

2019

Provider Manual

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Section I: Overview



SECTION I

Overview

# US Family Health Plan Important Phone Numbers and Addresses

**USFHP Billing Address** Change Healthcare

P.O. Box 981696

El Paso, TX 79998-1696

US Family Health Plan Claims

**EDI Specialist** (469) 282-3066

Fax (469) 282-3013

**Member Services** 1 (800) 678-7347

Fax (469) 282-3013

**Provider Relations** 1 (800) 678-7347

Fax (469) 282-3012

**Utilization Management** 1 (800) 446-1730

Fax 1 (800) 277-4926

**TRICARE Formulary** <http://www.tricare.mil/CoveredServices/Pharmacy/Drugs>

**Maxor Pharmacy** 1 (866) 408-2459

**Behavioral Health** 1 (800) 446-1730

Fax 1 (800) 277-4926

**Health Integrated Crisis Line** 1 (800) 323-0286

**Family Planning** Meritain Health Inc

P.O. Box 27083

Lansing, MI 48909-7083

**US Family Health Plan Website** <http://www.christushealthplan.org/>

# Introduction

In 1981, CHRISTUS Health began caring for military beneficiaries as a part of the Uniformed Service Treatment Facilities. In 1993, US Family Health Plan, along with other programs around the country, became the first government-sponsored managed care plan – the US Family Health Plan (USFHP).

Through this plan, we serve:

* Active Duty Dependents such as children and spouses
* Retired Military 64 years and younger and their dependents
* Retired Military over 65 years of age and their dependents who enrolled on or before September 30, 2012

Members of the US Family Health Plan receive services as part of health care benefits managed by the Primary Care Physician (PCP). Benefits are available only through the exclusive use of participating physicians, hospitals, medical centers, pharmacies, home health agencies, and other health care providers. No benefits are provided for use of nonparticipating providers (except in the case of emergencies, and when authorized in advance, for services not available from participating providers). A list of participating providers is found on the plan’s website at <http://www.usfhp.com/>, which is updated on a monthly basis.

As a provider for the US Family Health Plan, providers have agreed to follow and adhere to “Rules & Regulations,” which include, but are not limited to, all quality improvement, utilization management, credentialing, peer review, grievance, the 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 the US Family Health Plan at any time upon notice to the provider.

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied upon as such. 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 physician. The most up-to-date version of the Provider Manual is located on the Plan’s website at <http://www.usfhp.com/>. All terms and statements used in this manual will have the meaning ascribed to them by the USFHP and CHRISTUS Health and shall be interpreted by USFHP and CHRISTUS Health at their sole discretion.

# Glossary of Terms

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

**Adverse Action:** The adverse determination, i.e., denial, of a requested covered service, including the type or level of service which includes:

* Denial in whole of 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.

**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 and 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 (30) calendar days of receiving the request for the appeal.

**Benefit:** The amount payable by an insurer to a claimant, assignee, or beneficiary under each coverage in the group contract.

**Clean Claim:** A claim submitted by a physician or provider for medical care or health care services rendered to a member, with the data necessary for the 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.

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

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

**Covered Services:** Health care services and items the enrollee is entitled to receive under the DoD Managed Care Contract except for those services inconsistent with the Ethical and Religious Directives for Catholic Health Care, as published from time to time.

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

**DoD:** The United States Department of Defense.

**DoD Managed Care Contract:** The contract between the US Family Health Plan and the DoD under which certain covered services are to be provided to or arranged for enrollees/beneficiaries.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care to evaluate and/or stabilize the condition could result in:

* Placing the patient’s health in serious jeopardy
* Serious impairment to bodily functions
* Serious dysfunction of any bodily organ or part
* Serious disfigurement or, in the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Expedited Appeals:** A request to do a more time-sensitive medical necessity review of a denied urgent preservice or urgent concurrent service when the standard appeal time periods could seriously jeopardize the member’s life, health, or the ability to attain, maintain, or regain maximum function, or, in the opinion of the treating provider, 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.

**Medical Necessity:** Services that are sufficient in amount, duration, and scope to reasonably 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.

**MM/QI Committees:** Committees composed of physicians, the medical director, and other health care professionals that provide a mechanism for physician participation, communication and development and administration of the US Family Health Plan.

**Participating Provider**: A physician who has signed an agreement to provide US Family Health Plan-covered services to its members.

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

**Primary Care Physician:** Any US Family Health Plan Physician who is practicing medicine in the area of internal medicine, family practice, general practice, or pediatrics, who is deemed by US Family Health Plan to be a Primary Care Physician, and who, upon selection or assignment, shall be responsible for providing initial and primary care, maintaining the continuity of care, and initiating referrals for care of members who have selected or been assigned to such Primary Care Physician.

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

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

**Specialty Care Physician:** A US Family Health Plan Physician who is not a Primary Care Physician.

**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/Expedited:** 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. ***CHRISTUS Health Plan reserves the right to deny the request for urgent review for all medical requests outside of this definition.***

*If the prior authorization request is marked urgent but does not meet the urgent definition, your request for authorization will be processed under standard turn-around times. The provider will be notified of this change as determinations are made.*

Section II: Primary Care Providers



SECTION II

Primary Care Providers

# Primary Care Providers

## Provider Credentialing Requirements

US Family Health Plan (USFHP) credentials practitioners and certain facilities (hospitals, ambulatory surgery centers, home health agencies and skilled nursing facilities) prior to participation. Practitioners and facilities are recredentialed, at a minimum, every three (3) years. The credentialing/  
recredentialing process consists of the provider application process, verification of credentials with primary sources (excludes facilities), if required, and a review by the credentialing committee.

## Practitioner Participation Criteria

* Completed USFHP Provider/Group Application.
* Current license to practice medicine or operate facility without limitation, suspension, or restriction
* Current DEA/CDS certificate (if applicable)
* Current malpractice insurance coverage: minimum $1,000,000/$3,000,000
* Board Certification or completed appropriate training in the requested specialty
* Ability to meet USFHP Access and Availability standards
* Must be eligible to become a TRICARE Authorized Provider
* No current Medicare/TRICARE sanctions

## Facility Participation Criteria\*

* Completed USFHP Facility/Ancillary Application
* Current operating certificate
* Current Accreditation (if applicable)
* Current malpractice insurance coverage: minimum $1,000,000/$3,000,000 or consistent with state minimum standards
* Ability to meet USFHP Access and Availability standards
* Must be eligible to become a TRICARE Authorized Provider
* No Medicare sanctions
* TJ C or other Health Care Accreditation (if applicable)

## Facility Application Requirements\*

* Copy of current operating certificate
* Copy of current accreditation face sheet
* Copy of current malpractice coverage sheet (includes effective dates, policy number and amounts of coverage)
* 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.*

## Provider, Facility And Ancillary Contractual Requirements

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

* Provide continuous 24-hour, 7 day-a-week access to care
* Arrange for another physician (the "Covering Physician") to provide patient care or referral services to a member in the event that a participating provider is temporarily unavailable
* Utilize the US Family Health Plan's participating physicians and facilities when services are available and can meet the patient's needs
* Not discriminate on the basis of age, sex, handicap, race, color, religion, or national origin
* Accept patients transferring from out-of-network care to in-network facilities
* Not balance bill a member for providing services that are covered by the US Family Health Plan. You may only bill members for applicable deductibles, copayments, and/or cost-sharing amounts
* Not bill for charges that exceed contractually allowed reimbursement rates. May bill a member for a service or procedure that is not a covered benefit
* Prepare and complete medical and other related records in a timely fashion and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment
* Provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the member’s PCP within 10 business days of the member’s visit with the specialist
* Maintain medical records for five (5) years or 60 months from the last date in which service was provided to the member
* Transfer medical records within 10 business days or sooner if requested by a treating physician, after a member in your panel changes to another PCP
* Allow access to medical records for review by appropriate committees of the US Family Health Plan and, upon request, provide the medical records to representatives of the federal government and/or their contracted agencies
* Inform the US Family Health Plan within twenty-four 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 or any other state. Failure to comply with the above could result in termination from the Plan
* Inform the US Family Health Plan 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 with the US Family Health Plan
* Provide or assist the US Family Health Plan in obtaining Coordination of Benefits/Third-Party Liability Information
* Participate in the US Family Health Plan's quality improvement, utilization management, credentialing, peer review, grievance, National Quality Monitoring Contract (“NQMC”) programs, and other policies and procedures established and revised by US Family Health Plan or the DOD which also includes participation in evidence-based patient safety programs
* Abide by the US Family Health Plan rules and regulations, and also by all other lawful standards, policies, rules, and regulations of the CHRISTUS Health System.

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

### PRIMARY CARE PROVIDERS (PCP)

A PCP is a physician or nurse practitioner who manages the primary and preventive care of a CHRISTUS Health USFHP member and acts as a coordinator for specialty referrals and inpatient care.

### Role and General Responsibilities

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 the 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.

## Privacy And Release Of Medical Records

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. 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 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 to a health plan for health care operations of the health plan, 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, Provider may disclose protected health information for care management and/or utilization purposes. 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 in the Plan. This may occur when members change PCPs or if a PCP leaves the plan. All medical records must be transferred to the new PCP within 10 business days or sooner if requested by the treating physician. Medical records for US Family Health Plan members must be maintained for 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:

* Patient Identification
* Personal Data
* Allergies
* Chronic/Significant Problem List
* Chronic/Continuing Medication List
* Immunization History
* Informed Consent
* Provider Signature/Name, Each Entry
* Patient’s Signature on File
* Growth Chart (14 years of age and under)
* Initial Relevant History
* Smoking Status (12 years and older)
* Alcohol or Substance Use/Abuse (12 years and older)
* Date of Each Visit
* Chief Complaint
* Physical Exam Relevant to Chief Complaint
* Diagnosis/Impression for Chief Complaint
* Appropriate Use of Consultants
* Treatment/Therapy Plan
* Results discussed with Patient
* MD Review of Diagnostic Studies
* Results of Consultations
* Date of Next Visit
* Hospital Records
* Preventive Health Education

## Provider Rights

Providers have certain rights as participating providers of the US Family Health Plan. These rights include:

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

## Appointment Wait Time

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

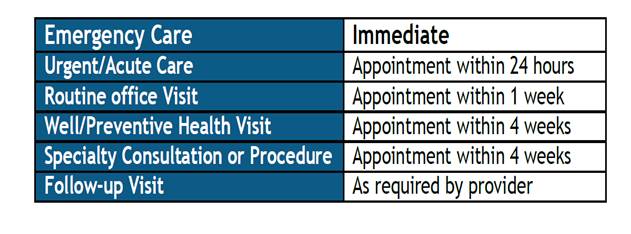
### Primary Care Physician or Primary Care Manager:

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

### Specialty Care Provider or Ancillary Provider:

Members must have access to a specialist within a 60-minute drive time from their residence.

US Family Health Plan defines access standards as the timeliness 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:



## Covering Physicians

Covering physicians will be reimbursed according to the contracted provider’s reimbursement rates. Covering physicians are responsible for urgent care only. 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 US Family Health Plan. A covering physician may not make routine referrals.

## Access Standards

|  |  |  |
| --- | --- | --- |
| **Service** | **Definition** | **Standard** |
| **Well Visits (Preventive Health Services)** | Health care services designed for the prevention and early detection of illness in asymptomatic people, generally including well woman exams, physical examinations, routine eye exams and immunizations | Within four (4) weeks |
| **Routine Care** | Non-urgent care for symptomatic conditions | As soon as possible; no later than one week |
| **Urgent Care (Acute)** | Acute but not life or limb- threatening | Less than 24 hours |
| **Emergency Care** | Life or limb-threatening illness or accident potentially leading to permanent disability or seriously jeopardizing health. Symptoms requiring immediate medical attention | Immediately |
| **Urgent/Expedited** | 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.  ***CHRISTUS Health Plan reserves the right to deny the request for urgent review for all medical requests outside of this definition.*** | Immediately |
| **After-Hours Care** | Care, provision for care, or direction of care by the provider during non- office hours | 24-hours-per-day 7 days-per-week |
| **Specialty Consultation**  **or Procedure** | Care, provision for care, or direction of care by the specialty provider | Within four (4) weeks |

* PCPs arrange for hospitalization and authorize urgent care, X‐rays, lab work, and other medical services when necessary
* PCPs see members for routine care, preventive, and annual physicals
* PCPs initiate and coordinate authorization requests

Except in cases of medical emergencies and services that may be self-referred, specialty and ancillary services may be accessed by members only upon referral by a PCP.

## Self-Referrals

Members may self-refer for annual well-woman exams and annual eye exams. Members may seek outpatient mental health services through their PCP, or they may self-refer to a network mental health provider. In those cases where a member self-refers, the network mental health provider shall notify the PCP of the self-referral.

## Pcp Referral To Network Specialists

PCP does not need prior/referral authorization to refer the member to an in-network specialist. Participating providers are listed in the provider directory, USFHP website, <http://www.usfhp.com/> or providers may call member services to verify in-network participation.

Once the member is seen by the specialist, a clearly legible specialty care consultation report must be sent to the PCP within 30 business days of the member’s visit to the specialist.

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

## Protection Of Privacy

Protect and maintain the confidentiality of all member records as required by applicable laws and regulations.

Maintain knowledge of information protection standards affecting job function, recognizing that confidential information is valuable, sensitive, and protected by law.

Maintain the appropriate confidentiality and privacy of all members.

## 24/7 Nurse Triage Line

The Plan has a 24/7 Nurse Triage line. Members can access this service toll-free for medical guidance/triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace the provider’s after-hours coverage commitment.

## Patient No Show

The patient’s PCP must review each chart for patients who fail to keep their scheduled appointments. A patient “No Show” should be documented in the patient’s medical record. Continual failure to keep appointments without notice of cancellation may be grounds for member disenrollment.

## Other Provider Information

### National Disaster Medical System (NDMS)

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

Providers and members are encouraged to use Medline Plus®, a web site 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. See the Medline Plus® site: <http://medlineplus.gov>.

### MEMBER GRIEVANCES AND COMPLAINTS

The Plan 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 a Member Services Representative, 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 10 days of the receipt of the grievance.

CHRISTUS Health Plan

Complaints, Appeals and Grievances Department

P.O. Box 169009

Irving, TX 75016

Phone: 1-844-282-0380

Section III: Benefits and Eligibility



SECTION III

Benefits and Eligibility

# Member Eligibility

US Family Health Plan provides covered medical benefits to its members. Following is a list of covered and noncovered services, although it is not all inclusive. 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, and other services as indicated. Members are responsible for payment of all services determined not to be medically necessary and not authorized by the physician.

## Selecting A PCP

Upon enrollment, the Plan 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). Physicians may establish, ahead of time, a limit on the number of US Family Health Plan members to be accepted into his or her panel. Physician panels can be opened and closed as necessary by the physician via written notification to the Provider Relations Department.

## Extended Care Health Options (ECHO)

Extended Care Health Options (ECHO) provides financial assistance only for active-duty family members with specific qualifying mental or physical conditions. Some conditions include (note: this list is not all-inclusive):

* Serious physical disability
* Moderate or severe mental retardation
* Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems)
* 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

Children may remain eligible for ECHO beyond the usual age limits in certain circumstances. If you believe a qualifying condition exists, talk to a case manager or with your regional contractor to determine eligibility for ECHO benefits. For more information, please visit: <http://www.tricare.mil/echo>.

## Catastrophic Cap Protection

USFHP offers members the reassurance of a “catastrophic cap” which limits the amount of money members are required to pay out of pocket for deductibles and co-insurance in a **calendar year** (January 1 – December 31). After the maximum dollar limit is reached, USFHP members will not pay any additional cost-share or deductibles for allowable health care services received during the remainder of the calendar year.

### CAT cap

|  |  |
| --- | --- |
| **If you are…** | **Your cap is…** |
| **An Active Duty Family** | $1,000 per family, per calendar year |
| **A Family Using TRICARE Reserve Select** | $1,000 per family, per calendar year |
| **All Others** | $3,000 per family, per calendar year |

Copayments are reinstated at the beginning of the next plan year, on January 1st, 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 amount TRICARE pays for each procedure or service. This is tied by law to Medicare’s allowable charges) for services
* TRICARE Prime point-of-service charges (if applicable)
* Enrollment premiums
* What happens to the catastrophic cap when an active duty sponsor retires? When the sponsor retires, the full deductible and cost shares are credited toward the previous family cap ($1,000) is credited to the new cap ($3,000) in the same calendar year.

## Member Disenrollment

### General Disenrollment

Members may become ineligible for US Family Health Plan 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 US Family Health Plan
6. Member inititated voluntary disenrollment requests.

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## Family Planning

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

# Behavioral Health

## Outpatient Mental Health And SUD

US Family Health Plan has contracted with Health Integrated to manage our Crisis Intervention Hot Line at 1 (800) 323-0286, open 24/7. US Family Health Plan manages UM referrals and preauthorizations for behavioral health services, including all health services, and treatment for alcoholism, substance abuse, drug addiction, and chemical dependency. US Family Health Plan staff is available at 1 (800) 678-7347.

**In-Network Behavioral Health Services** will NOT require prior authorization, but CHRISTUS Health Plan should be NOTIFIED of all patient inpatient admissions at 1 (800) 446-1730.

### Behavioral Health and Substance Use Disorder

**Outpatient health**

Description: 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**

Description: Inpatient Behavioral Health services are treatments for a Behavioral Health

condition as defined by the most recent DSM diagnosis codes.

**Partial hospitalization**

Description: Visits to a psychiatric facility day/partial hospitalization program without an overnight stay. Outpatient Mental Health Care (to include Partial Hospitalization Programs (PHPs), Intensive Outpatient Programs (IOPs), Opioid Treatment Programs (OTPs), Office-Based Opioid Treatment (OBOT), and outpatient treatment) does not require preauthorization.

Primary Care Manager (PCM)/PCP referral is not required for outpatient, office-based mental health and SUD visits; however, all other outpatient mental health and SUD services require a referral from the PCM/PCP.

## Medicare

A provider may not bill Medicare for US Family Health Plan-covered benefits provided to a US Family Health Plan member. Should a provider bill Medicare for US Family Health Plan covered services, the US Family Health Plan is required to investigate and if appropriate, dis-enroll the member from the Plan. Should a member possessing Medicare benefits dis-enroll 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. US Family Health Plan 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 US Family Health Plan as the primary insurance for all health care. US Family Health Plan becomes secondary to Medicare thereafter and covers coinsurance charges for which patients would otherwise be responsible. However, services provided to ESRD patients must continue to be authorized by the Plan in order to be reimbursable. 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 US Family Health Plan benefit and will be responsible for all charges related to ESRD.

## Coordination of Benefits/Third-Party Liability

The US Family Health Plan will coordinate benefits for those provided services that are also covered by Workers' Compensation or other third-party carriers. Third-party liability occurs when a US Family Health Plan patient 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 the US Family Health Plan in obtaining coordination of benefits/third-party liability information.

Provider shall accept payment from US Family Health Plan, plus any copayments as payment in full for all covered services provided to members and will not attempt to bill any other person, insurer, payor, or other entity for such services. Providers must provide US Family Health Plan information upon request about a member's other insurance coverage(s). Providers assign to US Family Health Plan 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 US Family Health Plan’s collection of other such benefits. Providers will be required to provide patient information updates upon request to allow US Family Health Plan to update records or other information.

## Copayments for Covered Services

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Active Duty Family Members | Retirees and Eligible Family Members *with* Medicare Part B | Group A - Retirees and Eligible Family Members *without* Medicare Part B | Group B - Retirees and Eligible Family Members *without* Medicare Part B | Tricare Young Adult (TYA) – Active Duty | Tricare Young Adult (TYA) - Retiree |
| Outpatient Services |  |  |  |  |  |  |
| Ambulance Services | $0 | $0 | $20 Copay (Air) / $41 Copay (Ground) Per Trip | $20 Copay (Air) / $41 Copay (Ground) Per Trip | $0 | $20 Copay (Air) / $40 Copay (Ground) Per Trip |
| Imaging  CT/MRI | $0 | $0 | $0 | $0 | $0 | $0 |
| Durable Medical Equipment, Prosthetic Devices, and Medical Supplies  When prescribed by your physician and secured through USFHP contracted providers. | 0% of contracted rate | 0% of contracted rate | 20% of contracted rate | 20% of contracted rate | 0% of contracted rate | 20% of contracted rate |
| Emergency Care  Emergency care obtained on an outpatient basis, network and non-network. Copayment (if applicable) is waived if admitted to hospital. | $0 | $0 | $61 Copay Per Visit | $61 Copay Per Visit | $0 | $61 Copay Per Visit |
| Eye Examination  One routine eye exam per plan year for Active Duty / One routine examination every other year for Retiree plan members. | $0 | $0 | $0 | $0 | $0 | $0 |
| Family Planning Services provided by Meritain Health, Inc. | Physician Visit: $0  Prescriptions: See section on prescription copayments | Physician Visit: $0  Prescriptions: See section on prescription copayments | Physician Visit: $20 Copay Per Visit  $30 copay Specialist  Prescriptions: See section on prescription copayments | Physician Visit: $20 Copay Per Visit  $30 copay Specialist  Prescriptions: See section on prescription copayments | Physician Visit: $20  $30 copay Specialist  Prescriptions: See section on prescription copayments | Physician Visit: $20 Copay Per Visit  Prescriptions: See section on prescription copayments |
| Home Health | $0 Per Visit | $0 Per Visit | $0 Per Visit | $0 Per Visit | $0 Per Visit | $0 Per Visit |
| Hospice | $0 | $0 | $0 | $0 | $0 | $0 |
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| --- | --- | --- | --- | --- | --- | --- |
|  | Active Duty Family Members | Retirees and Eligible Family Members *with* Medicare Part B | Group A - Retirees and Eligible Family Members *without* Medicare Part B | Group B - Retirees and Eligible Family Members *without* Medicare Part B | Tricare Young Adult (TYA) – Active Duty | Tricare Young Adult (TYA) - Retiree |
| Outpatient Services |  |  |  |  |  |  |
| Immunization for  Required Overseas Travel  No copayment is required  if part of an office visit | $0 | Not covered | Not covered | Not covered | $0 | Not covered |
| Laboratory and  X-Ray Services  No additional copayment (if required) is collected even if the services are performed separate from the office visit (i.e. different location or time). No copayment will be collected when these services are billed and provided as preventive services. | $0 | $0 | $0 | $0 | $0 | $0 |
| Maternity Care  Prenatal and postnatal visits | $0 per visit | $0 per visit | $30 per visit | $30 per visit | $0 per visit | $30 per visit |
| Partial Hospitalization for  Mental Health / Alcohol & Substance Abuse Treatment | $0 per visit | $0 per visit | $20 Copay Per Visit | $20 Copay Per Visit | $0 | $20 Copay Per Visit |
|  |  |  |  |  |  |  |
| Outpatient Surgery – Outpatient Hospital or Ambulatory Surgical Center | $0 | $0 | $61 Copay | $61 Copay | $0 | $61 Copay |
| Physical/Occupational Therapy  When medically necessary. When provided in home, any  applicable copayment for home health care applies. | $0 per visit | $0 per visit | $30 Copay Per Day | $30 Copay Per Day | $0 per visit | $30 Copay Per Day |

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| --- | --- | --- | --- | --- | --- | --- |
|  | Active Duty Family Members | Retirees and Eligible Family Members *with* Medicare Part B | Group A - Retirees and Eligible Family Members *without* Medicare Part B | Group B - Retirees and Eligible Family Members *without* Medicare Part B | Tricare Young Adult (TYA) – Active Duty | Tricare Young Adult (TYA) - Retiree |
| Outpatient Services | | | | | | |
| Physicians Services - Primary Care Physician | $0 per visit | $0 per visit | $20 Copay Per Visit | $20 Copay Per Visit | $0 per visit | $20 Copay Per Visit |
| Physician Services - Specialist | $0 per visit | $0 per visit | $30 Copay Per Visit | $30 Copay Per Visit | $0 per visit | $30 Copay Per Visit |
| Prescriptions  Up to a 30-day supply obtained directly from plan pharmacy. | $11 Generic  $28 Name Brand up to a 30-day supply  $53 non-formulary brand name and generic | $11 Generic  $28 Name Brand up to a 30-day supply  $53 non-formulary brand name and generic | $11 Generic  $28 Name Brand up to a 30-day supply  $53 non-formulary brand name and generic | $11 Generic  $28 Name Brand up to a 30-day supply  $53 non-formulary brand name and generic | $11 Generic  $28 Name Brand up to a 30-day supply  $53 non-formulary brand name and generic | $11 Generic  $28 Name Brand up to a 30-day supply  $53 non-formulary brand name and generic |
| Prescriptions  (Mail Order Pharmacy)  Up to a 90-day supply or less obtained through the USFHP Maxor Mail Order Pharmacy when authorized; includes prescriptions for nursing home patients.  \*Physician authorized | $7 Generic  $24 Name Brand up to a 90-day supply\*  $53 non-formulary brand/generic drugs | $7 Generic  $24 Name Brand up to a 90-day supply\*  $53 non-formulary brand/generic drugs | $7 Generic  $24 Name Brand up to a 90-day supply\*  $53 non-formulary brand/generic drugs | $7 Generic  $24 Name Brand up to a 90-day supply\*  $53 non-formulary brand/generic drugs | $7 Generic  $24 Name Brand up to a 90-day supply\*  $53 non-formulary brand/generic drugs | $7 Generic  $24 Name Brand up to a 90-day supply\*  $53 non-formulary brand/generic drugs |
| Radiation Therapy | $0 | $0 | $0 | $0 | $0 | $0 |
| Residential  Treatment Centers | $0 per day | $0 per day | $30 Copay Per Day | $30 Copay Per Day | $0 per day | $30 Copay Per Day |
| Speech Therapy  When medically necessary. When provided in home, the copayment for home health care applies. | $0 per visit | $0 per visit | $30 Copay Per Visit | $30 Copay Per Visit | $0 per visit | $30 Copay Per Visit |
| Well-Child Care  Up to 6 years of age, except as a preventive service. | $0 per visit | $0 per visit | $0 per visit | $0 per visit | $0 per visit | $0 per visit |

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Active Duty Family Members** | **Retirees and Eligible Family Members *with* Medicare Part B** | **Group A - Retirees and Eligible Family Members *without* Medicare Part B** | **Group B - Retirees and Eligible Family Members *without* Medicare Part B** | **Tricare Young Adult (TYA) – Active Duty** | **Tricare Young Adult (TYA) - Retiree** |
| **Preventive Services** |  |  |  |  |  |  |
| **Periodic Preventive Screenings**  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). | $0 | $0 | $0 | $0 | $0 | $0 |
| **Education and  Counseling Services**  The following education/ counseling services can be part of any visit to your PCP dietary assessment & nutrition; physical activity & exercise; cancer surveillance; tobacco, alcohol & substance abuse; accident & injury prevention; promotion dental health; stress and bereavement. | $0 | $0 | $0 | $0 | $0 | $0 |
| **Annual Physicals or  Well Woman Exams** Refer to the Preventive Health Services section to determine the age appropriate screenings you could be provided. (Presenting to your PCP’s office with medical problems during a well visit will be viewed as a regular office visit.) | $0 | $0 | $0 | $0 | $0 | $0 |
| **Immunizations**  Age appropriate immunizations are provided for vaccine-preventable diseases according to guidelines set forth by the  Centers for Disease Control. | $0 | $0 | $0 | $0 | $0 | $0 |

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Active Duty Family Members** | **Retirees and Eligible Family Members *with* Medicare Part B** | **Group A - Retirees and Eligible Family Members *without* Medicare Part B** | **Group B - Retirees and Eligible Family Members *without* Medicare Part B** | **Tricare Young Adult (TYA) – Active Duty** | **Tricare Young Adult (TYA) - Retiree** |
| **Preventive Services** |  |  |  |  |  |  |
| **Enhancement Seminars, Community Health Services, and Community Resource Coordination** | No charge | No charge | No charge | No charge | No charge | No charge |
| **24-hour Nurse/Health Information Library** | No charge | No charge | No charge | No charge | No charge | No charge |
| **Inpatient Services** |  |  |  |  |  |  |
| **Inpatient Mental Health / Alcohol & Substance Abuse Treatment (Inpatient)** | $0 per day | $0 per day | $150 Copay Per Admission | $150 Copay Per Admission | $0 | $150 Copay Per Admission |
| **Hospitalization**  Semiprivate room (and when medically necessary, special care units), general nursing, and hospital services. Includes inpatient physician and their 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. | $0 per day | $0 per day | $150 Copay Per Admission | $150 Copay Per Admission | $0 | $150 Copay Per Admission |
| **Maternity**  Hospital and professional services (prenatal, postnatal). Unlimited services with authorization, as medically necessary. | $0 per day | $0 per day | $150 Copay Per Admission | $150 Copay Per Admission | $0 | $150 Copay Per Admission |
| **Skilled Nursing  Facility Care**  Semiprivate room, regular nursing services, meals including special diets, physical occupational and speech therapy drugs furnished by the facility, necessary medical supplies and appliances. Unlimited services with authorization,  as medically necessary. | $0 per day | $0 per day | $30 Copay Per Day | $30 Copay Per Day | $0 | $30 Copay Per Day |
|  |  |  |  |  |  |  |

## Services Not Covered Under The US Family Health Plan

* Organ transplants considered to be experimental or investigational
* Convenience and personal care items that are billed separately such as telephone, television or radio
* Charges for care and supplies not ordered by a physician
* A stay at an inpatient skilled nursing facility, unless deemed medically necessary by the member's physician and authorized by the plan
* 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
* Non-medically necessary transportation costs
* Experimental/investigational procedures
* Acupuncture or acupressure
* Lodging costs during outpatient dialysis treatment
* Wages lost to the care-giver and the dialysis assistant during self-training
* Homemaker services
* Chiropractic or Naturopath services
* Meals delivered to the home
* Private duty nurses and nursing care on a full-time basis in the home
* Services performed by immediate relatives or members of the household
* Services for which neither the member nor another party acting on the member's behalf has a legal obligation to pay. Note: Under the US Family Health Plan, the member is covered only for services authorized or arranged by the Primary Care Physician (PCP). Care outside of the Plan will not be paid for by the US Family Health Plan, 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 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

## Informing Members About Noncovered Services

As part of usual good business practice, providers are expected to notify US Family Health Plan beneficiaries when a service is not covered. TRICARE policy includes a specific “hold harmless” policy for network 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 PAR provider except in the following situations:

* If the member did not inform the provider that he or she was a US Family Health Plan member, the provider may bill the beneficiary for services rendered.
* If the member was informed that the service was excluded or excludable and he or she agreed in advance to pay for that service, the provider may bill the member.

US Family Health Plan 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 noncovered service, the member should be asked to sign a waiver agreeing to pay for the noncovered service. A member’s agreement to pay for a noncovered 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 PAR provider does not obtain a signed waiver, and the service is not authorized by US Family Health Plan, 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 US Family Health Plan member to be considered fully informed, DoD regulations require that:

* The agreement is documented prior to the noncovered 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 US Family Health Plan member has agreed to pay in full for noncovered 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 was 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 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 Primary Care Physician, based on each individual case. Each US Family Health Plan 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 US Family Health Plan member is entitled to an annual eye exam performed by a network Optometrist/Ophthalmologist without PCP referral.

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:** No copay can be collected for preventive health services. Services provided should not be unbundled in order to collect a copayment.

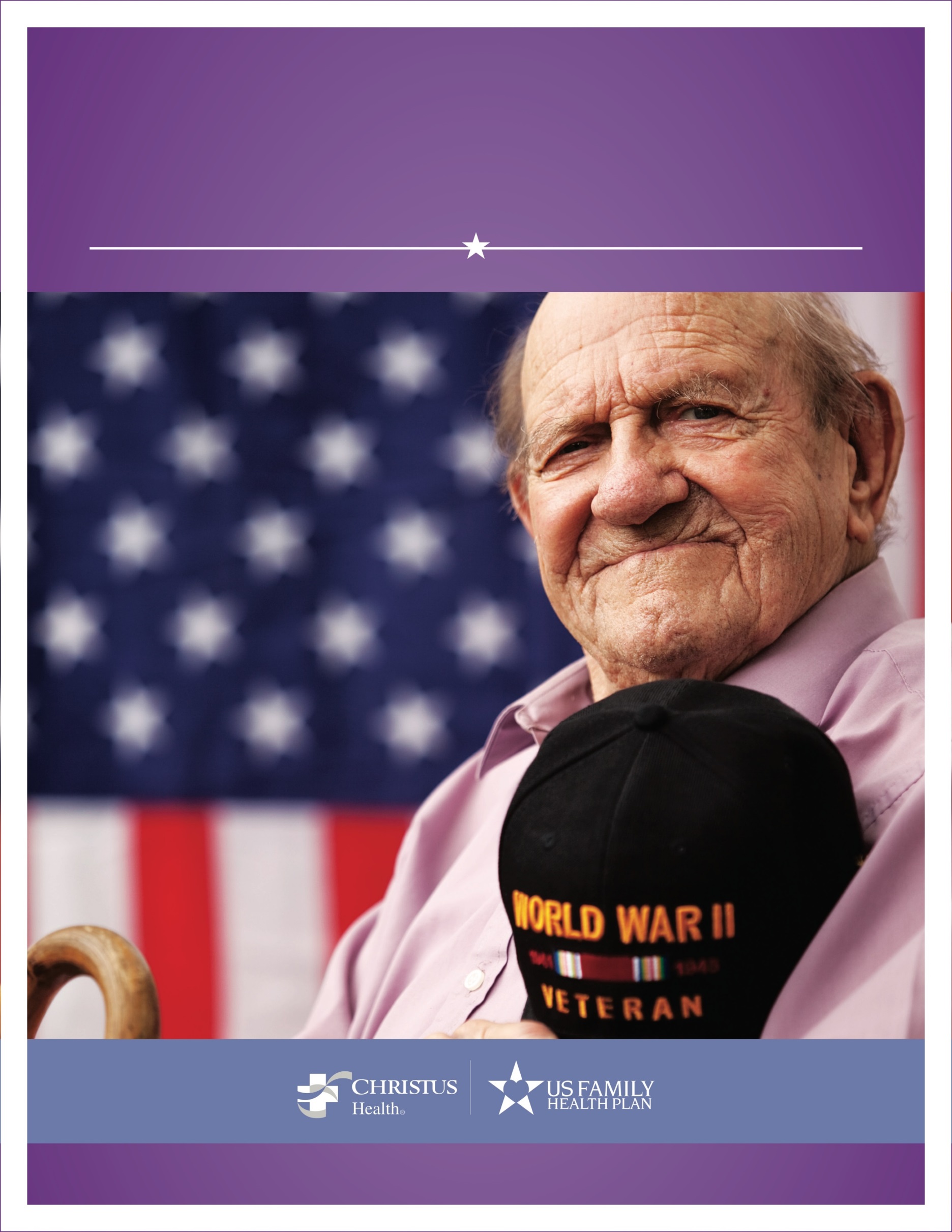
## Guideline Links

Preventive health guidelines followed by TRICARE policy can be found at: <http://www.tricare.mil/preventive>

USPTF (U.S. Preventive Services Task Force) guidelines can be accessed at: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html>

Recommendations on Preventive Pediatric Health Care from AAP can be accessed at: <https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx>

Section IV: Medical Management



SECTION IV

Medical Management

# Medical Management

## Prior-Authorization Guidelines

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

* Contact the UM/CM Department at 1 (800) 446-1730 for an urgent or emergent request, or
* Fax a routine request to 1 (800) 277-4926.

The following information will be requested from the provider:

* Provider name, address, and telephone number
* Patient name, ID number, and date of birth
* Diagnosis/ICD-9
* Procedure(s), if applicable
* Procedure code (CPT)
* Name of facility
* Date of admission/procedure
* Indications for admission/procedure
* Requested length of stay
* Pertinent clinical information

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

## Utilization Management Components

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

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

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

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

**Durable Medical Equipment:** Durable medical equipment (DME) is used primarily and customarily for a medical purpose, rather than primarily for transportation, comfort, or convenience. It can withstand repeated use and improves the function of a malformed, diseased, or injured body part or retards further deterioration of the patient’s physical condition. Specific DME items require prior authorization (see Services Requiring Prior Authorization). DME must be obtained through 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.

|  |  |
| --- | --- |
| **Treatment/Service** | **Notification Requirement** |
| Urgent admissions/observations | By the next business day after admission to the facility |
| Elective admissions/ observations/surgical procedures/ Outpatient procedures | 5 business days prior to the requested date of service |
| SNF/Rehab/Home health /Hospice | Initiation – 2 business days prior to requested Date of Admission (DOA)  Continuation – 7 days prior to requested Date of Service (DOS) |
| Diagnostic services/DME/ other procedures requiring authorization | 7 business days prior to requested DOS |

## 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 MCG Guidelines, Plan Clinical 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 physician reviewer’s determination to deny authorization. A denial letter will be sent to requesting provider in two (2) business days of the determination.

## Requests To Out-Of-Network Providers

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

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

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

## Requests For Case Management

The CHRISTUS Case management program plans and supports the care and education of members with catastrophic, complex, or chronic conditions 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 for the short term and long term. Disease Management is Health Management for members with specific chronic diseases.

Potential participants for Case management may be identified by the following

* Physician referral
* Facility admission/concurrent review process
* Retrospective analysis
* Member request
* Case Management criteria per the Case Management assessment policy
* Risk stratification utilizing Wellcentive RUB scores

Providers can refer members for case management evaluation by calling the UM Department at 1 (800) 455-9355.

## Obstetric Care

It is the responsibility of the member’s PCP to arrange for obstetric care for the member. The US Family Health Plan Referral/Authorization Request Form is to be completed by the PCP and forwarded to the network Obstetrician. Prior authorization to the US Family Health Plan UM/CM Department is to be initiated by the Obstetrician as soon as possible after confirmation of pregnancy. Medical care unrelated to the member’s pregnancy is to be provided by the PCP, with any referrals for specialty care being originated by the PCP. 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 at (800) 678-7347
* For Family Planning Assistance, please contact Meritain Health, Inc. at (888) 627-8889

## What Services Require Prior Authorization?

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

|  |  |
| --- | --- |
| * All out-of-network services * All inpatient acute care hospitalizations * Acute medical detoxification * All inpatient rehabilitation hospitalizations * All subacute admissions * All inpatient long-term acute care hospitalization * Air ambulance * Genetic testing and counseling and treatment of genetic inborn errors of metabolism disorders (IEM) * Dental services * Dialysis * Hospice services, inpatient and outpatient * Non-emergency ambulance transport * Nuclear medicine * Organ transplant services * Rehabilitation therapy (e.g. Cardiac, pulmonary) * Surgical procedures | * Bariatric or weight loss surgical procedures and treatment of morbid obesity * Breast implant removal * Cosmetic or reconstructive surgery * Cochlear implant * Clinical trial services * Child developmental/behavioral evaluations and testing * Botulinum toxin A injection (Botox) chelation therapy * Home health care * Durable medical equipment over $500 * Craniomandibular joint (CMJ) and temporomandibular joint dysfunctions (TMJ) * Hyperbaric oxygen therapy * Outpatient physical therapy * Prosthetic appliances and orthotics * Radiation therapy * Skilled nursing facility care; * Therapy (e.g. speech, occupational, and physical) |

This list may not include all services requiring Prior Authorization. If you need help determining if a service requires Prior Authorization, please contact Member Services at 1(800) 678-7347..

## Specialty Drugs Authorization Requirements (Not All Inclusive)

|  |  |
| --- | --- |
| * Interferon (Avonex) * Vantas (Histrelin Implant) * Remicade (Infliximab)\* * Activase (Alteplese) * Aranesp (Darbepoetin) * Botox (Botulinum Toxin Type A) * Enbrel (Etanercept)\* | * Desferal (Deferoxamine) * Growth Hormone (Somatropin)\* * Neulasta (Pegfilgrastim) * Maeugen (Pegaptnnib Sodium) * Lucentis (Raniblzumab) * IVIG (Immunine/Human Gamma Globulin |

*\* Authorization required if not dispensed through USFHP Network Pharmacy*

Section V: Pharmacy Services



SECTION V

Pharmacy Services

# Pharmacy Services

## Pharmacy Benefit – Tricare Formulary

Prescription drugs are covered by USFHP when ordered by a licensed provider. US Family Health Plan covers medically necessary FDA-approved prescription drugs that are included on the TRICARE Formulary.

The TRICARE Formulary covers most US Food and Drug Administration approved prescriptions. In general, for a medication to be covered under the US Family Health Plan 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 US Family Health Plan.

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 whether a specific drug is covered:

www.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.

An updated list of drugs requiring **prior authorization** from the TRICARE Formulary is located on the web at: www.usfhpformulary.com

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

**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.   
An updated list of TRICARE step therapy drugs can be found on the web at: [www.usfhpformulary.com](http://www.usfhpformulary.com)

To start a Prior Authorization, contact MaxorPlus at 800-687-0707 or fax 844-370-6203.

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

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 Maxor Plus 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. Nationwide Network Pharmacies include: Brookshire Brother, Brookshire Grocers, CVS, CVS inside Target, H-E-B Market Basket, Sam’s Club, Super 1 Grocery, and 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 can only be obtained by Maxor MXP Mail Order Pharmacy and the walk-in Maxor Pharmacies. The member is 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 as of February 1, 2018 according to the type of pharmacy and formulary status:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Pharmacy | Formulary Drugs | | Non-Formulary | Non-Covered Drugs |
|  | **Generic  Tier 1** | **Brand Name Tier 2** | **Tier 3** | **Tier 4** |
| **In-Network**  (up to a 30-day supply) | $11 | $28 | $53 | Full cost of drugs |
| **MAXOR Mail Order** & walk-in Maxor Pharmacies (up to 90-day supply) | $7 | $24 | $53 | Not available |
| **Out-of-Network**  (up to a 30-day supply) | 50% of total cost  applies after POS  deductible met | 50% of total cost  applies after POS  deductible met | 50% of total cost  applies after POS  deductible met | Full cost of drugs |

## Mail Order Information

US Family Health Plan requires that maintenance medication prescriptions routinely be filled via mail order through Maxor MXP Mail Order Pharmacy or the walk-in Maxor Pharmacies. 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 Plan 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 EPCS.

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 providerse must be filled at a network pharmacy in Louisiana.

Maxor Mail Order Pharmacy

P.O. Box 32050, Amarillo, TX 79120

Phone: 1 (866) 408-2459

Fax: 1 (866) 589-7656

**(Must be faxed directly from the physician’s office)**

## Smoking Cessation

Quitting can be hard. USFHP 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 OTC products are covered with a prescription.

## Pharmacy Benefit Limitations And Exclusions

Due to TRICARE restrictions, the USFHP pharmacy benefit excludes:

* 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)
* Over –the-counter (OTC) products or any pharmacy product purchased without a prescription
* Any prescription refilled before 75% of a previous filling has been used

Section VI: Clincial Quality Management Program



SECTION VI

Clinical Quality Management Program

# Clinical Quality Management Program

The US Family Health Plan has a comprehensive Clinical Quality Management Program (CQMP). The goal of the C QMP 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
* Credentialing
* Disease management
* 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)
* Patient safety
* Preventative health services
* Pharmacy Services Effectiveness
* Timely credentialing of providers and adequacy of the provider network
* Utilization management
* Complex Case Management
* Oversight of Quality Improvement and Performance Improvement Plans
* Policy and Procedure Oversight and training
* HEDIS (Healthcare Effectiveness Data and Information Set)
* Oversight of Health Plan Committee Structure
* Facilitation of the Quality Improvement Committee

All participating providers are required to comply with US Family Health Plan’s policies and procedures, including complying with, participating in, and implementing Quality Management Projects, including Patient Safety Programs. This includes, but is not limited to, implementing activities necessary and required to comply with external accreditation by the NCQA, 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:

* Review quality reports and take action to improve clinical outcomes as measured by HEDIS®
* Collaborate with the health plan to resolve member complaints regarding access to care, quality of care, provider service, or other issues upon request
* Provide feedback on the health plan via provider satisfaction surveys
* Provide medical records as requested for HEDIS®, quality of care investigations, or other medical record audits
* 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
* A number of providers are invited to participate in quality improvement committees. 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

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 the CHRISTUS 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). The Quality Director, Quality RN, or designee may refer cases to the Medical Director for review and recommendations. The results of such screens shall be reported within 15 days of the referral, with a final report in 30 days.

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

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

The Medical Director will recommend action as appropriate to the event, in keeping with CHRISTUS US Family Health Plans QMP, CHRISTUS US Family Health Plan Policies and Procedures, contractual requirements of the plan, requirements under the terms of the plans 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 Clinical 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/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 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 US Family Health Plan, the QIC, PRC, and the Credentialing Committee, act to immediately revoke, limit, or suspend the privileges of a participating provider. The affected provider 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 Plan will follow the Health Care Quality Improvement Act of 1986. The US Family Health Plan has a policy and process for conducting the required due process. The provider may request a copy of the policy at any time by contacting the 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 DoD, the US Family Health Plan is committed to the principles contained in a document released on March 12, 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. Physicians 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 at <http://www.hcqualitycommission.gov/>.

## 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. US Family Health Plan will conduct its activities in such a manner as to comply with the Health Care Portability and Accountability Act of 1996 and the Quality Improvement Act of 1986. US Family Health Plan will retain the privilege of protection and confidentiality afforded under this act. Communication will be point to point under the auspices of the CQI Committee, a Quality Assurance Committee of the Medical Staff. US Family Health Plan 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 National Disaster Medical System 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 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 at:

<https://phe.gov/Preparedness/responders/ndms/Pages/default.aspx>

**HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)**

Department of Defense requires CHRISTUS Health USFHP to report health care 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 October 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews

Medical Record Reviews (MRR) for HEDIS

CHRISTUS Health 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 Superior which allows them to collect PHI on our behalf.

How can Providers improve their HEDIS scores?

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

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI Department at CHP.[Qualitydepartment@christushealthplan.org](mailto:Qualitydepartment@christushealthplan.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 capture answers to questions like (but not limited to)

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

**[CLINICAL PRACTICE GUIDELINES](#TOC)**

Clinical Practice Guidelines are evidence-based guidelines used to help providers make decisions about specific clinical situations. CHRISTUS Health Plan Generations; Generations Plus 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. CHRISTUS Health plan reviews the Clinical Practice Guidelines at least every two years or more frequently if national guidelines changes within the two year time period.

Clinical Practice Guidelines are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decision are 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 <https://www.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 Customer Services at 1-800-446-1730.

**PREVENTIVE HEALTH GUIDELINES**

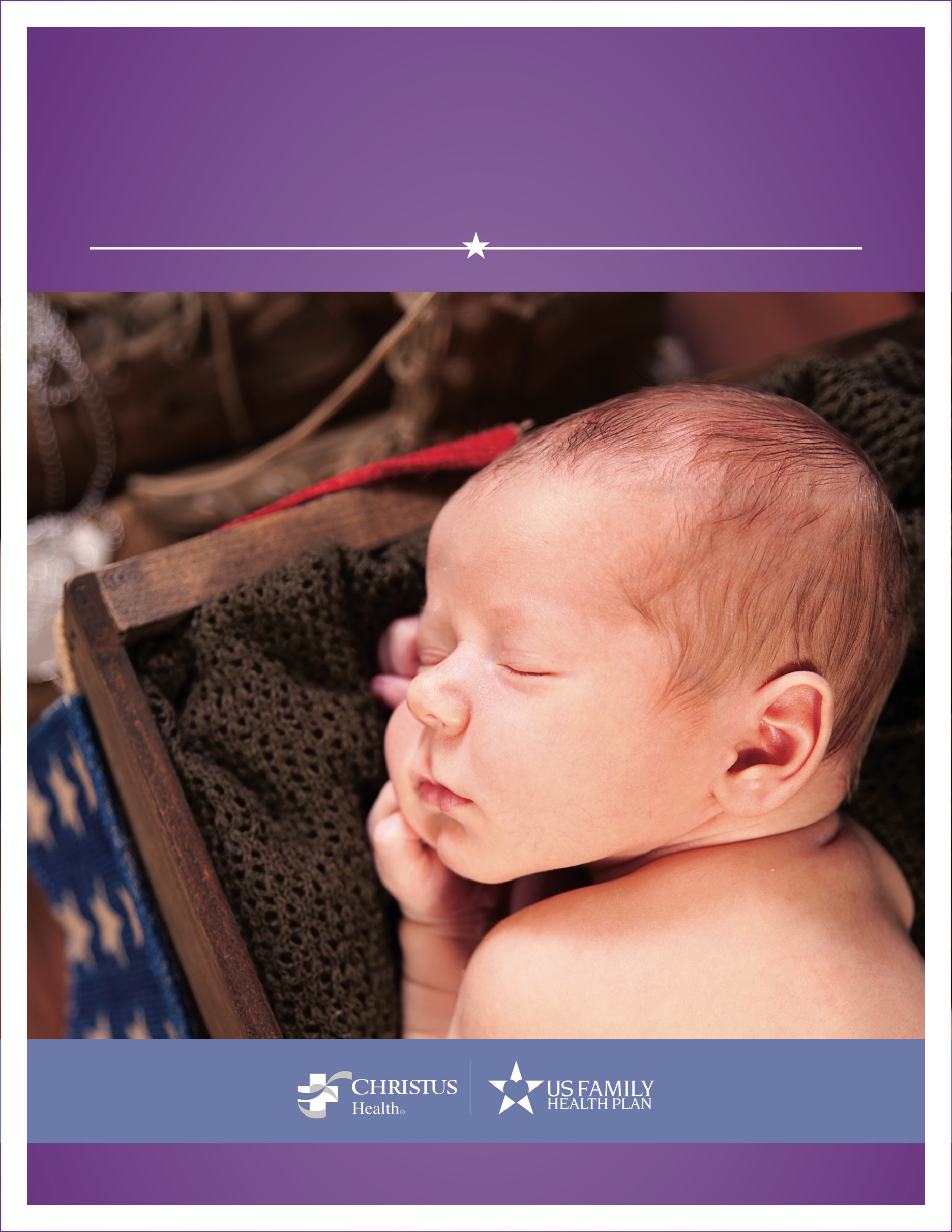
CHRISTUS Health Plan adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) for healthy adults and children with normal risks (Grade A and B), and the Centers for Disease Control and Prevention (CDC). Where there is a lack of sufficient 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 <https://www.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 Customer Services at 1-800-446-1730.

We review guidelines every two years or more frequently if national guidelines change within the two-year period

Section VII: Claims and Appeals



SECTION VII

Claims and Appeals

# 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. The US Family Health Plan will bear no liability to pay claims received after 365 days, and members cannot be balanced 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:

P.O. Box 981696

El Paso, Texas 79998-1696

Attn: USFHP Claims

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. 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.

## Edi Transactions

The Plan’s EDI transactions are performed via the following clearinghouses: Availity and Change Healthcare. The following provides information regarding each type of transaction and what is required in order to perform these transactions with the US Family Health Plan. 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 the US Family Health Plan.

### 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 the Availity, providers need to follow the instructions on the EDI Form.
* The form should be completed and sent to [Chp.ProviderNetwork@ChristusHealth.org](mailto:Chp.ProviderNetwork@ChristusHealth.org). For group providers, a form must be submitted for each physician 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 and 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 and 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 CHPEDIAlerts@Christushealth.org.

### ENCOUNTER DATA

Capitated 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 have agreed to comply with the plan’s dispute resolution process by signing the provider agreement which 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: 1) Administrative Disputes or 2) Disputes Concerning Professional Competence and Conduct.

1. Administrative Disputes may include, but are not limited to, a participating provider’s written notice to the 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.

Participating providers have the right to appeal their dispute to two (2) separate panels above   
the level of the Plan body involved in the dispute, each consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider who filed the dispute. In no case will panel members be assigned who 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, return receipt required, 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. Its 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 30 calendar days from the date the letter was received. Unless otherwise indicated, delivery will be assumed to have occurred 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 60 days of the request and the decision will be returned to the participating provider within 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 if required by law.

The following actions are required to be reported to the National Practitioner Data Bank (NPDB): terminations resulting from serious quality deficiencies, providers who terminate themselves while under investigation, and providers who terminate themselves with an action plan in place.

## Provider Appeals

If a provider disagrees with a Plan 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 letter and/or EOB.

* The appeal must be in writing and must be submitted to the Plan within ninety (90) calendar days 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 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 in a like manner to appeals
* Denials are always communicated in writing
* Second level medical necessity appeals are reviewed by an independent clinical provider in the like specialty who has not previously reviewed the case.

## Appeals Process

|  |  |
| --- | --- |
| **Level 1 Appeal**  Appeal of Initial Denial Determination | Written requests for reconsideration-appeal of initial denial determination may be submitted by the provider or member within the following time frames:   * Concurrent review request for reconsideration must be submitted by noon of the day following the day of receipt of the initial denial determination. * Expedited reconsideration of a preadmission/pre-procedure denial must be filed within three (3) calendar days after the date of the receipt of the denial determination. * All other requests for reconsideration must be filed within ninety (90) days after the date of the initial denial determination. * All appeals should be in writing. |
| **Level 2 Appeal** | * The 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/providers 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. Additional information on TRICARE policy can be found in the TRICARE Operations Manual 6010.56¬M, Chapter 12 at <http://manuals.tricare.osd.mil/>.

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: 1 (866) 416-2840

By Email:  [CHRISTUS.HP.AppealsandGrievances@christushealth.org](mailto:CHRISTUS.HP.AppealsandGrievances@christushealth.org)

# Reimbursement Methodologies

## Fee-For-Service (Professional Services)

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

|  |  |
| --- | --- |
| **Level** | **Fee Schedule** |
| **Level I** | The specific carve out fee schedule based on the provider’s contract with the plan. |
| **Level II** | **Medicare allowable fee schedule**  The Medicare fee schedule can be obtained free of charge from the website of the Centers for Medicare and Medicaid Services (CMS) at <http://www.cms.gov/>. The fee schedule can also be obtained from the website of TrailBlazer Health Enterprises, LLC, a CMS Contracted Intermediary/Carrier, at  <https://www.novitas-solutions.com/> |
| **Level III** | **TRICARE/CHAMPUS allowable fee schedule**  The TRICARE/CHAMPUS fee schedule is also available for free from the website of TRICARE Military Health System at <http://www.tricare.mil/> |
| **Level IV** | Based on the provider’s contract, a percentage of billed charges may apply for any codes that do not fall in any of the above fee schedules. If there is no default to pay codes that do not fall in any of the above fee schedules the codes could be denied. |
|  |  |

**The Plan updates fee schedules** in coordination with updated releases of new fee schedules from Medicare and CHAMPUS.

## Institutional Services

Unless otherwise indicated by the provider’s agreement, the US Family Health Plan reimburses inpatient institutional services rendered by contracted providers at the TRICARE/CHAMPUS DRG rate. The rates may be obtained from [www.tricare.osd.mil/drgrates](http://christusconnect.echristus.net/depts/hipm/chp/Provider%20Manuals/Provider%20Manual%20Workgroup%20%20-%2008.25.2017/www.tricare.osd.mil/drgrates). These rates are updated annually, and the Plan processes claims accordingly by date of service.

The US Family Health Plan reimburses outpatient institutional services rendered by contracted providers at a contractually agreed upon amount. Please refer to the provider’s agreement with the health plan for specific details.

## Copayments

It is the responsibility of the provider’s office to collect the basic office visit copayment at the time of the member's visit. If the copayment is NOT collected from the member, the provider’s office will NOT be reimbursed by the USFHP for that payment amount.

The USFHP would like to be notified of those members who routinely do not pay their copayment. Failure to make the required copayment is grounds for possible termination of the member from the plan. The copayment is a legal debt, owed by the member to the provider, and can be collected as such.

Section VIII: Compliance



SECTION VIII

Compliance

# Compliance

As an affiliate of CHRISTUS Health and as a contracted provider for the DoD, the US Family Health Plan adheres to a corporate strategy that underlines its commitment to health care integrity. The US Family Health Plan 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, the US Family Health Plan 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.

The US Family Health Plan is dedicated to the CHRISTUS “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 the US Family Health Plan, providers are expected to:

## Safety

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

## Quality Care

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

## Accurate Recording And Reporting

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

## 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

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 US Family Health Plan claim.

## 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:

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.

Examples:

* Overcharging: Submitting a claim for an item or service priced unusually high
* Billing for items or services not rendered or not provided as claimed
* Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary or are not specifically prescribed.
* Double billing resulting in duplicate payment
* Billing for noncovered services as if covered
* Billing using codes that do not match the service rendered, resulting in higher paid claim.

## 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.

* Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities1
* Ensure accuracy when submitting bills or claims for services rendered
* Submit appropriate Referral and Treatment forms
* Avoid unnecessary drug prescription and/or medical treatment

## 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 in 32 CFR 199.2 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 evidence 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; or
* Refusal to furnish or allow access to records.
* Overcharging: Billing for items or services that are substantially above list price or MSRP.

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.

## Reporting Fraud, Waste, and Abuse (FWA)

Reporting FWA contributes to efforts in lowering health care costs. Your anme and report may be kept anonymous. If you prefer anonymity, and do no wish to be contacted, please notate that within your report. For reporting options, please refer to the below resources:

* HOT LINE: 855-771-8072
* Secure Fax: 210-766-8849

eMail: [CHRISTUSHealthPlanSIU@CHRISTUSHealth.org](mailto: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 at <https://oig.hhs.gov/>

**Whistleblower – Sarbanes/Oxley Act**

### False Claims Act

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

### Criminal Investigation of Health Care Offenses

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

### Mail and Wire Fraud

Imposes criminal penalties for any scheme to defraud another of money or property by

using mail, private courier, telephone, fax or computer. Notably, each offense is considered a separate crime

### Social Security Act

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

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

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

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

Providers are prohibited from referring patients to health entities in which they have an

ownership relationship. Any health service receiving a “prohibited referral” is prohibited from billing for it. Health services include:

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

There are specific exceptions to the Stark laws, some related to Stocks and Bonds, and some related to certain physician services. The Sherman Antitrust Act-prohibits any ventures 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 ERs based solely on their inability to pay for services.

### Civil Rights Act of 1964

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

### Rehabilitation Act of 1973

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

Individuals protected are those with:

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

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

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

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

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

### Confidentiality and Disclosure Requirements Table 10

Requires that quality assurance documentation be kept confidential in DoD programs.

### The Freedom of Information Act

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