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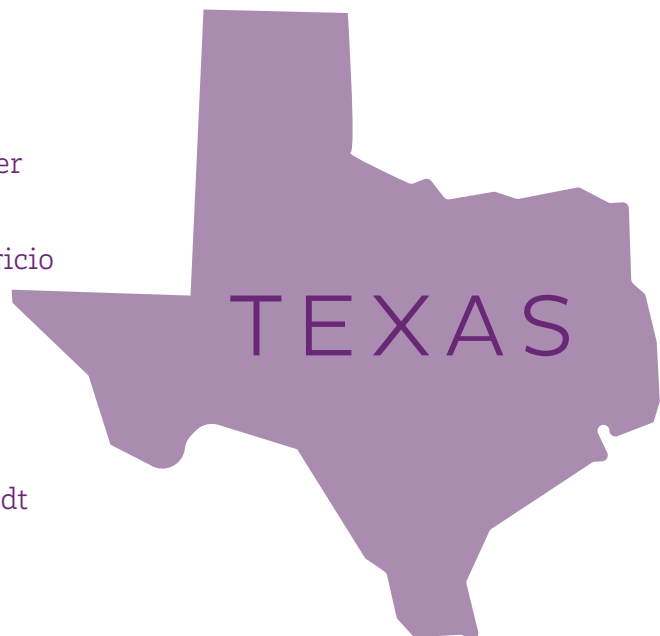


Texas Health Insurance Exchange

PROVIDER MANUAL

**CHRISTUS Health Plan covers members
in the following counties:**

Anderson	Harrison	Nueces
Aransas	Hays*	Orange
Bee	Hopkins	Rains
Bowie	Jasper	Red River
Brooks	Jefferson	Refugio
Caldwell	Jim Wells	San Patricio
Cass	Karnes	Smith
Cherokee	Kenedy	Titus
Comal	Kleberg	Tyler
Franklin	Live Oak	Upshur
Gregg	Marion	Van Zandt
Guadalupe	Morris	Wood
Hardin	Newton	



*only zip code: 78666

CHRISTUS Health Plan
Individual and Family Health Plan
Texas

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Important Contact Information

Provider Services Provider Assistance Translation	Tel: 844-282-3025 Fax: 210-766-8851
Claim Resolution	Fax: 866-416-2840
Utilization Management	Fax: 844-357-7562
Pharmacy Formulary (Express Scripts)	Provider Services: 800-211-1456 Help Desk: 800-922-1557
Behavioral Health (CHRISTUS Health Plan)	Tel.: 844-282-3025
Family Planning (HealthSmart)	Tel: 855-596-6740
Dental (Dentegra)	Member Services: 877-745-9687 Provider Services: 877-745-9687
Vision (Superior Vision)	Member Services: 800-879-6901 Provider Services: 866-819-4298
24-Hour Nurse Hotline	Tel: 844-581-3175
Claims Billing Address	P.O. Box 981654 El Paso TX 79998
Report Fraud & Non-Compliance	Hotline: 855-771-8072 ChristusHealthPlanSIU@ChristusHealth.org Secure Fax: 210-766-8849
Website	ChristusHealthPlan.org

Welcome to CHRISTUS Health Plan

Welcome to CHRISTUS Health Plan! We are delighted you have chosen to become a participating provider with CHRISTUS Health Plan. We view you as our partner in providing high quality, affordable health care to our members.

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

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

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

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

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

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

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

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

As a provider for 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 and revised by CHRISTUS Health Plan, CMS and the CHRISTUS Health Plan Provider Manual, as amended from time to time. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by CHRISTUS Health Plan at any time upon notice to the provider.

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied 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 contracts and credentials practitioners and certain facilities (hospitals, ambulatory surgery centers, home health agencies and skilled nursing facilities) prior to participation. Practitioners and facilities are re-credentialed, at a minimum, every three (3) years. The credentialing/re-credentialing process consists of the provider application process, verification of credentials with primary sources and a review by the credentialing committee. An executed contract is required prior to plan participation. Credentialing approval is not a guarantee of participation.

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

Provider Participation Criteria

- Completed Provider Application.
- Current license to practice medicine or operate facility without limitation, suspension, restriction.
- Current DEA/CDS certificate (if applicable).
- Current malpractice insurance coverage, consistent with the Provider's contract/Agreement.
- Board Certification or completed appropriate training in the requested specialty.
- Ability to meet access and availability standards.
- Must be eligible to become an approved provider.
- No state, Medicare or Medicaid sanctions.
- Network need.
- W9.

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:

- Provide continuous 24-hour, 7-day-a-week access to care

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

Provider Rights

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

- Ability to correct erroneous information identified during the Credentialing Process.
- Ability to review information submitted to support credentialing application.

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

Appointment Availability and Wait Times

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

Texas Health Insurance Exchange Appointment Standards

Appointment Type	Access Standards
PCP – Routine Visit	Three (3) weeks
Preventive Care or Periodic Health Evaluation	Four (4) months
Behavioral Health – Routine Visit	Ten (10) business days
Specialist	Routine specialty care referral within three (3) weeks
Urgent Care	Twenty-four (24) hours
Emergency Care	Upon arrival, including at non-network and out-of-area facilities
Behavioral Health – Non-Life-Threatening Emergency	Within six (6) hours

Travel Distance and Access Standards

CHRISTUS Health Plan maintains a provider network in accordance with regulations regarding provider to member ratios and monitors the adequacy of the network to ensure provision of quality care and services to its members. To ensure the network is sufficient to

meet the needs of members, the number; type and distribution of practitioners, pharmacies, and ancillary services are continuously monitored.

Evaluations of network availability may include, but are not limited to:

- Analysis of member grievance information.
- Geographic distribution analysis.
- Member and provider satisfaction surveys.
- Member-to-provider ratios.

Providers must offer and provide CHRISTUS Health Plan members appointments and wait times comparable to that offered and provided to other commercial members. CHRISTUS Health Plan routinely monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

Provider Phone Call Protocol

PCPs and specialist providers must:

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

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

24-Hour Access to Providers

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

- A covering physician.
- An answering service.
- A triage service or voicemail message that provides a second phone number that is answered.

If the provider's practice includes a high population of Spanish speaking members, it is recommended that the messages are recorded in English and Spanish.

Examples of unacceptable after-hours coverage include, but are not limited to:

- Calls received after-hours are answered by a recording telling callers to leave a message.
- Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed.
- Not returning calls or responding to messages left by patients after-hours within thirty (30) minutes.

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

Covering Providers

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

Authorizing an Out-of-Network Provider

If it is determined that CHRISTUS Health Plan does not have an in-network provider with the appropriate training and experience needed to treat a member's condition, CHRISTUS Health Plan will approve an out-of-network authorization. An in-network provider may request for out-of-network authorizations.

Note: Approvals will not be made based on the convenience for a member or a provider and CHRISTUS Health Plan may not approve the particular out-of-network provider requested. If CHRISTUS Health Plan approves the authorization, all services performed by the out-of-

network provider are subject to a treatment plan approved by CHRISTUS Health Plan in consultation with the member, the member's PCP, and the out-of-network provider. All services rendered by the out-of-network provider will require an authorization; however, **this is not a guarantee of payment**. Members are responsible for any applicable in-network cost-sharing and non-covered services. In the event that CHRISTUS Health Plan does not approve an authorization, any services rendered by the out-of-network provider will not be covered.

Change in Provider Information

Providers are required to notify both the CHRISTUS Health Plan Provider Relations Department and CMS through the CMS-contracted intermediary in writing of any changes in information regarding their practice. Such changes include:

- Name changes.
- Address changes (including changes for satellite offices).
- Phone number.
- Fax number.
- Hours of operation.
- Additions or terminations to a group.
- National provider identification (NPI) number changes.
- Tax ID number changes.

Voluntary Provider Terminations

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

Transitional Care

CHRISTUS Health Plan understands that when providers leave or are terminated from the Plan, members may require coverage for a period of time to ensure continuity of treatment. Members being treated by a provider whose contracted status has been terminated, may be able to continue ongoing treatment for covered services for up to ninety (90) days after the effective date of termination. In addition, pregnant members in their second or third trimester may be able to continue care with a former in-network provider through delivery and any postpartum care directly related to the delivery.

Note: Members must contact Member Services to request this continuity of care and request authorization prior to service. Former in-network providers must agree to accept the negotiated fee as payment in effect just prior to the termination. Additionally, the provider must agree to provide CHRISTUS Health Plan with necessary medical information related to the member's care and adhere to CHRISTUS Health Plan's policies and procedures, including those for assuring quality of care, obtaining pre-authorization, authorization, and

a treatment plan approved by CHRISTUS Health Plan. If a provider was terminated by CHRISTUS Health Plan, due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with the provider is not available.

Provider Request to Transfer a Member's Care

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

- A pattern of missed appointments.
- Breakdown in patient and provider relationship.
- Failure to follow the provider's recommended treatment plan.
- Failure to pay co-payments.
- Fraud.
- 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:

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

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

If the behavior persists, the provider should write a formal letter to the member and carbon copy (CC) to the CHRISTUS Health Plan Member Services Manager to advise of the situation and initiate transfer of the member to another PCP. The Member Services Department will contract 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 Relations Representative for additional assistance as needed.

Non-Discrimination

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

Suspected Child or Adult and Elder Abuse or Neglect

During an examination, cases of suspected child or adult and elder abuse or neglect might be uncovered during an examination, and should be reported immediately, by telephone or to a representative of the local Department for Social Services office, local law enforcement agency, or the Texas State Police, as appropriate.

Marketing

The development or use of any material that markets for CHRISTUS Health Plan is prohibited without prior written approval from CHRISTUS Health Plan. Prior to distributing marketing materials, documents, or other information to Medicare beneficiaries, Federal laws required CMS-contracted Marketplace Plans to obtain authorization from the Centers for Medicare and Medicaid Services (CMS).

Medical Records

CHRISTUS Health Plan provider representatives must be permitted access to the provider's office records and operations. This access allows CHRISTUS Health Plan to monitor compliance with regulatory requirements. Each provider office will maintain complete and accurate medical records for all CHRISTUS Health Plan members receiving medical services in a format and for the time-period 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, risk management, peer review studies, customer service inquiries, complaint and appeal processing, claims reconsideration, and other initiatives CHRISTUS Health Plan may be required to conduct. To comply with accreditation and regulatory requirements, CHRISTUS Health Plan may periodically perform documentation audits of some provider medical records. 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 members must be kept the longer of six (6) years or as required by each state.

On a periodic basis, the Plan may require access to medical records for the purpose of quality assessment, investigating complaints and appeals, credentialing, and peer review. Medical records are confidential and are considered Protected Health Information (PHI). Providers must comply with all state and federal laws concerning confidentiality of health and other information about CHRISTUS Health Plan members. Providers must maintain and adhere to policies and procedures regarding use and disclosure of health information that comply with HIPPA 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 members have the right to access their medical records; therefore, each provider must have a mechanism in place to provide this access. Appropriate communication of medical record information between treating providers is essential to promoting continuity and coordination of care.

Transfer of Medical Records

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

The following information must be included in every individual record:

- Patient identification.
- Personal data.
- Alcohol or substance use / abuse.
- Allergies.
- Appropriate use of consultants.
- Chief complaint.
- Chronic continuing medication list.
- Chronic significant problem list.
- Date of each visit.
- Date of next visit.
- Diagnosis impression.
- Growth chart (14 years of age and younger).
- 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 exams.
- Preventive health education.
- Provider signature / name on each entry.
- Results discussed with patient.
- Results of consultations.
- Smoking status.
- Treatment / therapy plan.
- Health Education and Wellness promotion services assessed by member.

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 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 behalf of the member.
- A **Living Will** allows the member to state his or her wishes in writing but does not name a patient advocate.
- A **Declaration for Mental Health Treatment** gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations.

CHRISTUS Health Plan directive policies include:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives. Providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CFR 489 subpart I.
- Advising members of their right to self-determination regarding advance directives by:
 - Encouraging members to request an advance directive form and education from their PCP at their first appointment.
 - Assisting members with questions about an advance directive. No CHRISTUS Health Plan employee may serve as witness to an advance directive or as a member's authorized agent or representative.
- Allowing CHRISTUS Health Plan associate, a facility or a provider to object conscientiously to an advance directive within certain limited circumstances if allowed by state law.
- Having Member Services, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis.
- Producing member materials containing information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual providers.

- The Health Plan issuing a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
 - Describes the range of medical conditions or procedures affected by the conscience objection.
 - Identifies the state legal authority permitting such objection.
 - Noting the presence of advance directives in the medical records when conducting medical chart audits.

Providers must:

- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive.
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider's office.
- For members who do not have an executed advance directive, ask if he or she would like advance directive information. If the member desires further information, provide member advance directive education.
- Comply with the Patient Self-Determination Act requirements.
- Discuss potential medical emergencies with the member, 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.
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive.

Closing a PCP Panel

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

Member Eligibility

Eligibility

The Federal Exchange will make eligibility decisions based upon the application submitted by the member. The member is responsible for notifying the Exchange about changes to their family circumstances that could affect eligibility such as an adoption, a birth, addition of another dependent, or a divorce.

To be eligible for covered benefits in accordance with CHRISTUS Health Plan contracts, members must be enrolled. In this context, the member is the individual who has applied for coverage on behalf of his/herself and his/her dependents, and to whom the contract was issued.

Verifying Eligibility

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


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 he/she enrolls with CHRISTUS Health Plan. Most providers ask to see the ID card each time the member comes to the office.

The ID card displays information such as:

- Member's Plan Name.
- Member First and Last Name.
- Member ID #.
- Contact Information for Member Services.
- Copayment Amounts.
- Deductible.
- Out-of-Pocket maximum.

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

CHRISTUS Health Plan		TX - EX	
Member		Medical Plan	
Subscriber Name: JOHN SAMPLE		PCP Office Visit: \$0 Copay after deductible	
Subscriber ID: SMPL0001		Specialist Office Visit: \$0 Copay after deductible	
Group Number:		Emergency Room: \$0 Copay after deductible	
Effective Date:		Urgent Care: \$0 Copay after deductible	
		OOP Max (Indiv/Family): \$8700/\$17400	
		WH Combined Ded (Indiv/Family): \$6700/\$17400	
		GHP TDI HMO	
Dependents:		Pharmacy Plan	
JANE SAMPLE		RxBIN: 003858	
JIMMY SAMPLE		RxPCN: A4	
		RxGRP: CHPHCRE	
		 Pharmacy administered by Express Scripts Holding Company	
		Preferred Generic Drug: \$0 Copay after deductible Generic Drug: \$0 Copay after deductible Brand Drug: \$0 Copay after deductible Non-Preferred Brand Drug: \$0 Copay after deductible Specialty Drug: \$0 Copay after deductible	
		Provider Services Submit Medical Claims to: P.O. Box 981854 El Paso, TX 79998-1838 Payor ID: 52106 Submit Dental Claims to: P.O. Box 1850 Alpharetta, GA 30023-1850 Submit Vision Claims to: 839 Eldridge Landing Rd, Ste 200 Linthicum, MD 21090	
		Member Services Member Services: 1-844-282-3025 TTY: 711 Superior Vision: 1-800-879-6901 Dentegra Dental: 1-877-745-9887 Pharmacy for Members: 1-844-569-2530 TDD Pharmacy: 1-800-759-1089 Assistance 24/7 Nurse Line: 1-844-581-3175	
CHRISTUS Health Plan is a licensed HMO in Texas. CHRISTUS Health Plan is also the sole owner of CHRISTUS Health Plan Louisiana, a licensed HMO in Louisiana which operates under the registered trade name of CHRISTUS Health Plan. Please visit www.christushealthplan.org for more information about your plan and to find information on how to locate an in-network provider.			

The ID Card above is shown for illustrative purposes only.

Grace Period

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)
CHRISTUS Health grace period policy is as follows, unless otherwise specified by applicable state or federal law.

For members not receiving advance payments of the tax credit: CHRISTUS Health Plan provides a grace period of thirty-one (31) days to members who are not receiving advance payments of the premium tax credit and who have previously paid at least one full month's premium during the benefit year. During the grace period, the policy will remain active. If any premium is not paid by the end of the grace period, coverage will be terminated as of the end of the period for which premium has been paid through.

The provider will refund any payments made to a provider on behalf of a member who ultimately loses coverage due to non-payment of premiums to CHRISTUS Health Plan within forty-five (45) days of receipt of written request by CHRISTUS Health Plan. CHRISTUS Health Plan may offset any amounts not paid within forty-five (45) days of receipt of notice from CHRISTUS Health Plan from amounts otherwise owed to the provider without any further action required. CHRISTUS Health Plan will deny claims that are received and not processed with dates of service beginning on the last day the premium was paid, after CHRISTUS Health Plan has confirmed that the grace period expired without premiums being paid in full.

For members receiving advance payments of the premium tax credit: CHRISTUS Health Plan provides a grace period of three (3) consecutive months to members receiving advance payments of the premium tax credits who have previously paid at least one full month's premium during the benefit year. During the grace period, the CHRISTUS Health Plan will:

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

If a member receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, CHRISTUS Health Plan will terminate the member's coverage on the last day of the first month of the 3-month grace period and deny claims incurred during months two and three of the 3-month grace period. The provider will refund any payments made to providers on behalf of members who ultimately lose coverage due to non-payment of premium with dates of service beginning

after the first month of the 3-month grace period to CHRISTUS Health Plan within forty-five (45) days of receipt of written request by CHRISTUS Health Plan.

CHRISTUS Health Plan may offset any amounts not paid within forty-five (45) days of receipt of notice from CHRISTUS Health Plan from amounts otherwise owed to the provider without Brix.

Member Rights & Responsibilities

Member Rights

The Plan Members have the following rights:

- A right to receive information about the organization, its services, its Practitioners and Providers, and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policies.

Member Responsibilities

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

- Consult their provider before receiving medical care, unless their condition is life threatening.
- Express their opinions, complaints or concerns in a constructive way to CHRISTUS Health Plan Member Services or to their provider.
- Follow plans and instructions for care that they have agreed to with their provider.
- Follow the Plan's Complaint and Appeal process when displeased with the Plan or a provider's actions or decisions.
- Inform the Plan of any changes in family size, address, phone number or membership status within thirty (30) calendar days of the change.
- Know the proper use of the services covered by the Plan.
- Make premium payments on time.
- Notify the Plan of other insurance coverage.
- Pay all charges or copay/coinsurance amounts, including those for missed appointments. This also applies to deductibles and any charges for non-covered benefits and services.
- Present their Plan ID card before they receive care.
- Promptly notify their provider if they will be delayed or unable to keep an appointment.
- Provide honest and complete information to those providing the care.
- Review and fully understand the information they receive about the Plan.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Refrain from any abusive or noncompliant behavior (verbal or physical) toward staff.

All members are responsible for understanding how the Plan works. They should carefully read and refer to their contract and their Summary of Benefits and Coverage (SBC).

Member Support Services

New Member Education

Members are encouraged to see their Primary Care Provider (PCP) within the first ninety (90) days of eligibility and 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 how to schedule appointments.

24-Hour Nurse Hotline

CHRISTUS Health Plan offers a 24/7 Nurse Hotline. Members can access this service toll free for medical guidance and/or 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 Hotline, members should call 844-581-3175.

Case Management

The Case Management program plans and manages the care of members with complex and/or chronic needs and those whose needs are acute, episodic or short term in nature. The goals of Case Management are the provision of quality care, enhancement of a member's quality of life and management of health care costs for short term and long term. Case Management support members identified with chronic conditions.

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

- Case Management criteria per policy.
- Facility admission/Concurrent review process.
- Member request.
- Retrospective analysis.
- Claim review.
- Member self-referral.
- Health Risk Assessment Results.

Providers can refer members for a case management evaluation by calling 800-446-1730 Option 2 or faxing information to 844-357-7562. Upon referral, members will be contacted for enrollment, will administer a telephone health assessment, and the Case Management team will work with PCPs to develop a Plan of Care.

Disease Management

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

The purpose of Disease Management is to:

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

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

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

Providers can refer members for a disease management evaluation by calling 800-446-1730 Option 2 or faxing information to 844-357-7562. Upon referral, members will be contacted for enrollment, will administer a telephonic health assessment, and the Disease Management team will work with PCPs to develop a Plan of Care.

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

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

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

Health Management and Education

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

Cultural Competency

CHRISTUS Health Plan places great emphasis on the wellness of its members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. CHRISTUS Health Plan encourages providers to provide culturally competent care that

aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).

CHRISTUS Health Plan maintains policies emphasizing the importance of culturally and linguistically competent care to CHRISTUS Health Plan's membership of all cultures, races, languages, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual enrollees while protecting and preserving the dignity of each member. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with patients and, in the long run, the health and wellness of the patients themselves.

Providers must ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act (ADA) including all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or denied the benefits of services, programs or activities of a public facility or be subjected to discrimination by any facility.

The following is a list of principles for health care providers to include knowledge, skills and attitudes related to cultural competency in the delivery of health care services to members.

Knowledge

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

The purpose of Disease Management is the:

- Understanding of the public health policies and its impact on minority patients and communities.

Skills

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

Attitudes

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

Cultural Diversity Resources for Providers

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

CLAS is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. CLAS is about respect and responsiveness; Respect the whole individual and Respond to the individual's health needs and preferences.

The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services.

Best Practices for Working with a Medical Interpreter

Working in the medical field, you have surely seen the need for an interpreter occasionally, if not every day. Fortunately, many clinics now make sure this type of professional is available to help doctors and patients communicate. If you are not yet used to having a medical interpreter in the office with you, here is how to get familiar with this situation so you and your patients can benefit from interpreting services right away.

A Physician's Practical Guide to Culturally Competent Care

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

HRSA: Culture, Language, and Health Literacy

Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. <https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy>

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

Intended to enhance cultural competence when serving American Indian and Alaska Native communities. Covers regional differences, cultural customs, spirituality, communications styles, the role of veterans and the elderly, and health disparities, such as suicide.

<https://store.samhsa.gov/product/American-Indian-and-Alaska-Native-Culture-Card/sma08-4354>

Covered and Non-Covered Services

Family Planning

Family planning services are covered as a part of the CHRISTUS Health Plan package of benefits. However, since this benefit is inconsistent with the Ethical and Religious Directives for Catholic Health Care, it is not provided by CHRISTUS Health owned entities. HealthSmart administers the family planning benefit for CHRISTUS Health Plan members. HealthSmart is not affiliated with CHRISTUS Health. Family Planning Services provided are paid directly through HealthSmart. Providers who have questions should contact HealthSmart directly at 855-596-6740.

Transplant Services

CHRISTUS Health Plan requires prior authorization for transplant services. This applies to both solid organ and bone marrow (stem cell) transplant procedures. Prior authorization can be requested by either the provider or the member. For members to obtain the maximum possible benefits, the member must obtain their transplant through the use of health plan contracted transplant providers; **Optum, Cigna 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: Phone 844-282-3025, Fax 844-357-7562.

Behavioral Health

CHRISTUS Health Plan is directly responsible for Behavioral Health Member Services, Provider Contracting, Credentialing, and claims payment to behavioral health providers. CHRISTUS Health Plan Member Services can be reached at 844-282-3025.

CHRISTUS Health Plan is responsible for Behavioral Health pre-authorization, referrals, and medical management of behavioral health services. Behavioral health services, including all Mental Health services, treatment for alcoholism, substance abuse, drug addiction and chemical dependency.

Behavioral Health Crisis Hotline is available to members 24-hours-per-day, 7-days-per-week at 800-323-0286. Providers should use this phone number to identify participating behavioral health providers, request pre-authorization for inpatient admissions and outpatient services.

Mental Health and Substance Use Disorder Parity

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

Behavioral Health Care Provider Access-to-Care Standards

Service Type	Time Frame
Behavioral Health - Routine Visits	Ten (10) business days
Behavioral Health Urgent Care	Twenty-four (24) hours
Following hospital discharge for a behavioral health condition	Within seven (7) days of the inpatient discharge date
Behavioral Health Non-Life-Threatening Emergency	Within six (6) hours

Texas Health Insurance Exchange Plans

Overview

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

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

The EHBs outlined in the ACA are as follows:

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

CHRISTUS Health Plan covers services described in the Summary of Benefits and Major Medical Expense Policy document for each CHRISTUS Health Plan type. If there are questions as to a covered service or required prior authorization, please contact CHRISTUS Health Plan Provider Services.

Texas Plans

<i>Plan</i>	<i>Type</i>	<i>Type</i>	<i>Type</i>	<i>Type</i>
<i>Platinum</i>	Platinum			
<i>Gold Plus</i>	Gold Plus Gold Plus Ltd Gold Plus Zero			
<i>Gold</i>	Gold Gold Ltd Gold Zero			
<i>Silver</i>	Basic Silver Silver 73% Silver 87% Silver 94% Basic Silver Ltd Basic Silver Zero	Silver HD Silver HD 73% Silver HD 87% Silver HD 94% Silver HD Ltd Silver HD Zero	Silver LD Silver LD73% Silver LD 87% Silver LD 94% Silver LD Ltd Silver LD Zero	Silver Plus HD Silver Plus HD 73% Silver Plus HD 87% Silver Plus HD 94% Silver Plus HD Ltd Silver Plus HD Zero
<i>Bronze</i>	Bronze Bronze Ltd Bronze Zero	Bronze HSA Bronze HSA Ltd Bronze Zero	Bronze Plus Bronze Plus Ltd Bronze Plus Zero	
<i>Catastrophic</i>	Catastrophic			

NOTE: Some Texas Plans are subject to an overall deductible and an out-of-pocket limit on expenses, as described below:

Overall Deductible	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. Copays do not count toward the deductible.
Out-of-Pocket Limit on Expenses	The out-of-pocket limit is the most a member could pay during a coverage period (usually one year) for their share of the cost of covered services.

*The Platinum Plan do not have a deductible

Quality Management Program

CHRISTUS Health Plan's Quality Management Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and service utilizing a multidimensional approach. This approach enables the Plan to focus on opportunities for improving operations processes as well as health outcomes and satisfaction of members and providers.

The scope of the Quality Management Program encompasses both clinical care, and services provided to external and internal customers. External customers defined as members, physicians, governmental agencies, whereas internal customers are various business partners, and associates. Quality Management clinical indicators and studies selected based on the health plan's demographic and epidemiological data. All outcomes analyzed for opportunities for improvement, and findings reported to the appropriate committee or individual. CHRISTUS health plan does not delegate Quality Management activities.

The Quality Management Program includes, but is not limited to, the following topics:

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

All participating providers are required to comply with the terms of this Provider Manual as well as Medical Management and Quality Management Programs.

Health Care Effectiveness Data Information Set (HEDIS®)

CMS requires Health Exchange Health Plans to report Health Care Effectiveness Data Information Set (HEDIS®) measures annually. HEDIS is a set of standardized Quality Indicators that measure 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®).

HEDIS rates can be calculated in two ways: administrative data or hybrid data.

- **Administrative data** consists of claim and encounter data submitted to CHRISTUS 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 CHRISTUS Health Plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 (effective Oct. 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews.

Medical Record Reviews (MRR) for HEDIS

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 any time, if any of your patient's medical records are selected for review, you will receive a call from a medical record review representative. Your prompt cooperation with the representative is greatly appreciated.

As a reminder, sharing of Protected Health Information (PHI) is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with CHRISTUS Health Plan, which allows them to collect PHI on our behalf.

How Can Providers Improve Their HEDIS Scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for each 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 most clean and efficient way to report HEDIS.
- Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Keep accurate chart/medical record documentation of each Member service and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.

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

Qualified Health Plan Enrollee Experience Survey (QHP)

The QHP survey is a member experience survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an

NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members' expectations. Member responses to the QHP survey 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)

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

Potential Quality Issues

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

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

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

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

Process

CHRISTUS Health Plan has a systematic method for the identification, reporting and processing of Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to CHRISTUS Health Plan members and to direct actions for improvement based upon the frequency and severity of the PQI.

It is CHRISTUS Health Plan's policy to accept a PQI referral through a variety of sources. These include but are not limited to:

- A Plan member.
- A Plan provider.
- A Plan staff member.
- Internal referrals from Grievances and Appeals.

All Potential Quality Issues identified will be tracked in the PQI log for the purposes of monitoring patterns to identify any potential trends or any significant sentinel events. All information obtained during and used in a QOC investigation held in strict confidence, according to the Plan confidentiality policies and in accordance with all relevant State and Federal Peer Review Laws and regulations.

A designated medical professional review all referred PQIs to identify whether a true QOC issue exists, after which the case will be assigned a severity score. Some cases will be referred to the Peer Review/Credentialing Committee based on CHP's policy.

Based on review by the Credentialing Committee, a provider may be placed on a Corrective Action Plan (CAP) or may be required to submit a Corrective Plan. The CAP will request follow up and evidence from the provider in question to demonstrate the corrective actions been implemented as specified.

All PQI outcomes are trended on a continuous 36-month basis. Any identifiable trends, regardless of outcome to the member, referred to the Quality Improvement Committee on a quarterly basis for potential action or educational opportunities.

Preventive Health Guidelines

Preventive Health Guidelines

Evidence-based care protocols have shown to improve patient outcomes through clinical research. Care delivery protocol values are evidence-based recommendations for care. CHRISTUS Health Plan recommends the adults and children preventive health guidelines established by U.S. Preventive Services Task Force (USPSTF) of the Agency for Healthcare Research and Quality (AHRQ). These preventive health guidelines include recommendations for screenings, testing, immunizations and counseling. Full references are available at the following website: [https://Homepage | United States Preventive Services Taskforce \(uspreventiveservicestaskforce.org\)](https://Homepage|UnitedStatesPreventiveServicesTaskforce(uspreventiveservicestaskforce.org)). Also for pediatric care we recommend: [periodicityschedule.pdf \(aap.org\)](periodicityschedule.pdf(aap.org)).

CHRISTUS Health Plan adopts nationally accepted evidence-based preventive services guidelines for healthy adults and children with normal risks (Grade A and B). 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.

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 consults with participating providers practicing in the community to adopt nationally recognized guidelines and standards. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to providers to facilitate improvement of health of our members. Find them online here: [Clinical Practice Guidelines | NCCIH \(nih.gov\)](ClinicalPracticeGuidelines|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 indicate 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 hard copy or can reach out to Provider Services at 844-282-3026.

Referral | Authorization Guidelines

CHRISTUS Health Plan Medical Management programs designed to assure members receive appropriate care at the right time, in the right setting. The Medical Management functions performed in accordance with State guidelines, Federal regulations and NCQA standards.

Providers and CHRISTUS Health Plan staff have no incentives, including compensation, based upon the quantity of adverse determinations. Nurses and Medical Directors collaborate with PCPs, specialists and other providers to assure members get the care they need in a proactive manner.

Role of Primary Care Provider

The Primary Care Provider (PCP) plays a critically important role in the medical care delivery model. The PCP works collaboratively with the member and all other providers to ensure 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 provider, 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.

Role of Specialist as Primary Care Provider

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

A determination will be made within thirty (30) calendar days from the date the request is received. A Medical Director will review the member and provider request and approve if the

specialist meets criteria for participation as a primary care provider, and there is a medical need for the specialist to act as the member's PCP. The effective date of the designation of the specialist as the PCP may not be applied retroactively.

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

Role of Specialists, Hospitals, and Ancillary Providers

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

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

Role of Medical Management Staff

Medical Management Utilization Management Nurses and Case Managers collaborate with provider to:

- Arrange for social intervention to improve care management.
- Conduct concurrent review of inpatient stays.
- Coordinate with other providers including 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 clinical guidelines to prevent readmissions.
- Provide prior authorization for those procedures 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 physicians who oversee the day-to-day health plan clinical operations. Their functions include:

- Interface directly with practicing physicians to resolve clinical issues.
- Make decisions related to the authorization of medically necessary services.
- Provide clinical guidance for the Medical Management staff.

Medical Directors are available for peer-to-peer discussion as needed regarding adverse determinations. Please call Medical Management at 844-282-3025 for a peer-to-peer discussion.

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

Peer-to-Peer Availability

Medical Directors conducting medical necessity reviews are available to discuss review determinations with the requesting/ordering provider or attending provider via peer-to-peer conversation. The peer-to-peer conversation allows the treating provider the opportunity to discuss the Medical Management determination before initiating the appeals process. A peer-to-peer conversation is available by calling the Medical Management department toll free at 800-446-1730 (Option 1).

A treating provider completes the Peer-to-Peer conversations within one (1) business day of the request. If the peer-to-peer discussion does not result in authorization of the request, the process includes informing the provider and member of their appeals rights during the notification.

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

- Verbal notification to treating provider.
- Fax notification to treating provider if verbal notification is unsuccessful.

Availability of Medical Management Staff

Medical Management (MM) staff is available 24/7, 365 days per year. Providers can reach the Medical Management department by phone 844-282-3025 or fax 844-357-7562 (non-urgent request) or 210-766-8812 (urgent request) after normal business hours an on-call nurse 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.*

*If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance and deductible amounts.

PCP Referrals to Network Specialists

The PCP does not need prior/referral authorization to refer the member to an in-network specialist. Participating providers are listed in the Provider Directory and online at ChristusHealthPlan.org. Providers may also call Provider Services to verify in-network participation.

Prior Authorization Guidelines

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

- Fax urgent and emergent requests to 210-766-8841.
- Fax a routine request to 844-357-7562.

The Provider will request the following information:

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

The Medical Management Department will process completed referrals containing all necessary information and supporting documentation. Please note authorizations are not a guarantee for payment.

Medical Management Components

Preadmission Review is the process of authorizing non-emergent medical and surgical hospitalizations.

Admission notification when the provider and/or hospital notifies Medical Management a CHRISTUS Health Plan member is admitted to the hospital.

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

Discharge Planning is the CHRISTUS Health Plan's Care Manager (Concurrent Review Nurse) responsibility 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 (Concurrent Review Nurse) will assist in discharge planning by arranging for any home care services, skilled nursing care, or medical equipment required after leaving the hospital. This process helps assure every member is provided with the appropriate care, both in the hospital and post discharge.

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

Ambulatory/Outpatient Review is the process of authorizing non-emergency selected diagnostic and surgical outpatient procedures.

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

Home Health Care is performed by a home health agency, a public or private agency that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy in the home. Custodial care is a non-covered benefit.

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

Medical Management Notification Requirements

There are specific notification requirements that apply to the Transplant and Hemo Dialysis services and treatments evaluated in each of the review components, in order to ensure payment. The provider must submit a Notification form along with the pertinent clinical information or call the Plan regarding proposed treatment and service.

Treatment Service	Notification Requirement
Transplant and Hemo Dialysis services and treatments	Within one (1) business day of Date of Service

Authorization Process

Information received via phone or electronic mail (email) will be reviewed for benefit coverage or determination of medical necessity. Appropriateness and medical necessity will be reviewed using MCG criteria, Plan clinical protocols, benefits, and coverage. Upon approval of authorization, the authorizations faxed to the requesting provider, and servicing provider.

Requests that do not meet the medical necessity criteria or coverage guidelines are sent to the Plan Medical Director. Peer-to-Peer information is provided to the requested provider to allow additional clinical information to be provided before an adverse determination is made. If the Plan Medical Director determines medical necessity criteria or benefit coverage is not established, notifications made to the requesting provider will include the physician reviewer's determination to deny authorization. A denial letters sent to requesting provider within two (2) business days of the determination.

Requests to Out-of-Network Providers

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

- 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. For Eligibility and Benefits, please contact Provider Services.

For Family Planning Assistance, please contact HealthSmart at 855-596-6740.

Medical Management Affirmative Statement

CHRISTUS Health Plan Medical 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 Medical Management decision makers do not encourage decisions that result in underutilization.

What Services Require Prior Authorization?

As of July 1st, 2022, Out-Of-Network services and providers (ONLY) require prior authorizations. You can find the prior authorization list at: Prior Authorization – CHRISTUS Health Plan.

If you need help determining if a service requires Prior Authorization, please contact Provider Services at 844-282-3025.

Specialty Drugs Authorization Requirements

Specialty Drug coverage may require an authorization. Please contact Provider Services.

Provider Obligations – Precertification

Providers are responsible for obtaining precertification from CHRISTUS Health Plan and for submitting the adequate required information before performing certain procedures or when referring members to non-contracted providers. CHRISTUS Health Plan will render a determination on the request within the appropriate period and provide notification of the decision.

Requests denied will generate a notice that includes the denial rationale and applicable appeal rights. Members will receive a denial letter as well that includes appeal rights.

Denials are the result of contractual issues with CHRISTUS Health Plan

The provider will not generate a member denial letter.

Appeals

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

Provider Liability Appeals | Provider Claims Disputes

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

Provider Complaints and Appeals

All participating providers have agreed to comply with the Plan's dispute resolution process by signing the Provider Agreement. The provider complaint process is available to any participating provider to resolve disputes with the Plan. The Plan distinguishes disputes by the following categories:

- **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 will make every effort to resolve provider dispute inquiries using consistent procedures for reviewing and responding to inquiries. Dispute reviews will be completed within thirty (30) days of receipt of the request.

A provider dispute must be sent in writing to:

CHRISTUS Health Plan Exchange
Attn: Appeal Processing
P.O. Box 169009
Irving | Texas 75016
Fax: 866-416-2840
ChristusCAG@christushealth.org

All requests must be submitted for review within one hundred eighty (180) days of an action taken or decision made by CHRISTUS Health Plan. For any dispute involving a denied claim, the 180-day period begins on the date of the CHRISTUS Health Plan remittance reflecting the denial. For any dispute related to a claim audit, the 180-day period begins on the date of the notice to the provider.

CHRISTUS Health Plan will forward the provider request to the appropriate area for research and resolution. When appropriate, the Medical Director will review the matter using appropriate peer input.

Providers will receive a payment or written response within thirty (30) calendar days describing how their request was resolved.

Competence or Conduct Dispute and Appeals to HMO

Providers may file a non-administrative dispute that involves actions by the Plan that relate to a participating provider's status within the Plan's provider network and any action by the Plan related to a participating provider's professional competency or conduct.

A competence or conduct provider dispute or appeal with CHRISTUS Health Plan can only be requested in writing.

Participating providers have the right to appeal their dispute to two (2) separate panels above the level of the Plan body involved in the dispute. Each panel consists of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. In no case will panel members be assigned who have been previously involved with the issue.

A panel will be convened within 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):

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

Member Complaints and Appeals

Member Complaints to HMO

A complaint is defined as any dissatisfaction expressed by a complainant orally or in writing to CHRISTUS Health Plan with any aspect of the CHRISTUS Health Plan's operations, including but not limited to:

- Dissatisfaction with plan administration.
- Procedures related to review or appeal of an adverse determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G.
- The denial, reduction or termination of a service for reasons not related to medical necessity.
- The way a service is provided.
- Disenrollment decisions expressed by a complainant.

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the member. Members, or a member's designee, can file a complaint with CHRISTUS Health Plan either in writing or verbally by contacting the Appeal and Grievance Representative at:

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

Verbal Complaints

The Appeals and Grievance Representative will acknowledge the verbal complaint no later than the fifth day of receipt and send a Complaint Form that must be returned for prompt resolution of the complaint. The acknowledgement letter will indicate a description of the complaint process and the thirty (30) calendar day time frame for resolution of the complaint. If the complaint form is not returned to the Appeals and Grievance Representative within fifteen (15) calendar days from date on letter, a determination will be made based on information available.

Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed one (1) business day from receipt of the complaint.

Once the complaint has been resolved, the Appeals and Grievance Representative will send a response letter to the member or member's designee with the resolution of the complaint, including the process to appeal the decision when the member or member's designee is not satisfied with CHRISTUS Health Plan's decision.

Member Appeals to HMO

If the member's complaint is not resolved to their satisfaction, members have the right to either:

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

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

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

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

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

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

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin | Texas 78714-9091
Fax: 512-490-1007
Online: ConsumerProtection@tdi.texas.gov
Phone: 800-252-3439

Member Expedited Appeals to HMO

The member or member's designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the member. Requests for an expedited appeal can be made verbally or in writing as indicated in the member complaint to HMO process listed above.

Expedited appeals for emergency care denials and denials of continued hospital stays will be reviewed by a Medical Director not involved in the original denial and is of the same or a

similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which the appeal is completed will be based on the medical immediacy of the condition, procedure, or treatment, but will not exceed seventy-two (72) hours from the date all information necessary to complete the appeal is received.

If the member or member's designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited. If the member or member's designee does not agree with this decision, they may submit a request for an Independent Review Organization as described below.

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

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin- |, Texas 78714-9091
Fax: 512-490-1007
Online: ConsumerProtection@tdi.texas.gov

Member Adverse Determination Appeals to HMO

A member, a person acting on behalf of the member, or the member's physician or health care provider may appeal an adverse determination orally or in writing. Any complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of the adverse determination. Appeals must be filed within one hundred eighty (180) days, following the Plan's denial notification.

Within five (5) working days from receipt of the appeal, an acknowledgement letter will be sent to the appealing party. The acknowledgement letter will include:

- The date of receipt of the appeal.
- A description of the appeal procedure and time frames.
- A list of the documents, such as new, previously unknown information, further reasonable documentation related to the case but not previously received or medical records will need to be submitted for review during the appeal process.

The provider will have five (5) business days to submit the additional information requested; and a one-page appeal form, if the appeal is oral.

As soon as possible, but in no case later than thirty (30) calendar days for pre-service appeals and no later than sixty (60) calendar days for post-service appeals, all available information will be reviewed by a provider who was not involved in making the initial adverse determination and a written notification of the appeal determination will be sent to the appealing party.

If the appeal is denied, the written notification to the member, member's designee, and member's provider shall include a clear and concise statement that includes:

- The clinical basis for the appeal's denial.
- The specialty of the physician making the denial.
- The right of the appealing party to seek review of the denial by an independent review organization and the procedures for obtaining the review.
- The right to an immediate appeal to an independent review organization in circumstances involving a condition that is life-threatening to the member.
- The right of the health care provider to set forth in writing, within ten (10) working days of the appeal denial, good cause for having a particular type of specialty provider review the case.

For expedited appeals, members must call 844-282-0380 and fax all related information to 866.416.2840. Standard appeals must be mailed to:

CHRISTUS Health Plan Exchange
Attn: Appeal and Grievance Department
P.O. Box 169009
Irving | Texas 75016
christusCAG@christushealth.org

External Review Process by MAXIMUS Federal Services

The member or member's designee may seek a review of CHRISTUS Health Plan's denial of an appeal of an adverse determination by MAXIMUS Federal Services free of charge. Our notice of determination of the appeal will include complete instructions for making a request for an external review by MAXIMUS Federal Services.

Expedited external review may be initiated at the same time as expedited internal appeals. MAXIMUS Federal Services is required to issue an urgent care decision no later than seventy-two (72) hours from receipt of the request for external review and no later than forty-five (45) days for standard request.

Pharmacy Services

CHRISTUS Health Plan includes coverage for prescription drugs. The CHRISTUS Health Plan pharmacy benefit management vendor.

The formulary includes coverage of generic drugs, as well as many brand-name drugs, non-preferred brands and specialty drugs. Formularies are reviewed by a Pharmacy and Therapeutics Committee composed of provider and pharmacists. Providers can view a copy of the formulary on the CHRISTUS Health Plan website.

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

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

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

Pharmacy-Related Service	Performed By	Notification	Contact Information
Prescription Drugs	ESI	ESI	Pharmacy Dept.: 800-451-6245 Help Desk: 800-922-1557 Fax: 877-329-3760
Coverage Determination	ESI	Standard and Expedited Coverage Reviews	800-935-6103
Formulary Exceptions	ESI	Coverage Review	800-935-6103

Prescription Drugs by Mail Order

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the provider must write on the maintenance drug prescription whether it is for a 30, 60 or 90 day supply.

When mailing in a prescription to the mail-order service for the first time, the member must verbally give consent to ship, which includes verifying shipping address before medication is mailed. The member should allow up to 14 business days for prescription to be processed and mailed. For refills of the same prescription, members should allow up to seven to ten (7-10) business days for processing and mailing. If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call 844-470-1531.

Coverage Determinations for Prescription Drug Benefits

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

- A decision about whether to provide or pay for a drug, including a decision not to pay because:
 - The drug is not on the Plan's formulary.
 - The drug is determined not to be medically necessary.
 - The drug is furnished by an out-of-network pharmacy.
 - We determine the drug is 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 Medical Management requirement.

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

- A **standard** decision made within the standard seventy-two-hour (72) timeframe.
- An **expedited** decision made within twenty-four (24) hours.

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

Formulary Exceptions

If a prescription drug is not listed in the CHRISTUS Health Plan formulary, please check the updated formulary on the express-scripts.com website. The website formulary is updated frequently with all changes.

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

- The prescribing provider can prescribe another drug that is covered on the formulary.

- The patient or prescribing provider may ask CHRISTUS Health Plan to make an exception (a type of coverage determination) to cover the non-formulary drug.

If the member pays out-of-pocket for a non-formulary drug and requests an exception CHRISTUS Health Plan approves, CHRISTUS Health Plan will reimburse the member. If the exceptions not approved, the member may appeal the Plan's denial. In some cases, CHRISTUS Health Plan will contact a member who is taking a drug not on the formulary. CHRISTUS Health Plan will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her provider if any of those drugs would be appropriate options for treatment. Members who recently joined CHRISTUS Health Plan may be able to get a temporary supply of a drug they are taking if the drug is not on the CHRISTUS Health Plan formulary.

Transition Policy

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

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

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

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

Claims, Encounters, & EDI Transactions

Claim Submissions

Health Exchange Plans are regulated by CMS and therefore claims billed are expected to reflect CMS billing practices, where possible. 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 the Plan, unless applicable law provides submissions may be in a paper format.

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

- A properly completed claim must be submitted electronically or by paper and the claim must not involve an investigation for coordination of benefits (COB), member eligibility, or subrogation, etc.
- Separate charges must be itemized on separate lines.
- Medical record documentation must validate the scope of the services provided and billed.
- Claims must be submitted according to the timely filing section of their respective contract. The Plan will bear no liability to pay claims received after the timely filing deadline is exceeded and members cannot be balanced billed for provider's failure to submit claims within their contracted timeframe.
- Include AMA-developed procedural coding.
- Include ICD-10, as required by state or federal regulations or statutes, diagnosis coding to the highest specification.
- Be submitted on original red and white CMS 1500 or UB-04 forms when filing paper claims. (Black and white copies or faxes will not be accepted).
- Not be handwritten.

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

Paper Claims Submissions

CHRISTUS Health Plan recognizes that occasionally, providers may need to submit claims on paper. Providers are required to submit paper claims on the appropriate UB-04 or CMS-1500 claim form. Providers should submit original red and white CMS 1500 or UB-04

forms. The Plan will not accept super-bills or similar submissions, or handwritten forms as valid claims.

CHRISTUS Health Plan Exchange
ATTN: Claims
P. O. Box 981654
El Paso | TX 79998-1654

EDI Transactions

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

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

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

Electronic Claims Submissions (837)

For submission of 837s, providers are to use Payor ID: 52106.

The Plans listed as CHRISTUS Health Plan of Texas and Louisiana.

Providers should ensure they have a valid NPI on file with the health plan.

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.

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

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

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

Claims Filing Deadlines

Providers should refer to their respective contracts for timely filing deadlines when submitting claims. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for a provider to submit claims will be ninety-five (95) days from the last date of service or date of discharge for Inpatient facility claim. If a provider enters into a formal dispute resolution process with the Plan, the provider should refer to the timeliness guidelines in the Dispute Resolution Section of this Manual.

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 completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Late Payment Penalties

If the Plan does not pay a clean claim within the state-mandated timeframe indicated above, CHRISTUS Health Plan will pay a late payment penalty in accordance with TDI regulations.

Delinquency Period Payments

Subsidized, on-exchange members with APTC are entitled to a three-month delinquency period for non-payment of premiums. Non-APTC members have thirty (30) days of non-payment. CHRISTUS Health Plan will process and pay any claims incurred by these members during this period. If the member is ultimately terminated for non-payment at the end of the delinquency period, the Plan will request refunds for any paid claims with dates of service beginning within this period. This policy is consistent with guidance from TDI.

Good Faith Payments

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

Incomplete Claims

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

Claim Corrections and Late Charges

Providers who believe they have submitted an incorrect or incomplete claim may submit an updated claim within the relevant timely filing period indicated in the Timely Filing of Claims 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.

Claims for Emergency Services

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

Checking the Status of a Claim

Providers can check the status of a claim by calling Provider Services.

Claims Explanation of Payment (EOP)

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

Collection of Cost Share

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

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

If a provider collects an upfront amount and it exceeds the member's cost share indicated in the EOP, CHRISTUS Health Plan requires the provider to issue a refund to the member within ten (10) business days of receipt of the EOP. Copayment and coinsurance amount for

the most common services are on a member's ID card. Providers can also check a member's outstanding copayment amount, coinsurance amount, or deductible by calling CHRISTUS Health Plan Member Services.

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, CHRISTUS Health Plan will not reimburse the Provider's office for the payment amount.

Balance Billing

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

This process is available to members with claims for medical services or supplies provided at in-network hospitals by the following types of out-of-network hospital-based physicians:

- Anesthesiologists.
- Assistant surgeons.
- Emergency department physicians.
- Neonatologists.
- Pathologists.
- Radiologists.

To be eligible for mediation, the member must have been balance billed more than \$500 (not including copayments, deductibles, or coinsurance amounts). If CHRISTUS Health Plan receives a mediation request from TDI for a qualifying claim, CHRISTUS Health Plan will notify the provider and arrange a teleconference call to resolve the dispute. The Plan will schedule the teleconference no later than thirty (30) days after the date the member submitted the request to TDI. CHRISTUS Health Plan will notify the provider and member of the date and time of the call and supply a toll-free conference line number.

If CHRISTUS Health Plan, the hospital-based provider, and member cannot settle the dispute during the teleconference; CHRISTUS Health Plan will submit a request to TDI for a formal mediation. To avoid out-of-network mediation situations, CHRISTUS Health Plan asks providers to make their best effort to refer members to in-network CHRISTUS Health Plan providers and labs. Providers are encouraged to call the Plan if they have a question about whether a specific provider or lab is in the Plan's network. Further information about this mediation process is available on the TDI website:

tdi.texas.gov/consumer/cpmmedication.html.

Reimbursement

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

Important Contact Numbers

Questions about your claims transmissions or status reports	Change Healthcare Help Desk: Change Healthcare.com
Questions about your claim status (receipt of completion dates)	Provider Services
Questions about claims received on a Remittance Advice	Provider Services
Need to know a Provider ID Number	Provider Services
Update provider, payee, UPIN, Tax ID number, payment address info Questions about changing or verifying provider information	Notify your Provider Relations Rep. in writing: CHRISTUS Health Plan Provider Relations P. O. Box 169009 Irving TX 75016 Fax: 210-766-8851

Non-Covered Services

Contracted providers may only bill CHRISTUS Health Plan members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered.

The agreement must be specific to the services being rendered and clearly state:

- The specific service(s) to be provided.
- A statement that the service is not covered by CHRISTUS Health Plan.
- A statement that the member chooses to receive and pay for the specific service(s).

The member is not obligated to pay for the service(s) if it is later found the service was covered by CHRISTUS Health Plan at the time it was provided, even if CHRISTUS Health Plan did not pay the provider for the service(s) because the provider did not comply with CHRISTUS Health Plan requirements.

Billing for "No Shows"

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

Overpayments and Withholds

Should CHRISTUS Health Plan determine 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 has 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) working days of the date the notice of overpayment was received. If the provider contests the refund request, the provider must identify the portion of the overpayment contested and the specific reasons for contesting the overpayment.

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

CHRISTUS Health Plan Exchange
Attn: Claims Recovery Unit
P.O. Box 169001
Irving | Texas 75016-9001

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

Provider Reimbursement

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

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.

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 medically necessary services are provided only to eligible beneficiaries by authorized providers under existing law, regulation 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 is dedicated to the CHRISTUS Core Values of Dignity, Integrity, Excellence, Compassion and Stewardship; the Plan holds contracted physicians and providers to the same standards. As a participating provider in CHRISTUS Health Plan, providers are expected to:

Safety

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

Quality Care

- Provide quality care to all members by performing duties to the best of their abilities.
- Attempt to anticipate and understand member needs while meeting their expectations.
- Employ professionals with proper credentials and recognize 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 claims submitted for payment or reimbursement are for services 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, and documented, and filed according to all applicable laws and regulations.

Protection of Privacy

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

Ethical Practices

- Not mislead members or the public or cause them to request services they do not reasonably need.
- Treat all members with dignity, respect, and compassion.
- Respect and support the rights of all members.
- Respect and support the rights of all Health Plan associates by 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 informed consent can be obtained. Explanation of treatment must include:
 - Potential benefits and drawbacks.
 - Potential problems related to recovery.
 - Likelihood of success.
 - Possible results of non-treatment.
 - Significant alternatives.

Risk Management

CHRISTUS Health Plan maintains 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 or 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 and Abuse

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 CHRISTUS Medical Management standards, and federal and state laws. To advocate for the highest and best health for our Members, CHRISTUS Health Plan endorses treatment that is medically necessary, evidence based, provided by the proper specialist, at the right time, for the appropriate duration, in the most suitable location and at a reasonable cost. Reasonable cost is determined by fee schedules, or by CHRISTUS Health Plan. If these standards are not followed, there is higher likelihood Members will experience an unfavorable impact in payments for preventable costs, violation of criminal laws, civil codes and statutes.

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 comparisons, audits, interviews, surveillance, and other activity deemed necessary. When non-compliance occurs, CHRISTUS 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 CHRISTUS Health Plan Members.
- 6) Termination of Provider Contract and from the CHRISTUS Health Plan Network.
- 7) Referral to Law Enforcement Federal, State and local law enforcement agencies.

Reporting Possible FWA or Provider Non-Compliance to CHRISTUS Health Plan -Can be anonymous, if preferred:

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

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

Federal and State Regulations: A partial list of potential federal and state violations if FWA has occurred:

The False Claims Act

Statute: 31 U.S.C. §§ 3729-3733 , 42 C.F.R. §§422.503, 423.504(B)(4)(VI), etc.

The Anti-Kickback Statute

Statute: 42 U.S.C. § 1320a-7b(b)

Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law

Statute: 42 U.S.C. § 1392nn

Regulations: 42 C.F.R. §§ 411.350-.389

The Exclusion Authorities

Statutes: 42 U.S.C. §§ 1320a-7, 1320c-5

Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law

Statute: 42 U.S.C. § 1320a-7a

Regulations: 42 C.F.R. pt. 1003

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

Important Statutes

CHRISTUS Health Plan hopes providers find this information helpful. However, if providers would like more information regarding compliance programs, please visit OIG's website at [Whistleblowers.org](https://www.whoiswhistleblowers.org).

False Claims Act

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

Criminal Investigation of Health Care Offenses

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

Mail and Wire Fraud

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

Social Security Act

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

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

Federal Anti-Referral Law (Stark Laws)

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

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

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

Emergency Medical Treatment and Active Labor Act (EMTALA)

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

Rehabilitation Act of 1973

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

- Blind/visual impairment.
- Cerebral Palsy, epilepsy or seizure disorder.
- Chronic diseases including AIDS, arthritis, cancer and diabetes.
- Deaf/hard of hearing.
- Drug/alcohol addiction.
- Mental retardation and psychiatric disorders.
- Orthopedic handicap, spinal cord/traumatic brain injury.
- Physical or mental impairment which substantially limits one or more major activities of daily living.
- Specific learning disability, and certain speech disorders.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Mandates security and confidentiality of individually identifiable Protected Health Information (PHI) must be stored and transmitted securely, must notify patients of their rights, and where to submit complaints, and patients must have access to their medical records.

Provider Resources

The CHRISTUS Health Plan Provider Portal can be found online at ChristusHealthPlan.org.

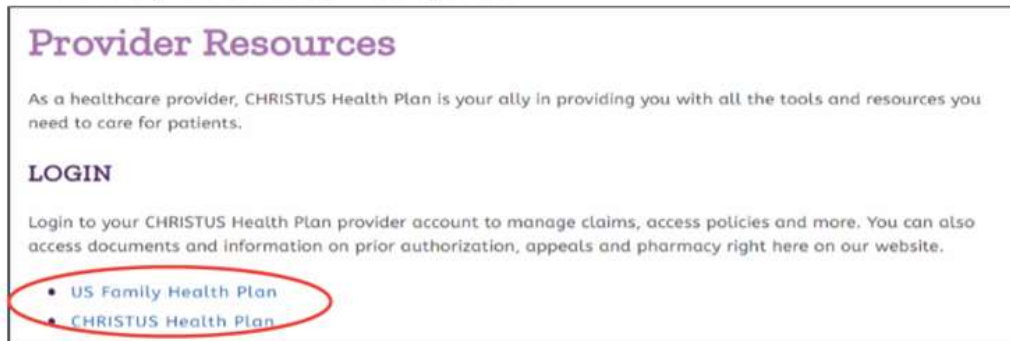
1. Visit ChristusHealthPlan.org. In the upper right hand corner, click Sign In.



2. Click Providers Login.



3. Select the plan for which you are a provider.



To create a new profile, select "Click here to create a new user".

Select user type (Office or Vendor) and click Select. A Vendor User can view all providers associated with the same tax ID. An Office User can submit referrals/authorizations and view members on panel. All required fields must be complete. Click Create Account.

Provider Website

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

- Authorizations.
- Claims Submissions and Status.
- Forms (Prior Authorization, etc.).
- Member Eligibility.
- Monthly Patient Listings.
- Payments History.
- Pharmacy Preferred Drug Listing.
- Provider Manual.
- Quick Reference Guides.
- Secure Provider Portal.
- Trainings.
- 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 the CHRISTUS Health Plan Provider Manual. They are intended to provide a point of reference when the terms appear in this manual.

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

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

- Administrative practices of the health care plan affect the availability, delivery, or quality of Health Care Services.
- Claims payment, handling or reimbursement for Health Care Services and terminations of coverage.

Adverse Determination: A determination by a Health Maintenance Organization (HMO) or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate.

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

Annual Out-of-Pocket Maximum (OOP Max): A specified dollar amount of covered services received in a calendar year is the most a member will pay (cost sharing responsibility) for the calendar year.

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

Application: The forms, including required medical underwriting questionnaires, if any, each subscriber is required to complete when enrolling for coverage.

Beneficiary: A recipient of insurance benefits.

Calendar Year: The period beginning Jan. 1 and ending Dec. 31 of any given year. The initial calendar year period is from a member's effective date of coverage and ends on Dec. 31, which may be less than 12 months.

Case Management: A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and

human service needs. It is characterized by advocacy, communication, and resource management, and promotes quality and cost-effective interventions and outcomes.

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

Certification: A decision by a health plan that a health care service requested by a provider or grievant has been reviewed and, based upon the information available, meets the Plan's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

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

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

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

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

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

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

Coinsurance: 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 member's authorized representative with the health plan or a delegated contractor's processes other than an action associated with the disposition of a claim (i.e., adverse determination of a benefit).

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

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

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

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

Copayment: The amount members are required to pay to a participating provider or other authorized provider in connection with the provision of health care services.

Cost Sharing: Any contribution members make towards the cost of their covered health care services as defined in their policy. This includes Deductibles and Copayments.

Coverage: Benefits extended under the member's policy, subject to the terms, conditions, limitations, and exclusions of the policy.

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

- Administered or ordered by a physician or other qualified provider.
- Incurred while the member's coverage is in force under the Policy.
- Medically necessary to the diagnosis and treatment of an injury or illness.
- Not excluded by any provision of the Policy.

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

Cultural Competence: Possession of the knowledge, skills, and attitudes needed to provide effective health care for diverse populations, 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.).

Denial: Refusal to approve services or payment to a provider for covered or non-covered services under a member's benefit plan. Types of denials include:

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

Deductible: Part of the contribution members make toward the cost of their health care, also known as cost sharing. It means the amount the member is required to pay each calendar year, directly to the provider in connection with covered health care services before CHRISTUS Health Plan begins to pay covered benefits.

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

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

Diagnostic Service: Procedures ordered by a provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

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

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

Durable Medical Equipment (DME): Equipment or supplies prescribed by a provider that are medically necessary for the treatment of an illness or accidental injury, or to prevent the member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or accidental injury, and includes items such as oxygen equipment, wheelchairs, hospital beds, crutches, and other medical equipment.

Effective Date: 12:01 a.m. of the date on which the member's coverage begins.

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

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

Emergency Care or Emergency Care Services: Covered services furnished by a provider who is qualified to provide Emergency Care Services. The services needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition: A severe injury or the sudden onset of a medical condition. The injury or medical condition must be one which manifest itself by acute symptoms in the absence of immediate medical attention a prudent layperson with an average knowledge of health and medicines would expect that:

- Such person's life or health would be in serious jeopardy.
- Bodily functions would be seriously impaired.
- A bodily organ or part would be seriously damaged.
- With respect to a pregnant woman having contractions, there is inadequate time to safely transfer the woman to another hospital for delivery or a transfer may pose a threat to the health or safety of the woman or the unborn child.

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.

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

Exchange: The Health Insurance Exchange Marketplace.

Excluded Services: Health care services are not covered services and the Plan will not pay for it.

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

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

- A technology must have final approval from the appropriate regulatory government bodies.
- The scientific evidence as published in evidence-based, peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcome.;
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigational settings.

Explanation of Benefits (EOB): A statement sent to covered individuals by a health plan explaining services provided, amount billed, 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 list the services amounts billed, denials, adjustments and payment for one or more claims.

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

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

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

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

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

Grievance: A written complaint submitted by or on behalf of an enrollee regarding any aspect of the member's health care services, including but not limited to the:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
- Administrative practices of the health care plan affect the availability, delivery or quality of health care services.

- Claims payment, handling or reimbursement for health care services.
- Matters pertaining to the contractual relationship between an enrollee or subscriber and a health care plan.

Grievant: Any of the following:

- A policyholder, subscriber, enrollee, or other individual, or person's authorized representative or provider, acting on behalf of the person with the person's consent, entitled to receive health care benefits provided by the health care plan.
- An individual, or persons authorized representative, who may be entitled to receive health care benefits provided by the health care plan.

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

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

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

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

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

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

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

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

Health Maintenance Organization: Any person or entity who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

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

Health Care Common Procedure Coding System (HCPCS): A set of codes used by Medicare to describe 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 (DME) and ambulance service. HCPCS are nationally defined there is a provision for local use of certain codes.

HHS: The United States Department of Health and Human Services.

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

ICD-10: The universal coding method used to document the incidence of disease, injury, mortality and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. This system is used to group patients into diagnosis related groups (DRGs), prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

Illness: A sickness or disease, including all related conditions and occurrences, requiring health care services.

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

Independent Review Organization (IRO): An entity certified by the Commissioner to conduct reviews. By law, an IRO must not be affiliated with the HMO which has denied a request for authorization for proposed treatment. IROs perform an administrative review of the medical necessity and appropriateness of health care services being provided or proposed to be provided, which has been denied twice as not medically necessary or not appropriate.

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

In-network: Care received from a participating provider.

Inpatient: A patient admitted to a hospital requires at least one overnight stay.

Insurance: A method of providing money to pay for specific types of losses that may occur. Insurance is a contract between one party and another. The policy states what types of losses are covered, what amounts will be paid for each loss and for all losses, and under what conditions.

Limits: Quantity or monetary thresholds associated with a particular benefit.

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

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

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

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

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

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

Medically Necessary: A treatment, drug, device, procedure, supply or service 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 shall not be considered 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, the level of care 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).
- 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: Title XVIII of the Social Security Act and all amendments thereto.

Member: An individual:

- Who meets each of the enrollment and eligibility requirements described in this Policy.
- Who has been properly enrolled in coverage with the Plan.
- For whom the Plan has received any required premium for the enrolled coverage.

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

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

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

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

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

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

Network Provider: Provider is the 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.

Non-Participating Provider: A provider not contracted with CHRISTUS Health Plan.

Nurse Practitioner: An Advanced Practice Registered Nurse who has additional responsibilities for administering patient care than RNs.

Obstetrician/Gynecologist (OB/GYN): A physician board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

Out-of-Network Services: Health care services obtained from a non-participating provider.

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

Outpatient Hospital: A place to receive covered services while not an inpatient. Services considered outpatient include, but are not limited to, services in an emergency room regardless whether the member is admitted as an Inpatient in a hospital.

Participating Provider: A physician, provider, hospital or health care facility has an agreement with CHRISTUS Health Plan to accept the Plan's rates and payments as payment in full when providing health care services to members.

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

Physician: One of the following:

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

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

Physician Assistant: A person who has graduated from a nationally-recognized physician assistant or assistant surgeon program; or who is currently certified by the national

commission of Physician Assistants. A Physician Assistant must be licensed to practice medicine under the supervision of a licensed physician in the state in which they practice.

Plan: The health benefit plan established by CHRISTUS Health Plan and selected by the member to provide health care services to members, as it exists on the effective date of this policy or as subsequently amended as provided herein.

PPACA: The federal Patient Protection and Affordable Care Act.

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

Pre-Authorization: A decision by a health care plan that a health care service requested by a practitioner/provider or covered person has been reviewed and, based upon the information available, meets the health care plan's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

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

Prescription Drugs: Drugs for which sale or legal dispensing requires the order of a provider with legal authority to prescribe drugs.

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

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

Primary Care Services: Services provided by a PCP or primary provider of health care services.

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

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

Provider: An entity performs or furnishes a medical, behavioral health, and/or dental service/treatment to members AND is recognized under Section 1866(e) of the Social Security Act. Also, a duly licensed hospital, physician, or other practitioner of the healing arts authorized to render health care services within the scope of their license.

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

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

Provider Network: A list of the providers that are participating providers.

Qualified Health Plan (QHP): Health care coverage has been determined to meet the requirements in state and federal law for coverage to be offered through the Exchange.

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

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

Quality Improvement Committees: Committees composed of a provider, the Medical Director, and other health care professionals that provide a mechanism for provider participation, communication and development and administration of CHRISTUS Health Plan.

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

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

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

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

Referral: An authorization granted by the participating physician/primary care provider for use of another provider.

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

Second Opinion: An opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the medical necessity and appropriateness of the initial proposed health service.

Service Area: A geographic area approved by CMS and/or the state Department of Insurance, within which an eligible individual may enroll in a Health Insurance Exchange Plan.

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

Skilled Nursing Facility (SNF): A place that:

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

Specialist: A physician who provides covered services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint, or muscle conditions and psychiatrists care for members with Behavioral Disorders or Mental Illness/Disorders.

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

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

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

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

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

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

Termination Date: 11:59 p.m. on the last day of the month for which premiums were paid and the date the member's coverage ends.

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

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

Treatment Plan: A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, 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: Medically necessary health care services provided in emergencies or after a PCP's normal business hours for unforeseen conditions due to illness or injury and are not life-threatening but require prompt medical attention.

Urgent Illness: A non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains; a rising fever despite having taken medication; new ear pain; an asthma attack where medications are not helping; an animal bite; an object in the eye or eye infection; a cut may need stitches; a child with severe vomiting or

diarrhea; a possible broken bone; shortness of breath; a sore throat; flu symptoms; a urinary tract infection; or a migraine headache where medicines are not relieving the pain.



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