PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

SUMMER 2018

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

This newsletter features important information pertaining to providers in the JHHC network: Priority Partners, Johns Hopkins Employer Health Programs (EHP), Johns Hopkins US Family Health Plan, and Johns Hopkins Advantage MD. Please contact your Provider Relations coordinator with any questions about this information.

// INTRODUCTION

For many, summertime signals long, sunny days, a slower, easy pace, and maybe a vacation to get away from it all. Here at JHHC Provider Relations, however, summer is full of activity, as new health care policies and procedures go into effect and we gear up for a busy fall season.

In the summer 2018 issue of Provider Pulse, our quarterly newsletter, you'll find timely information on new Maryland health care legislation—effective July 1—pertaining to contraceptive coverage, audiology services and the state's strategy to manage opioid and prescription painkiller abuse.

Your essential summer reading list also includes articles on:

- Working with you to reach our colorectal cancer screening goal
- Member incentives for essential preventive screenings
- Streamlining our processes with new provider claim and appeal request forms
- Network access requirements
- Updates to our formularies

Partnerships with providers like you play an indispensable role in JHHC's commitment to high-quality, accessible medical services that improve the overall health of our members. We thank you for all you do every day for our members.

–Jennifer Sandoval
AVP, Network Strategy & Innovation, Provider Relations

// CLAIMS AND BILLING

New Provider Forms for Submission of Payment Disputes and Clinical/ Medical Necessity Denial Review Requests

As part of our ongoing efforts to improve the workflow for provider inquiries, we have updated the process for submitting payment disputes and clinical/medical necessity denial reviews.

Effective Sept. 1, 2018, please use the new forms noted below.

For **Priority Partners, Johns Hopkins US Family Health Plan, and Employer Health Programs (EHP),** we now offer two separate forms for **Provider Payment Disputes and Medical Necessity/Clinical Appeal Requests.**

- **Provider Claims/Payment Dispute and Correspondence Submission Form:** Use this form for provider claim/payment disputes and claim correspondence only. Please do not use this form for clinical/medical necessity appeal requests.
- **Provider Appeal Submission Form-Clinical/Medical Necessity Appeals Only:** Use this form when you want to appeal a clinical/medical necessity denial. If you are a provider submitting appeals through CareLink, please attach this form to your appeal.

For **Johns Hopkins Advantage MD**, one new form for payment disputes, with or without a request for clinical review, will be introduced shortly.

Please be sure to submit a separate form for each request.

These new forms can be found on **www.jhhc.com** at the *For Providers* tab, in the "Resources and Guidelines" section under "**Forms**."

// POLICIES AND PROCEDURES

Referral and Authorization Requests Not Accepted in HealthLINK

A recent audit of our systems showed that some providers have attempted to enter referral and authorization requests in **HealthLINK@Hopkins**. In some cases, these requests were voided and the requests were sent back to the provider.

Referral and authorization requests should not be entered into our system through HealthLINK. For all lines of business, referral and authorization requests to our Utilization Department (UM)

must be submitted **only** via the FAX numbers listed below:

- **Advantage MD:** 410-424-2621
- **EHP:** 410-762-5205
- **Priority Partners:** 410-762-5205 or 410-424-4603
- **USFHP:** 410-762-5205 or 410-424-4603

Providers are able to check their authorization status in HealthLINK once they are submitted by FAX. However, if you also send the initial referral request through HealthLINK, it will be rejected and you will then be notified that the referral request needs to be faxed to UM.

Important Reminder: Inpatient Referral Fax Numbers

To maintain the efficiency of our processes and to make sure referrals are received by the correct staff person in our Utilization Management (UM) department, please make sure that you send inpatient referrals and preauthorization requests to the following fax numbers **only**:

- **Priority Partners/EHP and USFHP:** 410-424-4894
- **Advantage MD:** 844-240-1864
- **Johns Hopkins Hospital:** 410-762-5203
- **Johns Hopkins Bayview:** 410-762-5204

These fax numbers are also listed in our provider manuals and Quick Reference Guides. Please do not fax to any other numbers assigned to UM staff. The fax capabilities of these other numbers have been deactivated. If you continue to fax to numbers other than the ones listed above, you will receive multiple error messages.

// QUALITY CARE

Johns Hopkins Advantage MD Member Initiatives For Preventive Screenings

As a health care provider, you fully appreciate the value of preventive health for our members. Johns Hopkins Advantage MD introduces new initiatives that will help motivate your Advantage MD patients to complete essential preventive screenings. The initiatives will also improve some of the quality measures tied to Advantage MD's performance in our Stars Ratings Program.

Advantage MD will focus on the following member initiatives that can directly improve the quality of life for our members, your patients:

1. **InSure® One FIT™ Program**
   We want to connect our members to health care services in the simplest way possible. Advantage MD is collaborating with Quest Diagnostics to conduct the InSure® One FIT™ Program. FIT stands for the fecal immunochemical test, a type of screening used to detect colorectal cancer. Your Advantage MD patients may receive a FIT kit in the mail to complete and send back to Quest Diagnostics for processing. If your patient completes the FIT kit, you will receive the results via fax. This initiative is projected to launch in August 2018 and will run until the end of the year.
2. **Member Telephone Outreach- Preventive Screenings**
   Advantage MD is conducting telephone outreach, which focuses on care coordination and assists members who have not selected a primary care physician (PCP). Some of our staff here at JHHC will also make outreach calls to remind and help members to take their medication as prescribed by their PCP.
3. **Preventive Screening Reminder Letter**
   One of Advantage MD's goals is to empower our members with the necessary information they need to make healthy decisions. Advantage MD will launch a mail campaign to members that encourages them to obtain the flu vaccine and other necessary preventive screenings important to well-being and overall health.

For any questions regarding these member initiatives, please contact your provider engagement liaison or network manager. Thank you for all that you do every day to deliver high-quality health care to our Advantage MD members.

Help Us Achieve the Goal for Colorectal Cancer Screenings

For 2018, the National Colorectal Cancer Roundtable has set goals to increase colorectal cancer screening rates to at least 80 percent. Achieving this goal can lead to the prevention of colorectal cancer diagnosis and/or death related to colorectal cancer.

The Johns Hopkins Advantage MD plan annually assesses performance on the colorectal cancer screening measure. With your collaboration, the Advantage MD PPO plan achieved a rate of 72.51 percent for the colorectal cancer screening measure on the 2018 HEDIS® annual audit.

Although this is an admirable measure of compliance, we are still a few percentage points shy of the 80 percent goal. Please join us in our effort to reach the 80 percent mark for colorectal

cancer screening by the end of 2018.

We can support your efforts to increase colorectal cancer screening rates with the following guidance on ways to improve the screening process and highlight areas where current practice may fall short.

Multiple appropriate screening methods—with recommended frequencies—are available to patients. (Screening frequency is subject to change depending on the patients' medical and family history):

Stool-Based Test	
Test	**Frequency**
Fecal Occult Blood Test (FOBT)	Every year
Fecal Immunochemical Test (FIT-DNA)	Every one to three years
Visualization Tests	
Colonoscopy	Every 10 years
CT colonography (virtual colonoscopy)	Every five years
Flexible sigmoidoscopy	Every five years

It's understandable that some people may be hesitant about getting a colonoscopy, so talk about alternatives, if appropriate, to the member's specific health needs.

Advantage MD also has an FOBT program to offer members an alternative to the colonoscopy. Through this program, members would receive a test kit in the mail. For more information on this program, please contact your provider engagement liaison.

Another colorectal cancer screening choice is Cologuard. This safe, DNA-based test uses a stool sample and is easy for people to complete in the comfort of their own home. To learn more about this option, please visit www.cologuardtest.com.

One last tip: Developing a good patient-provider relationship is essential to raising the compliance rate. Again, we appreciate your efforts in collaborating with us to achieve our goals and are grateful for the care that you deliver consistently to our members.

// PHARMACY

Find the Latest Formulary Information Online

A variety of pharmacy information and resources for each of our plans is available to you at **www.jhhc.com** > For Providers > **Our Health Plans.**

This includes information related to the pharmacy formulary, pharmaceutical restrictions or preferences, requesting a benefit exception, step therapy, generic substitution, and other pharmacy management procedures. The pharmacy formularies are specific to each plan and are updated regularly to include new medications and the latest safety information.

For additional information on the pharmacy formularies and updates for each plan, visit the following links:

- **Advantage MD formulary**
- **EHP formulary**
- **Priority Partners formulary**
- **USFHP formulary**

You may also call the JHHC Pharmacy department at **888-819-1043** for questions or concerns for Priority Partners, EHP, and Johns Hopkins USFHP, or call **877-293-5325** (option 2) for Advantage MD.

MD Opioid Prescribing Policies and Guidance and Prescription Drug Monitoring Program

In response to widespread abuse of opioids and other prescription drugs across the state, Maryland has introduced new policies and programs for Priority Partners and other Managed Care Organizations (MCO).

Maryland Opioid Prescribing Guidance and Policies

The following policies apply to both Priority Partners and Medicaid Fee-for-Service:

Policy

Pre-authorization is required for long-acting opioids, fentanyl products, methadone for pain, and any opioid prescription that results in a patient exceeding 90 morphine milli-equivalents (MME) per day.[1] A standard 30-day quantity limit for all opioids is set at or below 90 MME per day.

The CDC advises that "clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence

[1] Instructions on calculating MME is available at: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

of individual benefits and risks when considering increasing dosage to ≥50 MME/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." In order to prescribe a long-acting opioid, fentanyl products, methadone for pain or opioids above 90 MME daily, a pre-authorization must be obtained every six months.

The pre-authorization requires the following attestations:

- The provider has reviewed CDS prescriptions in the PDMP
- A patient-provider agreement
- Screening patient with random urine drug screen(s) before and during treatment
- A naloxone prescription was given or offered to the patient/patient's household members.

Patients with cancer, sickle cell anemia or in hospice are excluded from the pre-authorization process but they should also be kept on the lowest effective dose of opioids for the shortest required duration to minimize risk of harm. *Priority Partners may choose to implement additional requirements or limitations beyond the state's policy.*

Naloxone should be prescribed to patients who meet certain risk factors. Both the CDC and Centers for Medicaid and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids.[2] We encourage providers to prescribe naloxone— an opioid antagonist used to reverse opioid overdose— if any of the following risk factors are present:

- History of substance use disorder
- High dose or cumulative prescriptions that result in over 50 MME
- Prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics
- Other factors, such as drug-using friends/family

Guidance

Non-opioids are considered first line treatment for chronic pain. The CDC recommends expanding first line treatment options to non-opioid therapies for pain. In order to address this recommendation, the following evidence-based alternatives are available within the Medicaid program:

- NSAIDs
- Duloxetine for chronic pain
- Diclofenac topical
- Certain first line non-pharmacological treatment options (e.g. physical therapy)

[2] CDC guidance: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm; and CMS guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf)

Providers should screen for substance use disorder. Before writing for an opiate or any controlled substance, providers should use a standardized tool(s) to screen for substance use. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an example of a screening tool.[3] Caution should be used in prescribing opioids for any patients who are identified as having any history of substance use disorder. Providers should refer any patient who is identified as having a substance use disorder to a substance use treatment program.

SBIRT is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables providers to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. The provision of SBIRT is a billable service under Medicaid. Visit **mmcp.health.maryland.gov/MCOupdates** > FY 2016 Transmittals > **form PT 43-16**.

Patients identified with substance use disorder should be referred to substance use treatment. Maryland Medicaid administers specialty behavioral health services through a single administrative services organization: Beacon Health Options. If you need assistance in locating a substance use treatment provider, Beacon Health Options may be reached at 800-888-1965. If you are considering a referral to behavioral health treatment for one of your patients, visit **maryland.beaconhealthoptions.com** and click "Non Behavioral Health Providers."

Providers should use the PMDP every time they write a prescription for CDS. Administered by MDH, the PDMP gives healthcare providers online access to their patients' complete CDS prescription profile. Practitioners can access prescription information collected by the PDMP at no cost through the CRISP health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other health care facilities. Providers that register with CRISP get access to a powerful virtual health record that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports and clinical documents, as well as PDMP data.

For more information about the PDMP, visit the **Behavioral**

[3] A description of these substance use screening tools may be accessed at: http://www.integration.samhsa.gov/clinical-practice/screening-tools

Health Administration page on the MDH website. If you are not already a registered CRISP user you can register for free at **crisphealth.force.com/crisp2_login**. PDMP usage is highly encouraged for all CDS prescribers and will become mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law) in July 1, 2018.

If Priority Partners is implementing any additional policy changes related to opioid prescribing, we will notify beneficiaries and you.

Maryland Prescription Drug Monitoring Program

Priority Partners complies with the Maryland Prescription Drug Monitoring Program (PDMP). The PDMP is an important component of the MDH initiative to halt the abuse and diversion of prescription drugs. The MDH is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. MDH does not collect data on any other drugs.

Pharmacies must submit data to the MDH at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the MDH is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories, and document compliance with therapeutic regimens.

New registration access to the MDH database is granted to prescribers and pharmacists who are licensed by the state of Maryland and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the MDH database must certify before each search that they are seeking data solely for the purpose of providing healthcare to current patients. Authorized users agree that they will not provide access to the MDH to any other individuals, including members of their staff. Register at **crisphealth.org** > Services > **Prescription Drug Monitoring Program**.

Corrective Managed Care Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the state's criteria for corrective managed care. The Corrective Managed Care (CMC) program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call **800-654-9728** if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Priority Partners will work with the state in these efforts and adhere to the state's opioid preauthorization criteria.

USFHP Pharmacy Network Change

Your Johns Hopkins US Family Health Plan members now have access to all Walgreens pharmacies to fill their prescriptions. Please note that this includes any former Rite Aid that has converted to a Walgreens. Until July 1, Rite Aid had been the exclusive pharmacy provider for Johns Hopkins USFHP. New member ID cards were mailed out in mid-June with the updated prescription information, as well as a reminder letter instructing members to visit any Walgreens for their pharmacy needs.

The mail-order prescription process for Johns Hopkins USFHP members remains the same.

In the coming months, Rite Aid pharmacies will be phased out of the USFHP network. Walgreens will become Johns Hopkins USFHP's sole pharmacy network provider.

Priority Partners Copay Waiver

Priority Partners has established policies and procedures to make sure members comply and are consistent with medication regimens prescribed by their PCPs.

One such program is the Priority Partners copay waiver. In-network pharmacies cannot withhold services or prescriptions, even if members cannot afford the copayment when they pick up their medications. Maryland legislation pertaining to Managed Care Organizations states that pharmacies cannot deny members their medication for inability to pay.

However, the member's inability to pay does not excuse the debt and they can be billed for the copayment at a later time.

// REMINDERS

MDH Introduces ePREP: A One-Stop Shop

The Maryland Department of Health (MDH) has launched a new electronic Provider Revalidation and Enrollment Portal (ePREP)—your one-stop shop for enrollment, re-enrollment, revalidation, provider updates and demographic changes.

Please visit the ePREP website at at **mmcp.health.maryland.gov/Pages/ePREP.aspx** for questions and instructions on credentialing. The call center can be reached at 844-463-7768.

Network Access Standards

JHCC complies with state regulations designed to help make sure our plans and providers can give members access to care in a timely manner. These state regulations require us to ensure members are offered appointments within the following time frames:

Priority Partners

Service	Appointment Wait Time (not more than):
Initial prenatal appointments	10 business days from request, or from the date the MCO receives a Health Risk Assessment (HRA) for the new enrollee (unless enrollee continues care with established provider and established provider concludes that no initial appointment is necessary), whichever is sooner.
Family Planning appointments	10 days from the date enrollee requests appointment
High Risk enrollee appointments	15 business days from MCO's receipt of the enrollee's completed HRA
Urgent Care appointments	48 hours from date of request
Routine, Preventative Care, or Specialty Care appointments	30 days from initial request or, where applicable, from authorization from PCP.
Initial newborn visits	14 days from discharge from hospital (if no home visit has occurred)
Initial newborn visits if a home visit has been provided	30 days from date of discharge from hospital
Regular optometry, lab, or x-ray appointments	30 days from date of request
Urgent optometry, lab or x-ray appointments	48 hours from date of request
Wait for enrollee inquiries on whether or not to use an emergency facility	30 minutes

Employer Health Programs (EHP)

Service	Appointment wait time (not more than):
History & Physical Exam	90 calendar days
Routine health assessment	30 calendar days
Non-urgent (symptomatic)	7 calendar days
Urgent Care	24 hours
Emergency Services	24 hours

Johns Hopkins US Family Health Plan

Service	Appointment wait time (not more than):
Well patient	4 weeks
Specialist	4 weeks
Routine	1 week
Urgent	24 hours
Office Wait Time	30 minutes

Johns Hopkins Advantage MD

Service:	Appointment Wait time (not more than):
PCP Routine/Preventive Care	30 calendar days
PCP Non-Urgent (Symptomatic)	7 calendar days
PCP Urgent Care	Immediate/Same Day
PCP Emergency Services	Immediate/Same Day
Specialist Routine	30 calendar days
Specialist Non-Urgent (Symptomatic)	7 calendar days
Behavioral Health Routine Initial	10 business days
Behavioral Health Routine Follow-up	30 calendar days
Behavioral Health Urgent	48 hours
Behavioral Health Emergency	6 hours
Office Wait Time	30 minutes

Outpatient Referral and Preauthorization Guidelines Update

The Outpatient Referral and Preauthorization Guidelines outline the requirements for many outpatient services for our EHP, Priority Partners and Johns Hopkins USFHP members. These guidelines are updated quarterly and posted to the Johns Hopkins HealthCare website. To ensure that the most up-to-date referral and preauthorization guidelines for outpatient services are being followed, visit **www.jhhc.com** > For Providers > **Resources & Guidelines.**

The following are the most recent changes for the June 2018 Outpatient Referral and Preauthorization Guidelines update:

EHP

- Howard County General Hospital: Preauthorization required (voiding dysfunction only) for Hypnosis
- Suburban Hospital Standard Plan: Preauthorization required for Bariatric Surgery; Preauthorization required for visits >6 for Nutritional Counseling
- Johns Hopkins Hospital/Health System Corporation Union Plan: No benefit for Hypnosis

Priority Partners

Preauthorization is required for:

- TMS-Transcranial Magnetic Stimulation*
- Gender Transition* (Limitations & Exclusions)

Johns Hopkins USFHP

No referral or preauthorization is required for:

- Ambulance
- Urgent Care Center

For related medical policies, please go to* **www.jhhc.com > *For Providers* > **Policies**

Changes to Maryland Contraceptive Equity Act

Due to new legislation, Priority Partners will only be allowed to dispense a 12-month supply of a contraceptive when ordered by a qualified provider. This provision went into effect July 1, 2018.

Senate Bill 774/House Bill 994, which passed during the recent Maryland legislative session, overturned previous legislation that allowed insurers to dispense a two-month supply of contraceptives for new family planning prescriptions. This was intended to ensure that the medication was well-tolerated and effective for the patient before prescribing a long-term dose. The Maryland bills state that only a 12-month supply of contraceptives can be dispensed in a single prescription.

Priority Partners cannot charge copays for any contraceptives or require prior authorization for an intrauterine device (IUD) or implantable rod that is FDA-approved and obtained under a written prescription, unless the FDA has issued a black box warning (a warning on the prescription drug or device's label designed to call attention to serious or life-threatening risks).

New Priority Partners Benefit: Audiology Services for Children and Adults

Starting July 1, 2018, Priority Partners, in cooperation with the Maryland Health Department's (MDH) HealthChoice program, began providing the following benefits to all Medicaid participants, regardless of age:

- Medically necessary audiology services
- Hearing aids
- Cochlear implants
- Auditory osseointegrated devices

Previously, audiology coverage was limited to participants under the age of 21 and provided through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Coverage details—including the MDH's new benefit package, fee schedule and preauthorization requirements for audiology services—are published in a revised Audiology Services section of the EPSDT manual on the MDH website (**mmcp.health.maryland.gov/epsdt).**

- The fee-for-service schedule for audiology services will not differ for children and adults.
- Medical necessity criteria for children and adults will vary in the new coverage package.
    - For example, children will be eligible for coverage of unilateral or bilateral hearing aids at any degree of hearing loss.
    - Adults with moderate hearing loss will be eligible for initial coverage of unilateral aids, with bilateral aids only covered when specific criteria are met.
- Prior authorization is required for hearing aids, cochlear implants and auditory osseointergrated devices. Prior authorization requirements will be the same for children and adults.
- Referrals to an audiologist by the member's PCP are required for audiology services.

Autism Care Demonstration Program Update for Johns Hopkins USFHP

TRICARE has updated the Autism Care Demonstration (ACD) program effective January 29, 2018.*

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

Referrals

A referral for Applied Behavior Analysis (ABA) services under the ACD is required. A physician-primary care manager (P-PCM) or a specialized Autism Spectrum Disorder (ASD) diagnosing provider may submit the referral for ABA services. The beneficiary must be diagnosed with ASD using DSM-5 criteria by an approved provider. The referral for ABA services must contain documentation of the age of the child and year of the initial ASD diagnosis, documentation of any comorbid psychiatric and medical disorders, and level of symptom severity (level of support required per DSM-5 criteria under ASD). The level of symptom severity must be submitted by the specialized ASD diagnosing provider. The diagnosing/referring provider must provide a copy of the referral for ABA services to the beneficiary's parent(s)/caregiver(s). If the initial diagnosis is made by a P-PCM, the P-PCM must submit a referral for a specialized ASD diagnosing provider who must confirm the diagnosis of ASD within one year.

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

Outcome Measures

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

Pervasive Development Disorder Behavior Inventory (PDDBI)

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

Vineland-3

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

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

SRS-2

This outcome measure must be completed at baseline (within one year of the initial diagnosis) and every two years thereafter to align with the Periodic ABA Program Review. The parent form is required. The Total Score Results and Treatment Subscale Results must be submitted to JHHC. The SRS-2 must be completed and submitted by the specialized ASD diagnosing provider. If

the specialized ASD diagnosing provider cannot complete the requirement, the following providers may do so:

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

If you have questions or need additional assistance, please call the Behavioral Health Utilization Management team at 410-424-4830.

* TRICARE Operations Manual 6010.56-M, February 1, 2008 Chapter 18, Section 18 Department of Defense (DoD) Comprehensive Autism Care Demonstration.

Updated and Expanded Priority Partners Provider Manual Available Aug. 1

On Aug. 1, 2018, the newly updated and expanded Priority Partners provider manual will be available on our website, **www.jhhc.com**, as an important reference and resource for our network of providers.

The 2018 update of the manual contains required information on Priority Partners benefits, services and processes, and also incorporates new information that providers need to know to help us remain in compliance with state mandates for managed care organizations (MCO).

New and expanded information in the 2018 Priority Partners provider manual:

- Appeals process, including a new form to use for clinical/medical necessity appeals, effective Sept. 1
- Payment dispute process, including a new form to use for claims/payment disputes, effective Sept. 1
- Utilization management section
- Updated benefits, including audiology services, contraceptive services, and site of service requirements
- Changes to the Rare and Expensive Case Management Program (REM)
- Guidance for Maryland opioid prescribing policies
- Additions to the Maryland Prescription Drug Monitoring Program (PDMP)

Access the **2018 Priority Partners provider manual** on our website at **www.jhhc.com** > For Providers > Resources & Guidelines > **Manuals**. Please note and review the new information, benefits and processes outlined in the manual.

If you have any questions about the 2018 Priority Partners manual, please call the Provider Relations department at 888-895-4998.

Important notice:
Please distribute this information to your billing departments.

PROVIDER pulse

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Johns Hopkins HealthCare
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