Our Philosophy

Johns Hopkins EHP is founded on three guiding principles.

*Medical care is a sacred trust and privileged relationship between patient and doctor that must be respected.*

*Each member is treated with dignity and respect. EHP values patient confidentiality and vows to service each patient’s health care needs professionally and efficiently.*

*Each plan member is EHP’s most important member.*

We put this philosophy to work every day in the way that we manage the care of our members and process your claims.
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Introduction

Employer Health Programs (EHP) views our providers as valuable resources for the success of the EHP program. Your continued independence, clinical freedom and satisfaction are essential to the program’s overall effectiveness. This Provider Manual is intended to maximize the value of the program for you and your EHP members by enhancing your knowledge of how to effectively administer its policies and procedures.

This manual has been updated and should be used as a reference and source document for both providers and their office personnel. EHP will continue to update the manual based on changes within the program or the provider and/or the member’s needs.

It is important to understand that this manual clarifies various provisions of the EHP Payor Addendum that you have already signed, and is incorporated as part of that document. In the event that a conflict is identified between a provision of this manual and the EHP Payor Addendum, the EHP Payor Addendum will always take precedence.

As an EHP provider, you’ve joined a team of professionals dedicated to cost-effective, patient-centered, quality health care, and it’s our goal to keep you informed.
Overview

Johns Hopkins HealthCare LLC was founded in 1994 as a joint venture between the Johns Hopkins Hospital and the Johns Hopkins School of Medicine.

In 1996, the Johns Hopkins Health System created Employer Health Programs (EHP) as a vehicle to provide health benefits for its employees. EHP is a way for employers to self-fund their benefits programs (as opposed to purchasing insurance). Johns Hopkins HealthCare LLC is the administrator (often called a third party administrator or TPA) of these benefit programs for EHP clients.

JHHC provides a wide spectrum of products and services for our 51,000 plus EHP members. Our provider network consists of more than 14,000 primary and specialty care providers and 30 facilities. We also contract with many of the major facilities and ancillary services providers in the Mid-Atlantic region.

JHHC is currently contracted with the following employer groups.

• AON Corporation
• Johns Hopkins Bayview Medical Center
• Broadway Services, Inc.
• Johns Hopkins Health System Corporation/ Johns Hopkins Hospital
• Johns Hopkins Home Care Group
• Johns Hopkins University
• Johns Hopkins University Student Health Program
• Howard County General Hospital
• Suburban Hospital, Inc.

Each plan is tailored to meet the needs of each individual client and range from a tightly managed, HMO-type plan to a loosely managed, open access plan with many varieties in-between.
Section II
PROVIDER INFORMATION
Primary Care Provider (PCP)

A Primary Care Provider (PCP) is a physician or nurse practitioner who manages the primary and preventive care of Employer Health Programs (EHP) members and acts as a coordinator for specialty referrals and inpatient care.

Roles and Responsibilities

Primary care includes comprehensive health care, 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.

Providers give or arrange for the provision of covered services for members in a manner consistent with professionally recognized health care standards and JHHC procedures such as:

- Providing timely, accessible health care to members.
- Providing PCP accessibility standards for members.
- Emergency – a sudden, severe onset of illness or a medical problem requiring immediate attention. The member should receive care immediately.
- Urgent – a sudden, severe onset of illness or a medical problem requiring attention within 24 hours. The member should be seen the same day or within 24 hours.
- Routine – a medical problem or illness that is ongoing but presents no immediate medical danger or acute distress. The member should be scheduled as soon as the PCP has an opening in his/her schedule, but within three weeks.
- Health Maintenance – Preventive care services should be scheduled within two to 12 weeks or within the preventive care guidelines established by the JHHC Medical Policy and Standards Committee.
- Maintaining coverage for Emergency Services 24 hours a day, 7 days a week with a participating provider. PCPs are required to have one of the following mechanisms in place to ensure proper after-hours coverage for their practice:
  1. Practitioner has an answering service with specific instructions on how the member can reach the practitioner directly for urgent services and how to access emergency services
  2. Pager service to gain access to the practitioner with specific instructions on how the member can reach the practitioner directly for urgent services and how to access emergency services
  3. Answering machine with specific instructions on how the member can reach the practitioner directly for urgent services and how to access emergency services
- Cooperating and complying with JHHC utilization management procedures.
- Cooperating and complying with all JHHC quality management policies and procedures and performance improvement activities.
- Not differentiating or discriminating in the treatment of members on the basis of source of payment for covered services, gender, age, race, color, religion, origin, place of residence, economic or health status, disability, or medical condition, including mental as well as physical condition, claims experience or medical history.
- Complying with credentialing and re-credentialing requirements.
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.

**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.

**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:

- Provision of specialty services upon referral by the PCP.
- Recommending appropriate treatment plans and providing written reports to the referring PCP to ensure continuity of care.

**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 act as liaisons between Johns Hopkins HealthCare and our participating provider network. The network is divided into geographic territories and specialty areas, and each territory is assigned to a Network Manager and Coordinator. The department can be reached by phone at 410-762-5385 or 888-895-4998, or by fax at 410-424-4604.

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. Visit http://www.hopkinsmedicine.org/johns_hopkins_healthcare to view the territory grid and for Network Manager contact information.

**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 sources include:

- The EHP 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.
- “Hopkins Across the Board” is a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories and news pertaining to our three lines of business, including EHP.
- “Connections” is a member newsletter that is produced quarterly. It features human interest stories, resource information, health tips, book reviews and a host of other information suited for the member.
- EHP 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 EHP provider network community at http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines.html

**Changes in Provider or Site Status**

Changes to provider information (i.e. telephone number, address, covering physicians, etc.) must be submitted to Provider Relations, via fax or mail, on the provider’s letterhead. When possible, notification of changes should be made at least thirty (30) days in advance of the change.

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 mail or fax.

**Johns Hopkins HealthCare LLC**

6704 Curtis Court  
Glen Burnie, MD 21060  
Attn: Provider Relations Department  
Fax: 410-424-4604

The JHHC 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 PCP specialist or practice group at least thirty (30) calendar days prior to the effective termination date or within thirty (30) calendar days of notification from the provider, and assists them in selecting a new provider.

In some cases, members may be able to continue care with a terminated provider for a short period of time after the provider 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. A summary is listed in this manual, and can be referenced on the website as well. If you have additional questions, please contact Provider Relations at 410-762-5385 or 888-895-4998.
HealthLINK@Hopkins

HealthLINK@Hopkins is a secure, online portal for Johns Hopkins EHP 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.

Credentialing

The Johns Hopkins HealthCare (JHHC) Credentialing Program is dedicated to the careful selection and credentialing of practitioners for inclusion in the EHP 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), Healthcare Integrity and Protection Data Bank (HIPDB), Office of the 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 Special Credentials Review Committee (SCRC), a committee of the Board of Directors of JHHC. It is the responsibility of the SCRC to approve the participation status of all applicants. 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 non-discriminatory 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 JHHC, EHP provider network.

**Types of Providers Requiring Credentialing**

Practitioners who practice in outpatient settings are required to be credentialed. The types of providers that must be credentialed by JHHC prior to participating in the USFHP provider network include but is not limited to:

- Primary Care Physicians (medical and osteopathic)
- Specialty Physicians (medical and osteopathic)
- Podiatrists
- Certified Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Chiropractors
- Physical Therapists
- Audiologists
- Speech Therapists
- Occupational Therapists
- Clinical Psychologists (doctoral)
- Clinical Social Workers
- Professional Counselors
- Marriage and Family Therapists
- Optometrists
- Organizations including Hospitals, Home Health Agencies, Skilled Nursing Facilities, and Free-Standing Surgical Centers

**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
CAHQ, may become a member by requesting an invitation through JHHC. There is no cost to the provider for using CAHQ. Contact Provider Relations at 410-762-5385, or at 888-895-4998.

Alternately, the practitioner may request a hard-copy MUCF from JHHC or go online to the Maryland State website at http://www.mdisinsurance.state.md.us/sa/documents/MDUniformCredentialingApplication12-07.pdf and download the MUCF.

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 EHP patients, education including residency and fellowship programs, clinical experience(s) for at least the past 5 years, malpractice/professional liability insurance coverage, medical and professional certifications held, licenses held for at least the past 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.

Upon receipt of the application, the practitioner 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 practitioner must submit will be noted in the notification. 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 EHP 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, facsimile (fax), email, or correspondence to the credentialing department, or the network manager at 888-895-4998, for their geographic area. The mailing address for JHHC is:

**Johns Hopkins HealthCare LLC**
Attn: Credentialing Department
6704 Curtis Court
Glen Burnie, MD 21060
410-424-4619

Currently, the following verifications are completed in addition to the 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), URAC, 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 is 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. See “JHHC Provider Grievance Process.”

**Credentialing Organizational Providers**

Organizational providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, 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 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 corrective 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, National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), State and Federal guidelines and regulations:

1. Current licensure as 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, or Medicare or Medicaid entity.
4. Accreditation status with nationally recognized entities for health care quality including but not limited to the Joint Commission on Accreditation of Healthcare Organizations (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 assessments/evaluations or CMS review.
6. Onsite review for organizations without accreditation or State/CMS review.
7. Professional liability/malpractice insurance

Re-Credentialing
Re-credentialing is performed at a minimum of every three 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, facsimile (fax), email, or correspondence to the credentialing department at 410-424-4619, or the senior network manager at 888-895-4998, responsible for this type of organization. The mailing address for JHHC is:

Johns Hopkins HealthCare LLC
Attn: Credentialing Department
6704 Curtis Court
Glen Burnie, MD 21060

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 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 30 days to appeal the decision. See “JHHC Provider Grievance Process.”
Provider Notification to JHHC

The practitioner or organization must notify JHHC in writing within five (5) days, unless otherwise stated below, following the occurrence of any of the following events:

1. Provider's license to practice in any state is suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to JHHC immediately.
2. Provider learns that he/she/it has become a defendant in any malpractice action relating to a member who also names JHHC as a defendant, or receives any pleading, notice or demand of claim or service of process relating to such a suit, or is required to pay damages in any such action by way of judgment or settlement.
3. Provider is disciplined by a State licensing board or a similar agency.
4. Provider is sanctioned by or debarred from participation with Medicare/Medicaid; notification of any such action must be furnished in writing to JHHC immediately.
5. Provider is convicted of a felony relating directly or indirectly to the practice of medicine; notification of any such action must be furnished in writing to JHHC immediately.
6. There is a change in the provider's business address or telephone number.
7. Provider becomes incapacitated such that the incapacity may interfere with patient care for twenty-one (21) consecutive days; Notification of any such action must be furnished in writing to JHHC immediately.
8. Any change in the nature or extent of services rendered by the provider.
9. Provider's professional liability insurance coverage is reduced or canceled.
10. Any other act, event, occurrence or the like which materially affects the provider's ability to carry out the provider's duties under the Agreement.

The occurrence of one or more of the events listed above may result in the termination of the Provider Participation Agreement, and relevant payor, for cause or other remedial action, as JHHC in its sole discretion deems appropriate.

Immediate Termination of Participation

JHHC may terminate a Participating Provider Agreement immediately “for cause.” Examples of “for Cause” termination may be defined as but not limited to:

- Fraud
- Patient Abuse
- Incompetence
- Loss of Licensure
- Loss of participation status in State, Federal, Medicare or Medicaid payor programs

Voluntary Termination of Participation

Either the provider or JHHC may voluntarily terminate the Participating Provider Agreement with written notice to the non-terminating party at least ninety (90) days prior to the effective date of termination. The provider will continue to provide or arrange for services for any 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.
**JHHC Provider Grievance Process**

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 Chief Medical Director will convene an appeal panel comprised of three qualified clinicians who represent the provider community within the EHP 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 panel 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 member(s) in selecting a new practitioner.

In some cases, member(s) 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.
Important Contact Information

**Care Management**
410-424-4480
800-261-2421

**Case/Disease Management**
888-309-4576

**Client Relations**
410-424-4600 (fax)

**Corporate Compliance**
410-424-4996
compliance@jhhc.com

**Customer Service**
410-424-4450
800-261-2393

**Customer Service Suburban Hospital**
866-276-7889

**Dental – United Concordia Companies, Inc.**
866-851-7576

**EHP Website**
www.ehp.org or www.jhhc.com

**Health Coach Services**
800-957-9760
healthcoach@jhhc.com

**Health Education**
800-957-9760

**Mental Health & Substance Abuse**
410-424-4476
800-261-2429

**Pharmacy (Mail Order Only)**
800-213-0879

**Pharmacy Customer Service Phone**
888-543-4921

**Pharmacy Provider Prior-Authorization**
888-413-2723
888-836-0730 (fax)

**Provider Relations**
410-762-5385
888-895-4998
410-424-4604 (fax)

**Student Health Program**
Customer Service
410-424-4485
888-400-0091

Network Hospitals

Johns Hopkins HealthCare LLC has contracts with the majority of hospital facilities within the State of Maryland. For a complete and up-to-date listing of these hospitals please refer to the provider search function at www.jhhc.com and search by health plan (Johns Hopkins Employer Health Programs (EHP)).
Billing and Claims

Office Visit Co-Payment
Providers should collect the applicable office visit co-payment and/or deductible from the member at the time of service. Providers should note that co-payment amounts are variable and different plans may have different co-payment amounts or no co-payment at all. If a co-payment is applicable, the co-payment will be listed on the front of the EHP identification card.

Co-Insurance
Network providers providing service to members are encouraged to collect any applicable co-insurance after EHP has made payment to the physician. The physician remittance will indicate the member’s co-insurance liability.

Claims Submission
Claims should be filed using a standard CMS 1500 or UB-04 claim form. Claims must be submitted within 180 days of the date of service.

Under some circumstances, the following attachments may be requested in order for a claim to be processed:

- A referral or consultant treatment plan
- Treatment Plans may be required for certain specialty services such as physical therapy
- An explanation of benefits statement from the primary payor
  - Required if EHP is the secondary payor
- A Medicare Remittance Notice
  - Required if the claim involves Medicare as a primary payor
- A description of the procedure or service, which may include the medical record
  - May be required if a procedure or service rendered has no corresponding CPT or HCPCS code
- Operative notes
  - May be required if the claim is for multiple surgeries, or includes modifier 22,58,62,66,78,80,81 or 82
- Anesthesia records documenting the time spent on the service;
  - May be required if the claim for anesthesia services rendered includes modifiers P4 or P7
- Documents referenced as contractual requirements in a global contract:
  - May be required if there is a global contact between JHHC and a health care practitioner, hospital, or person entitled to reimbursement.
- An ambulance trip report;
  - May be required if the claim is for ambulance services submitted by an ambulance company licensed by the Maryland Institute for Emergency Medical Services Systems;
Office visit notes;

- May be required if the claim includes modifier 21 or 22, or an audit of the health care practitioner, hospital, or person entitled to reimbursement demonstrated a pattern of fraud, improper billing or improper coding.

Admitting notes, except in the case of emergency services rendered in accordance with Health-General Article, 190701(d) a 19-712.5 Annotated Code of Maryland;

- May be required if the claim for services provided is outside of the time or scope of the authorization, or when there is an authorization in dispute.

Physician notes, except in the case of emergency services rendered in accordance with Health-General Article, 190701(d) a 19-712.5 Annotated Code of Maryland

- May be required if the claim for services provided is outside of the time or scope of the authorization, or when there is an authorization in dispute.

Itemized bill, except in the case of emergency services rendered in accordance with Health-General Article, 190701(d) a 19-712.5 Annotated Code of Maryland

- May be required if the service is rendered in a hospital and the hospital claim does not have prior authorization for admission, or is inconsistent with JHHC concurrent review determination rendered before the delivery of services, regarding the medical necessity of the service.

Remittance Advice Statement

The items listed below correspond with the Remittance Advice Form that EHP currently follows. Together they provide specific information regarding the review and interpretation of the EHP Remittance Advice. This remittance is used for all providers who submit claims to Johns Hopkins HealthCare. Thus, there may be sections that are not applicable for posting and reconciliation of certain claims.

Payee ....................... The name and address of the payee as indicated on the submitted claim.

Check Date ................. The date the check (if any) was prepared.

Payee Number .............. The payee's tax identification number.

Check Number ............. The number of the check (if any).

Date of Service ............ The “from” and “to” dates submitted on the claim.

Procedure Code ............ Procedure or revenue code which best describes the service(s) rendered.

Billed Amount .............. The amount identified by the provider as a charge for a service or procedure.

Charges Above Max ........ The portion of the billed amount that is in excess of the established fee maximum for the procedure. This amount is not a member liability.

Disallowed Amount ........ The dollar value of a service which is not eligible for payment.

Allowed Amount ............ The amount eligible for payment.

Deduct/Co-pay/Coins ....... Identifies the member's liability for cost-sharing features (deductible, co-payment and/or co-insurance) of the program.

Other Insurance Paid ...... The total dollar amount paid by any other insurance carrier or Medicare.
Subscriber Liability. The dollar amount which the provider may collect from the subscriber. This amount includes any applicable deductible, co-payment, co-insurance and charges for non-covered services.

Net Payable. The total dollar amount being paid for the procedure. The Allowed Amount minus deductible, co-payment/co-insurance minus Other Insurance Paid equals Net Payable.

Remark Code. The code number that identifies a message to the provider regarding payment of the claim. Codes are defined at the end of the remittance.

Patient Name. The name of the member for whom services were provided.

ID. The member's 11-digit identification number assigned by EHP. The ID number should always be referenced when contacting EHP regarding a claims matter or the status of a member.

Account Number. The member's account number derived from the CMS 1500 form or the UB-04 form.

Claim Number. The number assigned to a specific claim by claim number should always be referenced when contacting EHP regarding a claim's matter.

Provider Name. The name of the provider who provided services for submitted claim.

Provider ID. The identification number assigned to the specific provider submitting the claim.

Line of Business. The code indicating in which lines of business the patient is a member. EHP's line of business code is E.

Claim Total. The total dollar value of all individual line items submitted on a single claim.

Payable Total. The total of all payable claims included in the remittance advice.

Remittance Total. The overall total of all claims included in the remittance advice.

Remark Code. Definition of all remark codes indicated on the remittance.

Coordination of Benefits

Benefits will be coordinated when members are covered under both EHP and another health care benefit plan. When EHP is considered the primary coverage, EHP will reimburse the full amount for covered medical services, which is the physician’s billed charge or the contracted fee schedule (less any applicable co-payment, co-insurance, or deductible), whichever is less.

When EHP is secondary, it will reimburse the physician the difference between the benefit paid by the primary plan and the amount that would be paid under the EHP plan in the absence of other coverage.

If EHP is the secondary plan, only covered expenses up to the Plan’s fee schedule may be covered. Any applicable co-pays, co-insurance or deductibles under the two plans still apply.

The plan of the member’s employer is the primary plan. To determine benefits for covered dependent children, the plan of the parent whose birthday falls earliest in the year is the primary plan for children. In the case of children whose parents are legally separated or divorced, a court order setting responsibility for health care expenses supersedes the birthday rule.
When EHP is the secondary plan, it will deem the primary plan to have made all benefit payments that would have been made had the member complied with all of the rules of the primary plan. For example, if you fail to submit a claim in a timely manner to the primary plan or do not get the required authorization for treatment, EHP will make its secondary payment based on the payment the primary plan would have made if the claim was submitted on time or the required authorization was obtained.

When EHP 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 the charges or the EHP fee maximum, whichever is less. EHP will never pay more than it would have as the primary program. In either case, the physician cannot balance bill the member.

Complaints, Grievances and Appeals

Providers, as well as members, may submit complaints to EHP, in writing, to the Complaint and Grievance Department. However, complaints may be received by any employee in Johns Hopkins HealthCare.

Timeframe for resolution of a complaint:

- Administrative Complaint .................................................. 60 days
- Emergency Medical Complaint ........................................... 24 hours
- Non-Emergency Medical Complaint ..................................... 30 business days

Grievance Process

Providers or members may submit a written request for reconsideration (a grievance) of the original resolution of a complaint. A resolution will be sent within 30 days of receipt of all pertinent information.

Providers or members may submit grievances to EHP in writing to the attention of the Complaint and Grievance Department.

Appeals Process

Johns Hopkins HealthCare (JHHC) will reconsider denial decisions upon request by an EHP member, member’s guardian or participating provider.

Appeals generally fall into two categories:

- Administrative Appeals are usually the result of an automatic denial.
- Automatic denials entail a simple decision based on fact.

Examples of automatic denials include:

- The patient is not a member
- The member was not eligible at the time service was rendered
- The service was not authorized by a PCP (for specific plans)
- The claim was submitted with incorrect coding
- The claim was denied for failure to meet the timely filing requirements
- The service is not covered by the plan
- The service is obtained from a non-participating provider without pre-authorization (for specific plans)
- The service is in a category where benefits have been exhausted.
- Any payment issues regarding overpayment/underpayment
- Any COB request
Providers, members, or member’s guardians may appeal or request a reversal or an adjustment of a denied or paid claim. All Administrative Appeals must be received within **90 business days** of the date of the denial.

All appeals should clearly state the reason for the appeal.

Claims resubmitted without documentation identifying the claim as an “appeal” or “corrected claim” will be reprocessed and automatically rejected as a “duplicate claim.”

All appeals should be mailed to:

**Johns Hopkins HealthCare LLC**  
Attn: Appeals Department  
6704 Curtis Court  
Glen Burnie, MD 21060

Medical Appeals (Emergency and Non-Emergency) generally involve some interpretation or judgment. Examples of medical denials include:

- Questions of medical necessity  
- Administration of Benefit Plan Design  
- Matters requiring clinical decision making

Most appeals of Utilization Management denials fall into this category unless it is demonstrated that a factual error occurred. Medical Appeals (Emergency and Non-Emergency) will be reviewed by a health plan medical director.

**Emergency Medical Appeal**

In cases where the PCP or attending physician believes that non-coverage of a treatment, procedure or service (which has been given or is proposed to be given) will have an immediate adverse effect on the health of the member, the member’s guardian, the PCP or the attending physician may request an immediate Emergency Medical Appeal by contacting the Care Management Department at 410-424-4480 or 800-261-2421 or fax 410-424-4603.

**Non-Emergency Medical Appeal**

In cases which relate to the health of a member, but do not qualify as an Emergency Medical Appeal, a provider, member or member’s guardian may request an appeal by contacting the Appeals Department in writing.

The timeframe for a response to an appeal is as follows:

- Administrative complaint ................................................................. 60 days
- Emergency Medical Complaint ..................................................... 24 hours
- Non-Emergency Medical Complaint .............................................. 30 business days
- Urgent/Emergent Pre-Service Appeal ............................................. 36 hours
- Non-urgent Pre-Service Appeals .................................................... 15 calendar days
- Non-urgent Post Service ................................................................. 30 calendar days

All appeals must be received within ninety (90) business days of the date of denial.
Overview of Services

Johns Hopkins Employer Health Programs (EHP) is committed to high-quality, cost-effective health care. Below is a list of services provided for most of our plan members. We offer a variety of cost-effective plans, meaning that specific covered service and co-pays may vary.

Plan Designs

- Single Option plans (HMO-type) – Care must be coordinated by the Primary Care PCP
- Dual Option plans – Care coordinated by primary care PCP or the member self-refers to participating physician and/or provider
- Triple Option plans (POS) – Care coordinated by primary care PCP or member self-refers to participating physicians and/or providers or member refers to nonparticipating physician and/or providers
- PPO plans – member self-refers to participating physicians and/or providers, or member self-refers to non-participating physicians and/or providers.

Refer to the specific Plan’s Schedule of Benefits for details.

For additional details on our plans and particular plan offerings, contact Customer Service at 410-424-4450, or 800-261-2393.
### Benefit Chart

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment of Illness</strong></td>
<td>Primary Care Visit (Primary Care Provider)</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Services &amp; Treatment</td>
</tr>
<tr>
<td></td>
<td>Specialty Care Office Visit</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>General Physical Exam</td>
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<tr>
<td></td>
<td>Diagnostic Services</td>
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<td></td>
<td>Well Child Care</td>
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<td></td>
<td>Mammogram</td>
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<td></td>
<td>GYN Exam</td>
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<tr>
<td><strong>Immunizations</strong></td>
<td>For Common Communicable Diseases</td>
</tr>
<tr>
<td><strong>Laboratory and X-Ray</strong></td>
<td>Laboratory Tests</td>
</tr>
<tr>
<td></td>
<td>Imaging Exams</td>
</tr>
<tr>
<td></td>
<td>X-Ray Exams and Ultrasound</td>
</tr>
<tr>
<td><strong>Urgent Care Emergency Room</strong></td>
<td>See SPD for specific coverage</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>Generic</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand &amp; Non-preferred Brand</td>
</tr>
<tr>
<td></td>
<td><strong>This benefit varies among plans</strong></td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td>Dental care for EHP members is provided by United Concordia Companies,</td>
</tr>
<tr>
<td></td>
<td>Inc. (UCCI) which has a network of about 3,500 dentists in Maryland and</td>
</tr>
<tr>
<td></td>
<td>is also a national network.</td>
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<tr>
<td></td>
<td><strong>This benefit varies among plans</strong></td>
</tr>
<tr>
<td><strong>National Network</strong></td>
<td>EHP offers a national network of providers outside the state of Maryland</td>
</tr>
<tr>
<td></td>
<td>through MultiPlan’s PHCS Healthy Directions. For members who are</td>
</tr>
<tr>
<td></td>
<td>traveling, residing or have children studying outside of Maryland, the</td>
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<tr>
<td></td>
<td>National Network covers them. For some plans, providers within Maryland</td>
</tr>
<tr>
<td></td>
<td>may be used. Call the EHP Customer Service department for more</td>
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<td>information.</td>
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</tbody>
</table>

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**Selecting or Changing a PCP or OB/GYN**

When members enroll in Johns Hopkins EHP, the member and each family member are encouraged to choose and establish a relationship with a PCP from our extensive network. Members can select a PCP for themselves and a different PCP for each of their covered dependents. Females covered by the EHP Plan who are age 14 years or older may choose an OB/GYN as their PCP to coordinate their obstetrical and gynecological care needs.

Members wishing to select a PCP and/or OB/GYN may make a selection at the time of enrollment, or call EHP Customer Service at 410-424-4450 or 800-261-2393. The PCP change will become effective the first day of the next month following the date a member requests a change.
Members enrolled in the basic medical plan must choose a PCP and OB/GYN in order for services to be covered. The PCP and OB/GYN name will be located on the front of the members’ I.D. card.

Sample EHP I.D. Card

The EHP Formulary is a guide for health care providers, plan participants and clients. Please note that prescription drugs benefits vary among EHP employer groups.

Pharmacy Coverage

Pharmacy coverage may vary by employer group. The following is a list of covered drugs under the EHP Prescription Drug Plan:

- Drugs approved by the US Food and Drug Administration (FDA) that require a prescription from a physician or other lawful prescriber, unless specified otherwise
- Compounded medications of which at least one ingredient is a prescription drug and the compounded drug is not a copy of a commercially FDA approved drug product
- Insulin on prescription
- Disposable Insulin syringes and needles for self-administered injections
- Blood/Urine test strips and lancets

The following drugs are excluded from the EHP Prescription Drug Plan:

- Medications to treat cosmetic conditions resulting from the normal aging process
- Medications whose sole use include treatment of hair loss, hair thinning, and any other related conditions
- Medications that are not approved for treatment of a medical condition by the FDA
• Vitamins (except those vitamins which by law require a prescription)
• Covered drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescription in excess of the number of refills specified by the prescriber or by law
• Medications dispensed for any illness or injury covered by any federal, state or local government Workers’ Compensation act or occupational disability law
• Immunization agents, biological sera, blood or blood plasma
• Drugs labeled, Caution-Limited by Federal Laws to Investigational Use, or experimental drugs, even though a charge is made to the member drugs
• Non-legend drugs, except those listed under the covered drugs list
• Medications that are to be taken by or administered to the member while the member is a patient in a licensed hospital, rest home, sanitarium, or extended care facility. Convalescent hospital, nursing home, or similar institution that operates, or allows to be operated on its premise, a facility for dispensing pharmaceuticals
• Medication delivery implants, devices or durable medical equipment (except hypodermic needles and syringes for self-administered injections)
• Replacement of damaged, lost, spilled, or stolen medication
• Herbal, mineral, and nutritional supplements
• Legend drugs and non-legend drugs which are not approved by the U.S. Food and Drug Administration, for commercial distribution in the U.S.

Co-pay Tier
All EHP members have a three-tier drug benefit. With a three-tier drug benefit, your prescription medications fall into one of three tiers. Each tier has a different co-pay or out of pocket expense.

The three-tiered co-payment benefit consists of the following tiers:

• **Tier One:** All Generic Drugs (lowest co-pay) approved by the Food and Drug Administration. Generic drugs contain the same active ingredients as brand-name medications. Generics are chemically and therapeutically equivalent to brand drugs, but are available at a lower price.

• **Tier Two:** Preferred Brand Drugs (middle tier co-pay). These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions.

• **Tier Three:** Non-Preferred Brand (highest co-pay). These drugs often have either a generic equivalent or a preferred-brand drug alternative. This tier also includes new drugs not yet reviewed by the Johns Hopkins Health Care Pharmacy and Therapeutics Committee.

Retail Pharmacy Network
Johns Hopkins EHP through CVS/Caremark Inc. offers a nationwide Pharmacy network that includes most chain and independent pharmacies. Additional information regarding participating pharmacies is available at www.caremark.com

Mail Order Services
Mail Order services is provided by Caremark Inc. Additional information regarding Mail Order services is available at www.caremark.com.
Use of Generic Drugs

Members that request brand name drugs that have commercially available generic equivalents may incur a higher co-payment or payment of the difference in cost between the brand generic equivalents, in addition to applicable co-payment.

Prior-Authorization

Certain medications require prior authorization before coverage is approved, to assure medical necessity, clinical appropriateness and/or cost effectiveness. Coverage of these drugs is subject to specific criteria approved by physicians and pharmacists on the Johns Hopkins Health Care Pharmacy and Therapeutics Committee. Established criteria are based on medical literature, physician expert opinion, and FDA approved labeling information. This list is subject to change without notice and is not applicable to all EHP groups. Consult your SPD to determine if your plan is subject to this list.

Quantity Edits

Certain prescription medications have specific dispensing limitations for quantity and maximum dose. These dispensing limitations are based on generally accepted guidelines, drug label information approved by the Food and Drug Administration (FDA), current medical literature and input from a committee of physicians and pharmacists. The three types of quantity limits include the following:

• Coverage limited to one dose per day for drugs that are approved for once daily dosing
• Coverage limited to specific number of units over a defined time frame
• Coverage limited to approved maximum daily dosage

When medically necessary, an exception to quantity limits can be requested. This list is subject to change without notice and is not applicable to all EHP groups. Consult the Summary Plan Description (SPD) to determine which plan is subject to this list.

Generic Substitution

Generic substitution is mandatory when a generic equivalent is available. Cost share for members covered under the EHP pharmacy benefit vary by employer plan design. Member cost share for brand name drugs with a generic equivalent available is determined by the employer’s Summary Plan Description. Brand name drugs that have commercially available generic equivalents may:

• Incur a higher co-payment (tier 3)
• Require payment of the difference in price between the brand and generic equivalent, in addition to applicable co-payment

Contact Information about EHP Prescription Programs:

Customer Service Phone: ..................................................888-543-4921
Provider Prior-Authorization Phone: .................................888-413-2723
Provider Prior-Authorization Fax: .................................888-836-0730
Section IV
CARE MANAGEMENT
Care Management

Care Management is intensive coordination and evaluation of care that is appropriate when a member's health care needs are of high acuity and/or the member is at risk of repeat admissions and emergency room (ER) visits. The Case Management programs monitor, evaluate, and coordinate appropriate health care services for EHP members, ensuring quality care in a cost-effective manner.

Members will be screened by the Care Management staff for case management services upon enrolling in EHP, applying for disability, referral for specialty care, admission to an inpatient facility, receiving services outside the Primary Care Provider's (PCP) office, or upon referral by the patient, provider or family.

Population Health Initiative

As part of an ongoing commitment to quality care, JHHC provides a comprehensive one-of-a-kind case management program, The Population Health Initiative. The JHHC care management program is an integral component of a population health approach to providing services to benefit members with acute and chronic conditions. Through a unique design, members are placed in one of three levels, and depending on their level, are provided a variety of support, tools and services that assist them in understanding and managing their condition. This multi-tiered approach uses a population health approach and proactively identifies members with, or at risk for special needs and/or chronic health care problems. Case managers professionally manage these members in a manner that improves care, promotes wellness and manages/reduces costs. The Population Health Initiative was developed to give members individual support and services that are needed to help them understand and self-manage their medical conditions. Assistance is offered depending on the member’s need.

Complex Case Management and Monitored Case Management programs monitor, evaluate, and coordinate appropriate health care services for EHP members, ensuring quality care in a cost-effective manner. JHHC Case Management utilizes claims, pharmacy and adjusted clinical groups (ACGs) to analyze members. Therefore, correct coding is essential in order to utilize data in the most effective manner.

Members will be offered case management services when:

- Admitted to acute or rehabilitation facilities
- Receiving outpatient treatments of a complex nature
- Receiving complex in-home care
- Data demonstrates member has extensive health care needs
- The provider, member or family request case management

All programs are voluntary, opt out and individualized to the need of the member. Our case management programs include interventions aimed at populations in which it is important for the member to learn to take care of themselves and their health.

EHP case managers are registered nurses or social workers and are responsible for case management activities and interventions. Interventions aim to produce positive clinical outcomes, reduce inappropriate utilization of health services and improve financial outcomes while enhancing member and provider satisfaction. These interventions consist of the following:

- Comprehensive assessment to include physical/psychosocial, spiritual and financial needs
- Develop a plan of care
- Intense outpatient follow up
Monitor the member to detect signs of worsening disease symptoms
Assess willingness to change
Ensure adherence to treatment
Provide ongoing communication to track and review progress
Ongoing education
Assist with scheduling provider/specialty appointments and obtaining referrals
Obtain medical equipment and supplies
Arrange/coordinate needed services/care
Inform members and providers of the member’s benefits
Work collaboratively with all involved parties (i.e. providers, behavioral health, health education, home care, vendors)
Provide education of advance care planning
Foster member independence

Referral for Case Management

Our Population Health Initiative services are voluntary and are provided at no cost to the member. Members identified with certain needs may be automatically enrolled, but are under no obligation to participate in these programs.

Providers wishing to initiate case management services can either e-mail populationhealth@jhhc.com or call 410-762-5206 or 800-557-6916. We are available Monday through Friday from 8 a.m. to 5 p.m. Any voicemail messages received after normal business hours will be addressed the following business day. All referrals to case management must include:

- Name of member
- Date of Birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within five (5) business days.

Please do not send the following to case management:

- Bills
- Authorizations
- Pre-authorizations
- DME/Home care referrals
- Provider referrals
Member Identification

Members are identified for targeted Case Management interventions through the following mechanisms:

- 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 School of Public Health

Screening

The clinical screener, a registered nurse fully qualified and knowledgeable about the case management we have to offer, will work collaboratively with the PCP to assess whether the member meets inclusion criteria for the program. Case management is voluntary and the member can withdraw from the program at any time.

Complex Case Management

Complex Case Management is the highest level of intervention in the population health continuum and provides case management services for members with the most complex medical conditions or those that have multiple conditions. EHP recognizes that individuals often have two or more health problems that can be well served by evidenced-based care management. These members, such as adults with asthma, diabetes, cardiovascular conditions, chronic obstructive pulmonary disease, sickle cell, pain management, Alzheimer’s, seizure disorders, developmental disabilities, chronic kidney disease or chronic lung disease are contacted by a case manager, who assesses their health status, works with them to develop a self-management plan, helps get them into care and monitors their status.

Children with complex needs have specialized needs. Complex case management is provided to children 18 years and younger with chronic conditions such as asthma, diabetes, sickle cell disease, neurological devastation, various genetic syndromes, cancer, post organ transplant, or morbid obesity.

Episodic Case Management is provided for a period of up to three months for adult members whose health care needs are a low acuity. Examples of diagnoses for short-term management are:

- Cellulitis
- Members on short-term antibiotic therapy
- Routine fracture care
- Burns, second degree
- Members recently discharged from hospital receive call to assess needs and set follow up appointments

Once a member is identified with complex medical conditions or a special need, our highly qualified staff assists the member with coordinating services, accessing available resources and serving as a member advocate.

Upon referral to complex case management, the case manager completes a comprehensive general and condition specific assessment. A care plan and a self-management plan are completed for all EHP members.
in Level One Complex Case Management. The care plan and self-management plan is based on an evaluation of the member’s health status, including co-morbidities, clinical history, utilization history, current and past medications, activities of daily living, mental health status, status of life planning activities, cultural and linguistic needs, caregiver resources, an evaluation of available benefits and barriers to care. In addition to the general assessment, the case manager assesses quality of life and motivation to change.

Key content within the JHHC adopted preventive and non-preventive clinical practice guidelines, that demonstrate a strong association to improve health outcomes as indicated in the evidence-based medical literature, is incorporated into the assessments, care plan and self-management plan. This content is shared with practitioners in communication between the case managers and providers.

**Specialty Case Management Programs**

**Partners with Mom**

Partners with Mom is a maternity case management program that targets high-risk moms with a history or current symptoms of asthma, diabetes, pre-term labor, substance abuse, hypertension, multiple pregnancies, congenital anomalies and/or adolescent pregnancy. Pregnant mothers with other high-risk OB diagnoses that may benefit from case management interventions are also considered for inclusion into the program.

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

**Physical Rehabilitation**

Comprehensive case management is provided for members who are disabled due to neurological disease or physical injuries via our Rehabilitation case management program. The program consists of regular contact with the rehabilitation case manager to develop and implement a coordinated plan of care including primary care, specialty care, rehabilitation providers, specialty DME providers and community resources. The mission of this program is to promote wellness, minimize preventable complications and maximize functional abilities.

**Omega Life**

Omega Life is a palliative care program for members with cancer facing a potentially life-threatening illness. When a member is faced with a new or recurrent issue with cancer, the role of the RN case manager is that of educator, health system navigator, symptom monitor, and communicator with the PCP and various specialists. When the member doesn’t know who to call, he or she can speak to the Omega Life case manager, who is available from 8 a.m. to 9 p.m. daily. This case manager can access various other disciplines such as social work and pastoral care to support the member, either through discharge or through hospice, according the member’s condition, needs and preferences.

**Positive Health Partners**

Positive Health Partners, the HIV/AIDS case management program, employs RNs and social work case managers as well as an outreach substance abuse coordinator that are experienced in the standards of HIV care. The case managers target interventions according to the member’s specific needs. Interventions for members requiring case management needs include frequent contact to monitor medication adherence and DME needs; monitoring appointment adherence; providing culturally sensitive education about HIV-related issues; monitoring labs related to ant-retroviral therapy and trending collected data to analyze population level trends. For social needs, case managers connect members with community resources and services.
**Integrated Renal Solutions/End Stage Renal Disease**

Integrated Renal Solutions (IRS) provides case management for members with End-Stage Renal Disease (ESRD) who have begun dialysis. The case manager, a registered nurse with a background in ESRD, provides bi-monthly visits to members during the hemodialysis treatment or during the monthly visit when the member has peritoneal dialysis. During these encounters, information/education is provided regarding options for renal replacement therapy (hemodialysis, peritoneal dialysis and transplantation), and the challenges and advantages of each modality.

In addition, adequacy of dialysis is monitored based on the National Kidney Foundation Dialysis Outcomes Quality Initiative Guidelines (DOQUI). The case manager collaborates with the appropriate providers to achieve and maintain these quality standards. The case manager also assists the member in preventing complications and with problem solving related to dialysis treatment, accessing care, medication, and management of the primary diagnosis. In addition to the bi-monthly visits, the case manager is available to members and providers via phone, fax and e-mail.

**Monitored Case Management**

Members who have less complicated asthma, diabetes, and/or cardiovascular disease receive a moderate intensity intervention. These members may benefit from ongoing monitoring and improvement of self-management skills. An action plan and a self-management plan are developed for all members in monitored case management. A staff of clinical technicians and personal case managers monitors the member's health status and ongoing needs over time. Members are encouraged to use TeleWatch, a remote monitoring system. The personal care managers encourage progress towards health goals and provide guidance and tools aimed at improving overall self-management of asthma and diabetes.

**Treatment Planning**

The care manager will review the case with the PCP/specialist and record a brief medical history, identify what health promotion and maintenance services are currently being provided, and what alternative care is appropriate.

The care manager and the PCP/specialist will determine what additional services, and/or alternative care would benefit the members.

If needed, the care manager implements the new services including discussion with the members, setting up services with network providers, determining data elements to be collected and time frames for re-evaluation.

Data will routinely be collected (using concurrent and retrospective review and reporting) to evaluate the effectiveness and efficiency of care.

The PCP/specialist will work with the Care Manager by communicating any significant changes in the member's condition, problems with service delivery, and working with alternative care opportunities for the members.

The care manager will enter significant changes in the member's health status, new treatments or services, into a database and continually ensure that the appropriate level of care management is in place. The care manager will also communicate regularly with any health care team of providers involved in the member's care to ensure that the care remains a covered benefit, and recommend changes to the plan of care to the PCP.

Identified patient care issues outside medical policy guidelines will be brought to the attention of the PCP/admitting physician and the EHP Medical Director.
**Lifestyle Management**

Lifestyle management is the lowest level of intervention in The Population Health Initiative. There are some members with conditions that are more easily kept under control. These members will receive routine mailings of material about their condition. These educational materials focus on keeping the member’s self-management skills up-to-date so they can continue to lead full lives and avoid any future deterioration or complications. These members may be contacted by a health coach that will assist them with developing goals that will assist with lifestyle management.

**Other Population Health-based services include:**

- Periodic communication of educational materials targeted specifically to the member’s health status, chronic/complex condition, diet, exercise, and stress management and focused on increasing self-management skills and preventing complications
- Communication of information to the member and health care practitioner(s) based on data obtained from medical and pharmacy claims, including prescription medication history
- Utilization of the TeleWatch Patient Monitoring System, which allows members to enter data about their health status from the comfort of their home for certain conditions. TeleWatch provides information to help the JHHC case manager and their provider monitor their condition
- Outreach to selected members upon discharge from an inpatient facility to home to ensure coordination of follow-up, assistance in obtaining needed durable medical equipment, and assistance accessing services and community resources
- Assistance to members transitioning from hospital to a post-acute care facility to home by working with providers, members and their families concerning discharge planning, care coordination, and member and family education.
- Assistance with access to behavioral health services, provided by JHHC treatment coaches that assist initiating care and accessing behavioral health care services. You can access this service by calling 888-309-4573.

We encourage members to take advantage of the services provided by our JHHC case management programs.

**Other Services**

EHP Mental Health and Substance Abuse Services can be arranged by calling 410-424-4476 or 800-261-2429. Members in the JHHSC, JHH or Howard County General Hospital Basic Plan and AON Corporation must coordinate services prior to seeking care by calling the Mental Health and Substance Abuse phone line.

**Health Coach Program**

Johns Hopkins EHP offers members the opportunity to have a personal Health Coach. When an EHP member wants to make a lifestyle change such as weight loss, quitting smoking, or improving nutrition, the Health Coach program can help members make that change. Health Coaches assist members by setting goals, offering ongoing support and encouragement and by working with members one-on-one. Members can reach a Health Coach by calling 800-957-9760 or by sending an email to: healthcoach@jhhc.com. Please note that the Health Coach program is not a benefit to all EHP clients and/or members.
**Nurse Chat**

Nurse chat is a new benefit that is provided at no cost to our members. It provides real time access to a registered nurse who can give medical advice to members about a health situation. EHP members can call and be connected directly with a nurse, who will answer a member’s questions. To reach Nurse Chat, call 866-796-1855, PIN 380.

**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 inter-provider 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: http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines.html.

**Additional Resources**

Additional resources on the EHP website include:

- Anesthesia Guidelines
- Appeals Form- Rejection Review
- Appeals Response Grid
- Care Management
- Claims Retraction
- Clinical Practice Guidelines
- Coding Documents
- Emergency Department Review Process
- Find A Lab
- Forms
- Medical Record Standards
- Pre-Authorization Criteria For Outpatient Specialty Services at Kennedy Krieger Institute
- Preventive Screen Questionnaire
- Preventive Health Guidelines
- Outpatient Referral Guidelines
- Quick Reference Guide
- Sudden & Serious Criteria List
- Substance Abuse Assessment Tool (CAGE)
- Urgent Care Centers
- Utilization Management Medical Policies
Quality Improvement

The Quality Improvement (QI) Program at JHHC provides a comprehensive process for improving the quality and safety of clinical care and services provided to our members. The program is dedicated to ensuring the JHHC mission to improve the lives of our plan members by providing access to high-quality, cost-effective, member centered health care. It is a continuous process by which clinical and service quality is assessed, opportunities for improvement are identified, action is implemented, and effectiveness of interventions are evaluated. The entire program is reviewed and evaluated by the quality improvement committees annually. This evaluation is used by the committees to identify priorities for the following year.

Providers are expected to participate in the quality improvement activities of the health plan. These activities include monitoring clinical effectiveness through HEDIS and other data collection activities, review of complaints, assessment of provider satisfaction through an annual survey, assessment of medical record documentation through audits of member records, and quality improvement initiatives. Providers may be asked to collaborate with the health plan on patient safety or quality improvement projects.

In addition, a number of providers are invited to participate on our quality improvement committees. Their perspective as participating practitioners is valuable in evaluating and improving clinical effectiveness, provider satisfaction, and member satisfaction. JHHC also relies on input from participating providers in development of preventive care guidelines and clinical practice guidelines.

If you are interested in receiving the full description of the QI Program, or information on our progress on meeting our goals, please contact your Provider Relations Network Manager.

The Mission of the Quality Improvement Program is to:

• Ensure all activities meet accreditation standards, state and federal regulations and contract requirements
• Evaluate services and care delivery with respect to outcomes (e.g. member and provider satisfaction)
• Analyze plan outcomes as compared to national industry benchmarks
• Identify opportunities for improvement in both the clinical and service areas
• Evaluate the overall effectiveness of the program on a yearly basis

The Quality Improvement Objectives are:

• To continue to monitor member and provider satisfaction and identify opportunities for improvement through data analysis from the annual Member and Provider Satisfaction Surveys
• To maintain Full Accreditation status through continued compliance with URAC Health Network standards
• To improve Claims Processing by keeping the percent of claims processed in less than 30 days above 90 percent while maintaining accuracy scores above 98 percent
• To meet or exceed organizational performance standards for Customer Service
• To monitor participation of EHP members in the various Disease Management program
• To continue to monitor the HEDIS measures annually
• To identify and develop action plans for those opportunities for improvement identified through the NQMC auditing process
• To maintain compliance with the Comprehensive Quality Management Program through the JHHC Quality of Care Referral & review process
• Identify the appropriate method to monitor consult report timeliness
• To monitor health improvement activities as reported in the previous year’s Comprehensive Quality Improvement Work Plan
Quality Improvement Initiatives
The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of health care performance measures that is developed and maintained by the National Committee for Quality Assurance (NCQA). Examples of HEDIS measures are Comprehensive Diabetes Care, Childhood Immunizations, yearly Well Child Exams for Children Ages 3-6 and yearly Adolescent Well Care Exams.

Consumer Assessment Health Plan Surveys (CAHPS)
Member satisfaction surveys developed by NCQA are completed on an annual basis. Approximately 1,500 members are contacted yearly for the survey.

JHHC Accreditation
The National Committee for Quality Assurance (NCQA) is a private, 501 (c)(3) not-for-profit organization, dedicated to improving health care quality. NCQA has helped to build a consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what is important, how to measure it, and how to promote improvement. The NCQA seal is a widely recognized symbol of quality. NCQA’s Health Plan Accreditation evaluates the quality of health care that health plans provide to their members. The standards are intended to help organizations achieve the highest level of performance possible, reduce patient risk for untoward outcomes, and to create an environment of continuous improvement.

Johns Hopkins Employer Health Programs received a NCQA rating of Commendable as a health plan. NCQA awards are achieved through evaluation of service and clinical quality processes and practices that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. In addition, the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results are in the highest range of national performance standards.

Quality Improvement Committees
The Johns Hopkins Health Care Quality Improvement Committees are designed to address client and consumer requirements and needs. Each committee has distinct responsibilities and the membership includes the appropriate stakeholders and subject matter experts.

Participating Plan Providers
JHHC relies on interactions and recommendations from participating plan providers to develop preventive care guidelines, clinical pathways, practice guidelines and action plans for quality improvement initiatives. Feedback from providers is a critical element in the Quality Improvement Program. Therefore, participating providers serve as members of clinical quality improvement committees and clinical QI activities are communicated to providers via newsletters, mailings to individual providers, and group education/communication sessions.

Board of Directors
The JHHC Board of Directors has the final authority and responsibility for the quality of health care and services provided to members. Annually, the Board reviews the results of the previous year’s Quality Improvement Program and approves the Quality Improvement Plan for the following year.

Quality Improvement Work Group (QIWG)
Role
The Quality Improvement Work Group maintains oversight and approves the Quality Improvement Program and Work Plan. It also implements and monitors the Quality Improvement Initiatives as directed by the Board of Directors.
Responsibilities

- Monitor sub-committee activities through reports by chairpersons
- Review annually and adopt preventive health, practice guidelines, and activities
- Approves the Annual Quality Improvement Program
- When available, evaluate HEDIS and other audit data related to quality measures and provide recommendations for improvement
- Delegate any of the above activities to sub-committees or ad hoc work groups with appropriate oversight
- Monitor ongoing activities supporting accreditation
- Review Quality of Care activities

Process Management Team (PMT)

Role
The Process Management Team identifies opportunities to improve the overall operational performance of the organization, develops necessary procedures and makes recommendations to the organization’s executive staff.

Responsibilities

- Provide a forum for all functional areas to identify/present opportunities to improve organizational performance that affect multiple functional areas
- Approves non-clinical Quality Improvement Projects
- Establishes goals for operational performance
- Monitors progress in meeting quality improvement goals
- Reviews proposed departmental policies and procedures that affect or are impacted by other functional areas
- Make recommendations for new policies and procedures
- Distributes approved departmental procedures to other departments
- Reviews customer service performance data
- Analyzes trends in member complaints and identifies organizational opportunities for improvement
- Ensures organizational compliance with accreditation standards
- Reviews annual Member and Provider Satisfaction Survey results and makes recommendations to the Board of Directors, as indicated, for organizational improvement strategies

JHHC Scientific & Benefit Advisory Committee (SABAC)

Role
The Johns Hopkins HealthCare LLC’s Scientific Assessment & Benefits Advisory Committee’s primary responsibility is to review and evaluate current and new, unique or unusual medical technology for safety and efficacy, and to formulate recommendations regarding coverage for services not identified as a benefit or exclusion in Summary Plan Descriptions, coverage certificates or member handbooks. The term “medical technology” refers to procedures, treatments, services, devices or therapeutics that may or may not have medical efficacy.
Responsibilities
Advisory, with respect to:

- Medical technology review
- Benefits review for inclusion in Summary Plan Descriptions, coverage certificates or member handbooks
- Development & recommendations for approval of utilization review criteria for the organization to the appropriate oversight committees
- Review and approve all UM criteria annually

Special Credentials Review Committee (SCRC)

Role
The Special Credential Review Committee (SCRC) is a committee of the JHHC Board of Directors. The SCRC has final authority for decisions on credentialing applications.

Responsibility
- Review and discuss credentialing applications and related information
- Approve or disapprove applications submitted by providers for participation status
- Annual review and approval of credentialing policies and procedures
- Review delegation oversight and make determinations regarding delegation

Pharmacy and Therapeutics Committee (P & T)

Role
The Pharmacy and Therapeutics Committee is primarily responsible for the oversight and monitoring of pharmacy Utilization Management and Quality Improvement activities.

Responsibilities
- Reviews and approves policies and procedures concerning the appropriate use of drugs
- Reviews and approves educational activities related to drug use
- Manages the preferred drug list
- Reviews and approves the quality assurance programs designed to maintain appropriate drug prescribing, distribution, and administration of drugs
- Reviews and approves adverse drug event monitoring programs
- Reviews and approves the Drug Use Evaluation (DUE) process
- Reviews reports and literature used to support and develop drug use management programs
- Distributes Committee decisions to all staff members involved in direct patient care
Prospective, Concurrent, & Retrospective Review

Prospective Reviews are performed for elective inpatient services, outpatient surgery (in ambulatory centers and hospitals) and specific drugs. Care Management requires the following information:

- patient demographic information
- attending physician and facility
- date of procedure
- procedure proposed
- diagnosis
- pertinent clinical data

Requests that do not meet standardized clinical criteria are referred to the Medical Director for review and a determination. The decision is communicated by phone and in writing within two working days of the determination.

Potential denials are referred to the Medical Director for a final determination. The denial is given verbally and in writing to the attending physician, the PCP, and the member, if the member is adversely affected by the decision.

Certain types of admissions are referred to a care coordinator to obtain the following types of information:

- Description and duration of signs and symptoms
- Significant tests performed including dates, results and recommendations as applicable
- Family history
- Plan of treatment

These cases are reviewed by the care coordinator. In consultation with the medical director, if the case does not meet medical criteria or if services could be provided in a less intense setting, the coordinator or medical director will notify the PCP, or attending physician, within two working days to advise and discuss alternatives.

If criteria for emergency admission are not met, the case will be referred to the medical director for review. Determination will be made within 24 hours after receipt of required information. The member and PCP, or attending physician, are notified via telephone and in writing if criteria is not met and informed of the appeals process.

Utilization Management

EHP is committed to maintaining the health and wellness of its members by encouraging preventive services, and insuring that members receive quality medical services in the appropriate settings.

Many EHP Plans do not have a PCP or referral requirement in order to obtain benefits. Please verify benefits with Member Services to determine if this is a requirement for the member’s plan. Members without a PCP referral requirement are still encouraged to select a PCP for preventative care coordination.
The PCP and the member together should determine the best course of health care services for that member. Members are asked to select a PCP from the EHP Provider network which can be accessed through our website.

The PCP will refer to another provider when the patient requires treatments that are outside the scope of the PCP’s practice.

In exceptional circumstances, where a specialist physician is providing comprehensive care for a member, the specialist may be designated as the member’s PCP. The member, the member’s original PCP, and the member’s specialist PCP must all concur. The designation of a specialist as a PCP must be approved by the medical director and be re-approved on an annual basis. The member, PCP or specialist may terminate the arrangement at any time by notifying the medical director. Under the agreement, the specialist is responsible for providing all primary care services and coordination of referrals. Under the agreement, the specialist is not required to coordinate specialty care with the original PCP.

Each female member 14 years of age and older may select, in addition to her PCP, an EHP OB/GYN or midwife for routine gynecologic/obstetric care, which is required for basic plan members.

**Inpatient Utilization Management**

The Utilization Management Program is designed to focus on processes that will enable EHP to coordinate efficient and effective medical care to its members. The underlying tenant of the utilization strategy is that the PCP is the best individual to determine what care should be provided and to coordinate that care for members.

Utilization Management (UM) is provided for all members in acute or sub-acute settings. InterQual criteria is used to review length of stay, intensity of service, and severity of illness. UM evaluates for possible movement to lower levels of care without compromising the plan of care or promotion of health. On-site RN review is provided at The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. All other facilities are reviewed telephonically.

The nurses collaborate with the discharge planners in assuring that a safe discharge and appropriate follow-up is in place. Referrals to case management programs are made based on review of the member’s post discharge needs and/or chronic conditions. JHHC medical directors are available for consultation in difficult or complicated cases and will consult with the attending physician when needed to develop the most appropriate plan of care for the member.

**Confidentiality of Records**

All patient records and related information are considered confidential and will be protected as such throughout the course of all operations and communications.

**Experimental Treatment**

Experimental treatment, defined as the use of any treatment, procedure, equipment, device, drug or drug usage that the plan administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency and effectiveness that has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered.
The plan administrator will make a determination on a case-by-case basis, using the following principles as generally establishing that something is experimental:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If the drug, device, equipment, treatment or procedure, or the patient informed consent document utilized with the drug, device, equipment, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval;
- If Reliable Evidence* shows that the drug, device, equipment, treatment or procedure is the subject of ongoing Phase II clinical trials; is the subject of research, experimental study or the investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- If Reliable Evidence* shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

*Reliable Evidence refers to published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, equipment, treatment or procedure; or the written informed consent used by the treatment facility or by another facility studying substantially the same drug, device, equipment, treatment or procedure.

The Utilization Management department can be reached at 800-261-2421, or at 410-424-4480.

Referrals

The PCP has the responsibility to provide and arrange for all health care services for his or her EHP members. Authorization for a more inclusive list of services, requiring preauthorization information to outpatient referral guidelines posted on the EHP website, is required whenever a member is referred by the PCP including but not limited to:

- Inpatient Admissions
- Speech Therapy
- Home Health Care
- Out-of-Area Coverage

Many EHP plans do not have a PCP referral requirement in order to obtain benefits. Please verify benefits with Member Services to determine if it is a requirement of the member’s plan. Members without a PCP referral requirement are still encouraged to select a PCP for preventative care coordination. However, Notification/Authorization for services listed above should be requested by treating physicians.
Procedures

PCPs or their designated staff may refer a member by telephone, fax, or mail.

Telephone Referrals

Members may be referred by telephone 24 hours a day, seven days a week by calling 410-424-4480, 800-261-2421 or by fax to 410-424-4890. The following will be requested:

- Member Name
- Member ID Number
- Specialist Name
- Diagnosis
- Time Span of Referral
- Ancillary Service Limitation

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 date span. If not included, the referral will default to one visit in one year. Refer to our Outpatient Referral Guidelines posted on the EHP website.

Referral Information for Specialists

The specialist must follow the specific referral provided by the PCP. A “Consult and Treat” referral from the member’s PCP allows the specialist to render services within their specialty to treat the member for the condition specified by the PCP on the referral. This includes ancillary services such as laboratory, radiology, physical and occupational therapy, as well as specialized procedures including the treatment plan and recommendations.

These referrals do not include additional referrals from a specialist to another specialist or to specialty clinics. The specialist must contact the Care Management department for any services that require pre-authorization.

Members without a Referral

If a member arrives at the specialist’s office without a written referral, do not turn the member away. Referrals can be verified by calling the Provider First Line at 410-424-4450, or at 888-895-4998.

Members Who Can Self-Refer

If a member’s benefit plan includes a specific option, or a “no PCP” referral requirement and the member obtains care directly from a specialist, a referral is not needed from the PCP. The specialist may coordinate services directly. However, an inpatient admission requires pre-authorization by Care Management.
Written Referrals

The completion of a referral form is required for a referral. The form provides written documentation for the PCP, the member and the specialist physician. To refer a member in writing, one copy of the completed referral form should be given to the member. The second copy should be forwarded to the specialist and the third copy should be mailed or faxed to EHP at 410-424-4895.

EHP Outpatient Referral and Pre-Authorization Guidelines

Section V
COMPLIANCE
Medical Record Documentation

JHHC ensures that the medical records of all PCPs in our network are maintained in a manner that is current, detailed, organized, permits effective and confidential patient care and quality review, and meets established goals for medical record keeping by conducting medical record documentation audits. The medical record documentation standards are available to all practitioners and appropriate staff via the plan website. The standards include a requirement for a member specific record that includes the member name or identification number on each page of the record.

JHHC has developed performance goals for reviews of medical record documentation that include best practices, acceptable and not acceptable ranges. Practitioners that score in the “not acceptable” range will be required to submit a corrective action plan (CAP). Practitioners will be notified in writing of audit results. A copy of all correspondence related to the Medical Record Documentation audit will be included in the practitioner’s file. The audit results will be analyzed and presented to the appropriate Quality Improvement Committee.

Member Enrollment and Disenrollment

A member should choose a PCP (internist, family practitioner, or pediatrician) based upon personal choice and/or residence zip code. Once accepted into the practice, the member agrees to obtain all routine care from the PCP or another provider to whom the member is referred to by the PCP.

Once enrolled, the member will be issued an EHP identification card. The enrollment period will be in effect for 12 months. If the member becomes dissatisfied with their PCP, the member may choose another PCP from the network. The member should contact Customer Service to initiate the change.

Member Rights, Member Responsibilities

You have the right to:

• Be treated with respect for your dignity and privacy.
• Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage limitations.
• Receive information, including information on treatment options and alternatives in a manner you can understand.
• Participate in decisions regarding your health care, including the right to refuse treatment.
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
• Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
• Exercise your rights and know that the exercise of those rights will not adversely affect the way that EHP or our providers treat you.
• File complaints, appeals, and grievances with us.
• Request that ongoing benefits be continued during appeals (although you may have to pay for the continued benefits if our decision is upheld in the appeal).
• Receive a second opinion from another provider in EHP’s network if you disagree with your provider’s opinion about the services that you need. Contact us at 800-261-2393 for help with this.
• Receive other information about us such as how we are managed. You may request this information by calling 800-261-2393.
• Receive information about the organization, its services, its practitioners, and provider and member rights and responsibilities.
• Make recommendations regarding the organization’s member rights and responsibilities policy.

You have the responsibility to:
• Carry your membership card with you at all times and know your eligibility status with EHP. If you lose your card, you can obtain a new one by calling Customer Service, or from your HealthLINK@Hopkins account.
• Follow your plan’s referral and prior authorization guidelines and polices.
• Cancel doctor’s appointments if you cannot keep them.
• Pay any applicable co-pay, coinsurance, and deductible at the time of service.
• Report any other health insurance coverage to your doctor and to EHP.
• Report any communicable diseases, family history, problem with substance abuse, and any other information your doctor may need in order to provide adequate care.
• Cooperate with health care providers and follow their instructions.
• Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Compliance with Contract, Federal, State and Local Regulations

Providers will comply with all Federal, State and Local requirements. However, providers 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 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.
Privacy and Release of Member Information and/or Records and/or Confidentiality

It is the policy of Johns Hopkins HealthCare 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).

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.

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 Johns Hopkins community has taken steps to ensure that we comply with these requirements regarding the use, disclosure, security, and transmission of an individual’s (alive or dead) health information in any form (e.g., on paper, transmitted electronically, recorded or spoken), the treatment of their health condition, and/or the billing/payment for their health services.

The HIPAA Privacy Rule permits a provider to disclose protected health information to a health plan for the quality-related 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). Thus, a provider may disclose protected health information to a health plan for the plan’s Health care Effectiveness Data and Information Set (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.

A health care provider may also disclose protected health information for care management and/or utilization purposes. The HIPAA Privacy Rule permits a provider to disclose protected health information to a health plan for the health care operations activities of the health plan, provided that the health plan has or had a relationship with the patient 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”).

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.
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: Medical Review for Initial Determination.

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.

Fraud And Abuse

Health Care Fraud – What You Should Know

Johns Hopkins HealthCare (JHHC) wants to find and stop health care fraud. On average, health care fraud accounts for 10 percent of our nation’s annual health care expenditure. An estimated $68 billion is lost annually due to health care fraud. While most claims payment errors are just the result of mere oversights, there continues to be a small number of health care providers who intentionally engage in conduct intended to commit fraud.

Health care fraud is defined as any deliberate and dishonest act committed with the knowledge that it could result in an unauthorized benefit to the person committing the act or someone else who is similarly not entitled to the benefit. Examples of health care fraud are:

- Misrepresentation of the type or level of service provided
- Misrepresentation of the individual rendering service
- Billing for items and services that have not been rendered
- Billing for services that have not been properly documented
- Billing for items and services that are not medically necessary
- Seeking payment or reimbursement for services rendered for procedures that are integral to other procedures performed on the same date of service (unbundling)
- Seeking increased payment or reimbursement for services that are correctly billed at a lower rate (up-coding)
How Can I Help as a Provider?

- 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
- Report all suspicions of fraud by contacting one of the following appropriate JHHC lines of business: Priority Partners, Employer Health Plan, or US Family Health Plan or:
  1. Call: 410-424-4996 or contact your Provider Relations representative who will forward your inquiry to the Compliance Department
  2. Write:
      **JHHC Compliance Department**
      6704 Curtis Court
      Glen Burnie, MD 21060
      3. Email: Compliance@jhhc.com
      4. Fax: 410-424-4996

What happens to me if I report a concern?

Johns Hopkins HealthCare takes its responsibility to protect your ‘right to report’ seriously! No Health Plan employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, the Health Plan has enacted zero-tolerance policies and annually trains all personnel on their obligation to uphold the highest integrity when handling compliance related matters. Any individual who reports a compliance concern has the ‘right’ to remain nameless and JHHC commits to enforcing this ‘right’!

In an effort to deter these and other instances of fraud, the JHHC Corporate Compliance Department routinely performs validation audits of claims and medical record documentation. In addition, the JHHC Corporate Compliance Department investigates all detected outliers and other deviations from standard practice as well as all allegations of health care fraud it receives from recipients and others and reports substantiated allegations to the appropriate regulatory authorities who may, in turn, perform its own fraud investigation and take action against those who are found to have committed fraud.