

## Authorization Notification

**Providers** - When you request 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.

## Tackling Fraud

If you have questions regarding health care fraud or would like to report fraud committed by or against a US Family Health Plan member, network provider, or JHHC employee, please contact the JHHC Corporate Compliance Department at 410-424-4996 or [compliance@jhhc.com](mailto:compliance@jhhc.com).

## Peer to Peer Conversation

After you've received a verbal notification of a denial, but before an actual written notification has been sent to you, you have the right to discuss determinations with the Medical Director, according to the Johns Hopkins HealthCare Policy entitled: Medical Review for Initial Determination.

## New Site

Johns Hopkins Community Physicians has a new site located in Canton Crossing. The new site, which opened in October, is located in the 1st Mariner Building at 1501 S. Clinton Street, Suite 200, Baltimore, MD 21224. The phone number is 410-522-9940.

## IMPORTANT NUMBERS AND WEBSITES

### Provider Services

410-424-4528  
1-800-808-7347

### Care Management

410-424-4480  
1-800-261-2421

### Provider First Line

1-888-819-1043

### Mental Health Services

1-888-281-3186

### Pharmacy Services

410-338-3300

### Health Education

410-762-5348  
1-866-391-1870  
[kwatson@jhhc.com](mailto:kwatson@jhhc.com)  
[djordan@jhhc.com](mailto:djordan@jhhc.com)

### US Family Health Plan Website

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

## For Your Information

### Claim Submissions

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

### Appeal Submissions

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

## JHHC INTRODUCES NEW PROGRAM, NEW COORDINATOR FOR USFHP MEMBERS

Johns Hopkins HealthCare (JHHC) is proud to announce a new, value-added program for US Family Health Plan members. JHHC has dedicated a registered nurse to work specifically with USFHP members during their transition from the hospital to either a sub-acute and/or skilled care facility setting, and then to home.

Just over two months ago, Lisa LaChapelle joined the JHHC team as a Transitional Care Coordinator. Her experience as a registered nurse in the field of Medical Surgical Nursing, Geriatrics, and as a Certified Case Manager, together make Lisa the perfect person for this unique job position.

"I always wanted to work with retired military. I'm excited about this job, and I'm looking forward to getting this program rolling", said Lisa, who is also the spouse of a military retiree.

In this position, Lisa will visit members in the hospital and in nursing homes to develop a relationship with both the member and the family. Their care will also be discussed with the member's physician with emphasis focused on the member's long term needs.

In addition to the role that Lisa holds, the transitional care program also includes patient safety, medication reconciliation, and improved satisfaction along all transition points of the program at Johns Hopkins HealthCare.

Lisa will also work to ensure that clients who need sub-acute and/or skilled care are in the most appropriate center and that their transfer to a sub-acute and/or skilled care facility has been



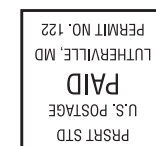
Lisa LaChapelle, Transitional Care Coordinator, US Family Health Plan at Johns Hopkins HealthCare.

coordinated and arranged. She will be using InterQual criteria.

She will also ensure that members are educated regarding their disease "red flags"; will reconcile medication between home and facilities; will coordinate the transition to outpatient case and disease management programs when appropriate after discharge; will coordinate all home health care needs after discharge; and will assist members with long term care options.

Although this is a new program at JHHC, Lisa's enthusiasm for it has already been expressed to those around her. Her goal is to make a positive difference in the lives of USFHP members. Look for Lisa to make an impact.

*For additional information, please contact Polly Howard, Director, Care Management at 410-762-5230.*



# MEDICAL DIRECTOR'S CORNER

## NEW TECHNOLOGY AND EVIDENCE BASED MEDICINE

The United States is a world leader in the development of new devices and procedures aimed at improving patient care and outcomes. With that knowledge in mind, we have been asked how the health plans that make up Johns Hopkins HealthCare decide on the implementation of new technology, and how each health plan decides if and when to pay for this new technology.

At JHHC we take our obligation seriously to evaluate and then cover new technology that benefits our members. We also take into account our role as stewards of the resources needed to pay for that technology. As new technology is rolled out there are studies performed and published attempting to show that the technology leads to good outcomes in patient care.

The gold standard is the double blind controlled study published in a peer reviewed journal (the evidence). Unfortunately many studies fall short of this standard and need to be critically evaluated to make a coverage decision. Recent items that we have reviewed include Breast MRI, CT angiography, and capsule endoscopy, among others.

Larger health plans are able to have technology assessment departments that review most new technology. One of those plans relies on a TEC advisory group that is widely used. TRICARE Management Activity (for USFHP) also has a staffed tech assessment process. We participate in those discussions and rely on much of that information.

We subscribe to a technology assessment service provided by the Winifred S. Hayes Incorporated. This company has a staff that reviews the literature on new technology and assigns a rating ranging from proven to unproven. If the Hayes report is very clear, we usually accept it and make our coverage decisions accordingly. In unclear situations we also use another service provided by a company called Up to Date. We will also review the published policies of other major health plans.

When the evidence still remains unclear, or a provider or group of providers asks for further consideration, we rely on a group called the Scientific Assessment and Benefits Advisory Committee (SABAC). That group is chaired by Dr. Howard Garber, one JHHC's medical directors. The committee consists of a number of Johns Hopkins full time faculty physicians (representing many specialties) as well as practicing physicians.

With new technology where the use or indications remain unclear, the SABAC group reviews and discusses the published literature and may even ask for further review by an expert faculty member or group. A final recommendation is then made to our medical policy committee regarding if and for what indications to cover the technology. In cases where the evidence is not yet complete, but appears promising, SABAC will take another look at the appropriate time.



Dr. Robert Kritzer, Deputy Chief Medical Director, JHHC

# POLICY CHANGES

## MRI REIMBURSEMENT

**Providers:** We have updated our policy regarding reimbursements for Magnetic Resonance Imaging (MRI) of the breast (CPT Codes 77058, 77059, and 0159T), based upon pertinent medical criteria. The effective date is January 1, 2008.

JHHC will approve MRI of the breast for members who have had a previous conventional mammogram and /or sonogram in the following circumstances:

- To detect intracapsular (silent) rupture of silicone gel-filled breast implants;
- To detect implant rupture in symptomatic members;
- To detect local tumor recurrence in breast cancer members who have undergone mastectomy and breast reconstruction with an implant;
- To detect local tumor recurrence in individuals with breast cancer who have radiographically dense breasts or old scar tissue from previous breast surgery that compromises the ability of combined mammography and ultrasonography;
- To assess tumor location, size, and extent before and/or after neoadjuvant chemotherapy in persons with locally advanced breast cancer, for determination of eligibility for breast conservation therapy;
- To detect the extent of residual cancer in the recently postoperative breast after incomplete lumpectomy with positive margins when the member still desires breast conservation and local re-excision is planned;
- To localize the site of primary occult breast cancer in individuals with adenocarcinoma suggestive of breast cancer discovered as axillary node metastasis or distant metastasis without focal findings

on physical examination or on mammography/ultrasonography;

- To guide localization of breast lesions to perform needle biopsy when suspicious lesions exclusively detected by contrast-enhanced MRI cannot be visualized with mammography or ultrasonography; or
- To evaluate persons with a diagnosis of lobular carcinoma in situ (LCIS).

JHHC will approve MRI of the breast as screening for members under the following circumstances:

- Patients considered to be at high familial risk for breast cancer, defined as those with a family history that is suggestive of hereditary breast cancer.
- Two or more first degree relatives with breast cancer;
- One first degree relative and two or more second degree or third degree relatives with breast cancer;



- One first degree relative with breast cancer before the age of 45 years and one other relative with breast cancer;
- One first degree relative with breast cancer and one or more relatives with ovarian cancer;
- Two second degree or third degree relatives with breast cancer and one or more with ovarian cancer;
- One second degree or third degree relative with breast cancer and two or more with ovarian cancer;
- Three or more second degree or third degree relatives with breast cancer;
- One first degree relative with bilateral breast cancer;
- Presence of a BRCA1 or BRCA2

mutation;

- Unilateral breast cancer MRI to evaluate opposite breast;
- Patients with a known BRCA 1 or BRCA 2 mutation;
- Patients in whom mammography is technically limited due to anatomic factors; e.g. those with dense or distorted breasts (on a case by case basis subject to review);
- In-patients with positive margins after lumpectomy for evaluation of residual tumor; or
- In-patients with locally advanced breast cancer to determine response during (as opposed to before and after) neoadjuvant chemotherapy.

JHHC considers MRI of the breast unproven and will not approve payment in the following circumstances:

- To further characterize indeterminate breast lesions identified by clinical exam, mammography or ultrasound;
- For the diagnosis of low suspicion findings on conventional testing not indicated for immediate biopsy and referred for short-interval follow up;
- For the diagnosis of a suspicious breast lesion in order to avoid biopsy;
- As a screening technique in average risk patients;
- To confirm implant rupture in symptomatic individuals whose ultrasonography shows rupture;
- To differentiate benign from malignant breast disease, especially clustered microcalcifications;
- To differentiate cysts from solid lesions (use ultrasound); or
- To map the size and extent of primary tumors in persons with localized breast cancer.

Pre-authorization is required and can be obtained by contacting Care Management at 410-424-4480 or 1-800-261-2421.

*For additional questions or concerns regarding the changes to this policy, please contact your Network Manager or Network Coordinator at 410-424-4400.*

The Banner newsletter is published quarterly for US Family Health Plan network providers by Johns Hopkins HealthCare LLC, External Affairs and Communications Department. **JHHC President** – Patricia Brown; **Chief Operating Officer** – Jeffrey Joy; **USFHP Vice President** – Mary Cooke; **Communications Manager** – Donna L. Chase. To submit information or articles, email [dchase@jhhc.com](mailto:dchase@jhhc.com).

