JOHNS HOPKINS

MEDICINE

US FAMILY HEALTH PLAN

# Provider Manual

**Revised**
**2008**

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# I. INTRODUCTION

## A. US Family Health Plan Overview

The US Family Health Plan is a program sponsored by the Department of Defense. US Family Health Plan providers offer TRICARE Prime coverage to active-duty family members, military retirees, and their family members.

The US Family Health Plan at Johns Hopkins is the only TRICARE Prime option that gives members access to Johns Hopkins primary care physicians, specialists, and facilities in addition to a contracted network of community providers. Together, we support the mission of the US Family Health Plan:

- To provide quality health care for uniformed services members;
- To have well cared for and extremely satisfied members;
- To demonstrate quality, value, and operational effectiveness to a growing enrollee population; and
- To continue as a permanent and respected health care partner in the Military Health System.

US Family Health Plan members must have all non-emergency care coordinated through a Primary Care Physician. The plan is founded upon the PCP model in order to help members establish a strong and continuous relationship with a physician and to provide members with a vital link to various health care services.

Primary care management coupled with strong case and disease management programs ensures that the Plan provides best value health care services in support of the Military Health System. Because of our focus on comprehensive health care management, the US Family Health Plan does not offer the point-of-service option available under other TRICARE Prime programs.

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

# B. Description of US Family Health Plan

## 1. TRICARE Overview

Through Military Treatment Facilities and civilian resources, TRICARE offers several plans that provide services to active duty family members and retired uniformed service members and their families, including US Family Health Plan and TRICARE Prime.

### a) US Family Health Plan

The US Family Health Plan is a "Designated Provider" of the TRICARE Prime benefit and a permanent part of the military health system. The US Family Health Plan offers the same uniform benefit and cost structure under TRICARE Prime as the Managed Care Support Contractors, and additional enhanced benefits offered only to our members. The Johns Hopkins Medicine excellence-in-care that sets the US Family Health Plan apart from other plans.

### b) TRICARE Prime

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

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

## 2. Member Information

### a) Rights and Responsibilities

***Information Disclosure***

Members have the right to receive accurate, timely, and easily understood information, including information about covered benefits, cost sharing, the provider network, and US Family Health Plan policies and procedures.

Members or their legal representatives have the right to obtain complete and accurate information about their diagnosis, treatment, and prognosis from their health care provider.

Members have the right to obtain information necessary to give informed consent from their health care provider, before the start of any procedure or treatment. Except in emergencies, this information should include the name of the specific procedure or treatment, the medically significant risks and benefits involved, and the probable length of recovery.

Members have the right to information about alternatives for care or treatment.

Members have the right to know the name of the health care provider responsible for coordinating their care and the name of the provider responsible for a particular procedure or treatment.

Members have the right to be notified if their treatment is part of an experimental, research, or educational project that will affect their care. Members have the right to refuse to participate in such projects.

Members have the right to information about the relationship of the Plan to other health care or educational institutions.

***Health Information and Personal Privacy***

Members have the right to communicate with health care providers and the Plan in confidence and to have the confidentiality of their individually identifiable health care information protected.

Members have the right to expect that all records and communications about their care are confidential and will not be released without their written permission, except when release is required or authorized by federal or state law. Health information concerning members will be secured from unauthorized access.

Members have the right to review, copy, and request amendments to their own medical and Plan records.

Members have the right to every consideration of their privacy and confidentiality of information, within the limits of the law. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. Those not directly involved in their care must have their permission to be present. Their legal representative has the right to access information contained in the medical record within the limits of the law.

Members have the right to personal privacy in the course of receiving medical care, including privacy in the exam rooms, offices, labs, procedure rooms, and all other clinical areas. Members have the right to expect that all appropriate courtesies and cautions will be extended by staff, especially when disrobing and after having disrobed.

***Choice of Health Care Providers***
Members have the right to a choice of health care providers that is sufficient to ensure access and high-quality health care.

***Access to Emergency Services***
Members have the right to access emergency services when and where the need arises. The Plan provides payment when a member presents to an emergency department with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in placing the member's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

***Participation in Treatment Decisions***
Members have the right and responsibility to participate fully in all health care decisions. Members who are unable to participate fully in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators. Members have the right, as permitted by law, to have a designated representative decision maker in the event members should become incapable of

making an informed decision.

Members or their legal representatives have the right to obtain from their health care provider complete and current information about their diagnosis, treatment and prognosis in words members can understand.

Members or their legal representatives have the right to participate in decisions about the intensity and scope of their treatment, within the limits of the organization's philosophy and mission and applicable law and regulation.

Members have the right to expect reasonable continuity of care.

Members have the right to express their wishes regarding their future health care by way of a living will or advance directives. Members have the right to be educated and informed about advance directives. The advance directive will be documented in their medical record. Members have the right to expect their health care provider to abide by their advance directive to the extent provided by law.

Members have the right to refuse treatment to the extent permitted by law. Members have the right to be informed of the medical consequences of refusing treatment.

Members have the right to participate in the consideration of ethical issues that arise in their health care.

***Appeals, Complaints and Grievances***
Members have a right to a fair and efficient process for resolving differences with the Plan and health care providers including a system of internal review and an independent system of external review.

**Members have the right to express complaints and concerns about the quality of their care without fear of reprisal or compromise of future access to care.**

***Nondiscrimination and Respect***
Members have the right to be treated with dignity and respect, to receive care without regard to race, color, creed, religion, sex, age, national origin, sexual orientation, or disability. Members have the right to access to an interpreter when members do not understand

the language of the community.

Members have the right to respectful, responsive care directed to fostering their comfort and dignity, providing appropriate treatment for primary and secondary symptoms as desired by members or their designated representative, appropriately managing pain and responding to members and their family's psychosocial, spiritual, and cultural concerns.

***Member Responsibilities***

Members are responsible for becoming knowledgeable about their health plan coverage including all covered benefits, limitations, and exclusions. Members are also responsible for becoming knowledgeable about US Family Health Plan policies and procedures including rules regarding the use of emergency services, the use of network providers, and referral and authorization requirements. Members are responsible for following the administrative and operational procedures of the Plan and all health care providers.

Members are responsible for providing accurate and complete information about present complaints, past illness, and allergies, hospitalizations, medications, and other matters relating to their health. Members are responsible for reporting unexpected changes in their condition to their health care provider.

Members are responsible for making it known whether they clearly comprehend a contemplated course of action and what is expected. Members are also responsible for clearly communicating wants and needs.

Members are responsible for working with the health care provider to develop a treatment plan and for following the recommended treatment plan. Members are also responsible for the consequences of refusing treatment or failing to follow instructions provided by their health care provider.

Members are responsible for keeping appointments and, when unable to do so, for notifying the appropriate health care professional.

Members are responsible for being considerate of the rights and property of other patients and health care personnel.

Members are responsible for informing the Plan of any change in name, address, phone number, or other health insurance information and for maintaining up-to-date information in the Defense Enrollment Eligibility Reporting System (DEERS).

Members are responsible for informing their health care provider if they have an advance directive, living will, or a durable power of attorney for health care or similar documents.

Members are responsible for informing health care providers of problems with their care so that they may assist members in resolving them.

Members are responsible for maintaining healthy habits and avoiding knowingly the spread of disease.

Members are responsible for using the Plan's internal complaints, grievances, and appeals processes to address concerns.

Members are responsible for recognizing the risks and limits of medical care and the human fallibility of the health care professional.

Members are responsible for reporting wrongdoing, fraud, and abuse to the appropriate Plan or legal authorities.

Members are responsible for being aware of the health care provider's duty to be reasonably efficient and equitable in providing services.

## 3. Information and Assistance

### a) Important Contact Numbers

| | |
|---|---|
| *After-Hours Services* | **Care Plus Center at EBMC**<br>410-522-9800<br>**FMH Immediate Care**<br>301-829-5800<br>**Immediate Care Medical Center**<br>410-833-5000<br>**Medical Access, Inc.**<br>301-428-1070<br>**Patient First**<br>Bel Air 410-638-6480<br>Lutherville 410-583-2777<br>Laurel 301-497-1820<br>Owings Mills 410-902-6776<br>Perry Hall 410-529-9200<br>**Nighttime Pediatrics at Waugh Chapel and Adult Care**<br>301-261-6483<br>*(See page 40 for additional listings).* |
| *Care Management*<br>*Out of Area*<br>*FAX* | 410-424-4480<br>1-800-557-6916<br>410-424-4606 |
| *Defense Enrollment Eligibility Reporting System (DEERS)* | 1-800-538-9552<br>Fax 1-831-655-8317 |
| *Eligibility Verification/Enrollment* | 410-424-4780 |
| *Laboratory Services* | Contact the Member's PCP |
| *Health Educator* | 410-762-5348 or kwatson@jhhc.com |
| *Medical Director* | 410-424-4480 |
| *Mental Health and Substance Abuse Services* | **Baymeadow Health Services**<br>410-424-4476 or 1-800-261-2429 |
| *Performance Improvement/ Risk Management* | 410-338-3610 |
| *Pharmacy Services* | 410-338-3300 |
| *Provider Services*<br>(Benefit eligibility and claims status) | 410-424-4528 or 1-800-808-7347 |
| *Provider Relations* | Refer to Network Managers Territory List on following page |
| *Quality Improvement* | 410-424-4882 |
| *Radiology* | Contact the Member's PCP |
| *Referrals* | Contact the Member's PCP |

## b) Network Managers Territory List

| NETWORK MANAGERS | NETWORK COORDINATORS | TERRITORY ASSIGNMENTS |
|---|---|---|
| **Weine Berhe, Senior Network Manager**<br>301-421-1295<br>1-800-952-8783<br>fax: 301-421-1296 | **Christine Titus Supervisor**<br>410- 424-4630 | Johns Hopkins CPA<br>Johns Hopkins Hospital<br>Johns Hopkins Bayview Medical Center<br>Johns Hopkins Community Physician City Sites |
| **Terri Krysiak**<br>410-424-4866 | **Sandra Moore**<br>410-424-4645 | Baltimore City<br>Howard County |
| **Gitu Mirchandani**<br>410-424-4685 | **Maria DiSebastiano**<br>410-424-4624 | Anne Arundel County<br>Charles County<br>St. Mary's County<br>Calvert County |
| **Sherry Riley, Senior Network Manager**<br>410-803-9562<br>1-866-293-8753<br>fax: 410-803-9563 | **Shirley Griffin**<br>410-424-4686 | Baltimore County<br>Harford County<br>Cecil County<br>New Castle County, Delaware<br>Southern Pennsylvania |
| **Barbara Metz**<br>301-777-0920<br>1-800-873-1423<br>fax: 301-777-0989 | **Sandra Moore**<br>**410-424-4645** | Carroll County<br>Frederick County<br>Allegany County<br>Washington County<br>Garrett County<br>West Virginia |
| **Tony Cooper**<br>410-424-4867 | **Maria DiSebastiano**<br>410-424-4624 | Montgomery County<br>Prince George's County<br>Washington, DC<br>Northern Virginia |
| **Lory Marciniak**<br>443-249-0184<br>1-800-303-2561<br>Fax: 443-249-0193 | **Shirley Griffin**<br>410-424-4686 | Caroline County<br>Dorchester County<br>Kent County<br>Queen Anne's County<br>Somerset County<br>Talbot County<br>Wicomico County<br>Worcester County<br>Delaware (except New Castle County) |

### c) Primary Care Health Centers

## *Baltimore City*

1. **East Baltimore Medical Center**
   1000 E. Eager Street
   Baltimore, Maryland 21202
   410-522-9800, ext. 103

2. **Johns Hopkins Community Physicians at Tindeco**
   2809 Boston Street
   Baltimore, Maryland 21224
   410-522-9940

3. **Johns Hopkins Community Physicians at Wyman Park**
   3100 Wyman Park Drive
   Baltimore, Maryland 21211
   410-338-3000

## *Anne Arundel County*

4. **Johns Hopkins Community Physicians at Annapolis**
   900 Bestgate Road, Suite 303
   Annapolis, Maryland 21401
   410-224-8220

5. **Johns Hopkins Community Physicians at Odenton**
   1132 Annapolis Road
   Odenton, Maryland 21113
   410-874-1400

### *Baltimore County*

6. **Johns Hopkins Community Physicians at Green Spring Station**
   2360 W. Joppa Road, Joppa Concourse Building, Suite 306
   Lutherville, Maryland 21093
   410-847-3535

7. **Johns Hopkins Community Physicians at Greater Dundalk**
   2112 Dundalk Avenue
   Baltimore, Maryland 21222
   410-288-4800

8. **Johns Hopkins Community Physicians at White Marsh**
   4924 Campbell Boulevard, Suite 200
   White Marsh, Maryland 21236
   443-442-2300

### *Carroll County*

9. **Johns Hopkins Community Physicians at Westminster**
   410 Malcolm Drive, Suite C
   Westminster, Maryland 21157
   410-857-2300

### *Frederick County*

10. **Johns Hopkins Community Physicians at Frederick**
    195 Thomas Johnson Drive
    Frederick, Maryland 21702
    301-696-1520

### *Harford County*

**11. Johns Hopkins Community Physicians at Riverside**
1321 Riverside Parkway, Suite A
Belcamp, Maryland 21017
410-575-6611

### *Howard County*

**12. Johns Hopkins Community Physicians at Howard County**
6350 Stevens Forest Road, Suite 102
Columbia, MD 21046
443-259-3770

### *Montgomery County*

**13. Johns Hopkins Community Physicians at Montgomery Grove**
15201 Shady Grove Road, Suite 202
Rockville, Maryland 20850
301-990-3190

### *Prince George's County*

**14. Johns Hopkins Community Physicians at Laurel**
13960 Baltimore Boulevard
Laurel, Maryland 20707
410-880-6132

### *Washington County*

**15. Johns Hopkins Community Physicians at Hager Park**
324 East Antietam Street, Suite 203
Hagerstown, Maryland 21740
301-791-0600

**d) Network Hospitals**

Johns Hopkins Bayview Medical Center
Anne Arundel Medical Center
Bowie Health Center
Carroll Hospital Center
Frederick Memorial Hospital
Garrett County Memorial Hospital
Greater Baltimore Medical Center
Harford Memorial Hospital
Holy Cross Hospital
Howard County General Hospital

Johns Hopkins Hospital
Kennedy Krieger Institute
Laurel Regional Hospital
Montgomery General Hospital
Mt. Washington Pediatric Hospital
North Arundel Hospital
Prince George's Hospital Center
Shady Grove Adventist Hospital
St. Agnes Hospital
St. Joseph's Medical Center
Suburban Hospital
Upper Chesapeake Medical Center
Washington Adventist Hospital
Washington County Hospital

**e) Web Site Addresses**

Visit the US Family Health Plan on the Johns Hopkins Web site at

www.hopkinsmedicine.org/usfhp

The TRICARE Policy Manual can be accessed on-line through the DoD TRICARE Prime website at www.tricare.osd.mil

**f) Mailing Addresses**

**Claims Submission:**
US Family Health Plan
Claims Department
P.O. Box 33
Glen Burnie, MD 21060-0033

**Appeals Submission:**
US Family Health Plan
Appeals Department
P.O. Box 0203
Glen Burnie, MD 21060-0203

# II. PROVIDER INFORMATION

## A. Provider Services

The Provider/Member Services Department representatives respond to member and provider telephone calls, written comments, requests, complaints or compliments about membership, benefits or services. Acting as a member's advocate, representatives investigate informal member complaints. If the member is dissatisfied with the result of the investigation and feels a need to file a formal complaint or grievance, the department will provide information about how to proceed with a written appeal. The department number is 410-424-4528 or 1-800-808-7347.

## B. Provider Relations

The Provider Relations Department acts as a liaison between Johns Hopkins HealthCare and its participating provider network. The network is divided into geographic territories and specialty areas, which are assigned to a Network Manager and Coordinator. *(Please refer to the Network Manager Territory Assignment in Section 1, Page 10.)*

The Provider Relations department 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 US Family Health Plan 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 also an essential responsibility of the department. Upon request, your Network Manager will train providers and their office staff regarding the US Family Health Plan program and its benefits. Additional updates regarding policies and procedures can be accessed through the US Family Health Plan provider manual, provider newsletters, and a variety of mailings.

The US Family Health Plan provider manual is a guide to our plan. The manual includes an overview of the plan as well as information on Primary Care Physician and specialist responsibilities, service and benefit information, claims payment and reimbursement, Care Management services and referral guidelines.

The Banner, the US Family Health Plan provider newsletter, is produced four times a year to advise providers of changes in policies and procedures, as well as supply information on programs available to our members.

Providers should contact their Network Manager directly for issues related to contracting, provider set-up and education.

## C. Primary Care Physicians

A Primary Care Physician (PCP) is a physician or nurse practitioner who manages the primary and preventive care of a US Family Health Plan member and acts as a coordinator for specialty referrals and inpatient care.

### 1. Role/General Responsibilities

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

### 2. Medical Record Documentation

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

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

***Confidentiality***

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

## D. Specialty Providers

### 1. Role/General Responsibilities

Responsibilities of the Specialty Provider include:

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

### 2. Requirements for Reporting to Primary Care Physician

***Treatment Report from Specialist to PCP***

**Special Note:**

**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.**

## E. Guidelines and Standards

### 1. Member Eligibility Verification

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

Before providing services, a provider should verify eligibility by calling Provider Services at 410-424-4528 or toll free at 1-800-808-7647 within Maryland.

**a) Member Enrollment and Disenrollment**

TRICARE - eligible members may enroll in TRICARE Prime at any time during the year simply by completing an enrollment application and paying an applicable enrollment fee, if applicable. No eligible member who lives in the geographic service area shall be denied enrollment, re-enrollment, or be required to disenroll because of a prior or current medical condition.

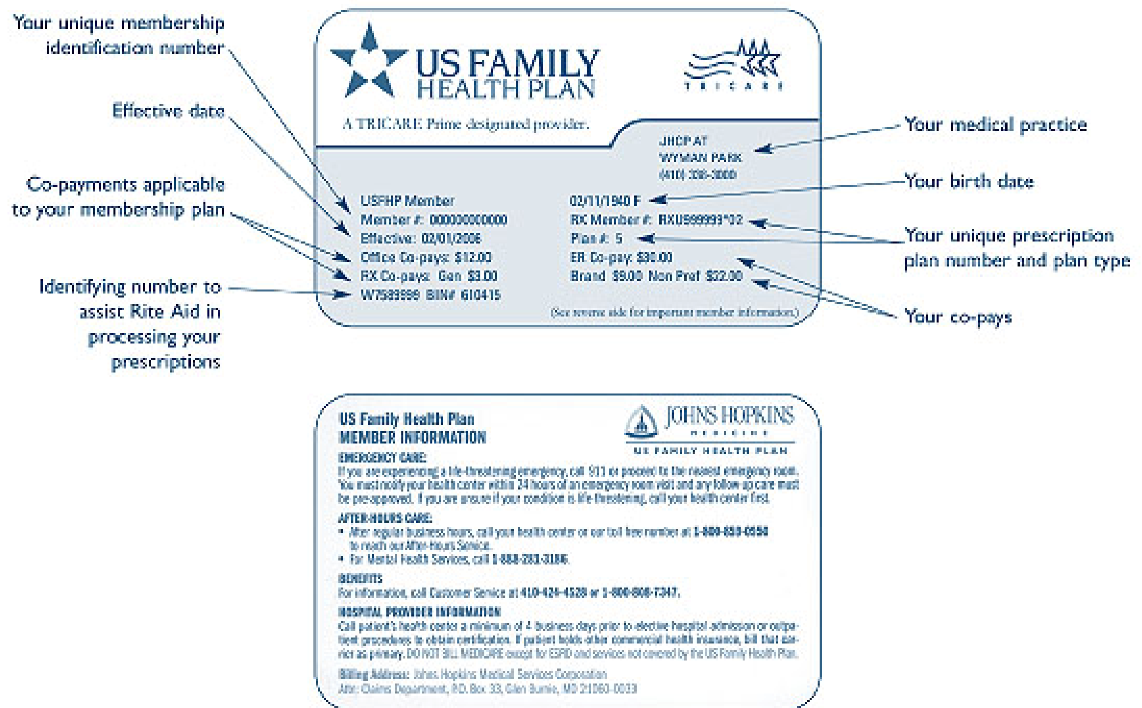
A member should choose a PCP (internist, family practitioner, or pediatrician) based upon personal choice and/or residence zip code. Once accepted into the practice, the member agrees to obtain all routine care from the PCP or another provider to whom the enrollee is referred by the PCP.

Once enrolled, the member will be issued a US Family Health Plan Enrollment Card. The enrollment period will be in effect for 12 months. However, should the member be dissatisfied with the initial choice of PCP, the member may choose another primary care physician from within the network. The member should notify Customer Service in writing to initiate the change. Those members changing primary care sites will receive an updated enrollment card.

Disenrollment is the responsibility of the member and may occur at the end of the 12-month period or when moving out of the area. A member who requests early disenrollment, for reasons other than moving out of the area, may not re-enroll in TRICARE Prime for 12 months.

### b) Sample Identification Card

Identification cards are issued to US Family Health Plan members. This is what the member will see when reviewing their cards.




The information on the back of your membership card helps you obtain care you may require unexpectedly. It also gives health care providers information on how to process your claims. Please remember to carry this membership card with you at all times.

## 2. Access Standards

To ensure that illness is evaluated in a timely manner, members must have access to PCP services either by telephone or by appointment, 24 hours a day, seven days a week. When a provider's office is closed, the Plan offers *After Hours Triage*, a program staffed by RNs and backed up by PCPs. Using standardized protocols, the nurses triage, advise, and authorize use of urgent care facilities and emergency rooms. Additionally, a staff physician is on call for *After Hours Triage* 24-hours-a-day to provide medical oversight, advice and consent under appropriate circumstances.

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

**Emergency:** A medical emergency is the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to the life, limb, or sight, and requires immediate medical treatment, or which manifests painful symptoms requiring immediate palliative effort to relieve suffering. In an emergency, in the absence of care, the member could reasonably be expected to suffer serious impairment or death. Examples of emergencies are heart attack, severe chest pain, cerebrovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, suicidal tendencies, and other acute conditions. During office hours, the PCP is required to coordinate emergency services and notify Care Management that the emergency admission is authorized. After hours, the member should call the After Hours Triage Nurse who will advise the member about where and when to obtain care.

**Urgent:** a sudden, severe onset of illness or a medical problem requiring attention within 24 hours. With an urgent problem, the member should be seen that same day or within 24 hours.

**Routine:** a medical problem or illness that is ongoing but presents no immediate medical danger or acute distress.

**Health Maintenance:** well visits, preventive care services.

**a) Appointment Availability**

| **Wait Times for Primary Care Appointments** | |
|---|---|
| **Appointment Type** | **Standard (Not to Exceed)** |
| Health Assessment | 4 weeks |
| Routine Visit | 1 week |
| Urgent | 24 hours |

***Specialty Care Appointments***

- Access determined by PCP based on nature of care required.
- Wait time no longer than 4 weeks
- Travel time no longer than one hour.

**b) Travel Time to PCP's Office**

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

**c) Office Wait Time**

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

## 3. Medical Record Documentation Standards

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

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

**Confidentiality**

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

## 4. Privacy and Release of Patient Information/Records

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

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

The privacy and security components of HIPAA provide broad reaching protections for individually identifiable health information. The transaction and code sets component to HIPAA requires conformity to precise rules in the electronic transmission of financial health information. The Johns Hopkins community has taken steps to ensure that we comply with these requirements regarding the use, disclosure, security, and transmission of an individual's (alive or dead) health information in any form (e.g., on paper, transmitted electronically, recorded or spoken), the treatment of their health condition, and/or the billing/payment for their health services.

## 5. Quality Improvement Initiatives

### Health Plan Employer Date Information Set (HEDIS)

Providers are expected to participate in quality improvement activities and must assume responsibility for clinical practice improvement as well as for patient care. Monitored are: HEDIS, comprehensive diabetic care, colon and rectal screening, adult access to preventative care and children's access to primary care.

### Consumer Assessment Health Plan Surveys

Member satisfaction surveys are completed on an annual basis, using the methodology of the NCQA (National Committee for Quality Assurance)/HEDIS. Approximately 1,500 members are contacted yearly for the survey.

## 6. Compliance with Contract, Federal, State, and Local Regulations

Providers will comply with all Federal, State and Local requirements and will:

- make no distinction in the provision of services based on age, sex, disability, race, color, religion or national origin.
- not deny a member any service, benefit or availability of a provider based on age, sex, disability, race, color, religion or national origin.
- not 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.
- not segregate or separate treatment based on age, sex, disability, race, color, religion or national origin.
- not treat a member differently from others in receiving any covered service or benefit that is offered to other members.
- not treat a member differently from others in order to provide a service or benefit.
- not assign times or places to obtain services based on age, sex, disability, race, color, religion or national origin.

## 7. Notice of Changes in Provider/Site Status

Additions, deletions, or other changes in provider's office information must be communicated in writing to the Network Manager/Network Coordinator as soon as possible (FAX: 410-424-4604).

**Terminations must be submitted at least 90 days prior to effective date.**

# III. Covered Benefits, Limitations and Exclusions

## A. Covered Benefits

### 1. Overview of TRICARE Prime Benefit

TRICARE Prime is a managed care option for active duty family members (ADFMs) and retired service members. TRICARE Prime enrollees are assigned a primary care physician (PCP) who provides and coordinates for care, maintains patient health records, and refers patients to specialists, if necessary. Specialty care must be arranged and approved by US Family Health Plan to be covered under TRICARE Prime. Primary care is provided at a Johns Hopkins Community Physicians location.

ADFMs are not responsible for any co-payments. ADFMs enrolled in USFHP do not have co-payments except for pharmacy co-payments, or when enrolled in Program for Persons with Disabilities (PFPWD). Retirees and their families without Medicare B coverage enrolled in TRICARE Prime are responsible for co-payments when seeking care from a network provider.

### 2. Summary of Healthcare Benefits

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

**(See chart on following page)**

## TRICARE Prime Benefits

| | Cost for active-duty family members | Cost for retirees, family members, and survivors | Cost for retirees and family members enrolled in Medicare Part B |
|---|---|---|---|
| **Outpatient Services** | | | |
| Office visits | $0 | $12 | $0 |
| Maternity care (prenatal, postnatal) | $0 | $0 | $0 |
| Well-child care (birth to age 6) | $0 | $0 | $0 |
| Routine physical examinations | $0 | $0 | $0 |
| X-ray and lab tests[1] | $0 | $0 | $0 |
| Ambulatory surgery (same day) | $0 | $25 | $0 |
| Physical therapy (when medically necessary) | $0 | $12 | $0 |
| **Inpatient Services** | | | |
| Hospitalization (semi-private room and board) | $0 | $11 per day/ $25 min. charge per admission | $0 |
| Maternity care (prenatal, delivery, postnatal hospital and professional services) | $0 | $11 per day/ $25 min. charge per admission | $0 |
| Physician services | $0 | $0 | $0 |
| General nursing services | $0 | $0 | $0 |
| Diagnostic tests, including lab and X-ray | $0 | $0 | $0 |
| Operating room, anesthesia, and supplies | $0 | $0 | $0 |
| Medically necessary supplies and services | $0 | $0 | $0 |
| Physical therapy (when medically necessary) | $0 | $0 | $0 |
| **Mental Health Services** | | | |
| Outpatient care individual (subject to medical review)[2] | $0 | $25 per visit | $0 |
| Outpatient care group (subject to medical review)[2] | $0 | $17 per visit | $0 |
| Partial hospitalization, mental health (up to 60 days per Plan year) | $0 | $40 per day | $0 |
| Inpatient hospital psychiatric care (subject to medical review)[3] | $0 | $40 per day | $0 |
| **Substance Abuse Treatment** | | | |
| Outpatient care individual[4] | $0 | $25 per visit | $0 |
| Outpatient group/family therapy | $0 | $17 per visit | $0 |
| Inpatient services (up to 7 days for detoxification per year)[5] | $0 | $40 per day | $0 |
| Inpatient rehabilitation (up to 21 days per year)[5] | $0 | $40 per day | $0 |
| **Other Services** | | | |
| Ambulance services (when medically necessary) | $0 | $20 per occurrence | $0 |
| Dental care — basic preventive care | Reduced fees | Reduced fees | Reduced fees |
| Durable medical equipment | $0 | 20% | $0 |
| Emergency room services[6] (including out of area) | $0 | $30 | $0 |
| Comprehensive eye examination (1 per Plan year) | $0 | $12 | $0 |
| Family planning services | $0 | $12 | $0 |
| Radiation/chemotherapy office visits | $0 | $12 | $0 |
| Prescription drugs[7] | $3 generic, $9 brand | $3 generic, $9 brand | $3 generic, $9 brand |
| Mail-order prescription drugs[7] | $3 generic, $9 brand | $3 generic, $9 brand | $3 generic, $9 brand |
| Skilled nursing facility care | $0 | $11 per day/ $25 min. charge per admission | $0 |
| Home health care (part-time skilled nursing care) | $0 | $12 per visit | $0 |
| Out of area (emergency services only) | $0 | $30 | $0 |
| **Catastrophic Cap** (maximum out-of-pocket expense per family) | $1,000 per plan year | $3,000 per plan year | $3,000 per plan year |
| **Enrollment Fee** | $0 | $230 individual[8] $460 family[8] | $0 (with proof of Part B enrollment) |

## 3. Durable Medical Equipment

Durable medical equipment may be covered if deemed medically necessary. DME must be authorized by the PCP, and purchased, or rented from a Plan provider. Co-payments are applied for retirees and their family members who do not carry Medicare Part B. Active duty

family members and retirees with current medical Part B do not have to pay the co-payment for covered durable medical equipment.

## 4. Pharmacy Services

The pharmacy network is comprised of all Rite Aid Pharmacies in Maryland, Washington, D.C., Virginia, West Virginia, and Pennsylvania. Members are required to fill all prescriptions at either a Rite Aid Pharmacy in any of these states or through the Rite Aid mail order pharmacy. Retail prescriptions may be filled for up to a 30-day supply and mail order up to a 90-day supply. However, members may fill up to a 90-day supply at a Rite Aid Pharmacy for the same co-pay as mail order.

***Medications***

The following are covered pharmacy benefits:

- Most Food and Drug Administration-approved prescription medications
- Compounded medications of which at least one ingredient is a prescription drug
- Insulin
- Insulin syringes and needles
- Blood/Urine test strips
- Lancets
- Alcohol swabs

The following medications are not covered under the USFHP Program:

- Medications to treat cosmetic conditions resulting from normal aging process
- Medications whose sole use is to stimulate hair growth
- Medications for investigational use
- Medications for obesity and/or weight reduction
- Medications for smoking cessation
- Homeopathic and herbal preparations
- Multivitamins, except, prenatal vitamins for females up to 45 years of age
- Fluoride preparations
- Over-the-counter medications, with the exception of insulin products and diabetic supplies
- Yohimbine

**Generic Drug Policy**

When available, the use of therapeutically equivalent generic drugs is required. Generic drugs will be dispensed in accordance with the FDA Orange Book "AB" rating. In the event a prescriber requires a brand name drug that is available generically, the prescriber must indicate "DAW" and write a clinical reason on the prescription for the use of the drug. Refer to the JHHC/USFHP preferred drug list for a complete listing of preferred drugs.

The following injectable drugs are covered under the pharmacy benefit. Drugs are listed by generic name with brand name(s) in parentheses.

Adalimunab injection (Humira)
Anakinra injection (Kineret)
Darbepoetin alfa injection (Aranesp)
Efalizumab (Raptiva)
Epoetin alfa, recombinant (Epogen, Procrit) Etanercept injection (Enbrel)
Filgrastim injection (Neupogen)
Fondaparinux injection (Arixtra)
Glatiramer acetate injection (Copaxone)
Goserelin acetate implant syringe (Zoladex)
Interferon Alfacon-1 (Infergen)
Interferon Alpha 2a (Roferon-A)
Interferon Alpha 2b (Intron A, Rebetron)
Interferon Beta 1a (Avonex, Rebif)
Interferon Beta 1b (Betaseron)
Leuprolide depot and subcutaneous injections (Lupron, Eligard)
Low Molecular Weight Heparins (Fragmin, Lovenox)
Pegfilgrastim injection (Neulasta)
Peginterferon alfa-2a injection (Pegasys)
Peginterferon alfa-2b injection (PEG-intron)
Somatropin (Genotropin, Humatrope,Norditropin, Nutropin, Saizen, Serostim)
Teripartide injection (Forteo)

These drugs require prior authorization. Request for authorization may be obtained by contacting the Pharmacy Department at 410-424-4490 or 1-888-819-1043 or by faxing a letter of medical necessity to 410-424-4607.

**Co-payments**

| Type of Drug | Co-payment for up to a 90-day supply |
|---|---|
| Generic | $3 |
| Preferred Brand | $9 |
| Non-preferred brand | $22 |

## 5. Mental Health and Substance Abuse

***What is Covered***

The plan provides medically and psychological necessary services for the diagnosis and treatment of substance abuse and mental health conditions provided by licensed professionals including psychiatrists, psychologists, social workers, substance abuse counselors and Licensed Clinical Professional Counselors. Covered services include:

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

US Family Health Plan patients may self-refer to a participating mental health provider for the first eight outpatient mental health visits by calling 410-424-4830 or 1-888-281-3186. All subsequent services must be authorized by the Plan.

Treatment for chemical and alcohol dependency at approved inpatient or outpatient treatment facilities is covered when pre-authorized by the Plan. Both detoxification and rehabilitation days are counted toward mental health maximums. Substance abuse rehabilitation services are limited to one admission per year, with a lifetime maximum of three admissions.

***What Is Not Covered***

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

- Opiod replacement therapy such as methadone
- Marital and/or coping counseling
- Sexual Functioning Disorders
- Support services and/or groups not conducted by a licensed professional
- Learning disabilities, including psychological testing for academic and intelligence testing

## 6. Additional Benefits

**Dental Care**

Under a separate agreement, the Plan has arranged for members to receive dental services from selected community dentists under a discounted fee structure referred to as the Dental Value Network (DVN).

**Hospice Care**

Hospice Care is a program that provides an integrated set of services and supplies for the care of the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and some limited home care. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

***Note:*** *Eligibility determinations and referrals for approved hospice care providers are made by primary care physicians or specialists using established medical criteria.*

**Ambulance Service**
Benefits are provided for medically necessary life-sustaining ambulance transport when the use of any other method of transportation is inadvisable. If a retiree over age 65 or a retiree family member does not carry Medicare Part B, the co-payment is $20 per occurrence for ambulance services. Active duty family members and retirees with current Medicare Part B do not have a co-payment for ambulance.

**Diagnostic Services**
If authorized by your primary care physician or specialist, the following are covered without an additional co-payment:

- Pathology/lab services
- Nuclear medicine services
- Cardiovascular studies

**Disease Management**
For members with diabetes, cancer, asthma, chronic obstructive pulmonary disease, renal disease, cardiovascular or other chronic medical problems, the US Family Health Plan provides the innovative Disease Management Program. Depending on the member's needs and health status, services are likely to include:

- Regular contacts with a personal nurse case manager to review diet, medications and other related health information
- Access to Johns Hopkins physicians who specialize in that member's condition
- Access to TeleWatch monitoring system that allows health care providers to monitor a member with a telephone-based system from anywhere they are – even when traveling.
- Education materials about a member's condition, tips on managing symptoms
- Assistance with coordinating specialty care and the use of benefits

# B. Benefit Limitations and Exclusions

## 1. General Exclusions

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

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

## 2. Specific Exclusions

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this manual, the following specifically are excluded:

a) Services and supplies not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury or for the diagnosis and treatment of pregnancy or well-baby care.

b) X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography, cancer screening papanicolaou (PAP) tests and other tests allowed under the Preventive Services policy.

c) Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

d) Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis. NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

e) Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breastfeeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

f) Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by US Family Health Plan.

g) Custodial care. The term "custodial care" means treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that (i) can be rendered safely and reasonably by a person who is not medically skilled; or (ii) is or are designed mainly to help the patient with the activities of daily living, also known as "essentials of daily living."

h) Domiciliary care. The term "domiciliary care" means care provided to a patient in an institution or homelike environment because (i) providing support for the activities of daily living in the home is not available or unsuitable; or (ii) members of the patient's family are unwilling to provide the care.

i) Inpatient stays primarily for rest or rest cures.

j) Costs of services and supplies to the extent amounts billed are over the allowed cost or charge.

k) Services or supplies for which the member or sponsor has no legal obligation to pay; or for which no charge would be made if the member or sponsor was not eligible under US Family Health Plan; or whenever US Family Health Plan is a secondary payor for claims subject to the DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges.)

l) Services or supplies furnished without charge.

m) Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under US Family Health Plan, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid).

n) Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

o) Unproven drugs, devices, and medical treatments or procedures.

p) Services and supplies provided or prescribed by a member of the member's immediate family, or person living in the member's or sponsor's household.

q) Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

r) Services and supplies provided under circumstances or in geographic locations requiring a Non-availability Statement, when such a statement was not obtained.

s) Services or supplies which require pre-authorization if pre-authorization was not obtained. Services and supplies not provided according to the terms of the pre-authorization. An exception to the requirement for pre-authorization may be granted if the services otherwise would be payable except for the failure to obtain pre-authorization.

t) Psychoanalysis or psychotherapy provided to a member or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a member or sponsor, regardless of diagnosis or symptoms that may be present.

u) Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

v) Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all US Family Health Plan requirements for coverage are not excluded.

w) Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for, except if benefits provided under such laws are exhausted.

x) Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in 32 CFR 199.4(e)(8).

y) Surgery performed primarily for psychological reasons (such as psychogenic).

z) Electrolysis.

aa) Dental care or oral surgery, except as specifically provided in 32 CFR 199.4(e)(10).

bb) Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of jaw or any procedure of similar purposes; regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in 32 CFR 199.4(e)(15).

cc) Services and supplies related to transsexualism or other such conditions as gender dysphoria (including, but not limited to, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7).

dd) Sex therapy, sexual advice, sexual counseling, sex behavior medication, psychotherapy for mental disorders involving sexual deviations (i.e., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

ee) Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

ff) Treatment of dyslexia.

gg) Surgery to reverse surgical sterilization procedures.

hh) Non-coital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other non-coital reproductive technologies.

ii) Non-prescription contraceptives.

jj) Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

kk) Preventive care, such as routine annual, or employment-requested physical examinations; routine screening procedures; immunizations; except as provided in the Preventive Services policy.

ll) Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

mm) Counseling services that are not medically necessary in the treatment of a diagnosed medical condition. For example, educational counseling, vocational counseling, and counseling for socioeconomic purposes, stress management, life-style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in 32 CFR 199.6. Services provided by alcoholism rehabilitation counselors are covered only

when rendered in a TRICARE-authorized treatment setting and only when the cost of those services is including in the facility's TRICARE -determined allowable cost rate.
NOTE: Diabetes Outpatient Self-Management Training is covered.

nn) Acupuncture, whether used as a therapeutic agent or as an anesthetic.

oo) Hair transplants, wigs, or hairpieces, except as allowed in accordance with section 744 of the DoD Appropriations Act for 1981.

pp) Self-help, academic education or vocational training services and supplies, unless the provisions of 32 CFR 199.4(b)(1)(v) relating to general or special education apply.
NOTE: See 32 CFR 199.5 for training benefits under PFPWD.

qq) Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

rr) General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises are also excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of a comprehensive program of physical therapy.

ss) Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not any educational or occupational defect.

tt) Eye exercises or visual training (orthoptics).

uu) Eye and hearing examinations except as specifically provided in 32 CFR 199.4(c)(2)(xvi) or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in conjunction with well-baby care is not excluded.
NOTE: Under the PFPWD, vision and hearing examinations for establishing a qualifying condition, confirming the severity of the disabling effects of a qualifying condition, or measuring the extent of function loss may be cost-shared.

vv) Prostheses, other than those determined to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

ww) Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

xx) Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under 32 CFR 199.4(e)(6).

yy) Hearing aids or other auditory sensory enhancing devices.
NOTE: Hearing aid services may be cost-shared only for eligible members through the Program for Persons with Disabilities because of a hearing disability or multiple disabilities, one of which involves a hearing disability.

zz) Services or advice rendered by telephone are excluded, except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is not excluded when:

i) The procedure without electronic transmission of data or biotelemetry is otherwise an explicit or derived benefit; and
ii) The addition of electronic transmission of data or biotelemetry to the procedure is found to be medically necessary and appropriate medical care which usually improves the efficiency of the management of a clinical condition in defined circumstances; and
iii) That each data transmission or biotelemetry device incorporated into a procedure that is otherwise an explicit or derived benefit of this section, has been classified by the FDA, either separately or as a part of a system, for use consistent with the defined circumstances in 32 CFR 199.4(g)(52)(ii).

aaa) Air conditioners, humidifiers, dehumidifiers, and purifiers.

bbb) Elevators or chair lifts.

ccc) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

ddd) Items of clothing or shoes, even if required by virtue of an allergy.

eee) Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care, except as specifically covered.

fff) Enuretic conditioning programs.

ggg) Autopsy and postmortem.

hhh) All camping even though organized for a specific therapeutic purpose, and even though offered as part of an otherwise covered treatment plan or offered through an approved facility.

iii) Housekeeping, homemaker, or attendant services, sitter or companion (for exceptions see 32 CFR 199.4(e)(19) regarding hospice care).

jjj) All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider.

kkk) Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone (for exceptions, see 32 CFR 199.4(e)(19) regarding hospice care).
NOTE: Admission kits are covered.

lll) Services and supplies related to smoking cessation regimens.

mmm) Megavitamin psychiatry therapy, orthomolecular psychiatric therapy.

nnn) All transportation except by ambulance, as specifically provided under 32 CFR 199.4(d) and (e)(5).
NOTE: Transportation of a PFPWD member to or from a facility or institution to receive otherwise allowable services or items may be cost-shared. Transportation of an accompanying medical attendant to ensure the safe transport of the PFPWD member may be cost-shared.

ooo) All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in 32 CFR 199.4(a)(6).

NOTE: For the exception for certain travel expenses and non-medical attendants, see 32 CFR 199.17(p)(4)(vi).

ppp) Services and supplies provided by other than a hospital, unless the institution has been approved specifically by US Family Health Plan. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities.

## C. Immediate Care Centers

**Care Plus Center at EBMC**
1000 East Eager Street
Baltimore, MD 21202
410-522-9800

**FMH Immediate Care**
1502 South Main Street
Mt. Airy, MD 21771
301-829-5800

850 Oak Street
Frederick, MD 21702
301-698-8374

**Immediate Care Medical Center**
11722 Reisterstown Road
Reisterstown, MD 21136
410-833-5000

7010 Ritchie Highway
Glen Burnie, MD 21061
410-760-4500

**Medical Access, Inc.**
19504 Amaranth Drive
Germantown, MD 20874
301-428-1070

**Patient First**
*Bel Air*
560 West MacPhail Road
410-638-6480

*Lutherville*
10755 Falls Road, Suite 160
410-583-2777

*Laurel*
3357-B Corridor Marketplace
301-497-1820

*Owings Mills*
10210 Reisterstown Road
410-902-6776

*Perry Hall*
8830 Belair Road
410-529-9200

**Nighttime Pediatrics at Waugh Chapel and Adult Care**
2401 Brandermill Blvd., #100
Gambrills, MD 21054
301-261-6483

**Nighttime Pediatrics North and Adult Care Too**
8125 Ritchie Highway, Suite H
Pasadena, MD 21122
410-647-6483

**Nighttime Pediatrics of Annapolis and Adult Care**
2114 Generals Highway
Annapolis, MD 21401
410-224-6483

**Nighttime Pediatrics of Annapolis and Adult Care**
4175 N. Hanson Court, #301
Bowie, MD 20716
410-224-6483

**Nighttime Pediatrics – Rockville**
12220 Rockville Pike
Rockville, MD 20852
301-881-5000

**Urgent Care - Pennsylvania**
13424 Pennsylvania Avenue, #104
Hagerstown, MD 21742
240-313-3100

# IV. Care Management and Disease Management

The Care Management Department monitors, evaluates and coordinates appropriate health care services for US Family Health Plan members by reviewing and authorizing admissions, lengths of stay and referrals. Decisions are based on standardized criteria and clinical judgment.

## A. Referrals

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

The following procedures must be reviewed for medical necessity and an authorization number must be obtained before performance of these procedures:

Cardiology
- Cardiac Counter Pulsation

Dermatology
- All services

ENT
- All services

General Surgery
- Gynescomastia
- Wound Care, including Debridement >10 visits

HEMATOLOGY
- All services

IMAGING & LAB
- DEXA Scans
- PET Scans

OB/GYN
- Abortion – physician must certify that the mother's life is in danger

Ophthalmology
- Blepharoplasty

- Excision of Chalazion

Oral Surgery
- Alveolectomy/Alveolplasty
- Mandibular Vestibuloplasty
- Temporomandibular Joint Procedures (TMJ)

Orthopedics
- Carpel Tunnel surgical decompression

Plastic Surgery
- All services

Podiatry
- Bunionectomy

  Note: Podiatry – Routine services, ie, removal of corns, callouses, and trimming of toenails are covered if member has a diagnosed systemic medical disease affecting the lower limbs (Diabetes and PVD only). Routine services for all other diagnoses are not a covered benefit.

Rehabilitation
- Cardiac Rehabilitation
- OT/PT > 12 visits per diagnosis
- Pain Management
- PVD Rehabilitation
- Pulmonary Rehabilitation
- Speech Therapy

Urology
- Penile Implants
- Vasovasotomy

Other
- Biofeedback
- Clinical Trials
- Developmental Delay
- Diabetic Education, including self-management and training
- Feeding Programs
- Genetic Testing
- Iron Infusion, except for ESRD, which requires a referral only
- Interferon Therapy
- Neurospychological Testing
- Nutritional Counseling

### Mental Health Referrals

A referral from the Primary Care Physician ***is not*** required for Mental Health Services. The member may self-refer to a US Family Health Plan network provider for up to eight outpatient visits a year. Members who wish to self-refer to a network provider, should be instructed to contact Mental Health Services at 1-888-281-3186 to obtain the names of network Mental Health provider. Mental health network providers are located on the campus of Johns Hopkins Bayview Medical Center and Johns Hopkins Hospital, and throughout the area where primary care sites are located.

When a member self-refers, the mental health provider should notify the PCP of the referral. To ensure continuity of care and a complete medical record, the mental health specialist must submit a treatment report to the PCP within 10 days of the initial session. The treatment plans from the mental health provider should be mailed or faxed to:

**Baymeadow Health Services**
**P.O. Box 0268**
**Glen Burnie, Maryland 21060**
**(410)-424-4891**

### Referrals to Out-of-Network Providers

All referrals to Out-of-Network Providers must be pre-authorized by the Medical Director and are limited to services that cannot be provided in the network.

### Referral Supervision and Coordination for Specialty Care

The PCP must make an initial diagnosis prior to referring the member for specialty services. Once a member is referred to a specialty provider, the PCP must provide ongoing oversight. Subsequent specialty referrals need to be approved by the PCP. Except in the case of a medical emergency, the PCP refers specialty and tertiary services within the Johns Hopkins Network, or according to the referral patterns appropriate for the site. The Practice Manager is responsible for overseeing compliance with appropriate referral patterns.

### Requirements for Network Specialists

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

## B. Pre-authorizations

Pre-authorization is required for:

- all inpatient, selected outpatient, and ambulatory services,
- certain specific drug treatments,
- selected durable medical equipment,
- home health care,
- hospice,
- ambulance, and
- selected ambulatory services.

Pre-authorization is required for all out-of-network services. The PCP must get authorization from Care Management. The PCP should call or FAX the Inpatient Coordinator with the following information: PCP name and contact number, along with any information substantiating the need to use an out-of-network hospital or provider. This information will be given to the Inpatient Care Coordinator (nurse) for review process. The request is then forwarded to the Medical Director for a final decision. If approved, the Intake Coordinator will call the specialist and/or hospital with authorization. If not approved, the Intake Coordinator will contact the PCP to refer the member to an in-network provider or hospital.

To contact Care Management regarding pre-authorization for Out-of-Network Services, call 410-424-4480 or 1-800-261-2421 and select Option 1 or fax the information to 410-424-4606.

Pre-admission Review is required for all elective admissions and ambulatory surgeries and an initial length of stay is assigned. The Medical Director reviews for approval or denial all cases that do not meet criteria.

All elective and urgent **Inpatient Admissions** must be pre-authorized. The PCP should complete the pre-authorization form two weeks prior to the requested admission date for an **elective** admission and within 72 hours of the requested admission date for an **urgent** admission.

**Provisional Covered Benefits**

Specific surgical procedures/diagnoses that may be a provisionally covered benefit are referred to the Medical Director for determination of coverage. The PCP and member will be advised of the determination within two working days. Either may appeal this decision.

### Ambulatory Care

All proposed admissions are reviewed to determine if the service could be provided in an ambulatory setting. The Nurse Care Coordinator, after consultation with the Medical Director, will notify the PCP of an adverse decision and discuss alternatives.

## C. Out-of-Network Services (Emergent Care/Out of Area)

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

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

## D. Prospective, Concurrent, and Retrospective Review

### Prospective Review

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

- demographic,
- attending physician and facility,
- date of procedure,
- procedure proposed,
- diagnosis and
- 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 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 are notified via telephone and in writing if criteria are not met and informed of the appeal process.

## E. Inpatient Utilization Management

The Utilization Management Program is designed to focus on processes that will enable the US Family Health Plan 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 enrollees.

Utilization Management (UM) is provided for all patients in acute or sub acute settings. Integral criteria are 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 plan of care or promotion of health. Professional nurses review with the attending physician, case managers and/or social workers in the facilities. On-site RN review is provided at The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. All other facilities are reviewed telephonically. The nurses collaborate with the discharge planners in assuring that a safe discharge and appropriate follow-up is in place. Referrals to the case management/disease management programs are made based on review of the member's post discharge needs and/or chronic conditions. Johns Hopkins HealthCare 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.

## F. Case Management

Case Management is intensive coordination and evaluation of care that is appropriate when a member's health care needs are of high acuity and/or member is at risk of repeat admission and ED visits. Disease Management is a form of Case Management that is disease specific. The Case Management and Disease Management Programs monitor, evaluate, and coordinate appropriate health care services for US Family Health Plan members, ensuring quality care in a cost effective manner. Johns Hopkins Healthcare Case Management utilizes claims, pharmacy and adjusted clinical groups data to analyze members. Therefore, correct coding is essential in order to utilize data in the most effective manner.

Members will be screened by the Case Management staff for case management services upon enrolling in US Family Health Plan, applying for disability, referral for specialty care, admission to an inpatient facility, receiving services outside the Primary Care Physician's office, and upon referral by the provider, patient or family.

Members will receive case management services when:

- admitted to acute or rehabilitation facilities,
- receiving outpatient treatments of a complex nature,
- receiving complex in-home care,
- data shows that member has extensive healthcare needs
- the physician, member or family request case management.

**Referral for Case Management**

Providers wishing to initiate Case Management services can either email casemanagement@jhhc.com or call 410-762-5206/ 1-800-557-6916.

All referrals to Case management must include:

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

Providers will receive a response within two to three business days.

Please do not send the following to Case Management:

- Bills
- Authorizations
- Pre-authorizations
- DME/Home Care referrals
- Provider referrals

Disease Management is an information-intensive series of clinical processes and services across the continuum of health care that identifies the medically at-risk populations and professionally manages members in a manner that improves care, promotes wellness, and manages/reduces cost.

All care provided to US Family Health Plan/TRICARE Prime members will be coordinated and evaluated to ensure that the care provided is medically necessary and consumes resources in the most efficient way possible in order to produce an expected outcome.

JHHC or US Family Health Plan Disease Management Care Managers are responsible for Disease Management activities for JHHC Plan members.

The following target diseases are the focus of Disease Management efforts:

- High-risk obstetrics
- Special needs child, including NICU
- Complex Medical Program – manages members with multiple chronic medical conditions including:
  - Cardiovascular diseases
  - Diabetes
  - Asthma
- HIV/AIDS
- Diabetes
- End-stage renal disease
- Physical rehabilitation
- Palliative care

**DISEASE MANAGEMENT PROGRAMS**

**Partners with Mom**

"Partners with Mom" is a maternity Disease Management program that targets high risk moms with a history or current symptoms of Asthma, diabetes, preterm labor, HIV, substance abuse, hypertension and adolescent pregnancy. Moms with other high-risk OB diagnoses that may

benefit from case management intervention are also considered. Through early identification and intervention, the program has reduced ante partum admissions, decreased NICU births, and improved maternal/fetal outcomes. “Partners with Mom” RN case managers are available for onsite high-risk clinic sessions to provide the critical resources and services providers sometimes need at a minutes notice. Case managers work closely with the provider and patient to improve compliance, coordinate care and maximize favorable outcomes.

**Children with Special Needs**

This program provides RN case management for children with chronic conditions such as asthma, diabetes, Sickle Cell Disease, neurological devastation, various genetic syndromes, cancer, post organ transplant, NICU graduates with co-morbidities or morbid obesity. The case managers actively interface with multiple sub-specialty providers, home health community agencies and the school system, as applicable, to meet the specific physical, psychosocial and emotional needs of the developing child and family across the continuum of childhood.

**NICU**

A Neonatal Nurse Practitioner provides case management for infants hospitalized in NICU facilities across the state of Maryland. On-site review is performed at high volume NICUs and the remaining NICUs are monitored telephonically. Specific interventions include securing initial transport to in-network facility via transport team, negotiating appropriate NICU bed rate, obtaining Coordination of Benefit information, monitoring post-acute stays, discharge planning with the hospital based case manager, and generating appropriate referrals to the Children with Special Needs program. In addition, the program tracks moms with NICU births who were not previously managed in the maternity high-risk program “Partners with Mom”. The goal is to enroll these moms in the high-risk maternity program so that intervention can occur with subsequent pregnancies. A comprehensive database tracks all member information.

**Physical Rehabilitation**

Comprehensive case management is provided for members who are disabled due to neurological disease or physical injuries via the Physical Rehab Program. Included is regular contact with a Certified Registered Rehabilitation Nurse to develop and implement a coordinated plan of care, which includes primary care, specialty care, rehabilitation providers, specialty DME providers and community services. The mission of this program is to promote wellness, minimize preventable complications and

maximize functional abilities.

**Telemedicine**
The Telemedicine Program features a unique approach to Case Management for US Family Health Plan members with diagnoses of heart failure, diabetic heart failure or diabetes with coronary artery disease, hypertension, peripheral vascular disease, obesity and/or retinopathy.

In addition to supporting the patient and family, the Telemedicine Program case managers monitor patient self-reported data such as weight, blood pressure, blood glucose, and symptoms using the TeleWatch Patient Monitoring System. Reports are generated and forwarded to the primary care and specialty providers prior to office visits or to highlight clinical variances and alerts. The case managers are able to assist physicians by providing clinically relevant data, information and suggestions based on current practice guidelines and national standards.

The nurse case managers provide ongoing heart failure and diabetes education focused on nutrition and weight control, activity and medication education and adherence. The nurse teaches the patient to self-monitor and enter data in the TeleWatch system. Each member is provided a digital blood pressure cuff, scale and blood glucose meter, as needed.

**Cardiac**
The Telemedicine team also provides case management for the complex cardiac patient. Case managers with expertise in cardiac care provide coordination of care services as well as patient education on cardiac disease processes, diagnostic procedures and interventions, and medications.

**Asthma**
Members with Asthma are risk-stratified according to the National Asthma Education and Prevention Program (NAEPP).

**Guidelines for the Diagnosis and Treatment of Asthma**
A Case Manager with training in the disease meets with the patient to assess the patient's and/or family's understanding of his/her condition and medical treatment regimen. The program educates the patient on proper use and care of the equipment specific to asthma. These include inhalers and discus, spacer, nebulizer machine and the peak flow meter (PFM). Use of the PFM guides the member in use of medications and alerts to when to call the provider or go to the emergency room. Where

indicated, dust mite covers for mattress and pillow are provided. Preventive care is promoted in the recommendation of yearly flu vaccines and the pneumovax vaccine at specified intervals, where there is no contraindication. Additional nurse CM interventions may be to facilitate evaluations with allergy, immunology and/or pulmonary specialists.

**COPD/Emphysema**
Chronic Obstructive Pulmonary Disease (COPD) or emphysema, is the fourth leading cause of death in the United States. The cause and effect on the lungs vary from asthma. However, some of the drugs and equipment used to care for COPD patients are similar to asthma. Our Complex Medical Team care managers utilize the NIH National Heart, Lung and Blood Institute 2003, Global Initiative for Chronic Obstructive Lung Disease, as they partner with the Primary Care Physician in the development of care of the member.

**Complex Medical Team**
Johns Hopkins HealthCare recognizes that individuals often have two or more health problems, or co-morbid conditions that can be well served by evidence-based care management. The Complex Medical Team (CMT) was developed to address the needs of these patients. The Episodic RN case manager provides short-term assistance where a patient may need help with transition from hospital to home or with a complex home care regimen. The Complex Medical Team, comprised of nurses, social workers and care management assistants, manage long-term needs.

Coordination of care with the Behavioral Health Team was improved for more rapid communication between the nurse care managers and the Behavioral Health team in recognition that care of the mental and physical health of an individual cannot be compartmentalized. Staff identifies at-risk members with multiple co-morbidities via ACGpm scores, a method of predictive modeling developed by the Johns Hopkins University Bloomberg School of Public Health.

**Omega Life**
Omega Life is a palliative care program for cancer patients facing a potentially life-threatening illness. When a patient is faced with a new or a recurrent issue with cancer, the role of the case manager is that of educator, health systems navigator, symptom monitor, and communicator with the PCP and various specialists. When the patient doesn't know whom to call or is reticent to call the physician, he can speak to the Omega Life case manager who is available 8a-9p daily. This case manager can access various other disciplines such as social work and pastoral care to

support the patient either to discharge or through hospice, according to the patient's condition, needs and preferences.

**HIV/AIDS**

The HIV/AIDS Disease Management Program employs RN and Social Work case managers and an outreach substance abuse coordinator that are experienced in the standards of HIV care. The case managers target interventions according to the patients' specific needs. Interventions for patients requiring complex medical case management include frequent contact to monitor medication adherence and DME needs; assisting with arranging transportation to appointments and monitoring appointment adherence; providing culturally sensitive education about HIV-related issues; monitoring labs related to antiretroviral therapy and trending collected data to analyze population level trends. For social needs, case managers connect members with community resources and services. The HIV/AIDS Program case managers regularly attend conferences and seminars to stay current with new research findings about HIV care and to follow accepted HIV care guidelines. In addition, the HIV/AIDS Disease Management Program works with DHMH and the State AIDS Administration in identifying and reporting HIV positive and AIDS-defined members.

**Integrated Renal Solutions/End-Stage Renal Disease**

Integrated Renal Solutions (IRS) provides Case Management/Disease Management for patients with end-stage renal disease (ESRD) who have begun chronic dialysis. The Case Manager, a RN with a background in ESRD, provides disease management through bi-monthly visits to patients during the hemodialysis treatment, or during the monthly office visit when the member has selected peritoneal dialysis. During these encounters information/education is provided regarding options for renal replacement therapy (hemodialysis, peritoneal dialysis, and transplantation), and the challenges and advantages of each. In addition, adequacy of dialysis is monitored based on the National Kidney Foundation Dialysis Outcomes Quality Initiative guidelines (DOQI), and the Disease Manager collaborates with appropriate providers to achieve and maintain these quality standards. The Case Manager also assists the member in preventing complications and with problem solving related to dialysis treatment, access care, medications, and management of the primary diagnosis. In addition to the bi-monthly visits, the Case Manager is available to members and provider via phone, fax, and email.

**Member Identification:**
Members are identified for targeted disease management interventions through the following mechanisms:
- Claims and encounters
- Pharmacy data
- Laboratory data
- Health Risk Assessments

PCP referrals may be called into the Disease Management department at 410-424-4894.

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

**Treatment Planning:**
The Case Manager will review the case with the PCP and record a brief medical history, identify what health promotion and maintenance services are currently being provided, and what alternative care is appropriate for this member.

The Case Manager and the PCP will determine what additional services, and/or alternative care would benefit the member.

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

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

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

The Case Manager will enter significant changes into a database regarding the member's health status, new treatments or services and continually insure the appropriate level of care management is in place.

The Case Manager will communicate regularly with any health care team members involved in the member's care to ensure the care remains a covered benefit, and recommend changes to the plan of care to the PCP.

Identified patient care issues outside established medical policy guidelines will be brought to the attention of the PCP/admitting physician and the JHHC Medical Director.

## G. National Cancer Institute Trials

Through our contract with the DoD, the Plan has access to the National Cancer Institute (NCI) to treat our patients who suffer from cancer. Plan members who meet specific criteria will have access to promising new cancer therapies in test stages. If accepted in to the trial, patients will have access to treatment not in the TRICARE benefit.  The DoD finances some of the sponsored studies including Phase II and Phase III protocols approved by the NCI for all types of cancer.  More information is available about this program at www.cancer.gov or contact the Care Management Department at 1-800-557-6916.

# V. Quality Management

**1. Purpose:**

The purpose of the Quality Improvement Program at JHHC is to provide a comprehensive process for the management of potential and actual quality of care and service related issues. It is dedicated to ensuring the JHHC mission of providing an excellent managed care infrastructure, thereby striving to improve the quality of patient care while reducing the cost. It is a continuous process by which quality is assessed, opportunities for improvement are identified, corrective action plans are implemented, and effectiveness is evaluated.

**2. Definition:**

Healthcare Quality Improvement is a continuous process undertaken to ensure that individuals and groups of patients receive care of the highest standards, and represents current best practices. These processes maximize member satisfaction and safety; optimize healthcare outcomes and overall improved provider satisfaction with the health plan services.

**3. Scope:**

The scope of the Quality Improvement Program is to improve areas involving both the service component and clinical aspects of care. This effort encompasses the continuum of the care delivery system: inpatient, outpatient, skilled nursing, rehabilitation, and emergency services. It also includes the services that encompass monitoring; customer service, member satisfaction, and provider satisfaction with health plan services. In all activities, the Quality Improvement Program ensures compliance with applicable accreditation standards, and state and federal regulations.

**4. Responsibility and Accountability:**

The Board of Directors of Johns Hopkins HealthCare LLC is responsible for the overall Quality Improvement Program. In meeting this responsibility, the Board has delegated oversight of the Quality Improvement Program to the President. The Senior Director of Quality Improvement and Member Initiatives is responsible for implementation and monitoring of the Quality Improvement Program.

**5. Program Evaluation:**

The program is reviewed annually to assure achievement of goals established by the Quality Improvement Committees, QIOC (Quality Improvement Oversight Committee, PMT (Process Management Team) and PROFAC (Professional Advisory Committee). The results will be analyzed to determine the effectiveness of the interventions for improvement in patient care and service outcomes. The plan, its objectives and activities will be revised or enhanced for the upcoming year as

directed by the analysis of the data collected. This evaluation will take into account the various program descriptions and work plans. The revised Quality Improvement Program is presented to the Board of Directors annually once approved by the Quality Improvement Committees. Once approved internally, the plan, including appropriate addendum is forwarded to regulatory agencies as required.

**Mission Statement**

The Mission of the Quality Improvement Program is to:

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

## Quality Improvement Plan

### 1. Objectives

For FY 2006, Quality Improvement Objectives have been identified for each program (Please see Addendums A, B, and C). These objectives were developed from an analysis of the information available and are specific to each population of members at Johns Hopkins HealthCare (JHHC).

### 2. Quality Improvement Initiatives:

Quality Improvement initiatives are identified through analysis of the population demographics, characteristics, high volume, high dollar and problem prone conditions specific and prevalent to a specific population. Potential quality improvement initiatives are identified through routine monitoring by a department or quality improvement committee. Recommendations for initiatives are reviewed and selected for implementation by QIOC, PROFAC and PMT. The selection of activities is based upon the likelihood that a measurable improvement will occur in one of the following: (1) an important clinical outcome; (2) service aspects related to member or provider satisfaction; (3) total healthcare costs (4) patient safety.

### 3. Work Plan:

In order to meet each program's annual quality improvement objectives and maintain the mission of this Quality Improvement Plan, a Comprehensive Work Plan has been created. This work plan outlines activities for each program with responsibilities across multiple departments. For each activity a scope, purpose,

data type, person(s) accountable, proposed interventions, and reporting schedule are identified. The person or group who is identified as accountable for an activity is responsible for monitoring the progress of the activity toward an identified goal. They are also responsible for reporting progress to the appropriate quality improvement committee according to the schedule.

**4. Quality of Care Program:**

In the course of their daily responsibilities, the Care Management/Utilization Management Coordinators will screen patient encounters for potential quality of care issues or adverse events. All such occurrences are reported to the Quality Improvement Department for follow up. The information will be reviewed and acted upon as directed by the physician advisors. The results will be tracked in a database to allow for trending.

**Quality of Care Complaints**: Member complaints regarding quality of care are referred to the Quality Improvement Department for follow up. As above, the information is reviewed and acted upon as directed by physician advisors. The results are tracked and trended along with the Quality of Care Referrals described above.

All results of the Quality of Care Program, unless deemed not to be a quality issue, will be reported to the credentialing committee during the recredentialing process.

**5. Data Collection and Analysis:**

Data will be collected from multiple sources. These sources may include: medical record review, administrative claims data, pharmacy claims data, member and provider surveys, customer service reports, complaints and grievance data, and clinical data as submitted by Care Coordinators. Johns Hopkins HealthCare LLC is committed to maintaining excellent data systems and as such pledges support in the collection, management and analysis of data needed for the QI Program.

The security, integrity, and confidentiality of all patient information will be maintained according to the corporation's policies and procedures as well as state and federal regulations. JHHC is compliant with HIPAA regulations and is fully DISCAP accredited.

Analysis of data will be performed using traditional statistical methods including means, modes, median and percentages. An independent vendor will conduct compliance audits, as needed, to ensure a high level of data integrity. Also an independent vendor will conduct the annual member satisfaction survey to assure unbiased results and a venue for member to share their perception on the plan

anonymously. This will provide performance data suitable for comparison on national, regional and local levels.

## Quality Improvement Committees

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

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

**a. Board of Directors**

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

- Quality Improvement Oversight Committee (QIOC), which provides oversight and coordination of all clinical quality improvement activities, and
- Professional Advisory Committee (PROFAC), which provides oversight and coordination of all Priority Partners quality improvement activities, and
- Process Management Team (PMT), which provides oversight and coordination of all service and process quality improvement activities.

**b. Quality Improvement Oversight Committee (QIOC)**

**Role**: The Quality Improvement Oversight Committee maintains oversight and approves the Quality Improvement Program and Work Plan. It also implements and monitors the Quality Improvement Initiatives as directed by the Board of Directors.

**Responsibilities:**

- Monitor sub-committee activities through reports by chairpersons.
- Review annually and adopt preventive health, practice guidelines, and activities.
- Approves the Quality Improvement Annual Program.

- When available, evaluate HEDIS and other audit data related to quality measures and provide recommendations for improvement.
- Delegate any of the above activities to sub-committees or ad hoc work groups with appropriate oversight
- Monitor ongoing activities supporting accreditation.
- Review Quality of Care activities.

**c. Process Management Team (PMT)**

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

**Responsibilities:**

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

**d. JHHC Scientific & Benefit Advisory Committee (SABAC)**

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

**Responsibilities:**
Advisory, with respect to:

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

**e. Credentialing Committee**

**Role:** The Johns Hopkins HealthCare LLC Credentialing Committee has primary responsibility to review all credentialing and recredentialing files and make recommendations regarding individual providers interested in affiliating with Johns Hopkins HealthCare LLC.

**Responsibility:**

- Reviews all materials relevant to a candidate regarding credentialing and recredentialing matters as identified in credentialing policies and procedures.
- Completes necessary peer review during credentialing and recredentialing process.
- Applies existing criteria to each file and make a formal recommendation to the Special Credential Review Subcommittee regarding each candidate.
- Reviews and revises all policies and procedures related to all credentialing and recredentialing activities, at a minimum biannually.
- Reviews and revises all policies and procedures related to credentialing delegation oversight.
- Monitors delegation oversight activities and makes recommendations regarding delegation to the Special Credentials Review Committee (SCRC).

**f. Special Credentials Review Committee (SCRC)**

**Role:** The Special Credential Review Subcommittee (SCRS) is a subcommittee of the JHHC Board of Directors. The SCRS has final authority for decisions on credential applications.
Responsibility:

- Review and discuss credentialing application and related information.
- Approve or disapprove applications submitted by providers for participation status.
- Annual review and approval of credentialing policies and procedures.

Review delegation oversight and make determinations regarding delegation

**g. Utilization Management Committees (UMC)**

**Role:** To oversee utilization management activities at JHHC, to promote continuity of care and optimize member benefits, to monitor medical expense cost overruns, and over- and under-utilization of services.

**Responsibilities:**
- Ensure accurate administration of benefits
- Oversees tasks of the Utilization Review Department
- Compiles medical management data into annual reports and presents them to the QIOC or PROFAC.
- Coordinates provider satisfaction survey.
- Evaluates access to care and oversees improvement initiatives.
- Identifies trends in over and under utilization of services and recommends improvement initiatives for areas identified.
- Review and revise annually the Utilization Management Plan.

**h. Pharmacy and Therapeutics Committee**

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

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

## Additional Committees

***National Quality Mandatory Contractor (NQMC) Interface*:** The Quality Improvement Department of the USFHP will coordinate the retrieval and submit to the NQMC all required information for the quality oversight and review, as per the terms of the contract. The Quality Improvement Coordinator will analyze and track quality issues as reported by the NQMC monthly report.

***Regional Quality Management Committees:*** In addition to the structure and functions of the committees as described in the Quality Improvement Plan, the JHHC Quality Improvement Department will participate as required in regional quality management committees.

### Quality Improvement Objectives

1. Continue to monitor member and provider satisfaction and identify opportunities for improvement through data analysis from the annual Member and Provider Satisfaction Surveys.
2. To maintain Full Accreditation status through continued compliance with URAC Health Network standards.
3. To improve Claims Processing by keeping the percent of claims processed in less than 30 days above 90% while maintaining accuracy scores above 98%.
4. To meet or exceed organizational performance standards for Customer Service.
5. To monitor participation of USFHP members in the various Disease Management programs.
6. To continue to monitor the HEDIS measures annually as selected by the US Family Health Plan Alliance.
7. To identify and develop actions plans for those opportunities for improvement identified through the NQMC auditing process.
8. To maintain compliance with the Comprehensive Quality Management Program (TOM Ch.7, Sect. 4) through the JHHC Quality of Care Referral & review process.
9. Identify the appropriate method to monitor consult report timeliness.
10. To monitor health improvement activities as reported in the 2006 Comprehensive Quality Improvement Work plan.

# VI. Appeals

**Appeals should be sent to:**

US Family Health Plan/TRICARE
Attn: Appeals
P.O. Box 0203
Glen Burnie, MD 21060-0203

**Factual Determinations**

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

**Medical Appeals**

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

Items that cannot be appealed by the provider include:

- allowable charge
- member (member) eligibility
- network provider/contract disputes
- provider not authorized
- ineligible member
- factual determination (not a covered service or benefit; see benefit plan).

# VII. Reimbursement and Claims

## A. Claims Filing Guidelines

**Claims Submission and Processing**

- Network Providers are required to bill for all services and submit fee-for-service claims on a HCFA 1500 form or UB 92 within 180 days of the date of service. Appeals for denied claims or requests for reconsideration for repayment must be submitted within 90 working days of the date of the denial.
- Code all services with CPT (Current Procedural Terminology) codes; code all diagnoses with the 5-digit ICD-9-CM codes or DSM-IV codes for psychiatric disorders to the highest level of specificity for the current year.
- Routine clean claims are processed within 30 days.
- Submit appeals to:

  US Family Health Plan
  Appeals Department
  P.O. Box 0203
  Glen Burnie, MD 21060-0203

## B. Submission Address

Submit the completed claim to:

US Family Health Plan
Claims Department
P.O. Box 33
Glen Burnie, MD 21060-0033

## C. Other Health Insurance

**TRICARE Last Pay**

Under the law, TRICARE benefits are payable only for charges remaining unpaid after all other health coverages, except Medicaid and other programs identified by TRICARE Management Activity (TMA), have paid benefits. TMA has identified the following programs as being secondary to TRICARE:

- Medicaid,
- Indian Health Service,

- State Victims Assistance/Crime Compensation Plans,
- Maternal and Child Health Program and
- Veterans Administration.

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

**Lack of Payment by Other Health Insurer**

TRICARE will not pay amounts that have been denied by the other coverage because the claim was not filed timely with the other coverage or the member failed to meet some other requirement of coverage. When such a claim is received, JHHC will develop the claim for a statement from the other coverage as to how much would have been paid had the claim met the other coverage's requirements. If such a statement is provided to JHHC by the member, the claim will be processed as if the other coverage actually paid the amount shown on the statement. If no such statement is received, the claim will be denied.

**Waiver of Benefits**

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

## D.Medicare Leakage

**Coordination of Benefits between Medicare and US Family Health Plan**

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

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

## E. Third Party Liability

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

1. **US Family Health Plan Payor Status**. If other health insurance coverage exists, Plan coverage is available only as a secondary payor (except in cases involving Medicaid, Indian Health Services, and Veteran's Administration) and only after a claim has been filed with the double coverage plan and a payment determination issued. A double coverage payment determination must be issued regardless of any provisions contained in the other coverage. As secondary payor, the Plan's liability is no greater than it would have been in the absence of double coverage and does not extend to non-covered services. The Plan is responsible for the lower of the amount it would have paid as primary payor or the balance after the other health insurance has paid.

2. **Primary Payor Disputes.** As a TRICARE Prime Designated Provider, under Federal Law, Title 10, U.S.C., Chapter 55, Section 1079 (j)(1), the US Family Health Plan always serves as the secondary payor when double coverage applies. The Plan does not compromise its secondary payor status unless directed to do so by TRICARE Management Activity (TMA). The Plan attempts to resolve all disputes over primary payor status directly with the double coverage plan and maintains written documentation of all dispute resolution efforts.

   For Plan members with double coverage and Medicare, it is the policy of the US Family Health Plan to accept reduced payments from the other health insurance plan that recognizes its primary status but only pays an amount that supplements the benefit payable by Medicare if Medicare would otherwise be primary. This policy is in accordance with all TRICARE Management Activity directives. When a payor refuses to recognize its primary status and to issue

referrals or preauthorization accordingly, the Plan issues the referral or pre-authorization and documents the payor dispute in its records.

3. **Lack of Payment by Other Health Insure.** The Plan is prohibited from paying amounts denied by the other health insurer because the claim was not filed in a timely manner or because the member failed to satisfy some other requirement. If a statement from the other health insurer regarding how much would have been paid had all requirements been met is provided to the Plan, the claim may be processed as if the other health insurer actually paid the amount shown on the statement. If no such documentation is provided, the Plan must deny the claim.

4. **Prohibition on Waiving OHI Benefits.** Members may not waive benefits due from any Insurance Plan or Medical Service or Health Plan. If a double coverage plan provides, or may provide, benefits for a service, a claim must be filed with the double coverage plan. Refusal by the member to claim benefits from other health insurance must result in a denial of Plan benefits.

5. **Determination of Double Coverage.** The Plan maintains accurate and current other health insurance information in order to coordinate double coverage benefits. All double coverage information is verified with the member and the other health insurance plan. When the Plan is aware of the existence of an effective double coverage plan, the other health insurance plan must submit evidence of processing with the claim before the Plan adjudicates the claim as secondary payor.

6. **Marketing and Enrollment Limitations.** The Plan does not intentionally market to and enroll Military Health System (MHS) members who have other health insurance or are enrolled in the MHS direct care system. Marketing efforts are directed toward those MHS members listed on the DEERS data file provided by the government. MHS members covered under the Federal Employee Health Benefits Plan (FEHBP) may enroll in the Plan after providing proof that they have elected to suspend their FEHBP coverage in accordance with 5 CFR Part 890 or they may join the plan without suspending coverage and they will be counted towards the allowed members with OHI.

7. **Timely Filing.** The timely filing limit for COB claims is 180 days from the date the primary insurance adjudicated the original claim.

8. **Court Order.** US Family Health Plan is primary except in circumstances listed above. The Plan will dispute any court orders stating otherwise and pay as secondary.

## F. Worker's Compensation

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

## G.Fraud and Abuse

Abuse generally describes incidents and practices that may directly or indirectly cause financial loss to the Government under TRICARE or to TRICARE members. Abuse is defined in 32 CFR 199.2. Providers have obligations to furnish services and supplies under TRICARE at the appropriate level and only when and to the extent medically necessary as determined under 32 CFR 199.9. The quality must meet professionally recognized standards of health care and be supported by adequate medical documentation as may reasonably be required to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. A provider's failure to comply with these obligations can result in sanctions. Abuse situations are a sufficient basis for denying all or any part of TRICARE cost-sharing of individual claims.

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

- A pattern of waiver of member (patient) cost-share or deductible.
- Improper billing practices, such as charging TRICARE members rates for services and supplies that are in excess of those charges routinely charged by the provider to the general public, commercial health insurance carriers, or other federal health benefit entitlement programs for the same or similar services. (Dual fee schedules – one for TRICARE members and one for other patients or third-party payers. Such as, billing other third-party payers the same as TRICARE is billed but accepting less than the billed amount as reimbursement.)

- Pattern of submitting claims for non-medically necessary services or, if medically necessary, not to the extent rendered. Battery of diagnostic tests are given when, based on the diagnosis, fewer tests were needed.
- Care of inferior quality. Consistently furnishing medical or mental health services not meeting accepted standards of care.
- Failure to maintain adequate medical or financial records.
- Refusal to allow the Government (TRICARE Management Activity) or its contractors access to records related to TRICARE claims.
- Billing substantially in excess of customary or reasonable charges unless it is determined by TMA that the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities when it is accepted medical practice to make an extra charge in such cases.
- Unauthorized use of the term "TRICARE " in private business.

Fraud is defined in 32 CFR 199.2. -under TRICARE, includes but is not limited to the following:

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

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

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

- billings or TRICARE claims for services which would be covered except for the frequency or duration of the services, such as billing or submitting a claim for two one-hour psychotherapy sessions furnished on separate days when the actual service furnished was a two-hour therapy session on a single day;
- spreading the billing or claims for services over a time period that reduces the apparent frequency to a level that may be cost shared by TRICARE;

- charging to TRICARE, directly or indirectly, costs not incurred or reasonably allowed to the services billed or claimed under TRICARE, for example, costs attributable to non-program activities, other enterprises, or the personal expenses of principals; or
- Billing or submitting a claim on a fee-for-service basis when in fact a personal service to a specific patient was not performed and the service rendered is part of the overall management of, for example, the laboratory or x-ray department.
- Breach of a provider participation agreement, which results in the member (including parent, guardian, or other representative) being billed for amounts, which exceed the TRICARE-determined allowable charge or cost.
- Misrepresenting dates, frequency, duration or description of services rendered, or of the identity of the recipient of the services or the individual who rendered the services.
- Submitting falsified or altered TRICARE claims or medical or mental health patient records, which misrepresent the type, frequency, or duration of services or supplies or misrepresent the name(s) of the individuals who provided the services or supplies.
- Duplicate billings or TRICARE claims, including billing or submitting TRICARE claims more than once or the same services, billing or submitting claims both to TRICARE and other third-parties (such as other health insurance or government agencies) for the services, without making full disclosure of material facts or immediate, voluntary repayment or notification to TRICARE upon receipt of payments which combined exceed the TRICARE-determined allowable charge of the services involved.
- A provider misrepresenting his or her credentials. A provider concealing information or business practices, which bear on his/her qualifications for authorized TRICARE provider status, such as a provider representing that he or she has a qualifying doctorate in clinical psychology when the degree is not from a regionally accredited university.

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

- One provider performing services for another provider and the latter bills as though he had actually performed the services (e.g. a weekend fill-in);
- providing service as an institutional employee and billing as a provider for the services;

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

# IX. Appendix

## A. Provider Update Information

**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.

**Peer to Peer Conversation**
After a provider receives a verbal notification of a denial, but before an actual written notification has been sent to the provider, the provider has the right to discuss determinations with the Medical Director, according to the Johns Hopkins HealthCare Policy entitled: Medical Review for Initial Determination.

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

**Disputes**
The parties hereto encourage the prompt and equitable settlement of all disputes, controversies, or claims ("Disputes") between or among them, including those arising out of this Agreement or the Payor Addenda. At any time, any party may give the other written notice that it desires to settle a Dispute. Within (10) days of delivery of such notice, the parties agree to meet in good faith to resolve such Dispute. If such Dispute cannot be resolved within a reasonable amount of time, the parties agree to resolve such Dispute in accordance with JHHC's written dispute resolution policies and procedures, as set forth in the Provider Manual. Such dispute resolution policies and procedures shall include, but not be limited to, policies and procedures to resolve disputes relating to Provider's status as Participating Provider or Provider's professional competency or conduct.

## B. List of Acronyms

| Acronym | Meaning |
|---|---|
| ADSM | Active Duty Service Member |
| CHAMPUS | Civilian Health and Medical Program for the Uniformed Services |
| CM | Care Management |
| DEERS | Defense Enrollment Eligibility Reporting System |
| DoD | Department of Defense |
| DP | Designated Provider |
| ESRD | End Stage Renal Disease |
| JHHC | Johns Hopkins Community Physicians |
| MH | Mental Health |
| MHS | Military Health System |
| MR | Medical Record |
| MTF | Military Treatment Facility |
| MCSC | Managed Care Support Contractor |
| NQMC | National Quality Monitoring Contractor |
| PCP | Primary Care Physician |
| PFPWD | Program for Persons with Disabilities |
| PPN | Preferred Provider Network |
| OCS | Office of Clinical Services |
| TFL | TRICARE for Life |
| TMA | TRICARE Management Activity |
| UM | Utilization Management |
| US FHP | US Family Health Plan & Uniformed Services Family Health Plan |

## C. Glossary

**Adverse Determination**: An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or member's eligibility to participate in a plan, and including with respect to group health plans, a denial, reduction or termination of, or a failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

**Appeal:** Request for review of an adverse determination.

**Attending Physician**: The physician who is primarily responsible for a member's care in an inpatient hospital setting.

**Authorized Representative:** An individual who has been authorized in writing by the member to act on their behalf. The authorization must be signed by the member. Certain exceptions may apply; see Operations Manual 6010.51-M, Chapter 13, Section 2.

**Authorized Services:** Those serviced authorized by the Plan to be provided to the member upon recommendation by the primary care physician (PCP).

**Benefit:** A covered service as defined in 32 CFR 144.

**Catastrophic Cap:** An upper limit on out-of-pocket expense placed on US Family Health Plan covered medical bills. The enrollment year limit for an active-duty family is $1,000. Plan retiree families have a catastrophic loss protection limit of $3,000 per enrollment year. Dental charges under United Concordia's Dental Value Network do not count toward these caps.

**Concurrent Care:** Is care or treatment that is in process at time of review, and any reduction or termination in a plan-approved term is an adverse determination.

**Contractor(s):** US Family Health Plan programs or Managed Care Support Contractors.

**Co-Payment:** The fee you are required by law to pay at the time of service.

**Custodial Care:** Care provided by the non-medically skilled, mainly to help patients with activities of everyday living**.**

**Defense Enrollment Eligibility Reporting System (DEERS):** The worldwide computerized Military Health System that lists all Uniformed Services members. Active-duty member are listed automatically.

**Dependent:** The spouse, eligible child, adult disabled child, or parents of a military sponsored deemed to be entitled to military benefits as determined by military regulations.

**Durable Medical Equipment:** Medical Equipment such as wheelchairs, hospital beds, oxygen, and respirators. Covered when medically necessary and arranged by the plan

**Eligible Person:** A Military Health System (MHS) member who remains eligible in DEERS.

**Emergency:** Sudden and unexpected onset of life, limb, or sight which threatening conditions requiring immediate medical attention.

**Enrollee:** A Uniformed Services member who voluntarily and affirmatively seeks and is accepted for enrollment in the Plan. Eligibility for enrollment in the Plan is based on eligibility for military health care benefits, as indicated in DEERS.

**Enrollment Period:** The period of time during which enrollees agree to receive covered services solely under the Plan. In general, each enrollment period is 12 months.

**Factual Determination:** Issued in cases involving: coverage issues, hospice care, denials based on sections other than 32 CFR 199.4, and both medically necessity and factual determinations. Medical or peer review may be necessary to reach a factual determination; e.g. for advice on whether regulation or policy criteria are met.

**Initial Determination:** A determination issued (following review by a second level reviewer) that the health care services furnished or proposed to be furnished to a patient are not medically necessary. This determination is appealable.

**Inpatient:** A person treated overnight in a hospital as a registered bed patient incurring a change for room and board, upon the recommendation of a physician.

**Managed Care Support Contractor (MCSC):** The civilian contractor designated by DoD to operate TRICARE in a particular region in partnership with the MTFs. The MCSC for Region 1 is Health Net Federal Services.

**Medical Necessity:** A collective term for determinations based on medical necessity, mental health benefits, appropriate level of care, custodial care or other reasons relative solely to reasonableness, necessity or appropriateness.

**MHS:** Military Health System

**Outpatient Care:** Outpatient care includes diagnostic and treatment services, supplies, and medicines provided and used at a hospital or other covered facility under the direction of a physician.

**Plan:** US Family Health Plan as presented in this document.

**Pre-service Request:** A request for authorization.

**Primary Care Physician (PCP):** Each US Health Plan member has a primary care physician who knows the member's medical history, provides most of the member's health care, writes referrals for and monitors any specialist care or tests that are necessary and helps the member prevent medical problems in the future. US Family Health Plan primary care physicians specialize in internal medicine, family practice or pediatrics.

**Provider:** A health care professional, institution, facility or agency licensed by the appropriate authority and operating according to law, including a hospital, physician, doctor of podiatry (D.P.M.), licensed clinical psychologist (Ph.D), certified nurse practitioner, physicians assistant, certified nurse-midwife, or mental health counselor.

**Reconsideration Request:** A formal review requested in writing by the member regarding the initial appeal determination or decision

**Referral:** A formal, written recommendation from a PCP that directs an enrollee to receive health care services from another specified care provider. Entitlement to such services shall not exceed the limits of the referral and is subject to all terms and conditions of the group contract. For referred services to be paid for by the Plan, a referral is necessary.

**Room and Board:** Charges made b a hospital or other covered institution for the cost of a room, general-duty nursing care, and other services routinely provided to all inpatients, not including special care units.

**Semi-Private Charge:** The charge made by a hospital for a room containing two (2) or more beds, but not including the charge made by the hospital for special care units.

**Service Area:** US Family Health Plan service area includes the zip codes in the geographic service area approved by DoD. Moving outside the service area is a valid reason to disenroll from the Plan.

**Skilled Nursing Facility (SNF):** An institution that meets all the following requirements: (1) is licensed by the appropriate public authority as a skilled nursing facility: (2) is accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients; (3) is engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board; and (4) is a freestanding or a designated unit of another licensed health care facility.

**Split Enrollment:** Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/contractors, including Managed Care Support (MSC) contractors and Uniformed Services Family Health Plan (USFHP) designated providers.

**TRICARE Extra:** The TRICARE option that operates like a civilian preferred provider network, or PPN. These participating providers have agreed to charge the TRICARE-allowable fees. However, for using this network of preferred physicians and specialists, the government will pay a slightly larger share of the medical costs incurred. As TRICARE Standard, not enrollment or referrals are required.

**TRICARE Prime:** This benefit provides the most comprehensive coverage for health care benefits at the lowest cost. Each member has a primary care physician who manages all of the individual's health care**.**

**TRICARE Standard:** The new name for the health care option formerly known as CHAMPUS. Under TRICARE Standard, eligible members may choose any physician they want for health care and the government will pay a percentage of the cost. Eligible members are not required to enroll or pay an enrollment fee.

**US Family Health Plan Member Card:** The card issued by the Plan, identifying a military member as a member of the Plan and including important benefit and compliance information.