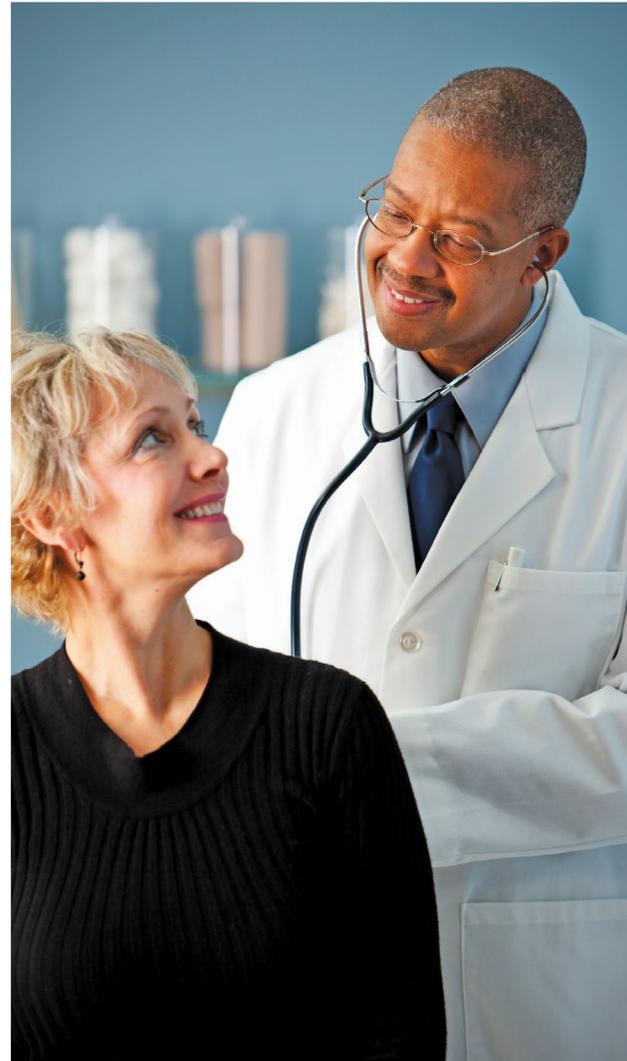
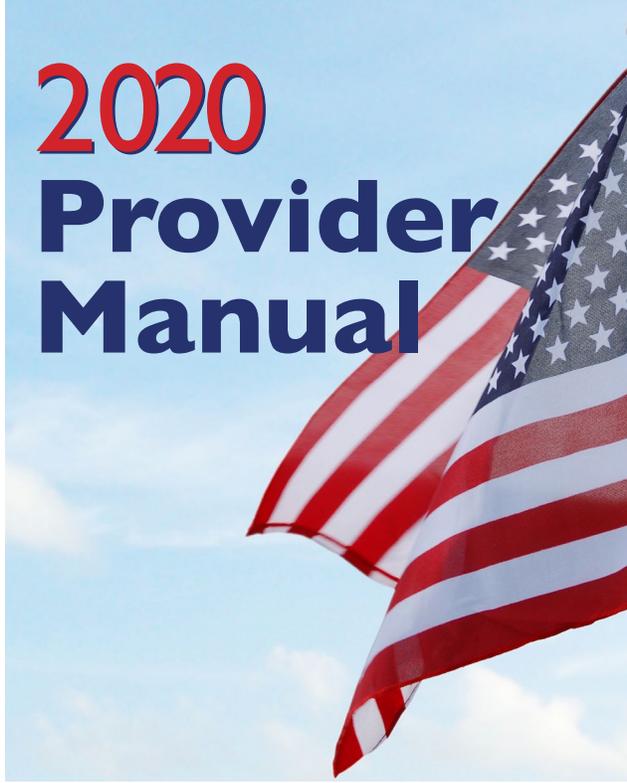


USFHP Johns Hopkins US Family Health Plan

2020 Provider Manual



The Johns Hopkins US Family Health Plan Provider Manual
is a guide to our plan.

The manual includes an overview of the plan
with specific information on:

Primary Care Provider and Specialist Responsibilities

Services and Benefit Information

Quality Improvement

Claims Payments and Reimbursements

Care Management Services

Compliance Regulations



JOHNS HOPKINS
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US FAMILY HEALTH PLAN

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JOHNS HOPKINS

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US FAMILY HEALTH PLAN

SECTION I

Overview



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Johns Hopkins US Family Health Plan

The Johns Hopkins US Family Health Plan (USFHP) is a managed care program sponsored by the Department of Defense (DoD) as a designated provider of TRICARE Prime. The plan offers comprehensive TRICARE Prime health care benefits to members of the uniformed services and is modeled after a health maintenance program similar to a Health Maintenance Organization (HMO).

TRICARE Prime, the DoD sponsored military managed health care program, provides enhanced primary and preventive services with nominal cost sharing to military members and their families. The program was implemented in this region in 1998 to expand access to health care and control costs. Under TRICARE Prime, members are required to select a Primary Care Provider (PCP) who is responsible for coordinating all their health care, including specialty referrals. Members who enroll with TRICARE Prime may choose one of three networks:

- ★ Military Treatment Facilities (MTFs)
- ★ Managed Care Support Contractor (MCSC) provider network
- ★ US Family Health Plan TRICARE Prime network (e.g., Johns Hopkins)

With this model, members select a primary care provider (PCP) as their medical provider. The PCP works with the member to oversee their entire health care. Johns Hopkins USFHP is the only TRICARE Prime option that gives members access to Johns Hopkins primary care physicians, specialists, and facilities in addition to a contracted network of community providers.

Johns Hopkins USFHP is a managed care option for active duty dependents, retirees (not yet 65) and their dependents, and for a limited number of members over 65 who were eligible to remain in the program due to their status on October 1, 2012. Johns Hopkins USFHP members are assigned a PCP who provides and coordinates care, maintains patient health records, and refers members to specialists, if necessary.

Active Duty Family Members (ADFM)s are not responsible for any copayments. ADFMs enrolled in Johns Hopkins USFHP do not have copayments except for pharmacy copayments, or when enrolled in Extended Care Health Option (ECHO). Retirees and their families without Medicare B coverage enrolled in Johns Hopkins USFHP are responsible for copayments when seeking care from a network provider.

Johns Hopkins USFHP currently has numerous sites throughout Maryland, Southern Pennsylvania, Northern Virginia, the District of Columbia and Delaware. Johns Hopkins supports the mission of Johns Hopkins USFHP by:

- ★ Providing quality health care for uniformed service members
- ★ Having well-cared for and extremely satisfied members
- ★ Demonstrating quality, value, and operational effectiveness to a growing member population
- ★ Continuing as a permanent and respected health care partner in the Military Health System

If Members Move Out of the USFHP Service Area

Members must take action and enroll in a TRICARE option within 90 days of a qualifying life event, including a move out of the USFHP service area.

If members do not take action within 90 days, they will no longer be enrolled in TRICARE Prime-- they will only be able to access military health benefits at a military installation's hospital or clinic on a space-available basis.

Strong care management programs ensure that the plan provides best value health care services in support of the Military Health System.

Johns Hopkins USFHP has provided health care services to members of all ages, including Medicare-eligible members, since 1993. Today, we continue our long-standing history of service and commitment to caring for members of all ages.

Note: If a member joined the plan before September 30, 2012, they do not need to do anything to remain in the plan after they turn age 65. If a member enrolled October 1, 2012 or after, the member will be required to transition to TRICARE for Life and enroll in Medicare when they reach age 65.

The Johns Hopkins USFHP offers the following:

- ★ No enrollment fee for active duty dependents
- ★ Nominal copays per office visit (retirees/dependents)
- ★ No copay per office visit (active duty family members or retirees w/Medicare)
- ★ Guaranteed appointments (access standards)
- ★ PCP supervised and coordinated care
- ★ Coverage when away from home



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN

SECTION II

Provider Information



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Primary Care Providers (PCP)

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

Role and General Responsibilities

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

Medical Record Documentation

Providers must maintain a member medical record that accurately reflects the preventive, routine, and specialty care provided. All records pertaining to a member's care must be in one central medical record. The member's name must be on each page of notes, lab results, and consults, and the provider must initial and date each test or lab result indicating it has been reviewed.

The DoD may request a review of a member's medical record. If the member has signed a consent form for medical information, the PCP must submit copies of the entire medical record or portions thereof as specified on the release form.

Confidentiality

Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information according to the terms of the Participating Provider Agreement and Payor Addendum.

Supervision and Coordination for Specialty Care

The PCP must make an initial diagnosis prior to referring the member for specialty services. Once a member is referred to a specialty provider, the PCP must provide ongoing oversight. Subsequent specialty referrals need to be approved by the PCP. Except in the case of a medical emergency, the PCP refers specialty and tertiary services within the Johns Hopkins network.

Specialty Providers

A specialty provider is a medical practitioner who specializes in a branch of medicine or surgery, such as cardiology or neurosurgery. When outside the scope of the PCP's practice, the PCP refers the member to the appropriate service or specialist.

Responsibilities of the specialty provider include the provision of specialty services upon referral by the PCP; and recommending appropriate treatment plans and providing written reports to the referring PCP to ensure continuity of care.

Specialty providers must also ensure that members are billed correctly. DO NOT bill Medicare for services covered by Johns Hopkins USFHP.

Required Billing Procedures

- ★ Private insurance is primary and must be billed first. This includes federal and state employee insurance, but not Medicare supplements.
- ★ If the patient does not hold private insurance, Johns Hopkins USFHP is primary, and must be billed first.
 - Exception: Medicare may be billed as primary (first) for services related to End Stage Renal Disease (ESRD) or for services not otherwise covered by the plan.

Providers billing Medicare for services other than ESRD not covered by the plan must reimburse Medicare.

Treatment Report from the Specialist to PCP

The PCP should receive an initial report of services and treatment, which may be oral as long as a written report is provided to the PCP within 10 calendar days from the date of service or sooner if the member's condition warrants a shorter time frame.

Provider Services (CUSTOMER SERVICE)

Representatives from the Customer Service department respond to and document all member and provider telephone calls, written comments, and requests. Complaints are forwarded to the complaints and grievance department. Acting as the member's advocate, representatives investigate informal member complaints. If the member is dissatisfied with the result of the investigation and feels a need to file a formal complaint or grievance, the department will provide information about how to proceed with a written appeal.

Provider Relations

The Provider Relations department is a collective team of professionals who are liaisons between Johns Hopkins HealthCare (JHHC) and our participating provider network. The network is divided into geographic territories and specialty areas, and each is assigned a network manager and coordinator.

The Provider Relations team is responsible for network development, maintenance, and education. Network development includes soliciting new providers in service areas and specialty areas to accommodate the needs of our growing membership.

The department is also responsible for network maintenance including updates and changes to provider information, account set-up, and fee schedules.

Provider education is an essential responsibility of the department. Your network manager, upon request, will train you and your office staff regarding the plan's program and its benefits. For a listing of network managers and territories, please call Provider Relations at 410-762-5385 or 888-895-4998.

Provider Communication

Support information such as updated policies, procedures, guidelines, or resources can be accessed through the provider manual, provider newsletter, the website, or through a variety of mailings. Communication opportunities include:

- ★ The Johns Hopkins USFHP Provider Manual is a guide to our plan. The manual includes an overview of the plan as well as information on PCP and specialist responsibilities, service and benefit information, claims payment and reimbursement, care management services, and referral guidelines.
- ★ *Provider Pulse* is a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories, and news pertaining to our health plans, including Johns Hopkins USFHP.
- ★ Johns Hopkins USFHP providers may utilize the website to find useful and updated information such as the provider manual, policies, forms, guidelines, announcements, and a host of other information specifically developed for the Johns Hopkins USFHP network community at: www.hopkinsmedicine.org/usfhp.

Changes in Provider or Site Status

Additions, deletions, or other changes to the provider's office information must be communicated in writing to the territory network manager or coordinator as soon as possible via email at ProviderChanges@jhhc.com. You can also mail or fax changes to:

Johns Hopkins HealthCare
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Provider Relations Department
Telephone: 888-895-4998
Fax: 410-424-4604

National Disaster Medical System (NDMS)

Johns Hopkins USFHP is encouraging all acute-care medical/surgical hospitals in our provider network to become members of the National Disaster Medical System (NDMS). Contracted providers, who are eligible for NDMS participation, are encouraged to become part of this disaster recovery initiative. Johns Hopkins USFHP will provide program information to all eligible providers and include reminders periodically through our provider newsletter and on our website. The NDMS is a federally coordinated system that augments the nation's medical response capability. The NDMS supplements an integrated national medical response capable of assisting state and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts.

The National Response Framework utilizes the NDMS as part of the Department of Health and Human Services, Office of Preparedness and Response, under Emergency Support Function #8 (ESF #8), Health and Medical Services, to support federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters including:

- ★ Natural disasters
- ★ Major transportation accidents
- ★ Technological disasters
- ★ Acts of terrorism including weapons of mass destruction events

For more information, please review the NDMS recruitment link at:
<https://www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx>

Johns Hopkins USFHP Sample Identification Card

Below are samples of the Johns Hopkins USFHP Identification card. On the left is the front of the card, and on the right is the back of the card.

 JOHNS HOPKINS MEDICINE US FAMILY HEALTH PLAN		A TRICARE Prime designated provider.
PCN: Grp: E00015/001 BIN:	Name: JOHNNY TESTCASE PCM: DR BOB ROBERTS PCM Phone #: (301)824-3343 Member #: 123456789012 Effective: 1/1/2020	CoPays: PCP: 15 Spec: 25 ER: 20 www.hopkinsushfp.org

US Family Health Plan MEMBER INFORMATION	 
EMERGENCY CARE: If you are experiencing a life-threatening emergency, call 911 or proceed to the nearest emergency room. You must notify your primary care manager within 24 hours of an emergency room visit and any follow up care must be pre-approved. If you are unsure if your condition is life-threatening, call your Primary Care Manager first.	
AFTER-HOURS CARE: Contact your primary care provider's after hours service. For nurse advice and answers to your health questions 24 hours a day, contact our Nurseline: 1-844-344-4218	
BEHAVIORAL HEALTH SERVICES: 1-888-281-3186	
BENEFITS: For information, call Customer Service at 410-424-4528 or 1-800-808-7347	
HOSPITAL PROVIDER INFORMATION Call the plan five days prior to an elective admission or outpatient procedure to obtain authorization. If the patient holds other commercial health insurance, bill that carrier as primary.	
DO NOT BILL MEDICARE except for ESRD and services not covered by the US Family Health Plan. For Claims Submission only: P.O. Box 830479 Birmingham, AL 35283-0479	

Access Standards

To ensure that illness is evaluated in a timely manner, members must have access to PCP services either by appointment or telephone, 24 hours a day, seven days a week.

When a provider's office is closed, the plan offers After Hours Triage, a program staffed by RNs and backed up by PCPs. The nurses triage, advise, and authorize use of urgent care facilities and emergency rooms using standardized protocols. Additionally, a staff physician is on call for After Hours Triage 24 hours a day to provide medical oversight, advice, and consent under appropriate circumstances.

The following accessibility guidelines are to be followed by all providers:

- ★ **Emergency** – the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to the life, limb, or sight, and requires immediate medical treatment, or which manifests painful symptoms requiring immediate palliative effort to relieve suffering. In an emergency, in the absence of care, the member could reasonably be expected to suffer serious impairment or death. Examples of emergencies are heart attack, severe chest pain, cerebrovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, suicidal tendencies, and other acute conditions. During office hours, the PCP is required to coordinate emergency services and notify the Care Management department that the emergency admission is authorized. After hours, the member should call the After Hours Triage Nurse, who will advise the member about where and when to obtain care.
- ★ **Urgent** – a sudden, severe onset of illness or a medical problem requiring attention within 24 hours. With an urgent problem, the member should be seen that same day or within 24 hours.
- ★ **Routine** – a medical problem or illness that is ongoing, but presents no immediate medical danger or acute distress.
- ★ **Health Maintenance** – well visits and preventive care services.

APPOINTMENT AVAILABILITY

Wait times for Primary Care Appointments

Appointment Type and Standard (Not to Exceed)

Health Assessment – 4 weeks

Routine Visit – 1 week

Urgent – 24 hours

Specialty Care Appointments

- ★ Access determined by PCP based on nature of care required
- ★ Wait time no longer than four (4) weeks
- ★ Travel time no longer than one hour or 60 miles

Travel Time to PCP's Office

A member's travel time should not exceed the TRICARE Prime standard of 30 minutes or a 40-mile radius from home to the delivery site. JHHC shall require members electing to enroll, but residing outside the 30 minute travel time area, to sign written documentation informing the member of their choice and that the member voluntarily waived the 30 minute access standard.

Office Wait Time

The wait time in the office in non-emergency situations shall not exceed 30 minutes.

Credentialing

The Johns Hopkins HealthCare (JHHC) Credentialing Program is dedicated to the careful selection and credentialing of practitioners for inclusion in the Johns Hopkins USFHP provider network. JHHC credentialing criteria defines the licensure, education, and training criteria practitioners must meet to be considered for inclusion into the JHHC participating network.

Prior to becoming JHHC network participants, all providers must successfully complete the credentialing process. Providers are requested to submit information, subject to verification by JHHC, to support and provide evidence of appropriate education, training, clinical experience, licensure, professional liability insurance, clinical associations, and professional history. JHHC verifies the submitted information and obtains additional information from the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), General Services Administration (GSA), state licensing boards, medical specialty boards, professional certification boards, and HireRight (USIS) to compile a complete and full credentialing file.

The provider's credentialing file is reviewed by the chief medical officer at JHHC. If an applicant is deemed to be high risk, those applications are reviewed by the Special Credentials Review Committee (SCRC), a committee of the Board of Directors of JHHC. Notification is sent to the provider at the conclusion of the SCRC activity informing the provider of the outcome of the SCRC decision.

JHHC does not discriminate on the basis of race, ethnicity, national origin, gender, age, sexual orientation, or type of procedure or patient in which the provider specializes. The credentialing process and decision-making are monitored to ensure nondiscriminatory practices are followed.

Credentialing Requirements

All providers and facility/hospitals that are required to be credentialed must remain in full compliance with JHHC credentialing criteria as set forth in the JHHC credentialing policies and procedures, and with all applicable federal, state, and local laws and regulations. Each provider or facility/hospital must complete an appropriate application as an applicant for initial participation, and, minimally, every three years thereafter (recredentialing event) for as long as the provider or facility/hospital remains an active participant in the Johns Hopkins USFHP provider network.

Types of Providers Requiring Credentialing

The following types of providers must be credentialed by JHHC prior to participating in the Johns Hopkins USFHP provider network:

Institutional Providers

- ★ Hospitals, acute care, general, and special
- ★ Organ transplantation centers
- ★ Organ transplant consortia
- ★ Hospitals, psychiatric
- ★ Hospitals, long-term (tuberculosis, chronic care, or rehabilitation)
- ★ Skilled nursing facilities
- ★ Residential treatment centers
- ★ Christian Science sanatoriums
- ★ Infirmaries
- ★ Other special institutional providers
- ★ Freestanding ambulatory surgical centers
- ★ Birthing centers
- ★ Psychiatric partial hospitalization programs
- ★ Hospice programs
- ★ Substance use disorder rehabilitation facilities

Individual Professional Providers

- ★ Doctors of medicine
- ★ Doctors of osteopathy

Other Allied Health Professionals

- ★ Clinical psychologist
- ★ Doctors of optometry
- ★ Doctors of podiatry or surgical chiropody
- ★ Certified nurse midwives
- ★ Certified nurse practitioners

- ★ Certified clinical social worker
- ★ Certified psychiatric nurse specialist
- ★ Certified physician assistants
- ★ Certified registered nurse anesthetist
- ★ Other individual paramedical providers
- ★ Licensed registered physical therapists and occupational therapists
- ★ Audiologists
- ★ Speech therapists, speech pathologists
- ★ Registered dietitian
- ★ Nutritionist

Extramedical Individual Providers

- ★ Certified marriage and family therapists
- ★ Mental health counselor

Credentialing Practitioners

Initially, practitioner applicants must submit the Maryland Uniform Credentialing Form (MUCF) to apply for participation. The MUCF is available through the Council for Affordable Quality Healthcare (CAQH) on their website. Practitioners who wish to use the online application via CAQH, but are not members of CAQH, may become a member by requesting an invitation through JHHC. There is no cost to the provider for using CAQH.

Alternately, the practitioner may request a hard-copy MUCF from JHHC, or go online to the Maryland State website at: insurance.maryland.gov/Insurer/Pages/HealthcareProviders.aspx

The hard copy application must be returned to JHHC for processing.

The practitioner's application must be complete including all service locations from which the practitioner will provide medical service to Johns Hopkins USFHP patients, education including residency and fellowship programs, clinical experience(s) for at least the past five (5) years, malpractice/professional liability insurance coverage, medical and professional certifications held, licenses held for at least the past five (5) years, DEA and CDS registrations, clinical affiliations with facilities/hospitals, malpractice claim history, and contact information. The application must be signed and dated by the applicant including an attestation that serves as a release of information and a statement that the information contained within the application is true and accurate. Additionally, the practitioner must respond to all disclosure questions pertaining to clinical and professional experience and history.

The provider will be notified of any outstanding documentation that is needed to complete the credentialing file. Examples include legal documents to augment malpractice claims, licensing board disciplinary actions, or disbarment or restriction of privileges by any federal, state or local jurisdiction or other health care related entity with which the applicant had a professional relationship.

The practitioner is also notified if JHHC identifies any discrepancies between the information included in the application and information obtained during the credentialing process from outside sources (e.g., NPDB, OIG, etc.). Adverse information pertaining to the clinical competence, professional judgment, compliance with state or federal regulations, patient safety, or contractual compliance may be grounds for refusal of acceptance into the Johns Hopkins USFHP provider network or termination of ongoing participation.

Practitioners have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Practitioners also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. They may do so by telephone, fax, email, or correspondence to the credentialing department or the network manager for their geographic area.

Currently, the following verifications are completed in addition to collection of the application information and validation of the contractual relationship between JHHC and the practitioner. These verifications are performed in accordance with the TRICARE Operations Manual, National Committee for Quality Assurance (NCQA), state and federal guidelines, and regulations:

1. Current licensure as an independent vendor in the state where service will be rendered
2. Education – degrees, internship, residency, and fellowship programs completed relevant to current licensure
3. Medical board certification
4. Professional certification
5. Work history for the past five (5) years (gaps of six (6) months or greater must have explanation of the gap)
6. Hospital admitting privileges (clinical associations)
7. DEA registration and CDS certification as appropriate for scope of practice
8. Professional liability insurance
9. Malpractice activity and history
10. Federal, Medicare, or Medicaid sanctions
11. Disciplinary actions by licensing boards, educational institutions, professional organizations, or medical service providers including facilities
12. Criminal history background check including National Sex Offender Registry (USIS/HireRight)

The practitioner is requested to provide responses to disclosure questions related to:

1. History of chemical dependency and substance or alcohol abuse
2. History of license revocations or disciplinary actions
3. History of criminal convictions other than minor traffic violations
4. History of loss or limitation to clinical privileges
5. History of complaints filed with local, state, or national societies or licensing boards
6. History of refusal or cancellation of professional liability insurance
7. History of federal, Medicare, or Medicaid sanctions including restrictions on DEA or CDS
8. Reasons for the inability to perform essential functions of the position with or without accommodation(s)

During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by JHHC since the prior credentialing event is also included in the credentialing file, and subject to consideration for ongoing participation.

The decision to approve initial or continued participation, or to terminate a provider's participation, will be communicated in writing within sixty (60) days of the SCRC's decision. In the event that the provider's participation or continued participation is denied, the provider will be notified by certified mail. If continued participation is denied, the provider will be allowed thirty (30) days to appeal the decision.

Procedure for Criminal Background Checks for Prospective USFHP Providers

JHHC is required to initiate criminal background checks per Tricare regulations on initial providers that request to participate with the Johns Hopkins US Family Health Plan (USFHP).

HireRight is a company JHHC utilizes to conduct the criminal background checks. JHHC will initiate the process by requesting that HireRight send an invitation to the applicant to complete a criminal background check by entering in the provider's email address that is listed on their credentialing application.

- ★ The applicant will receive an email from HireRight containing the web address and login information to fill out the background screening information necessary to complete the background check. Please be advised that a secure online portal is used for the applicant to provide their personal information.
- ★ Once the applicant signs in using the authentication information provided in the email, they will be required to set up their own password. Instructions will be provided with a brief explanation of what to expect when completing the required information.
- ★ The applicant will be prompted to provide information appropriate to the screening order (JHHC Criminal Background Check Package). Once complete, the applicant will review the accuracy of the information they entered and then provide an electronic consent.
- ★ The applicant will review the disclosure and authorization forms, check the two certification boxes and provide an electronic signature.
- ★ A confirmation message will display an estimated date of completion for the background check.

Credentialing Organizational Providers

Organizational providers include hospitals, home health agencies, skilled nursing facilities, ambulatory surgical centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.

Organizational providers must complete a credentialing application, available directly from JHHC via the senior network manager responsible for the type of organization that is applying. The credentialing application requires the signature of the organization's authorized representative and serves as an attestation that the health care facility/organization agrees to the assessment requirements. The authorized representative's signature also serves as a release of information to verify credentials externally.

Upon receipt of the application, the organization is notified of receipt of the application and that the credentialing process has been initiated. Any outstanding documentation that will be needed to complete the credentialing file that the organization must submit will be noted in the notification. Examples include legal documents to augment malpractice claims history, licensing board disciplinary actions and/or correction action plans, or disbarment or restriction of privileges by any federal, state, or local jurisdiction or other health care accreditation entities.

Currently, the following verifications are completed in addition to collection of the application information. These verifications are performed in accordance with the TRICARE Operations Manual, NCQA, state and federal guidelines, and regulations:

1. Current licensure as a health care delivery organization as an independent vendor in the state where service will be rendered
2. Any restrictions to a license imposed by the licensing agency
3. Any limitations or exclusions imposed by the federal government, Medicare, or Medicaid entity

4. Accreditation status with nationally recognized entities for health care quality including, but not limited to, the Joint Commission (JCAHO), Community Health Accreditation Program (CHAP), Healthcare Facilities Accreditation Program (HFAP), the American Osteopathic Association (AOA), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Commission on Accreditation of Rehabilitation Facilities (CARF)
5. For non-accredited organizations, JHHC will accept a state assessment/evaluation or CMS review
6. Onsite review for organizations without accreditation or state/CMS review
7. Professional liability / malpractice insurance

Re-credentialing is performed at a minimum every three (3) years. During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by JHHC since the prior credentialing event is also included in the credentialing file and subject to consideration for ongoing participation.

Organizations have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Organizations also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. Such requests may be done by telephone, fax, email, or correspondence to the credentialing department or the senior network manager responsible for this type of organization. The mailing address for JHHC is:

Johns Hopkins HealthCare LLC
 7231 Parkway Drive, Suite 100
 Hanover, MD 21076
 Attn: Credentialing Department

The decision to approve initial or continued participation, or to terminate an organization's participation, will be communicated in writing within sixty (60) days of the SCRC's decision. In the event that the organization's participation or continued participation is denied, the organization will be notified by certified mail. If continued participation is denied, the organization will be allowed thirty (30) days to appeal the decision. See "JHHC Provider Grievance Process."

Termination of Participation

Provider agreements may be terminated by JHHC, effective immediately for cause. Examples of for cause may be defined as, but not limited to:

- ★ Fraud
- ★ Patient abuse
- ★ Incompetence
- ★ Loss of licensure
- ★ Loss of participation status in state or federal payor programs (Medicare, Medicaid)

Contractual or Voluntary Terminations

Either the provider or JHHC may terminate the provider agreement with written notice to the non-terminating party at least 90 days prior to the termination date. The provider will continue to provide, or arrange for covered services for covered members prior to the effective date of termination and following termination for any member whose medical condition requires a continuing course of treatment where alternative arrangements have not been made.

Right to Appeal Termination

Should a practitioner or organization be terminated from the network, or otherwise not be approved for participation through the recredentialing process, the provider has the right to appeal the SCRC's decision, consistent with JHHC's credentialing policies and procedures.

The provider has no appeal right if the cause of termination was due to:

- ★ Revocation or loss of licensure
- ★ Conviction of fraud
- ★ Initial credentialing is denied

The provider has thirty (30) calendar days to submit the request for a first-level appeal following notification of an adverse decision regarding the provider's participation status with JHHC. JHHC will then notify the provider of receipt of the request for an appeal.

The credentialing department designee will convene an appeal panel comprised of three qualified clinicians who represent the provider community within the USFHP provider network. At least one of the panelists will be a clinical peer of the appellant. (For the purpose of this requirement, a clinical peer is a provider who holds the same licensure and specialty as the appellant.) Knowledge of the matter shall not preclude any individual from serving as a member of the panel; however, involvement with any earlier decision concerning the initial determination for termination or corrective action(s) precludes the individual from serving as a panelist.

The panel will review the appeal information submitted by the appellant and render a recommendation to the SCRC to uphold or overturn the initial decision. The SCRC decision will be rendered within thirty (30) calendar days from receipt of the appeal request.

If the SCRC and the panel decide to uphold the initial termination decision, the provider may request a second-level appeal and request the opportunity for a personal hearing. Personal appearance hearings will be scheduled at the convenience of the hearing panelists and the provider, but not to exceed sixty (60) calendar days from the receipt by JHHC of the second-level appeal request.

The provider has the right to be represented by an attorney or another person of the provider's choice during the appeal process. In lieu of a personal hearing, the provider may opt for a second panel decision with no personal appearance. The panelist in this situation will render a recommendation to the SCRC within thirty (30) days of receipt of the second-level appeal. In either situation (personal appearance or appeal panel), the panelists render a recommendation to the SCRC to either uphold or overturn the initial decision. The SCRC decision will be rendered within thirty (30) calendar days from the date of the second-level appeal. Second-level appeals are final and binding.

Panelists for the second-level appeal are selected as described above in the first-level appeal.

Subsequent to the decision of any appeal panel, the provider will be notified in writing via First Class U.S. Postal Service Certified Mail of the SCRC's decision.

Transition of Care upon Provider Termination

The JHHC Participating Provider Agreement requires all providers to give at least ninety (90) days advance notice of contract termination. JHHC notifies members affected by the termination of a primary care practitioner specialist or practice group at least thirty (30) calendar days prior to the effective date of termination or within thirty (30) calendar days of notification from the practitioner, and assists the members in selecting a new practitioner.

In some cases, members may be able to continue care with a terminated practitioner for a short period of time after the practitioner leaves the network. If this situation applies, JHHC will discuss this with you at the time of your termination.

More information about your obligations upon contract termination is located in your provider agreement. If you have additional questions, please contact Provider Relations at 410-762-5385 or 888-895-4998.

Contact Information

Customer / Provider Services

(benefit eligibility, claims status)

410-424-4528

800-808-7347

Mental Health/Substance Abuse Services

410-424-4830

888-281-3186

*Appointment Locator Service

888-309-4573

**Members can speak to and work with staff that can help them find urgent and routine appointments with Mental Health and Substance Abuse Professionals.*

Care Management

410-762-5206

800-557-6916

Fraud & Abuse

410-424-4996

410-762-1527 fax

compliance@jhhc.com

Health Coach Services

800-957-9760

healthcoach@jhhc.com

Health Education

800-957-9760

healtheducation@jhhc.com

Web Site Addresses

USFHP – www.hopkinsmedicine.org/usfhp

TRICARE – www.tricare.mil

FORMULARY – <https://www.hopkinsusfhp.org/members/my-benefits/pharmacy/>

Nurse Line

866-444-3008

Enter PIN #382

Mail Order Pharmacy

410-235-2128 (Maryland residents)

800-345-1985 (Non-Maryland residents)

Quality Improvement

410-424-4538

Provider Relations

410-762-5385

888-895-4998

410-424-4604 fax

Utilization Management

410-424-4480

800-261-2421

Performance Improvement/ Risk Management

410-338-3610

Superior Vision

800-879-6901

United Concordia Dental

800-332-0366

Under a separate agreement, the plan has arranged for members to receive dental services from selected community dentists under a discounted fee structure.

Claims Submission

Johns Hopkins HealthCare

PO Box 830479

Birmingham, AL 35283

Attn: USFHP Claims

Appeals Submission

Johns Hopkins HealthCare

7231 Parkway Drive, Suite 100

Hanover, MD 21076

Attn: USFHP Appeals

Network Hospitals

Johns Hopkins HealthCare LLC has contracts with the majority of hospital facilities within Maryland, Pennsylvania, Delaware, and Washington, D.C. For a complete and up-to-date listing of these hospitals, please refer to the provider search function at www.jhhc.com.

Member Safety

Providers will be encouraged to participate in plan-sponsored patient safety programs. The plan encourages optimizing patient outcomes and communication through the implementation of a patient safety program that will provide an evidence-based approach utilizing information, people, and resources to achieve the best clinical quality outcomes and the prevention of medical errors and patient harm. The DoD currently uses a comprehensive set of evidence based and field-tested tools and strategies called Team Strategies and Tools to enhance Performance and Patient Safety (TeamSTEPPS™) that are applicable to any health care setting.

Confidentiality

Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information according to the terms of the Participating Provider Agreement and Payor Addendum.

Member Eligibility Verification

All TRICARE eligible members listed in the DoD's Enrollment Eligibility Reporting System (DEERS) database as eligible for military health care benefits may enroll in TRICARE Prime. These non-active duty individuals include the spouse, former spouse, and children of active duty personnel, retirees, and their spouses and children, survivors, and former spouses. The plan may not enroll active duty members.

Before providing services, a provider should verify eligibility by calling Provider Services at 410-424-4528 or toll free at 800-808-7647 in Maryland.

SECTION III

Care Management



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Care Management

Johns Hopkins US Family Health Plan is committed to becoming the leader in care management population health solutions. Our care management model promotes prevention skills, performs health risk identification, and manages member compliance to avoid costly treatments. We not only outreach to the sickest members to stabilize and manage conditions, we guide healthy members further along the prevention path. Through our four main service areas of Preventive, Transitional, Complex, and Maternal/Child, we catch members wherever they are on the health continuum.

Member Identification

Members are identified for targeted care management interventions through the following means:

- ★ Claims and encounters
- ★ Pharmacy data
- ★ Laboratory data
- ★ PCP, hospital staff, and other referrals from the health care team
- ★ Utilization management staff
- ★ Member self-referral
- ★ Predictive modeling using ACGs (Adjusted Clinical Groups) developed by the Johns Hopkins Bloomberg School of Public Health
- ★ Provide education of advance care planning
- ★ Foster member independence

Enhanced Care Management

Care Management is an intensive coordination and evaluation of care that is appropriate when a member is part of a special needs population.

Enhanced case management services are available for members who are part of a special needs populations including:

- ★ Children with special health care needs
- ★ Children in state-supervised care
- ★ Individuals with a physical disability
- ★ Individuals with a developmental disability
- ★ Pregnant and postpartum women
- ★ Individuals who are homeless
- ★ Individuals with HIV/AIDS
- ★ Individuals with a need for substance abuse treatment

For assistance in coordinating care for a special needs member, contact us at 410-762-5206 or 800-557-6916, or fax a completed USFHP Member Referral form to the appropriate department as indicated on the form.

Service Areas

Preventive Health

Services are provided to members showing a potential risk, an anticipated risk, or a known risk, with the intent to prevent that risk from becoming a significant care need. Includes health and wellness promotion such as exercise, nutrition and screenings, but these services are also designed to stabilize a member's health to prevent it from worsening.

Qualified health care professionals will provide assistance to help close gaps in care, which may include: annual wellness visits, screenings, monitoring labs to ensure therapeutic levels of a medication, earlier intervention, and engagement with a health care provider to proactively manage a potential health exacerbation based on clinical indicators (i.e. elevated blood pressure and HbA1c that are not within range). Services include:

- ★ Health maintenance and prevention reminders to promote self-management skills
- ★ Health Education
- ★ Recommendations on how to manage and maintain overall health and wellness

Complex Care

Complex care management is the intensive level of intervention in the population health continuum and provides care management services for members with one or more complex medical conditions and over or under utilization of health care services. Johns Hopkins USFHP recognizes that individuals often have two or more health problems that can be well served by evidenced-based care management.

We provide service to adults with asthma, diabetes, cardiovascular conditions, chronic obstructive pulmonary disease, sickle cell, cancer, pain management, Alzheimer's, rehabilitative needs, HIV/AIDS, seizure disorders, developmental disabilities, chronic kidney disease and chronic lung disease. We provide services to children 18 years and younger with chronic conditions such as asthma, diabetes, sickle cell disease, neurological devastation, various genetic syndromes, cancer and morbid obesity, or after an organ transplant.

Services include:

- ★ Complex Care Management Assessment completed on all members
- ★ Coordinate transitions of care that do not fit within the Transitional Care Services model
- ★ Coordinate care with PCPs, specialists, DME/service providers
- Support self-management
- ★ Address barriers and gaps in care by creating innovative solutions and involving community resources
- ★ Assist with pharmacy preauthorizations, medical necessity reviews and quality of care referrals
- ★ Education on signs and symptoms of worsening disease
- ★ Identify appropriate level of care

Transition of Care

Provided following a health event, such as a recent hospitalization, the diagnosis of an illness, a life-changing event such as a birth, or a decision to receive long-term care services). Designed to assist members and their loved ones with coordinating a set of clinical resources and navigating the complexities of the health care system.

Services include:

- ★ Coordination of durable medical equipment and supplies
- ★ Medication management and reconciliation
- ★ Appointments with providers (existing and newly identified)
- ★ Understanding diagnosis
- ★ Establish a relationship with providers

Maternal/Child Health

Partners with Mom is a maternity care management program that targets all pregnant women. High-risk moms with a history or current symptoms of asthma, diabetes, pre-term labor, substance abuse, hypertension, and/or adolescent pregnancy are followed by our OB nurse care manager. Pregnant mothers with other high-risk OB diagnoses that may benefit from care management interventions are also considered for inclusion into this program. Pregnant women with no risk factors receive ongoing assessments during the pregnancy to identify any potential risks.

If a baby needs care in the NICU, our care managers work with the parents to ensure their understanding of their baby's care. We also assist the parents in their transition home.

Through early identification and intervention, the program has reduced antepartum admissions, decreased NICU births, and improved maternal/fetal outcomes. Partners with Mom care managers are available for onsite, high-risk clinic sessions to provide the critical resources and services needed. Care managers work closely with the provider and member to improve compliance, coordinate care, and maximize favorable outcomes.

This care management service area will also serve high-risk and at-risk pediatric members from birth through age 18.

Behavioral Health

For members living with a mental health condition such as depression, autism spectrum disorder, anxiety or addiction, we provide care management services. Johns Hopkins USFHP benefits may include access to confidential care coordination support.

These clinicians use a unique team approach to assist you through your treatment needs. Services include coordination with all providers, treatment resources, and health coaching.

Johns Hopkins USFHP behavioral health services can be obtained by calling 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m.

Other Services

Health Coaching

The Health Coaching program offered to members age 18 years and older is an evidence-based lifestyle management and disease prevention program. The target population includes members who have well managed chronic conditions or are at risk for developing chronic conditions.

Risk factors may include: hypertension, high cholesterol, obesity and pre-diabetes. The program focuses on the areas of smoking cessation, weight loss, nutrition, fitness and stress management. Improvements in these areas have been shown to reduce the frequency and length of hospitalizations and over the long term should reduce the incidence of chronic health conditions.

Health Education

The health education program provides educational seminars to promote awareness of health, increase knowledge, and provide members with the skills and tools needed to improve their health.

Health educators plan, deliver, and evaluate behavior modification programs with the goal of improving overall health outcomes and reducing disability. In addition to offering awareness through health education tables, waiting room literature and bulletin boards, the health education staff also offers a catalog of classes specific to the needs of individual sites. These classes are developed and/ or approved by nationally known institutes and associations, such as the National Institute of Aging, American Heart Association, American Diabetes Association, American Cancer Association and others. Health coaching and health education services can be accessed by calling our Health Promotion and Wellness team at 800-957-9760.

Clinical Practice Guidelines

Clinical practice guidelines were developed for our providers, as well as our members, to assist with decisions about appropriate health care under special clinical circumstances.

The use of these guidelines allows for the measurement of their impact on outcomes and may reduce interprovider variation in diagnosis and treatment.

We have incorporated the latest scientific basis and expert opinion into these guidelines. The guidelines are updated or revised at a minimum of every two years. Please refer to our website for the most updated versions at: www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines.html.



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN

SECTION IV

Quality Improvement



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Clinical Quality Management Program

Executive Summary

The Clinical Quality Management program (QI) is designed to support the highest level of performance in beneficiary service, access to care, and health outcomes when compared to national and industry quality benchmarks.

Mission of the Quality Improvement Program

Johns Hopkins USFHP QI program activities support and promote the Johns Hopkins USFHP mission to improve the lives of our plan members by providing access to high quality, cost effective, member-centered health care. In addition, the Johns Hopkins USFHP QI program supports the Johns Hopkins Medicine mission to improve the health of the community and the world by setting the standard of excellence in medical education, research, and clinical care.

Johns Hopkins USFHP QI program uses nationally recognized measures of quality as follows:

- ★ Agency for Healthcare Research and Quality (AHRQ)
- ★ National Quality Forum (NQF)
- ★ NCQA standards for quality and member safety

Continuous Quality Improvement

The QI program functions within the Institute for Healthcare Improvement's triple aim framework (www.ihl.org), which is to simultaneously: 1) Improve the experience of care (including quality and satisfaction www.ihl.org); 2) Improve the health of populations; and 3) Reduce the per capita cost of health care. The QI program uses the Continuous Quality Improvement (CQI) process to develop and evaluate initiatives to improve member health, experience, and quality of care in alignment with the triple aim.

Quality Improvement Program Goals

The QI program goals are to:

- ★ Be the top performing health plan in the military health system
- ★ Improve the quality and safety of clinical care, including behavioral health, and services provided to members
- ★ Support and promote the Johns Hopkins USFHP mission to improve the lives of members by providing access to high quality and member-centered healthcare
- ★ Promote utilization of the principles of CQI
- ★ Utilize data, outcome studies, and evidence-based criteria in order to analyze, monitor, evaluate, and report clinical quality and member safety
- ★ Support programs and initiatives led by other Johns Hopkins USFHP departments through the provision of quality data and analytics
- ★ Serve a culturally and linguistically diverse membership through customer service and marketing lead activities
- ★ Serve members with complex health needs through the care management and special needs programs
- ★ Support coordination of activities and audits that demonstrate compliance with applicable regulatory and accreditation requirements

Member Safety Program

Johns Hopkins USFHP has embraced the innovative patient safety model developed by the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality in order to promote quality improvement and patient safety activities within the health plan. The Armstrong Institute is working to advance the science of safety and quality through an array of projects and initiatives.

The member safety program outlines Johns Hopkins USFHP's plan for monitoring quality of care, disparities of care, and tracking outcomes of QI initiatives and studies related to safety. The QI department also works in collaboration with other Johns Hopkins USFHP departments and Johns Hopkins Medicine to promote quality clinical outcomes and prevent harm to members. Member safety activities performed throughout the organization include, but are not limited to, the following:

- ★ Quality of care reviews (clinical, behavioral, and pharmacy quality issues)
- ★ Monitoring of member complaints/grievances
- ★ Medical record chart audits identified through AHRQ Patient Safety Indicator software
- ★ Drug utilization reviews and identification/communication of drug recalls (Pharmacy department)
- ★ Monitoring for quality and appropriateness of member care (Care Management department)
- ★ Referral of potential adverse events as identified through review of concurrent services for hospitalized members (Utilization Management department)
- ★ Provider credentialing activities (Credentialing department)

Quality Improvement Objectives

QI objectives are developed annually as a result of the analysis of quality initiatives and studies. Additional objectives are developed throughout the year as needed and are based upon gap analysis of HEDIS®, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results, complaint data and other quality-related data. QI objectives are specific to the needs and opportunities identified for USFHP members.

HEDIS and CAHPS

HEDIS measures performance on important dimensions of care and service. HEDIS consists of 95 measures across seven (7) domains of care. USFHP reports on approximately 30 measures, which may vary from year to year based on changes to NCQA requirements. The QI department coordinates all activities associated with the collection, validation and submission of HEDIS data. Johns Hopkins USFHP has contracted with an NCQA-certified vendor to conduct external HEDIS audit activities to ensure compliance with data collection processes and validation of data prior to submission. Johns Hopkins USFHP has IT resources with strict controls allowing for the confidential transmission of data via Interactive Data Submission System (IDSS) tool to NCQA.

The CAHPS survey is designed to capture information regarding member experience with network providers and health plan operations. Surveys are administered annually by external NCQA-certified survey vendors per protocol as defined in the current HEDIS Specifications Volume 3.

Quality Improvement Initiatives

A quality initiative is a focused action that is taken by the health care organization, provider, or practitioner with the goal of improving the quality of health care services, access to care, and member health outcomes.

Multiple factors are considered during initiative development to include the prospective impact to members, as well as the likelihood that measurable improvement will occur. In light of differences in the populations served at Johns Hopkins USFHP, the QI department also considers national health care campaigns deemed significant and supported by the various regulatory agencies governing Johns Hopkins USFHP product lines (i.e. Department of Health and Human Services' Partnership for Patients and Million Hearts campaigns) during the initiative development process. QI initiatives and projects are routinely monitored and revised as appropriate through the QI work plan.

Quality Improvement Annual Program Description and Work Plan

The QI work plan is a dynamic document that reflects planned activities for the upcoming year in addition to objectives and goals related to those activities. The program description is updated annually, or more frequently, if necessary. The work plan is routinely evaluated and updated as recommended by Johns Hopkins USFHP QI committees. Various departments at Johns Hopkins USFHP are responsible for action items in this work plan. The QI program description and work plan are approved annually through the Quality Improvement Committees, and then ultimately by the Johns Hopkins USFHP Board of Directors.

Quality Improvement Program Evaluation

On an annual basis, a multidisciplinary team evaluates the outcomes of quality initiatives and studies and the overall effectiveness of the QI program. The QI evaluation is approved by QI committees, with ultimate approval by the Johns Hopkins USFHP Board of Directors. The QI program evaluation, including a line of business specific addendum if appropriate, is submitted to regulatory agencies as required.

Provider's Role

Providers are expected to cooperate with health plan quality improvement, patient safety, and performance improvement activities to improve the quality of care, quality of service, and member experience. Providers also are expected to allow the health plan to use performance data for the purposes of quality improvement initiatives. Examples of the provider's role in the health plan quality program include:

- ★ Review quality reports and take action to improved clinical outcomes as measured by HEDIS
- ★ Collaborate with the health plan to resolve member complaints regarding access to care, quality of care, provider service or other issues upon request
- ★ Provide feedback on the health plan via provider satisfaction surveys
- ★ Provide medical records as requested for HEDIS, quality of care investigations, or other medical record audits
- ★ Collect and share quality and performance data for the purposes of joint quality initiatives
- ★ Participate in member satisfaction initiatives, including improving access to care
- ★ Participate in quality improvement committees upon request

A number of providers are invited to participate in quality improvement committees. Their perspective as participating providers is valuable in evaluating and improving clinical effectiveness, provider satisfaction, and member satisfaction. USFHP also relies on participating providers to provide feedback on clinical practice guidelines, preventive health guidelines, medical policy, and pharmacy policy.

If you are interested in obtaining additional information about the quality improvement program, including a copy of the full QI program description, please contact your provider network manager.

SECTION V

Utilization Management



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Utilization Management

USFHP is committed to maintaining the health and wellness of all our members and through our Utilization Management (UM) department, ensuring that care is provided at the right time and in the right setting. The underlying utilization strategy is that the PCP is the best individual to determine what care should be provided and to coordinate that care for members. The UM department evaluates requests for services for medical care, behavioral health, and substance abuse treatment based on appropriate benefit provisions, clinical criteria or guidelines, and local health care delivery options. The USFHP pharmacy formulary and pharmacy utilization management procedures are established by the Department of Defense (DoD) Pharmacy and Therapeutics Committee. USFHP members are subject to quantity limits, prior authorization, and step-therapy requirements established by the DoD. (*Refer to the Benefits section*)

Information Used to Make UM Decisions

The Medical Management department will review or may request information relevant to any UM decision for coverage used to determine medical necessity. UM staff gathers pertinent information, which may include any or all of the following:

- ★ The procedure/treatment type, length of stay requested, procedure codes(s) and diagnosis code(s)
- ★ Office and hospital records
- ★ A history of the presenting problem
- ★ A clinical exam
- ★ Diagnostic testing results
- ★ Treatment plans and progress notes
- ★ Patient psychological history
- ★ Information on consultations with the treating practitioner
- ★ Evaluations from other health care practitioners and providers
- ★ Photographs
- ★ Operative and pathological reports
- ★ Rehabilitation evaluations
- ★ A printed copy of criteria related to the request
- ★ Information regarding benefits for services and procedures
- ★ Information from responsible family members
- ★ Individual clinical circumstances and history

The type of service requested determines which medical documentation or criteria will be required. When sufficient information is not available to make a determination, every effort is made to obtain the necessary information within the specified time frame. If our Medical Management department cannot obtain relevant documentation, it must make or recommend a decision to the provider/health plan based on the material available.

Clinical Review Criteria

USFHP utilizes the Tricare Policy Manual, Tricare Operations Manual, and Tricare Prior Authorization Clinical Criteria to determine benefit coverage and medical necessity. Clinical review criteria that are objective and evidence-based are also used to evaluate the medical necessity of pharmacy, medical, and behavioral health care services and include commercial criteria, InterQual®, and Alere Neonatal Clinical Management Guidelines, as well as internally developed medical and pharmacy policies. The medical criteria used for utilization management decisions are available to providers upon request by calling the UM department.

Utilization management decision making is based only on appropriateness of care and service and existence of coverage. JHHC staff may not participate in the review of any case, in which he/she has professional or personal involvement or where judgment may be compromised. There are no rewards to practitioners, providers, or care management staff to encourage barriers to care and service through the issuance of denials of coverage or requested services. There are no financial incentives for utilization management decision makers to encourage decisions that result in underutilization of services.

Medical Policy

Medical policies are internally developed criteria based on the most current research available at the time of policy development and state whether a medical technology, procedure, drug, or device is medically necessary or investigational. TRICARE Operations Manual and specific contract benefits supersede medical policy. Please refer to our website for the most updated version of medical policies at: hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/policies/medical_policies.html.

Accessing Utilization Management

UM staff are available to providers and members between the hours of 8 a.m. and 5 p.m. Monday through Friday on regular business days by calling 410-424-4480 or 888-401-3592. If UM staff is unavailable to take the call during normal business hours, or for after-hours the caller will have the option of leaving a voice mail message. TTY/TDD services are available for anyone with hearing or speech difficulties. Language assistance, in the member's chosen language, is available as needed. On call inpatient utilization review nurses are available after-hours for urgent requests from hospitals, DME, or home health providers by paging 800-307-9730.

Utilization Management fax numbers:

- 410-424-4603 – Referrals not requiring utilization review
- 410-762-5205 – Outpatient authorization/medical review
- 410-762-5250 – Durable medical equipment
- 410-424-4894 – Inpatient authorization
- 410-424-4839 – Behavioral health treatment plans

Preservice, Concurrent, and Postservice Review

Prior authorization is required for inpatient and certain outpatient services and supplies and for specific medications. Requests for admissions and services requiring prior authorization require submission of member information and clinical documentation, which may include:

- ★ Demographics
- ★ Attending physician and facility
- ★ Date of procedure
- ★ Procedure or equipment requested
- ★ Medication requested (see pharmacy prior authorization)
- ★ Diagnosis
- ★ Pertinent clinical data
- ★ Description and duration of symptoms
- ★ Results of diagnostic tests
- ★ Consultation reports

Prior authorization is required for all out-of-network services. All elective inpatient admissions must be approved prior to the admission.

Inpatient Preservice and Concurrent Review

In the inpatient setting, prior authorization through prospective review is required for all acute hospital, sub-acute nursing facility, acute rehabilitation, inpatient hospice, inpatient substance abuse treatment, and mental health admissions. All proposed elective or urgent admissions will be reviewed to determine if the service could be provided in an ambulatory care setting.

Notification of an inpatient admission must be sent within 48 hours of the admission. Inpatient admissions that have not been preauthorized will be reviewed for medical necessity from the date of notification to USFHP through discharge.

Once notification of an admission is received, a utilization review nurse will request clinical information to conduct concurrent review using clinical criteria to evaluate for possible movement to a lower level of care without compromising the plan of care, and to anticipate discharge needs.

If a delay in service, treatment, procedure, or discharge is identified during the process of utilization review for an inpatient stay, and the delay will result in, or is anticipated to result in an overall extended length of stay, the hospital days resulting from the delay in service/treatment/procedure/discharge will be denied.

Outpatient Preservice Review

Outpatient services requiring preauthorization include: certain surgical procedures, imaging studies, and durable medical equipment; home health and hospice care; ambulance transfers; requests for Category III or unlisted CPT codes; and speech therapy. Physical and occupational therapy require authorization after the twelfth visit of each episode of care.

Services requiring prior authorization are outlined in the USFHP Outpatient Referral and Preauthorization Guidelines, which can be accessed on the JHHC provider site: www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/.

Postservice Review

Retrospective review may be conducted when benefit provisions permit and for utilization review of an inpatient admission when the member's medical condition prevented the hospital from determining the patient's insurance status, or when the identity of a member could not be determined. Postservice review is also conducted of inpatients stays if a member is discharged on a weekend or holiday.

Authorizations and Denials

Requests for prior authorization determinations are made in a timely manner to accommodate the urgency of the members' clinical situation, thereby minimizing disruption and/or delay to the provision of health care services.

TRICARE requires authorization notification within two days but not to exceed five working days following receipt of the request and all required information. Notification of concurrent inpatient requests are made within 24 hours or up to 72 hours if additional information is required to make the determination.

During the process of utilization review for inpatient and outpatient services, including behavioral health services, if TRICARE benefit criteria are not met an administrative denial will be issued. When medically necessary/clinical criteria are not met, the case is reviewed by a JHHC medical director to determine if coverage will be approved. If denied, providers are notified and given the opportunity for a peer-to-peer conversation to discuss the decision with the JHHC medical director. Written notification of the denial will be sent to the primary care provider, specialist, and member explaining the reason for the denial, information on the appeal process, and information on how to request a copy of the criteria or benefit provision used to make the decision.

Providers may check and verify prior authorization requirements for procedures and services through JHHC's Prior Authorization Lookup tool (JPAL). Located in the [HealthLINK portal](#), JPAL offers a user-friendly way for providers to look up prior authorization requirements without needing to call Customer Service.

Providers can simply click on the JPAL link in [HealthLINK](#) to access this tool.

- ★ Search by specific procedure code or procedure description.
- ★ Search results are organized by procedure code, modifier, procedure description, and individual line of business.
- ★ Clicking on the procedure code link or on any line of business link brings up specific details, such as the rules pertaining to prior authorization for each line of business and access to the medical policy document.

NOTE: JPAL is a way to look up prior authorization requirements only; it does not handle prior authorization requests. Please follow JHHC's policies and procedures as usual to request an authorization:

- ★ Confirm the status of all procedures before delivery of service.
- ★ If prior authorization status is unclear, submit an authorization request.
- ★ Authorizations are not a guarantee of payment.

Referrals

The PCP is responsible for determining when a member's health care needs require a referral to a specialty care provider. The PCP is responsible for arranging all member referrals and specialty care. A referral is valid for one year from the date it was written. The PCP must include the number of visits and time. If not included, the referral will default to one visit in one year.

Services requiring a referral are outlined in the USFHP Outpatient Referral and Preauthorization Guidelines, which can be accessed on the JHHC provider site: www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/.

Referrals to Specialists

For covered specialty office visits referred by a participating provider, no referral or authorization is required unless listed in the preauthorization section of the USFHP Outpatient Referral and Preauthorization Guidelines.

When a PCP refers a Johns Hopkins USFHP member for specialty care, the specialist must follow the PCP's specific referral. If the specialist wishes to perform services broader or different in scope than that on the referral, including referral to another specialist, the specialist must obtain further authorization from the PCP.

All procedures performed in ambulatory surgery centers (place of service 24), and outpatient hospital settings (place of service 22) require a referral to be submitted to JHHC. If these procedures/services require preauthorization, clinical notes are also required to be submitted.

Health Referrals

Prior authorization or primary care manager (PCM) referral is not required for outpatient, office-based mental health and substance use disorder visits; however, Partial Hospital (PHP) and Intensive Outpatient Program (IOP) services require a referral from the PCM. Members who would like assistance locating a mental health or substance abuse provider should be instructed to contact Behavioral Health at 888-281-3186 to obtain the names of network behavioral health providers. Behavioral health network providers are located on the campus of Johns Hopkins Bayview Medical Center and Johns Hopkins Hospital, and throughout the area where primary care sites are located.

Referrals to Out-of-Network Providers

All referrals to out-of-network providers must be preauthorized through UM and are limited to services that cannot be provided in the network. Clinical notes must be submitted for all out-of-network requests. USFHP is a managed care plan; to minimize the member's out-of-pocket expenses, it is recommended to provide referrals when needed to in-network participating providers, unless the service cannot be provided within the network.

Out of Network Services

If a member becomes ill or injured, and requires care while outside the plan service area (but within the continental United States), that care will be covered by the plan if authorized by the PCP or nurse care coordinator.

Members who are outside of the plan service area (central Maryland) may seek emergency care by calling their regular health center for a referral to an approved facility. In a life-threatening situation, members should go to the nearest emergency room. Members who received emergency care without a referral must be coordinated through JHHC and the PCP.

Communication with Covered Person

JHHC welcomes all opportunities for the provider community to speak freely with their members or other designated parties connected to this organization. Participating practitioners are encouraged to discuss treatment options with members, regardless of benefit coverage limitations. You should explain the pros and cons of each treatment option so the member can make an informed decision.

Peer-to-Peer Conversation

After a provider receives a verbal notification of a denial, but before an actual written notification has been sent to the provider, the provider has the right to discuss determinations with the medical director, according to the Johns Hopkins HealthCare policy entitled: UM 48 Clinical Review Process-Secondary Medical Review.

Authorization Notification

When a provider requests an authorization for a member, and Johns Hopkins HealthCare approves that authorization, we ask that you notify the member that their authorization has been approved.

Third Party Liability

It is the policy of Johns Hopkins HealthCare to do the following:

- ★ **Johns Hopkins USFHP Payor Status.** If other health insurance coverage exists, plan coverage is available only as a secondary payor (except in cases involving Medicaid, Indian Health Services, and Veteran's Administration) and only after a claim has been filed with the double coverage plan and a payment determination issued. A double coverage payment determination must be issued regardless of any provisions contained in the other coverage. As secondary payor, the plan's liability is no greater than it would have been in the absence of double coverage and does not extend to non-covered services. The plan is responsible for the lower of the amount it would have paid as primary payor or the balance after the other health insurance has paid.
- ★ **Primary Payor Disputes.** As a TRICARE Prime designated provider, under federal law, Title 10, U.S.C., Chapter 55, Section 1079 (j)(1), the US Family Health Plan always serves as the secondary payor when double coverage applies. The plan does not compromise its secondary payor status unless directed to do so by Defense Health Agency (DHA). The plan attempts to resolve all disputes over primary payor status directly with the double coverage plan and maintains written documentation of all dispute resolution efforts.
 - For plan members with double coverage and Medicare, it is the policy of the US Family Health Plan to accept reduced payments from the other health insurance plan that recognizes its primary status but only pays an amount that supplements the benefit payable by Medicare if Medicare would otherwise be primary. This policy is in accordance with all TRICARE management activity directives. When a payor refuses to recognize its primary status and to issue referrals or prior authorization accordingly, the plan issues the referral or prior authorization and documents the payor dispute in its records.

- ★ **Lack of Payment by Other Health Insurer.** The plan is prohibited from paying amounts denied by the other health insurer because the claim was not filed in a timely manner or because the member failed to satisfy some other requirement. If a statement from the other health insurer regarding how much would have been paid had all requirements been met is provided to the plan, the claim may be processed as if the other health insurer actually paid the amount shown on the statement. If no such documentation is provided, the plan must deny the claim and no member may be balanced billed.
- ★ **Prohibition on Waiving OHI Benefits.** Members may not waive benefits due from any insurance plan or medical service or health plan. If a double coverage plan provides, or may provide, benefits for a service, a claim must be filed with the double coverage plan. Refusal by the member to claim benefits from other health insurance must result in a denial of plan benefits.
- ★ **Determination of Double Coverage.** The plan maintains accurate and current other health insurance information in order to coordinate double coverage benefits. All double coverage information is verified with the member and the other health insurance plan. When the plan is aware of the existence of an effective double coverage plan, the other health insurance plan must submit evidence of processing with the claim before the plan adjudicates the claim as secondary payor.
- ★ **Marketing and Enrollment Limitations.** The plan does not intentionally market to and enroll Military Health System (MHS) members who have other health insurance or are enrolled in the MHS direct care system. Marketing efforts are directed toward those MHS members listed on the DEERS data file provided by the government. MHS members covered under the Federal Employee Health Benefits Plan (FEHBP) may enroll in the plan after providing proof that they have elected to suspend their FEHBP coverage in accordance with 5 CFR Part 890 or they may join the plan without suspending coverage and they will be counted towards the allowed members with OHI.
- ★ **Timely Filing.** The timely filing limit for COB claims is 180 days from the date the primary insurance adjudicated the original claim.
- ★ **Court Order.** The Johns Hopkins US Family Health Plan is primary except in circumstances listed above. The plan will dispute any court orders stating otherwise and pay as secondary.

Worker's Compensation

TRICARE benefits are not payable for work-related illnesses or injury that is covered under a worker's compensation program. The TRICARE member may not waive his or her worker's compensation benefits in favor of using TRICARE benefits. The member must apply for worker's compensation benefits. Failure to apply does not change the TRICARE exclusion.

SECTION VI

Benefits



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Summary of Health Care Benefits

Johns Hopkins USFHP provides a comprehensive range of preventive, diagnostic and treatment services as defined by the DoD in accordance with TRICARE Prime benefit. Although a specific benefit or service may be listed as covered, it will be provided and paid for only if, in the judgment of the provider, it is medically necessary for the prevention, diagnosis, or treatment of an illness or condition. No oral statement of any personnel shall modify or otherwise affect these benefits under this plan, or be used in the prosecution or defense of a claim under this plan.

For a summary of the costs and benefits under the Johns Hopkins USFHP, please visit the website at: www.hopkinsmedicine.org/usfhp and click on Members and Visitors on the left hand tab; then click on Summary of Costs & Benefits.

Pharmacy and Medications

Formulary and Copayments

Johns Hopkins USFHP utilizes the TRICARE pharmacy formulary. The TRICARE pharmacy formulary is a list of generic and brand prescription drugs that are covered under the TRICARE benefit. USFHP members are responsible for a portion of the cost (copayment) of their medications.

The TRICARE formulary is a tiered, open formulary and includes generic formulary drugs (Tier 1), brand name formulary drugs (Tier 2), and non-formulary drugs (Tier 3). Additional information about the DoD Pharmacy and Therapeutics review and list of formulary drugs as well as related drug tier/copay can be found here: https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/usfhp/index.html.

USFHP members are responsible for a portion of the cost of their medications, or copay. Copays are subject to change at TRICARE's discretion. The TRICARE formulary contains three cost levels for USFHP members. The current cost shares are as follows:

Tier 1 (Generic Formulary Drugs):

\$13.00 for up to a 30-day supply.

Tier 2 (Brand Name Formulary Drugs):

\$33.00 for up to a 30-day supply

Tier 3 (Non-Formulary Drugs):

\$60.00 for up to a 30-day supply

For home delivery and pharmacy network retail up to a 90-day supply (maintenance medications only), the copays are as follows:

\$10.00 for Generic Formulary Drugs

\$29.00 for Brand Name Formulary Drugs

\$60.00 for Non-Formulary Drugs

Note: Certain medications may not be excluded/not covered per TRICARE pharmacy program.

Providers can view the cost share for a medication using the TRICARE formulary search tool. Providers can also search for lower cost alternative medications to a medication they are currently prescribing.

The Johns Hopkins USFHP plan allows retail prescription processing at Walgreens pharmacies across the United States. Prescriptions may be filled for up to a 90-day supply. For members who prefer to use a mail order program, Walgreens pharmacy provides this service. The contact information, directions, and request form for mail order prescription fills can be found on the plan's website at https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/usfhp/pharmacy.html.

Covered Medications *(not all inclusive)*

This option allows Johns Hopkins USFHP members to fill prescriptions at any Walgreens pharmacy, without having to submit a claim. You may fill prescriptions for up to a 90-day supply at any network pharmacy. The Johns Hopkins USFHP pharmacy program provides outpatient coverage to beneficiaries for medications that are approved for marketing by the U.S. Food and Drug Administration (FDA) and that generally require prescriptions. Other covered medications include:

- ★ Compounded medications of which at least one ingredient is a legend drug
- ★ Insulin
- ★ Insulin syringes and needles
- ★ Glucose test strips
- ★ Lancets
- ★ Tobacco cessation products covered by the tobacco cessation benefit

Other OTC drugs and supplies covered by the pharmacy benefit:

- ★ Cetirizine tablets
- ★ Fexofenadine tablets
- ★ L-evonorgestrel. Emergency contraceptive used to prevent pregnancy. It's also known as Plan B. It's available to all beneficiaries for free without a prescription. (Plan B One-Step Emergency Contraceptive)
- ★ Loratadine tablets
- ★ Omeprazole (generic of Prilosec OTC)

Non-Covered Medications *(not all inclusive)*

Prescription medications used to treat conditions that are not currently covered by USFHP either by statute or regulation are likewise excluded from the pharmacy benefit.

Excluded medications include:

- ★ Drugs prescribed for cosmetic purposes
- ★ Fluoride preparations
- ★ Food supplements
- ★ Homeopathic and herbal preparations
- ★ Over-the-counter products (except insulin and diabetic supplies, and select OTC products.)
- ★ Weight reduction products
- ★ Certain prescription medications removed from the TRICARE pharmacy benefit program.

Prior Authorization and Medical Necessity

Some medications require prior authorization before they can be dispensed. For a list of prior authorization drugs, please visit the TRICARE formulary search tool.

To initiate a prior authorization: providers must complete and fax the Prior Authorization form along with supporting clinical documentation to the Johns Hopkins HealthCare pharmacy department at 410-424-4037. Download a copy of the Medical Review Drug Code Prior Authorization form here: www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.

During the pharmacy prior authorization review process, if TRICARE benefit criteria are not met, an administrative denial will be issued. When medically necessary/clinical criteria are not met, the case is reviewed by a JHHC pharmacist or medical director to determine if coverage will be approved. Written notification of the denial will be sent to the requesting provider and member explaining the reason for the

denial, information on the appeal process, and information on how to request a copy of the criteria or benefit provision used to make the decision. Decision and notification time-frames for all non-urgent preservice requests will not exceed five business days.

Quantity Limits

The DoD Pharmacy and Therapeutics Committee has established quantity limits for certain medications.

If a USFHP member's medical condition warrants use of quantities greater than listed quantity limit for their medication, providers may submit a prior authorization request for use of the higher quantity. Providers must provide medical justification for use of the higher quantity. Quantity limits are detailed on the TRICARE formulary search tool.

Step Therapy

Step therapy involves prescribing a safe, clinically effective, and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.

Drugs subject to step therapy will be approved for first-time users only after they have tried one of the preferred agents on the DoD uniform formulary.

Note: If a prescription was filled within 180 days prior to implementation of step-therapy, the member will not be affected by step therapy requirements and will not be required to switch medications.

Generic Drugs Policy

DoD's policy on generic drugs requires the pharmacy to substitute generic medications for brand-name medications when a generic equivalent is available. Brand-name drugs with a generic equivalent may be dispensed only if providers submit a medical necessity request and approval is granted by USFHP. In those cases USFHP members will pay the brand-name copayment. Use the applicable form on the USFHP provider website.

Generic drugs are chemically identical to their branded counterparts. They are made with the same active ingredients and produce the same effects as their brand name equivalents. The FDA requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Also, the FDA requires that all drugs, including generic drugs, be safe and effective.

Specialty Medications

Specialty medications are usually high-cost, self-administered injectable, oral, or infused drugs that treat serious chronic conditions. These drugs typically require special storage and handling, and may not be readily available at a local pharmacy. Specialty medications may also have side effects that require pharmacist and/or provider monitoring.

Specialty Medications – Pharmacy Benefit: Are self-administered and processed through the member's pharmacy benefit. These medications are available at a network retail or specialty pharmacy and may require prior authorization. You may search for the specialty medications covered under pharmacy benefit on the Tricare Formulary. Use the Prior Authorization form to request prior authorization for self-administered specialty medications.

Some medications may not be available to you at Walgreens pharmacy because the medication's manufacturer limits the medication to specific pharmacies through limited distribution practices. When a provider submits a request for use of a limited distribution drug, upon authorization approval, the JHHC USFHP Pharmacy Review department will forward the request to a contracted specialty pharmacy.

The specialty pharmacy will coordinate delivery of the medication to the patient's home or physician's office.

Specialty Medications – Medical Benefit: Are administered by a provider or under supervision of a provider and processed through the member’s medical benefit. Providers may supply these medications and bill the health plan for the medication and related administration using HCPCS Codes or J codes.

To find the HCPCS Codes that require medical necessity prior authorization and site-of-service prior authorization, visit USFHP Provider website.

Mental Health and Substance Abuse

What Is Covered

The plan provides medically and psychologically necessary services for the diagnosis and treatment of substance abuse and mental health conditions provided by licensed professionals including psychiatrists, psychologists, social workers, substance abuse counselors, and licensed clinical professional counselors.

Covered services include:

- ★ Diagnostic evaluation
- ★ Psychological testing
- ★ Psychiatric treatment (including individual, family, and group therapy)
- ★ Hospitalization (including inpatient professional services) subject to medical review
- ★ Appointment locator

Please refer new or existing members to the Emergency Department (ER) within six hours of notification of a non-life threatening behavioral health situation.

Johns Hopkins USFHP members may self-refer to a participating mental health provider office-based mental health and substance use disorder treatment. Non-office based mental health and substance use disorder treatment (e.g. intensive outpatient or partial hospitalization) require a PCM referral. All inpatient admissions require a preauthorization. Members also have access to an appointment locator service. By calling 888-309-4573, members can speak to and work with staff that can help them find urgent and routine appointments with mental health and substance abuse professionals.

Treatment for chemical and alcohol dependency at approved inpatient or outpatient treatment facilities is covered when prior authorized by the plan.

Autism Care Demonstration Program

Tricare has updated the Autism Care Demonstration (ACD) program effective January 29, 2018, TRICARE Operations Manual 6010.59-M, April 1, 2015 Chapter 18, Section 4, Section 18 Department of Defense (DoD) Comprehensive Autism Care Demonstration.

We’d like to emphasize two areas that cover referrals and mandatory outcome measures. JHHC requires that these outcome measures accompany the initial and concurrent requests for authorization. Please be aware that failure to submit these required documents may result in delayed authorizations or possible denial of services. If you need assistance locating providers who can assist with these outcome measures if you cannot complete them, please call JHHC USFHP at 410-424-4830 or 800-261-2429.

Referrals

A referral for Applied Behavior Analysis (ABA) services under the ACD is required. A physician-primary care manager (P-PCM) or a specialized Autism Spectrum Disorder (ASD) diagnosing provider may submit the referral for ABA services. The beneficiary must be diagnosed with ASD using DSM-5 criteria by an approved provider. The referral for ABA services must contain documentation of the age of the child and year of the initial ASD diagnosis, documentation of any comorbid psychiatric and medical disorders, and level of

symptom severity (level of support required per DSM-5 criteria under ASD). The level of symptom severity must be submitted by the specialized ASD diagnosing provider. The diagnosing/referring provider must provide a copy of the referral for ABA services to the beneficiary's parent(s)/caregiver(s). If the initial diagnosis is made by a P-PCM, the P-PCM must submit a referral for a specialized ASD diagnosing provider who must confirm the diagnosis of ASD within one year.

The specialized ASD diagnosing provider must complete the outcome measures as described below. If the specialized ASD diagnosing provider cannot complete the outcome measures requirement within one year of the initial diagnosis, then the specialized ASD diagnosing provider can contact JHHC for assistance locating a provider who can complete the outcome measures (see contact information above).

Outcome Measures

For all beneficiaries participating in the ACD, outcome evaluations must be completed and reported, using norm-referenced, valid, and reliable evaluation tools (see DoD form 1423). Outcome measures may be completed via telehealth (see the TPM, Chapter 7, Section 22.1 for requirements).

Pervasive Development Disorder Behavior Inventory (PDDBI)

This outcome measure must be completed at baseline and every six months. Only the Parent form is required at baseline. The Parent form and the Teacher form must be submitted every six months thereafter to align with the treatment plan submission and reauthorization. The teacher form may be completed by the teacher or the board-certified behavior analyst (BCBA/BCBA-D). Responsibility for the completion of the Teacher form by the BCBA/BCBA-D cannot be delegated except to a teacher who meets the requirements specified in the PDDBI manual. The Domain/Composite Score Summary Table must be submitted to JHHC with the initial request and at every six month renewal. Only authorized ABA supervisors are eligible to submit the PDDBI.

Vineland-3

This outcome measure must be completed at baseline (within one year of the initial diagnosis) and every two years thereafter to align with the Periodic ABA Program Review. The Parent form, the Interview form, or the Teacher form will be accepted. The Score Summary Profile, to include the Maladaptive Behavior Results Submission, must be submitted to JHHC. The Vineland must be completed and submitted by the specialized ASD diagnosing provider. If the specialized ASD diagnosing provider cannot complete the requirement, the following providers may be authorized to do so:

- ★ A TRICARE authorized independent provider (TRICARE authorized independent providers must use the assessment code for their discipline for reimbursement)
- ★ A BCBA/BCBA-D
- ★ Parents/caregivers may provide the TRICARE authorized independent provider or the authorized ABA supervisor a school-completed Interview or Teacher form for submission to JHHC to meet this requirement.

Note: The Vineland-2 can be accepted in lieu of the Vineland-3 until December 31, 2017.

SRS-2

This outcome measure must be completed at baseline (within one year of the initial diagnosis) and every two years thereafter to align with the Periodic ABA Program Review. The Parent form is required. The Total Score Results and Treatment Subscale Results must be submitted to JHHC. The SRS-2 must be completed and submitted by the specialized ASD diagnosing provider. If the specialized ASD diagnosing provider cannot complete the requirement the following providers may be to do so:

- ★ A TRICARE authorized independent provider (TRICARE authorized independent providers must use the assessment code for their discipline for reimbursement)
- ★ A BCBA/BCBA-D

What Is Not Covered

Mental health and substance abuse services require plan certification of medical necessity. Every effort is made to assist members with the necessary services at the right level of care. There are exclusions to the plan. The following are examples of excluded services:

- ★ Sexual functioning disorders
- ★ Support services and/or groups not conducted by a licensed professional
- ★ Learning disabilities, including psychological testing for academic and intelligence testing

Other Covered Benefits

Ambulance Service

Benefits are provided for medically necessary, life-sustaining ambulance transport when the use of any other method of transportation is inadvisable. If a retiree over age 65 or a retiree family member does not carry Medicare Part B, the copayment is \$41.00 per occurrence for ambulance services. Active duty family members and retirees with current Medicare Part B do not have a copayment for ambulance.

Diagnostic Services

If authorized by the primary care provider or specialist, the following are covered without an additional copayment when performed by an in-network provider:

- ★ Pathology/lab services
- ★ Nuclear medicine services
- ★ Cardiovascular studies
- ★ Radiology/ultrasound services

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) may be covered if deemed medically necessary. DME must be authorized by the PCP, and purchased or rented from a plan provider. Copayments are applied for retirees and their family members who do not carry Medicare Part B. Active duty family members and retirees with current Medicare Part B do not have to pay the copayment for covered durable medical equipment.

Extended Care Health Option (ECHO)

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

- ★ Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability
- ★ Extraordinary physical or psychological condition causing the beneficiary to be homebound
- ★ Moderate or severe mental retardation
- ★ Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems)
- ★ Serious physical disability

ECHO Benefits

ECHO benefits, services and supplies are not available through the basic USFHP program. ECHO coverage provides benefits such as:

- ★ Assistive services (e.g., those from a qualified interpreter or translator)
- ★ Durable equipment, including adaptation and maintenance
- ★ Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- ★ Medical and rehabilitative services
- ★ In-home respite care services (can only be used in a month when at least one other ECHO benefit is being received):
 - ★ ECHO respite care—up to 16 hours per month (limited to the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam)
 - ★ EHHC respite care—up to eight hours per day, five days per week for those who qualify
Note: The EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a skilled nursing facility
- ★ Training to use assistive technology devices
- ★ Institutional care when a residential environment is required
- ★ Special education (which can include applied behavioral analysis)
- ★ Transportation under certain limited circumstances (includes the cost of a medical attendant when needed to safely transport the beneficiary)

ECHO Eligibility Process

For general questions, potential ECHO enrollees or family members may call the USFHP customer service telephone number at 410-424-4528 or 800-808-7347. USFHP also has a dedicated ECHO team. A member of the ECHO team will assist members by answering more detailed questions regarding the eligibility and enrollment process. To enroll in the ECHO program, members must be currently enrolled in Johns Hopkins USFHP, enrolled in the Exceptional Family Member Program (EFMP) of their branch of service and provide medical documentation that a qualifying condition exists. USFHP will grant provisional ECHO enrollment (for 90 days) while the sponsor completes the EFMP forms. Upon receipt of the application and documentation, members will receive a decision letter with their eligibility status.

ECHO Costs

Active-duty sponsors pay a cost-share that is based on their pay grade and is separate from other USFHP program cost-shares. The monthly cost-share is one fee per sponsor, not per ECHO beneficiary.

Sponsor's Pay Grade	Monthly Cost-Share	Sponsor's Pay Grade	Monthly Cost-Share
E-1 to E-5	\$25	WO-5, O-5	\$65
E-6	\$30	O-6	\$75
E-7, O-1	\$35	O-7	\$100
E-8, O-2	\$40	O-8	\$150
E-9, W-1, W-2, O-3	\$45	O-9	\$200
W-3, W-4, O-4	\$50	O-10	\$250

The maximum government cost-share is \$36,000 per beneficiary, per calendar year. Sponsors are responsible for the cost of ECHO benefits that exceed this limit.

Note: The ECHO Home Health Care (EHHC) benefit is not subject to the \$36,000 per CY maximum government cost-share. The sponsor's cost-share does not count toward the annual catastrophic cap. ECHO costs cannot be shared between family members.

For more information about ECHO, you can also visit www.tricare.mil (see benefit information) or go to www.hopkinsmedicine.org/usfhp/ECHO/index.html.

Emergency and Urgent Care Services

Non-Emergency Urgent Care in the Plan Area

For non-emergency medical conditions requiring prompt attention, members need to contact their PCP before seeking care. If they call after office hours, the PCP after-hours line should provide information and guidance on where they should seek care.

Non-Emergency Urgent Care outside the Plan Area

If a member becomes ill or injured and requires urgent, but not emergency, care while traveling, the member is required to call their PCP office during regular hours or by using the after-hours service. For advice, plan members may contact the 24-hour nurse line at the number on the back of the member ID card. They must be referred by the PCP prior to seeking care to ensure that their care will be covered by the plan.

To locate an in-network urgent care center, use the Search for a Provider tool:
hopkinsmedicine.org/usfhp/find_doctor

Choose "Hospital or Facility," then under Specialty, choose "Urgent Care Center."

Emergency Services out of the Country or at Sea

If a member becomes ill or injured while in another country or at sea and requires urgent care, they can go to the nearest emergency room or medical facility to receive the necessary treatment. The hospital or facility may demand immediate payment; if they do, the member needs to ask for treatment information, bills, and receipts. Within seven (7) days of their return, the member will need to submit itemized bills and receipts to the Customer Service department along with an explanation of the services and the identification information from their Johns Hopkins USFHP identification card.

Hospice Care

Palliative care to manage symptoms at the end of life for terminally ill members is covered. Eligibility determinations are made using established medical criteria. Members should be referred to approved hospice care providers; prior-authorization is required.

National Cancer Institute (NCI) Clinical Trials

USFHP Members have access to NCI sponsored clinical trials; prior authorization is required.

Point of Service Benefit (POS)

USFHP members have a Point of Service option (POS) should they seek unauthorized care with an out-of-network provider. POS benefits are only paid after the individual or family deductible is met. Unauthorized out-of-network claims are considered for payment at the lesser of either 50 percent of the allowed amount or 50 percent of billed charges. Use of the extensive participating provider network is recommended.

General Exclusions

The plan does not provide coverage and will not pay for:

- ★ Services not considered medically necessary or clinically appropriate for diagnosis and treatment as determined by a physician
- ★ Services or procedures that are experimental or of a research nature
- ★ Any services (including vaccinations) provided for employment, licensing, immigration, recreational travel, or other administrative reasons
- ★ Cosmetic, plastic, or reconstructive surgery not related to medical treatment
- ★ Most custodial or convalescent care (caring for someone's daily needs, such as eating, dressing, and simple bandage changes) in an institution or home
- ★ Routine dental care and dental X-rays, treatment of teeth, gums, alveolar process or gingival issues, cranial mandibular disorders, and other issues related to the joint
- ★ Services provided or charges incurred prior to the effective date of coverage under the plan
- ★ Services provided or received after the date coverage is terminated under the plan

Note: This list is not all-inclusive and additional limitations may exist.

SECTION VII

Claims and Appeals



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Claims Submission and Processing

Network providers are required to bill for all services and submit fee-for-service claims on a CMS 1500 form or UB 04 within 180 days of the date of service. Appeals for denied claims or requests for reconsideration for repayment must be submitted within 90 calendar days of the date of the denial.

- ★ Code all services with CPT (Current Procedural Terminology) codes; code all diagnoses with the appropriate ICD-10 codes or DSM-5 codes for psychiatric disorders to the highest level of specificity for the current year
- ★ Routine clean claims are processed within 30 days

Submit the completed claim to:

Johns Hopkins HealthCare

P.O. Box 830479

Birmingham, AL 35283

Attn: USFHP Claims

Provider Claims/Payment Dispute Process

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and USFHP for reason(s) including but not limited to:

- ★ Corrected claim
- ★ Rejected untimely filing of claim
- ★ Coordination of benefits (EOB of primary carrier required)
- ★ Itemized bill requested
- ★ Invoice attached/MUE denial
- ★ Overpaid/underpaid per contract
- ★ Fee schedule
- ★ Contract rate
- ★ Not duplicate claim
- ★ Authorization on file (authorization number required)
- ★ Referral attached

Responses to itemized bill requests, submission of corrected claims and submission of COB/third-party liability information should also be sent with the Provider Claims/Payment Dispute and Correspondence Submission Form.

No action is required by the member. **Payment disputes do not include medical appeals.** Providers will not be penalized for filing a payment dispute. All information will be confidential in accordance with USFHP's policies and/or applicable law or regulation. The Adjustments department will receive, distribute and coordinate all payment disputes. To submit a payment dispute, complete the *Provider Claims/Payment Dispute and Correspondence Submission Form* located online at https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html and mail to:

Johns Hopkins HealthCare LLC

Adjustments Department

7231 Parkway Drive, Suite 100

Hanover, MD 21076

Or fax to 410-424-2800

USFHP must receive the payment dispute within 90 calendar days of the paid date of the explanation of payment (EOP). The provider must submit **a written request, including an explanation of the issue in dispute, the reason for dispute and supporting documentation** such as an EOP, a copy of the claim, medical records or contract page.

The Adjustments department will research and determine the current status of a payment dispute. A determination will be made based on the available documentation submitted with the dispute and a review of USFHP systems, policies and contracts.

A determination will be sent to the provider within 30 calendar days from receipt of the payment dispute. If the decision is made to adjust the claim to allow full reimbursement, an EOP will be mailed to the provider. If the decision is made to partially adjust the claim or uphold the previous decision, a payment dispute response letter will be mailed to the provider. The response letter will include:

- ★ Provider name
- ★ Member name, ID number and date of birth
- ★ Date of service
- ★ Claim number
- ★ Dispute number
- ★ Date of initial filing of concern
- ★ Written description of the concern
- ★ Decision
- ★ Further dispute options

Other Health Insurance

Under the law, TRICARE benefits are payable only for charges remaining unpaid after all other health coverage, except Medicaid and other programs identified by Defense Health Agency (DHA), have paid benefits. DHA has identified the following programs as being secondary to TRICARE:

- ★ Medicaid
- ★ Indian Health Service
- ★ State victims assistance/crime compensation plans
- ★ Maternal and Child Health program
- ★ Veterans Administration

If other coverage exists, TRICARE coverage is available only as secondary payor, and only after a claim has been filed with the other plan and a payment determination issued. This must be done regardless of any provisions contained in the other coverage. When TRICARE is secondary, it will reimburse the physician for covered services in conjunction with the primary plan so that the two programs pay no more than 100 percent of charges or the JHHC fee maximum, whichever is less. JHHC will never pay more than it would have as the primary payor. In either case, the physician may not balance bill the member.

Lack of Payment by Other Health Insurer

TRICARE will not pay amounts that have been denied by the other coverage because the claim was not filed timely with the other coverage or the member failed to meet some other requirement of coverage. When such a claim is received, JHHC will develop the claim for a statement from the other coverage as to how much would have been paid had the claim met the other coverage's requirements. If such a statement is provided to

JHHC by the member, the claim will be processed as if the other coverage actually paid the amount shown on the statement. If no such statement is received, the claim will be denied.

Waiver of Benefits

TRICARE members may not waive benefits due from their double coverage plans. If a double coverage plan provides benefits for services, a claim must be filed with the double coverage plan. Refusal by the member to claim benefits from the other coverage must result in a denial of TRICARE benefits.

Medicare Leakage

For members with coverage under both Medicare and Johns Hopkins USFHP, Medicare cannot be billed for services *covered* by USFHP. Providers filing Medicare claims, or who have claims filed on their behalf, are in violation of the conditions of participation with USFHP and are subject to disenrollment.

Members having coverage under both Medicare and USFHP may only use Medicare benefits for *non-covered* USFHP services (such as ESRD and chiropractic care). Providers billing Medicare for services covered by USFHP are subject to termination from the USFHP network. Federal regulations preclude the federal government from paying twice for services.

Appeals

Appeals should be sent to:

Johns Hopkins HealthCare

7231 Parkway Drive, Suite 100

Hanover, MD 21076

Attn: USFHP Appeals

Fax: 410-762-5304

Appeals of Factual Determinations

- ★ Denial determinations based on coverage limitations contained in 32 CFR 199, the TRICARE policy manual and other TRICARE guidance are considered factual determinations. If it is determined that the service or supply is covered but is not medically necessary, the denial will be a medical necessity determination
- ★ Providers must appeal within 90 calendar days after date of denial
- ★ JHHC will send written notice of its reconsideration determination within 30 calendar days of receipt of the appeal

Appeals of Medical Necessity Determinations

If UM denies a service or treatment to a network provider, they have two (2) levels of appeal. To avoid conflict of interest situations, JHHC will not allow a provider or committee member to review health care services or make denial determinations if he/she has been professionally involved, or where judgment may be perceived as compromised. An initial denial determination is final and binding unless it is reconsidered and revised through a formal written appeal.

Items that cannot be appealed by the provider include:

- ★ Allowable charge
- ★ Member eligibility

- ★ Network provider/contract disputes
- ★ Provider not authorized
- ★ Ineligible member
- ★ Factual determination (not a covered service or benefit; see benefit plan)

Provider Notification of Appeals

An appeal must be filed within 90 calendar days after notification of a denial. The network provider must file in a timely manner or lose all rights to appeal. The provider will be notified of the determination in writing within three days of receipt of the appeal for expedited requests, and within 30 calendar days for non-expedited appeals. A second or final level of appeal may be filed if the first level appeal results in an adverse determination. These must be filed within 90 calendar days after the participating provider is notified of the first level appeal determination.

Provider Appeal Request Form Process

Clinical Medical Necessity Appeals

A clinical/medical necessity appeal is any appeal between the health care provider and USFHP for reason(s) including but not limited to:

- ★ ER
- ★ Observation
- ★ Code review/claim check
- ★ Level of care
- ★ Out of network
- ★ Not a covered benefit
- ★ Lack of authorization/authorization discrepancy
- ★ Medical necessity
- ★ Pharmacy claims
- ★ Preservice claims

Clinical/medical necessity appeals must be received within 90 calendar days of the date on the denial letter. The provider must submit **an appeal letter, including the reason for appeal, and supporting documentation** including medical records.

Clinical documentation relevant to the decision will be retrospectively reviewed by a licensed/registered nurse. Established clinical criteria will be applied to the appeal. After retrospective review, the appeal may be approved or forwarded to the plan medical director for further review and resolution.

A determination will be sent to the provider within 30 calendar days from receipt of the appeal. If the decision is made to adjust the claim to allow full reimbursement, an EOP will be mailed to the provider. If the decision is made to partially adjust the claim or uphold the previous decision, an appeal response letter will be mailed to the provider. The response letter will include:

- ★ Provider name
- ★ Member name, ID number and date of birth
- ★ Date of service
- ★ Claim number

- ★ Dispute number
- ★ Date of initial filing of concern
- ★ Written description of the concern
- ★ Decision
- ★ Further dispute options

Please fill out the *Provider Appeal Request Form-Clinical/Medical Necessity/Administrative Appeals Only* form, which is located online at https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html.

Provider Complaint Process

Johns Hopkins USFHP appreciates provider feedback. If you are dissatisfied with personnel, services, or quality of care, please call your Provider Relations representative. You may also call customer service to report a complaint at 410-424-4528 or 800-808-7347 or email usfhpcustomerservice@jhhc.com. We will make every effort to resolve the complaint to your satisfaction during your initial call. If your complaint is not resolved to your satisfaction, please file a written complaint. Your written complaint will then be forwarded to the Provider Relations department for additional investigation.

Written Complaint Procedure

If you wish to file a written complaint, please send it to:

Johns Hopkins HealthCare LLC

Attn: Provider Relations Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Please include a detailed description in your letter, including dates and names of individuals involved.

Resolution Process

If you have any questions or concerns during the process, please feel free to discuss with your Provider Relations representative.

Providers are expected to participate in the resolution of member complaints related to access to care, quality of care, quality of service and office site quality. Johns Hopkins USFHP may request an expedited response (24 hours to five calendar days, depending upon the urgency of the complaint) in order to ensure timely resolution of the member's complaints.

Customer Assignment to New PCM or Specialist

USFHP providers (PCMs and specialists) have a limited right to request a beneficiary be assigned to a new provider. A provider may request to have a beneficiary moved to the care of another provider due to the following behaviors:

- ★ Fraudulent use of services or benefits
- ★ The beneficiary is disruptive, unruly, threatening, or uncooperative to the extent that member seriously impairs USFHP or the provider's ability to provide services to the beneficiary or to obtain new beneficiaries, and the aforementioned behavior is not caused by a physical or behavioral health condition
- ★ Repeated refusal to comply with office procedures essential to the functioning of the PCM's practice or to accessing benefits under the managed care plan

The provider should make reasonable efforts to address the beneficiary's behavior that has an adverse impact on the patient/physician relationship, through education and counseling, and, if medically indicated, referral to appropriate specialists.

If the beneficiary's behavior cannot be remedied through reasonable efforts and the provider feels the relationship has been irreparably harmed, the provider should notify the USFHP QI department.

USFHP will research the concern and decide if the situation warrants requesting a new provider assignment. If so, USFHP will document all actions taken by the provider and USFHP to resolve the situation. This may include beneficiary education and counseling. A USFHP provider cannot request a disenrollment based on adverse change in a member's health status or utilization of services medically necessary for treatment of a beneficiary's condition.

Procedure

USFHP may take immediate action in accordance with Tricare Operations Manual 6010.59-M, April 1, 2015, Chapter 13, Section "Threats Against Contractor." In all other instances, once USFHP has reviewed the provider's request and determined that the physician/patient relationship has been irreparably harmed, the beneficiary will receive a minimum of thirty (30) days notice that the physician/patient relationship will be ending. Notification must be in writing, sent by certified mail, and USFHP must be copied on the letter sent to the beneficiary. The provider will continue to provide care to the beneficiary during the thirty (30) day period or until the beneficiary selects or is assigned to another provider. USFHP will assist the beneficiary in establishing a relationship with another provider.

The provider will transfer, at no cost, a copy of the medical records of the beneficiary to the new provider and will cooperate with the beneficiary's new provider in regard to transitioning care and providing information regarding the beneficiary care needs.

A beneficiary may also request a change in PCM for any reason. The PCM change that is requested by the beneficiary will be effective the first day of the month following the receipt of the request, unless circumstances require an immediate change.

Billing for Non-Covered Services

As outlined in the TRICARE Operations Manual 6010.59-M, April 1, 2015, Chapter 5, Section 1, a network provider may not require payment from beneficiaries for any excluded services that the beneficiary received from the network provider and the beneficiary is "held harmless." Excluded or excludable services include TRICARE statutory exclusions (e.g. cosmetic procedures, certain durable medical equipment items or supplies) or services considered to be unproven or experimental. Providers are required to follow all applicable prior authorization requirements, as Hold Harmless provisions apply. An **Acknowledgment and Financial Responsibility Statement** is available for members to fill out and the form is also listed in the Forms section in the back of this manual.



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN

SECTION VIII

Compliance



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN



Compliance with Contract, Federal, State, and Local Regulations

Provider is expected to conduct all of his/her/its activities related to the provision of health care services to members in the USFHP in full compliance with your participating provider agreement, and all federal, state, and local laws and regulations, including, but not limited to:

Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse (FWA), including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 (/uscode/text/31/3729) et seq.) and the anti-kickback statute (section 1128B(b)) of the Act; and HIPAA administrative simplification rules at 45 CFR parts 160, 162 (/cfr/text/45/160), and 164 (/cfr/text/45/164).

Provider is also expected to conduct his/her/its activities in compliance with this Provider Manual and USFHP's policies and procedures.

Discrimination Against Members

Provider will not deny, limit, or condition the coverage or furnishing of benefits to members on the basis of any factor that is related to health status, including, but not limited to, medical condition, including mental health and physical illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

In addition, provider will not:

- ★ Make distinctions in the provision of services based on age, sex, disability, race, color, religion, or national origin
- ★ Deny a member any service, benefit or availability of a provider based on age, sex, disability, race, color, religion, or national origin
- ★ Provide a service or benefit that is different, or provide in a different manner or on a different schedule, from any other member for any reason other than medical necessity and/or capacity
- ★ Segregate or separate treatment based on age, sex, disability, race, color, religion, or national origin
- ★ Treat a member differently from others in receiving any covered service or benefit that is offered to other members
- ★ Treat a member differently from others in order to provide a service or benefit
- ★ Assign times or places to obtain services based on age, sex, disability, race, color, religion, or national origin

Medical Record Documentation and Retention

Provider must maintain members' medical record documentation in a manner that is current, detailed, organized, promotes effective and confidential patient care and quality review, and meets generally accepted standards and established goals for medical record keeping. To access and review the plans' Medical Record Documentation Policy in its entirety to which provider is subject with respect to USFHP members, please click on the following hyperlink: www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines (See: Medical Record Documentation Standards Policy).

Provider is required to comply with all applicable federal and state laws and regulations and your participating provider agreement terms and conditions regarding document retention.

Audit Process

USFHP, or a designee, has the right to conduct audits of your records with respect to services provided to members. Provider must comply with all applicable laws, regulations, and your participating provider agreement regarding cooperation, assistance, and provision of audit information as requested, and maintenance of records. All documents and/or data submitted for audit must be certified by provider (based on best knowledge, information, and belief) as being accurate, complete, and truthful.

Audits look for practices that result in unnecessary costs or under or over utilization of services, including audits to identify improper payments, payment for services that do not meet appropriate standards of care, errors, duplicate or redundant charges, unbundled services, lack of substantiating documentation, etc.

Audits may be conducted on site or may be conducted as desk audits.

Privacy and Release of Member Information and/or Records

It is the policy of JHHC to protect the privacy rights of all patients, health plan members, employees, students, and donors; to maintain the confidentiality of patient information, health plan information, medical records, research information, and business operations; and to comply with all applicable laws and regulations, including the privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) and the HiTECH Act.

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

The privacy and security components of HIPAA provide broad reaching protections for individually identifiable health information. The transaction and code sets component to HIPAA requires conformity to precise rules in the electronic transmission of financial health information.

The HIPAA privacy rule permits provider to disclose protected health information to a health plan for health care operations of the health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164 .506(c)(4). Health care operations includes care management, utilization review activities, and similar activities. See 45 CFR 164 .501 (definition of health care operations). Thus, provider may disclose protected health information for care management and/or utilization purposes. Provider may also disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

Member Rights and Responsibilities

We value the members of our Johns Hopkins USFHP health care family. Our members have certain rights and responsibilities which are communicated to them upon enrollment and annually thereafter. We encourage providers to review the Members' Rights and Responsibilities Statement located on the Johns Hopkins USFHP member website at the following location: <http://www.hopkinsmedicine.org/usfhp/PDF/handbook/Member%20Rights%20and%20Responsibilities.pdf>.

Standard of Conduct

In order to affect Johns Hopkins USFHP's commitment to the highest legal and ethical standards, USFHP has adopted the JHHC Code of Conduct. A copy of JHHC's Code of Conduct can be found at: www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/ (see Standard of Conduct). Provider is required to either adopt and abide by the JHHC Code of Conduct or implement a code of conduct that incorporates requirements consistent with JHHC's Code of Conduct.

Provider's Code of Conduct must set forth your overarching principles and values by which you operate. It must also provide the standards by which your employees, independent contractors, and downstream and related entities (subcontractors) will conduct themselves, including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations, and policies.

All employees, independent contractors, and subcontractors of provider are required to comply with all applicable laws, whether or not specifically addressed in the Code of Conduct in that compliance is everyone's responsibility. This includes reporting of issues of noncompliance and potential fraud, waste and abuse (FWA). Provider must provide guidance to its employees, independent contractors, and subcontractors regarding how to report potential compliance issues. In addition, it is the responsibility of provider to ensure that all reported issues are promptly addressed and corrected.

Provider's Code of Conduct should include provisions to ensure employees and independent contractors (including managers, officers, and directors), as well as subcontractors responsible for the administration or delivery of benefits, are free from any conflict of interest in administering or delivering benefits to USFHP members. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage.

General Compliance and Fraud, Waste, and Abuse Education

It is strongly recommended that providers and their employees, independent contractors, and subcontractors receive training in the identification and prevention of fraud, waste, and abuse. Free training is available on CMS' Medicare Learning Network (MLN Provider Compliance website): www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html. The Centers for Medicare and Medicaid Services (CMS) Medicare Parts C and D Fraud, Waste, and Abuse and General Compliance training provide a comprehensive overview. In addition, JHHC's provider website contains educational resources for providers.

Fraud

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

1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payments, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRICARE claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.”

Examples of fraud, under TRICARE, include, but are not limited to, the following:

Submitting TRICARE claims (including billings by providers when the claim is submitted by the member) for services, supplies, or equipment not furnished to, or used by, TRICARE members. Examples:

- ★ Billing or claiming services when the provider was on call and did not provide any specific medical care to the member
- ★ Providing services to an ineligible person and billing or submitting a claim for the services in the name of an eligible TRICARE member
- ★ Billing or submitting a TRICARE claim for an office visit for a missed appointment
- ★ Billing or submitting a TRICARE claim for individual psychotherapy when a medical visit was the only service provided

Billing or submitting a TRICARE claim for costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items. Examples:

- ★ Billing for TRICARE claims for services which would be covered except for the frequency or duration of the services, such as billing or submitting a claim for two one-hour psychotherapy sessions furnished on separate days when the actual service furnished was a two-hour therapy session on a single day
- ★ Spreading the billing or claims for services over a time period that reduces the apparent frequency to a level that may be cost shared by TRICARE
- ★ Charging to TRICARE, directly or indirectly, costs not incurred or reasonably allowed to the services billed or claimed under TRICARE, for example, costs attributable to non-program activities, other enterprises, or the personal expenses of principals
- ★ Billing or submitting a claim on a fee-for-service basis when in fact a personal service to a specific patient was not performed and the service rendered is part of the overall management of, for example, the laboratory or x-ray department
- ★ Breach of a provider participation agreement, which results in the member (including parent, guardian, or other representative) being billed for amounts, which exceed the TRICARE-determined allowable charge or cost

- ★ Misrepresenting dates, frequency, duration, or description of services rendered, or of the identity of the recipient of the services or the individual who rendered the services
- ★ Submitting falsified or altered TRICARE claims or medical or mental health patient records, which misrepresent the type, frequency, or duration of services or supplies or misrepresent the name(s) of the individuals who provided the services or supplies
- ★ Duplicate billings or TRICARE claims, including billing or submitting TRICARE claims more than once or the same services, billing or submitting claims both to TRICARE and other third-parties (such as other health insurance or government agencies) for the services, without making full disclosure of material facts or immediate, voluntary repayment or notification to TRICARE upon receipt of payments which combined exceed the TRICARE-determined allowable charge of the services involved
- ★ A provider misrepresenting his or her credentials. A provider concealing information or business practices, which bear on his/her qualifications for authorized TRICARE provider status, such as a provider representing that he or she has a qualifying doctorate in clinical psychology when the degree is not from a regionally accredited university
- ★ Alteration of patient records and/or claim forms

Reciprocal Billing: Billing or claiming services that were furnished by another provider or furnished by the billing provider in a capacity other than as billed or claimed. For example, practices such as the following:

- ★ One provider performing services for another provider and the latter bills as though he had actually performed the services (e.g. a weekend fill-in)
- ★ Providing service as an institutional employee and billing as a provider for the services
- ★ Billing for professional services when the services were provided by another individual who was an institutional employee
- ★ Billing for professional services at a higher provider profile than would be paid for the person actually furnishing the services, (for example, bills reflecting that an M.D. or Ph.D. performed the services when services were actually furnished by a licensed social worker, psychiatric nurse, or marriage and family counselor)
- ★ An authorized provider billing for services that were actually furnished by an unauthorized or sanctioned provider
- ★ Submitting TRICARE claims at a rate higher than a rate established between TRICARE and the provider, if such a rate has been established. For example, billing or claiming a rate in excess of the provider's most favored rate limitation specified in a residential treatment center agreement
- ★ Arrangements by providers with employees, independent contractors, suppliers, or others that appear to be designed primarily to overcharge TRICARE through various means (such as commissions, fee-splitting, and kickbacks) used to divert or conceal improper or unnecessary costs or profits
- ★ Agreements or arrangements between the supplier and recipient (recipient could be either a provider or member, including the parent, guardian, or other representative of the member) that result in billings or claims, which include unnecessary costs or charges to TRICARE

Abuse

Abuse generally describes incidents and practices that may directly or indirectly cause financial loss to the Government under TRICARE or to TRICARE members. Abuse is defined in 32 CFR 199.2 “...any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary costs, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term abuse includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim.”

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

Abuse, under TRICARE, includes, but is not limited to, the following:

- ★ A pattern of waiver of member (patient) cost-share or deductible
- ★ Improper billing practices, such as charging TRICARE members rates for services and supplies that are in excess of those charges routinely charged by the provider to the general public, commercial health insurance carriers, or other federal health benefit entitlement programs for the same or similar services. (Dual fee schedules – one for TRICARE members and one for other patients or third-party payers. Such as, billing other third-party payers the same as TRICARE is billed but accepting less than the billed amount as reimbursement)
- ★ Pattern of submitting claims for non-medically necessary services or, if medically necessary, not to the extent rendered. Battery of diagnostic tests are given when, based on the diagnosis, fewer tests were needed.
- ★ Care of inferior quality. Consistently furnishing medical or mental health services not meeting accepted standards of care.
- ★ Failure to maintain adequate medical or financial records
- ★ Refusal to allow the government (TRICARE Management Activity) or its contractor’s access to records related to TRICARE claims
- ★ Billing substantially in excess of customary or reasonable charges unless it is determined by DHA that the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities when it is accepted medical practice to make an extra charge in some cases
- ★ Unauthorized use of the term TRICARE in private business

Waste

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

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

- ★ Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities¹
- ★ Validate all member ID cards prior to rendering service
- ★ Ensure accuracy when submitting bills or claims for services rendered
- ★ Submit appropriate referral and treatment forms
- ★ Avoid unnecessary drug prescription and/or medical treatment
- ★ Report lost or stolen prescription pads and/or fraudulent prescriptions

Reporting Fraud, Waste, and Abuse (FWA)

Johns Hopkins USFHP takes its responsibility seriously to protect the integrity of the care its members receive, its health plan, and the program it administers. Reporting of FWA is essential for its prevention, detection, and correction. There are numerous methods by which a report relating to FWA can be made.

Reports of actual or suspected FWA involving USFHP can be made to the Johns Hopkins HealthCare Compliance department. Individuals making a report may do so anonymously using the contact information below. All reports are taken seriously and investigated and to the extent possible kept confidential.

- ★ Telephone: 410-424-4996 or toll free at 844-422-6957
- ★ Fax: 410-762-1527
- ★ Email Johns Hopkins Compliance Department at: Compliance@jhhc.com
- ★ By mail at:

Johns Hopkins HealthCare Compliance Department

Attn: Director of Corporate Compliance
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Provider is responsible for reporting all incidents of actual and/or suspected fraud, waste, and abuse. No Johns Hopkins HealthCare employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, JHHC has enacted zero-tolerance policies and annually trains all personnel on their obligation to uphold the highest integrity when handling compliance related matters.

¹**SAM** – The Excluded Parties List System (“EPLS”) is maintained by the GSA, now a part of the System for Awards Management (“SAM”). The EPLS is an electronic, web-based system that identifies those parties excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States. www.sam.gov

LEIE – This list is maintained by HHS OIG and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. <http://exclusions.oig.hhs.gov>

All employees, independent contractors, and subcontractors of provider are required to comply with all applicable laws, whether or not specifically addressed in the Code of Conduct, and must report issues of noncompliance and potential FWA through the appropriate mechanisms established by provider without fear of retaliation. Any individual who reports a compliance concern has the right to remain anonymous and Johns Hopkins USFHP commits to enforcing this right.

Provider is responsible for providing guidance to your employees, independent contractors, and subcontractors regarding how to report potential compliance issues. Provider is responsible for promptly addressing and correcting all issues brought to your attention. Provider is required to notify Johns Hopkins Compliance department of any issues involving the Johns Hopkins USFHP. Failure to report any possible violation or suspected FWA that provider knows about may result in investigation of provider and potentially disciplinary action.

Reporting of Other Compliance Concerns

Provider, and its employees, independent contractors, and subcontractors are required to report concerns about actual, potential, or perceived misconduct to the JHHC Corporate Compliance department at the numbers/addresses noted above.

Any concerns about program noncompliance or suspected FWA should always be reported to the JHHC Compliance department using the contact information listed in the Reporting Fraud, Waste, and Abuse section above. Immediately below is a list of examples of such reporting. The list is not intended to be all inclusive:

- ★ HIPAA violations, such as, but not limited to: inappropriate use and disclosure of protected health information (PHI) or personally identifiable information (PII), breach, or suspected identify theft that impact Johns Hopkins USFHP members and/or providers
- ★ Allegations that the complainant has been contacted by “someone” representing themselves as a JHHC or USFHP employee inappropriately requesting member PHI or PII
- ★ Instances where provider becomes aware that an individual or entity involved with the Johns Hopkins USFHP has become excluded and/or debarred from participation in federal and/or state programs

For reporting all other issues, contact USFHP Customer Service at 800-808-7347. Immediately below is a list of examples of such reporting. The list is not intended to be all inclusive.

- ★ Quality of care received from a Johns Hopkins USFHP contracted provider or any entity
- ★ Access to care
- ★ Coverage decision (medical or pharmacy)
- ★ Filing a grievance



JOHNS HOPKINS

M E D I C I N E

US FAMILY HEALTH PLAN

SECTION IX

Plan Initiatives



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US FAMILY HEALTH PLAN





He@lthLINK HOPKINS

YOUR SECURE, INTERACTIVE HEALTH PORTAL

Available 24 hours a day, seven days a week, HealthLINK@Hopkins provides members and providers with easy and secure internet-based access to health and administrative information.

HealthLINK@Hopkins

HealthLINK@Hopkins is a secure, online portal for Johns Hopkins USFHP members and their in-network providers.

As a **provider** you can:

- ★ Submit claims and search for existing claims
- ★ Review electronic remittance advice and download onto a PC
- ★ Search for members based on name, member ID, PCP, or DOB run reports such as member rosters
- ★ Check the status of referrals and authorizations
- ★ Directly enter referrals and certain services for prior authorization
- ★ Correspond securely with Customer Service

First-time users must register for an account at www.jhhc.com. If at any time you need assistance with registration, contact your network manager directly or Provider Relations at 410-762-5385 or 888-895-4998.

The HealthLINK Quick Reference Guide, which can be found on our website, will help you navigate the portal with ease.



Text4baby provides free text messages three times a week with information to help new mothers through pregnancy and the baby's first year.

Text4baby

Text4baby provides free weekly text messages to pregnant Johns Hopkins USFHP mothers, with information to help them through their pregnancy and the baby's first year.

Participating members:

- ★ Get support during their pregnancy
- ★ Get support throughout baby's first year
- ★ Receive totally free text messages each week
- ★ Receive accurate health information and resources in a format that is personal and timely
- ★ Learn useful tips about prenatal care, labor signs, nutrition, breastfeeding, and more

If you think your patient would benefit from this service, tell them to text BABY to 511411, or go online to www.text4baby.org to sign up!

Text4baby is a free service of the National Healthy Mothers, Healthy Babies Coalition. This is for informational purposes only. The Text4baby program is not a program of Johns Hopkins HealthCare LLC, Johns Hopkins US Family Health Plan, and we are not responsible for any advice or messages provided by the Text4baby program.



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SECTION X

Important Forms



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Provider Claims/Payment Dispute Request Form

https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/claims-and-payment-disputes.pdf

Provider Appeal Request Form

https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/provider-appeal-submission-form.pdf

Psychological Testing Request Form

https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/psych-testing-form.pdf

Acknowledgment and Financial Responsibility Statement

https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/updated_files/usfhp_acknowledgement_financial_responsibility_statement.pdf



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www.jhhc.com

