



Hopkins ElderPlus PROVIDER MANUAL



2012

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Hopkins ElderPlus *Mission Statement*

The mission of Hopkins ElderPlus is to support the independence of the frail elderly and help them stay in their own homes and communities as long as possible.

VALUES

We value comprehensive care for the frail elderly by using an interdisciplinary team to promote wellness.

We value excellence by always striving to work at our highest level of performance and commitment.

We value quality service by making every effort to exceed expectations.

We value diversity by fostering an environment of mutual support, respect and cooperation.

We value progress by supporting new ideas and creative thinking.

We value compassion by encouraging sensitivity to the needs of our participants, caregivers and co-workers.

We value effectiveness by measuring our performance to produce the best possible results and quality of life.

We value participation by including participants, caregivers and staff in decision making.



Welcome To Hopkins ElderPlus

As a contracted provider of services, you have a special place in the Hopkins ElderPlus program. Through efficient and effective use of services that focus on enhancing the participants' functional capacity, we can achieve our program goal of managing the frail elderly in their community as long as it is socially, medically and economically feasible.

This manual is provided to you as an overview of the Hopkins ElderPlus program including our mission, values and some of our procedures.

Overview of Hopkins ElderPlus

Hopkins ElderPlus is a joint venture of Hopkins ElderPlus, the Centers for Medicare and Medicaid (CMS) and the State of Maryland Department of Health and Mental Hygiene (DHMH) formed to provide community-based services to the frail elderly who reside in one of the approved zip codes in Baltimore City and Baltimore County.

Hopkins ElderPlus is part of the national Program of All-Inclusive Care for the Elderly (PACE).

Eligibility:

To be eligible to enroll as a Hopkins ElderPlus member, an individual must be:

- a. 55 years or older
- b. A resident of one of the approved zip codes (21202, 21205, 21206, 21213, 21214, 21217, 21218, 21219, 21220, 21221, 21222, 21224, 21227, 21231, 21237, 21052)
- c. Eligible for nursing home placement based on Maryland's established level of care criteria as determined by the Delmarva Foundation

The Hopkins ElderPlus interdisciplinary team assesses all potential enrollees prior to admission. Once enrolled, the participant's care is planned and directed by the interdisciplinary team. Care is focused on preventive services and functional maintenance as well as ongoing medical care.

Hopkins ElderPlus offers a full range of services which include, but are not limited to, adult day health care, home care, inpatient acute and long-term services, primary medical care, prescription medications, laboratory tests, x-rays and durable medical equipment.

Lock-In Provision:

Once a participant is enrolled in the program, Hopkins ElderPlus becomes the sole provider of services. This feature, known as "lock in," assures a coordinated and comprehensive approach to all services.



Provider Requirements

All providers of services to Hopkins ElderPlus members agree to abide by and be subject to all Johns Hopkins HealthCare LLC policies and procedures currently in effect or which may be adopted from time to time in the future.

All providers of services to Hopkins ElderPlus members must meet all applicable Federal and State requirements including, but not limited to the following:

- a. Medicare or Medicaid participation requirements (if the provider is an organizational contractor, such as a hospital or nursing home)
- b. Medicare or Medicaid requirements applicable to the services it furnishes (if the provider is a practitioner or supplier)
- c. All contract provisions related to:
 - a. Service Delivery
 - b. Member Rights
 - c. Quality Assessment and Performance Improvement Activities

Referral/Billing Procedures

The following procedures must be followed for all routine services provided to Hopkins ElderPlus participants. All non-emergency services must be authorized by Hopkins ElderPlus before services are rendered. Providers who render emergency services must notify Hopkins ElderPlus within 24 hours or the next business day after that service has been rendered.

1. Hopkins ElderPlus will contact the provider requesting the specific service by telephone. An authorization form will be completed at that time and forwarded to the provider.
2. The provider will receive a consultation request form at the time of the patient visit.
3. Claims should be mailed to:

Johns Hopkins HealthCare LLC
6704 Curtis Court
Glen Burnie, MD 21060
Attn: Claims, Hopkins ElderPlus
4. Providers should use the CMS 1500 or UB 04 forms to submit their claims. (Do not bill Medicare, Medicaid or the participant.)
5. Any questions regarding reimbursement should be directed to JHHC Provider Relations at 410-762-5385, or 888-895-4998.
6. To reach a Hopkins ElderPlus manager on-call, please contact 410-550-7044.

Free Communication with Members

As stated in the Johns Hopkins HealthCare LLC Participating Provider Agreement: Nothing in this agreement nor any payor addenda shall preclude or restrict a provider from discussing or communicating to covered persons, public officials, or other individuals, information that is necessary or appropriate for the delivery of health care services, including communications that relate to treatment alternatives, regardless of benefit limitations; communications that are necessary or appropriate to maintain the provider-patient relationship while the covered person is under the provider's care; communications that relate to a covered person's right to appeal a coverage determination with which the provider or covered person does not agree; and opinions and the basis of an opinion about public policy issues.

Claim Appeals

PROVIDER ADMINISTRATIVE APPEALS PROCESS

All claims administrative appeals must be submitted in writing within 90 business days from the date of payment or denial. Appeals should contain all supporting documentation with a copy of the claim.

Appeals should be mailed to:

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

Johns Hopkins HealthCare LLC (JHHC) will reconsider administrative denial decisions upon request by a provider.

The Appeals process is as follows:

- Providers may file an appeal to request reconsideration of an administrative denial.
- Providers will receive written acknowledgement within five business days of receipt of an appeal.



- The first-level appeal must be filed within 90 business days after notification of the denial.
- The second-level appeal must be filed within 20 business days after notification of the first-level appeal decision.
- The first- and second-level appeals will be resolved within 90 business days of receipt of the first-level appeal.
- Written notification of the appeal resolution decision will be generated and sent to the appellant within 30 days.
- Payment for claim denials that have been overturned after the appeal will be paid within 30 days.

We will not take any punitive action against a provider for utilizing our provider complaint process.

PROVIDER CLINICAL APPEALS PROCESS

All Clinical appeals must be submitted in writing within 30 business days from the date of denial. Appeals should contain all supporting documentation.

Appeals should be mailed to:

Hopkins ElderPlus
Director, Hopkins ElderPlus
4940 Eastern Avenue
Baltimore, MD 21224
410-550-7044
410-550-7045 fax

RECONSIDERATION FOR CLINICAL APPEALS

If the treating physician would like to discuss their case with a physician reviewer for reconsideration of their original denial, the physician can call the Hopkins ElderPlus director at 410-550-7044.



Quality Assessment and Performance Improvement

Hopkins ElderPlus has a comprehensive Quality Assessment and Performance Improvement (QAPI) Plan that includes both internal and external review processes. This program monitors quality issues through chart audits, grievance reports, statistical information and other data sources, and develops and implements changes to enhance program quality and effectiveness.

The Hopkins ElderPlus Joint Practice Committee (JPC) is a quality assessment committee that provides oversight of the QAPI. The HEP director and medical director co-chair the JPC and communicate with providers if and when their cooperation is needed to ensure quality and/or performance improvement.

Member Rights and Responsibilities

MEMBER RIGHTS

► **You have the right to be treated with respect.**

You have the right to be treated with dignity and respect at all times, to have all your care kept private, and to get compassionate, considerate care. You have the right to:

- Get all of your health care in a safe, clean environment.
- Be free from harm. This includes physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff that you do not need to treat your medical symptoms or to prevent injury.
- Be encouraged to use your rights in the HEP program.
- Get help, if you need it, to use the Medicare and Medicaid grievance and appeals processes, and your civil and other legal rights.
- Be encouraged and helped to talk to HEP staff about changes to policies and services you think should be made.
- Use a telephone while at the HEP Center and to make or receive private calls.
- Not have to do work or services for the HEP program.
- Not have photographs of you taken or used without your written permission.



► **You have the right to be protected against discrimination.**

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Color
- National Origin
- Religion
- Age
- Sex
- Sexual orientation
- Mental or physical ability
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a social worker at the HEP program to help you resolve your problem.

If you have any questions, you can call the Office of Civil Rights at 800-368-1019, or TTY 800-537-7697.

► **You have a right to information and assistance.**

You have the right to get accurate, easy-to-understand information and to have someone help you make informed health care decisions. You have the right to:

- Have someone help you if you have a language or communication barrier so you can understand all information given to you.
- Have the HEP program translate the information into your preferred language if your first language is not English and you cannot speak English well enough to understand the information being given to you.
- Get marketing materials and HEP rights in English and in any other frequently used language in your community. You can also get these materials on audiotape, if necessary.
- Get a written copy of your rights from the HEP program. The HEP program must also post these rights in a public place in the HEP center where it is easy to see them.
- Be fully informed in writing of the services offered by the HEP program. This includes telling you which services are provided by contractors instead of the HEP staff. You must be given this information before you join, at the time you join, and when there is a change in services.
- Look at, or get help to look at the results of the most recent review of the HEP program. Federal and State agencies review all HEP programs. You also have a right to review the HEP program's plans to correct any problems that are found at inspection.



▶ **You have the right to a choice of providers.**

You have the right to choose a health care provider within the HEP program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services. You have the right to request and receive information about any provider's education and training.

▶ **You have a right to access emergency services.**

You have the right to get emergency services when and where you need them without the HEP program's approval. A medical emergency is when you think your health is in serious danger and every second counts. You may have a bad injury, sudden illness or an illness quickly becomes much worse. You can get emergency care anywhere in the United States.

▶ **You have a right to participate in treatment decisions.**

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions, or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right to:

- Have all treatment options explained to you in a language you understand, be fully informed of your health status and how well you are doing, and make health care decisions. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.
- Have the HEP program help you create an advance directive. An advance directive is a way for you and your doctor to talk about the type of treatments you want or don't want in case you cannot speak for yourself. An advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- Participate in making and carrying out your plan of care. You can ask for your plan to be reviewed at any time.
- Be given reasonable advance notice, verbally and in writing, of any plan to move you to another treatment setting and the reason you are being moved. If this is necessary, it will be clearly written in your record.



► **You have a right to have your health information kept private.**

You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under State and Federal laws.

You also have the right to receive a copy of your medical records. You have the right to look at your medical records with a member of the medical staff.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used, which went in to effect April 14, 2003. If you have any questions about this privacy rule, call the office for Civil Rights at 800-368-1019, or TTY 800-537-7697.

► **You have a right to file a complaint.**

You have a right to complain about the services you receive or that you need and/or if you don't receive the quality of your care, or any other concerns or problems you have with the HEP program. You have the right to a fair and timely process for resolving concerns with your HEP program. You have the right to:

- A full explanation of the complaint process.
- Be encouraged and helped to freely explain your complaints to HEP staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- Appeal any treatment decision by the HEP program, staff or contracted providers.

► **You have a right to leave the program.**

If for any reason, you do not feel that the HEP is what you want, you have the right to leave the program. At your request, HEP will assist you to leave the program. The timing of your leaving must follow the guidelines of the State of Maryland.

MEMBER RESPONSIBILITIES

- ▶ **To provide accurate health care information to the HEP team so that appropriate care can be given.**

To allow HEP access to medical records from former providers. To cooperate with team members who are assessing your needs.

- ▶ **To provide accurate information regarding eligibility requirements such as changes in address, finances, etc.**

- ▶ **To accept all health care from HEP providers.**

This is also known as “lock-in.” It means that you agree to use the HEP providers of care for all your health care needs.

Life-threatening situations, requiring emergency care, are excluded from the “lock-in” agreement.

- ▶ **To notify HEP at the first opportunity of any use of out-of-plan services including emergency care.**

Use the Manager On-Call pager system to inform HEP of any changes. The Nurse-On-Call is available 24 hours per day by calling 410-550-7044.

- ▶ **To participate in the development of your care plan with the HEP team.**

- ▶ **To treat all participants, visitors and staff with respect.**

Respect the confidentiality of other HEP participants.

- ▶ **When applicable, make a monthly financial payment to HEP according to:**

- HEP private pay guidelines
- HEP nursing home requirements
- HEP assisted living requirements



Member's/Caregiver's Guide to the Grievance and Appeals Procedures

GRIEVANCES:

1. A grievance is a verbal or written complaint expressing dissatisfaction with service delivery or quality of care. A grievance may be given to HEP staff members during normal business hours or to the HEP Manager On-Call who is available by pager 24 hours/day. The pager number is 410-550-7044.
2. A HEP staff member will discuss with you and provide in writing the specific steps with time frames that HEP will take to resolve your complaint. A staff member will investigate the complaint and respond to you within thirty (30) days.
3. If you are satisfied with the HEP response, the complaint is considered resolved.
4. If you are not satisfied with the HEP response, tell the HEP staff member that you are not satisfied. The HEP staff member will send a written report to the HEP Director for review.
5. The HEP Director will send you a written response to the grievance within thirty (30) days.
6. If you are not satisfied with the HEP director's response, you may send a written grievance. If you want assistance, the HEP social workers will help you with the written grievance process. A written grievance must be received by the HEP administration within one month (30 days) of the action taken by the staff or the HEP Director.
7. Within 30 days, you will receive a final report from the Johns Hopkins Bayview Medical Center, Vice President of Care Management. If the decision is not in your favor, a copy of the report will be sent to Medicaid.
8. HEP will take all steps to protect your confidentiality in the grievance process. HEP will continue to provide all required services to you during the grievance process.

MEMBER APPEALS:

1. The HEP director will send you a written notice if HEP plans to deny coverage or payment for a service you have requested or if HEP wants you to leave the program against your will.
2. The written notice will tell you how to appeal the decision. You must appeal within 30 days of the notice. If you want assistance, the HEP social workers will help you with the written appeals process.
3. As soon as your health condition requires it, but no later than 30 days after receiving the appeal, you will receive a written report that describes your appeal, the actions taken and the outcome of a third-party review. The written report will include information about your additional appeals rights under Medicare and Medicaid. The HEP social worker can assist you with an appeal to Medicare and/or Medicaid.
4. If the appeal is decided in your favor, HEP will furnish the disputed service as expeditiously as your health condition requires.
5. If the appeal is not decided in your favor, HEP will send a copy of the final report to Medicare and Medicaid.
6. HEP will take all steps to protect your confidentiality in the appeals process.
7. HEP will continue to provide all undisputed required services to you during the appeals process.
8. For a Medicaid participant, HEP will continue to provide disputed services until a final determination is made if:
 - a. HEP proposes to terminate or reduce a service currently being provided, and
 - b. The participant requests that HEP continue to provide the services with the knowledge that he/she may be liable for the cost if the final determination is not in the participant's favor.

MEMBER APPEAL RIGHTS UNDER MEDICARE AND MEDICAID

If you are eligible for Medicare, Medicaid, or both, you have the right to file an appeal directly with Medicare and/or Medicaid.

At your request, a HEP social worker will help you contact Medicare and/or Medicaid directly.

Note: Private pay participants have access to the HEP appeals process only.



Credentialing and Re-Credentialing

The JHHC Credentialing process is an important component of the JHHC Quality Assurance Program. JHHC's Credentialing process requires that practitioners undergo a credentialing cycle at least every three years. The Special Credentials Review Committee (SCRC) is JHHC's credentialing governing body and is responsible for approving providers for inclusion in the JHHC provider network.

The goal of credentialing is to ensure that JHHC has a qualified multidisciplinary practitioner panel to deliver safe, effective and appropriate care to its members. At the time of initial credentialing, and prior to issuing approval, all provider candidate applications undergo the following primary source verifications:

- Licensure
- Education
- Malpractice History
- Criminal background check (USIS)
- Federal, State and Local sanctions and disbarments/exclusions
- Medical Board Certification (if applicable)
- Medicare/Medicaid participation status
- DEA/CDS Registrations
- Hospital Affiliation

Practitioners are re-credentialed at least every three years. Therefore, practitioners credentialed on or before July 1, 2011, must be re-credentialed on or before June 30, 2014. In order to facilitate timely re-credentialing, 120 days prior to the practitioner's expiration date, JHHC's Credentialing department will interrogate the Council for Affordable Quality Healthcare (CAQH) website to obtain a Maryland Uniform Credentialing Form (MUCF) for each provider. If the provider participates with CAQH, JHHC will retrieve the MUCF and initiate a re-credentialing cycle. For providers who do not use CAQH, JHHC will call, fax, or email notification of the need for re-credentialing and will attempt to obtain a MUCF from the provider.

Practitioners are required to:

- Update and re-attest the CAQH MUCF online application; or,
- Submit a completed current copy of the State of Maryland Uniform Credentialing Form (UCF)
- Ensure that all information is up-to-date and accurate before signing the authorization for release of information
- Attach the required documentation (e.g., professional liability cover sheet)

If using a MUCF:

- Mail with cover sheet to:
Johns Hopkins HealthCare
6704 Curtis Ct.
Glen Burnie, MD 21060
Attn: Credentialing Department
- Fax with cover sheet to Credentialing department at 410-762-5302.

Continued network participation is dependent upon completion of the re-credentialing process within the established timeframe. Please contact your Provider Relations Network Manager at 410-762-5385, or 888-895-4998, or the Credentialing department at 410-424-4619, if you have questions about the credentialing process.

TERMINATION OF PARTICIPATION

Provider Agreements may be terminated by JHHC, effective immediately “For Cause.” Examples of “for cause” may be defined as but not limited to:

- Fraud
- Patient abuse
- Incompetence
- Loss of licensure
- Loss of participation status in State or Federal Payor Programs (Medicare, Medicaid).

For additional information about your obligations upon contract termination, please reference your provider agreement. If you have additional questions, please contact Provider Relations at 410-762-5385, or 888-895-4998.

RIGHTS TO APPEAL TERMINATION

No appeal rights are available if there is a:

- Revocation of license,
- Conviction of fraud, or
- Initial credentialing is denied

Providers, who are eligible for appeal, must submit their request in writing within thirty (30) calendar days of their original termination. The chief medical director will convene an appeal panel comprised of three qualified practitioners. At least one practitioner is a clinical peer of the appealing provider who is not otherwise involved in JHHC network



management operations activities. For the purpose of this requirement, a clinical peer is a provider with the same type of license. The panel shall not include any individual who is in direct economic competition with the affected provider, professionally associated with or related to the provider, or otherwise might directly benefit from the outcome. Knowledge of the matter shall not preclude any individual from serving as a member of the panel; however, involvement with any earlier decision concerning the initial determination or corrective action will require the individual to remove him/herself from the panel.

Within thirty (30) calendar days of a first panel review, and after reviewing any written statements submitted by the provider and any other relevant information, the panel will render a decision. The chief medical director, or designee, will notify the affected provider in writing within fifteen (15) calendar days of the panel's decision. This notice will be sent either by certified mail return receipt requested or FedEx.

If the provider requests a second review, the provider is subject to the following:

- The burden of proof remains with provider to explain their actions or lack of actions;
- The provider may submit a written statement for the panel's consideration;
- The provider may submit the written statements of others for the panel's consideration;
- The provider may submit other documents relevant to the determination; and
- The practitioner may request a personal appearance before the second-level panel.

A determination by the second-level review panel is final with no further appeal rights.

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.



Hopkins ElderPlus *Identification Card*



4940 Eastern Ave.
Baltimore, Maryland 21224

PACE

Name: ELDER PLUS SAMPLE

I.D. #: 000909399*01

Group #: H00002/001

Effective Date: 01/01/2010



Bin #: 004336
PCN ADV
Group RX4290

This person is a member of Hopkins ElderPlus, a
Program of All-Inclusive Care for the Elderly (PACE).

**Hopkins ElderPlus is not liable for payment for services offered
without its prior authorization except in the case of an emergency.**

For emergencies, call **911**.

For medical services, call the 24 hour On-call person,
(410) 283-5575

For information regarding coverage and benefits, please call
the following numbers during the normal business hours:
Members 410-550-7044 or Providers 410-424-4450

If this ID card is found, please mail to:
Hopkins Elder Plus
4940 Eastern Ave Baltimore, MD. 21224

Return Postage Guaranteed



Hopkins ElderPlus Services Provided

Services Provided	Covered
CALENDAR YEAR DEDUCTIBLE	
Per individual	None
Per family	None
COINSURANCE OUT-OF-POCKET MAXIMUM (Including Deductible)	
Per individual	None
Per family	None
TREATMENT OF ILLNESS OR INJURY	
Primary care office visit	100%
Specialty care office visit	100%
Diagnostic services and treatment	100%
PREVENTIVE SERVICES	
Mammogram	100%
GYN exam	100%
IMMUNIZATIONS AND INOCULATIONS	
For common communicable diseases (e.g., Diphtheria, Per-tussis, Measles, Mumps, Rubella, Poliomyelitis, Tetanus)	100%
PRESCRIPTION DRUGS	
ALLERGY TESTS AND PROCEDURES	
Allergy tests	100%
Desensitization materials and serum	100%

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Hopkins ElderPlus *Services Provided* (continued)

Services Provided	Covered
LABORATORY AND X-RAY PROCEDURES	
Laboratory tests, imaging exams, X-ray exams and ultra-sound	100%
SURGICAL PROCEDURES	
Professional services for inpatient and outpatient surgery	100%
Medically necessary reconstructive and/or surgically implanted prosthetic devices	100%
MEDICAL SUPPLIES	
Disposable supplies (e.g., ostomy bags, diabetic supplies, syringes)	100%
URGENT CARE CENTER	
Physician visit	100%
Diagnostic services and treatment	100%
EMERGENCY SERVICES	
Emergency care	100%
AMBULANCE TRANSPORTATION	
Transportation when medically necessary to and/or from a hospital	100%
HOSPITAL CARE	
Inpatient care (semi-private unless private accommodations are approved for medical reasons)	100%
Medically necessary intensive care	100%
Other inpatient services including preadmission testing	100%
Hospital inpatient days limitation	Unlimited
Skilled nursing/Rehabilitation facility	100%
Outpatient services including outpatient testing prior to outpatient surgery	100%
Outpatient surgery facility charges including free-standing surgical centers	100%

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Hopkins ElderPlus *Services Provided* (continued)

Services Provided	Covered
CHEMOTHERAPY/RADIATION THERAPY	
(Includes physician services & materials)	100%
ACUPUNCTURE	
Medically necessary for anesthesia, pain control, and therapeutic purposes	100%
HOME HEALTH SERVICES	
Medically necessary services coordinated by clinical case managers	100%
HOSPICE CARE	
Inpatient and home	Not Covered
End of Life Care	100%
MEDICALLY NECESSARY SERVICES	
Non-developmental medically necessary services coordinated by clinical case managers	100%
PHYSICAL/OCCUPATIONAL THERAPY	
Medically necessary services	100%
DURABLE MEDICAL EQUIPMENT	
Medically necessary equipment, prosthetic appliances, and medical supplies	100%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	
Inpatient Care for Mental Health	100%
Outpatient Treatment for Mental Health	100%
Inpatient Care for Substance Abuse/Inpatient Care for Alcohol Abuse	100%
Outpatient Treatment for Substance Abuse & Detoxification	100%

Important Phone Numbers

Managers On-Call 24/7

410-550-7044

Provider First Line/Customer Service

888-819-1043

Provider Relations

410-762-5385

888-895-4998

410-424-4604 fax

Authorizations & Referrals

Hopkins ElderPlus

410-550-7044

410-550-7045 fax

JHHC Corporate Compliance

410-424-4996

410-424-4996 fax

compliance@jhhc.com







Hopkins

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2012

www.jhhc.com