



# 2020 Johns Hopkins Employer Health Programs **PROVIDER MANUAL**



JOHNS HOPKINS  
**EHP**  
*Your health. Your life. Your future.*

# 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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# Section I **INTRODUCTION**



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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 (JHHC) 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 more than 54,000 EHP members. Our provider network consists of more than 14,000 primary and specialty care providers and more than 30 hospitals in Maryland. Members also have access to a nationwide network of over 600,000 providers and hospitals through MultiPlan's PHCS Healthy Directions Network. MultiPlan is a vendor that contracts with providers nationwide.

JHHC is currently contracted with the following employer groups:

- Anne Arundel Medical Center
- Broadway Services, Inc.
- Howard County General Hospital/TCAS
- Johns Hopkins Bayview Medical Center
- Johns Hopkins Health System Corporation
- Johns Hopkins HealthCare
- Johns Hopkins Home Care Group
- Johns Hopkins Hospital
- Johns Hopkins University Student Health Program
- Johns Hopkins University
- Sibley Memorial Hospital
- Suburban Hospital

Each plan is tailored to meet the needs of each individual client.





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# Section II

## **PROVIDER INFORMATION**



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

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.
- Behavioral Health-Refer new or existing members to the Emergency Department (ER) within six hours of notification of a non-life threatening behavioral health situation.
- 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/voicemail 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

As a courtesy, a dedicated Specialty Appointment Line is available to all EHP members. This service helps members navigate and schedule new specialty appointments with a Johns Hopkins provider.

This line is not intended to guarantee members a specific turnaround time to be seen, but will ensure that when it's possible, EHP members will be seen within a reasonable period of time for their specific health issue.

## 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. Provider complaints are forwarded to the Provider Relations department for investigation and resolution. Member complaints are forwarded to the Complaints and Grievances department.

## 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 contracting network manager and coordinator. The department can be reached by phone at 888-895-4998.

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 contracting network manager, upon request, will train you and your office staff regarding the plan's program and its benefits.

For an up-to-date listing of our network manager territory grid, visit [www.jhhc.com](http://www.jhhc.com).

## Provider Communication

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

- *Provider Pulse* is a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories, and news pertaining to our four health plans, including EHP.
- *My EHP* is a member newsletter that is produced three times a year. It features human interest stories, resource information, health tips, 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 [www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines.html](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 JHHC Provider Relations as soon as possible via email at [ProviderChanges@jhhc.com](mailto:ProviderChanges@jhhc.com). You can also mail or fax changes to:

### **Johns Hopkins HealthCare LLC**

Attn: Provider Relations  
7231 Parkway Drive, Suite 100  
Hanover, MD 21076  
Fax: 410-424-4604

# 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), Office of the Inspector General (OIG), General Services Administration (GSA), state licensing boards, medical specialty boards, and professional certification boards 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 nondiscriminatory practices are followed.

## Credentialing Requirements

All providers and facility/hospitals that are required to be credentialed must remain in full compliance with JHHC credentialing criteria as set forth in the JHHC credentialing policies and procedures and with all applicable federal, state, and local laws and regulations. Each provider or facility/hospital must complete an appropriate application as an applicant for initial participation and, minimally, every three years thereafter (recredentialing event) for as long as the provider or facility/hospital remains an active participant in the 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 EHP 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 CAQH, may become a member by requesting an invitation through JHHC. There is no cost to the provider for using CAQH. 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 <https://insurance.maryland.gov/Insurer/Pages/HealthCareProviders.aspx> 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 five years, malpractice/professional liability insurance coverage, medical and professional certifications held, licenses held for at least the past five 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, 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  
7231 Parkway Drive, Suite 100

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 National Committee for Quality Assurance (NCQA) and 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

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 NCQA, and 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, 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  
7231 Parkway Drive, Suite 100  
Hanover, MD 21076

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 that 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 Participating Provider 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 credentialing department designee 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 panelist in this situation will render a recommendation to the SCRC within thirty (30) days of receipt of the second-level appeal. In either situation (personal appearance or appeal panel), the panelists render a recommendation to the SCRC to either uphold or overturn the initial decision. The SCRC decision will be rendered within thirty (30) calendar days from the date of the second-level appeal. Second-level appeals are final and binding.

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

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

## **Transition of Care upon Provider Termination**

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

# Important Contact Information

## **EHP Customer Service**

800-261-2393  
410-424-4450

## **National Provider Network/MultiPlan**

866-980-7427

## **Mental Health and Substance Abuse Services**

800-261-2429  
410-424-4476

## **EHP Care Management**

800-261-2421  
410-424-4480  
410-424-4890 fax

## **Case Management**

800-557-6916  
populationhealth@jhhc.com

## **Utilization Management**

800-261-2421  
410-424-4480

## **Corporate Compliance**

410-424-4996  
410-762-1527 fax  
compliance@jhhc.com

## **Provider Relations**

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

## **\*Suburban Hospital Customer Service**

866-276-7889

## **Appeals**

410-762-5383

## **\*Dental – United Concordia Companies, Inc.**

866-851-7576

## **\*Health Coaching Services**

800-957-9760  
healthcoach@jhhc.com

## **Health Education**

800-957-9760

## **\*Pharmacy (Mail Order Only)**

888-543-4921

## **Pharmacy Provider Prior Authorization for Medical Necessity**

(fax numbers may vary): refer to provider website  
[https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/our\\_plans/ehp/index.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/index.html)

## **Websites**

[www.ehp.org](http://www.ehp.org)  
[www.hopkinsmedicine.org](http://www.hopkinsmedicine.org)

*\*Not applicable to all EHP members.  
Consult specific schedule of benefits.*

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.

## Network Hospitals

Johns Hopkins HealthCare LLC has contracts with the majority of hospital facilities within Maryland. For a complete and up-to-date listing of EHP participating hospitals, please refer to the provider search tool at [www.jhhc.com](http://www.jhhc.com).



# He@lthLINK HOPKINS

YOUR SECURE, INTERACTIVE HEALTH PORTAL

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

## HealthLINK@Hopkins

HealthLINK@Hopkins is a secure, online portal for Johns Hopkins 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](http://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.

## Billing and Claims

### Office Visit Copayment

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

### Coinsurance

Network providers providing service to members are encouraged to collect any applicable coinsurance after EHP has made payment to the physician. The physician remittance will indicate the member's coinsurance 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.

If you are submitting your claims on paper and would like to submit electronically, or would like to receive payment electronically, contact our EDI Analyst at EDI@jhhc.com or 410-424-4710. You can also submit and check the status of claims through HealthLINK@Hopkins, the secure, online web portal for JHHC providers and EHP members. Contact Provider Relations at 888-895-4998 to learn more.

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**

## Provider Claims/Payment Dispute Process

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

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

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

No action is required by the member. **Payment disputes do not include medical appeals.** Providers will not be penalized for filing a payment dispute. All information will be confidential in accordance with EHP's policies and/or applicable law or regulation. The Adjustments department will receive, distribute and coordinate all payment disputes. To submit a payment dispute, complete the *Provider Claims/Payment Dispute and Correspondence Submission Form* located in the Forms section in the back of this manual or online at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/forms.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html) and mail to:

### Johns Hopkins HealthCare LLC

Adjustments Department  
7231 Parkway Drive, Suite 100  
Hanover, MD 21076

Or fax to 410-424-2800

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

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

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

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

## 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 that is not eligible for payment

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

**Deduct/Copay/Coins** . . . Identifies the member's liability for cost-sharing features (deductible, copayment and/or coinsurance) of the program

**Other Insurance Paid** . . The total dollar amount paid by any other insurance carrier or Medicare

**Subscriber Liability** . . . The dollar amount that the provider may collect from the subscriber. This amount includes any applicable deductible, copayment, coinsurance, and charges for non-covered services.



<b>Net Payable</b> . . . . .	The total dollar amount being paid for the procedure. The allowed amount minus deductible, copayment/coinsurance minus other insurance paid equals net payable
<b>Remark Code</b> . . . . .	The code number that identifies a message to the provider regarding payment of the claim. Codes are defined at the end of the remittance.
<b>Patient Name</b> . . . . .	The name of the member for whom services were provided.
<b>ID</b> . . . . .	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.
<b>Account Number</b> . . . . .	The member's account number derived from the CMS 1500 form or the UB-04 form
<b>Claim Number</b> . . . . .	The number assigned to a specific claim by claim number should always be referenced when contacting EHP regarding a claim's matter.
<b>Provider Name</b> . . . . .	The name of the provider who provided services for submitted claim.
<b>Provider ID</b> . . . . .	The identification number assigned to the specific provider submitting the claim
<b>Line of Business</b> . . . . .	The code indicating in which lines of business the patient is a member. EHP's line of business code is E.
<b>Claim Total</b> . . . . .	The total dollar value of all individual line items submitted on a single claim
<b>Payable Total</b> . . . . .	The total of all payable claims included in the remittance advice
<b>Remittance Total</b> . . . . .	The overall total of all claims included in the remittance advice
<b>Remark Code</b> . . . . .	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 copayment, coinsurance, 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 copays, coinsurance 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.

## Member Complaints and Grievances

A complaint is a written or verbal expression of dissatisfaction. EHP members may submit complaints to EHP via phone by calling customer service at 410-424-4450 or 800-261-2393. Members may also submit a complaint in writing to:

### **Johns Hopkins EHP**

Attn: Member Complaints and Grievances Department  
7231 Parkway Drive, Suite 100  
Hanover, MD 21076

Timeframes for resolution of a member complaint are:

- Administrative complaint . . . . . 30 days after the complaint is filed
- Emergency medical complaint . . . . . 24 hours after complaint is filed
- Non-emergency medical complaint. . . . . 5 days after the complaint is filed

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

### **Complaint Reconsideration Process**

If a member is dissatisfied with the initial resolution of a complaint, the member may submit a verbal or written request for reconsideration of the original resolution of a complaint. A resolution will be sent to the member within 30 days from when the reconsideration was filed.

### **Provider Complaint Process**

Providers may contact their Provider Relations network manager to file a complaint. The Provider Relations department can be reached by phone at 410-762-5385 or 888-895-4998, or by fax at 410-424-4604.

### **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 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 preauthorization (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 faxed to: 410-762-5304.

Or

Mailed to:

**Johns Hopkins HealthCare LLC**

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

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.

## **Provider Appeal Requests Process**

### **Administrative Appeals vs. Clinical Medical Necessity Appeals**

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

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

## Administrative Appeals

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical information was not submitted).

If EHP overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed or the requester will be notified of the action that needs to be taken.

## Clinical/Medical Necessity Appeals

A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied before services are rendered (preservice) and care denied after services are rendered (postservice), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

EHP offers a medical necessity appeal process that provides members, member representatives and providers the opportunity to request and participate in the re-evaluation of adverse actions. The member, member representatives and providers will be given the opportunity to submit written comments, medical records, documents or any other information relating to the appeal. EHP will investigate each appeal request, gathering all relevant facts for the case before making a decision.

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

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

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

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

Please fill out the *Provider Appeal Request Form-Clinical/Medical Necessity/Administrative Appeals Only* form, which is in this manual under the Forms section or online at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/forms.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html).

The form and other related clinical information should be filled out and mailed to:

**Johns Hopkins HealthCare LLC**

Appeals Department  
7231 Parkway Drive, Suite 100  
Hanover, MD 21076

Or fax to 410-762-5304

## 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 800-557-6916.

## 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:

- Urgent/emergent preservice appeal . . . . . 36 hours
- Non-urgent preservice appeal . . . . . 15 calendar days
- Non-urgent postservice . . . . . 30 calendar days

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

# Prospective, Concurrent, and Retrospective Review

Prospective reviews are performed for elective inpatient services, outpatient surgery (in ambulatory centers and hospitals), and specific drugs. The Care Management department 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 ensuring that members receive quality medical services in the appropriate settings.

### **EHP plans do not require a PCP or referrals in order to obtain benefits.**

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.

### **Overview**

Johns Hopkins EHP, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- EHP does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

- Access to UM Staff is available. EHP associates are available at least eight hours a day during normal business hours, Monday through Friday, for inbound communications regarding UM inquiries. Health plan UM associates are available eight hours a day, Monday through Friday, during normal business hours, excluding some state and federal holidays. NCC clinical services unit associates are available 24 hours a day, seven days a week. EHP offers TDD/TTY services for deaf, hard of hearing or speech-impaired members. For all members who request language services, EHP provides services free of charge through bilingual staff or interpreter to help members with UM issues.

## Criteria and Clinical Information for Medical Necessity

Johns Hopkins HealthCare LLC (JHCC) medical policies, which are publicly accessible on its website [www.jhhc.com](http://www.jhhc.com), are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for all JHCC lines of business.

McKesson InterQual criteria will continue to be used to determine medical necessity for acute inpatient care. In the absence of licensed McKesson InterQual criteria, EHP may use JHHC medical policies or clinical utilization management (UM) guidelines. A list of the specific JHHC medical policies used will be posted and maintained on the JHHC website and can be obtained in hard copy by written request. The policies described above will support preauthorization requirements, acute inpatient care, clinical-appropriateness claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts will supersede McKesson InterQual, JHHC medical policy, and JHHC clinical UM criteria. Medical technology is constantly evolving, and JHHC reserves the right to review and periodically update medical policy and utilization management criteria. The JHHC Utilization Management department reviews the medical necessity of medical services using:

- State guidelines
- JHHC medical policies
- McKesson InterQual (inpatient care)
- JHHC clinical utilization management guidelines

EHP follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. To learn more about these procedures, visit the Providers and Physicians section of the JHHC website at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/policies/](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/policies/)

These procedures apply to:

- Preauthorization
- Concurrent reviews
- Retrospective reviews

Only a medical director/physician reviewer may make an adverse determination (denial) based on medical necessity. Requests for services/care should include current applicable and appropriate ICD and CPT codes and relevant clinical information. Appropriate clinical information includes:

- Office and/or hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic testing results

- Treatment plans and progress notes
- Psychosocial history
- Consultation notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Estimated/anticipated length and/or frequency of treatment

## Referral/Preauthorization Process

Referrals to in-network specialists are not required for payment; however, EHP highly recommends PCPs supply the member with instructions for follow-up care. Visit the For Providers section of our website to download a Personalized *Treatment Plan* form under Communications Repository > Forms.

## Preauthorization and Notification

### General

Some covered services require **preauthorization** prior to services being rendered, while other covered services require notification prior to being rendered.

Notification is a communication received from a provider informing EHP of the intent to render covered medical services to a member. For services that are emergent or urgent, notification should be provided within 24 hours or by the next business day.

- Notification is received by telephone, fax or electronically.
- Member eligibility and provider status (in-network and out-of-network) is verified.

Preauthorization is the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered and a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

Services requiring preauthorization include but are not limited to:

- Elective inpatient admissions
- Select outpatient and specialty care provided outside of the PCP's scope of practice
- High-tech radiology
- Durable medical equipment
- Home health services
- Skilled nursing facilities
- Out-of-network services

To verify whether or not a particular service requires preauthorization, visit our website for the most recent guidelines.

Providers may also view preauthorization requirements through the Johns Hopkins Prior Authorization Lookup tool (JPAL), a resource that checks and verifies preauthorization requirements for services and procedures. Located in the [HealthLINK portal](#), JPAL offers a user-friendly way for providers to look up preauthorization requirements without needing to call Customer Service.



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

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

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

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

Preauthorization is **not** required for the following medically necessary covered services:

- Routine laboratory tests (excluding genetic testing) performed in the PCP's office or contracted laboratory
- Routine x-rays, EKGs, EEGs or mammograms at a network specialist office with referral, at a freestanding radiology facility or at some network hospitals

The medical director will periodically review and revise this list with the expectation that additional services will be added as practice patterns of the network warrants.

### **Preauthorization Determination Time Frames**

For services that require preauthorization, EHP will make a determination in a timely manner so as not to adversely affect the health of the member. The determination will be made within two business days of receipt of necessary clinical information, but no later than seven calendar days from the date of the initial request.

## **Inpatient Utilization Management**

The Utilization Management program (UM) 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.

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. Onsite RN review is provided at The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. All other facilities are reviewed by telephone.

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.

## Inpatient Services

### Inpatient Admission Preauthorization

Notification/preauthorization requirements are as follows:

- Except for an emergency admission, the admitting physician is responsible for contacting EHP to obtain preauthorization for a hospital admission.
- The hospital is responsible for notifying EHP and the Department of Mental Health and Hygiene of the birth of a child in accordance with the admission time frames noted below.
- For transfer of a newborn from the nursery to the NICU or to another level of care, or to detain a newborn beyond the OB global period, the hospital must notify EHP within 24 hours or by the next business day. These circumstances are considered separate, new admissions and are not part of the mother's admission.

### Inpatient Admission Notification Time Frames

- All elective admissions must receive prior approval through Provider Services at least 72 hours prior to the admission or scheduled procedure.
- Urgent and emergent admissions require notification to EHP within 48 hours or by the next business day following the presentation of emergency services.

The following information should be provided to the Utilization Management department for preauthorization at 410-424-4894 (FAX):

- Member's name
- Member's address
- Member's EHP ID number
- Member's date of birth
- Member's PCP
- Scheduled date of admission and/or surgery
- Name of hospital
- Member's diagnosis
- Attending provider
- Clinical information (if applicable)

All EHP members scheduled for inpatient surgery must be admitted to the hospital on the day of the surgery except in preapproved medically necessary cases. EHP will **not** pay for any costs associated with admissions on the day before surgery unless specific medical justification is provided and approved. Each member's case will be examined individually in this respect.

The following are **not** acceptable reasons for an admission before surgery:

- Member, provider or hospital convenience
- Routine laboratory or X-ray
- NPO (i.e., nothing by mouth)
- Distance or transportation to the hospital
- Most preps

Upon notification, EHP reviews the clinical basis for admission and authorizes benefits for the admission. The medical director reviews any potential denial of coverage after evaluating the member's medical condition, medical criteria and practice standards.

## **Inpatient Specialist Referrals**

Referrals to in-network specialists are not required for payment; however, EHP highly recommends PCPs supply the member with instructions for follow-up care. The *Personalized Treatment Plan* form can be found in the Forms section in the back of this manual or online at [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/forms.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/forms.html).

## **Inpatient Admission Review**

- All medical inpatient hospital admissions, including those that are urgent and emergent, will be reviewed for medical necessity within one business day of the facility notification to EHP.
- Clinical information for the initial (admission) review will be requested by EHP at the time of the admission notification.
- For medical admissions, the facilities are required to provide the requested clinical information within 24 hours of that request.
- If the information is not received within 24 hours, an administrative adverse determination (i.e., a denial) will be issued.
- EHP will adhere to NCQA determination and notification time frames for inpatient reviews.

## **Inpatient Concurrent Review**

Each network hospital will have an assigned concurrent review clinician. The concurrent review clinician will conduct a review of the medical records electronically or by telephone to determine the authorization of coverage for a continued stay.

- The concurrent review clinician will conduct continued stay reviews daily and will review discharge plans unless the member's condition is such that it is unlikely to change within the upcoming 24 hours and discharge-planning needs cannot be determined.
- When the clinical information received meets the applicable nationally recognized clinical criteria, or guidelines, approved days and bed-level coverage will be communicated to the facility for the continued stay.
- The EHP concurrent review clinician will help coordinate discharge planning needs with the designated facility staff and the attending provider. The attending provider is expected to coordinate with the member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.
- EHP will authorize covered length of stay one day at a time based on the clinical information provided to support the continued stay. Additional information may be requested in order to make a determination, and must be provided within 24 hours of the request. If the information is not received within the 24 hours, an administrative adverse determination (i.e., a denial) will be issued.

Exceptions to one-day-at-a-time authorizations may be made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days. Examples of confinements may include NICU, CCU, rehabilitation and cesarean section or vaginal deliveries. Exceptions are made by the medical director/physician reviewer.

Upon notification of the intention to deny, the member's treating physician can request a physician-to-physician review to provide additional information not previously submitted to EHP.

The request for this review must be made within 24 hours of the notification of intent to deny. To initiate this request the physician may contact EHP at 800-261-2421 from 8:30 a.m. to 5:30 p.m. Eastern time.

## Discharge Planning

Discharge planning is designed to assist the provider with coordination of the member's discharge when acute care (i.e., hospitalization) is no longer necessary.

When a lower level of care is necessary, EHP works with the provider to help plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as:

- Hospice facility
- Skilled nursing facility
- Home health care program (e.g., home IV antibiotics)

When the provider identifies medically necessary services for the member, EHP will assist the provider and the discharge planner in providing timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow the applicable nationally recognized clinical criteria or guidelines and documentation requirements. Authorizations include, but are not limited to transportation, home health, durable medical equipment (DME), follow-up visits to providers or outpatient procedures.

## Outpatient Services

### Outpatient Preauthorization

Preauthorization is required and must be requested at a minimum of 72 hours before the service/procedure/etc. must be provided. This applies to the following types of care (the list may be modified periodically):

- Home health care
- Hospice programs (notification only for outpatient hospice services)
- Skilled nursing or extended care facilities
- DME
- Cardiac rehabilitation
- Telephonic pacemaker check
- Outpatient diagnostic radiology

Please visit our website for the most recent Outpatient Referral Guidelines.

In addition, preauthorization is required for all out-of-network care (certain exclusions apply) and for specialty visits (i.e., services beyond the initial evaluation and management) if performed by a nonparticipating provider.

For preauthorization requirements for behavioral health services, please call 410-424-4845 or 800-261-2429.

### Ambulatory Surgery Preauthorization

EHP is committed to providing quality, accessible health care in the most efficient manner. In most cases, certain outpatient services can be safely performed in a freestanding facility rather than a hospital outpatient setting. Therefore, certain types of outpatient surgery/services will require site-of-service preauthorization if hospital outpatient service is requested. Services that cannot be safely and effectively provided at a freestanding site will be precertified at hospitals in these areas. These ambulatory surgical procedures must receive coverage approval through the Medical Management department at least 72 hours prior to the scheduled procedure.

For code-specific preauthorization requirements for these services when performed in a participating clinic/outpatient facility/ambulatory surgery center, visit [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/downloads/resources\\_guidelines/OutPatientGuidelines\\_EHP\\_2018.pdf](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/resources_guidelines/OutPatientGuidelines_EHP_2018.pdf)

## Preauthorization Requirement Review and Updates

EHP will review and revise policies when necessary. The most current policies are available on the JHHC website.

## Second Opinions

EHP will provide for a second opinion from a qualified health care professional within the network, or, if necessary, arrange for the member to obtain one outside the EHP network.

EHP may also request a second opinion at its own discretion. This includes but is not limited to the following scenario:

- A second opinion review of the case will be performed by the EHP medical director before a transfer to an intermediate care facility or a long-term care facility is implemented.

When EHP requests a second opinion, EHP will make the necessary arrangements for the appointment, payment and reporting. Once the second opinion is completed, EHP will inform the member and the PCP of the results and the consulting provider's conclusion and recommendation(s) regarding further action.

# 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 is 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 (FDA) 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

*\*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.*

- 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

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

## 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 outpatient referral or preauthorization information, is posted on the EHP website at [www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/).

Common referrals/prior authorizations include, but are not limited to:

- Inpatient admissions
- Speech therapy
- Home health care
- Out-of-area coverage

**Members are encouraged to select a PCP for preventive 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 JHHC 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 preauthorization.

## Members Can Self-Refer

All EHP members can self-refer to a specialist. The specialist may coordinate services directly. However, an inpatient admission requires preauthorization by the Care Management department.

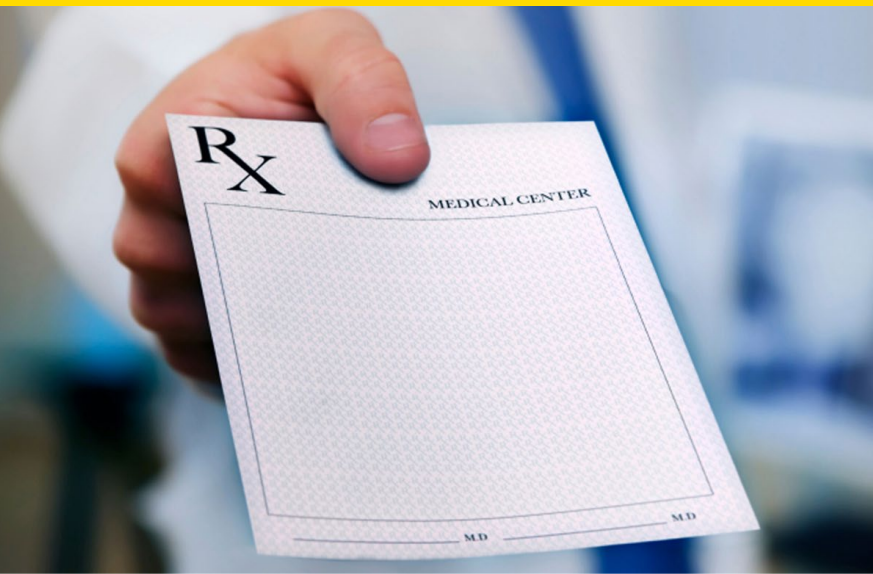
## Written Referrals

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.



# Section III

## **COVERED BENEFITS**



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# 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 copays may vary.

## Plan Designs

EHP provides benefits for many employers, each plan offering specific covered benefits and services, prescription drug coverage, and copayment amounts. Regardless of the plan, EHP does not cover services not performed by a physician; services covered by worker compensation; automobile accidents; services deemed experimental, investigational, or not medically necessary by EHP; or services listed as non-covered benefits listed in the Summary Plan Description (SPD).

- 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 statement 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.

## Statements of Benefits for Employer Groups

- **Anne Arundel Medical Center:** [benefits.ehp.org/#/anne-arundel-medical-center](https://benefits.ehp.org/#/anne-arundel-medical-center)
- **Broadway Services Inc.:** [benefits.ehp.org/#/broadway-services-inc](https://benefits.ehp.org/#/broadway-services-inc)
- **Howard County General Hospital/TCAS:** [benefits.ehp.org/#/howard-county-general-hospital](https://benefits.ehp.org/#/howard-county-general-hospital)
- **Johns Hopkins Bayview Medical Center:** [benefits.ehp.org/#/johns-hopkins-bayview-medical-center](https://benefits.ehp.org/#/johns-hopkins-bayview-medical-center)
- **Johns Hopkins Health System Corporation:** [benefits.ehp.org/#/johns-hopkins-health-system-corporation](https://benefits.ehp.org/#/johns-hopkins-health-system-corporation)
- **Johns Hopkins HealthCare:** [benefits.ehp.org/#/johns-hopkins-health-care](https://benefits.ehp.org/#/johns-hopkins-health-care)
- **Johns Hopkins Home Care Group:** [benefits.ehp.org/#/johns-hopkins-home-care-group](https://benefits.ehp.org/#/johns-hopkins-home-care-group)
- **Johns Hopkins Hospital:** [benefits.ehp.org/#/johns-hopkins-hospital](https://benefits.ehp.org/#/johns-hopkins-hospital)
- **Johns Hopkins University Student Health Program:** [benefits.ehp.org/#/johns-hopkins-student-health-program](https://benefits.ehp.org/#/johns-hopkins-student-health-program)
- **Johns Hopkins University:** [benefits.ehp.org/#/johns-hopkins-university](https://benefits.ehp.org/#/johns-hopkins-university)
- **Sibley Memorial Hospital:** [benefits.ehp.org/#/sibley-memorial-hospital](https://benefits.ehp.org/#/sibley-memorial-hospital)
- **Suburban Hospital:** [benefits.ehp.org/#/suburban-hospital](https://benefits.ehp.org/#/suburban-hospital)

## Benefit Chart

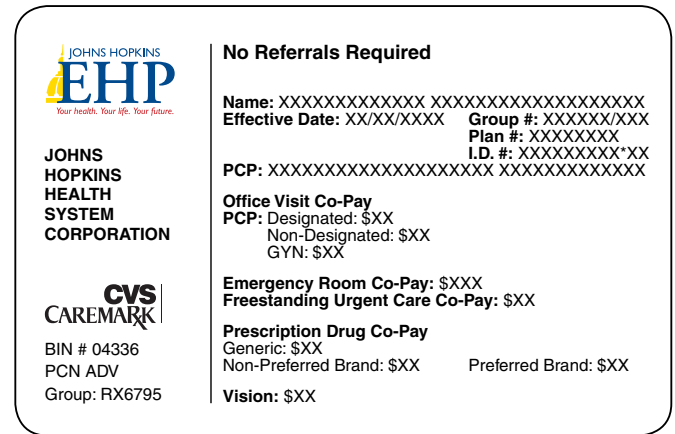
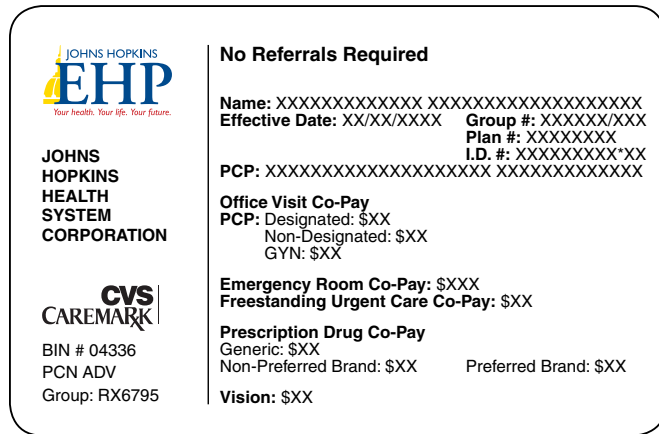
BENEFIT	COVERAGE
<b>Treatment of Illness</b>	Primary care visit (PCP) Diagnostic services and treatment Specialty care office visit
<b>Preventive Services</b>	General physical exam Diagnostic services Well child care Mammogram GYN exam Colonoscopy
<b>Immunizations</b>	For common communicable diseases
<b>Laboratory and X-Ray</b>	Laboratory tests Imaging exams X-ray exams and ultrasound
<b>Urgent Care Emergency Room</b>	See Summary Plan Description for specific coverage
<b>Pharmacy</b>	Prescription drug benefits vary among EHP employer groups. For details, please refer to the EHP pharmacy formulary available on <a href="https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/pharmacy_formulary/index.html">https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/pharmacy_formulary/index.html</a> .
<b>Dental</b>	Dental care coverage differs for EHP plan members depending on the employer to which they are associated. Please refer to the SPD for additional dental care coverage details. <i>** This benefit varies among plans**</i>
<b>National Network</b>	EHP offers a national network of providers outside the state of Maryland through MultiPlan's PHCS Healthy Directions. For members who are traveling, residing, or have children studying outside of Maryland, the national network covers them. For some plans, providers within Maryland may be used. Call the EHP Customer Service department for more information.

## 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 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 date a member requests a change.

# Sample EHP ID Card



\*ID cards vary from one employer group to another.

## Pharmacy Benefits

EHP prescription benefit may vary. Please refer to plan's formulary on the website.

Pharmacy coverage may vary by employer group.

For employer groups with the EHP prescription benefit, the following is a list of benefits covered under the EHP prescription drug plan:

- Drugs approved by the 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
- Disposable insulin syringes and needles for self-administered injections
- Blood/urine test strips and lancets

The following types of medications are examples of exclusions from the EHP prescription drug plan benefit:

- 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

- Non-legend drugs, except those listed on the EHP pharmacy formulary (list of covered drugs)
- 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
- Medication delivery implants, devices, or durable medical equipment (except hypodermic needles and syringes for self-administered injections)
- Herbal, mineral, and nutritional supplements
- Legend drugs and non-legend drugs that are not approved by the FDA for commercial distribution in the U.S.

## EHP Pharmacy Formulary

The EHP pharmacy formularies may vary and are available on [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/our\\_plans/ehp/pharmacy\\_formulary/index.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/pharmacy_formulary/index.html). As a guide for the health care providers, each formulary includes a list of preferred pharmaceuticals. The formularies are updated on a regular basis, including when a new generic or brand-name medication becomes available and as discontinued drugs are removed from the marketplace. The EHP formularies are subject to change at any time. Formulary updates are posted on the website quarterly and as changes occur.

## Copay Tier

Some EHP Members covered by the EHP pharmacy benefit have a three-tier drug benefit. Each tier has a different copay or out-of-pocket expense. Members are responsible for a portion of the cost of their medications.

The three-tier copayment benefit consists of the following tiers:

- **Tier One: Generic (lowest copay).** Generic drugs have the lowest out-of-pocket cost for members and are usually placed on Tier 1. Generic products are displayed in the formulary in lowercase *italics*.
- **Tier Two: Preferred brand drugs (middle tier copay).** Preferred brand-name drugs have a significant safety or efficacy advantage compared to similar agents. These agents have an intermediate out-of-pocket cost for members. These products are usually placed on Tier 2 and are displayed in the formulary in CAPITAL LETTERS.
- **Tier Three: Non-preferred brand (higher copay).** Non-preferred brand-name drugs do not have a significant clinical advantage in terms of effectiveness, safety and clinical outcomes compared to similar agents. These drugs have higher out-of-pocket cost for members. In most cases, there will be Tier 1 or Tier 2 alternatives for products found in this tier. Non-preferred brand-name drugs covered under the pharmacy benefit are not displayed in the formulary and may process in Tier 3.

## Generic Substitution

**EHP encourages use and prescribing of generic medications.** Brand-name drugs with generic equivalents may be excluded in some formularies, depending on member's benefit. If the prescriber or member chooses a brand-name drug with a generic equivalent, the member may be required to pay a higher copay. If a member or a provider requests a brand-name drug for which a generic equivalent is available, the member may pay the Tier 3 copay plus the difference between the brand and generic cost. Copays for members covered under the EHP pharmacy benefit vary by employer plan design. Please view the EHP formularies available on [https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/our\\_plans/ehp/pharmacy\\_formulary/index.html](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/pharmacy_formulary/index.html).

## 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 the Pharmacy and Therapeutics Committee. Established criteria are based on medical literature, physician expert opinion, and Food and Drug Administration (FDA) approved labeling information.

Providers may request prior authorization electronically at [https://www.caremark.com/wps/portal/HEALTH\\_PRO\\_PRIOR\\_AUTH\\_INFO](https://www.caremark.com/wps/portal/HEALTH_PRO_PRIOR_AUTH_INFO) or by calling CVS/caremark's Prior Authorization department at 800-294-5959.

## Quantity Limits (MDL)

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 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. If your patient's medical condition warrants use of quantities greater than the listed quantities for each drug, you may request prior authorization for a higher quantity. Providers may request prior authorization electronically at [https://www.caremark.com/wps/portal/HEALTH\\_PRO\\_PRIOR\\_AUTH\\_INFO](https://www.caremark.com/wps/portal/HEALTH_PRO_PRIOR_AUTH_INFO) or by calling CVS/caremark's Prior Authorization department at 800-294-5959.

## Step Therapy

Certain covered medications are required to satisfy specific step therapy criteria. Step therapy criteria simply means that for certain drug products, members must first have tried one or more prerequisite medications to treat their condition before other medications are covered through their benefit.

When medically necessary, providers may request an exception to the step therapy requirement and ask for prior authorization. Providers may request prior authorization electronically at [https://www.caremark.com/wps/portal/HEALTH\\_PRO\\_PRIOR\\_AUTH\\_INFO](https://www.caremark.com/wps/portal/HEALTH_PRO_PRIOR_AUTH_INFO) or by calling CVS/caremark's Prior Authorization department at 800-294-5979.

## Retail Pharmacy Network

Johns Hopkins EHP, through CVS/caremark Inc., offers a nationwide pharmacy network that includes most chain and independent pharmacies. The retail pharmacy network includes over 64,000 pharmacies nationwide. Visit [www.caremark.com](http://www.caremark.com) to locate a participating network pharmacy.

*Please note that these pharmacy benefits differ for Johns Hopkins University and Anne Arundel Medical Center employer groups.*

## Mail Order Services

For employer groups with the EHP prescription benefit, mail order services are provided by CVS/caremark. This service offers a convenient and cost-effective option for EHP members to obtain medications that they take on an ongoing basis. Members can receive up to a 90-day supply of chronic use medications and have these medications delivered to the location of their choice. For additional information, visit [www.caremark.com](http://www.caremark.com).



# Section IV **CARE MANAGEMENT**



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# Care Management

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

**Care management is available to members and their dependents.**

## Care Management

Care management services are voluntary and are provided at no cost to the member. Members identified with certain needs may be automatically enrolled, but are not obligated to participate in these programs.

Providers wishing to initiate care management services can either email [populationhealth@jhhc.com](mailto: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. Voicemail messages received after normal business hours will be addressed the following business day. All referrals must include:

- Date of birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within two (2) business days.

# Member Identification

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

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

# Screening

Once a EHP member is identified for care management services, a screening process begins to determine which care management program will best meet each individual member's need. Clinical and non-clinical screening support enables referral processing to be timely. Care management is voluntary and the member can withdraw from the program at any time.

# Service Areas

## Preventive Health

Services are provided to members showing a potential risk, an anticipated risk, or a known risk, with the intent to prevent that risk from becoming a significant care need.

Includes health and wellness promotion such as exercise, nutrition and screenings, but these services are also designed to stabilize a member's health to prevent it from worsening.

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

Services include:

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

## Complex Care

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

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

Services include:

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

## Transition of Care

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



Services include:

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

## Maternal/Child Health

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

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

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

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

## Behavioral Health

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

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

EHP's behavioral health services can be obtained by calling 800-557-6916, Monday – Friday, 8 a.m. – 5 p.m.

## Other Services

### Health Coaching

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

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

## Health Education

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

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

## Clinical Practice Guidelines

JHHC has adopted Clinical Practice Guidelines developed by specialty groups, associations, and other medical organizations as the foundation of our population health programs. The complete list of adopted guidelines and web links to download copies is available on the For Providers section of the jhh.com website: [http://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/)



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# Section V

## Quality Improvement



# Quality Improvement

## Introduction

The Quality Improvement (QI) program for JHHC is designed to achieve the highest level of performance when compared to industry benchmarks. The QI program is accountable to national benchmarks as evidenced by involvement with the NCQA accreditation and Healthcare Effectiveness Data and Information Set (HEDIS®) programs.

## Mission of the Quality Improvement Program

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

- Agency for Healthcare Research and Quality (AHRQ)
- National Quality Forum (NQF)
- NCQA standards for quality and member safety
- National Institute of Medicine (IOM)

## Continuous Quality Improvement

The QI program functions within the Institute for Healthcare Improvement's ([www.ihl.org](http://www.ihl.org)) triple aim framework, which is to simultaneously: 1) Improve patient experience of care (including quality and satisfaction); 2) Improve the health of populations; and 3) Reduce the per capita cost of health care.

The QI program uses the Continuous Quality Improvement (CQI) process to develop and evaluate initiatives to improve patient health, experience, and quality of care in alignment with the triple aim.

## Quality Improvement Program Goals

QI program goals are to:

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

## Member Safety Program

JHHC has embraced the innovative patient safety model developed by the Johns Hopkins Medicine Armstrong Institute of Patient Safety and Quality in order to promote quality improvement and patient safety activities within the health plan. The Armstrong Institute is working to advance the science of safety and quality through an array of projects and initiatives. The Director of Quality Improvement attends Armstrong Institute Quality Improvement and Patient Safety committees and shares information regarding patient outcomes, patient satisfaction, and patient safety trends.

The member safety program outlines JHHC's plan for monitoring quality of care, disparities of care, and tracking outcomes of QI initiatives and studies related to safety. Activities of the Member Safety program include, but are not limited to, the following activities:

- Quality of care reviews (clinical, behavioral, and pharmacy quality issues)
- Medical record chart audits identified through AHRQ patient safety indicator software
- Safety activities associated with regulatory compliance oversight

## Member Rights and Responsibilities

We value our members as a part of the EHP health care family. Members have the following rights and responsibilities:

### **Members have the right to:**

- Be treated with respect for their dignity and privacy
- Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage
- Receive information, including information on treatment options and alternatives, in a manner they can understand
- Participate with providers in decisions regarding their 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 medical records and request that they be amended or corrected as allowed
- Exercise member rights and to know that the exercise of those rights will not adversely affect the way that EHP or our providers treat patients
- File complaints, appeals, and grievances about the organization or the care we provide
- Request that ongoing benefits be continued during appeals (although members 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 members disagree with their provider's opinion about the services that they need. Members can contact us at 800-261-2393 for help with this
- Receive other information about us such as how we are managed. Members may request this information by calling 800-261-2393
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Make recommendations regarding the organization's member rights and responsibilities policy

### **Members have the responsibility to:**

- Carry their membership card at all times and know their eligibility status with EHP. If they lose your card, they can obtain a new one by calling Customer Service, or from their HealthLINK@Hopkins account
- Follow their plan's referral and prior authorization guidelines and policies
- Cancel appointments if they are unable to keep them
- Pay any applicable copay, co-insurance, and deductible at the time of service.
- Report any other health insurance coverage to their provider and to EHP.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their provider.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

## **Quality Improvement Objectives**

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

## **HEDIS and CAHPS®**

HEDIS measures performance on important dimensions of care and service. HEDIS consists of a total of 81 measures across five domains of care. Johns Hopkins HealthCare reports on approximately 22 to 30 measures/submeasures, which may vary from year to year and by product/line of business. The QI department coordinates all activities associated with the collection, validation, and submission of HEDIS data. JHHC has contracted with an NCQA-certified vendor to conduct external HEDIS audit to ensure compliance with data collection processes and validation of data prior to submission. JHHC has IT resources with strict controls allowing for the confidential transmission of data via an Interactive Data Submission System (IDSS) tool to NCQA.

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

## **Quality Improvement Initiatives**

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

QI initiatives are identified through analysis of data, which include, but are not limited to, the following areas:

- HEDIS results
- Member Satisfaction Survey results (CAHPS)
- QOC reviews
- Provider Satisfaction Survey results
- Utilization management data
- Pharmacy and medical claims data
- Member complaint data

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

## Quality Improvement Annual Program Description and Work Plan

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

## Quality Improvement Program Evaluation

On an annual basis, a multidisciplinary team evaluates the outcomes of quality initiatives and studies and the overall effectiveness of the QI program. The QI evaluation is approved by QI committees, with ultimate approval by the JHHC Board of Directors.

## Provider's Role

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

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

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

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





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# Section VI **COMPLIANCE**



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# Compliance with Contract, Federal, State and Local Regulations

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

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

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

## Discrimination Against Members

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

In addition, 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 order to provide a service or benefit
- Assign times or places to obtain services based on age, sex, disability, race, color, religion, or national origin

# Medical Record Documentation and Retention

Providers must maintain members' medical record documentation in a manner that is current, detailed, organized, promotes effective and confidential patient care and quality review, and meets generally accepted standards and established goals for medical record keeping. To access and review the plans' Medical Record Documentation Standards Policy in its entirety to which the providers are subject with respect to EHP members, please click on the following hyperlink: [www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/) (See: Medical Record Documentation Standards Policy).

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

## Audit Process

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

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

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

## Privacy and Release of Member Information and/or Records

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

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

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

The HIPAA Privacy Rule permits providers to disclose protected health information to a health plan for health

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

## **Standard of Conduct**

In order to affect Johns Hopkins Employer Health Programs' commitment to the highest legal and ethical standards, EHP has adopted Johns Hopkins HealthCare's (JHHC) Code of Conduct. A copy of JHHC's Code of Conduct can be found at: [www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/providers\\_physicians/resources\\_guidelines/](http://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/). Providers are required to either adopt and abide by the JHHC Code of Conduct or implement a code of conduct that incorporates requirements consistent with JHHC's Code of Conduct.

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

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

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

## **General Compliance and Fraud, Waste and Abuse Education**

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

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

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

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

- Telephone: 410-424-4996 or toll free at 844-422-6957
- Fax: 410-762-1527
- Email Johns Hopkins Compliance department at: [Compliance@jhhc.com](mailto:Compliance@jhhc.com)
- By mail at:

**Johns Hopkins HealthCare Compliance Department**

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

Providers are responsible for reporting all incidents of actual and/or suspected fraud, waste, and abuse.

No JHHC employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, JHHC has enacted zero-tolerance policies and annually trains all personnel on their obligation to uphold the highest integrity when handling compliance-related matters.

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

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

Fraud is defined as: knowingly and willingly executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Health care fraud examples include but are not limited to the following:

- 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)

Abuse is defined as actions that may, directly or indirectly, result in: unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between fraud and abuse depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

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

Both fraud and abuse can expose a provider, contractor, or subcontractor to criminal and civil liability. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

Providers are responsible for implementing methods to prevent fraud, waste, and abuse. Listed below are some common prevention techniques. This list is not meant to be all-inclusive.

- Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities<sup>1</sup>
- 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

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

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

## Reporting of Other Compliance Concerns

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

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

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

For reporting all other issues, contact EHP Customer Service at 800-261-2393. Immediately below is a list of examples of such reporting. The list is not intended to be all inclusive.

- Quality of care received from an EHP contracted provider or any entity
- Access to care
- Coverage decision (medical or pharmacy)
- Filing a grievance





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# Section VII

## FORMS



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## **Provider Claim/Payment Dispute Form**

[https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/downloads/resources\\_guidelines/claims-and-payment-disputes-072018.pdf](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/resources_guidelines/claims-and-payment-disputes-072018.pdf)

## **Provider Appeal Request Form**

[https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/downloads/resources\\_guidelines/appeal-submission-form-072018.pdf](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/resources_guidelines/appeal-submission-form-072018.pdf)

## **Psychological Testing Form**

[https://www.hopkinsmedicine.org/johns\\_hopkins\\_healthcare/downloads/all\\_plans/psych-testing-form.pdf](https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/psych-testing-form.pdf)

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