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<td>US Family Health Plan Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 981696</td>
</tr>
<tr>
<td></td>
<td>El Paso</td>
</tr>
<tr>
<td><strong>Electronic Data Interchange (EDI)</strong></td>
<td><a href="mailto:CHPIMSupport@ChristusHealth.org">CHPIMSupport@ChristusHealth.org</a></td>
</tr>
<tr>
<td>**Member Services</td>
<td>Provider Relations**</td>
</tr>
<tr>
<td></td>
<td>Fax 210.766.8851</td>
</tr>
<tr>
<td>**Utilization Management</td>
<td>Behavioral Health**</td>
</tr>
<tr>
<td></td>
<td>Fax 800.277.4926</td>
</tr>
<tr>
<td><strong>TRICARE Formulary</strong></td>
<td>USFHPFormulary.com</td>
</tr>
<tr>
<td><strong>Maxor Pharmacy</strong></td>
<td>Tel. 866.408.2459</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td>Meritain Health, Inc.</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 27083</td>
</tr>
<tr>
<td></td>
<td>Lansing</td>
</tr>
<tr>
<td></td>
<td>Tel. 888.627.8889</td>
</tr>
<tr>
<td><strong>Reporting Fraud or Abuse</strong></td>
<td>FWA Hot Line: 855.771.8072</td>
</tr>
<tr>
<td></td>
<td>FWA Secure Fax: 210.766.8849</td>
</tr>
<tr>
<td></td>
<td>Dedicated email: <a href="mailto:ChristusHealthPlanSIU@ChristusHealth.org">ChristusHealthPlanSIU@ChristusHealth.org</a></td>
</tr>
<tr>
<td><strong>Website</strong></td>
<td>ChristusHealthPlan.org</td>
</tr>
</tbody>
</table>
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, 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 can be found at ChristusHealthPlan.org and is 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 Regulation, 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, as amended from time to time. Further, 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 upon 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.
Primary Care Providers

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 acts as a coordinator for specialty requests through Utilization Management.

Primary care includes comprehensive health care and support services, and 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 that 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, every three (3) years. The credentialing | re-credentialing process consists 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 | 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 | TRICARE sanctions

Facility Participation Criteria*
- Ability to meet USFHP access and availability standards
- Completed USFHP facility | 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 that require 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 to which the provider agrees to comply:

- 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 that a primary care provider is temporarily unavailable.
- Inform USFHP immediately, in writing, of changes in licensure 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 medical records for five (5) years (60 months) from the last date in which service was provided to the member.
- No balance billing a member for services that are 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 and other related records in a timely fashion and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.
- Provide 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 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 reaching protections for individually identifiable health information. The transaction and code sets 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 that the health plan has or had 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 PCP to another. 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 or sooner 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 require that the following information should be included in every individual patient record:

- Alcohol or Substance Use | Abuse (12 years and older)
- Allergies
- Appropriate Use of Consultants
- Chief Complaint
- Chronic | Continuing Medication List
- Chronic | Significant Problem List
- Date of Each Visit
- Date of Next Visit
- Diagnosis | 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 | Name, Each Entry
- Results Discussed with Patient
- Results of Consultations
- Smoking Status (12 years and older)
- Treatment | 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 that is related to professional competency or conduct.
- Request that any adjudicated claim be reconsidered if they feel it was not paid appropriately.
- Request that 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>Emergency Care</th>
<th>Immediate</th>
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<tbody>
<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**
Covering providers are reimbursed according to the contracted provider’s reimbursement rates. 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>
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<tr>
<td>Well Visit (Preventive Health Services)</td>
<td>Health care services designed for the prevention and early detection of illness in asymptomatic people, generally including well woman exams, physical exams, routine eye exams, and immunizations.</td>
<td>With four (4) weeks</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 (Acute)</td>
<td>Acute but not life- or limb-threatening</td>
<td>Less than 24 hours</td>
</tr>
<tr>
<td>Urgent</td>
<td>Expedited</td>
<td>When the treatment requested is required to prevent imminent, serious deterioration in the member’s health or threatens to jeopardize the member’s ability to regain maximum function.</td>
</tr>
<tr>
<td>Specialty Consultation or Procedure</td>
<td>Care, provision for care, or direction of care by the specialty provider.</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 affecting job function, recognizing that 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.

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.

Member Grievances and Complaints
USFHP encourages members to resolve individual inquiries and concerns or problems at the point of service. In the event that 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 that 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
**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 of 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.

![Member ID Card front](image)

![Member ID Card back](image)

**Verifying Eligibility**
You may call Member Services to check benefits, Mon. – Fri., 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 also 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 the member’s 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, ahead of time, a limit on the number of USFHP members to be accepted into his or her panel. Provider panels can be opened and closed as necessary by the provider via 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:
- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability;
- Extraordinary physical or psychological condition causing the member to be homebound;
- Moderate or severe mental retardation;
- Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems); or
- Serious physical disability.

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 that occurs 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.
Catastrophic Cap Protection

US Family Health Plan offers members the reassurance of a “catastrophic cap,” which limits the amount of money members are required to pay out of pocket in a calendar year (Jan. 1 – Dec. 31). After the maximum dollar limit is reached, USFHP members will not pay any additional cost-share for allowable health care services received during the remainder of the calendar year.

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>
<tr>
<td>TRS Members</td>
<td>Follow Group B</td>
<td>$1,044 per family</td>
</tr>
<tr>
<td>TRR Members</td>
<td>Follow Group B</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 that a non-participating provider may charge above the TRICARE maximum allowable charge (the maximum TRICARE pays for each procedure or service. This is tied by law to Medicare’s allowable charges) for services.
- TRICARE Point-of-Services charges.
- Enrollment premiums.

Member Disenrollment and Changes

Members may become ineligible for USFHP benefits for many reasons, including the following:

1) The Military identification card expires, or the Department of Defense eligibility system indicates the member is ineligible.
2) Member makes a permanent move out of the service area.
3) A determination can be made that the member has provided false information to the Plan, committed fraud with respect to the Plan or permitted someone else to do so with respect to the Plan.
4) Member fails to pay an applicable enrollment fee.
5) Members use other health care services in the Military Health System or the Medicare program without prior approval of the USFHP.
6) Member initiated voluntary disenrollment requests.
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 provided 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.

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
Visits to a psychiatric facility day | partial hospitalization program 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 are 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 Medicare coverage is obtained by the member, Medicare 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 | Third-Party Liability**

US Family Health Plan will coordinate benefits for those provided services that are also covered by Workers’ Compensation or other third-party carriers. The Plan and Department of Defense (DOD) require that the member reports any other health insurance coverage to the Plan.

Third-party liability occurs when a USFHP member suffers injury or illness that was caused by the negligence of or intentional act of a third party. Examples of third-party liabilities are automobile insurance, workers’ compensation, homeowners’ liability, etc. Benefits will also be coordinated with a “no-fault” auto insurance carrier if allowable under the specific state law. It is the responsibility of the physician to provide or assist USFHP in obtaining coordination of benefits | third-party liability information.

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. Providers must provide USFHP information upon request about a member’s other insurance coverage(s).

Providers assign to USFHP all of the provider’s rights and any other benefits that may be payable in respect to a member and agrees to use their best efforts to determine other benefit coverage, assisting USFHP’s collection of other such benefits. Providers will be required to provide patient information updates upon request to allow USFHP to update records or other information.
### 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 Groups A &amp; B</th>
<th>TRICARE Young Adult (TYA) – Active Duty</th>
<th>TRICARE Young Adult (TYA) – Retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Services</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Periodic Preventive Screenings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age and gender appropriate screening tests for the early detection of disease and/or disease risk factors including: Cancer Screening – mammography, pap smears, sigmoid and colonoscopy, and fecal occult blood testing; Infectious Disease Screening – Tuberculosis, Rubella, and Hepatitis; Cardiovascular – Cholesterol and Blood Pressure; Other – vision screening, lead toxicity, hearing (as part of annual physical).</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</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 activity &amp; exercise; cancer surveillance; tobacco, alcohol &amp; substance abuse; accident &amp; injury prevention; promotion dental health; stress and bereavement.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</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 screenings you could be provided. (Presenting to a PCP’s office with medical problems during a well visit will be viewed as a regular office visit.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</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>
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<td>TRICARE Young Adult (TYA) – Retiree</td>
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<td>------------------------------------------------------------------------</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>
<td></td>
<td></td>
<td></td>
</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</strong> (When prescribed by a provider and secured through USFHP-contracted providers)</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> (provided through Meritain Health, Inc.)</td>
<td>Physician Visit: $0</td>
<td>Physician Visit: $0</td>
<td>Physician Visit: $20 per visit</td>
<td>Physician Visit: $20 per visit</td>
<td>Physician Visit: $20 per visit</td>
</tr>
<tr>
<td><strong>Prescriptions:</strong> See section on prescription copayments</td>
<td>Prescriptions: See section on prescription copayments</td>
<td>Prescriptions: See section on prescription copayments</td>
<td>Specialist: $31 copay</td>
<td>Specialist: $31 copay</td>
<td>Specialist: $31 copay</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>
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<td>TRICARE Young Adult (TYA) – Retiree</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
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<td>----------------------------------------</td>
<td>------------------------------------</td>
</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) copayments and/or cost-shares information can be found at tricare.mil/cost</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 $30 Copay per Visit-Specialist</td>
<td>$0 per visit</td>
<td>$20 Copay Per Visit-Primary $30 Copay per Visit-Specialist</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>$20–$31 Copay dependent upon the specialty of the physician performing the office surgery</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 Type</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>Physical Occupational Therapy</td>
<td>$0 per visit</td>
<td>$0 per visit</td>
<td>$31 Copay per day</td>
<td>$0 per visit</td>
<td>$31 Copay per day</td>
</tr>
<tr>
<td></td>
<td>(When medically necessary</td>
<td>(When provided in home, any applicable copay for home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(When provided in home,</td>
<td>health applies)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>any applicable copay for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
<td>$13 Generic</td>
</tr>
<tr>
<td>supply obtained directly from</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>network pharmacy)</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
</tr>
<tr>
<td></td>
<td>name and generic</td>
<td>name and generic</td>
<td>and generic</td>
<td>and generic</td>
<td>and generic</td>
</tr>
<tr>
<td>Prescriptions (Mail-Order</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
</tr>
<tr>
<td>Pharmacy) (up to a 90-day</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>supply or less obtained</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
<td>$60 Non-formulary brand</td>
</tr>
<tr>
<td>through Maxor Mail Order</td>
<td>name and generic</td>
<td>name and generic</td>
<td>and generic</td>
<td>and generic</td>
<td>and generic</td>
</tr>
<tr>
<td>Pharmacy when authorized;</td>
<td>(includes prescriptions</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>includes prescriptions for</td>
<td>for nursing home patients.)</td>
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</tr>
<tr>
<td>Residential Treatment Centers</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>Speech Therapy</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></td>
<td>(When medically necessary</td>
<td></td>
<td></td>
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<td></td>
<td>(When provided in home,</td>
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<tr>
<td></td>
<td>the copay for home</td>
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</tr>
<tr>
<td></td>
<td>health care applies)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Well-Child Care</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></td>
<td>(Up to 6 years of age,</td>
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<tr>
<td></td>
<td>except as a preventive</td>
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</tr>
<tr>
<td></td>
<td>service)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Alcohol &amp;</td>
<td>$0 per day</td>
<td>$0 per day</td>
<td>$156 Copay per admission</td>
<td>$0 per day</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>(Mental Health)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Active Duty Family Members</td>
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</tr>
<tr>
<td>Hospitalization</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>$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>Maternity</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>$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>Skilled Nursing Facility</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>
<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>
</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 deemed 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 | investigational procedures.
- Homemaker services.
- Lodging costs during outpatient dialysis treatment.
- Meals delivered to the home.
- Non-medically necessary transportation costs.
- 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 member is 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 part of usual 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 that 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 that the beneficiary received from the participating provider except in
the following situations:

- If the member did not inform the provider that he or she was a USFHP member, the
  provider may bill the beneficiary for services rendered.
- If the member was informed that the service was excluded, and he or she agreed in
  advance to pay for that 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 member should be 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 evidenced by written records. Examples of acceptable written
records include:

- Provider office or medical record documentation written prior to receipt of the
  services demonstrating that the USFHP member was informed that 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 that 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 that 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 that:

- 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 service is documented
  in writing.
- General agreements to pay, such as those routinely signed by patients, are not
  evidence that 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 services 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 could not 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 | 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 services being rendered.

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) | 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 | 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 | 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 that every member is provided with appropriate care, both in the hospital and post discharge.
Retrospective Review: The process of review that occurs before payment of any claims for which Precertification | Authorization did not occur. The review will consist of assessing the medical necessity of all services not previously approved. Clinical information will be reviewed for appropriateness using clinical guidelines, plan protocols and TRICARE benefits and coverage as appropriate.

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

Skilled Nursing, Long-Term Acute Care, and Rehabilitation Facility Authorization: Skilled nursing facilities (SNF), long-term acute care facilities (LTAC) and rehabilitation facilities are specially qualified facilities or designated units in a hospital 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 prior orders by the attending physician and authorization by the UM | 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.

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 part or retards further deterioration of the patient’s physical condition. Specific DME items require prior authorization (see Services Requiring Prior Authorization). DME must be obtained through 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>Urgent admissions</td>
<td>observations</td>
<td>By the next business day after admission to the facility</td>
</tr>
<tr>
<td>Elective admissions</td>
<td>observations</td>
<td>5 business days prior to the requested date of service (DOS)</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF)</td>
<td>Rehabilitation</td>
<td>Initiation – 2 days prior to request date of admission (DOA)</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>Durable medical equipment (DME)</td>
<td>7 business days prior to requested DOS</td>
</tr>
</tbody>
</table>

Authorization Process
Information received either via phone or electronic means in the UM | CM Department will be reviewed for coverage and benefits. Appropriateness and medical necessity will be reviewed using 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 that will 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.

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 | 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 | 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.

If you need help determining if a service requires Prior Authorization, please contact Provider 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.

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

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

The TRICARE Formulary covers most FDA-approved prescriptions. In general, for a medication to be covered under the USFHP pharmacy benefit, it must:

- Be a prescription medication approved by the FDA.
- Be prescribed in accordance 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.

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.

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

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. Non-preferred drugs are covered if the preferred medication is ineffective or poorly tolerated. 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.

For an updated list of drugs requiring prior authorization from the TRICARE Formulary, go to USFHPFormulary.com.
DoD quantity limitations are in place for some drugs. TRICARE quantity limits information can be found on the web at: USFHPFormulary.com.

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.

**Drug Denial Appeals**
Administrative and clinical drug denial letters are issued along 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

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
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 Tier 3</th>
<th>Non-Covered Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic Tier 1</td>
<td>Brand Name Tier 2</td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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</td>
<td>$10</td>
<td>$29</td>
<td>$60</td>
</tr>
<tr>
<td>(up to a 90-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 that 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, the following process must be used:

- 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.
  - The initial 30-day prescription will be filled at any of the affiliated walk-in network pharmacies.
  - 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 or 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 that every member receives quality care in a timely and accessible fashion and to provide a mechanism for evaluating the appropriateness of member care. The purpose of the CQMP is to assure timely identification, assessment, and resolution of known or suspected problems | 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, including 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. These reviews are conducted to assure that
appropriateness of care, medical necessity, reasonableness of care and intensity of services occur. 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 also 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 take action 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 then 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 or 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 that the matter is addressed through the Quality Improvement Committee (QIC).

**Note:** When a situation occurs that is deemed to pose an immediate threat to the health and safety of beneficiaries, the 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 that 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 that 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 | 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 and civilian volunteers to ensure that 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 medical and 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.

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 and timely claims and encounter data and submission using appropriate CPT, ICD-10 (effective Oct. 1, 2015) and HCPCS codes can 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 | medical record documentation of each member and document conversation | 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 and 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 for 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?
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.

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.

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 separate 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 will not be 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 that claims submitted for payment or reimbursement are for services that are medically necessary.

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 that 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:

- Availity
- 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 that you are setup to interact with Availity or Change Healthcare prior to performing any EDI transactions involving USFHP.

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

**Availity | Payor ID: USFHP**
The plan is listed as US Family Health Plan (Texas and Louisiana).

**OR**

**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 Availity or 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 provider’s 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 Availity or Change Healthcare and choose this transaction.

You will be able to obtain the following information electronically via Availity or 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 Availity or Change Healthcare. Contact the health plan to ensure that both your NPI 1 and NPI 2 (if applicable) are captured in the plan's system.

You can obtain the following information via Availity or 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:

- Availity Help Desk: 800.292.4548, Option 2.
- 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 Complaints and Appeals

Provider Complaints
All participating providers agree to comply with the plan's dispute resolution process by signing the provider agreement that includes a dispute resolution clause. The provider complaint process is available to any participating provider to resolve disputes with the Plan.

The Plan distinguishes disputes by the following categories: Administrative Disputes or Disputes Concerning Professional Competence and Conduct.

1. Administrative Disputes may include, but are not limited to, a participating provider's written notice to US Family Health Plan challenging, appealing or requesting reconsideration of a claim denial or payment, factual determinations by Utilization Management, and / or contractual concerns.

2. Disputes Concerning Professional Competence or Conduct are non-administrative disputes that involve actions by the Plan that relate to a participating provider's status within the Plan's provider network and any action by the Plan related to a participating provider's professional competency or conduct.

USFHP participating providers have the right to appeal disputes up to a second level. The Plan's internal panel will consist of three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider who filed the dispute. In no case will the panel members be assigned that have been previously involved with the issue.

At each level, the provider has the right to submit relevant information:

- When appropriate, the Medical Director will review the matter first, using appropriate peer input. If not satisfactorily resolved, the dispute will be referred to the first-level panel.
- The first-level panel will discuss the dispute and make a decision. The decision will be forwarded, in writing, to the disputing provider, and when necessary, the second-level appeal rights, procedures, and timeframes will be provided. The provider has the right to challenge the findings of the decision.
- The decision of the second-level panel is final. The decision will also be transmitted in writing.

In order to maintain the right to use the dispute resolution process, a signed written appeal from the participating provider must be received within thirty (30) calendar days from the date the resolution letter was received. Unless otherwise indicated, delivery will be assumed to have occurred five (5) days after mailing.

The provider has the right to challenge the findings of the decision and to present relevant documentation and information in support of his / her dispute or appeal. A panel will be convened within sixty (60) days of the request and the decision will be returned to the
participating provider within sixty (60) days of the written appeal received date. When an adverse action is taken or if the provider voluntarily relinquishes participation while undergoing investigation and/or peer review, it is noted in the Credentialing File and reported as required by law.

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

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

**Provider Appeals**

If a provider disagrees with a decision regarding medical necessity or claim payment, the decision or payment may be appealed. Instructions on how and where to submit an appeal will be provided on the denial (resolution) letter and/or EOB.

- The appeal 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 appeal should include all documentation that supports the provider’s position. Any costs incurred in providing documentation will not be reimbursed by the Plan.
- Providers will receive a payment or written response generally within thirty (30) calendar days [can take up to ninety (90) days], describing how their appeal was resolved and the basis for the resolution.
- Please note that 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 you are not satisfied with this determination, you may appeal in writing to TRICARE Quality Monitoring Contractor (TQMC), KePRO. Appeals for Reconsideration must be filed within ninety (90) calendar days from the date of this determination. Reconsideration requests should include an explanation as to the nature of the reconsideration appeal and any concerns that you believe should be addressed. Request for reconsideration should be submitted, along with a copy of this determination, to the following:

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

| Level 1 Appeal | Written requests for reconsideration may be submitted by the provider or member 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/preprocedure denial must be filed within three (3) calendar days after the date of the receipt of the denial determination.  
| Appeal of Initial 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) from providers for an appeal of reconsideration when a contractor upholds an initial determination on reconsideration. The TQMC will make a determination of the reconsideration request within the following time frames:  
|                | - Three (3) working days for expedited reconsideration appealed by a member.  
|                | - Thirty (30) days after receipt of the required documentation for review of reconsideration denial of cases not identified as an expedited reconsideration.  
|                | The TQMC will notify all parties of the determination of appeal of US Family Health Plan’s reconsideration. |
| Appeal of Reconsideration Determination | Members and/or providers can request an appeal of reconsideration when US Family Health Plan upholds an initial denial determination on 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
P.O. Box 169009
Irving | TX 75016

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

By Email: CHRISTUS.HP.AppealsandGrievances@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 that members and their personal representatives have the right to access information regarding the identity and licensure of their caregivers.

Accurate Recording and Reporting

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

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

US Family Health Plan and the Special Investigations Unit follow the requirements, standards and guidelines listed in the TRICARE Operations Manual (TOM), Program Integrity Sections 3 and 5, for dealing with fraud, waste and abuse (FWA). The TOM serves 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.

Fraud, waste and abuse include deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider, in relation to a USFHP claim. They also include billing for non-standard, unnecessary medical treatment, services or equipment, as defined by the TRICARE benefit plan, CHRISTUS Health Medical Management, or medical and professional associations.

Providers should avoid practice patterns that, directly or indirectly, result in unnecessary health care costs, such as misrepresenting the appropriate procedure codes, improper bundling or unbundling of services, or creating internal policies and procedures causing inappropriate financial gain. It is presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks).

Fraud
TRICARE defines fraud using the definition located in 32 CFR 199.2. In this citation, fraud is defined as:

1. A deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payments; or
2. A claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that:
   a. omits a material fact; and
   b. is false or fictitious as a result of such omission; and
   c. is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact.

It is presumed that, if a deception or misrepresentation is established and a TRICARE claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks). This presumption may only be rebutted by “clear and convincing evidence.”
Examples of fraud, under TRICARE, include, but are not limited to, the following:

- Billing for items or services not rendered or not provided as claimed.
- Billing for non-covered services as if covered.
- Billing using codes that do not match the service rendered, resulting in higher paid claim.
- Double billing resulting in duplicate payment.
- Overcharging – Submitting a claim for an item or service priced unusually high.
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary or are not specifically prescribed.
- Submitting TRICARE claims (including billings by providers when the claim is submitted by the member) for services, supplies, or equipment not furnished to, or used by, TRICARE members.

Waste
Waste is defined as the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.

Both fraud and abuse can expose a provider, contractor or subcontractor, to criminal and civil liability. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources. The provider is responsible for implementing methods to prevent fraud, waste, and abuse. Listed below are some common prevention techniques.

This list is not meant to be all-inclusive.

- Avoid unnecessary drug prescription and or medical treatment.
- Ensure accuracy when submitting bills or claims for services rendered.
- Screen all employees and contractors at time of hire or contract and monthly thereafter to prevent reimbursement of excluded and or debarred individuals and or entities.
- Submit appropriate referral and treatment forms.

Abuse
Abuse generally describes incidents and practices that may directly or indirectly cause financial loss to the government under TRICARE or to TRICARE members.
Abuse is defined as “...any practice that is inconsistent with accepted sound fiscal, business, or professional practice that results in a TRICARE claim, unnecessary costs, or TRICARE payment for services or supplies that are:

1. Not within the concepts of medically necessary and appropriate care as defined in this Regulation; or
2. That fail to meet professionally recognized standards for health care providers. The term “abuse” includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider, in relation to a TRICARE claim.”

Providers have obligations to furnish services and supplies under TRICARE at the appropriate level and only when and to the extent medically necessary as determined under 32 CFR 199.9. The quality must meet professionally recognized standards of health care and be supported by adequate medical documentation as may reasonably be required to confirm the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. A provider’s failure to comply with these obligations can result in sanctions. Abuse situations are a sufficient basis for denying all or any part of TRICARE cost-sharing of individual claims.

Examples of potential abuse (practices inconsistent with sound fiscal, business, or medical procedures and services not considered to be reasonable and necessary) include:

- A pattern of claims for services that are not medically necessary, or if necessary, not to the extent rendered.
- Care of inferior quality (does not meet accepted standards of care).
- Failure to maintain adequate clinical or financial records.
- Overcharging - Billing for items or services that are substantially above list price or MSRP.
- Refusal to furnish or allow access to records.

In addition, unbundling, fragmenting, or code gaming to manipulate the Physician’s Current Procedural Terminology (CPT) codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive.

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

**Discipline for Non-Compliance**

If non-compliance occurs, the Compliance Department follows oversight agency guidelines, as listed in the agency Operations Manual, and if permitted, will determine the next steps, which may include, suspension, termination, recoupment, an onsite audit, a partial invoice audit, a full invoice audit, referral to law enforcement or other actions deemed appropriate.
Reporting Fraud, Waste, and Abuse (FWA)
Reporting FWA contributes to efforts in lowering health care costs. Your name and report may be kept anonymous. If you prefer anonymity, and do not wish to be contacted, please notate that within your report.

For reporting options, please refer to the resources below:
FWA Hotline: **855.771.8072**
FWA Secure Fax: **210.766.8849**
E-Mail: CHRISTUSHealthPlanSIU@ChristusHealth.org
Important Statutes

We hope that you find this information helpful. However, if you would like more information regarding compliance programs, please visit OIG’s web site, oig.hhs.gov.

False Claims Act
Imposes civil liability on any person | entity submitting false claims to the US government and federal contractors. It also protects informers or whistleblowers from retaliation by their employer. The False Claims Act deals mainly with the federal government.

Sarbanes | Oxley Act 18 U.S.C. §1514A
Civil action to protect whistleblowers against retaliation by employers for reporting fraud perpetrated by publicly traded companies.

Criminal Investigation of Health Care Offenses
Imposes criminal penalties for any person willfully obstructing such investigation(s), for example, withholding medical records.

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

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

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

There are a limited number of exceptions to the Social Security law known as “safe harbors,” which provide immunity from criminal prosecution.
Federal Anti-Referral Law (Stark Laws)
Providers are prohibited from referring patients to health entities in which they have an ownership relationship. Any health service receiving a “prohibited referral” is prohibited from billing for it.

Health services include:
- DME equipment and supplies.
- Home health services, inpatient and outpatient hospital service.
- Intravenous and enteral (tube feeding) nutrients and supplies.
- Lab and radiology.
- Orthotic and prosthetic devices and supplies.
- Outpatient prescription drugs.
- Physical therapy and occupational therapy.

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

Emergency Medical Treatment and Active Labor Act (EMTALA)
Prohibits hospitals that receive Medicare funds from transferring out patients in their emergency rooms based solely on their inability to pay for services.

Civil Rights Act of 1964
Prohibits any federally funded program from discriminating on the basis of race, creed, color, or national origin.

Rehabilitation Act of 1973
Prohibits qualified handicapped individuals from being discriminated against in any program or activity receiving federal funds.

Individuals protected are those with:
- Blind | visual impairment or deaf | hearing impairment.
- Cerebral Palsy, epilepsy or seizure disorder.
- Chronic diseases, including AIDS, arthritis, cancer, and diabetes.
- Drug | alcohol addiction.
- Has a record of such an impairment or has it currently.
- Mental retardation and psychiatric disorders.
- Orthopedic handicap, spinal cord | traumatic brain injury.
- Physical or mental impairment that substantially limits one or more major activities of daily living.
- Specific learning disability and certain speech disorders.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Mandates that security and confidentiality of individually identifiable protected health information (PHI) must be stored and transmitted securely, patients must be notified of their rights, and where to submit complaints, and patients must have access to their medical records.

Alcohol and Drug Abuse and Mental Health Administration Reorganization Act
Specifies that alcohol and drug abuse records are kept confidential and requires certain court orders.

Confidentiality and Disclosure Requirements Table 10
Requires that quality assurance documentation be kept confidential in Department of Defense programs.

Freedom of Information Act (FOIA)
Enacted to reach a balance between the right of the public to know, and the needs of government to keep information private. The Department of Defense has specific procedures by which information is made available to the public that requires a written request.
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: The timelines within which a member can obtain available services, in accordance with the Department of Defense (DoD)’s access and availability requirements.

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 or the 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; and
- Failure to act within timeframes for the health plan’s Prior Authorization review process.

Allowable Charge: The maximum amount TRICARE will authorize for medical and other health services furnished by physicians, medical groups, professional providers, independent laboratories, suppliers of ambulance services, and suppliers of Durable Medical Equipment, Prostheses, Orthotics, and Supplies.

Appeal: The formal process by which a member or his/her authorized representative requests a review of the health plan’s or delegated contractor’s adverse determination of a covered service due to lack of medical necessity. The appeal (reconsideration process) consists of a review of the evidence of findings upon which it was based and any other evidence the parties submit or the health plan or regulatory agency obtains. A standard appeal resolution is made within thirty (30) calendar days of receiving the request for the appeal.

Balance Billing: Occurs when a health care provider bills a member for the balance of the amount not paid to them by US Family Health Plan for the health care services a member received.

Beneficiary: A recipient of insurance benefits.
**Benefit:** The health care items or services covered under a health plan.

**Brand Name Drug:** A drug sold under a specific, trademarked brand name, available by prescription or over the counter.

**Care Manager:** Health care team member responsible for coordinating a member’s care and working with the patient and Utilization Management in arranging for the member’s discharge needs.

**Catastrophic Cap:** The most a member pays out of pocket annually for TRICARE covered services.

**Claim:** A request for payment from a health insurance provider for services, procedures or a drug.

**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; and
- 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 member’s authorized representative with the health plan or a delegated contractor’s processes other than an action associated with the disposition of a claim, i.e., adverse determination of a benefit.

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

**Coordination of Benefits (COB):** An insurance claims review process used when two or more carriers insure a beneficiary. The process determines the liability of each carrier in order to eliminate duplication of 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 percentage of the total cost of a covered health care service that you pay.

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

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

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

**Deductible:** The amount of covered expenses that must be paid by a member before benefits are payable by the insurance company.

**Defense Enrollment Eligibility Reporting System (DEERS):** A database of uniformed service members (sponsors), family members, and others worldwide who are entitled under law to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated.

**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.

**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, or
- In the case of pregnant women, serious jeopardy to the health of the fetus.

**Expeditied 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 is made within seventy-two (72) hours or sooner if the member’s condition warrants.

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

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

**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 submitted by or on behalf of an enrollee regarding any aspect of the member's health care services, including but not limited to the:
1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
2) Administrative practices of the health care plan that affect the availability, delivery or quality of health care services;
3) Claims payment, handling or reimbursement for health care services; or
4) Matters pertaining to the contractual relationship between an enrollee or subscriber and a health care plan.

Health 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 resource for the public on issues of health plan quality.

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

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 | 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 Out-of-Pocket:** A set amount capping what a member can spend on deductibles, coinsurance and copays for the plan year. After the maximum is met, the plan covers 100% of expenses.

**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 | Quality Improvement Committees: Committees composed of a provider, the Medical Director, and other health care professionals that provide a mechanism for provider participation, communication and development and administration of CHRISTUS Health 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: Title XVIII of the Social Security Act and all amendments thereto.

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

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

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

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

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

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

Non-Participating Provider: A provider that is not participating in the USFHP network.

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 physician who has signed an agreement to provide US Family Health Plan–covered services to its members.

Peer Review Committee: A committee of health care providers, which has the following functions:
- Evaluates or improves the quality of health care rendered by providers
- Determines whether rendered health care services were performed in compliance with the applicable standards of care
- Determines whether the cost of 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: Drugs for which sale or legal dispensing requires the order of a provider with legal authority to prescribe drugs.

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

Primary Care Provider (PCP): The physician, nurse practitioner or physician assistant a member sees first for most health problems. The PCP makes sure members get the care they need to keep them healthy. The PCP also may talk with other physicians and providers about the member’s care and refer them for specialized care. PCPs include, but are not limited to family practice physicians; general practitioners; internists; pediatricians; obstetricians and/or gynecologists (OB/GYNs). The PCP is responsible for providing primary care services. These include annual examinations, routine immunizations, and treatment of non-emergency acute illnesses and injuries.

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

Provider Agreement: A legal agreement between a payer 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 list of the providers that are participating providers.
Quality Improvement (QI) Program: A comprehensive system designed to assess and continually improve the processes and outcomes of care and services provided to health plan members.
**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) Is legally operated as a Skilled Nursing Facility;
2) Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a physician;
3) Provides continuous 24-hour a day nursing service by or under the supervision of a Licensed Practical Nurse (LPN);
4) Maintains a daily medical record on each patient; and
5) Provides Rehabilitation services, such as Physical, Occupational and Speech therapy, and may provide other multidisciplinary services, such as Respiratory Therapy, dietician/nutrition services, and medical social work.

**Specialist**: A physician who provides covered services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint, or muscle conditions and psychiatrists 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 Date: 11:59 p.m. on the last day of the month for which premiums were paid and the date that the member’s coverage ends.

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

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

TRICARE: Formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TRICARE is a health care program of the United States Department of Defense Military Health System that provides civilian health benefits for military personnel, military retirees and their dependents, including some members of the reserve component.

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

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