2023

CHRISTUS® Health Plan

Guardian Generations (HMO) Generations Plus (HMO)

PROVIDER MANUAL

CHRISTUS Health Plan covers members in the following counties:

Bernalillo
Los Alamos
Rio Arriba
Sandoval
San Miguel
Santa Fe
Taos

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) Medicare Advantage plans

New Mexico

Table of Contents

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) Plans
Important Phone Numbers and Addresses

Member & Provider Services Claim Resolution Utilization Management Provider Translation Assistance	Tel.: 844-282-3026 Fax.: 210-766-8851 Website: CHRISTUSHealthPlan.org
Pharmacy | Formulary	ESI: 844-470-1531 Help Desk: 800-922-1557
Dental (Delta Dental)	Tel.: 888-818-7929
Vision (Block Vision)	Member Services: 800-879-6901 Provider Services: 866-819-4298
Hearing (Amplifon)	Tel.: 866-687-6756
24-Hour Nurse Hotline	Tel.: 844-581-3174
Claims Billing Address	P.O Box 981651 El Paso | TX 79998-1651
Reporting Fraud or Non-Compliance	**FWA HOT LINE:** 855-771-8072 Secure Fax: 210-766-8849 Website: CHRISTUSHealthPlanSIU@CHRISTUSHealth.org

Welcome to CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO)!

We are delighted you have chosen to become a participating provider with CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans. We view you as our partner in providing high quality, affordable health care to our members.

CHRISTUS Health Plan, headquartered in Irving, Texas, is a health and well managed care company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the people the Plan serves across the country.

CHRISTUS Health Plan is dedicated to managing the right populations in the right way while reducing the rising health care cost trends. Key to this strategy is the engagement of members and their families with a team of providers using population health tools to identify high-risk members and gaps in care for all members that transcend the continuum of care, from the community to primary care to acute care. Our staff will work collaboratively with you to create a positive experience for you and our members, your patients, and CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO). Any time you have a question, please feel free to call your local Provider Engagement Consultant or your Medical Director.

Members of CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans receive services as part of their health care benefits managed by the Primary Care Provider (PCP). Benefits are available only through the exclusive use of participating providers, hospitals, medical centers, pharmacies, home health agencies, and other health care providers. Benefits are not included for 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 available on the Plan's website, ChristusHealthPlan.org, updated on a regular basis.

This provider manual furnishes participating providers and their office staff with important information concerning CHRISTUS Health Plan policies and procedures, claim submission, adjudication requirements, and guidelines used to administer CHRISTUS Health Plan. This manual replaces and supersedes any and all other previous versions and is available at ChristusHealthPlan.org.

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

Please contact your local Provider Engagement Consultant for specific information in relation to your Provider Agreement, including but not limited to:

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

CHRISTUS Health Plan providers have agreed to follow and adhere to "Rules and Regulations," which include, but are not limited to:

- All quality improvement, utilization management, credentialing, peer review, grievance, and other policies and procedures established by CHRISTUS Health Plan. The Centers for Medicare and Medicaid Services (CMS) and the CHRISTUS Health Plan Provider Manual, as amended from time to time.

Furthermore, the policies and procedures set forth may be altered, amended, or discontinued by CHRISTUS Health Plan at any time upon notice to the provider.

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

Provider Participation Requirements

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

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

Practitioner Participation Criteria

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

Facility Participation Criteria

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

Provider, Facility and Ancillary Contractual Requirements

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

- Abide by the CHRISTUS Health Plan Generations rules and regulations.
- Accept patients transferring from out-of-network care to in-network facilities.
- Allow access to medical records for review by appropriate committees of CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) and,

upon request, provide the medical records to representatives of the Federal Government and/or their contracted agencies.

- Arrange for another provider (the "Covering Provider") to provide patient care or referral services to a member in the event a participating provider is temporarily unavailable.
- Do not balance bill a member for providing services covered by CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans. Providers may only bill members for applicable deductibles, co-payments, and/or cost-sharing amounts.
- Do not bill members for charges that exceed contractually allowed reimbursement rates. Providers may bill a member for a service or procedure that is not a covered benefit after securing written consent.
- Do not discriminate based on age, sex, handicap, race, color, religion or national origin.
- Inform CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) 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, which would affect a provider's practicing status.
- Inform CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) within 24 hours, in writing, of any revocation or suspension of the provider's Drug Enforcement Agency (DEA) number, certificate or other legal credential authorizing the provider to practice in the state of Texas, or any other state. Failure to comply with the above could result in termination from the Plan.
- Maintain medical records for six (6) years from the last date services were provided to the member, or as required by applicable law.
- Participate in CHRISTUS Health Plan's quality improvement, utilization management, credentialing, peer review, grievance, other policies and procedures established by CHRISTUS Health Plan that also includes participation in evidence-based patient safety programs.
- Prepare and complete medical and other related records in a timely fashion and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.
- Provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the member's PCP within thirty (30) business days of the member's visit with the specialist.
- Provide continuous 24-hour, 7-day a week access to care.
- Provide or assist CHRISTUS Health Plan Generations in obtaining Coordination of Benefits/Third Party Liability Information.
- Transfer medical records within ten (10) business days or sooner if requested by a treating provider, after a member changes to another PCP.

- Utilize CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans participating providers and facilities when services are available and can meet the patient's needs.

Provider Rights

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

- All providers have the right to communicate with patients about their treatment, regardless of benefit coverage.
- Appeal any action taken by CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans that affects their status with the network and/or related to professional competency or conduct.
- Ask to have any adjudicated claim reconsidered if they feel it was not paid appropriately.
- Provide feedback and suggestions on how to improve services for providers and members through written correspondence, the Health Plan's annual Provider Satisfaction Survey, or via the Physician Advisory Committee.
- Request CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans remove a member from their care if an acceptable patient-provider relationship cannot be established with a CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plan member who has selected them as his/her provider.
- Request to serve on the Quality Improvement Committee or other committees formed by CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans.

Covering Providers

Covering providers are reimbursed according to the contracted provider's reimbursement rates. It is the responsibility of the contracted PCP to have his/her covering provider render care according to the benefit and appointment guidelines outlined in this Provider Manual.

Appointment Wait Time

Wait times in any provider's office *should not exceed 30-45 minutes* for non-emergent visits.

Appointment Standards

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans defines appointment standards as the timeliness within which a member can obtain available services. When a member calls to make an appointment, it must be made within the following guidelines:

Service	Definition	Standard
Routine Care Primary and Specialist	Non-urgent care for symptomatic conditions	Within 7 calendar days

Immediate 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
Preventive Care or Periodic Health Evaluation	Health care services designed for the prevention and early detection of illness in asymptomatic people, generally including well woman exams, routine physical examinations, routine eye exams, and immunizations.	30 calendar days

Medical Records

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

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

The provider's medical records must be available for Utilization and Risk Management, peer review studies, Member Services inquiries, Quality Improvement initiatives, satisfaction surveys, Grievance and Appeal processing, Claims reconsideration, and other initiatives CHRISTUS Health Plan may be required to conduct. To comply with accreditation and regulatory requirements, the Plan may periodically perform documentation audits of some provider medical records. If an audit indicates non-compliance of any area, an internal corrective action plan may be initiated with the provider.

Standards

Participating providers must have a system in place for maintaining medical records that conform to regulatory standards. All medical records pertaining to CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members must be kept the longer of six (6) years or as required by each state. On a periodic basis, the Plans may require access to medical records for the purpose of quality assessment, investigating grievances and appeals, credentialing, and peer review.

Confidentiality

Medical records are considered confidential, Protected Health Information (PHI). Providers must comply with all state and federal laws concerning the confidentiality of all health related and other information about CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members. Providers must maintain and adhere to policies and procedures regarding use and disclosure of health information that comply with HIPAA and other applicable laws. A complete listing of all compliance policies and procedures can be found on the CHRISTUS Health Plan website at **Policies and Procedures - CHRISTUS Health Plan**.

Release of Medical Records

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

Transfer of Medical Records

There may be times when a member's medical records need to be transferred from one PCP to another PCP within 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 ten (10) business days or sooner if requested by the treating provider.

The following information must be included in every individual patient record:

- Patient identification
- Personal data
- Alcohol or substance use/abuse
- Allergies
- Appropriate use of consultants
- Chief complaint
- Continuing medication list
- Date of each visit
- Date of next visit
- Diagnosis/impression
- Growth chart (14 years of age and under)
- Hospital records, as applicable
- Immunization history
- Informed consent
- Initial relevant history
- MD review of diagnostic studies
- Patient's signature on file, for insurance purposes
- Physical exam
- Preventive health education
- Provider signature and name on each entry

- Results discussed with patient
- Results of consultations
- Significant problem list
- Smoking status
- Treatment/therapy plan
- Health Education and Wellness promotion services assessed by member

Risk Adjustment Data Validation

Participation in Risk Adjustment Data Validation is required of all providers, and it is important that providers are aware that medical records may be requested from their office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of Claim and Encounter Data and identify additional conditions not captured through this mechanism.

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (Health Insurance Privacy and Accountability Act [HIPAA] implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the "general consent" of the member. A general consent form should be an integral part of the medical record file. Information on risk adjustment is available at cms.gov.

Advance Directives

Advance Directives are written instructions that:

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

There are three types of Advance Directives:

- A **Durable Power of Attorney** (POA) for health care allows the member to name a patient advocate to act on their behalf.
- A **Living Will** allows the member to state his or her wishes in writing, but does not name a patient advocate.
- A **Declaration for Mental Health Treatment** gives instructions regarding a member's future mental health treatment if the member becomes unable to make personal decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration, with or without conditions and limitations.

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans advance directive policies include:

- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives. Providers must adhere to this act and

to all state and federal standards as specified in SSA 1902(a) (57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CRF 489 subpart I;

- Advising members of their right to self-determination regarding advance directives;
- Assisting members with questions regarding advance directives. CHRISTUS Health Plan Generations(HMO), Generations Plus (HMO) and Guardian (HMO) plan employees may not serve as a witness to an advance directive, or as a member's authorized agent or representative;
- CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objections will be stated clearly and notes the range of medical conditions or procedures affected by the conscientious objections, identify the state legal authority permitting such objection and note the presence of advance directives in the medical records when conducting medical audit charts.
- Encouraging members to request an advance directive form, as well as education from their PCP at their first appointment;
- Having Member Services, Provider Services and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis;
- Member materials will contain information, as applicable, regarding provisions for conscientious objection. Materials explain the differences between institution-wide objections based on conscience and those raised by individual providers;
- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to withhold or withdraw the medical or surgical means, or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession;
- While members have the right to formulate an advance directive, a CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan associate, a facility or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law;

Providers Must:

- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact.
- Ask the member if he or she would like advance directive information. If the member desires further information, provide member advance directive education and any applicable resources available.
- Comply with the Patient Self-Determination Act requirements
- Discuss potential medical emergencies with the member and/or family/significant other and with the referring provider, if applicable.
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate (DNR)

directive or the provider and member's discussion and action regarding the execution or non-execution of an advance directive.
- Make an advance directive part of the member's medical record and put in a prominent place.
- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive.
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive.

Affirmative Statement - Providers should communicate with patients about their treatment, regardless of benefit coverage.

Non-Discrimination

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans participating providers have agreed to provide care to Plan members in the same manner and with the same standards they follow in providing care to patients who are not CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members.

Providers cannot differentiate or discriminate against any CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plans member in the delivery of health care services consistent with covered benefits based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Closing a PCP Panel

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

Provider Request to Transfer a Member's Care

Members have a right to change providers. Likewise, providers have a right to request a transfer of a member to the care of another provider when the provider feels the provider-patient relationship has been compromised due to:
- Breakdown in patient/provider relationship.
- Failure to follow the provider's recommended treatment plan.
- Failure to pay co-payments.
- Fraud

- A pattern of missed appointments.
- Unruly or abusive behavior.

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

- Expresses commitment to work with the member – carbon copy (CC) the CHRISTUS Health Plan Member Services Manager.
- Refers to the specific behavior.
- Refers to the specific incident (date).

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

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

Voluntary Provider Termination

Providers may terminate their contract with CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans according to the terms of their provider agreement. Termination of a provider agreement does not release the provider from the obligation to arrange for the provision of services and transition of member care. Providers must continue to provide medical care to assigned members until the effective date of termination.

CMS Medicare Advantage Guidelines

CHRISTUS Health Plan is responsible for including certain CMS Medicare Advantage related provisions in the policies and procedures distributed to providers. A summary of these provisions can also be accessed via the CMS website. This list should only be used as a guide and may not include all applicable changes and updates.

Providers:

- May not discriminate against members in any way based on health status.
- May not distribute CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans marketing materials or forms to members without CMS approval of the materials or forms.
- May not impose cost-sharing on members for influenza vaccine or pneumococcal vaccine.
- Must allow members direct access to screening mammography and influenza vaccination services.
- Must cooperate with Plan procedures to inform members of health care needs that require follow-up and provide necessary training to members regarding self-care.

- Must document in a prominent part of the member's medical record whether the member has executed an advance directive.
- Must ensure that each new member has an initial health assessment within ninety (90) calendar days of enrollment.
- Must ensure members have adequate access to covered health services.
- Must ensure the hours of operation are convenient to members, and do not discriminate against members and necessary services are available to members twenty - four (24) hours a day, seven (7) days a week. Primary care providers must have backup coverage for absences.
- Must provide covered health services in a manner consistent with professionally recognized standards of health care.
- Must provide female members with direct access to a women's health specialist for routine and preventive health services.
- Must provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.

Each of us (CHRISTUS Health Plan Generations and the provider) must provide the other written notice if electing to terminate the agreement without cause. Reasonable advance written notice of terms at least 90 days Without Cause (6.2 Termination without cause)– Please refer to your contract.

Marketing

In compliance with Medicare Advantage requirements, the CHRISTUS Health Plan Generations line of business products including: Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans network providers may not develop or use materials that market CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans without the prior approval of CHRISTUS Health Plan Generations.

Under Medicare Advantage regulations, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage Plan unless the materials meet Center for Medicare (CMS) marketing guidelines and are submitted to CMS for review and approval. Please contact the Member Services department with any questions about permissible involvement in CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans marketing activities.

Enrollment

CHRISTUS Health Plan Generations network providers may not distribute or accept enrollment applications from prospective members. If a patient has questions about becoming a CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plan member, please direct him or her to the CHRISTUS Health Plan Member Services phone line at 844 - 282 - 3026.

Member Eligibility

Eligibility Criteria

To be eligible for Medicare Advantage coverage with CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans, an individual must:

- Permanently reside in the CHRISTUS Health Plan Generations service area.
- Be covered by Medicare Parts A and B.
- Be a United States citizen or are lawfully present in the United States.

Member ID Card

The Member Identification (ID) card is issued to members upon enrollment and contains information regarding benefit coverage, copayments, and telephone numbers for questions regarding those benefits. Each member receives an ID card when they enroll in a CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plans. Providers are encouraged to ask to see the ID card each time the member has an office visit. The ID card displays information such as:

- Subscriber | Member Name
- Subscriber | Member ID #
- Copayment Amounts
- Prescription Drug Coverage (not applicable for CHRISTUS Health Plan Guardian (HMO) members)

Below is a sample of the CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) Member ID Cards:

This card above is for illustrative purposes only.

The card above is for illustrative purposes only.

Sample of CHRISTUS Health Guardian (HMO) ID Card

The card above is for illustrative purposes only.

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

Verifying Eligibility with CHRISTUS Health Plan
A provider may confirm member eligibility directly with CHRISTUS Health Plan. Call Provider Services at **844-282-3026**.

Verifying Eligibility with CMS
Providers may verify eligibility directly with CMS for any Medicare Advantage Plan. CMS issues an "H" number to identify all Medicare Advantage Plans. This number is used to assist providers in verifying eligibility for their patients.

CHRISTUS Health Plan Generations State-Assigned "H" Number: H1189

To verify eligibility with CMS, please reference the following contact numbers per CHRISTUS Health Plan Generations state assignment:
New Mexico: Novitas Solutions, **855-880-8424** and website: http://www.novitas-solutions.com/webcenter/portal/MedicareJH.

New Mexico 2023 Service Area: Bernalillo, Los Alamos, Rio Arriba, Sandoval, San Miguel Santa Fe, and Taos counties.

Collection of Copayments and Coinsurance

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

Member Payment for Non-Covered Services

Providers may charge CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members for non-covered services. However, such charges must be the usual and customary fee the provider would charge all other patients. The CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plan member must agree in writing to accept payment responsibility for the non-covered service prior to receiving that service. Many providers utilize the Advance Beneficiary Notice of Non-Coverage for this purpose (a sample provided below).

(A)Notifier(s):

(B) Patient Name: (C) Identification **Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the *(D)* below.

	(D)	(E)Reason	Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the *(D)* listed above.

Note; If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

CI OPTION 1. I want the *(D)* listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I** can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

0 OPTION 2. I want the *(D)* listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

CI OPTION 3. I don't want the *(D)* listed above. I understand with this choice I am **not** responsible for payment, and **I** cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-42271TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

	a) **Signature:**	*(J)* **Date:**	

Acceding to the Pawn& Reductoa Act of 1995. no rei035 are required to reword :o a coLeccon of :r.for—•mon unless it nispzys a valid OMB conaol number. The valid 0143 conuol number for th's afcanaton collect:or. is 093S-0565. The eme re iced to complete this informaton collecion:s estimated to overape7 Mb.lti per relpome, ixtuis; tte time to teslew mscructoos. se/ND eidrig tine mourcts, gate: the data :cadet *or;4* complex and renew the idorsdca collecton. If you have co=en rats concerning the accsracy of the nme estsore or summons for improcmg this fem. please wre to: CMS. 7503 Sedziry Boulevard. Arm: PRA Reports Cleataxe OfEcet.Baldmore.M.xyland 21244 - 1550.

loan C.DAS-K-131 (03:0S) tom. Approved UNIE No. U934-0DOO

Member Rights and Responsibilities

Providers are required to adhere to the Centers for Medicare and Medicaid Services (CMS) and CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan requirements concerning issuing letters and notices. CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members have the right to timely quality care and treatment provided with dignity and respect. Providers must respect the rights of all CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members.

Member Rights
Medicare Advantage members have the right:

- To be treated with respect and understand their need for privacy and dignity.
- To get help in a prompt, courteous, responsible and culturally competent manner.
- To be provided information regarding their health care benefits.
- To be provided information regarding any limitations and services not covered by the Plan.
- To have their medical information explained to them by their provider, and in a method, they understand.
- To communicate with their provider about their care.
- To expect the Health Plan not to interfere with any contracted providers communicating with them about their treatment choices.
- To have the Health Plan send them to another contracted provider if he/she does not agree to a treatment because of moral or religious grounds.
- To be provided information about the list of contracted providers in their service area.
- To consent to all treatment, unless there is an emergency that prohibits them from signing a consent, or their health is in serious danger.
- To refuse treatment, including any trial treatment, and be informed of the possible outcome of their choice.
- To choose an advance directive and choose the type of care they receive if they become unable to express their wishes.
- To select, without interference, a primary care provider of their choice from the Health Plan's list of contracted providers.
- To make suggestions regarding the member rights and responsibilities policy.
- To file a complaint against the Health Plan.
- To file a complaint about the care they have received and to receive a timely response.
- To file a grievance if they are not satisfied with their Health Plan's decision regarding their complaint.
- To get "timely access" to any personal records and information.

Member Responsibilities

Medicare Advantage members have the responsibility:

- To know and confirm their benefits before getting treatment.
- To show their member ID card before receiving services.
- To protect their member ID card from being used by another person.
- To verify that the provider they receive service from is part of the Health Plan network.
- To keep scheduled appointments.
- To pay any copayments/coinsurance at the time of treatment.
- To ask questions and understand the care they are receiving.
- To follow the advice of their provider and be aware of the possible outcomes if they do not.
- To provide information when asked to the Health Plan and contracted providers that would contribute to improving their health status.
- To use emergency room services only for an injury or illness they think may be a serious threat to their life or health.
- To follow the agreed upon treatment plan by the member and provider.
- To treat all the Health Plan staff with respect and courtesy.
- To inform the Health Plan of any change in address.
- Refrain from any abusive or noncompliant behavior (verbal or physical) toward staff

The Medicare program has written a booklet called *Your Medicare Rights and Protection*. To receive a free copy, call 800-MEDICARE (800-633-4227) or TTY 711, 24 hours a day, 7 days a week. Members and providers can also access the Medicare website, Medicare.gov, to order the booklet or print it from their personal computer.

Covered and Non-Covered Services

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans provide covered medical benefits to its members. Following is a list of covered and non-covered 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 for all services determined not to be medically necessary and not authorized by the provider.

Transplant Services

The Health Plan requires authorization for transplant services. This applies to both solid organ and bone marrow (stem cell) transplant procedures. Prior authorization can be requested by either the provider or the member. For members to obtain the maximum possible benefits, the member must obtain their transplant through the use of health plan contracted transplant providers; **Optum, Cigna LifeSOURCE, LifeTRAC.** In-network transplant services may be provided outside of the Plan service area if the services are accessible and available to enrollees. For authorization and to initiate the Transplant Process, please call or fax your request to the CHRISTUS Health Medical Management team at **844-282-3025**, Fax **844-357-7562.**

Behavioral Health

CHRISTUS Health Plan is directly responsible for Behavioral Health (BH) member services, utilization management, provider contracting, credentialing, and claims payment to behavioral health providers. CHRISTUS Health Plan can be reached at **844-282-3026**. CHRISTUS Health Plan is responsible for BH pre-authorization, referrals, and medical management of behavioral health services. Behavioral health services include all Mental Health services, treatment for alcoholism, substance abuse, drug addiction and chemical dependency.

Original Medicare

A provider may not bill Medicare for CHRISTUS Health Plan Generations covered benefits provided to a CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plan member. Should a provider bill Medicare for CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans covered services; the Plan is required to investigate and, if appropriate, Dis-enroll member from the Plan. Should a member possessing Medicare benefits dis-enroll from the Plan, they will be covered by Original Medicare beginning the 1st day of the following month of disenrollment.

Non-Covered Benefits (Exclusions)

In addition to any exclusions or limitations described in the Benefits Chart, the following items and services are not covered under Original Medicare or by our Plan:

- Cosmetic surgery or procedures, unless due to an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a

breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

- Custodial care is care provided in a nursing home, hospice, or other facility setting when the Member does not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps the Member with activities of daily living, such as bathing or dressing.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our Plan. Experimental procedures and items are those items and procedures determined by our Plan and Original Medicare to not be accepted by the medical community.
- Eye Radial keratotomy, LASIK surgery; Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery; routine eye exam and eyewear allowance are covered; eyewear with a total refractive value of less than + 0.50 diopter in at least one eye; eyewear or professional services specific to contact lens wear (i.e., fitting, assessment and follow up) exceeding the benefit allowance; Orthotics, vision training, low vision aids or any supplemental training; Medical eye care services and diagnostic procedures; Any examination required by an employer as a condition of employment; Conditions covered by Worker's Compensation; Any services provided by another vision Plan or furnished by a non-contracting provider.
- Family Planning services.
- Fees charged by immediate relatives or members of their household.
- Full-time nursing care in their home.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Meals are covered after surgery or inpatient hospitalization for a chronic illness; for a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time.
- Naturopath Services (uses of natural or alternative treatments).
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Personal items in their room at hospital or skilled nursing facility, such as a telephone or television.
- Private duty nurses.
- Private room in a hospital, except when considered medically necessary.
- Reversal of sterilization procedures, sex change operations or gender identity reassignment and non-prescription contraceptive supplies.

- Routine dental care, such as extractions, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Routine foot care, with the exception of the limited coverage provided according to Medicare guidelines.
- Routine transportation.
- Services considered not reasonable or necessary, according to the standards of original Medicare, unless these services are listed by the Plan as covered services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan's cost-sharing amounts.
- Supportive devices for the feet, with the exception of orthopedic or therapeutic shoes for people with diabetic foot disease.
- Surgical treatment for morbid obesity, except when it is medically necessary and covered under Original Medicare.
- Transplants that use embryonic stem cells.

Quality Management Program

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans have a comprehensive Quality Management Program. The goal of the Quality Management Program is to ensure that every member has the opportunity to receive quality care in a timely and accessible fashion and to provide a mechanism for evaluating the appropriateness of member care. The purpose of the Quality Management Program is to ensure timely identification, assessment and resolution of known or suspected evidence-based quality deficits by continuously monitoring and evaluating the quality of care and services provided to our members.

The scope of the Quality Management Program includes oversight of all aspects of both clinical and administrative services provided to our members, including, but not limited to:

- Assessments of drug utilization for availability, appropriateness and cost-effectiveness.
- Audits and evaluations of clinical services and processes.
- Benchmark for disease prevention, chronic disease management and other appropriate quality of care measures.
- Care management (to include but not limited to; disease management, health promotion, complex disease management, behavioral health, care transitions), programs that are member-centric and address the health care needs of members with comprehensive medical, physical and mental health conditions
- Credentialing and re-credentialing of physicians, practitioners, and facilities.
- Development and implementation of clinical standards and guidelines.
- Evaluation of accessibility and availability of network providers.
- Evidenced based care delivery.
- Implementation of high-quality customer services standards and process.
- Member appeals and grievances.
- Oversight of health plan delegated activities.
- Potential Quality of Care safety concerns.
- Program design and structure.
- Quality Improvement activities that comply with CMS, NCQA, TDI, NM OSI, and all other regulatory agencies in which CHRISTUS Health Plan is contracted with.
- Utilization Management, focus on providing the appropriate level of services to members.

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

Quality Referrals

Any stakeholder may refer a matter for review as a potential quality issue (PQI). The Quality Management Clinical Quality Auditor Nurse will investigate and review all potential cases with the Chief Medical Officer (CMO) for discussion and recommendations prior to reporting to the Peer Review Committee (PRC). The CMO review may determine that:

- No quality issue exists
- Potential quality concerns exist

The CMO will recommend any action as appropriate to the event, in keeping up with CHRISTUS Health Plan Policies and Procedures, contractual requirements of the Plan and other relevant federal, state or local regulatory requirements. All PQIs will be reported to the Peer Review Committee, who in turn determines a severity level and action plan.

HEDIS® and Star Ratings

The Centers of Medicare and Medicaid Services (CMS) use the Five-Star Quality Rating System to determine member premium payment to Medicare Advantage plans and educate members on health plan quality. The Star Rating system consists of over 40 measures from nine different rating systems, the cumulative results of these measures make up the Star Rating assigned to each health plan.

Star Ratings have a significant impact on the financial outcome of Medicare Advantage plans by directly influencing the bonus payments and rebate percentage received. CMS will award quality-based bonus payments to high performing health plans based on their Star Ratings performance.

Five main components of the Star Ratings system:

1. HEDIS® (Health Effectiveness Data and Information Set) is a set of performance measures developed for the managed care industry. All claims are processed regularly to extract the NCQA (National Committee for Quality Assurance) defined measures. For example, this allows the health plan and CMS to determine how many enrollees have been monitored for diabetic control with an HgbA1c blood test.
2. CAHPS (Consumer Assessment of Health Care Providers and Systems) is a series of patient surveys rating health care experiences performed on behalf of CMS by an approved vendor.
3. Administrative measures evaluate a health plan's ability to address customer complaints, appeals, various enrollment items, and calls to its customer service line.
4. PDE (Prescription Drug Event) is data collected on various medications related events, such as high-risk medications, adherence for chronic conditions, and pricing.
5. HOS (Health Outcomes Survey) is a survey that addresses customers' perceptions of their health plan and recollection of specific provider care delivered over a two and a half (2.5) year time period.

How Can Providers Help to Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings as indicated by evidence-based care, or when recommended.
- Insure members/patients have timely encounters to insure yearly annual wellness visits and evidence based chronic disease management encounters for optimum care.
- Continue to discuss with your patients and document interventions regarding topics such as depressive screenings, fall prevention, bladder control and the importance of physical activity.
- Create office practices to identify patients needing recommended services at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes & properly document medical chart for all members. This includes appropriate diagnosis and Hierarchical Condition Category (HCC) risk codes.
- When available to you, review the gap in care files listing members with open gaps.
- Identify opportunities for you or your office to have an impact.

Healthcare Effectiveness Data Information Set® (HEDIS)

CMS requires Medicare Advantage (MA) Managed Care Health Plans 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 preventive screenings and chronic health care, developed by the National Committee for Quality Assurance (NCQA). Waivers published by CMS as a response to COVID 19, prohibited submission of 2019 quality data, but we expect resumption of submission for 2020 in 2021.

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, and HCPCS codes can reduce the necessity of medical record review.

Medical Records Review (MRR) for HEDIS

CHRISTUS Health Plan may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, if any of your patients' 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, which allows them to collect PHI on our behalf.

How Can Providers Improve Their HEDIS Scores?

- Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Keep accurate chart/medical record documentation of each Member service and document conversation/services.
- Submit claims and encounter data for every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with CHRISTUS Health Plan. Claims and encounter data is the cleanest and most efficient way to report HEDIS.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.
- Understand the specifications established for each HEDIS measure.
- Contact the Quality Department by calling Provider Service at 844-282-3026 or by emailing the Quality team at CHP.QualityDepartment@ChristusHealth.org.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI Department.

Consumer Assessment of Health Plan Providers and Services (CAHPS) Survey
The CAHPS survey is a member care experience survey 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. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
2. In the last 6 months, how often did your personal doctor spend enough time with you?
3. In the last 6 months, how often did your personal doctor listen carefully to you?
4. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
5. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
6. In the last 62 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

7. How likely are you to recommend your health plan to your family and friends, if they needed health coverage?
8. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
9. In the last 12 months, when you needed care for a behavioral health problem, how often did you get behavioral health care as soon as you needed?

Health Outcomes Survey (HOS)
The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping Medicare beneficiaries make informed health care choices.

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

- In general, would you say your health is: excellent, very good, good, fair or poor?
- Over the past 2 weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things? Feeling down, depressed or hopeless?
- During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
- Did you talk with a doctor or other health provider about your level of exercise or physical activity?
- In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?
- Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?
- There are many ways to control or manage leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?
- In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

If a provider would like additional information about CMS Star Ratings, HEDIS Measures, CAHPS and HOS Surveys, please contact Provider Services at 844-282-3026 or the QI Department by email at CHP.QualityDepartment@ChristusHealth.org.

Procedure for Unusual Provider Practice Patterns
Whenever a concern regarding the quality of care and | or services provided arises, all available records and related correspondence are screened by the Quality Management Department. The concern is then forwarded to the Medical Director for review and determination of any potential quality of care issues. If there is a question as to whether there is a potential for a quality issue or concern, the Peer Review Committee will review

the case and assign a severity. Follow up actions will take place, which include a provider letter, potential request for additional information, and in some cases corrective actions if deemed appropriate.

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 Quality Improvement Committee and Medical Management Committee at the next regularly scheduled meeting. The Quality Improvement Committee (QIC) may accept the Medical Director's assessment and follow up actions, or it may recommend another course of action based upon the information presented. When individual concerns represent a pattern of behavior, the Medical Director ensures the matters are addressed through the Peer Review Committee, and an updated summary is provided to the QIC.

Note: When a situation occurs that poses an immediate threat to the health and safety of a member, the Medical Director may, on behalf of the QIC and the Credentialing Committee, act to immediately revoke, limit or suspend the privileges of a participating provider. The affected provider will be notified immediately and other affected parties (i.e., Provider Services, Utilization Management, Quality Management and Plan Administration). In an event, the QIC will assemble at the earliest possible time to hear the situation and support or override the Medical Director's decision

The sanctioning process will follow the Healthcare Quality Improvement Act of 1986. The CHRISTUS 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.

Preventive Health Guidelines

Evidence-based care practices have been shown to improve patient outcomes through clinical research. Treatment protocol values are evidence-based recommendations for care. CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan recommends referring to several sources that can provide up to date preventative guidelines that are regularly maintained. The Medicare Preventive Service Chart found at: Preventive Services Chart | Medicare Learning Network® | MLN006559 May 2022 (cms.gov), also for pediatric care; periodically schedule.pdf (aap.org), and lastly The United States Preventive Services Taskforce (uspreventiveservicestaskforce.org). The USPSTF Guidelines includes services rated A or B recommended by the Adults and Children Preventive Health Guidelines established by United States Preventive Services Task Force (USPSTF). These preventive health guidelines include recommendations for screenings, tests, immunizations and counseling, among other helpful recommendations.

CHRISTUS Health Plan adopts nationally accepted evidence-based preventive services guidelines 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 online.

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy or contact Provider Service at 844-282-3026.

We review guidelines every two (2) years or more frequently if national guidelines change within the (2) year period.

Clinical Practice Guidelines

Clinical Practice Guidelines are evidence-based guidelines used to help providers make decisions about specific clinical situations. CHRISTUS Health Plan Generations consult with participating providers practicing in the community to adopt nationally recognized guidelines and standards. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to providers to facilitate improvement of health of our members. Clinical Practice Guidelines | NCCIH (nih.gov)

CHRISTUS Health Plan reviews the Clinical Practice Guidelines at least every two (2) years or more frequently if national guidelines change within the two (2) 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 decisions are the sole responsibility of their 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 online. Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy or can reach out to Provider Service at **844-282-3026**.

Member Support Services

New Member Education
Members are encouraged to visit their Primary Care Provider (PCP) within the first ninety (90) days of eligibility and to rely on the PCP to guide them through the health care delivery system.

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

24 | 7 Nurse Hotline
CHRISTUS Health Plan has a 24|7 Nurse Line. Members can access this service toll free for medical guidance and triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace the provider's after-hours coverage commitment. To reach the Nurse Line, members should call 844-581-3174.

Cultural Competency and Language Assistance
CHRISTUS Health Plan strives to provide services in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds by providing a culturally diverse provider network. The Plan gathers information from providers concerning languages, other than English, that are spoken in each office.

CHRISTUS Health Plan Member Services works with members to help choose providers who can speak the member's primary language. In addition, Member Services retains a telephonic interpreter service for assistance with non-English speaking and hard of hearing members. All providers' language preferences are listed on the online Provider Directory.

Providers are encouraged to deliver care in a manner that is sensitive to the cultural background and language of the patient. It is the responsibility of the provider to obtain and pay for interpreters for language interpretation other than English, as well as for visually impaired, hard of hearing, vision impaired and speech disabled patients.

Member Transportation

CHRISTUS Health Plan Plus offers a limited member transportation benefit to Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members. To verify the member's transportation benefit, the member or provider may call Member Services at least 24-72 hours prior to the time of need at 844-282-3026 to arrange transportation to and from medical appointments. Authorization is required for non-emergency, one-way trips and limited to 12 one-way trips to planned approved locations per year).

Case Management

The case management program plans and manages the care of members with complex chronic needs and those whose needs are acute, episodic or short term in nature. The goals

of case management are the provision of quality care, enhancement of member's quality of life, identification of goals that impact health, and management of health care costs.

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

- Concurrent review process
- Facility admission
- Health risk assessment
- Member request
- Provider referral
- Claims analysis
- Retrospective analysis

Providers can refer members for a case management evaluation by calling 800-446-1730 (Option 1) or **sending an email to casemanagementreferrals@christushealth.org**.

Referral | Authorization Guidelines

The CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans Medical Management program is designed to assure members receive appropriate care at the right time in the right setting.

The Medical Management functions are performed in accordance with Medicare guidelines, Federal regulations and NCQA standards. Providers and CHRISTUS Health Plan staff receive no incentives, including compensation, based upon the quantity of adverse determinations. Nurses and Medical Directors proactively collaborate with PCPs, specialists and other providers to assure members get the care they need.

Role of Primary Care Provider (PCP)
The Primary Care Provider (PCP) plays a critical role in the medical care delivery model. The PCP is typically a family practitioner or internist who provides non-surgical treatment of medical conditions. PCPs work collaboratively with the member and all other providers to ensure the appropriate care is delivered at the right time in the right setting.

Within this provider-centric model, the PCP:

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

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

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

Under unusual circumstances, specialists may serve as the PCP following approval of the Medical Director and the Medical Management Department. This can be arranged by contacting Medical Management at 844.282.3026. Generally, these situations involve members who are experiencing chronic, disabling or life-threatening illnesses.

Role of Specialists, Hospitals, and Ancillary Providers
Members are encouraged to utilize their PCP as their guide through the health care system. Other providers are also encouraged to work closely with members' PCPs to coordinate care.

It is expected that all other providers will report to the PCP regarding diagnosis, findings and treatment plans in a timely manner.

With the exception of medical emergencies, all providers are required to call prior to performing services listed on the Prior Authorization List. In addition, providers are required to work closely with Medical Management staff to coordinate the member's care.

Role of Medical Management
Utilization Management Nurses and Case Managers collaborate with providers to:

- Arrange for social and clinical intervention to improve quality of care.
- Conduct initial and concurrent review of inpatient stays.
- Coordinate with other providers including, but not limited to, Inpatient Rehab, LTAC, SNF, Home Health, Durable Medical Equipment (DME), and Hospice.
- Facilitate transfer of hospitalized patients to alternate levels of care.
- Participate in discharge planning using approved evidence-based clinical guidelines to prevent readmissions.
- Provide prior authorization for those procedures and services on the Prior Authorization List.
- Utilize the CHRISTUS Health Plan network of contracted providers where appropriate.

Role of Medical Director
Medical Directors are board certified, full time employed providers who oversee day-to-day Health Plan clinical operations.

Their functions include:

- Interface directly with practicing providers to resolve clinical issues.
- Make decisions related to the authorization of medically necessary services when requested.
- Facilitating peer-to-peer discussions with providers as needed regarding adverse determinations.
- Provide clinical guidance for the Medical Management staff.

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

Peer-to-Peer Availability
Medical Directors conducting medical necessity reviews are available to discuss review determinations with the requesting provider or attending provider via peer-to-peer conversation. The peer-to-peer conversation allows the treating provider the opportunity to discuss the Utilization Management determination prior to the initiation of the appeals

process. A peer-to-peer conversation is available by calling the Utilization Management department toll free number: 844-282-3026.

Peer-to-peer conversations are to be completed within one business day of request by a treating provider. Within one business day, there will be an opportunity to discuss the determination with the Medical Director or a covering Medical Director. If the peer-to-peer discussion does not result in authorization of the request, the process includes informing the provider and member of their appeal rights during the notification.

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

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

Availability of Medical Management Staff

Medical Management Utilization RN staff is available twenty-four (24) hours a day, seven (7) days a week to answer toll-free inbound calls from practitioners and providers requesting prior authorization or concurrent review for requested services. Medical Management staff will be available to discuss any issues with an authorization, provide guidance about information the Health Plan will need to make a medical necessity determination utilizing nationally recognized evidence based on guidelines, and provide determination. Providers can reach Medical Management by telephone at 844-282-3026 or by fax at 800-277-4926.

After normal business hours and on holidays, an on-call Utilization Management RN is available to provide direction.

Member Self-Referrals

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

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

PCP Referrals to Network Specialists

The PCP does not require prior authorization to refer the member to an in-network specialist. Participating providers are listed in the provider directory and on the CHRISTUS Health Plan website. Providers may also call Member Services to verify in-network participation of a specialist.

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

Prior Authorization Guidelines
The PCP must complete the CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans Referral/Authorization Form in its entirety and either:

- Send a fax to the Utilization Management Department at **210-766-8841** for an urgent or emergent request.
- Fax a routine request to **844-357-7562**.

The following information will be requested from the provider:

- Provider name, address, and telephone number
- Patient name, ID number, and date of birth
- Diagnosis
- 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

The Utilization Management department will process completed referrals containing all necessary information and supporting documentation.

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

Admission Notification: The provider and/or hospital notifies Utilization Management when a CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plan member is admitted to the hospital.

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

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

Retrospective Review: The process of review 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 MCG Criteria, Plan protocols and policies, and Medicare coverage.

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 (SNFs), Long Term Acute Care Facilities (LTAC) and Rehabilitation Facilities are specially qualified facilities or designated units in a hospital which have the staff and equipment to provide acute care, skilled nursing care or rehabilitation services and other related health services. CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans coverage includes, as a benefit, inpatient care in a participating SNF, LTAC or Rehabilitation Facility. Custodial care is a non-covered benefit.

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

Durable Medical Equipment (DME): Durable Medical Equipment 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 slows further deterioration of the patient's physical condition. DME must be obtained through CHRISTUS Health Plan contracted providers.

Utilization Management Notification Requirements
There are specific notification requirements that apply to the services evaluated in each of the review components, in order to ensure payment. The provider must call the Plan regarding proposed treatment and service done out-of-network and within the following notification guidelines:

Treatment | Service	Notification Requirement
Urgent admissions | observations	Services done in-network, by an in-network provider and/or at an in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is

	for out-of-network services, except in the case of emergency or urgent needed care.
Elective admissions | observations | surgical procedures | outpatient procedures	Services done in-network, by an in-network provider and/or at in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is required for out-of-network services, except in the case of emergency or urgent needed care.
SNF | Rehab | Hospice	Services done in-network, by an in-network provider and/or at in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is required for out-of-network services, except in the case of emergency or urgent needed care.
Home health	Services done in-network, by an in-network provider and/or at an in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is required for out-of-network services, except in the case of emergency or urgent needed care.
Diagnostic services | DME | other procedures requiring authorization	Services done in-network, by an in-network provider and/or at an in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is required for out-of-network services, except in the case of emergency or urgent needed care.

Authorization Process

Effective July 1st, 2022, services done in-network, by an in-network provider and/or at an in-network facility do not require prior authorization. If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is required for out-of-network services, except in the case of emergency or urgent needed care.

For out-of-network services, information received either by phone or electronically will be reviewed for benefit coverage or determination of medical necessity. Appropriateness and

medical necessity will be reviewed using MCG Guideline Criteria, Plan clinical protocols and policies, and Medicare benefits and coverage. Upon approval of authorization, the authorization is faxed to the requesting provider and servicing provider.

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

Requests to Out-of-Network Providers

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

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

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

Utilization Management Affirmative Statement

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

Services Requiring Prior Authorization

For Eligibility and Benefits or Mental Health Assistance, please contact Provider Services at **844-282-3026**.

Provider Obligations – Denial Notification

Providers are required to adhere to the Centers for Medicare & Medicaid Services (CMS) and CHRISTUS Health Plan Generations requirements concerning issuing letters and notices.

Skilled Nursing Facilities (SNFs) and Home Health Agencies
The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains it has been determined that continued coverage after a specific effective date will no longer be covered by the Plan. A NOMNC should be issued to a member at least two (2) days prior to discharge, or in advance of the last two (2) covered visits. This notice informs the member his or her stay or visits no longer meet coverage criteria.

In most cases, the notice is required to be issued by the provider and CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans are required to ensure proper delivery and that the member's signature is obtained. The member's signature is not an agreement with the denial; however, it is documentation he or she has received the notification.

The process to be followed:

- If a member refuses to sign the notice, the provider may contact the member's representative to sign on their behalf.
    - If no representative is available, the provider may annotate the notice to indicate the refusal and document notification was provided to the member, but the member refused to sign.
    - If a representative can be contacted, the representative should sign the notice. If in-person notification cannot be provided to a representative, he or she can be contacted by telephone to advise him or her of the notice and appeal rights.
    - If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). The notice should be annotated by the individual providing the notification to the representative indicating the date, time, person's name, relation to the member, telephone number called and that the notice was read to the representative, including all appeal rights.
- If a member (or representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or CHRISTUS Health Plan Generations Medicare Complaints, Appeals and Grievance department within the time frame indicated on the request.

Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two (2) days after an admission or at the preadmission visit (but not more than seven (7) calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This notice explains the beneficiary's rights as a hospital inpatient, including discharge appeal rights.

The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide a copy at that time. The hospital is also responsible for ensuring the member comprehends the content of the notice before obtaining the signature, should explain the notice if necessary and be able to answer any questions about the notice. Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable.

If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for contacting the representative by telephone to advise him or her of the appeal rights, or, if agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements).

Prior to discharge (but not more than two (2) days in advance of discharge), the hospital must deliver an additional copy of the signed notice to the member or representative in person. If the notice is provided on the day of discharge, the member must be given at least four (4) hours to consider his or her rights and to request a QIO review. It is recommended the hospital not provide the notice on the day of discharge.

If the member requests additional information regarding their discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two (2) calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice. This must occur, by midnight of the day of discharge, either verbally or in writing, before the person leaves the hospital.

Provider Obligations — In-Office Denials

There may be situations where a member disagrees with the provider's decision regarding a request for service or a course of treatment. At each patient encounter with a Medicare member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from CHRISTUS Health Plan Generations regarding the member's services.

The provider's notification must provide the member with the information necessary to contact Medicare. If a member or provider requests the Plan to provide a detailed notice of a

provider's decision to deny a service in whole or part, the Plan must give the member a written notice of the determination.

Provider Obligations – Precertification
Providers are responsible for obtaining precertification from CHRISTUS Health Plan and for submitting the adequate required information before performing certain procedures or when referring members to non-contracted providers. Please refer to the Summary of Benefits document for those procedures that require precertification or call Member Services.

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans will render a determination on the request within the appropriate time-frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans and the provider will not generate a member denial letter.

An initial organization determination is any determination (e.g. an approval or denial) made by CHRISTUS Health Plan Generations for coverage of medical services (Part B-covered services).

An initial coverage determination is any determination (e.g., an approval or denial) made by CHRISTUS Health Plan Generations for coverage of prescription drugs (Part D-covered services).

Provider Obligations – Appeals (Both Member and Provider Appeals)
Providers must cooperate with CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans and with members in providing necessary information to resolve the appeals within the required time frames. Providers must deliver the pertinent medical records and any other relevant information upon request and when initiating an appeal.

In some instances, providers must provide the records and information very quickly in order to allow CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans to make an expedited decision. The provider's participation in and the member's election of the Medicare Advantage Plan are an indication of consent to release those records as part of the health care operations.

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

Provider Complaints and Appeals

Medicare Health Plans, which include Medicare Advantage (MA plans), must meet the requirements for grievance and appeals processing under the Medicare Advantage regulations. All participating providers have agreed to comply with the plan's dispute resolution process by signing the provider agreement. The provider dispute process is available to any participating provider to resolve disputes with the Plan.

The Plan distinguishes disputes by the following categories:

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

Administrative Claim and Utilization Review Disputes to HMO
CHRISTUS Health Plan Generation will make every effort to resolve provider dispute inquiries using consistent procedures for reviewing and responding to inquiries.

Dispute reviews will be completed within sixty (60) days of receipt of the request. A provider dispute must be sent in writing to:

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO)
Attn: Claims Dispute
P.O. Box 169009
Irving | Texas 75016

All requests must be submitted for review within sixty (60) days of an action taken or decision made by CHRISTUS Health Plan Generations. For any dispute involving a denied claim, the sixty (60) day period begins on the date of the CHRISTUS Health Plan Generations remittance reflecting the denial.

For any dispute related to a claim audit, the sixty (60) day period begins on the date of the notice to the provider. CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans will forward the provider request to the appropriate area for research and resolution. When appropriate, the Medical Director will review the matter using appropriate peer input. Providers will receive a payment or written response generally within sixty (60) calendar days describing how their request was resolved.

Competence or Conduct Disputes and Appeals to HMO

Providers may file a non-administrative dispute that involves actions by the Plan that relate to a participating provider's status within the Plan's provider network and any action by the Plan related to a participating provider's professional competency or conduct. A competence or conduct provider dispute or appeal with CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans can only be requested in writing.

Participating providers have the right to appeal their dispute to two (2) separate panels above the level of the Plan body involved in the dispute, each consisting of at least three (3) qualified individuals, of which at least one (1) must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. Panel members who have previously been involved with the issue will not be assigned to the case.

A panel will be convened within sixty (60) days of the request and the decision will be returned to the participating provider within thirty (30) days of the closure of the panel. When an adverse action is taken or if the provider voluntarily relinquishes participation while undergoing investigation and/or peer review, it is noted in the Credentialing File and reported if required by law.

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

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

Non-Participating Medicare Provider Complaints and Appeals

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal or dispute a denial issued by the Plan. A non-participating provider appeal or dispute with CHRISTUS Health Plan Generations can only be requested in writing. CHRISTUS Health Plan Generation (HMO), Generations Plus (HMO) and Guardian (HMO) plans will issue a written acknowledgement letter on appeals and complaints within five (5) days and complete the review within sixty (60) days of receipt of the request.

All appeals and dispute requests from non-participating providers must be submitted to CHRISTUS Health Plan within sixty (60) calendar days from receipt of the Explanation of Payment (EOP) or denial letter issued by the Plan, unless a written request for filing time extension, noting good cause for delay, is submitted with the appeal or dispute request. A signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal or dispute must be included with the request. This form is located on the CMS website, cms.gov.

Appeals and dispute request with a missing or invalid Waiver of Liability form will not be reviewed until form | documentation is obtained from the non-participating provider. Some examples of claims that will be resolved through the appeal process:

- Denials result in zero payments (note member's responsibility does not constitute a payment).
- Partial paid claims with medical necessity denials.
- Medical necessity determination.
- Claims that involve partial or full financial recovery.

Some examples of claims will be resolved through the dispute process:

- Partial payments (note member's responsibility does not constitute a payment).
- Underpaid or overpaid claims.
- All other issues not related to medical necessity denials.

Providers are required to respond to requests for additional information within thirty (30) days of receipt of the request. In some instances, providers must provide the records and information very quickly in order to allow CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans to make an expedited decision.

Expedited inquiries should be directed via phone at **844-282-0380** or via fax at **866-416-2840**.

Standard inquiries must be mailed or faxed to:

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO)
Attn: Appeal and Grievance Department
P.O. Box 169009
Irving | Texas 75016
Fax: 866-416-2840

If CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans upheld or partially overturned the appeal request, it will submit a written explanation with the complete case file to the independent review entity (MAXIMUS Federal Services) contracted by CMS, no later than:

- For **expedited appeals** - no later than 24 hours from the date the Plan issue the expedited organization determination.
- For **standard post-service appeals** - no later than sixty (60) calendar days from the date the Plan receives the request for reconsideration.
- For **standard pre-service appeals** - no later than thirty (30) calendar days from the date the Plan receives the request for reconsideration.

Non-contracted providers that have exhausted the CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans internal dispute system and continue to believe they have been underpaid may contact CMS at **800-MEDICARE** and file a complaint that will be processed through the Complaints Tracking Module (CTM) in

addition to taking other action the provider deems appropriate. (**Note**: CMS does not offer advice to providers on their potential rights or options in a payment dispute with a plan.)

Member Grievances and Appeals

The Plan encourages members to resolve individual inquiries and concerns or problems at the point of service. In the event a member's grievance, complaint or 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 or office, or the services provided within ten (10) days of the receipt of the grievance.

Member Grievances to HMO

A grievance is defined as any complaint related to dissatisfaction expressed by telephone or in writing by a member or on behalf of a member, concerning CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans. The definition of complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clarifying the misunderstanding or supplying the appropriate information to the member's satisfaction. A complaint does not include an oral or written dissatisfaction with an adverse determination or appeals regarding claim payments and denials.

Below are some examples of problems typically dealt with through the plan grievance process:

- Problems getting an appointment, or having to wait an extended time for an appointment.
- Disrespectful or rude behavior by doctors, nurses or other clinic or hospital staff.

Complaints should be filed within sixty (60) calendar days from the complaint occurrence date. CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans will issue a written acknowledgement letter on complaints within five (5) days and complete the complaint within thirty (30) days of receipt of the request.

Expedited grievances will be reviewed within 24 hours whenever CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans extends the time frame to make an organization determination or reconsideration; or when the Plan refuses to grant a request for an expedited organization determination or reconsideration.

Members can contact CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) Plan Member Services at **844-282-3026** to file an oral complaint. Written complaints can be sent to:

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO)
Attn: Appeal and Grievance Department
P.O. Box 169009
Irving | Texas 75016
Fax: 866-416-2840

Member Appeals to HMO

Members and their providers will be notified by mail for any services or supplies that have been denied by CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans. Standard and expedited appeals may be submitted to the Plan for review.

Appeals must be filed within sixty (60) days following the CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans denial notification. Requests that involve emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized patients must be filed as quickly as possible following the CHRISTUS Health Plan denial notification.

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans will issue a written acknowledgement letter on standard appeal within five (5) days and complete the appeal within sixty (60) days for (internal organization determination); within seven (7) days for (adverse coverage determination). Pre-service appeals will be completed within thirty (30) days from receipt of the request.

Expedited appeals for initial organization determination and adverse coverage determination will be completed as quickly as the medical condition requires, and no later than seventy-two (72) hours from the time the internal review request was received.

For expedited appeals, members must call **844-282-0380** and fax all related information to **866-416-2840**. Standard appeals must be mailed or faxed to:

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO)
Attn: Appeal and Grievance Department
P.O. Box 169009
Irving | Texas 75016
Fax: 866-416-2840

Further Member Appeal Rights

If the Plan is unable to reverse the original denial decision in whole or part, the following additional steps will be taken. CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plans will forward the appeal to an Independent Review Entity (IRE) contracted with the federal government. The IRE will review the appeal and make a decision:

- Within seventy-two (72) hours if expedited.
- Within thirty (30) days if the appeal is related to authorization for health care.
- Within sixty (60) days if the appeal involves reimbursement for care.

If the IRE issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Council refuses to hear the case or issues and adverse decision, the member may be able to appeal to Federal court.

Medicare Member Liability – Appeal Time Frame Table
Medicare member appeals have standard and expedites processes per the table below:

Type of Appeal	Provider Timeline for Submission	Applies to	Appeal Review	Standard Turnaround Time	Expedited Turn Around Time
Payment	Sixty (60) calendar days from EOP	Denied payment for a service already received	CHRISTUS Health Plan Generations	Within sixty (60) calendar days	Not available
Service	Sixty (60) calendar days from denial letter	Denied request for a health service not already received	CHRISTUS Health Plan Generations	Within thirty (30) calendar days	Within seventy-two (72) hours
Prescription Drugs	Sixty (60) calendar days from denial letter	Denied request for a prescription drug not already received	CHRISTUS Health Plan Generations (not applicable for Guardian HMO plans)	Within seven (7) calendar days	Within seventy-two (72) hours
Discontinuation of SNF, HHA, or CORF services		Discontinuation of SNF, HHA, CORF services previously approved and no longer determined to be medically necessary (does not apply to pre-services or benefits denials)	Appeals should be lodged as per the denial letter issued to the appropriate QIO within the applicable time frame. The QIO will provide an immediate review. If the time frame has been missed, the appeal can be lodged with CHRISTUS Health Plan Generations, which will review the request as expedited (within 72 hours).		
Discontinuation of inpatient hospital care		When a Medicare member receives the "Important Message from Medicare" when being discharged from the hospital.			

Part D Prescription Drugs

The CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) Medicare plans include coverage of Medicare Part D prescription drugs (Part D coverage is not applicable for Guardian HMO plan). All plans include drug coverage under Medicare Part B.

The following chart depicts the pharmacy related services provided by CHRISTUS Health Plan, the entity responsible for providing or addressing questions regarding the service, as well as the contact information:

Pharmacy-Related Service	Performed by	Notification	Contact Information
Part D Prescription Drug Mail Order	ESI	Pharmacy Dept.: Pharmacy Help Desk: Fax:	844-470-1531 800-922-1557 877-329-9760
Coverage Determination	ESI	Standard Coverage Review: Expedited Coverage Review:	800-935-6103 800-935-6103
Formulary Exceptions	ESI	Coverage Review:	800-935-6103
Medication Therapy Program	ESI	Pharmacy Dept.: Pharmacy Help Desk: Fax: Website:	844-470-1531 800-922-1557 877-329-3760 ChristusHealthPlan.org
Covered Vaccines Under Part B	CHRISTUS	Member Services: Website:	844.282.3026 ChristusHealthPlan.org
Covered Vaccines Under Part D	ESI	Fax: Mail:	608-741-5483 Express Scripts ATTN: Med. D Claims PO Box 2858 Clinton | IA 52733-2858

Pharmacy claims are processed by Express Scripts (ESI), the Plan's pharmacy benefit management vendor. Medicare Part D prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Part D covered prescription drugs are listed in the CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans Medicare formulary. The formulary includes all generic drugs covered under the Part D program, as well as many brand-name drugs, non-preferred brands and specialty drugs.

The Medicare Part D formularies are reviewed by a Pharmacy & Therapeutics Committee composed of providers and pharmacists who have been approved by the Centers for Medicare & Medicaid Services (CMS). Providers can view a copy of the formulary on the CHRISTUS Health Plan website.

Some of these drugs have precertification or step-therapy requirements or quantity limits, defined as:

- Prior Authorization (PA): CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans requires the provider to get prior authorization before the drug will be approved for coverage.
- Quantity Limits (QL): For certain drugs, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans limits the amount of the drug it will cover for a given duration of time (i.e. 30 pills every 30 days).
- Step Therapy (ST): In some cases, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans requires trial and failure of certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a patient's medical condition, the Plan may not cover drug B unless they try drug A first. If drug A does not work for the patient, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans will then cover drug B.

The following chart depicts the member's drug coverage and financial responsibility based on the stage of coverage:

Stage 1 Yearly Deductible Stage	Stage 2 Initial Coverage Stage	Stage 3 Coverage Gap Stage	Stage 4 Catastrophic Coverage Stage
There is no deductible for the 2023 plan year. You begin in the initial Coverage Stage when you fill your first prescription of the year.	You stay in this stage until your year-to-date "total drug costs" total $4,660. Medicare sets this amount and rules for counting costs toward this amount. If you reach this amount, you leave the initial coverage stage and move into the Coverage Gap Stage.	During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% for the price of generic drugs. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,400. Medicare sets this amount and rules for counting costs toward this amount.	During this stage, the Plan will pay most of the cost of your drugs for the rest of the calendar year (through Dec. 31). The greater of: 5% of cost of the drug, or $4.15 copay for generics, $10.35 for all other drugs.

Prescription Drugs by Mail Order

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the provider must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to fourteen (14) business days for the prescription to be filled and mailing. It is recommended to have an emergency prescription at retail while the initial mail order prescription is being filled. For refills of the same prescription, members should allow up to 7-10 days for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call 844-470-1531. They will assist with obtaining an emergency supply of the member's medication until he or she receives the new supply.

The following chart depicts the member's copayments at each Tier:

	Standard retail cost-sharing (in network) (up to a 31-day supply)	Mail order cost-sharing (up to a 90-day supply)	Long-term care (LTC) cost-sharing (up to a 34-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations) (up to a 31-day supply)
Tier 1 (Preferred generic)	$4	$0	$4	$4
Tier 2 (Generic)	$10	$0	$10	$10
Tier 3 (Preferred brand)	$47	$47	$47	$47
Tier 4 (Non-preferred brand)	$100	$100	$100	$100
Tier 5 (Specialty)	33% coinsurance	Not Covered	33% coinsurance	33% coinsurance

Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Antiemetic drugs administered within 48 hours of chemotherapy.
- Certain oral cancer medications.

- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump in the home.
- Erythropoietin for individuals undergoing chronic renal dialysis.
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant.
- Injectable medications provided incidental to a provider's service.
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract.

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a provider's service require precertification from CHRISTUS Health Plan.

Covered Vaccines – Part B
Medicare Part B benefits include the following routine immunizations:

- Hepatitis B vaccine
- Influenza virus vaccine
- Pneumococcal pneumonia vaccine

Claims for Medicare Part B benefits should be submitted to CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans for processing and reimbursement.

Covered Vaccines – Part D
Medicare Part D generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans Medicare Formulary located online at ChristusHealthPlan.org.

Providers who do not have access to a vaccine on the formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to ESI for processing and reimbursement.

Covered Vaccines – Part B or Part D
Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D.

Vaccines that may be Part B or Part D are:

- Anthrax vaccine
- Hepatitis A vaccine
- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or

prevention of an illness) on a CMS 1500 claims form and submit to CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans.

Additional information is available on the CMS website under the Medicare Learning Network General Information page.

A coverage determination is any decision CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans makes regarding:

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

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

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

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

Formulary Exceptions

If a prescription drug is not listed in the CHRISTUS Health Plan Generations (HMO) Generations Plus (HMO) plans formulary, you can look up the drug information using the Online Searchable Formulary for Generations (HMO) or Online Searchable Formulary for the Generations Plus (HMO) plans link on the CHRISTUS Health Plan website. You can also look up the drug information on the Express Scripts website. The website formulary is updated frequently with any changes.

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

- The prescribing provider can prescribe another drug that is covered on the formulary.
- The patient or prescribing provider may ask the Plan to make a formulary exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a non-formulary drug and requests a formulary exception and the Plan approves, CHRISTUS Health Plan will reimburse the member minus the

appropriate copay for Tier 4. If the exception is not approved, the member may appeal the Plan's denial.

In some cases, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans will contact a member who is taking a drug that is not on the formulary or their prescribing provider and will give the member or prescribing provider the names of covered drugs used to treat the member's condition. The member and/or prescribing provider will be encouraged to evaluate if any of those covered drugs would be appropriate options for treatment.
Also, members who recently joined the Plan may be able to get a temporary supply of a drug they are taking if the drug is not on the CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans formulary.

Transition Policy
New members in CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) Medicare Advantage Plans may be taking drugs not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to determine if they should take a different medication that the Plan covers or request a formulary exception in order to get coverage for the drug.

During the period of time members are talking to their providers to determine the appropriate course of action, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans may provide a temporary supply of the non-formulary drug if those members need a refill during the first ninety (90) days of new membership in the Plan.

For current members affected by a formulary change from one year to the next, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans will provide a temporary supply of the non-formulary drug for members needing a refill for the drug during the first ninety (90) days of the new Plan year.

When a member goes to a network pharmacy and CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits (but is otherwise considered a Part D drug), the Plan will cover at least a one time, thirty (30) day supply (unless the prescription is written for fewer days). CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans will provide the member with a written notice if it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing provider to decide if switching to an appropriate formulary drug is an option.

If a new member is a resident of a long-term care facility (like a nursing home), CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans will cover a temporary thirty-one (31) day transition supply (unless the prescription is written for fewer days). If

necessary, the Plan will cover more than one refill of these drugs during the first ninety (90) days a member is enrolled in the Plan.

If the member has been enrolled in the Plan for more than ninety (90) days and needs a drug not on the formulary or is subject to other restrictions such as step therapy or dosage limits, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans will cover a temporary thirty-one (31) day emergency supply of drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current Medicare members who experience a change in their level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the non-formulary drug for up to thirty-one (31) days. An exception would be made if the prescription is written for fewer days. Please note the CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans transition policy applies only to those drugs that are Part D drugs.

To inquire about the status of a drug on the formulary, visit express-scripts.com.

Medication Therapy Management Program (MTMP)

As a Medicare Part D Sponsor, CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans must establish a Medication Therapy Management Program (MTMP) that:

- Is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries are appropriately used to optimize therapeutic outcomes through improved medication use.
- Is designed to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries.
- Is developed in cooperation with licensed and practicing pharmacists and physicians.
- May be furnished by pharmacists or other qualified providers.
- May distinguish between services in ambulatory and institutional settings.
- Is coordinated with any care management plan established for a targeted individual under a chronic care improvement program (CCIP).

Who May Qualify

Enrollees in the Sponsor's Part D Plan who:

- Have multiple chronic diseases AND
- Are taking multiple Part D drugs AND
- Are likely to incur annual costs of at least $4,935 for all covered Part D drugs (predetermined level specified by CMS).

Additional Expectations for CMS

- Once enrolled in the MTMP, a beneficiary will remain enrolled in MTMP for the remainder of the calendar year.

- Plan's MTMP will serve and provide interventions for beneficiaries who meet all three of the required criteria as defined above regardless of setting (i.e. ambulatory, long term care, etc.).
- The Plan will safeguard against discrimination based on the nature of your MTMP interventions (i.e. TTY if phone based, Braille if mail based, etc.).

How the CHRISTUS Health Plan Generations (HMO) and Generations Plus (HMO) plans MTMP Works
MTMP includes, but is not limited to the following elements:

- Enhanced enrollee understanding through beneficiary education counseling or other means that promote the appropriate use of medications and reduce the risk of potentially adverse events associated with the use of medications.
- Increased enrollee adherence to prescription medication regimens (for example, through medication refill reminders, special packaging, compliance programs and other appropriate means).
- Detection of adverse drug events and patterns of over use and under use of prescription drugs, therapy gaps or drugs that pose potential risks in the elderly.

As part of the MTMP, prescription claims are pre-reviewed and notification is sent to the enrolled patient's primary care provider (and other different providers involved in the patient's care) advising of possible drug therapy problems.

***Note: Part D coverage is not applicable for Guardian (HMO) plan**

Claims, Encounters and EDI Transactions

Claim Submissions

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

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

- Be submitted electronically or by paper to the billing address as directed on the back of the Members ID card. The claim must not involve an investigation for coordination of benefits (COB), member eligibility, or subrogation.
- Separate charges must be itemized on separate lines and medical record documentation must validate the scope of the services provided and billed.
- Be submitted according to the timely filing section of their respective participating provider agreement. CHRISTUS Health Plan Generations will bear no liability to pay claims received after the timely filing deadline is exceeded and members cannot be balance billed for provider's failure to submit claims within their contracted timeframe.
- Include AMA-developed procedural coding.
- Include ICD-10 diagnosis coding to the highest specification.
- Be submitted on original red and white CMS 1500 or UB-04 forms when filing paper claims. (*Black and white copies or faxes will not be accepted*).
- Not be handwritten.

Note: Claims must be paid within thirty (30) days of receipt.

Electronic Data Interchange (EDI) Routing

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

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

Providers are asked to direct all inquiries regarding electronic file exchange set up for HIPAA-compliant transactions to their local assigned Provider Relations Representative, or they may call Provider Services.

Clearinghouse

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

Electronic Claims Submissions (837)

- For submission of 837s, providers are to use Payor ID: 10629.
- The Plan is listed as CHRISTUS Health Medicare Advantage.
- Providers should ensure they have a valid NPI on file with the Plan.

Electronic Provider Remittance Advice (835)

- The EDI Form should be completed and sent to CHPEDIAlerts@christushealth.org
    - For group providers, submit a form for each provider associated with the group.
    - For ancillary providers or facilities, submit a form for each location.
- Once set up, the providers billing service | clearinghouse will receive email notification.

Electronic Enrollment Status (270)

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

Electronic Claim Status (276)

Providers can obtain electronic claims status (276/277) through Change Healthcare. Providers should ensure both their NPI 1 and NPI 2 (if applicable) are captured in the Plan's system.

Guidelines for Filing Clean Claims

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

Paper claims should be submitted to the following address:

CHRISTUS Health Plan Medicare Advantage
PO Box 981651
El Paso | TX 79998-1651

Claims Filing Deadlines

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

Providers must claim benefits by sending CHRISTUS Health Plan properly completed claim forms itemizing the services or supplies received and the charges. The Plan will not be liable for benefits if the Plan does not receive the completed claim forms prior to the timely filing deadline.

Claim Corrections

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

Checking the Status of a Claim

Providers can check the status of a claim by calling Provider Services or by going to the Provider Portal online at CHRISTUSHealthPlan.org/Providers.

Claims Payment Explanation of Payment (EOP)

An Explanation of Payment (EOP) is a summary statement included with the check to the provider, which lists the services, amounts billed, denials, adjustments and payment for one or more claims. CHRISTUS Health Plan uses system generated message codes to communicate with the providers on their EOP. These event codes are used to further explain claim payments, adjustments or denials. Please contact Member Services or a Provider Engagement Consultant for with your Explanation of Payment.

Electronic Encounter Data Submission

CHRISTUS Health Plan accepts encounter data electronically or via paper.

Claims Overpayments and Withholds

Should CHRISTUS Health Plan determine that it has overpaid a claim, CHRISTUS Health Plan will submit a written refund request to the provider. This request will include the patient's name, date(s) of service, amount of overpayment, all interest and/or penalties associated with the overpayment, and an explanation of how CHRISTUS Health Plan determined an overpayment had been made.

Upon receiving this request, the provider must issue the refund or submit a clear, written explanation of why the refund request is being contested within forty - five (45) calendar days of the date the notice of overpayment was received. If the provider contests the refund

request, the provider must identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

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

CHRISTUS Health Plan Generations (HMO), Generations Plus (HMO) and Guardian (HMO)
Attn: Claims Recovery Unit
P.O. Box 169001
Irving | Texas 75019-9001

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

Coordination of Benefits (COB) and Third-Party Liability (TPL)

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

Other third parties may be responsible for payment under automobile, liability or worker's compensation insurance. If a primary insurance has made payment or denied a claim, the EOP from the primary carrier must be included with the claim's submission to CHRISTUS Health Plan. Timely filing of the claim and EOP from the primary carrier starts 120 days from the date of the EOP from the primary carrier. Providers are required to identify on the claim form when other insurance is involved. Please note on the CMS 1500 claim form, Block 9 and 10 and UB-04 claim form blocks 50-51 and 58-62.

Reimbursement Methodologies

Reimbursement Fee Schedules

Covered Services are reimbursed in accordance with the reimbursement schedule in your Participating Provider Agreement. Please refer to your Participation Provider Agreement if you have questions regarding your reimbursement. You may contact Provider Services should you need further assistance.

Copayments

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

Integrity | Compliance

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

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

Safety

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

Quality Care

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

Accurate Recording and Reporting

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

Accurate and Appropriate Claims

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

Protection of Privacy

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

Ethical Practices

- Will 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.
- Respect and support the rights of all health Plan associates ensuring a zero - tolerance policy toward any potential member abuse (verbal or physical).
- Strive for excellence in quality of care and service provided to all served, regardless of race, color, religion, gender, orientation, disability, age or national origin.
- Clearly explain care, treatment and services to the member and family so that informed consent can be obtained. Explanation of treatment must include:
    - Likelihood of success
    - Possible results of non - treatment
    - Potential benefits and drawbacks
    - Potential problems related to recovery
    - Significant alternatives

Risk Management

CHRISTUS Health Plan maintains a risk management program designed to protect the life and welfare of members and employees. The risk management plan has the following characteristics:

- The risk management plan is approved by the governing body, and has coordination between the risk management activities and the quality improvement activities and initiatives
- The risk management program accounts for member safety and other critical issues
- Policies and procedures regarding a member being refused care of dismissed from care, and the management of impaired healthcare professionals
- Procedures to report and analyze member care delivery episodes, such as trauma death, or any other adverse incidents
- Periodic review of litigation matters that involve the organization, personnel, or other related healthcare professionals
- Review of member complaints and grievances
- Benefit coverage availability after regular business hours
- The prevention of unauthorized prescribing, and monitoring to prevent fraud, waste and abuse

- Clinical record audits and incorporation of audit results into the re-credentialing process
- Risk management education and training to all staff and communications of risk management program information to the provider network

Fraud, Waste or Abuse (FWA)

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

Special Investigations Unit: Governing agencies and regulatory bodies require CHRISTUS Health Plan (CHP) to staff a Special Investigations Unit (SIU) to detect, investigate, prevent, and deter fraud, waste, and abuse (FWA), involving Providers or Members within the CHRISTUS Health Plan network, and Non-Participating Providers who submit claims. The SIU uses automated data analysis tools, and proactive measures to evaluate post payment of claims, to verify compliance with the CHRISTUS Medical management standards, and federal and state laws. To advocate for the highest proper specialist, at the right time, for the appropriate duration, in the most suitable location, at a reasonable cost. Reasonable cost is determined by fee schedules, or by CHRISTUS Health Plan. If these standards are not followed, there is a high likelihood Members will experience an unfavorable impact, payments for preventable costs, and violation of criminal laws, civil codes and statues.

Investigations: The Special Investigations Unit (SIU) promptly and thoroughly investigates all reports of fraud, waste, and abuse (FWA) to detect if non-compliance is occurring, and details findings in a case report. Investigations may include claims data analysis, reviewing medical records, peer to peer comparisons, audits, interviews, surveillance, and other activity deemed necessary. When non-compliance is suspected, a referral is sent to all relevant agencies. When non-compliance occurs, CHRISTUS Health Plan will recoup paid claims revenue.

Examples: Issues and patterns considered non-compliant, which may be considered fraud, waste or abuse (FWA).

#	ISSUE	DESCRIPTION OF PATTERNS
1)	MEDICAL NECESSITY	Treatment, services or equipment not medically necessary, or extended duration, etc.
2)	BILLING	Overcharging, double billing, disguising codes, upcoding, non-covered services, etc.
4)	NON-COMPLIANCE	Not furnishing records requests, inadequate records, suspended license / convictions, etc.

Enforcement:
There are several possible outcomes for Provider non-compliance, which include one or more of the following:

1) Provider Education and Counseling
2) Formal Written Warning

3) Recoupment of Overpayments
4) Corrective Action Plan
5) Temporary Suspension from Billing and Treatment of CHP Members
6) Termination of Provider Contract and from the CHP Network
7) Referral to Law Enforcement Federal, State and local law enforcement agencies

Reporting Possible FWA or Provider Non-Compliance to CHRISTUS – Can be anonymous, if preferred. Please make a report if your suspect non-compliance involving a Provider or Member. Please contact the Special Investigation Unit (SIU) and describe your observations and experiences, so a representative will contact you to gather more details. If preferred, you may remain anonymous and will not be contacted. The options for reporting are:

- **FWA HOT LINE: 855-771-8072**
- Dedicated email: CHRISTUSHealthPlanSIU@CHRISTUSHealth.org
- Secure Fax: **210-766-8849**
- Mail: CHRISTUS Health Plan,
  Special Investigations
  919 Hidden Ridge Drive
  Irving | Texas 75038

Laws – Tip Five Fraud, Waste And Abuse Laws
The five most important Federal fraud and abuse laws that apply to physicians are the False Claims Act (FCA), the Anti-Kicked Statue (AKS), the Physician Self-Referral law (Stark Law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL). Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. As you begin your career, it is crucial to understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the Federal health care programs, or loss of your medical license from your State of medical board.

False Claims Act [31 U.S.C. §§ 3729–3733]
The civil FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claims filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law.

Anti-Kickback Statue [42 U.S.C. § 1320a–7b(b)]
The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for

Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

The Government does not need to prove patient harm or financial loss to the programs to show that a physician violated the AKS. A physician can be guilty of violating the AKS even if the physician actually rendered the service and the service was medically necessary. Taking money or gifts from a drug or device company or durable medical equipment (DME) supplier is not justified by the argument that you would have prescribed that drug or ordered that wheelchair even without a kickback.

Physician Self-Referral Law [42 U.S.C. §§ 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referral imaging services.

For more information, see CMS's Stark law Web site

Exclusion Statue [42 U.S.C. §§ 1320a–7]

OIG is legally required to exclude from participation in all Federal health care program individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances. OIG has discretion to exclude individuals and entities on several other grounds.

For more information, see Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs. For more information, see OIG's exclusion Web site.

Civil Monetary Penalties Law [42 U.S.C. § 1320a–7a]

OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation. Some examples of CMPL violations include: presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent, violating the AKS, providing false or misleading information expected to influence a decision to discharge, making false statements or mispresentations on applications or contracts to participate in the Federal health care programs.

Enforcement And Whistle –Blower Referrals:

CHRISTUS Health Plan utilizes all available enforcement tools, and techniques, to recover paid for fraudulent, wasteful, and abusive healthcare claims, including

offering full cooperation with law enforcement actions taken against fraudulent healthcare Providers. Report FWA to CHRISTUS Health Plan via the FWA HOT LINE 855-771-8072. Anonymous reports are accepted.

Website Resources

CHRISTUS Health Plan's website, CHRISTUSHealthPlan.org, offers a variety of tools to assist providers and their staff.

Available sources include:

- Case Management and Disease Management services
- Complaints and Appeals services
- Continuity of care criteria
- Forms and documents
- Guidelines to make clinical decisions
- Informative newsletters
- Member rights and responsibilities
- Pharmacy and provider directories
- Privacy statement and notice of privacy practices
- Quality measures
- Quick reference guides
- Fraud, Waste and Abuse and potential non-compliance reporting information
- Annual Member and Provider Satisfaction scores
- Training materials and job aids
- Utilization management services includes updates about authorization processes
- Policies and Procedures

Glossary of Terms

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

Advance Beneficiary Notice of Non-Coverage (ABN): A written notice a provider gives to a Medicare beneficiary before items or services are furnished when the provider believes Medicare probably or certainly will not pay for some or all of the items or services.

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

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

Ambulatory Care: Medical care delivered on an outpatient basis. Many medical conditions do not require hospital admission and can be managed without admission to a hospital. (i.e. an Ambulatory Surgery Center is an outpatient surgery facility.)

Annual Enrollment Period (AEP): A set time each fall when members can change their health or drugs plans or switch to Original Medicare. AEP takes place from Oct. 15 until Dec. 7.

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

Balance Billing: The practice of billing a patient for the fee amount remaining after insurer payment and co-payment have been made. HMO providers and Medicare providers are generally prohibited by their contract from balance billing members for covered services.

Beneficiary: A recipient of insurance benefits.

Benefit Period: The way that both our Plan and Original Medicare measures the use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day a member goes into a hospital or skilled nursing facility. The benefit period ends when the member has not received any inpatient hospital care (or care in a SNF) for 60 days in a row. If a member goes into a hospital or a SNF after one benefit period has ended, a new benefit period begins. Members must pay the hospital and SNF copayments for each benefit period. There is no limit to the number of benefit periods.

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

Centers for Medicare and Medicaid Services (CMS): The agency within the Department of Health and Human Services which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Certificate of Creditable Coverage: A written statement from a prior Health Plan documenting the length of time an enrollee was covered.

Claim: A notification to the insurance company that payment is due under the policy provisions; a medical bill.

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

Clean Claim: A claim submitted by a provider or provider for medical care or health care services rendered to a Member, with the data necessary for the Managed Care Organization (MCO) or subcontracted claims processor to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837- (claim type) encounter guides as follows:

- 837 Professional Combined Implementation Guide;
- 837 Institutional Combined Implementation Guide;
- 837 Professional Companion Guide; and
- 837 Institutional Companion Guide.
- National Council for Prescription Drug Programs (NCPDP) Companion Guide.

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

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

Coinsurance: The percentage of allowed charges for covered services for which the member is responsible for payment.

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

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including provider's services, physical therapy, social or psychological services, and outpatient rehabilitation.

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

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

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

Cost-sharing: Cost-sharing refers to amounts a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments:

- Any deductible amount a plan may impose before services or drugs are covered;
- Any fixed copayment amount a Plan requires when a specific service or drug is received;
- Any coinsurance amount a Plan requires when a specific service or drug is received.

Coverage Determination: A decision about whether a drug prescribed is covered by the Plan and the amount, if any, the member is required to pay for the prescription.

Covered Drugs: The term used to mean all of the prescription drugs covered by Plan.

Covered Services: All of the health care services and supplies covered by the Plan.

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

Creditable Prescription Drug Coverage: Prescription drug coverage (for example, from an employer or union) is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep the coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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

Current Procedural Terminology (CPT): A set of codes used for medical services and procedures to standardize claims processing and data analysis.

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

Deductible: The amount members must pay for health care or prescriptions before the health plan begins to pay.

Denial: Refusal to approve services or payment to a provider for covered or non-covered services under a member's benefit Plan.

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

Diagnosis: The nature of a disease; the identification of an illness represented on a medical claim by an ICD-10 code since 09/01/2015.

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

Disease Management: A coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition.

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

Donut Hole: This refers to a coverage gap within the defined standard benefit under the Medicare Part D prescription drug program. Under the defined standard benefit package, there is a gap in coverage between the initial coverage limit and the catastrophic coverage threshold. Within this gap, the beneficiary pays 100% of the cost of prescription drugs before catastrophic coverage kicks in.

Drug Formulary: Varying lists of prescription drugs approved by a given Health Plan for distribution to a covered person through specific pharmacies.

Durable Medical Equipment (DME): Equipment that is purchased or rented and can withstand repeated use. DME primarily and customarily used to serve a medical purpose rather than convenience or comfort. DME is generally is not useful to a person in the absence of an illness or injury. DME is appropriate for use in the home as prescribed by a provider. All requirements of the definition must be met before an item can be considered durable medical equipment. DME includes, but is not limited to, items such as standard oxygen delivery systems, hospital bed, wheelchair, walker or any other items determined to be medically necessary.

Durable Power of Attorney: A power of attorney which remains (or becomes) effective when the principal becomes incompetent to act for themselves.

Effective Date: Date in which an insured becomes eligible for benefits; policy start-date.

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

Eligibility Verification: Confirmation of a member's eligibility status within a health plan at the time of service.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, would lead a prudent layperson possessing an average knowledge of medicine and health to believe his or her condition, sickness, or injury is of such a nature 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 as in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Enrollee: A person enrolled in the Health Plan (insured, member, subscriber).

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

Evidence of Coverage (EOC): The document that explains the covered services, defines obligations, and explains rights and responsibilities as a member of the Plan.

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

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

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

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

Fee Schedule: A list of charges (or allowances) for specific procedures and services.

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

Formulary: See Drug Formulary.

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

Grievance: Any complaint or dispute expressing dissatisfaction with the manner in which the Plan or delegated entity provides health care services, regardless of whether any action can be taken.

Health Employer Data and Information Set® (HEDIS): A set of HMO performance measures maintained by the National Committee for Quality Assurance (NCGA). HEDIS data is collected annually and provides an informational resource for the public on issues of Plan quality.

Health Insurance Portability and Accountability Act (HIPAA): The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced: to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to

simplify the administration of health insurance; and for other purposes. This act protects privacy and regulates the use of protected health information.

Health Maintenance Organization (HMO): An entity that provides, offers, or arranges for comprehensive health care coverage of designated health services needed by members for a fixed, prepaid premium.

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

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

Home Health: Health care services and/or skilled care received in the home for those that are immobile and/or homebound.

Hospice: Care given to someone expected to live less than six months due to a terminal disease or condition. Hospice care is given at home or in a hospice center. It is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

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

ICD-10: This is the universal coding method used to document the incidence of disease, injury, mortality and illness. This system is used to group patients into DRGs, prepare hospital and provider billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

In-Area or In-Network: Services received in the member's Plan-designated service area.

Inpatient: A patient who is admitted to a hospital or clinic for treatment that requires at least one overnight.

Insurance: A contract between one party and another. The policy states what types of losses are covered, what amounts will be paid for each loss and for all losses, and under what conditions.
Limits: Quantity or monetary thresholds associated with a particular benefit.

List of Covered Drugs (Drug Formulary or Drug List): A list of prescription drugs covered by the Plan. The drugs on this list are selected by the Plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

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

Low Income Subsidy (LIS) or Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Malpractice Liability Coverage: Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the patient prove some injury and that the injury was the result of negligence on the part of the professional. A practitioner is liable for damages or injuries caused by malpractice.

Maximum Out-of-Pocket Amount: The most that members pay out-of-pocket during the calendar year for in-network covered Plan services. Amounts members pay for Plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount.

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Medicaid (or Medical Assistance): A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources.

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

Medically Necessary: A treatment, drug, device, procedure, supply or service that is considered necessary and appropriate for the diagnosis or treatment of an illness or injury in accordance with generally accepted standards of medical practice in the United States at the time provided. A treatment, drug, device, procedure, supply or service not considered as Medically Necessary if it:

- Is Experimental, Investigational or Unproven or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Physician, Hospital, or any other Provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;

- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Does not apply to cancer chemotherapy or other types of therapy that are subjects of on-going phase IV clinical trials;
- Involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- Involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

We may require you or your provider to furnish peer-reviewed, evidence-based scientific literature that demonstrates the service is required for the health of the member.

Medicare: The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide Members with all their Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) Plan.
When a Member is enrolled in a Medicare Advantage Plan, Medicare services are covered through the Plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). The plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Part A: The Medicare component that covers the costs of inpatient hospital services, confinement in nursing facilities or other extended care facilities after hospitalization, home care services following hospitalization, and hospice care.

Medicare Part B: The Medicare component that covers the costs of providers' professional services, whether the services are provided in a hospital, a provider's office, an extended-care facility, a nursing home, or an insured's home.

Medicare Part D: Prescription drug coverage. Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medicare-Covered Services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our Plan, must cover all of the services that are covered by Medicare Part A and B.

Member: A person with Medicare who is eligible to get covered services, who has enrolled in the Plan, and whose enrollment is confirmed by CMS.

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

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

National Accrediting Standards: URAC standards and all accrediting standards that the CHRISTUS Health Plan Generations is required to meet.

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

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

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

Non-Participating Provider: A provider that is not contracted, or does not accept the Plan. Also referred to as non-contracted, out-of-network or non-preferred.

Organization Determination: Any determination (e.g., an approval or denial) made by CHRISTUS Health Plan coverage of medical services (Part B-covered services).

Out-of-Pocket Costs: The amount of money the member pays for medical services after insurance has paid its contribution.

Out-of-Area or Out-of-Network: Services received outside the Plan's specified service area. Some plans may not cover out-of-area services, with the exception of emergency care.

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

Participating Provider: A provider who has signed an agreement to provide CHRISTUS Health Plan Generations covered services to Generations (HMO), Generations Plus (HMO) or Guardian (HMO) plan members.

Payer: The entity ultimately responsible for funding the payment for covered health services provided through the provider agreement. Sometimes used interchangeable with the word payor.

Plan: Refers to the Health Plan.

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

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

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

Primary Care Provider (PCP): Any CHRISTUS Health Plan Generations provider who is practicing medicine in the area of internal medicine, family practice, general practice or pediatrics, who is deemed by CHRISTUS Health Plan Generations to be a primary care provider, and who upon selection or assignment, shall be responsible for providing initial and primary care of Generations (HMO), Generations Plus (HMO) and Guardian (HMO) plan members who have selected or been assigned to such primary care provider.

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

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

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

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

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

Provider Engagement Consultant: Health plan employees based locally whose primary focus is helping providers understand how to work successfully within the Plan.

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

Recredentialing: A periodic review of the qualifications of a current network provider to verify that the provider still meets the standards for participation in the network.

Referral: An authorization granted by the participating PCP for use of another provider.

Request for Reconsideration: A request to reconsider the initial determination.

Risk Adjusted Payment System (RAPS): The CMS-Hierarchical Condition Category (CMS-HCC) is often referred to as Risk Adjusted Payment System (RAPS). The model predicts health cost expenditures by calculating the disease burden of the population. A patient's risk is measured by assessing their diagnostic characteristics (ICD-9), therefore appropriate coding is required to identify the patient's acuity level/actual health risk.

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

Skilled Nursing Facility (SNF): A licensed institution, as defined by Medicare, which is primarily engaged in the provision of skilled nursing care. SNFs are usually located within hospitals, but sometimes are located in rehab facilities or nursing homes. SNFs provide a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis. Examples of SNF care include the provision of such services as intravenous injections and physical therapy.

Special Enrollment Period (SEP): A set time when members can change their health or drug plans or return to Original Medicare. Situations of a Special Enrollment Period include: moving outside the service area, getting Extra Help with prescription drug costs, moving into a nursing home, or if the Plan violates the contract with the member.

Step Therapy: A tool that requires members to try another drug to treat the medical condition before the plan will cover the drug the provider may have initially prescribed.

Summary of Benefits (SOB): A list of covered services and their corresponding out-of-pocket costs.
Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65, and older. SSI benefits are not the same as Social Security benefits.

Tax Identification Number (TIN): A number assigned by the Federal Government in which a business or entity is identified for filing and paying taxes related to the business or entity.
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 an injury or disease under circumstances that create tort or contractual liability on third parties, including insurance companies, to pay damages.

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

Urgent Care or Urgently Needed Care: A CMS term, that refers to urgent care services that are medically necessary to treat an illness or injury that would result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation, in which further complications could result if treatment is not received.

844.282.3026 | TTY 711

Oct. 1 – Mar. 31 | 7 days a week | 8am – 8pm local time

Apr. 1 – Sept. 30 | 8am – 8pm local time

CHRISTUShealthplan.org