment that is a condition of parole or probation in lieu of sentencing</li> <li>• Treatment in a halfway house.</li> <li>• Residential Treatment Centers, unless for the treatment of Alcoholism or Substance Abuse.</li> <li>• Codependency treatment.</li> <li>• Bereavement and sexual counseling</li> <li>• Court-ordered treatment, or treatment that is a condition of parole or probation in lieu of sentence</li> </ul>
Military Service Disabilities	Care for military service connected disabilities to which Members are legally entitled to and for which facilities are reasonable available
Nutritional Supports and Supplements	Baby food (including formula or breast milk) or other regular grocery products that can be used with the enteral system for oral or tube feedings.
Out-of-Network Services Not Authorized	Services received out of network that require Pre-authorization, if Pre-authorization was not obtained.
Orthotic Appliances	<ul style="list-style-type: none"> <li>• Functional foot Orthotics, including those for plantar fasciitis, pes planus (flat feet), heel spurs and other Conditions, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints, except for Members with diabetes or other significant peripheral neuropathies.</li> <li>• Custom-fitted Orthotics, except for knee-foot-ankle Orthosis (KAFO) and/or ankle-foot Orthosis (AFO) for Members who meet nationally recognized guidelines.</li> </ul>
Prescription Drugs/Medicines	<ul style="list-style-type: none"> <li>• Compounded Prescription Drugs/Medicines</li> <li>• New Medications for which the determination of criteria for Coverage have not yet been established by the Plan</li> <li>• Over the counter (OTC) medications and drugs, except as listed on the <i>Formulary</i>.</li> <li>• Prescription Drugs/Medicines that require a Pre-authorization if no Pre-authorization was obtained</li> <li>• Prescription Drugs/Medicines purchased outside the United States.</li> <li>• Replacement Prescription Drugs/Medicines resulting from loss, theft or destruction</li> </ul>

	<ul style="list-style-type: none"> <li>• Prescription Drugs/Medicine, medicines, treatments, or devices that the Plan determines are Experimental, Investigational or Unproven.</li> <li>• Disposable medical supplies, except when provided in a hospital or a Participating Provider's office</li> <li>• Treatments and medications for the purpose of weight reduction or control, except as specified in COVERED BENEFITS</li> <li>• Nutritional supplements as prescribed by the attending Provider or as sole source of nutrition</li> <li>• Infant formula, under any circumstance</li> <li>• Prescription Drugs/Medicines for the treatment of sexual dysfunction or Infertility</li> <li>• Prescription Drugs/Medicines for cosmetic purposes</li> </ul>
Provider Services	<ul style="list-style-type: none"> <li>• Services provided by an Excluded Provider</li> <li>• Telephone visits, except as set forth in COVERED BENEFITS</li> <li>• Electronic mail by a Provider or consultation by telephone for which a charge is made to the patient.</li> <li>• Get acquainted visits without physical assessment or diagnostic or therapeutic intervention</li> </ul>
Prosthetic Devices	Artificial aids including speech synthesis devices, except as specified in COVERED BENEFITS
Reconstructive Surgery for Cosmetic Purposes	Cosmetic Surgery (examples include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery, asymptomatic scar revision, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty).
Rehabilitation and Therapy	<ul style="list-style-type: none"> <li>• Athletic trainers or treatments by athletic trainers</li> <li>• Vocational rehabilitation services</li> <li>• Long-term therapy or rehabilitation services, including treatment for chronic or incurable Conditions for which rehabilitation produces minimal or temporary change or relief. If Members reached maximum rehabilitation potential, a point where a significant improvement is unlikely to occur, or therapy for 4 consecutive months, additional therapy is considered long-term therapy or rehabilitation</li> <li>• Treatment of chronic Conditions (i.e.muscular dystrophy, down syndrome, cerebral palsy).</li> </ul>
Services Covered Under Another Program	<ul style="list-style-type: none"> <li>• Services eligible under any governmental program (except Medicaid), to the extent determined by law.</li> <li>• Services for which, in the absence of any health service plan, no charge would be made to the Member or their Dependent</li> </ul>
Services Provided Outside the United States	Any services or materials for non-Emergency Care or non-Urgent Care received outside the United States.
Sex Dysfunction	Treatment for sexual dysfunction, including medication, counseling and clinics
Sex Transformation	Surgery and drugs related to sex transformation
Skilled Nursing Facility Care	Custodial or domiciliary care
Speech Therapy	Therapy for stuttering Hearing aids and evaluation for fitting, except for Dependents under 18 years old Additional benefits beyond those listed in COVERED BENEFITS
Smoking Cessation	<ul style="list-style-type: none"> <li>• Hypnotherapy for smoking cessation counseling</li> <li>• Over the counter drugs, unless listed on the <i>Formulary</i></li> <li>• Acupuncture for smoking cessation purposes</li> </ul>
Transplant Services	<ul style="list-style-type: none"> <li>• Non-human organ transplants, except for porcine (pig) heart valve</li> <li>• Transportation costs for deceased Members</li> <li>• Embryonic or fetal stem cell transplants</li> <li>• Medical and hospital Services of an organ transplant donor when the transplant recipient is not a Member or the transplant procedure is not a Covered Benefit</li> <li>• Travel and lodging, except as specified in COVERED BENEFITS</li> </ul>
Treatment While Incarcerated	Services or supplies a Member receives while in custody of any state or federal law enforcement authorities, including while in jail or prison
Vision Care	<ul style="list-style-type: none"> <li>• Routine vision care and eye refractions, except as specified in COVERED BENEFITS</li> <li>• Corrective eyeglasses or sunglasses, frames, lenses, contact lenses, or fittings, except as specified in COVERED BENEFITS</li> <li>• Eye refractive procedures, including radial keratotomy, laser procedures and other techniques</li> <li>• Eye movement therapy</li> </ul>
Women's Health Care	<ul style="list-style-type: none"> <li>• Abortifacient drugs</li> <li>• Family planning services, excepted as specified in SPECIAL NOTICE ABOUT REPRODUCTIVE &amp; FAMILY PLANNING SERVICES Section of the Policy</li> </ul>
Work-Related Illnesses or Injuries, under any circumstances	

## FAMILY PLANNING

Family planning services are covered as a part of the CHRISTUS Health Plan package of benefits. However, since this benefit is inconsistent with the Ethical and Religious Directives for Catholic Health Care, it is not provided by CHRISTUS Health owned entities. HealthSmart administers the family planning benefit for CHRISTUS Health Plan members. HealthSmart is not affiliated with CHRISTUS Health.

Family Planning services provided are paid directly through HealthSmart. Providers who have questions should contact HealthSmart directly at (855) 596-6740.

## BEHAVIORAL HEALTH

CHRISTUS Health Plan is directly responsible for BH member services, provider contracting, credentialing, and claims payment to behavioral health providers. CHRISTUS Health can be reached at 1-844-282-3026. CHRISTUS Health is responsible for BH pre-authorization, referrals, and medical management of behavioral health services. Behavioral health services, including all Mental Health services, treatment for alcoholism, substance abuse, drug addiction and chemical dependency. Behavioral Health Crisis Hotline is available to members 24 hours per day/7 days per week at 1-800-323-0286. Providers should use this phone number to identify participating behavioral health providers, request pre authorization for inpatient admissions and outpatient services.

## Mental Health and Substance Use Disorder Parity

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

### Behavioral health care provider access-to-care standards

Service Type	Time Frame
Behavioral Health – Routine visits Specialist	10 business days Routine Specialty care referral within three weeks
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	24 hours
Following hospital discharge for a behavioral health condition	Within 7 days of the inpatient discharge date
Behavioral Health Non-Life Threatening Emergency	Within six hours

# TEXAS HEALTH INSURANCE EXCHANGE PLANS

## Overview

There are many factors that determine which plan a CHP member will be enrolled. The plans vary based on the individual liability limits or cost share expenses to the member. The phrase "Metal Tiers" is used to categorize these limits.

Under the Affordable Care Act (ACA), the Metal Tiers include Platinum, Gold, Silver and Bronze. Essential Health Benefits (EHBs) are the same with every plan. This means that every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act.

The EHBs outlined in the ACA are as follows:

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

CHP covers services described in the Summary of Benefits and Major Medical Expense Policy document for each CHP plan type. If there are questions as to a covered service or required prior authorization, please contact CHP Provider Service at 1-844-282-3025.

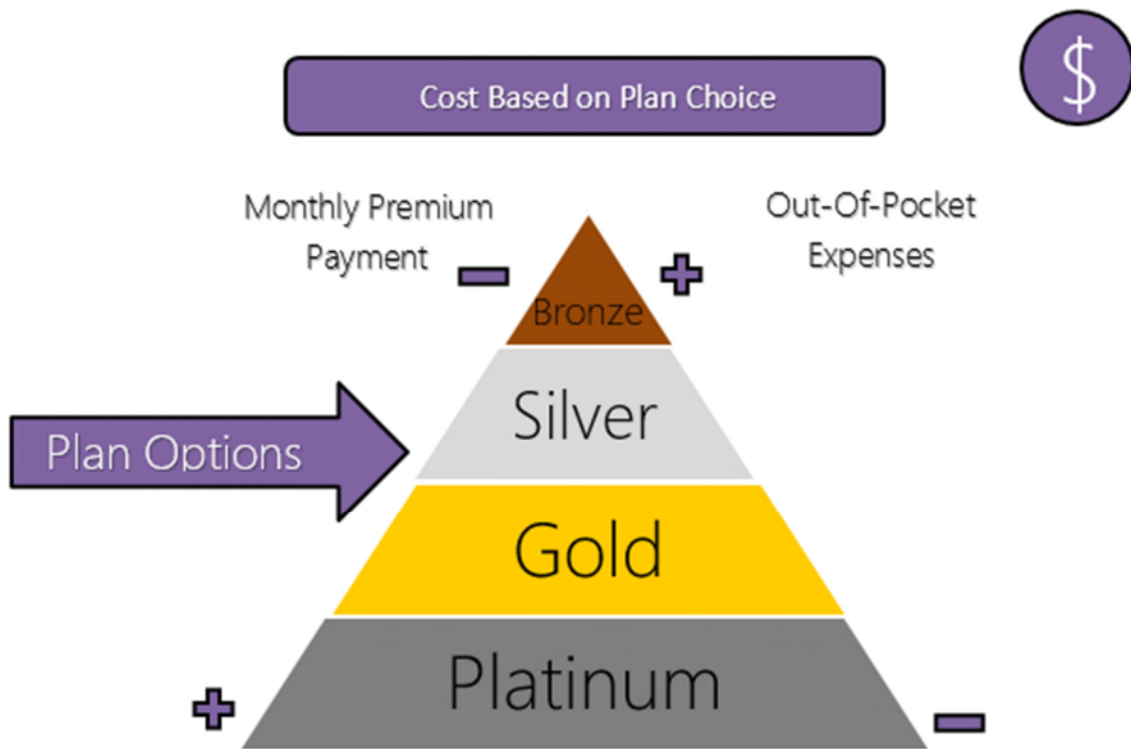
CHRISTUS Health Plan offers 12 different plan types within the Texas Health Insurance Exchange.

## TEXAS PLANS

PLAN	TYPE	TYPE
PLATINUM	PLATINUM	
GOLD	GOLD	
SILVER	SILVER HD	SILVER LD
BRONZE	BRONZE	
CATASTROPHIC	CATASTROPHIC	
AMERICAN INDIAN		

**NOTE: All Texas Plans are subject to an overall deductible and an out-of-pocket limit on expenses, with the exception of the American Indian Plan, as described below:**

Overall deductible	Members must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services. Copays do not count towards the deductible.
Out-of-pocket limit on expenses	The <u>out-of-pocket limit</u> is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.



The services covered by the Plan, as well as a description of the services, can be found in the following pages and Health Insurance Exchange Medical Benefits Chart. In addition, a detailed explanation of each of the 12 plans offered with applicable co-payments, deductibles and/or co-insurance requirements is found at the end of this Provider Manual.



# QUALITY MANAGEMENT PROGRAM

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CHRISTUS Health Plan has a comprehensive Quality Management Program. The goal of the Quality Management Program is to ensure that every member receives quality care in a timely and accessible fashion and to provide a mechanism for evaluating the appropriateness of member care. The purpose of the Quality Program serves to assure timely identification, assessment and resolution of known or suspected problems/trends by continuous monitoring and evaluation of care and services provided. The Quality Management Program includes, but is not limited to, the following topics:

- Access and availability of provider/services
- Accreditation and compliance
- Appeals
- Complaints and grievances
- Credentialing
- Disease management
- Improvement of member and provider satisfaction
- Medical record review at physician offices (types of medical record reviews include continuity of care and other focused reviews)
- Patient safety
- Pharmacy services effectiveness
- Preventative health services
- Timely credentialing of providers and adequacy of the provider network
- Timely resolution of complaints and appeals
- Utilization management

All participating providers are required to comply with CHRISTUS Health Plan's policies and procedures including complying with, participating in, and implementing quality management projects including patient safety programs. This includes but is not limited to implementing activities necessary and required to comply with external accreditation by the NQMC, JCAHO, URAC 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.

## QUALITY REFERRALS

Any stakeholder may refer a matter for review as a potential quality issue. The Director of Quality Services or designee may refer cases to the Medical Director for review and recommendations. The Medical Director's review may determine that:

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

The Medical Director will recommend any action as appropriate to the event, in keeping with CHRISTUS Health Plan Policies and Procedures, contractual requirements of the Plan and other relevant federal, state or local regulatory requirements.

## HEDIS

CMS requires Medicare Advantage (MA) Managed Care Health Plans to report Health Care Effectiveness Data Information Set (HEDIS)<sup>®</sup> measures annually. HEDIS is a set of standardized Quality Indicators that compare the performance of managed care plans in areas such as preventive screenings and chronic health care which was developed by the National Committee for Quality Assurance (NCQA)<sup>®</sup>.

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 effective October 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews

### Medical Record Reviews (MRR) for HEDIS

CHRISTUS Health Plan may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, if any of your 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 greatly 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 Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Superior which allows them to collect PHI on our behalf.

How can Providers improve their HEDIS scores?

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

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI Department at [qualitydepartment@christushealthplan.org](mailto:qualitydepartment@christushealthplan.org)

In addition, CMS mandates that certain Member Satisfaction Surveys are performed annually. These surveys include the following questions:

## Qualified Health Plan Enrollee Experience Survey (QHP)

### Qualified Health Plan Enrollee Experience Survey (QHP)

The QHP survey is a Member care experience survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to Members by an NCQA certified survey vendor. The survey provides information on the experiences of Members with health plan and practitioner services and gives a general indication of how well the plan is meeting the Members' expectations. Member responses to the QHP survey are used in various aspects of the quality program including monitoring of practitioner access and availability

The survey capture answers to questions like (but not limited to)

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

## Potential Quality Issues

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

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

**Clinician or Provider:** is any individual or entity engaged in the delivery of healthcare services licensed or certified by the State to engage in that activity, if licensure or certification is required by State law or regulation

**Corrective Action Plan (CAP):** is a plan approved by the appropriate quality improvement committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and timeframes for completion.

### Process

CHRISTUS Health Plan has a systematic method for the identification, reporting and processing of Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to CHP members and to direct actions for improvement based upon the frequency and severity of the PQI. It is CHP's policy to accept a PQI referral through a variety of sources. These include but are not limited to: Internal referrals from Grievances and Appeals; a Plan member; a Plan provider; a Plan staff member; an affiliate. All Potential Quality Issues which are identified will be tracked in the PQI log for the purposes of monitoring patterns to identify any potential trends or any significant sentinel events. All information obtained during and used in a quality of care investigation will be held in strict confidence, according to the Plan confidentiality policies and in accordance with all relevant State and Federal Peer Review Laws and regulations. A designated medical professional reviews all referred PQIs to identify whether a true Quality of Care issue exists after which the case will be assigned a severity score. Some cases will be referred to the Peer Review/Credentialing Committee based on CHP's policy. Based on review by the Credentialing Committee, a provider may be placed on a Corrective Action Plan (CAP) or may be required to submit a Corrective Action Plan. The Corrective Action Plan will request follow up and evidence from the provider in question to demonstrate that the corrective actions have been implemented as specified. All PQI outcomes are trended on a continuous 36 months' basis. Any identifiable trends, regardless of outcome to the member, will be referred to the Quality Improvement committee on a quarterly basis for potential action or educational opportunities.

**Reporting** To report a PQI, you may complete and fax a PQI Referral Form included in the Forms section at the end of this manual. The PQI form can be submitted anonymously.

# PREVENTATIVE HEALTH GUIDELINES

## PREVENTIVE HEALTH GUIDELINES

Evidence-based treatment protocols have been shown to improve patient outcomes through clinical research. Treatment protocol values are evidence-based recommendations for care. CHRISTUS Health Plan recommends the adults and children preventive health guidelines established by U.S. Preventive Services Task Force (USPSTF) of the Agency for Healthcare Research and Quality (AHRQ). These preventive health guidelines include recommendations for screenings, testing, immunizations and counseling. Full references are available at the following website:

<http://www.ahrq.gov/clinic/pocketgd1011/gcp10s1.htm>

## CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines are evidence-based guidelines used to help providers make decisions about specific clinical situations. CHRISTUS Health Plan consults with participating provider practicing in the community to adopt nationally recognized guidelines and standards.

Refer to the National Guideline clearing house website at <http://www.guideline.gov> for the following specific guidelines:

- 2013 ACCF/AHA guideline for management of heart failure
- 2014 evidence-based guideline for the management of high blood pressure in adults. Report from the panel members appointed to the Eighth Joint National Committee (JNC8)
- 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS guideline for the diagnosis and management of patients with stable ischemic heart disease
- Diagnosis and management of stable chronic obstructive pulmonary disease :a clinical practice guideline update from the American college of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society
- American Association of Clinical Endocrinologists medical guidelines for clinical practice for developing a diabetes mellitus comprehensive care plan
- American Association of Clinical Endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of postmenopausal osteoporosis
- Practice guideline for treatment of patients with major depressive disorder, third edition

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy.

# REFERRAL/AUTHORIZATION GUIDELINES

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CHRISTUS Health Plan Medical Management program is designed to assure that members receive appropriate care at the right time, in the right setting.

The Medical Management function is performed in accordance with State guidelines, Federal regulations and NCQA standards. Provider and CHRISTUS Health Plan staff have no incentives, including compensation, that are based upon the quantity of adverse determinations. Nurses and Medical Directors collaborate with Primary Care Providers, specialists and other providers to assure members get the care they need in a proactive manner.

## ROLE OF PRIMARY CARE PROVIDER

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

- Assesses the health care needs of each member
- Delivers primary care services
- Provides patient education, health screening and prevention services
- Guides the member through the healthcare system by arranging for specialty and ancillary care as needed.

For inpatient hospital and skilled nursing facility (SNF) admissions, the PCP (or assigned hospitalist) is responsible for:

- Obtaining the member's history and physical
- Formulating the patient's hospital plan of care and coordinating subspecialty consultation
- Overseeing the discharge plan and arrangements for follow-up care
- Communicating with case management, consulting provider, the patient and the patient's family
- Facilitating approval of all services for discharge and follow-up care.

## ROLE OF SPECIALIST AS PRIMARY CARE PROVIDER

A specialty physician may assume the responsibilities of a primary care provider as a primary care provider under specific circumstances, such as in the case of a Member with a disability or chronic/complex condition. The Member's signature is required for a specialist to serve as the Member's PCP. By allowing a specialist to act as a primary care provider, Members are able to draw upon the most appropriate care to meet their needs. In this capacity, the specialist is required to fulfill all of the responsibilities of a primary care provider and the specialist must agree to coordinate all of the member's care. Specialists who would like to be the Primary Care Provider should contact the Medical Management Department at 1-844-282-3077 for further information and to complete the request form.

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

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

## ROLE OF SPECIALISTS, HOSPITALS AND ANCILLARY PROVIDERS

Members are encouraged to utilize their Primary Care Provider as their guide through the healthcare system. Other providers are likewise encouraged to work closely with the Primary Care Provider to coordinate the care of the member. It is expected that all other providers will report back to the Primary Care Provider about diagnosis, findings, treatment plans and treatments in a timely manner.

With the exception of medical emergencies, all providers are required to call before performing services listed on the Prior Authorization List. In addition, providers are required to work closely with Medical Management staff to coordinate the member's health care within the CHRISTUS Health Plan delivery system.

## ROLE OF THE MEDICAL MANAGEMENT STAFF

Utilization Management Nurses and Case Managers collaborate with provider to:

- Utilize the CHRISTUS Health Plan network of contracted providers where appropriate
- Provide prior authorization for those procedures on the Prior Authorization List
- Conduct concurrent review of inpatient stays
- Participate in discharge planning using approved clinical guidelines to prevent readmissions
- Facilitate transfer of hospitalized patients to alternate levels of care
- Coordinate with other providers including SNF, Home Health, Durable Medical Equipment (DME), and Hospice
- Arrange for social intervention to improve care management.
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## ROLE OF MEDICAL DIRECTORS

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

- Provide clinical guidance for the Medical Management staff
- Interface directly with practicing physicians to resolve clinical issues
- Make decisions related to the authorization of medically necessary services
- Medical Directors are available for Peer to Peer discussion as needed regarding adverse determinations. Please call 1-844-282-3077 for a Peer to Peer discussion.

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

## PEER TO PEER AVAILABILITY

Medical Directors conducting medical necessity reviews are available to discuss review determinations with the requesting/ordering provider or attending provider via Peer-to-Peer conversation. The peer-to-peer conversation allows the treating provider the opportunity to discuss the Utilization Management determination before the initiation of the appeals process. A Peer-to-Peer conversation is available by calling the Utilization Management department toll free number: 1-800-678-7347. Peer-to-peer conversations are completed within one business day of request by a treating provider. If the Peer-to-Peer discussion does not result in authorization of the request, the process includes informing the provider and member of their appeal rights during the notification.

Providers will be notified of the availability of peer-to-peer using the following mechanisms:

- Verbal notification to treating provider
- Fax notification to treating provider
- Denial letter language

## AVAILABILITY OF MEDICAL MANAGEMENT STAFF

Medical Management (MM) staff is available on normal business days Monday through Friday from 8:00am to 5:00pm. Providers can reach the Medical Management department by calling: 1-800-678-7347 or Faxing: 1-800-277-4926. After normal business hours

and on holidays, an answering service is available to provide direction.

## MEMBER SELF-REFERRALS

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

- Annual well woman exam
- Annual mammogram
- Behavioral health outpatient services
- Disease management programs
- Hearing exam
- Optometry - annual eye exam and glasses
- Out-of-area dialysis

## PCP REFERRALS TO NETWORK SPECIALISTS

The PCP does not need prior/referral authorization to refer the member to an in-network specialist. Participating providers are listed in the provider directory, CHRISTUS Health Plan website or providers may call member services to verify in-network participation.

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

## PRIOR-AUTHORIZATION GUIDELINES

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

- Contact the Utilization Management Department at 1-844-282-3100 for an urgent or emergent request
- Fax a routine request to 1-800-277-4926

The following information will be requested from the provider:

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

Completed referrals containing all necessary information and supporting documentation will be processed by the Utilization Management Department.

## UTILIZATION MANAGEMENT COMPONENTS

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

**Admission Notification:** The provider and/or hospital notify Utilization Management when a CHRISTUS Health Plan member is

admitted to the hospital.

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

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

**Retrospective Review:** The process of review that occurs before payment of any claims for which Precertification/Authorization did not occur. The review will consist of assessing the medical necessity of all services not previously approved. Clinical information will be reviewed for appropriateness using InterQual® Criteria, Plan Protocols, and Contract coverage, as appropriate.

**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 specially qualified facilities or designated units in a hospital which have the staff and equipment to provide acute care, skilled nursing care or rehabilitation services and other related health services. CHRISTUS Health Plan coverage includes, as a benefit, inpatient care in a participating SNF, LTAC or Rehabilitation Facility. Prior authorization is required. Custodial care is a non-covered benefit.

**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 members upon receiving prior orders by the attending physician and authorization by the Utilization Management department. Requests for continuation of services will be reviewed on an ongoing basis to determine medical necessity. Custodial care is a non-covered benefit.

**Durable Medical Equipment:** Durable medical equipment (DME) is used primarily and customarily for a medical purpose, rather than primarily for transportation, comfort or convenience. It can withstand repeated use and improves the function of a malformed, diseased or injured body part or retards 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 Plan contracted providers.



## UTILIZATION MANAGEMENT NOTIFICATION REQUIREMENTS

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

Treatment/Service	Notification Requirement
Urgent admissions/ observations	With 1 business day of admission to the facility
Elective admissions/ observations/surgical procedures/ outpatient procedures	5 business days prior to the requested date of service
SNF/ Rehab/ Hospice	Initiation – 2 business days prior to requested date of admission Continuation – 3 days prior to requested date of service
Home health	Initiation – 2 business days prior to requested date of admission Continuation – 7 days prior to requested date of service
Diagnostic services/DME/ other procedures requiring authorization	7 business days prior to requested date of services

## AUTHORIZATION PROCESS

Information received either via phone or electronic means in the Utilization Management department will be reviewed for coverage and benefits. Appropriateness and medical necessity will be reviewed using InterQual® Criteria, Plan Clinical Protocols, benefits and coverage. Upon approval of authorization, the system generated authorization sheet is faxed to the requesting provider and servicing provider. Requests that do not meet the medical necessity or coverage guidelines are forwarded for further review.

If CHRISTUS Health Plan determines that medical necessity or benefit coverage is not established, notification is made to the requesting provider that will include the physician reviewer's determination to deny authorization. A denial letter will be sent to the requesting provider within two (2) business days of the determination.

## REQUESTS TO OUT-OF-NETWORK PROVIDERS

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

- For emergencies experienced in or out of the service area
- In urgent situations experienced outside the 48 contiguous states
- When other medically necessary services are unavailable from participating providers.

Most out-of-network requests for services will be sent to medical review and may require service negotiations, which could potentially delay the request.

## Authorization Requirements

- For Eligibility and Benefits, please contact Member Services at (844)-282-3025
- For Family Planning Assistance, please contact HealthSmart at 855-596-6740

### What Services Require Prior Authorization?

The following services require Prior Authorization. They are subject to the coverage rules in this policy

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• All out-of-network services</li> <li>• All inpatient acute care hospitalizations</li> <li>• Acute medical detoxification</li> <li>• All inpatient rehabilitation hospitalizations</li> <li>• All subacute admissions</li> <li>• All inpatient long-term acute care hospitalization</li> <li>• Air ambulance</li> <li>• Genetic testing and counseling and treatment of genetic inborn errors of metabolism disorders (IEM)</li> <li>• Dental services</li> <li>• Dialysis</li> <li>• Hospice services, inpatient and outpatient</li> <li>• Non-emergency ambulance transport</li> <li>• Nuclear medicine</li> <li>• Organ transplant services</li> <li>• Rehabilitation therapy (e.g. Cardiac, pulmonary)</li> <li>• Surgical procedures</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric or weight loss surgical procedures and treatment of morbid obesity</li> <li>• Breast implant removal</li> <li>• Cosmetic or reconstructive surgery</li> <li>• Cochlear implant</li> <li>• Clinical trial services</li> <li>• Child developmental/behavioral evaluations and testing</li> <li>• Botulinum toxin A injection (Botox) chelation therapy</li> <li>• Home health care</li> <li>• Durable medical equipment over \$500</li> <li>• Craniomandibular joint (CMJ) and temporomandibular joint dysfunctions (TMJ)</li> <li>• Hyperbaric oxygen therapy</li> <li>• Outpatient physical therapy</li> <li>• Prosthetic appliances and orthotics</li> <li>• Radiation therapy</li> <li>• Skilled nursing facility care;</li> <li>• Therapy (e.g. speech, occupational, and physical)</li> </ul> |
|--|--|

\*This list may not include all services requiring Prior Authorization. If you need help determining if a service requires Prior Authorization, please contact Utilization Management at 1(844)282-3020.

### Specialty Drugs Authorization Requirements (Not All Inclusive)

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Interferon (Avonex)</li> <li>• Vantas (Histrelin Implant)</li> <li>• Remicade (Infliximab)*</li> <li>• Activase (Alteplese)</li> <li>• Aranesp (Darbepoetin)</li> <li>• Botox (Botulinum Toxin Type A)</li> <li>• Enbrel (Etanercept)*</li> </ul> | <ul style="list-style-type: none"> <li>• Desferal (Deferoxamine)</li> <li>• Growth Hormone (Somatropin)*</li> <li>• Neulasta (Pegfilgrastim)</li> <li>• Maeugen (Pegaptnnib Sodium)</li> <li>• Lucentis (Ranibizumab)</li> <li>• IVIG (Immunine/Human Gamma Globulin)</li> </ul> |
|--|--|

## **PROVIDER OBLIGATIONS — PRECERTIFICATION**

Providers are responsible for obtaining precertification from CHRISTUS Health Plan and for submitting the adequate required information before performing certain procedures or when referring members to non-contracted providers. CHRISTUS Health Plan will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between CHRISTUS Health Plan and the provider will not generate a member denial letter.

## **PROVIDER OBLIGATIONS — APPEALS (BOTH MEMBER AND PROVIDER APPEALS)**

Providers must cooperate with CHRISTUS Health Plan and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow CHRISTUS Health Plan to make an expedited decision.

## **ADMINISTRATIVE APPEALS — PROVIDER LIABILITY APPEALS/PROVIDER CLAIMS DISPUTES**

Appeals or claim disputes that are the result of contractual issues between the provider and CHRISTUS Health Plan carry no member liability, and the member is held harmless for any payment over and above the applicable cost share. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

## PROVIDER COMPLAINTS AND APPEALS

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All participating providers have agreed to comply with the Plan's dispute resolution process by signing the provider agreement. The provider complaint process is available to any participating provider to resolve disputes with the Plan. The Plan distinguishes disputes by the following categories: 1) Administrative Disputes related to claims or claims payment; 2) Administrative Disputes not related to claims payment; and 3) Disputes Concerning Professional Competence and Conduct.

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

### ADMINISTRATIVE CLAIM AND UTILIZATION REVIEW DISPUTES TO HMO

CHRISTUS Health Plan will make every effort to resolve provider dispute inquiries using consistent procedures for reviewing and responding to inquiries.

- Dispute reviews will be completed within thirty (30) days of receipt of the request.
- A provider dispute must be sent in writing to:

**CHRISTUS Health Plan Exchange**

Attn: Claims Dispute  
P.O. Box 169001  
Irving, Texas 75016  
Fax#: 1-844-416-2840

- All requests must be submitted for review within 120 days of an action taken or decision made by CHRISTUS Health Plan.
- For any dispute involving a denied claim, the 120-day period begins on the date of the CHRISTUS Health Plan remittance reflecting the denial. For any dispute related to a claim audit, the 120 day period begins on the date of the notice to the provider.
- CHRISTUS Health Plan will forward the provider request to the appropriate area for research and resolution. When appropriate, the Medical Director will review the matter using appropriate peer input.
- Providers will receive a payment or written response generally within thirty (30) calendar days describing how their request was resolved.

### COMPETENCE OR CONDUCT DISPUTES AND APPEALS TO HMO

- Providers may file a non-administrative dispute that involves actions by the Plan that relate to a participating provider's status within the Plan's provider network and any action by the Plan related to a participating provider's professional competency or conduct.
- A competence or conduct provider dispute or appeal with CHRISTUS Health Plan can only be requested in writing.
- Participating providers have the right to appeal their dispute to two (2) separate panels above the level of the Plan body involved in the dispute, each consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. In no case will panel members be assigned who have been previously involved with the issue.
- A panel will be convened within 60 days of the request and the decision will be returned to the participating provider within 30 days of the closure of the panel. When an adverse action is taken or if the provider voluntarily relinquishes participation while undergoing investigation and/or peer review, it is noted in the Credentialing File and reported if required by law.
- The following actions are required to be reported to the National Practitioner Data Bank (NPDB): terminations resulting from serious quality deficiencies, providers who terminate themselves while under investigation and providers who terminate themselves with an action plan in place.

## MEMBER COMPLAINTS AND APPEALS

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### MEMBER COMPLAINTS TO HMO

A complaint is defined as any dissatisfaction expressed by a complainant orally or in writing to CHRISTUS Health Plan with any aspect of the CHRISTUS Health Plan's operations, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a complainant. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

Members, or a Member's designee, can file a complaint with CHRISTUS Health Plan either in writing or verbally by contacting the Appeal and Grievance Representative at:

**CHRISTUS Health Plan Exchange**  
Attn: Appeal and Grievance Department  
P.O. Box 169009  
Irving, Texas 75016  
Fax: 1-866-416-2840

If the complaint is received verbally:

- The Appeal and Grievance Representative will send a verbal complaint form documenting the verbal complaint. Once the Member or Member's designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member's designee will return the verbal complaint form to the Appeal and Grievance Representative.
- If the complaint form is not returned to the Appeal and Grievance Representative within 15 calendar days from date on letter, a determination will be made based on information available.
- Within five (5) business days of receipt of a complaint by a Member or Member's designee, the Appeal and Grievance Representative will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint.
- Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint.
- Once the complaint has been resolved, the Appeal and Grievance Representative will send a response letter to the Member or Member's designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member's designee is not satisfied with CHRISTUS Health Plan's decision.

## MEMBER APPEALS TO HMO

If the Member's Complaint is not resolved to their satisfaction, Members have the right to either:

- Appear in person before a complaint appeal panel in a location where they would normally receive Health Care Services or another agreeable location or
- Address a written Appeal to the complaint appeal panel.

CHRISTUS Health Plan will complete the complaint appeal process not later than the thirtieth (30th) calendar day after the date of the request (receipt date) for Appeal. If the Appeal of a Complaint relates to an ongoing emergency or denial of continued hospitalization, the resolution shall be concluded in accordance with the immediacy of the case and not later than one business day after the request for Appeal is received. The appeal panel will be composed of an equal number of the Plan staff, Physicians or other Providers, and Plan enrollees.

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

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

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

The Plan's notice of the final decision on an appeal shall include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision, along with the toll-free telephone number and address of the Texas Department of Insurance (TDI).

<b>Mail:</b>	Texas Department of Insurance Consumer Protection (111-1A) P.O. Box 149091 Austin, Texas 78714-9091
<b>Fax:</b>	(512) 490-1007
<b>Email:</b>	<a href="mailto:ConsumerProtection@tdi.texas.gov">ConsumerProtection@tdi.texas.gov</a>
<b>Phone:</b>	1-800-252-3439

## MEMBER EXPEDITED APPEALS TO HMO

The Member or Member's designee may:

- Ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the Member. Requests for an Expedited Appeal can be made verbally or in writing as indicated in the Member Complaint to HMO Process listed above.
- Expedited appeals for emergency care denials and denials of continued hospital stays will be reviewed by a Medical Director that was not involved in the original denial and is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review.
- The time frame in which the appeal is completed will be based on the medical immediacy of the condition, procedure, or treatment, but will not exceed 1 working day from the date all information necessary to complete the appeal is received.
- If the Member or Member's designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited.
- If the Member or Member's designee does not agree with this decision they may submit a request for an Independent Review Organization as described below.

Members may also file a complaint to the TDI by calling 1-800-252-3439 or in writing to:

**Mail:** Texas Department of Insurance  
Consumer Protection (111-1A)  
P.O. Box 149091  
Austin, Texas 78714-9091

**Fax:** (512) 490-1007

**Email:** [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

## MEMBER ADVERSE DETERMINATION APPEALS TO HMO

A Member, a person acting on behalf of the Member, or the Member's physician or health care provider may:

- Appeal an adverse determination orally or in writing. Any complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of the adverse determination.
  - Appeals must be filed within 30 days, following the Plan's denial notification.
  - Within 5 working days from receipt of the appeal, an acknowledgement letter will be sent to the appealing party.
  - The acknowledgement letter will include: the date of receipt of the appeal; a description of the appeal procedure and time frames; a list of the documents, such as new, previously unknown information, further reasonable documentation related to the case but not previously received or medical records that will need to be submitted for review during the appeal process.
  - The provider will have 5 business days to submit the additional information requested; and a one-page appeal form, if the appeal is oral.
  - As soon as practical, but in no case later than 30 calendar days of receipt of the appeal, all available information will be reviewed by a physician who was not involved in making the initial adverse determination and a written notification of the appeal determination will be sent to the appealing party.
  - If the appeal is denied, the written notification to the Member, Member's designee, and Member's provider shall include a clear and concise statement that includes: the clinical basis for the appeal's denial; the specialty of the physician making the denial; the right of the appealing party to seek review of the denial by an independent review organization and the procedures for obtaining that review; the right to an immediate appeal to an independent review organization in circumstances involving a condition that is life-threatening to the member; the right of the health care provider to set forth in writing, within 10 working days of the appeal denial, good cause for having a particular type of specialty provider review the case.
- 
- For expedited appeals, Members must call 1-844-282-0380 and fax all related information to 1-866-416-2840. Standard appeals must be mailed or faxed to:

CHRISTUS Health Plan Exchange

Attn: Appeal and Grievance Department  
P.O. Box 169009  
Irving, Texas 75016; Fax: 1-866-416-2840

## INDEPENDENT REVIEW (IRO) PROCESS

The Member or Member's designee may:

- Seek a review of CHRISTUS Health Plan's denial of an appeal of an adverse determination by an independent review organization assigned to the appeal in accordance with TIC Article 21.58C.
- The Member or Member's designee must complete the "Request for IRO Review" form and return to CHRISTUS Health Plan within 4 months from receipt of CHRISTUS Health Plan's decision.
- An Independent Review Organization (IRO) is an organization that has no connection to CHRISTUS Health Plan or with health care providers that were previously in the treatment or decisions made by CHRISTUS Health Plan about services that have not been provided.
- Once CHRISTUS Health Plan receives the completed form, the Plan will notify TDI of the Member's request for an IRO review.
- The standard time frame for the IRO process should take no longer than 20 calendar days from the date the completed form and all necessary information is received by the IRO.
  - If the Member has an emergency health condition, the IRO process should take no longer than 8 calendar days from the date the completed form and all necessary information was received by the IRO.



## PHARMACY SERVICES

CHRISTUS Health Plan includes coverage for prescription drugs. Pharmacy claims are processed by Express Scripts (ESI), the CHRISTUS Health Plan pharmacy benefit management vendor. The formulary includes coverage of generic drugs, as well as many brand-name drugs, non-preferred brands and specialty drugs. Formularies are reviewed by a Pharmacy & Therapeutics Committee composed of provider and pharmacists. Providers can view a copy of the formulary on the CHRISTUS Health Plan website. Some of these drugs have precertification or step-therapy requirements or quantity limits, defined as:

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

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

Pharmacy Related Service	Performed By	Notification	Contact Information
Prescription Drugs	ESI	ESI	1-800-451-6245 1-800-922-1557 1-877-329-3760
Coverage Determination-	ESI	Standard Coverage Review Expedited Coverage Review	1-800-935-6103 1-800-935-6103
Formulary Exceptions	ESI	Coverage Review	1-800-935-6103

## PRESCRIPTION DRUGS BY MAIL ORDER

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the provider must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to 7-10 days for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call 1-844-470-1531.

## COVERAGE DETERMINATIONS FOR PRESCRIPTION DRUG BENEFITS

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

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

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

- A standard decision made within the standard 72-hour time frame
- An expedited decision made within 24 hours

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

## FORMULARY EXCEPTIONS

If a prescription drug is not listed in the CHRISTUS Health Plan formulary, please check the updated [formulary, which can be located on the \[www.christushealthplan.org\]\(http://www.christushealthplan.org\)](#) website. The website formulary is updated frequently with any changes.

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

- The prescribing provider can prescribe another drug that is covered on the formulary.
- The patient or prescribing provider may ask CHRISTUS Health Plan to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a non-formulary drug and requests an exception CHRISTUS Health Plan approves, CHRISTUS Health Plan will reimburse the member. If the exception is not approved, the member may appeal the Plan's denial. In some cases, CHRISTUS Health Plan will contact a member who is taking a drug that is not on the formulary. CHRISTUS Health Plan will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her provider if any of those drugs would be appropriate options for treatment. Also, members who recently joined CHRISTUS Health Plan may be able to get a temporary supply of a drug they are taking if the drug is not on the CHRISTUS Health Plan formulary.

## TRANSITION POLICY

New members in CHRISTUS Health Plan may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug CHRISTUS Health Plan covers or request a formulary exception to get coverage for the drug.

During the period of time members are talking to their providers to determine the right course of action, CHRISTUS Health Plan may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in CHRISTUS Health Plan. For current members affected by a formulary change from one year to the next, CHRISTUS Health Plan will provide a temporary supply of the non-formulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and CHRISTUS Health Plan provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits, CHRISTUS Health Plan will cover at least a one time, 30-day supply (unless the prescription is written for fewer days). CHRISTUS Health Plan will provide the member with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing provider to decide if switching to an appropriate formulary drug is feasible. This policy also applies to current members who experience a change in the level of their care.

The Health Plan drug formulary is a listing of generic and brand-name prescription medications that are preferred for use by CHRISTUS Health Plan. CHRISTUS Health Plan may add or remove drugs from our formulary during the year. To inquire about the status of a drug on the formulary, visit [www.christushealthplan.org](http://www.christushealthplan.org).

# CLAIMS, ENCOUNTERS AND EDI TRANSACTIONS

## CLAIM SUBMISSIONS

Providers using electronic submission must submit all claims to CHRISTUS Health Plan using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic 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 Plan by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by CHRISTUS Health Plan, unless applicable law provides that submissions may be in a paper format.

A claim is processed promptly if it is approved or denied within the time required by the Agreement or the applicable regulation of the state in which CHRISTUS Health Plan is operating. For claims to be paid promptly:

- A properly completed claim must be submitted electronically or by paper and the claim must not involve an investigation for coordination of benefits (COB), member eligibility, or subrogation
- Separate charges must be itemized on separate lines, Medical record documentation must validate the scope of the services provided and billed
- Claims must be received within 95 calendar days of the date of service or, in accordance with the terms specified in the Provider Agreement. CHRISTUS Health Plan will bear no liability to pay claims received after the 95th day and members cannot be balanced billed for provider's failure to submit claims within this timeframe.
- Include AMA-developed procedural coding.
- Include ICD-9/10 diagnosis coding to the highest specification.
- Be submitted on original red and white CMS 1500 or UB-04 forms when filing paper claims. (Black and white copies or faxes will not be accepted).
- Not be handwritten.

Note: If submitted electronically, a claim must be paid within 30 days of receipt; and  
If submitted manually, a claim must be paid within 45 day of receipt.

## EDI TRANSACTIONS

### Electronic Data Interchange (EDI) Routing

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

- Eligibility Inquiry and Response (270)
- Health Care claims professional (837P)
- Health Care claims Institutional (837i)
- Healthcare electronic payment-remittance advice (835) transactions.
- Claims Inquire and Response (276)

Providers are asked to direct all inquiries regarding electronic file exchange set up for HIPAA compliant transactions to their local assigned Provider Relations Representative, or they may call our Member Services Team at 1-844-282-3025.

### Clearinghouse

The Plan's EDI transactions are performed via the clearinghouse, Change Healthcare. Providers should contact their clearinghouse or billing entity to ensure that they are set-up to interact with Change Healthcare prior to performing any EDI transactions involving CHRISTUS Health Plan.

### ELECTRONIC ENCOUNTER DATA SUBMISSION

CHRISTUS Health Plan accepts encounter data electronically or via paper.

**Electronic Claims Submissions (837)**

- For submission of 837s, providers are to use **Payor ID: 45-2106295 52106**
- The Plan is listed as **CHRISTUS Health TX HIX**
- Providers should ensure they have a valid NPI on file with the health plan.

**Electronic Provider Remittance Advice (835)**

- The EDI Form should be completed and sent to [EDIChristus@christushealth.org](mailto:EDIChristus@christushealth.org).
  - For group providers, submit a form for each provider associated with the group.
  - For ancillary providers or facilities, submit a form for each location.
- Once set up, the provider’s billing service/clearinghouse will receive email notification.

**Electronic Enrollment Status (270)**

Providers do not need to contact the Plan to be set up for this service. Providers only need to contact Change Healthcare and choose this transaction.

**Electronic Claim Status (276)**

Providers can obtain electronic claims status (276) through Change Healthcare. Providers should ensure that both their NPI 1 and NPI 2 (if applicable) are captured in the Plan’s system.

**PAPER CLAIMS SUBMISSION**

**Guidelines for Filing Clean Claims**

CHRISTUS Health Plan recognizes that occasionally providers may need to submit claims on paper. Providers are asked to submit paper claims on the appropriate UB-04 or CMS -1500 claim form. The Plan will not accept super-bills or similar submissions as valid claims.

CHRISTUS Health Plan Exchange  
 Attention: Claims  
 P.O. Box 981654  
 El Paso, Texas

**Claims Filing Deadlines**

Providers should refer to their respective contracts for timely filing deadlines when submitting claims. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for a provider to submit claims will be **95 days** from the last date of service. If a provider enters into a formal dispute resolution process with CHP, the provider should refer to the timeliness guidelines in the Dispute Resolution Section of this Manual. Providers must claim benefits by sending CHP properly completed claim forms itemizing the services or supplies received and the charges. CHP will not be liable for benefits if CHP does not receive completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Initial Claims		Reconsiderations or Claim Dispute/Appeals		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
95	95	120	120	95	95

### Late Payment Penalties

If CHP does not pay a clean claim within the state-mandated timeframe indicated above, CHP will pay a late payment penalty in accordance with TDI regulations. Similarly, if CHP processes and pays a portion, but not all, of the contracted rate on a clean claim, CHP will pay an underpayment penalty in accordance with TDI regulations.

The late an underpayment penalties stipulated by TDI are outlined in the table below:

Penalty Type	Payment Owed
Late claims: days 1-45 after deadline to pay*	Lesser of \$100,000 OR 50% of the difference between contracted rate and billed charges.**
Late claims: days 46-90 after deadline to pay)*	Lesser of \$200,000 OR 100% of the difference between contracted rate and billed charges.**
Late claims: days 91+ after deadline to pay*	Lesser of \$200,000 OR 100% of the difference between contracted rate and billed charges PLUS 18% annual interest.**
Underpaid claims: days 1-45 after deadline to pay*	Lesser of \$100,000 OR 50% of the underpayment amount.**
Underpaid claims: days 46-90 after deadline to pay*	Lesser of \$200,000 OR 100% of the underpayment amount.**
Underpaid claims: days 91+ after deadline to pay*	Lesser of \$200,000 OR 100% of the underpayment amount PLUS 18% annual interest on the underpayment amount.**

\*Calculated for each day past the timely payment deadline from either the original date received for clean claims or the date requested additional information was received for denied claims.

\*In institutional cases, 50% of the penalty is due to the provider and 50% is due to TDI. Per TDI regulations, CHP will aggregate payments owed to TDI at the end of each month. \*\*Calculated from the date of claim payment

### Delinquency Period Payments

Subsidized, on-exchange members are entitled to a three-month delinquency period for any non-payment of premiums. CHP will process and pay any claims incurred by these members during this period. If the member is ultimately terminated for non-payment at the end of the delinquency period, CHP will request refunds for any paid claims with dates of service beginning within this period. This policy is consistent with guidance from TDI.

### Good Faith Payments

If CHP, in its sole discretion, determines that it has denied or reimbursed a claim correctly but agrees to overturn the denial or issue additional payment in the interest of the member, these "Good Faith Payments" will not be eligible for any interest or penalties related to late payment.

### Incomplete Claims

Claims that are determined to be incomplete due to incorrect or missing required information (e.g. invalid CPT codes) will be denied. Providers will need to re-submit these claims with the appropriate information for the claims to be adjudicated.

### Claim Corrections and Late Charges

Providers who believe they have submitted an incorrect or incomplete claim may submit an updated claim within the relevant timely filing period indicated above in the Timely Filing of Claims section. The corrected claim must include bill type code 117 if it is an inpatient claim or code 137 if it is an outpatient claim. Updated claim submissions that do not have these codes may be denied as duplicate submissions.

### **Claims for Emergency Services**

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

### **Collection of Cost Share**

Covered services provided to CHP members may be subject to a deductible, a coinsurance amount, or a copayment amount. In these cases, the member will be liable for reimbursing the provider the relevant amount. CHP encourages providers to collect copayments upfront but to defer the collection of coinsurance amounts and outstanding deductibles until CHP has adjudicated the claim and an Explanation of Payment (EOP) has been received.

If a provider prefers to collect coinsurance amounts and outstanding deductibles upfront, CHP encourages the provider to check with the member whether the member expects other medical or prescription spending to occur on that day. If the member anticipates further spending, CHP encourages the provider to account for those amounts in the upfront collection.

If a provider collects an upfront amount that exceeds the member's cost share indicated in the EOP, CHP requires the provider to issue a refund to the member within **10 working days** of receipt of the EOP.

Copayment and coinsurance amounts for the most common services are indicated on a member's ID card. Providers can also check a member's outstanding copayment amount, coinsurance amount, or deductible by calling CHP Member Services at **1-800-323-0208**

### **Balance Billing**

Except for copayments and deductibles, providers must not invoice or balance bill CHP members for the difference between the provider's billed charges and the reimbursement paid by CHP. Additionally, if providers do not comply with rules laid out in their contracts, in this manual, or by state regulators (e.g. timely filing, surprise bills, pre-authorization checks, etc.), providers cannot hold members liable for payment. Additionally, CHP will comply with, and expects providers to be compliant with, TDI's mediation process for eligible out-of-network claims.

This process is available to members with claims for medical services or supplies provided in in-network hospitals by the following types of out-of-network hospital-based physicians: (i) radiologists, (ii) anesthesiologists, (iii) pathologists, (iv) emergency department physicians, (v) neonatologists, and (vi) assistant surgeons. To be eligible for mediation, the member must have been balance billed more than \$500 (not including copayments, deductibles, or coinsurance amounts). If CHP receives a mediation request from TDI for a qualifying claim, CHP will notify the provider and arrange a teleconference call to resolve the dispute. CHP will schedule the teleconference no later than 30 days after the date the member submitted the request to TDI. CHP will notify the physician and member of the date and time of the call and supply a toll-free conference line number. If CHP, the hospital-based physician, and member cannot settle the dispute during the teleconference, CHP will submit a request to TDI for a formal mediation.

To avoid Out-of-Network mediation situations, CHP asks providers to make their best effort to refer members to in-network CHP providers and labs. Providers are encouraged to call CHP if they have a question about whether a specific provider or lab is in CHP's network. Further information about this mediation process can be found on the TDI website:

<http://www.tdi.texas.gov/consumer/cpmmediation.html>

### **Checking the Status of a Claim**

Providers can check the status of a claim by calling Member Service at 1-844-282-3025.

### **Claims Payment Explanation of Payment (EOP)**

An EOP is a summary statement sent with the check to the provider which lists the services, amounts billed, denials, adjustments and payment for one or more claims. CHRISTUS Health Plan uses system generated message codes to communicate with the providers on their explanation of payment (EOP). These event codes are used to further explain claim payments, adjustments or denials. Please contact Member Service or a Provider Relations Representative for assistance with interpretation.

### **Non-Covered Services**

Contracted providers may only bill CHP members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

1. The specific service(s) to be provided.
2. A statement that the service is not covered by CHP.
3. A statement that the member chooses to receive and pay for the specific service.
4. The member is not obligated to pay for the service if it is later found that service was covered by CHP at the time it was provided, even if CHP did not pay the provider for the service because the provider did not comply with CHP requirements.

### **Billing for "No-Shows"**

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call in advance to cancel the appointment. The "no show" appointment must be documented in the medical record.

### **OVERPAYMENTS AND WITHHOLDS**

Should CHP determine that it has overpaid a claim, CHP 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 CHP determined that an overpayment had been made. CHP must make any refund requests within **180 calendar days** of the date of payment of the affected claim.

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 **45 working days** of the date the notice of overpayment was received. If the provider contests the refund request, the provider must identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

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

#### **CHRISTUS Health Plan Exchange**

Attn: Claims Recovery Unit

P.O. Box 169001

Irving, Texas 75016-9001

Should the provider fail to issue the refund or notify CHP of a contested overpayment within 45 working days, the amount of the overpayment may be deducted from future claims payments until CHP has been fully reimbursed. A written explanation will accompany all deductions made from future claims payments.

### **COORDINATION OF BENEFITS (COB) AND THIRD PARTY LIABILITY (TPL)**

Coordination of Benefits is a procedure to determine an insurer's liability when a person is covered by more than one insurer. CHRISTUS Health Plan is the primary payor for covered services provided to members. CHRISTUS Health Plan may become the secondary payor when services are also reimbursable under other medical insurance plans.

Other third parties may be responsible for payment under automobile, liability or worker's compensation insurance. If a primary insurance has made payment or denied a claim, the EOP from the primary carrier must be included with the claims submission to CHRISTUS Health Plan. The count for timely filing of the claim and EOP from the primary carrier starts on the date of the EOP from the primary carrier. Providers are required to identify on the claim form when other insurance is involved. Please note on the CMS 1500 claim form, Block 9 & 10 and UB -04 claim form blocks 50- 51 & 58-62.



# REIMBURSEMENT METHODOLOGIES

## FEE-FOR-SERVICE

Services provided under a fee-for-service contractual arrangement are reimbursed from the tiered fee schedule which appears below. During the pricing of claims, the Plan verifies whether there is an applicable rate configured at each level for the rendering provider for any given service before dropping to a subsequent level.

Level	Fee Schedule
Level I	The specific carve-out fee schedule based on the provider's contract with the Plan
Level II	<p>Medicare allowable fee schedule</p> <p>The Medicare fee schedule can be obtained free of charge from the website of the Centers for Medicare and Medicaid Services (CMS) at <a href="http://www.cms.gov">http://www.cms.gov</a>. The fee schedule can also be obtained from the website of TrailBlazer Health Enterprises, LLC, a CMS Contracted Intermediary/Carrier at <a href="https://www.novitas-solutions.org">https://www.novitas-solutions.org</a></p>
Level III	<p>Usual and Customary (UCR) schedule of billed charges per zip code.</p> <p>The charges are stratified into a percentile of submitted claims developed by FairHealth©.</p>

CHRISTUS Health Plan reimburses outpatient institutional services rendered by contracted providers at a contractually agreed upon amount. Please refer to the provider's Agreement with the health plan for specific details.

## COPAYMENTS

It is the responsibility of the provider's office to collect the basic office visit copayment at the time of the member's visit. If the copayment or deductible is not collected from the member, the provider's office will be reimbursed by CHRISTUS Health Plan.

# INTEGRITY/COMPLIANCE

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

The CHRISTUS Health Plan is dedicated to the CHRISTUS "Core Values" of Dignity, Integrity, Excellence, Compassion and Stewardship, and the Plan holds contracted physicians and providers to the same standards. As a participating provider in CHRISTUS Health Plan, providers are expected to:

## SAFETY

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

## QUALITY CARE

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

## ACCURATE RECORDING AND REPORTING

- Prepare and maintain all member and organizational data, 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 member and protect this information from breach of confidentiality or loss.

## ACCURATE AND APPROPRIATE CLAIMS

- Submit claims for payment or reimbursement only for services actually rendered and make sure that claims submitted for payment or reimbursement are for services that are medically necessary
- Submit claims for payment or reimbursement which are not knowingly false, fraudulent or otherwise incorrect. Establish an audit function to validate accuracy of claims submission
- Strive to make sure that all submitted claims are properly coded and documented, and filed according to all applicable laws and regulations.

## PROTECTION OF PRIVACY

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

## ETHICAL PRACTICES

- Not mislead members or the public or cause them to request services they do not reasonably need
- Treat all members with dignity, respect, and compassion
- Respect and support the rights of all members
- Strive for excellence in quality of care and service provided to all served, regardless of race, color, religion, gender, orientation, disability, age or national origin
- Clearly explain care, treatment and services to the member and family so that informed consent can be obtained. Explanation of treatment must include:
  - Potential benefits and drawbacks
  - Potential problems related to recovery
  - Likelihood of success
  - Possible results of non-treatment; and
  - Significant alternatives.

## **FRAUD, WASTE AND ABUSE**

CHP takes the detection, investigation and prosecution of fraud and abuse very seriously and has a fraud, waste and abuse (FWA) program that complies with the federal and state laws. CHP, in conjunction with its parent company, CHRISTUS Health Plan, operates a fraud, waste and abuse unit. CHP routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Manual. The CHP Special Investigation Unit (SIU) performs retrospective audits, which, in some cases, may result in taking actions against providers who commit fraud, waste and/or abuse. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularities
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify
  
- Some of the most common FWA practices include:
  - Unbundling of codes
  - Up-coding services
  - Add-on codes billed without primary CPT
  - Diagnosis and/or procedure code not consistent with the member's age
  - Use of exclusion codes
  - Excessive use of units
  - Misuse of benefits
  - Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-844-282-3100. CHP takes all reports of potential fraud, waste and abuse very seriously and investigates all reported issues. In addition, unbundling, fragmenting or code gaming to manipulate the Provider's Current Procedural Terminology (CPT) codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive.

As a provider, it is important to note that it is considered a crime to knowingly and willfully execute (or attempt to execute) a scheme to defraud a health care benefit program, or to obtain money or property from a health care benefit program through false representations.

### **FWA Program Compliance Authority and Responsibility**

CHP Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. CHP is committed to identifying, investigating, sanctioning and prosecuting suspected fraud, waste and abuse. The CHP provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

## **IMPORTANT STATUTES**

CHRISTUS Health Plan hopes that providers find this information helpful, however, if providers would like more information regarding compliance programs, please visit OIG's web site at [www.oig.hhs.gov](http://www.oig.hhs.gov) Whistleblower – Sarbanes/Oxley Act

### **False Claims Act**

Imposes civil liability on any person/entity submitting false claims to the US government.

### **Criminal Investigation of Health Care Offenses**

Imposes criminal penalties for any person willfully obstructing such investigation(s), for example, withholding medical records

## **Mail and Wire Fraud**

Imposes criminal penalties for any scheme to defraud another of money or property by using mail, private courier, telephone, fax or computer. Notably each offense is considered a separate crime.

## **Social Security Act**

A broad statute with civil and criminal penalties that covers many fraudulent and abusive activities including:

- Upcoding
- Providing services not medically necessary
- Unlicensed providers
- Offering kickbacks/bribes/rebates to influence the beneficiary to seek services from a provider excluded from participation with the Federal government

There are a limited number of exceptions to the Social Security law known as "safe harbors," which provide immunity from criminal prosecution.

## **Federal Anti-Referral Law (Stark Laws)**

Providers are prohibited from referring patients to health entities in which they have an ownership relationship. Any health service receiving a "prohibited referral" is prohibited from billing for it. Health services include:

- Lab and radiology
- Physical Therapy and Occupational Therapy
- DME equipment and supplies
- Intravenous and enteral (tube feeding) nutrients and supplies
- Orthotic and Prosthetic devices and supplies
- Home Health services, inpatient and outpatient hospital services
- Outpatient prescription drugs

There are specific exceptions to the Stark laws, some related to Stocks and Bonds, and some related to certain physician services. The Sherman Antitrust Act-prohibits any ventures which result in a monopoly or combination of restraint of interstate trade.

## **Emergency Medical Treatment and Active Labor Act-(EMTALA)**

Prohibits hospitals that receive Medicare funds from transferring out patients in their ERs based solely on their inability to pay for services.

## **Civil Rights Act of 1964**

Prohibits any federally funded program from discriminating on the basis of race, creed, color, or national origin.

## **Rehabilitation Act of 1973**

Prohibits qualified handicapped individuals from being discriminated against in any program or activity receiving federal funds. Individuals protected are those with:

- Physical or mental impairment which substantially limits one or more major activities of daily living
- Has a record of such an impairment or has it currently
- Blind/visual impairment or deaf/hearing impairment
- Cerebral Palsy, epilepsy or seizure disorder
- Drug/Alcohol addiction
- Mental retardation and Psychiatric disorders
- Orthopedic handicap, spinal cord/traumatic brain injury
- Specific learning disability, and certain speech disorders
- Chronic diseases including AIDS, arthritis, cancer and diabetes

## **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Mandates that security and confidentiality of individually identifiable protected health information (PHI) must be stored and transmitted securely, patients must be notified of their rights, and where to submit complaints, and patients must have access to their medical records.

## **Alcohol Drug Abuse and Mental Health Administration Reorganization Act**

Specifies that alcohol and drug abuse records are kept confidential and requires certain court orders.

## **The Freedom of Information Act**

Enacted to reach a balance between the right of the public to know, and the needs of government to keep information private. CHRISTUS Health Plan has specific procedures by which information is made available to the public that requires a written request.

## PROVIDER RESOURCES

### CHRISTUS Health Plan Website

### Provider Website

Information contained on our provider website includes, but is not limited to:

- The Provider Manual
- Quick Reference Guides
- Forms (Prior Authorization etc.)
- The Pharmacy Preferred Drug Listing
- Trainings

### Secure Provider Portal

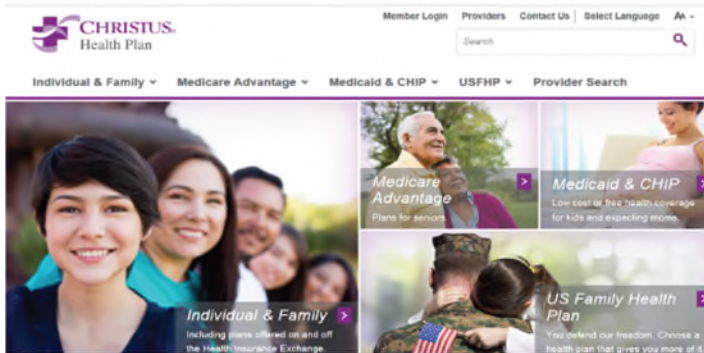
Information contained on our Secure Provider Portal,

<https://www.ChristusHealthPlan.org>:

- Member Eligibility
- Authorizations
- Claims Submissions & Status
- Payments History
- Monthly Patient Listings

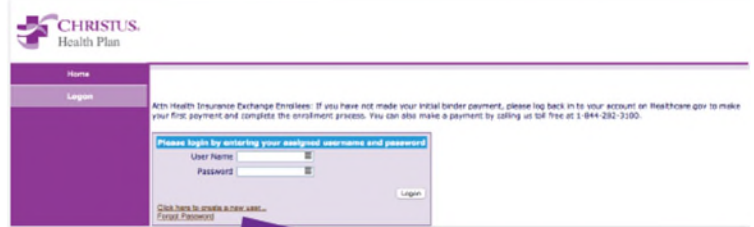
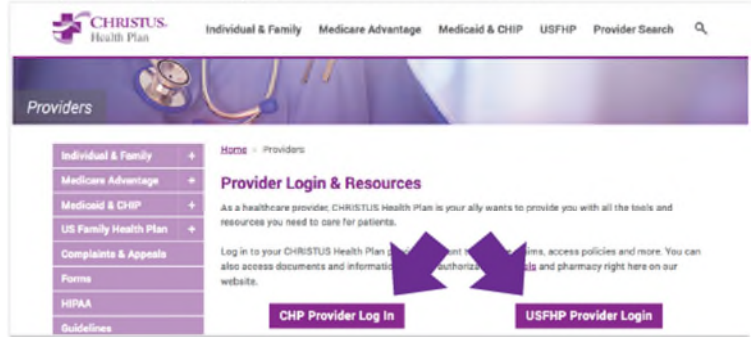
Go to [www.christushealthplan.org](http://www.christushealthplan.org)

- Click on **Providers** in the navigation
- On the next page, click on the **CHP Provider Login** button



Log in to your CHRISTUS Health Plan provider portal as a provider and you will find helpful information and resources with this secure section of our website. Providers can review their claims or previously submitted authorizations, validate member eligibility and look up prior authorizations.

If you are a provider, please click on the **CHP Provider**



**TIP:** Click here to create a new user.

# GLOSSARY OF TERMS

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

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

**Administrative Grievance/Complaint**—An oral or written complaint submitted by or on behalf of a Grievant regarding any aspect of a health benefits plan other than a request for Health Care Services, including but not limited to:

- administrative practices of the health care plan that affects the availability, delivery, or quality of Health Care Services;
- claims payment, handling or reimbursement for Health Care Services; and
- terminations of coverage.

**Adverse Determination** –A determination by a health maintenance organization 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.

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

**Annual Out-of-pocket Maximum** – A specified dollar amount of Covered Services received in a Calendar Year that is the most the Member will pay (Cost Sharing responsibility) for that Calendar Year.

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

**Application** – The forms, including required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for Coverage.

**Beneficiary** – A recipient of insurance benefits.

**Calendar Year** – The period of time beginning January 1 and ending December 31 of any given year. The initial Calendar Year period is from a Member’s Effective Date of coverage and ends on December 31, which may be less than 12 months.

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

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

**Certification** – A decision by a health plan that a Health Care Service requested by a Provider or Grievant has been reviewed and, based upon the information available, meets the Plan’s requirements for coverage and medical necessity, and the requested Health Care Service is therefore approved.

**Claim** – A notification to the insurance company that payment is due under the Contract provisions; a medical bill.

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

**Clean Claim** – A claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for the Managed Care Organization (MCO) or subcontracted claims processor to adjudicate 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; and
- 837 Institutional Companion Guide.
- National Council for Prescription Drug Programs (NCPDP) Companion Guide.
- Note: If submitted electronically, a claim must be paid within 30 days of receipt; and  
If submitted manually, a claim must be paid within 45 day 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 members.

**Coinsurance** – The percentage of allowed charges for Covered Services for which the Member is responsible for payment.

**Commissioner** – The Texas Commissioner of Insurance

**Complainant**– An enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

**Complaint** –Any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination under Section 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

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

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

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

**Contract** –The Contract includes the *Summary of Benefits and Coverage* and is a legal contract between the Member and CHRISTUS Health Plan.

**Coordination of Benefits (COB)** – Insurance claims review process used when a beneficiary is insured by two or more carriers. The process determines the liability of each carrier in order to eliminate duplication of payments.

**Copayment** – The amount that Members are required to pay to a Participating Provider or other authorized provider in connection with the provision of Health Care Services.

**Cost Sharing** – Any contribution Members make towards the cost of their Covered Health Care Services as defined in their Contract. This includes Deductibles and Copayments.

**Coverage/Covered** – Benefits extended under the Member's Contract, subject to the terms, conditions, Limitations, and Exclusions of the Contract.

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

- Administered or ordered by a Physician or other qualified Provider;
- Medically Necessary to the diagnosis and treatment of an Injury or Illness;
- Not excluded by any provision of the Contract; and
- Incurred while the Member's coverage is in force under the Contract.

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

**Cultural Competence** – Possession of the knowledge, skills, and attitudes needed to provide effective health care for diverse populations, taking into account the culture, language, values, and reality of the patient and patient's community.

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

**Custodial Care** – Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Member's Condition; Custodial Care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine drugs, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

**Denial** – Refusal to approve services or payment to a provider for covered or non-covered services under a member's benefit plan.

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



- Denial in whole or part of payment for a covered service;

**Deductible** – Part of the contribution that Members make toward the cost of their health care, also known as Cost Sharing. It means that amount the Member is required to pay each Calendar Year, directly to the Practitioner/Provider in connection with Covered Health Care Services before CHP begins to pay Covered Benefits.

**Diagnosis** – The nature of a disease; the identification of an illness. It is represented on a medical claim by an ICD-9/10 code.

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

**Diagnostic Service** means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

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

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

**Durable Medical Equipment** – Equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an Illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally 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 Member's coverage begins.

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

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

**Emergency Care or Emergency Care Services** –Health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize Emergency Medical Conditions.

**Emergency Medical Condition** –A severe Injury or a medical Condition of a recent onset and severity, including severe pain. The Injury or medical Condition must be one that would lead a prudent layperson with an average knowledge of medicine and health to believe that failure to get immediate medical care could: (a) place such person's life or health in serious jeopardy; (b) result in serious impairment to bodily functions; (c) result in serious impairment to a bodily organ or part; or (d) result in serious disfigurement; (e) or for a pregnant woman, result in serious jeopardy to the health of a fetus.

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

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

**Exchange** – The Texas Mexico Health Insurance Exchange

**Excluded Services** –Health Care Services that are not Covered Services and that the Plan will not pay for.

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

**Experimental, Investigational or Unproven** – Any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided; In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

- 1) A technology must have final approval from the appropriate regulatory government bodies;
- 2) The scientific evidence as published in evidence-based, peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- 3) The technology must improve the net health outcome;

- 4) The technology must be as beneficial as any established alternatives; and
- 5) The improvement must be attainable outside the Investigational settings.

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

**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.

**Fee Schedule** – A list of charges (or allowances) for specific procedures and services

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

**Follow-up Care** – The contact with, or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment

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

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug; Generally, a "generic" drug works the same as a brand name drug and usually costs less.

**Genetic Inborn Errors of Metabolism (IEM)** – A rare, inherited disorder that is present at birth and results in death or mental retardation if untreated and requires consumption of special medical foods.

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

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

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

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

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

**Health Employer Data and Information Set (HEDIS)** – A set of HMO performance measures that are maintained by the National Committee for Quality Assurance; HEDIS data is collected annually and provides an informational resource for the public on issues of health plan quality.

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

**Health Maintenance Organization** – Any person or entity who undertakes to provide or arrange for the delivery of basic Health Care Services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

**Health Plan** – An organized service to provide stipulated medical, hospital, and related services to individuals under a prepayment contract.

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

**Hospitalist** – A physician, usually an internist, who specializes in the care of hospitalized patients.

**ICD-9; 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 DRGs, prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

**Illness** – A sickness or disease, including all related Conditions and occurrences, requiring Health Care Services.

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

**Independent Review Organization (IRO)** – An entity that is certified by the Commissioner to conduct reviews; By law, an IRO must not be affiliated with the HMO which has denied a request for authorization for proposed treatment. IROs perform an administrative review of the Medical Necessity and appropriateness of Health Care Services being provided or proposed to be provided to a Texas resident which has been denied twice as not Medically Necessary or not appropriate.

**Injury** – Bodily injury due to an accident which results solely, directly and independently of disease, bodily infirmity, or any other causes.

**In-network** – Care received from a Participating Provider.

**Inpatient** – A patient who is admitted to a hospital that requires at least one overnight stay.

**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 prove some injury and that the injury was the result of negligence on the part of the professional. A practitioner is liable for damages or injuries caused by malpractice.

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

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

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

**Medical Management/Quality Improvement Committees**– Committees composed of provider, the medical director, and other healthcare professionals that provide a mechanism for provider participation, communication and development and administration of CHRISTUS Health Plan.

**Medical Necessity** – Services sufficient in amount, duration, and scope to reasonably achieve their purpose, 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 member's condition or the quality of medical care.

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

**Member** – An individual:

- who meets each of the enrollment and eligibility requirements described in the Contract;
- who has been properly enrolled in coverage with the Plan; and
- for whom the Plan has received any required Premium for the enrolled coverage.

**Member ID card** – Identification card issued to members upon enrollment in a health plan.

**Member Services** – A department within our plan responsible for answering Member's questions about their membership, benefits, complaints, and appeals.

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

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

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

**Network Pharmacy** – A network pharmacy is a pharmacy where members of the Plan can get their prescription drug benefits. In most cases, their

prescriptions are covered only if they are filled at one of the contracted network pharmacies.

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

**Non-Participating Provider** – A Provider that is not a Participating Provider.

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

**Out-of-Network Services** – Health Care Services Obtained from a Non-Participating Provider.

**Outpatient** – Services that do not necessitate an overnight hospitalization, but visit to a hospital, clinic, or associated facility for diagnosis or treatment.

**Outpatient Hospital** – A place to receive Covered Services while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether the Member is subsequently admitted as an Inpatient in a hospital.

**Participating Provider** – A Physician, Provider, Hospital or Health Care Facility that has an agreement with the Plan to accept the Plan’s rates and payments as payment in full when providing Health Care Services to Members.

**Payer** – The entity ultimately responsible for funding the payment for covered health services provided through the provider agreement. Used interchangeably with the word “payer”.

**Physician** – One of the following:

- A doctor of medicine, surgery, or osteopathy;
- A doctor of podiatry or a doctor of chiropractic; or
- Any other licensed Provider who is required to be recognized as a Physician by state law and acts within the scope of his/her license to treat an illness or injury.

**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 Plan and selected by the Member to provide Health Care Services to Members, as it exists on the Effective Date of the Contract or as subsequently amended as provided herein.

**PPACA** – The federal Patient Protection and Affordable Care Act.

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

**Pre-authorization** – A decision by a Health Care Plan that a Health Care Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Health Care Plan’s requirements for Coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

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

**Prescription Drugs** – Drugs for which sale or legal dispensing requires the order of a Provider with legal authority to prescribe drugs.

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

**Primary Care Provider or PCP** – The Physician or other Provider Members see first for most health problems. The PCP makes sure Members get the care they need to keep them healthy. The PCP also may talk with other Physicians and Providers about the Member’s care and refer them. PCPs include, but are not limited to family practice Physicians; general practitioners; internists; pediatricians; Obstetricians and/or Gynecologists (OB/GYNs). The PCP is responsible for providing Primary Care Services. These include annual examinations, routine immunizations, and treatment of non-emergency acute illnesses and injuries.

**Primary Care Services** – Services provided by a PCP or primary Provider of Health Care Services.

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

**Protected Health Information (PHI)** – PHI is any individually identifiable health information that relates to a patient’s past, present, or future physical or mental health and related health care services. PHI may include demographics, documentation of symptoms, examination and test results, diagnoses, and treatments. Personal information that is protected by the federal privacy policy.

**Provider** – An entity that performs or furnishes a medical, behavioral health, and/or dental service/treatment to members AND is recognized under Section 1866(e) of the Social Security Act.

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

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

**Provider** means a duly licensed Hospital, Physician, or other practitioner of the healing arts that is authorized to render Health Care Services within the scope of their license.

**Provider Network** – A list of the Providers that are Participating Providers.

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

**Qualified Individual** – With respect to the Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual or small group Exchange market.

**Qualified Medical Child Support Order** – An order from a State or Federal government agency or court. It requires a person to provide health care coverage for specific dependents.

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

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

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

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

**Referral** – An authorization granted by the Participating Physician/Primary Care Provider for use of another provider.

**Request for Reconsideration** – A request to reconsider the initial determination.

**Second Opinions** – Provide an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally making a recommendation for a proposed health service to assess the Medical Necessity and appropriateness of the initial proposed health service.

**Service Area** – A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan.

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

**Skilled Nursing Facility** – A place that:

- 1) Is legally operated as a Skilled Nursing Facility;
- 2) Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Physician;
- 3) Provides continuous 24 hour a day nursing service by or under the supervision of a Licensed Practical Nurse;
- 4) Maintains a daily medical record on each patient; and
- 5) Provides Rehabilitation services, such as Physical, Occupational and Speech therapy, and may provide other multidisciplinary services, such as Respiratory Therapy, dietician/nutrition services, and medical social work.

**Specialist** – A Physician who provides Covered Services for a specific disease or part of the body; Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart Conditions; and orthopedists who care for patients with certain bone, joint, or muscle Conditions and psychiatrists care for Members with Behavioral Disorders or Mental Illness/Disorders.

**Speech Therapy** – The treatment and exercises for treating voice and speech and swallowing disorders due to diagnosed Illness or Injury provided by a qualified Provider.

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

**Subluxation** – Misalignment, demonstrable by x-rays or Chiropractic examination, which produces pain and is correctible by manual manipulation

**Subscriber** – An individual who is the contract holder and is responsible for payment of premiums to CHRISTUS Health Plan.

**Summary of Benefits** – The written materials required by NMSA 1978 Section 59A-57-4 to be given to the Grievant by the health care plan or group contract holder.

**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 not the same as Social Security benefits.

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

**Termination Date** – 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

**Termination of Coverage** – The cancellation or non-renewal of coverage provided by a health care plan to a Grievant but does not include a voluntary termination by a Grievant or termination of a health benefits plan that does not contain a renewal provision;

**Third Party Liability** – Recovery of the reasonable value of care and treatment furnished or to be furnished by or for the government to persons entitled to such care and treatment when such persons suffer injury or disease under circumstances which create tort or contractual liability on third parties, including insurance companies, to pay damages.

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

**Urgent Care** – Medically Necessary Health Care Services provided in emergencies or after a Primary Care Provider's normal business hours for unforeseen Conditions due to Illness or Injury that are not life-threatening but require prompt medical attention.

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

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