CHRISTUS Health Plan
US Family Health Plan
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Billing Address
US Family Health Plan Claims
P.O. Box 981696
El Paso, TX 79998-1696

Electronic Data Interchange (EDI)
CHPIMSupport@ChristusHealth.org

Member Services | Provider Relations
Tel: 800.678.7347
Fax: 210.766.8851

Utilization Management | Behavioral Health
Tel: 800.446.1730
Fax: 800.277.4926

TRICARE Formulary
USFHPFormulary.com

Maxor Pharmacy
Tel: 866.408.2459

Family Planning
Meritain Health, Inc.
P.O. Box 27083
Lansing, MI 48909-7083
Tel: 888.627.8889

Reporting Fraud or Abuse
FWA Hot Line: 855.771.8072
FWA Secure Fax: 210.766.8849
Dedicated email:
ChristusHealthPlanSIU@ChristusHealth.org

SIU / FWA Website
ChristusHealthPlan.org
Introduction

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

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

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

The TRICARE benefit provided by USFHP includes a Point of Service (POS) option that provides limited coverage for unauthorized non-emergent out-of-network services. In order for POS coverage to apply, the care provided must be a TRICARE-covered benefit. While the POS option provides some coverage for unauthorized out-of-network care, members out of pocket costs may be significant.

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

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

US Family Health Plan providers agree to follow and adhere to Rules and Regulations which include but are not limited to; all quality improvement, utilization management, credentialing, peer review, grievance, National Quality Monitoring Contract (NQMC)
program and other policies and procedures established and revised by USFHP or the Department of Defense (DOD) and the USFHP Provider Manual that is amended from time to time. Furthermore, the policies and procedures set forth herein may be altered, amended or discontinued by CHRISTUS Health or USFHP at any time upon notice to the provider.

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied on as such. All terms and statements used in this manual will have the meaning ascribed to them by USFHP and CHRISTUS Health, and shall be interpreted by USFHP and CHRISTUS Health at their sole discretion. The most up-to-date version of the Provider Manual is located on the Plan’s website, ChristusHealthPlan.org/provider-resources.
Member Rights & Responsibilities

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

Also, as a provider, please be aware that notifications of Members Rights and Responsibilities are provided to all new members as well as maintained on the website at: www.usfhpenroll.com.

Member Rights
CHRISTUS Health US Family Health Plan members have the following rights:

- Receive considerate and respectful care with recognition of their personal dignity and privacy at all times
- Receive information about CHRISTUS Health USFHP, our services and their rights and responsibilities as our member
- Receive information about covered benefits and cost sharing.
- Have a candid discussion of all medically necessary treatment options, regardless of cost of benefit coverage
- Receive information from us in a way that works for all members. Our plan offers free language interpretation services for non-English speaking members that can be accessed by calling Member Services
- Understand an explanation of the diagnosis, treatment and prognosis of their health condition. Participate in decisions involving their health care, including mutually agreed-upon goals to the degree possible. Members who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members or other conservators
- Receive care and treatment in a safe environment and to be informed of the Facility’s rules and regulations that relate to patient and visitor conduct
- Members have the right to file grievances (feedback) and appeals, as outlined in the “Grievance (Feedback) and Appeals Process” section in the Member Handbook
- Request that ongoing benefits be continued during appeals (although they may have to pay for the continued benefits if a decision is upheld in the appeal)
- Request and receive a copy of their medical records and request that they be amended or corrected as allowed
- Receive information about provider and health care facilities, including information about the composition of our network
- Know the identity and professional status of the health care provider primarily responsible for providing and managing their care, as well as other health care personnel involved in their treatment
- To participate with a practitioner in making decisions about their health care and question the adequacy of the care being provided
- To have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Receive a second opinion from another doctor in USFHP's network if they disagree with your doctor's opinion about the services needed. Contact us at 1.800.67.USFHP (800.678.7347): TTY 711 for help with this
- Make recommendations regarding the organization's member rights and responsibilities policy

**Member Responsibilities**

*US Family Health Plan members, having the following responsibilities:*

- Carrying their Member ID card with them at all times and know their eligibility status with US Family Health Plan. Members can request a new card if it is lost by calling Member Services at 800.67.USFHP (800.678.7347); TTY 711
- Follow the Plan's referral and prior authorization guidelines and policies
- Becoming knowledgeable about their Plan coverage and options
- Providing their health plan, primary care provider and other health care providers complete information to provide the needed care, to the best of their knowledge, regarding medical history and other matters relating to their health
- Complying with the medical and nursing treatment plan, including the following the follow-up care, agreed upon by the member and the health care provider(s). This includes following all instructions of care provided by their providers, keeping appointments and notifying providers, in a timely manner, when an appointment cannot be kept. Members also have the responsibility of letting their provider know whether or not they understand the treatment plan and what is expected of them
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible. Becoming involved in specific health care decisions
- Being considerate of the rights of other patients, and of US Family health Plan personnel and network providers
- Being respectful of the property of other persons and facilities
- Following provider facility rules and regulations concerning patient conduct
- Reporting wrong doing and fraud to appropriate resources or legal authorities
Primary Care Manager

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

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

Provider Credentialing Requirements
USFHP 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 of every three (3) years. The credentialing and re-credentialing process consist of the provider application process, verification of credentials with primary sources (excludes facilities) and a review by the credentialing committee.

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

Facility Participation Criteria*
- Ability to meet USFHP access and availability standards
- Completed USFHP facility and ancillary application
- Current accreditation (if applicable)
- Current malpractice insurance coverage per contract requirements
- Current operating certificate
- Must be eligible to become a TRICARE authorized provider
- No Medicare sanctions
- The Joint Commission or other health care accreditation (if applicable)
- Signed and dated USFHP agreements
**Facility Application Requirements**
- Copy of current accreditation face sheet
- Copy of current malpractice coverage sheet (includes effective dates, policy number and amounts of coverage)
- Copy of current operating certificate
- Detailed explanations to any questions requiring an answer (any professional questions that have been answered YES; i.e. explanation of malpractice history)
- Signed and dated application attestation
- Signed and dated USFHP agreements

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

**Provider, Facility and Ancillary Contractual Requirements**
At a minimum, language in the contract includes the following conditions or programs that the provider agrees to comply with:
- Abide by USFHP rules and regulations and by all other lawful standards, policies, rules and regulations of CHRISTUS Health
- Accept patients transferring from out-of-network care to in-network facilities
- Allow access to medical records for review by appropriate committees of USFHP and upon request provide the medical records to representatives of the federal government and/or their contracted agencies
- Arrange for another physician (the "covering physician") to provide patient care or referral services to a member in the event a primary care provider is temporarily unavailable
- Inform USFHP immediately, in writing, of changes in license status, tax identification numbers, phone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change that would affect practicing status
- Inform USFHP within twenty-four (24) hours in writing of any revocation or suspension of the physician’s Drug Enforcement Agency (DEA) number, certificate or other legal credential authorizing the physician to practice in the state of Texas, Louisiana or any other state. Failure to comply with the above could result in termination from the plan
- Maintain member’s medical records for five (5) years (60 months) from the last date service was provided.
- No balance billing a member for services covered by USFHP. You may only bill members for applicable deductibles, copayments, and / or cost-sharing amounts
- No billing for charges that exceed contractually allowed reimbursement rates. May bill a member for a service or procedure that is not a covered benefit
- Not discriminate on the basis of age, sex, handicap, race, color, religion or national origin
- Participate in USFHP’s Quality Improvement, Utilization Management, credentialing, peer review, grievance, National Quality Monitoring Contract
("NQMC") programs and other policies and procedures established and revised by USFHP or the Department of Defense (DoD), which also includes participation in evidence-based patient safety programs

- Prepare and complete medical records in a timely fashion and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment and the outcome at completion or discontinuation of treatment.
- Provide 24-hour, 7 day-a-week access to care
- Provide clearly legible specialty care consultation or referral reports, operative reports and discharge summaries to the member’s PCP within ten (10) business days of the member’s visit with the specialist
- Provide or assist USFHP in obtaining Coordination of Benefits | Third-Party Liability Information
- Transfer medical records within ten (10) business days or sooner if requested by a treating physician, after a member in your panel changes to another PCP
- Utilize USFHP’s participating physicians and facilities when services are available and can meet the patient's needs

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

**Privacy and Releases of Medical Records**

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

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

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

See 45 CFR 164.506(c)(4)... “Health care operations” includes care management, utilization review activities, and similar activities. See 45 CFR 164.501 (definition of “health care operations”). Thus, a provider may disclose protected health information for care management and/or utilization purposes. A provider may also disclose protected health information to a health plan for the plan’s Health Care Effectiveness Data and Information Set (HEDIS®) purposes, as long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.
There may be times when a member’s medical records need to be transferred from one PCM to another PCP in the Plan. This may occur when a member changes PCPs or if a PCP leaves the plan. All medical records must be transferred to the new PCP within ten (10) business days if requested by the treating physician.

Medical records for USFHP members must be maintained for five (5) years (60 months) from the last date of service provided. Federal TRICARE regulations requires that the following information should be included in every individual patient record:

- Alcohol or Substance Use | Abuse (12 years and older)
- Allergies
- Appropriate Use of Consultants
- Chief Complaint
- Continuing Medication List
- Significant Problem List
- Date of Each Visit
- Date of Next Visit
- Impression for Chief Complaint
- Growth Chart (14 years of age and under)
- Hospital Records
- Immunization History
- Informed Consent
- Initial Relevant History
- MD Review of Diagnostic Studies
- Patient Identification
- Patient’s Signature on File
- Personal Data
- Physical Exam Relevant to Chief Complaint
- Preventive Health Education
- Provider Signature for each entry
- Results Discussed with Patient
- Results of Consultations
- Smoking Status (12 years and older)
- Treatment and/or Therapy Plan
**Provider Rights**
Providers have certain rights as participating providers of USFHP. These rights include:

- Appeal any action taken by USFHP that affects their status with the network and/or is related to professional competency or conduct
- Request any adjudicated claim be reconsidered, if they feel it was not paid appropriately
- Request USFHP remove a member from their care if an acceptable patient-physician relationship cannot be established with a member who has selected them as his/her physician

**Appointment Wait Time**
Wait times in any provider’s office should **not exceed 30 minutes** for non-emergent visits.

Members must have access to a PCP within a 30-minute drive time from their residence.

Members must have access to a specialist within a 60-minute drive from their residence. USFHP defines access standards as the timelines within which a member can obtain available services, in accordance with the Department of Defense’s access and availability requirements.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Waiting Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>Immediate</td>
</tr>
<tr>
<td>Urgent</td>
<td>Acute Care</td>
</tr>
<tr>
<td>Routine Office Visit</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>Well</td>
<td>Preventive Health Visit</td>
</tr>
<tr>
<td>Specialty Consultation or Procedure</td>
<td>Within 4 weeks</td>
</tr>
<tr>
<td>Follow-Up Visit</td>
<td>As required by provider</td>
</tr>
</tbody>
</table>

**Covering Providers**
Follow-up treatment should always occur with the member’s PCP. It is the responsibility of the contracted PCP to have his/her covering physician provide care according to the benefit and access guidelines outlined in this provider manual, whether or not the covering physician is affiliated with USFHP.
**Access Standards**

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

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

**Protection of Privacy**

USFHP providers should:

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

**24/7 Nurse Line**

USFHP has a 24-hour-a-day, 7-days-a-week nurse line. Members can access this service toll-free for medical guidance. Members are instructed based on nationally recognized triage protocols.

This service does not replace a provider’s after-hours coverage commitment.
**Patient No Show**
The patient’s PCP must review each chart for patients who fail to keep their scheduled appointments. A “No Show” patient should be documented in the patient’s medical record. Missed appointments are not a billable or reimbursable service by the Health Plan however a provider may choose to bill a member directly for recurring missed appointments.

**Other Provider Information**
National Disaster Medical System (NDMS)
All acute care medical and/or surgical hospitals are encouraged to become members of the NDMS. For more information, please visit:  
[phe.gov/Preparedness/responders/ndms/Pages/default.aspx](http://phe.gov/Preparedness/responders/ndms/Pages/default.aspx).

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

**Member Grievances and Complaints**
USFHP encourages members to resolve individual inquiries and concerns or problems at the point of service. In the event their request for assistance is not settled at the point of service, members should contact Member Services, who will work with members to resolve their concerns and issues.

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

CHRISTUS Health Plan  
Complaints, Appeals and Grievances Department  
P.O. Box 169009  
Irving TX 75016  
844.282.0380
BENEFITS AND ELIGIBILITY

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

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

Verifying Eligibility
You may call Member Services to check benefits Mon. – Fri. from 8 a.m. to 5 p.m. local time. Agents can assist in verifying your network status with USFHP, as well as a member’s eligibility and benefits. Member Services has the ability to check if an authorization is needed for services or if an authorization has already been initiated. Each time you contact Member Services, you will be given a call reference number that you can use to confirm benefits were provided in your records.
**Selecting a PCP**
Upon enrollment the member and their eligible family members select a Primary Care Physician (PCP). Members will only be assigned to PCPs with open panels (those currently accepting new members).

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

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

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

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

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

If you believe a qualifying condition exists, call Member Services at **800.678.7347** to determine eligibility for ECHO benefits. For more information, please visit: [Tricare.mil/echo](http://Tricare.mil/echo).
**Catastrophic Cap Protection**

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

<table>
<thead>
<tr>
<th>Sponsor or Beneficiary Type</th>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Duty Family Members</td>
<td>$1,000 per family</td>
<td>$1,044 per family</td>
</tr>
<tr>
<td>Retirees, their families, and others</td>
<td>$3,000 per family</td>
<td>$3,655 per family</td>
</tr>
</tbody>
</table>

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

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

**Family Planning**

Family planning services are covered as a part of the USFHP 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, Meritain Health, Inc. administers the family planning benefit for USFHP members. Meritain Health, Inc. is not affiliated with CHRISTUS Health.

Family planning services are paid directly through Meritain Health, Inc. Providers who have questions should contact Meritain directly at **888.627.8889**. Claims for family planning should be submitted to the address provided under Important Phone Number and Addresses on page 5.

**Transplant Services**

The Health Plan requires prior authorization for transplant services. This applies to both solid organ and bone marrow (stem cell) transplant procedures. Prior authorization can be requested by either the provider or the member. For members to obtain the maximum possible benefits, the member must obtain their transplant through the use of health plan contracted transplant providers; **Optum, Cigna Life SOURCE, LifeTRAC**. In-network transplant services may be provided outside of the Plan service area if the services are accessible and available to enrollees, and that the delivery is consistent with community patterns of care for original Medicare beneficiaries who reside in the same area. For authorization and to initiate the Transplant Process, please call or fax your request to the CHRISTUS Health Medical Management team: Phone 800-446-1730, Fax 800-277-4926.
**Behavioral Health and Substance Use Disorder**

*Outpatient Health*
Medically necessary visits to a provider for the treatment of a Behavioral Health or Substance Use Disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis codes.

*Inpatient Behavioral Health Services*
Inpatient Behavioral Health services are treatments for a Behavioral Health condition as defined by the most recent DSM diagnosis codes. Inpatient admissions do not require prior authorization unless admitting to an out-of-network facility.

*Partial Hospitalization*
Partial Hospitalization services are visits to a psychiatric facility for a day or partial day without an overnight stay. Outpatient Mental Health Care (to include Partial Hospitalization Programs, Intensive Outpatient Programs, Opioid Treatment Programs, Office-Based Opioid Treatment, and Outpatient Treatment) does not require preauthorization.

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

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

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

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

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

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

**Third-Party Liability**

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

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

**Provider Contract Coordination of Benefits section:**

4.07 Coordination of Benefits. Facility shall accept payment from USFHP plus any required co-payments as payment in full for all Covered Services provided to Enrollees, and shall not attempt to bill any other person, insurer, payor, or other entity for such services. Facility hereby assigns to USFHP all of its rights to any other benefits that may be payable in respect to an Enrollee. Facility shall use its best efforts to determine the availability of other benefits and to obtain any documentation required to facilitate USFHP’s collection of such other benefits.
## Copayments for Covered Services

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Active Duty Family Members</th>
<th>Retirees and Eligible Family Members with Medicare Part B</th>
<th>Retirees and Eligible Family Members without Medicare Part B</th>
<th>TRICARE Young Adult (TYA) – Active Duty</th>
<th>TRICARE Young Adult (TYA) – Retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Periodic Preventive Screenings</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Age and gender appropriate screening tests for the early detection of disease and</td>
<td></td>
<td></td>
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<tr>
<td>or disease risk factors including:</td>
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<tr>
<td>Cancer Screening - mammography, pap smears, sigmoid and colonoscopy, and fecal</td>
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<tr>
<td>occult blood testing; Infectious Disease</td>
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<tr>
<td>Screening - Tuberculosis, Rubella, and Hepatitis; Cardiovascular - Cholesterol</td>
<td></td>
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<tr>
<td>and Blood Pressure; Other - vision screening, lead toxicity, hearing (as part of</td>
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<tr>
<td>annual physical).</td>
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</tr>
<tr>
<td><strong>Education and Counseling Services</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Can be part of any visit to your PCP: dietary assessment &amp; nutrition; physical</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>activity &amp; exercise; cancer surveillance; tobacco, alcohol &amp; substance abuse;</td>
<td></td>
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</tr>
<tr>
<td>accident &amp; injury prevention; promotion dental health; stress and bereavement.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Annual Physicals or Well Woman Exams</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Refer to the Preventive Health Services section to determine the age appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>screenings you could be provided. (Presenting to a PCP's office with medical</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>problems during a well visit will be viewed as a regular office visit.)</td>
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</tr>
<tr>
<td>Service</td>
<td>Active Duty Family Members</td>
<td>Retirees and Eligible Family Members with Medicare Part B</td>
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</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Age appropriate immunizations are provided for vaccine-preventable diseases according to guidelines set forth by the CDC.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Enhancement Seminars, Community Health Services, and Community Resource Coordination</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>**24–Hour Nurse</td>
<td>Health Information Library**</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>$0</td>
<td>$0</td>
<td>$20 (Air) $41 (Ground) Per trip</td>
<td>$0</td>
<td>$20 (Air) $41 (Ground) Per trip</td>
</tr>
<tr>
<td>**Imaging (CT</td>
<td>MRI)**</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Prosthetic Devices, and Medical Supplies (When prescribed by a provider and secured through USFHP-contracted providers)</strong></td>
<td>0% of contracted rate</td>
<td>0% of contracted rate</td>
<td>20% of contracted rate</td>
<td>0% of contracted rate</td>
<td>20% of contracted rate</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>$0</td>
<td>$0</td>
<td>$62 per visit</td>
<td>$0</td>
<td>$62 per visit</td>
</tr>
<tr>
<td>(Copay is waived if admitted to the hospital.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eye Examination</strong></td>
<td>$0 One per year</td>
<td>$0 One every other year</td>
<td>$0 One every other year</td>
<td>$0 One per year</td>
<td>$0 One every other year</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>Physician Visit: $0</td>
<td>Physician Visit: $0</td>
<td>Physician Visit: $20 per visit</td>
<td>Physician Visit: $0</td>
<td>Physician Visit: $20 per visit</td>
</tr>
<tr>
<td>(provided through Meritain Health, Inc.)</td>
<td>Prescriptions: See section on prescription copayments</td>
<td>Prescriptions: See section on prescription copayments</td>
<td>Specialist: $31 copay</td>
<td>Prescriptions: See section on prescription copayments</td>
<td>Specialist: $31 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prescriptions: See section on prescription copayments</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health</strong></td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Service Description</td>
<td>Active Duty Family Members</td>
<td>Retirees and Eligible Family Members with Medicare Part B</td>
<td>Retirees and Eligible Family Members without Medicare Part B Groups A &amp; B</td>
<td>TRICARE Young Adult (TYA) – Active Duty</td>
<td>TRICARE Young Adult (TYA) – Retiree</td>
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</tr>
<tr>
<td>Immunization for Required Overseas Travel (No copay, if part of an office visit)</td>
<td>$0</td>
<td>Not covered</td>
<td>Not covered</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td>Laboratory and X-ray Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Maternity Care (Pre- and Postnatal visits)</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$20-$31 per visit</td>
<td>$0 per visit</td>
<td>$20-$31 per visit</td>
</tr>
<tr>
<td>Partial Hospitalization for Mental Health</td>
<td>Alcohol &amp; Substance Abuse Treatment</td>
<td>$0 per visit</td>
<td>$20 Copay Per Visit - Primary</td>
<td>$0 per visit</td>
<td>$20 Copay Per Visit - Primary</td>
</tr>
<tr>
<td>$31 Copay per Visit - Specialist</td>
<td>$31 Copay per Visit - Specialist</td>
<td>$31 Copay per Visit - Specialist</td>
<td>$31 Copay per Visit - Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery (Hospital or Ambulatory Surgical Center)</td>
<td>$0</td>
<td>$0</td>
<td>$62 Copay</td>
<td>$0</td>
<td>$62 Copay</td>
</tr>
<tr>
<td>Outpatient Surgery (Physician Office)</td>
<td>$0</td>
<td>$0</td>
<td>$20-$31 Copay dependent upon the specialty of the physician performing the office surgery</td>
<td>$0</td>
<td>$20-$31 Copay dependent upon the specialty of the physician performing the office surgery</td>
</tr>
<tr>
<td>Service</td>
<td>Active Duty Family Members</td>
<td>Retirees and Eligible Family Members with Medicare Part B</td>
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</tr>
<tr>
<td>Physical</td>
<td>Occupational Therapy</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$31 Copay per day</td>
<td>$0 per visit</td>
</tr>
<tr>
<td></td>
<td>(When medically necessary (When provided in home, any applicable copay for home health applies.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$20 Copay per visit</td>
<td>$0 per visit</td>
<td>$20 Copay per visit</td>
</tr>
<tr>
<td>Specialist</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$31 Copay per visit</td>
<td>$0 per visit</td>
<td>$31 Copay per visit</td>
</tr>
<tr>
<td>Prescriptions (up to a 30-day supply obtained directly from network pharmacy)</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
</tr>
<tr>
<td></td>
<td>$33 Brand name</td>
<td>$33 Brand name</td>
<td>$33 Brand name</td>
<td>$33 Brand name</td>
<td>$33 Brand name</td>
</tr>
<tr>
<td></td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
</tr>
<tr>
<td>Prescriptions (Mail-Order Pharmacy) (up to a 90-day supply or less obtained through Maxor Mail Order Pharmacy when authorized; includes prescriptions for nursing home patients.)</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
</tr>
<tr>
<td></td>
<td>$29 Brand name*</td>
<td>$29 Brand name*</td>
<td>$29 Brand name*</td>
<td>$29 Brand name*</td>
<td>$29 Brand name*</td>
</tr>
<tr>
<td></td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
<td>$60 Non-formulary brand name and generic</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Residential Treatment Centers</td>
<td>$0 per day</td>
<td>$0 per day</td>
<td>$31 Copay per admission</td>
<td>$0 per day</td>
<td>$31 Copay per admission</td>
</tr>
<tr>
<td>Speech Therapy (When medically necessary (When provided in home, the copay for home health care applies.)</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$31 Copay Per Visit</td>
<td>$0 per visit</td>
<td>$31 Copay Per Visit</td>
</tr>
<tr>
<td>Well-Child Care (Up to 6 years of age, except as a preventive service)</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$0 per day</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
</tr>
<tr>
<td></td>
<td>Active Duty Members</td>
<td>Retirees and Eligible Family Members with Medicare Part B</td>
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</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>$0 per day</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
</tr>
<tr>
<td>Semiprivate room (and when medically necessary, special care units), general nursing, and hospital services. Includes inpatient physician and surgical services, meals (including special diets), drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, X-ray and other radiology services necessary, medical supplies and appliances, blood and blood products. Unlimited services with authorization, as medically necessary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>$0 per day</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
</tr>
<tr>
<td>Hospital and professional services. Unlimited services with authorization, as medically necessary</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>$0 per day</td>
<td>$0 per day</td>
<td>$31 Copay per day</td>
<td>$0 per day</td>
<td>$31 Copay per day</td>
</tr>
<tr>
<td>Semiprivate room, regular nursing services, meals including special diets, physical or occupational or speech therapy, drugs furnished by the facility, necessary medical supplies and appliances. Unlimited services with authorization, as medically necessary</td>
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</tr>
</tbody>
</table>
**Services Not Covered Under US Family Health Plan**
The following is a list of services not covered by USFHP (not all inclusive):

- A stay at an inpatient skilled nursing facility. Unless considered medically necessary by the member’s physician and authorized by the plan
- Acupuncture or acupressure
- Charges for care and supplies not ordered by a physician
- Chiropractic or naturopath services
- Convenience and personal care items that are billed separately such as telephone, television or radio
- Cosmetic or plastic surgery except as may be necessary to correct a severe disfigurement or to correct the disorder of a normal bodily function
- Custodial care
- Experimental or investigational procedures
- Homemaker services
- Lodging cost during outpatient dialysis treatment
- Meals delivered to the home
- Non-medically necessary transportation cost
- Organ transplants considered experimental or investigational
- Private duty nurses and nursing care on a full-time basis in the home
- Services for which neither the member nor another party acting on the member’s behalf has a legal obligation to pay. **NOTE:** Under USFHP, the members covered only for services authorized or arranged by their PCP. Care outside of the Plan will not be paid for by the USFHP, except in emergency situations. Non-preapproved urgently needed care is a covered benefit only when the member is traveling outside of the 48 contiguous states
- Services performed by immediate relatives or members of the household
- Services related to education, elective travel, employment, licensing, or other administrative reasons
- Services related to the treatment of End Stage Renal Disease (ESRD). Special rules apply for the coverage and payment for maintenance kidney dialysis
- Wages lost to the caregiver and the dialysis assistant during self-training

**Informing Members about Non-Covered Services**
As a part of good business practice, providers are expected to notify USFHP beneficiaries when a service is not covered. TRICARE policy includes a specific “hold harmless” policy for network participating providers and recommends out-of-network providers also follow a similar process to document beneficiary notification.
Hold Harmless Policy for Network Providers
A network provider may not require payment from a beneficiary for any excluded or excludable services the beneficiary received from the participating provider except in the following situations:
- If the member did not inform the provider he or she was a USFHP member, the provider may bill the beneficiary for services rendered
- If the member was informed the service was excluded and he or she agreed in advance to pay for the service, the provider may bill the member

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

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

For a USFHP member to be considered fully informed, DoD regulations require:
- The agreement is documented prior to the non-covered service being rendered
- The agreement is in writing – a verbal agreement is not valid under DoD policy
- The specific service, date of service, and estimated cost of services documented in writing
- General agreements to pay, such as those routinely signed by patients, are not evidence the USFHP member knew specific services were excluded

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

Without a signed advance waiver, the provider could be denied reimbursement and cannot bill the member.
Preventive Health Guidelines
US Family Health Plan views preventive health as the foundation of services for its members. The Plan covers a variety of periodic health examinations and other services such as immunizations, disease-specific screening, cancer screening, annual physicals, school physicals, counseling services, mammograms, cholesterol screenings, blood pressure checks, and health screenings that conform to the recommendations of the TRICARE Policy Manual and the United States Preventive Services Task Force.

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

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

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

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


Medical Management

Prior Authorization Guidelines
The PCP must complete the USFHP Referral/Authorization Form in its entirety and either:
- Contact the Utilization Management (UM) and/or Case Management (CM) Department at 800.446.1730 for an urgent or emergent request, or fax the request to the urgent fax line at 210.766.8841.
- Fax a routine request to 800.277.4926.

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

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

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

Admission Notification: The physician and/or hospital notifies UM and/or CM when a USFHP member is admitted to the hospital.

Continued Stay Review (Concurrent Review): 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: The Care Manager is responsible for coordinating a member’s care and will work with the patient and Utilization Management in arranging for the member’s discharge needs. The 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 every members 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 and/or Authorization did not occur. The review will consist of assessing the medical necessity of all services not previously approved. Clinical information is reviewed for appropriateness using clinical guidelines, plan protocols, and TRICARE benefits and coverage as appropriate.

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

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

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 an order signed by the attending physician and authorization by the UM and/or CM Department. Requests for continuation of services will be reviewed as an ongoing basis to determine medical necessity. Custodial care is a non-covered benefit.

Durable Medical Equipment (DME): Durable Medical Equipment (DME) is used primarily and customarily for 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 parts or slows further deterioration of the patient’s physical condition. Specific DME items require prior authorization (see Services Requiring Prior Authorization). DME must be obtained through USFHP-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.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Service</th>
<th>Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective admissions</td>
<td>observations</td>
<td>surgical procedures</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF)</td>
<td>Rehabilitation</td>
<td>Home health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>Durable medical equipment (DME)</td>
<td>other procedures requiring authorization</td>
</tr>
</tbody>
</table>

Authorization Process

Information received either via phone or electronic means in the UM and/or CM Department will be reviewed for coverage and benefits. Appropriateness and medical necessity will be reviewed using evidence-based clinical guidelines, plan protocols and TRICARE 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 to the Medical Reviewer for determination regarding medical necessity or benefit coverage. If the Medical Reviewer determines that medical necessity or benefit coverage is not established, notification is made to the requesting provider which include the Medical Reviewer’s determination to deny authorization. A denial letter will be sent to the requesting provider in two (2) business days of the determination.

Utilization Management Affirmative Statement

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

Requests for Case Management

The USFHP Case Management program plans and supports the care and education of members with catastrophic, complex, or chronic conditions (disease management) and those members who are undergoing a transition of care (e.g. hospital to home).
The goals of Case Management are the provision of quality care, enhancement of member’s quality of life, and management of health care costs. Disease Management is health management for members with specific chronic diseases.

**The following may identify potential participants for Case Management:**

- Physical referral
- Facility admission and concurrent review process
- Retrospective analysis
- Member request
- Case Management criteria per the Case Management assessment policy

Providers can refer members for Case Management evaluation by calling the UM Department at **800.446.1730**, Option 2.

**Obstetric Care**

Prior authorization to the USFHP UM and/or CM Department is to be initiated by the Obstetrician for delivery, out-of-network services, or providers not covered within the Plan’s network.

Obstetric care includes the following:

- Initial evaluation
- Urinalysis
- Hepatitis screening
- Ultrasounds, when medically necessary
- Physical examination
- CBC or H&H
- Alpha-fetoprotein
- Vaginal delivery after cesarean (VDAC)
- Pelvic examination
- Blood typing
- Cesarean section
- Ectopic pregnancy with tuboplasty
- Pap smear
- Rh factor, Rh antibody titer if Rh negative
- Vaginal delivery
- Postpartum care
- Sixth week office visit with Pap smear
**Authorization Requirements**
For Eligibility and Benefits, please contact Member Services, **800.678.7347**.
For Family Planning Assistance, please contact Meritain Health, Inc., **888.627.8889**.

**Services Requiring Prior Authorization**
You can find a list of services requiring Prior Authorization at [ChristusHealthPlan.org](http://ChristusHealthPlan.org).

If you need help determining if a service requires Prior Authorization, please contact Member Services, **800.678.7347**.

**Specialty Drugs Authorization Requirements**
Specialty drug coverage may require an authorization. Please contact us at **800.678.7347** or visit our website at [ChristusHealthPlan.org](http://ChristusHealthPlan.org).

*Authorization required if not dispensed through CHRISTUS Health USFHP Network Pharmacy.*
Pharmacy Services

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

The TRICARE Formulary covers most FDA-approved prescriptions. In general, covered medications under the USFHP pharmacy benefit, must be:
- A prescription medication approved by the FDA
- Prescribed with good medical practice and established national standards of quality care

Medications that are not medically necessary for the diagnosis or treatment of an illness are not covered by USFHP.

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

Use the TRICARE Formulary search tool to see if a specific drug is covered: USFHPFormulary.com.

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

To start a prior authorization, contact MaxorPlus at 800.687.0707 or fax 844.370.6203.

If a USFHP member needs a medication that requires prior authorization or step therapy as determined by the DoD P&T Committee. MaxorPlus will fax a request for medical information (including diagnosis). This prior authorization form must be filled out entirely and returned by fax 844.370.6203.

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

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

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

For an updated list of drugs requiring prior authorization from the TRICARE Formulary, go to [USFHPFormulary.com](http://USFHPFormulary.com).

DoD quantity limitations are in place for some drugs. TRICARE quantity limits information can be found on the web at: [USFHPFormulary.com](http://USFHPFormulary.com).

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

**Specialty Drugs Authorization Requirements**
Certain specialty drugs are preferred to be dispensed through MaxorPlus and may require prior authorization.

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

The local Maxor Pharmacy locations are:
- Maxor – Downtown (Houston)
- Maxor – Clear Lake (Houston)
- Maxor – Port Arthur

Nationwide Network Pharmacies include:
- Brookshire Brothers
- Brookshire Grocers
- CVS (freestanding or inside Target)
- H-E-B
- Market Basket
- Sam’s Club
- Super 1 Grocery
- Walmart

Independent Network Pharmacies include:
- Ed’s Pharmacy
- Inwood Pharmacy
The network pharmacies can be used for first time and urgent care fills only. Prescriptions filled at a network pharmacy are limited to a maximum of 30-day supply. A 90-day supply can only be obtained by Maxor MXP Mail Order Pharmacy and the walk-in Maxor Pharmacies.

Members are responsible for a copayment to the pharmacy for each prescription filled or refilled. There is no copayment for drugs administered by a health-care professional. The table below outlines members copayments according to the type of pharmacy and formulary status:

<table>
<thead>
<tr>
<th>Type of Pharmacy</th>
<th>Formulary Drugs</th>
<th>Non-Formulary</th>
<th>Non-Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic Tier 1</td>
<td>Brand Name Tier 2</td>
<td>Tier 3</td>
</tr>
<tr>
<td>In-Network (up to a 30-day supply)</td>
<td>$13</td>
<td>$33</td>
<td>$60</td>
</tr>
<tr>
<td>MAXOR Mail Order &amp; Walk-In Maxor Pharmacies (up to a 90-day supply)</td>
<td>$10</td>
<td>$29</td>
<td>$60</td>
</tr>
<tr>
<td>Out-of-Network (up to a 30-day supply)</td>
<td>50% of total cost applies after Point of Service (POS) deductible met</td>
<td>50% of total cost applies after POS deductible met</td>
<td>50% of total cost applies after POS deductible met</td>
</tr>
</tbody>
</table>

**Mail Order Pharmacy**

USFHP requires maintenance medication prescriptions routinely be filled via mail order through Maxor MXP Mail Order Pharmacy or the walk-in Maxor Pharmacies.

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

In order to facilitate the mail order process, members must use the following process:
• When issuing a first-time prescription for a maintenance medication, please write two prescriptions; one for a 30-day initial supply and one for a 90-day maintenance supply.
  o The initial 30-day prescription will be filled at any of the affiliated walk-in network pharmacies.
  o The 90-day prescription will be filled through Maxor MXP Mail Order Pharmacy. Prescriptions can be mailed, faxed, e-prescribed or called into the pharmacy.
• Maxor MXP Mail Order Pharmacy is SureScript enabled for Electronic Prescribing for Controlled Substances.

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

Maxor Mail Order Pharmacy
P.O. Box 32050
Amarillo, TX 79120
Phone: 866.408.2459
Fax: 866.589.7656
(Prescriptions must be faxed directly from the provider’s office)

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

Pharmacy Benefit Limitations and Exclusions
Due to TRICARE restrictions, the USFHP pharmacy benefit excludes:
• Any prescription refilled before 75% of a previous filling has been used
• Drugs prescribed for cosmetic purposes including but not limited to drugs used for hair growth or wrinkle reduction
• Homeopathic and herbal preparations
• Multivitamins (except prenatal vitamins for pregnant women)
• OTC products, except when covered by the TRICARE Formulary
• Any pharmacy product purchased without a prescription
Clinical Quality Management Program

CHRISTUS Health US Family Health Plan has a comprehensive Clinical Quality Management Program (CQMP). The goal of the CQMP is to ensure 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 CQMP is to assure timely identification, assessment, and resolution of known or suspected problems and trends by continuous monitoring and evaluation of care and services provided.

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

- Access and availability of provider services
- Accreditation and compliance
- Complaints, grievances and appeals to include timely resolution
- Complex Case Management
- Disease Management
- Engage patients and families in their health
- Ensure adequate privacy and security protection for protected health information
- Facilitation of the Quality Improvement Committee
- HEDIS (Healthcare Effectiveness Data and Information Set)
- Improvement of member and provider satisfaction
- Medical record review (types of medical record reviews include continuity of care HEDIS, potential quality of care issues, patient safety indicators, and retrospective data validation. As well as other focused reviews)
- Oversight of Health Plan committee restructure
- Oversight of Quality Improvement and Performance Improvement Plans
- Patient safety
- Pharmacy services effectiveness
- Policy and Procedure oversight and training
- Preventive health services
- Reduce hospital admissions and readmissions
- Timely credentialing of providers and adequacy of the provider network
- Utilization Management (UM)

All participating providers are required to comply with USFHP’s policies and procedures, including complying with, participating in, and implementing Quality Management Projects. As well as Patient Safety Programs. This includes, but is not limited to implementing activities necessary and required to comply with external accreditation by the National committee for Quality Assurance (NCQA), Utilization Review Accreditation Committee (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.

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

**Provider’s Role**
Providers are expected to cooperate with Health Plan Quality Improvement, patient safety, and performance improvement activities to improve the quality of care; quality of service and member experience. Providers are expected to allow the health plan to use performance data for the purposes of quality improvement initiatives.

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

If you are interested in obtaining additional information about the Quality Improvement Program, including a copy of the full Quality Improvement Program description, please contact your provider network manager or reach out to USFHP Quality team at CHP.QualityDepartment@ChristusHealth.org.

**Quality Referrals**
Any stakeholder may refer a matter for review as a Potential Quality of Care Issue (PQI). A PQI is any suspected provider quality of care or service issue that has the potential to impact the level of care being provided to the enrollee/patient. Providers may include independent physicians, medical groups, hospitals, nurses, ancillary providers and their staff as well as Health Plan staff.

The Quality Director, Quality RN, or designee may refer cases to the Medical Director for review and recommendation. The results of such screens shall be reported within fifteen (15) days of the referral, with a final report in thirty (30) days.
The Medical Director’s review may result in such determinations as:

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

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

**Procedure for Unusual Provider Practice Patterns**

Whenever a concern regarding the clinical quality of care and services provided arises, all available records and related correspondence are screened by the Quality Improvement Department. The concerns are forwarded to the Medical Director for review and determination of any PQIs.

Individual concerns that do not represent a pattern of behavior or do not seriously jeopardize patient care. Welfare may be individually addressed by the Medical Director and summarized to the Peer Review Committee (PRC) at its next regularly scheduled meeting. The PRC may accept the Medical Director’s assessment and follow-up actions, or it may recommend another course of action based upon the information presented.

All PQIs are assigned a severity level of 1-4, with 4 being the most severe. The PRC will determine the final severity level of the PQI. When individual concerns represent a pattern of behavior, the Medical Director shall ensure the matter is addressed through the Quality Improvement Committee (QIC).

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

The sanctioning process of the Health Plan will follow the Health Care Quality Improvement Act of 1986. USFHP has a policy and process for conducting the required due process. The provider may request a copy of the policy at any time by contacting the Medical Director or the Quality Department.
President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry

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

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

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

Sentinel Event Review Process

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

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

USFHP will conduct its activities in such a manner as to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Quality Improvement Act of 1986. USFHP will retain the privilege of protection and confidentiality afforded under this act. Communication will be point-to-point under the auspices of the QIC Committee and Quality Assurance Committee of Medical Staff. USFHP will require that information provided in compliance with mandatory releases of information will not compromise the protected and privileged nature of the information.
**National Disaster Medical System (NDMS)**

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

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

All information above is quoted from the National Disaster Medical System website, [phe.gov/preparedness/responders/ndms/pages/default.aspx](http://phe.gov/preparedness/responders/ndms/pages/default.aspx).

**Healthcare Effectiveness Data Information Set (HEDIS)**

The Department of Defense requires USFHP to report Healthcare Effectiveness Data Information Set (HEDIS®) measured annually. HEDIS is a set of standardized Quality Indicators that compare the performance of managed care plans in areas such as preventative screenings and chronic health care, which was developed by the National Committee for Quality Assurance (NCQA).

HEDIS rates can be calculated in two ways: administrative data or hybrid data.
- Administrative data consists of claim and encounter data submitted to the 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 timely claims encounter data and submission using appropriate CPT, ICD-10 (effective Oct. 1, 2015) and HCPCS codes reduce the necessity of medical record reviews

**Medical Record Reviews (MRR) for HEDIS**

USFHP 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 USFHP, which allows them to collect PHI on our behalf.

**Improving HEDIS Scores**
- 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 and medical record documentation of each member and document conversations for all services
- Submit claims and encounter data for each service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Superior
- Claims and encounter data is the most clean and efficient way to report HEDIS
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure
- Understand the specifications established for each HEDIS measure

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI Department via email, CHP.QualityDepartment@ChristusHealth.org.

**Consumer Assessment of Health Plan Providers and Services (CAHPS) Survey**
The CAHPS 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. It also gives a general indication of how well the Plan is meeting the members expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

The survey captures answers to questions like (but not limited to):
1. Did you get an appointment with your doctor as quickly as you thought you needed to?
2. How was the 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 the provider's office staff to return your call?
8. How often did this provider seem informed about your care with specialists?
9. Did the office give you information about what to do if you needed care during 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?

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

Clinical practice guidelines are evidence-based guidelines used to help providers make decisions about specific clinical situations. USFHP consults with participating providers practicing in the community to adopt nationally recognized guidelines and standards. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to providers to facilitate improvement of health of our members.

Clinical practice guidelines are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider’s clinical judgement regarding the appropriate treatment of a patient in any given case.

Clinical Practice Guidelines that have been formally adopted can be accessed on our website at [ChristusHealthPlan.org/providers/provider-guidelines](http://ChristusHealthPlan.org/providers/provider-guidelines).

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy, or can reach out to Provider Services at 800.678.7347.

**Preventive Health Guidelines**

US Family Health Plan adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) for healthy adults and children with normal risks (Grade A and B), and the Centers for Disease Control and Prevention (CDC). Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources.

Preventive Health Guidelines that have been formally adopted can be accessed on our website at [ChristusHealthPlan.org/providers/provider-guidelines](http://ChristusHealthPlan.org/providers/provider-guidelines).

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy or can reach out to Provider Services at 800.678.7347.
Claims and Appeals

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

- Be submitted within 365 days following the original date of service or date of discharge
- US Family Health Plan will bear no liability to pay claims received after 365 days, and members cannot be balance billed for the provider's failure to submit claims within 365 days
- Include AMA-developed procedural coding
- Include ICD-10 diagnosis coding to the highest specification
- Have charges listed on separate lines; Charges should always be itemized.
- Be submitted on original red and white CMS 1500 or UB-04 forms when filing paper claims *(Black and white copies or faxes are not accepted)*
- Not be handwritten
- Be mailed to the following address when submitting paper claims:
  
  US Family Health Plan Claims  
  P.O. Box 981696  
  El Paso, Texas 79998-1696

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

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

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

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

Strive to make sure all submitted claims are properly coded, documented, and filed according to all applicable laws and regulations.
Questions Regarding Claims Payment
If you have questions regarding the payment of a claim, we can help. Contact Member Services at 800.678.7347.

EDI Transactions
The Plan’s EDI transactions are performed via the following clearinghouses:
- Change Healthcare

The following sections provide information regarding each type of transaction and what is required in order to perform these transactions with USFHP. Contact your clearinghouse or billing entity to ensure you are setup to interact with Change Healthcare prior to performing any EDI transactions involving USFHP.

Electronic Claims Submissions (837)
For submission of 837s, providers are to use:

Change Healthcare:
- Payor ID: 90551

Ensure you have a valid NPI on file with the Health Plan.

Electronic Provider Remittance Advice (835)
In order to receive electronic remittance advice (835) from Change Healthcare, providers need to follow the instructions on the EDI Form.

The form should be completed and sent to: CHPIMSupport@ChristusHealth.org.

For group providers, a form must be submitted for each provider associated with the group.

For ancillary providers or facilities, a form must be submitted for each location.

Once set up, the providers billing service/clearinghouse will receive notification via e-mail.

Electronic Enrollment Status (270 | 271)
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.

You will be able to obtain the following information electronically via Change Healthcare:
- Member Name
- Subscriber ID
- Address
- Group | Plan | Product Number
- Eligibility Time Frame
- Status (Active or Inactive)
• DOB
• Insurance Type
• Gender
• Home Phone Number
• Co-pay (Office and ER)
• Pharmacy (Maxor) Contact Number
• PCP Name
• PCP NPI
• PCP Contact Number

**Electronic Claim Status (276 | 277)**
Providers can obtain electronic claims status (276 | 277) through Change Healthcare. Contact the health plan to ensure both your NPI 1 and NPI 2 (if applicable) are captured in the plan’s system.

You can obtain the following information via Change Healthcare:
• Member Name
• Subscriber ID
• Servicing Provider
• Servicing Provider NPI
• Date of Service (from and to)
• Claim Number
• Check Date
• Check Number
• Total Claim Charge Amount
• Total Claim Payment Amount
• Claim Status (paid, pended, voided, etc.)

Should you have any questions regarding EDI transactions with the Plan, please feel free to contact your office’s clearinghouse:
• Change Healthcare Help Desk: **800.845.6592**, Option 2

**Encounter Data**
Participating providers are required to submit their encounter data on a monthly basis. Encounter data should be submitted on an original red and white CMS 1500 or UB-04 form. **Faxes and black and white copies are not permitted.**
Provider Grievance, Disputes, and Appeals

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

Disputes
Disputes are disagreements between a network provider and the contractor concerning payment for services provided by the network provider and are not appealable per Tricare Operations Manual Chapter 12 section 3 Sub section 1.3.2.1 Network Provider or Entity/Contractor Disputes. Disputes include communications regarding TRICARE – determined allowable cost or charge for services or supplies.

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

Provider Appeals
A request for review of an initial determination is classified as a Reconsideration. A request for review of a Reconsideration is considered an Appeal. Network providers, without the beneficiary’s consent through the completion of a signed OAR, are not considered proper appealing parties per Tricare Operations Manual Chapter 12, Section 3 § 1.2 and as such are unable to submit requests for Reconsiderations nor Appeals.

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

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

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

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

**Appeal Rights**

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

**TRICARE Quality Monitoring Contractor (TQMC)**
KePRO
ATTN: Reconsiderations and Appeals
777 East Park Drive
Harrisburg, PA 17111
## Appeal Process

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

All appeals of reconsideration decisions made by TQMC are final and binding.
All appeals should be sent, in writing, to the following:

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

By Fax:   US Family Health Plan
          Attn: Medical Appeals
          Fax: 866.416.2840

By Email: CHRISTUSCAG@christushealth.org
Compliance

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

US Family Health Plan is dedicated to the CHRISTUS Health “Core Values” of Dignity, Integrity, Excellence, Compassion, and Stewardship, and we hold contracted physicians and providers to the same standards. As a participating provider in USFHP, providers are expected to:

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

**Quality Care**
- Provide quality care to all 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 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, as well as 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
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
  - Significant alternatives
**Fraud, Waste and Abuse**

**Fraud, Waste, and Abuse (FWA)** – Prevention, Detection, Examples, Enforcement and Reporting

US Family Health Plan and the CHRISTUS Health Plan Special Investigations Unit follow the requirements, standards and guidelines listed in the TRICARE Operations Manual (TOM). Program Integrity Sections 3 and k, for dealing with fraud, waste and abuse (FWA). The TOM services as the prevailing standard in any circumstance when a difference may occur with the general USFHP policies and procedures for the Special Investigations Unit, Compliance and all departments collaborating on Anti-FWA activities.

**Special Investigations Unit:** Governing agencies and regulatory bodies require CHRISTUS Health Plan (CHP) to staff a Special Investigation Unit (SIU) to detect, deter and prevent fraud, waste, and abuse, involving Providers or members within the CHRISTUS Health Plan network. The SIU monitors, reviews, and analyzes Provider utilization and claims activity to verify compliance with CHRISTUS Medical management and medical treatment standards. To advocate for the highest and best health care for members, CHP endorses treatment that is medically necessary, evidence based, and provided by the proper cost. If these standards are not followed there is a higher likelihood of an unfavorable impact on members, generation preventable health care costs, and the possibility SIU will receive a report of non-compliance.

**Investigations:** The SIU promptly and thoroughly investigates all reports of fraud, waste, and abuse to detect if non-compliance is occurring. SIU performs claims data analysis, reviews medical records, conducts audits by phone and onsite, leads interviews, collaborates with health care professionals, cooperates with federal, state and local law enforcement, and details findings in a report. When non-compliance is confirmed, a referral is sent to governing agencies, regulatory officials, and law enforcement as appropriate. CHP will recoup overpayments for paid claims, when fraud, waste, and abuse, occur.

**Examples:** A list of issues and patterns considered non-compliant, which may be considered fraud, waste, and abuse.
<table>
<thead>
<tr>
<th>#</th>
<th>ISSUE</th>
<th>DESCRIPTION OF PATTERNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>MEDICAL NECESSITY</td>
<td>Treatment, services or equipment not medically necessary, or extended duration, etc.</td>
</tr>
<tr>
<td>2)</td>
<td>BILLING &amp; CODING</td>
<td>Overcharging, double billing, wasteful, non-covered services, upcoding, disguising, misuse, pattern of incorrect coding, etc.</td>
</tr>
<tr>
<td>3)</td>
<td>COMPLIANCE</td>
<td>Inadequate Medical Records, suspended license, convictions, not furnishing records</td>
</tr>
</tbody>
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**Discipline for Non-Compliance**

If non-compliance occurs, the Compliance Department follows oversight agency guidelines, as in the TRICARE Operations Manual, and if permitted, will determine the next steps, which may include, administrative remedies provided for in § 199.9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions. CHRISTUS actions may include other actions deemed appropriate, such as the following:

1) Provider Education and Counseling  
2) Formal Written Warning  
3) Recoupment of Non-Compliant Claims Paid and Overpayments  
4) Corrective Action Plan  
5) Temporary Suspension from Billing and Treatment of CHP Members  
6) Termination of Provider Contract and from the CHP Network  
7) Referral to Law Enforcement Federal, State and local law enforcement agencies

**Fraud Reporting or Other Compliance Issues**

Please make a report if you suspect non-compliance involving a Provider or Member / Beneficiary, non-Member, any third party, etc. Please contact the Special Investigations Unit (SIU) and describe your observations and experiences, so a representative will contact you to gather more details. If preferred, you may remain anonymous and will not be contacted.

The options for reporting are:
Federal and State health Care Fraud and Abuse Laws: A partial list of potential federal and state violations if FWA has occurred:

The TRICARE Operations Manual: Definition of fraud and abuse is located in 32 CFR 199.2


False Claims Act

The Anti–Kickback Statute
Statute: 42 U.S.C. § 1320a–7b(b)
Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law
Statute: 42 U.S.C. § 1395nn
Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities
Statutes: 42 U.S.C. §§1320a–7, 1320c–5
Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law
Statute: 42 U.S.C. § 1320a–7a
Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute
Statute: 18 U.S.C. §§1347, 1349

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

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

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

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

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

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

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

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

**Adverse Determination:** A determination by a Health Maintenance Organization (HMO) or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate. The adverse determination, i.e., denial of a requested covered service, including type or level of service, which includes:
• Denial in whole for a service
• Denial in part of a service, i.e., has been limited, reduced, suspended, or terminated
• Denial in whole or part of payment for a covered service
• Failure by the health plan to provide a service in a timely manner as defined by federal and/or state regulations
• Failure to act within timeframes for the health plan’s Prior Authorization review process

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

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

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

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

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

**Case Management (Defined in 32 CFR 199.2):** A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual’s health needs, including.

**Catastrophic Cap:** The National Defense Authorization Act (NDAA) for Fiscal Years (FYs) 1988 and 1989 (Public Law 100–180) amended Title 10, USC, and established catastrophic loss protection for TRICARE beneficiary families on a Government fiscal year basis. The law placed fiscal year limits or catastrophic caps on beneficiary liabilities for deductibles and cost-shares under the TRICARE Basic Program. Specific guidance may be found in the TRM, Chapter 2, Section 2. NDAA for FY 2017 amended Title 10, USC to change calculations to a calendar year basis, beginning January 1, 2018. The last quarter of calendar year 2017 was applied to the FY 2017 calculations to bridge the gap.
Claim: Any request for reimbursement for health care services rendered, received from a beneficiary, a beneficiary's representative, or a network or no-network provider, by a contractor on any TRICARE-approved claim for, or approved electronic medium.

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

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

Clean Claim: A claim submitted by a provider for medical care or health care services rendered to a member, with the data necessary for the 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
- 837 Institutional Companion Guide
- National Council for Prescription Drug Programs (NCPDP) Companion Guide

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

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

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

Complaint (Grievance): Any dispute or expressed level of dissatisfaction, either verbally or in writing, by a member or members authorized representative with the health plan or a delegated contractor’s processes other than an action associated with the disposition of a claim, i.e., adverse determination of a benefit.
Continuity of Care: Follow up of health care services from a specific individual professional provider as part of a specific procedure or service that was performed within the previous six months in order to not disrupt therapy or repeat services.

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

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

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

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

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

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

2. A completed a Criminal History Background Check (CHBC), for all personnel required by law to have a CHBC prior to awarding of privileges or the delivery of services within the following considerations:
   - If a CHBC has been initiated, but not completed, the MTF Commander/eMSM Manager has the authority to allow awarding of privileges and initiation of services if delivered under clinical supervision.
   - The mechanism for accomplishing the CHBC may vary between MTFs/eMSMs and should be determined during phase-in/transition and be agreed to by the MTF Commander/eMSM Manager.
   - Regardless of the mechanism for initiating and completing a CHBC, the cost shall be borne by the contractor.

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

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

Deductible: Payment by the beneficiary of the first $50 of the CHAMPUS determined allowable costs of charges for covered outpatient services or supplies in any one fiscal year; aggregate payment by two or more beneficiaries who submit claims for the first $100. Effective January 1, 2018.

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

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

2. Verifying members’, former members’, and their dependents’ eligibility for health care benefits in the direct facilities and for TRICARE.

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

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

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

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

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

Durable Medical Equipment (DME): Equipment or supplies prescribed by a provider that are medically necessary for the treatment of an illness or accidental injury or to prevent the 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: Covered services that are furnished by a provider who is qualified to provide Emergency Care Services. The services are needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his/her condition, sickness, or injury is of such a nature that failure to receive immediate medical attention could result in:
- Placing the patient’s health in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of pregnant women, serious jeopardy to the health of the fetus

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

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

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

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

Formulary: A list of prescription drugs chosen and covered by a health plan with prescription drug benefits. The DoD Pharmacy & Therapeutics (P&T) Committee (a body of military physicians and pharmacists) and approved by the Director of the Defense Health Agency (DHA) establishes a uniform formulary, which is a list of covered generic and brand name drugs. This formulary also contains a third tier of drugs that are non-formulary and a fourth tier of drugs that are non-covered. Prescriptions for non-formulary drugs are dispensed at a higher copay. The formulary is updated on a quarterly basis.
**Generic Drug**: A drug with the same active-ingredient formula as a brand name drug without a trademarked name. Generic drugs usually cost less than brand name drugs.

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

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

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

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

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

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

**In-network**: Care received from a participating provider.

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

**Insurance**: A method of providing money to pay for specific types of losses which may occur. Insurance is a contract between one party and another. The policy states what types of losses are covered, what amounts will be paid for each loss and for all losses; and under what conditions.
Limits: Quantity or monetary thresholds associated with a particular benefit.

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

Malpractice Liability Coverage: Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the patient 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.

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

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

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

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

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

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

Member: An individual:
- who meets each of the enrollment and eligibility requirements described in this Policy
- who has been properly enrolled in coverage with the Plan
- for whom the Plan has received any required premium for the enrolled coverage

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

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

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

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

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

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

Obstetrician/Gynecologist (OB/GYN): A physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Obstetricians and Gynecologists.
Out-of-Network Services: Health care services obtained from a non-participating provider.

Outpatient: Services that do not necessitate 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 TRICARE authorized that is required, or has agreed by entering into a TRICARE participation agreement or by an act of indicating “accept assignment” on the TRICARE claim form to accept the TRICARE-allowable amount as the maximum total charge for a service or item rendered to a TRICARE beneficiary, whether the amount is paid for fully by TRICARE or requires cost-sharing by the TRICARE beneficiary.

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

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

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

Physician: One of the following:

- A doctor of medicine, surgery, or osteopathy;
- A doctor of podiatry or a doctor of chiropractic; 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.

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

Physician Assistant: A person who has graduated from a nationally recognized physician assistant or assistant surgeon program; or who is currently certified by the national commission of Physician Assistants. A Physician Assistant must be licensed to practice medicine under the supervision of a licensed physician in the state in which they practice.
Plan: The health benefit plan established by CHRISTUS Health US Family Health Plan and selected by the member to provide health care services to members, as it exists on the effective date of this policy or as subsequently amended as provided herein.

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

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

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

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

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

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

Protected Health Information (PHI):
1. IIHI that is:
   a. Transmitted by electronic media;

   b. Maintained in electronic medical; or

   c. Transmitted or maintained in any other form or medium.

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

2. PHI excludes IIHI in:
   a. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g;

   b. Records described at 20USC 1232g(a)(4)(B)(iv); and

   c. Employment records held by a covered entity in its role as an employer.

   d. Regarding a person who has been deceased for more than 50 years.
Note: As defined in HIPAA of 1996.

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

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

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

**Provider Network:** A group HCPs with which a managed care contractor has made contractual or other arrangements with to provide health care at a discounted rate.

**Quality Improvement (QI) Program:** An approach to quality management that builds upon traditional quality assurance methods by emphasizing:
1. The organization and systems (rather than individuals);
2. The need for objective data with which to analyze and improve processes; and
3. The ideal that system and performance can always improve even when high standards appear to have met.

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

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

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

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

**Summary Health Information (HIPAA Definition)**

Information that may be IIHI, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

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

As defined in HIPAA of 1996.

**Specialist**: A physician who provides covered services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint, or muscle conditions and psychiatrists who care for 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 try another drug to treat the medical condition before the Plan will cover the drug the physician may have initially prescribed.

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

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

**Supplemental Security Income (SSI)**: A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.
**Tax Identification Number (TIN):** A number assigned by the Federal Government by which a business or entity is identified for filing and paying taxes related to the business or entity.

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

**Third-Party Liability:** Recovery The recovery by the Government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries of illness caused by a third-party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third-party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third-party. TPL recoveries are made under the authority of the FMCRA (42 USC paragraph 2651 et sec). Other potential sources of recovery in favor of the Government in TPL situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10 USC paragraphs 10790, 1086(g), and 1095(b.)

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

**Urgent Care:** Medically necessary treatment that is required for a sudden illness or injury that is not life threatening, but does require immediate professional attention to avoid further complications resulting from non-treatment. Treatment is usually performed outside an Emergency Room (ER) setting.

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