2024 Provider Manual

US Family Health Plan

JOHNS HOPKINS
HEALTH PLANS

The Johns Hopkins US Family Health Plan Provider Manual is a guide to our plan.

The manual includes an overview of the plan with specific information on:

Primary Care Provider and Specialist Responsibilities

Services and Benefit Information

Quality Improvement

Claims Payments and Reimbursements

Care Management Services

Compliance Regulations

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SECTION 1:
Overview

Johns Hopkins US Family Health Plan

Johns Hopkins US Family Health Plan (USFHP) is a managed care program sponsored by the Department of Defense (DoD) as a designated provider of TRICARE® Prime. The plan offers comprehensive TRICARE Prime health care benefits to members of the uniformed services and is modeled after a health maintenance program similar to a Health Maintenance Organization (HMO).

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. Under TRICARE Prime, members are required to select a primary care provider (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
- US Family Health Plan TRICARE Prime network (e.g., Johns Hopkins)

With this model, members select a primary care provider (PCP) as their medical provider. The PCP works with the member to oversee their entire health care. USFHP gives members access to Johns Hopkins primary care physicians, specialists, and facilities in addition to a contracted network of community providers.

USFHP is a managed care option for active duty dependents, retirees (not yet 65) and their dependents, and for a limited number of members over 65 who were eligible to remain in the program due to their status on Oct. 1, 2012. USFHP members are assigned a PCP who provides and coordinates care, maintains patient health records, and refers members to specialists, if necessary.

Active Duty Family Members (ADFMs) enrolled in USFHP do not have copayments except for pharmacy copayments, or when enrolled in Extended Care Health Option (ECHO). Retirees and their families without Medicare B coverage enrolled in USFHP are responsible for copayments when seeking care from a network provider.

USFHP currently has numerous sites throughout Maryland, Southern Pennsylvania, Virginia, parts of West Virginia, District of Columbia and Delaware. Johns Hopkins supports the mission of USFHP by:

- Providing quality health care to members
- Having well-cared for and extremely satisfied members
- Demonstrating quality, value, and operational effectiveness to a growing member population
- Continuing as a permanent and respected health care partner in the Military Health System

Members must take action and enroll in a TRICARE option within 90 days of a qualifying life event, including a move out of the USFHP service area.

If members do not take action within 90 days, they will no longer be enrolled in TRICARE [1]Prime — they will only be able to access military health benefits at a military installation's hospital or clinic on a space-available basis.

Strong care management programs ensure that the plan provides best value health care services in support of the Military Health System.

USFHP 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.

Note: If a member joined the plan before Sept. 30, 2012, they do not need to do anything to remain in the plan after they turn age 65. If a member enrolled Oct. 1, 2012 or after, the member will be required to transition to TRICARE for Life and enroll in Medicare when they reach age 65.

USFHP offers the following:

- No enrollment fee for active duty dependents
- Nominal copays per office visit (retirees/dependents)
- No copay per office visit (active duty family members or retirees w/Medicare)
- Guaranteed appointments (access standards)
- PCP supervised and coordinated care
- Coverage when away from home

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[1]TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

SECTION 11:
Provider Information

Primary Care Providers

A primary care provider (PCP) is a physician or nurse practitioner who manages the primary and preventive care of a USFHP member and acts as a coordinator for specialty referrals and inpatient care.

Role and 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 PCP's practice. The PCP's office is responsible for identifying sources of specialty care, making referrals, and coordinating that care.

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 a review of a member's medical record. After the member has signed the required consent form for 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.

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.

Specialty Providers

A specialty provider is a medical practitioner who specializes in a branch of medicine or surgery, such as cardiology or neurosurgery. When outside the scope of the PCP's practice, the PCP refers the member to the appropriate service or specialist.

Responsibilities of the specialty provider include the provision of specialty services upon referral by the PCP; and recommending appropriate treatment plans and providing written reports to the referring PCP to ensure continuity of care. Consistent with commercial timeframes and in support of continuity of care for the member, Johns Hopkins Health Plans (Johns Hopkins Health Plans) requires that all consultation or referral reports, operative reports, and discharge summaries be provided to the primary care manager within 30 calendar days.

Specialty providers must also ensure that members are billed correctly. DO NOT bill Medicare for services covered by USFHP.

Required Billing Procedures

- Private insurance is primary and must be billed first. This includes federal and state employee insurance, but not Medicare supplements.
- If the patient does not hold private insurance, USFHP is primary, and must be billed first.
  - » Exception: Medicare may be billed as primary (first) for services related to End Stage Renal Disease (ESRD) or for services not otherwise covered by the plan.

Providers billing Medicare for services other than ESRD not covered by the plan must reimburse Medicare. See also: Medicare Leakage page 61.

Treatment Report from the Specialist to PCP

The PCP should receive an initial report of services and treatment, which may be oral as long as a written report is provided to the PCP within 30 calendar days from the date of service or sooner if the member's condition warrants a shorter time frame.

Provider Services (Customer Service)

Representatives from the Customer Service department respond to and document all member and provider telephone calls, written comments, and requests. Complaints are forwarded to the complaints and grievance department. Acting as the 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.

Provider Relations

The Provider Relations department is a collective team of professionals who are liaisons between Johns Hopkins Health Plans (Johns Hopkins Health Plans) and our participating provider network. The network is divided into geographic territories and specialty areas, and each is assigned a network manager and coordinator.

The Provider Relations team is responsible for network development, maintenance, and education. Network development includes soliciting new providers in service areas and specialty areas to accommodate the needs of our growing membership.

The department is also responsible for network maintenance including updates and changes to provider information, account set-up, and fee schedules.

Provider education is an essential responsibility of the department. Your network manager, upon request, will train you and your office staff regarding the plan's program and its benefits. For a listing of network managers and territories, please call Provider Relations at 410-762-5385 or 888-895-4998 (option 4).

Provider Communication

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

- The USFHP Provider Manual is a guide to our plan. The manual includes an overview of the plan as well as information on PCP and specialist responsibilities, service and benefit information, claims payment and reimbursement, care management services, and referral guidelines.
- *Provider Pulse* is a provider newsletter that is produced quarterly. It contains resource information, updates regarding policies and procedures, feature stories, and news pertaining to our health plans, including USFHP.
- USFHP providers may utilize the website to find useful and updated information such as the provider manual, policies, forms, guidelines, announcements, and a host of other information specifically developed for the USFHP network community at: HopkinsHealthPlans.org

Changes in Provider or Site Status

Additions, deletions, or other changes to the provider's office information must be communicated to the territory network manager or coordinator as soon as possible via email at ProviderChanges@jhhp.org or through our online Digital Provider Information Update Form. You can also mail or fax changes to:

Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Provider Relations Department
Telephone: 888-895-4998
Fax: 410-762-5302

National Disaster Medical System

USFHP is encouraging all acute-care medical/surgical hospitals in our provider network to become members of the National Disaster Medical System (NDMS). Contracted providers, who are eligible for NDMS participation, are encouraged to become part of this disaster recovery initiative. USFHP will provide program information to all eligible providers and include reminders periodically through our provider newsletter and on our website. The NDMS is a federally coordinated system that augments the nation's medical response capability. The NDMS supplements an integrated national medical response capable of assisting state and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts.

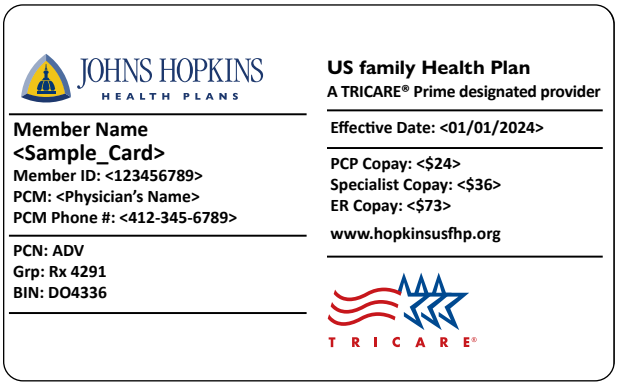
The National Response Framework utilizes the NDMS as part of the Department of Health and Human Services, Office of Preparedness and Response, under Emergency Support Function #8 (ESF #8), Health and Medical Services, to support federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters including:

- Natural disasters
- Major transportation accidents
- Technological disasters
- Acts of terrorism including weapons of mass destruction events

For more information, please review the NDMS recruitment link at:
https://aspr.hhs.gov/NDMS/Pages/join-ndms.aspx

USFHP Sample Identification Card

Below are samples of the USFHP Identification card. On the left is the front of the card, and on the right is the back of the card.



Access Standards

To ensure that illness is evaluated in a timely manner, members must have access to PCP services either by appointment or telephone, 24 hours a day, seven days a week.

When a provider's office is closed, the plan offers Nurse Chat, a program staffed by RNs and backed up by PCPs. The nurses triage, advise, and authorize use of urgent care facilities and emergency rooms using standardized protocols. 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 accessibility guidelines are to be followed by all providers:

- **Emergency** – 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 the Utilization Management department 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 and preventive care services.

APPOINTMENT AVAILABILITY

Wait times for Primary Care Appointments

Appointment Type and Standard (Not to Exceed)

Well-Patient Visit – 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 four (4) weeks
- Travel time no longer than one hour or 60 miles

Travel Time to PCP's Office

A member's travel time should not exceed the TRICARE Prime standard of 30 minutes for primary care and 60 minutes for specialty care from home to the service delivery site. Johns Hopkins Health Plans shall require members electing to enroll, but residing outside the 30 minute travel time area, to sign written documentation informing the member of their choice and that the member voluntarily waived the 30 minute access standard.

Office Wait Time

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

Credentialing

The Johns Hopkins Health Plans (Johns Hopkins Health Plans) Credentialing Program is dedicated to the careful selection and credentialing of practitioners for inclusion in the USFHP provider network. Johns Hopkins Health Plans credentialing criteria defines the licensure, education, and training criteria practitioners must meet to be considered for inclusion into the Johns Hopkins Health Plans participating network.

Prior to becoming Johns Hopkins Health Plans network participants, all providers must successfully complete the credentialing process. Providers are requested to submit information, subject to verification by Johns Hopkins Health Plans, to support and provide evidence of appropriate education, training, clinical experience, licensure, professional liability insurance, clinical associations, and professional history. Johns Hopkins Health Plans verifies the submitted information and obtains additional information from the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), General Services Administration (GSA), state licensing boards, medical specialty boards, professional certification boards, and HireRight (USIS) to compile a complete and full credentialing file.

The provider's credentialing file is reviewed by the chief medical officer at Johns Hopkins Health Plans. If an applicant is deemed to be high risk, those applications are reviewed by the Special Credentials Review Committee (SCRC), a committee of the Board of Directors of Johns Hopkins Health Plans. Notification is sent to the provider at the conclusion of the SCRC activity informing the provider of the outcome of the SCRC decision.

Johns Hopkins Health Plans does not discriminate on the basis of race, ethnicity, national origin, gender, age, sexual orientation, or type of procedure or patient in which the provider specializes. The credentialing process and decision-making are monitored to ensure nondiscriminatory practices are followed.

Credentialing Requirements

All providers and facility/hospitals that are required to be credentialed must remain in full compliance with Johns Hopkins Health Plans credentialing criteria as set forth in the Johns Hopkins Health Plans credentialing policies and procedures, and with all applicable federal, state, and local laws and regulations. Each provider or facility/hospital must complete an appropriate application as an applicant for initial participation, and, minimally, every three years thereafter (recredentialing event) for as long as the provider or facility/hospital remains an active participant in the USFHP provider network.

Types of Providers Requiring Credentialing

The following types of providers must be credentialed by Johns Hopkins Health Plans prior to participating in the USFHP provider network:

Institutional Providers

- Hospitals, acute care, general, and special
- Organ transplantation centers
- Organ transplant consortia
- Hospitals, psychiatric
- Hospitals, long-term (tuberculosis, chronic care, or rehabilitation)
- Skilled nursing facilities
- Residential treatment centers
- Christian Science sanatoriums
- Infirmaries
- Other special institutional providers
- Freestanding ambulatory surgical centers

- Birthing centers
- Psychiatric partial hospitalization programs
- Hospice programs
- Substance use disorder rehabilitation facilities

Individual Professional Providers

- Doctors of medicine
- Doctors of osteopathy

Other Allied Health Professionals

- Clinical psychologist
- Doctors of optometry
- Doctors of podiatry or surgical chiropody
- Certified nurse midwives
- Certified nurse practitioners
- Certified clinical social worker
- Certified psychiatric nurse specialist
- Certified physician assistants
- Certified registered nurse anesthetist
- Other individual paramedical providers
- Licensed registered physical therapists and occupational therapists
- Audiologists
- Speech therapists, speech pathologists
- Registered dietitian
- Nutritionist

Extramedical Individual Providers

- Certified marriage and family therapists
- Mental health counselor

Credentialing Practitioners

Initially, practitioner applicants must submit the Maryland Uniform Credentialing Form (MUCF) to apply for participation. The MUCF is available through the Council for Affordable Quality Healthcare (CAQH) on their website. Practitioners who wish to use the online application via CAQH, but are not members of CAQH, may become a member by requesting an invitation through Johns Hopkins Health Plans. There is no cost to the provider for using CAQH.

Alternately, the practitioner may request a hard-copy MUCF from Johns Hopkins Health Plans, or go online to the Maryland State website at: insurance.maryland.gov/Insurer/Pages/HealthcareProviders.aspx

The hard copy application must be returned to Johns Hopkins Health Plans for processing.

The practitioner's application must be complete including all service locations from which the practitioner will provide medical service to USFHP patients, education including residency and fellowship programs, clinical experience(s) for at least the past five (5) years, malpractice/professional liability insurance coverage, medical and professional certifications held, licenses held for at least the past five (5) years, DEA and CDS registrations, clinical affiliations with facilities/hospitals, malpractice claim history, and contact information. The application must be signed and dated by the applicant including an attestation that serves as a release of information and a statement that the information contained within the application is true and accurate. Additionally, the practitioner must respond to all disclosure questions pertaining to clinical and professional experience and history.

The provider will be notified of any outstanding documentation that is needed to complete the credentialing file. Examples include legal documents to augment malpractice claims, licensing board disciplinary actions, or disbarment or restriction of privileges by any federal, state or local jurisdiction or other health care related entity with which the applicant had a professional relationship.

The practitioner is also notified if Johns Hopkins Health Plans identifies any discrepancies between the information included in the application and information obtained during the credentialing process from outside sources (e.g., NPDB, OIG, etc.). Adverse information pertaining to the clinical competence, professional judgment, compliance with state or federal regulations, patient safety, or contractual compliance may be grounds for refusal of acceptance into the USFHP provider network or termination of ongoing participation.

Practitioners have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Practitioners also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. They may do so by telephone, fax, email, or correspondence to the credentialing department or the network manager for their geographic area.

Currently, the following verifications are completed in addition to collection of the application information and validation of the contractual relationship between Johns Hopkins Health Plans and the practitioner. These verifications are performed in accordance with the TRICARE Operations Manual, National Committee for Quality Assurance (NCQA), state and federal guidelines, and regulations:

1. Current licensure as an independent vendor in the state where service will be rendered
2. Education – degrees, internship, residency, and fellowship programs completed relevant to current licensure
3. Medical board certification
4. Professional certification
5. Work history for the past five (5) years (gaps of six (6) months or greater must have explanation of the gap)
6. Hospital admitting privileges (clinical associations)
7. DEA registration and CDS certification as appropriate for scope of practice
8. Professional liability insurance
9. Malpractice activity and history
10. Federal, Medicare, or Medicaid sanctions

11. Disciplinary actions by licensing boards, educational institutions, professional organizations, or medical service providers including facilities
12. Criminal history background check including National Sex Offender Registry (USIS/ HireRight)

The practitioner is requested to provide responses to disclosure questions related to:

1. History of chemical dependency and substance or alcohol abuse
2. History of license revocations or disciplinary actions
3. History of criminal convictions other than minor traffic violations
4. History of loss or limitation to clinical privileges
5. History of complaints filed with local, state, or national societies or licensing boards
6. History of refusal or cancellation of professional liability insurance
7. History of federal, Medicare, or Medicaid sanctions including restrictions on DEA or CDS
8. Reasons for the inability to perform essential functions of the position with or without accommodation(s)

During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by Johns Hopkins Health Plans since the prior credentialing event is also included in the credentialing file, and subject to consideration for ongoing participation.

The decision to approve initial or continued participation, or to terminate a provider's participation, will be communicated in writing within sixty (60) days of the SCRC's decision. In the event that the provider's participation or continued participation is denied, the provider will be notified by certified mail. If continued participation is denied, the provider will be allowed thirty (30) days to appeal the decision.

Procedure for Criminal Background Checks for Prospective USFHP Providers

Johns Hopkins Health Plans is required to initiate criminal background checks per Tricare regulations on initial providers that request to participate with the USFHP.

HireRight is a company Johns Hopkins Health Plans utilizes to conduct the criminal background checks. Johns Hopkins Health Plans will initiate the process by requesting that HireRight send an invitation to the applicant to complete a criminal background check by entering in the provider's email address that is listed on their credentialing application.

- The applicant will receive an email from HireRight containing the web address and login information to fill out the background screening information necessary to complete the background check. Please be advised that a secure online portal is used for the applicant to provide their personal information.
- Once the applicant signs in using the authentication information provided in the email, they will be required to set up their own password. Instructions will be provided with a brief explanation of what to expect when completing the required information.
- The applicant will be prompted to provide information appropriate to the screening order (Johns Hopkins Health Plans Criminal Background Check Package). Once complete, the applicant will review the accuracy of the information they entered and then provide an electronic consent.

- The applicant will review the disclosure and authorization forms, check the two certification boxes and provide an electronic signature.
- A confirmation message will display an estimated date of completion for the background check.

Credentialing Organizational Providers

Organizational providers include hospitals, home health agencies, skilled nursing facilities, ambulatory surgical centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.

Organizational providers must complete a credentialing application, available directly from Johns Hopkins Health Plans via the senior network manager responsible for the type of organization that is applying. The credentialing application requires the signature of the organization's authorized representative and serves as an attestation that the health care facility/organization agrees to the assessment requirements. The authorized representative's signature also serves as a release of information to verify credentials externally.

Upon receipt of the application, the organization is notified of receipt of the application and that the credentialing process has been initiated. Any outstanding documentation that will be needed to complete the credentialing file that the organization must submit will be noted in the notification. Examples include legal documents to augment malpractice claims history, licensing board disciplinary actions and/or correction action plans, or disbarment or restriction of privileges by any federal, state, or local jurisdiction or other health care accreditation entities.

Currently, the following verifications are completed in addition to collection of the application information. Verifications include CMS Care Compare results for hospitals and Skilled Nursing Facilities (SNF). These verifications are performed in accordance with the TRICARE Operations Manual, NCQA, state and federal guidelines, and regulations:

1. Current licensure as a health care delivery organization as an independent vendor in the state where service will be rendered
2. Any restrictions to a license imposed by the licensing agency
3. Any limitations or exclusions imposed by the federal government, Medicare, or Medicaid entity
4. Accreditation status with nationally recognized entities for health care quality including, but not limited to, the Joint Commission (JCAHO), Community Health Accreditation Program (CHAP), Healthcare Facilities Accreditation Program (HFAP), the American Osteopathic Association (AOA), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Commission on Accreditation of Rehabilitation Facilities (CARF)
5. For non-accredited organizations, Johns Hopkins Health Plans will accept a state assessment/evaluation or
   CMS review
6. Onsite review for organizations without accreditation or state/CMS review
7. Professional liability /malpractice insurance

Re-credentialing is performed at a minimum every three (3) years. During re-credentialing events, information regarding quality of service and patient satisfaction that has been gathered by Johns Hopkins Health Plans since the prior credentialing event is also included in the credentialing file and subject to consideration for ongoing participation.

Organizations have the right to inquire about the status of their application or may review any information collected from primary sources during the credentialing process. Organizations also have the right to explain any information that may vary substantially from that provided, and/or may correct any erroneous information that has been collected. Such requests may be done by telephone, fax, email, or correspondence to the credentialing department or the senior network manager responsible for this type of organization. The mailing address for Johns Hopkins Health Plans is:

Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: Credentialing Department

The decision to approve initial or continued participation, or to terminate an organization's participation, will be communicated in writing within sixty (60) days of the SCRC's decision. In the event that the organization's participation or continued participation is denied, the organization will be notified by certified mail. If continued participation is denied, the organization will be allowed thirty (30) days to appeal the decision. See "Johns Hopkins Health Plans Provider Grievance Process."

Termination of Participation

Provider agreements may be terminated by Johns Hopkins Health Plans, 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)

Contractual or Voluntary Terminations

In accordance with termination agreements in contract, either the provider or Johns Hopkins Health Plans may terminate the provider agreement with written notice to the non-terminating party at least 90 days prior to the termination date. The provider will continue to provide, or arrange for covered services for covered members prior to the effective date of termination and following termination for any member whose medical condition requires a continuing course of treatment where alternative arrangements have not been made.

Right to Appeal Termination

Should a practitioner or organization be terminated from the network, or otherwise not be approved for participation through the recredentialing process, the provider has the right to appeal the SCRC's decision, consistent with Johns Hopkins Health Plans's credentialing policies and procedures.

The provider has no appeal right if the cause of termination was due to:

- Revocation or loss of licensure
- Conviction of fraud
- Initial credentialing is denied

The provider has thirty (30) calendar days to submit the request for a first-level appeal following notification of an adverse decision regarding the provider's participation status with Johns Hopkins Health Plans. Johns Hopkins Health Plans will then notify the provider of receipt of the request for an appeal.

The credentialing department designee will convene an appeal panel comprised of three qualified clinicians who represent the provider community within the USFHP provider network. At least one of the panelists will be a clinical peer of the appellant. (For the purpose of this requirement, a clinical peer is a provider who holds the same licensure and specialty as the appellant.) Knowledge of the matter shall not preclude any individual from serving as a member of the panel; however, involvement with any earlier decision concerning the initial determination for termination or corrective action(s) precludes the individual from serving as a panelist.

The panel will review the appeal information submitted by the appellant and render a recommendation to the SCRC to uphold or overturn the initial decision. The SCRC decision will be rendered within thirty (30) calendar days from receipt of the appeal request.

If the SCRC and the panel decide to uphold the initial termination decision, the provider may request a second-level appeal and request the opportunity for a personal hearing. Personal appearance hearings will be scheduled at the convenience of the hearing panelists and the provider, but not to exceed sixty (60) calendar days from the receipt by Johns Hopkins Health Plans of the second-level appeal request.

The provider has the right to be represented by an attorney or another person of the provider's choice during the appeal process. In lieu of a personal hearing, the provider may opt for a second panel decision with no personal appearance. The panelist in this situation will render a recommendation to the SCRC within thirty (30) days of receipt of the second-level appeal. In either situation (personal appearance or appeal panel), the panelists render a recommendation to the SCRC to either uphold or overturn the initial decision. The SCRC decision will be rendered within thirty (30) calendar days from the date of the second-level appeal. Second- level appeals are final and binding.

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

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

Transition of Care upon Provider Termination

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

In some cases, members may be able to continue care with a terminated practitioner for a short period of time after the practitioner leaves the network. If this situation applies, Johns Hopkins Health Plans will discuss this with you at the time of your termination.

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

Facilities/SNFs falling below three stars will be required to submit a corrective action plan and may be suppressed from the network directory.

Contact Information

Customer/Provider Services
(benefit eligibility, claims status)
410-424-4528
800-808-7347

Mental Health/Substance Disorder Services
410-424-4830
888-281-3186

*Appointment Locator Service
888-309-4573
**Members can speak to and work with staff that can help them find urgent and routine appointments with Mental Health and Substance Disorder Professionals.*

Care Management
800-557-6916
caremanagement@jhhp.org
410-424-4885 (fax)

Fraud & Abuse
410-424-4971
410-424-2708 fax
FWA@jhhp.org

Health Education
800-957-9760
healtheducation@jhhp.org

Nurse Line
866-444-3008
Enter PIN #382

Mail Order Pharmacy
410-235-2128 (Maryland residents)
800-345-1985 (Non-Maryland residents)

Quality Improvement
410-424-4538

Provider Relations
410-762-5385
888-895-4998
410-424-4604 fax

Utilization Management
Inpatient Initial: 410-424-2602
Outpatient: 410-424-2603

Performance Improvement/ Risk Management
410-338-3610

Superior Vision
800-879-6901

United Concordia Dental
800-332-0366
Under a separate agreement, the plan has arranged for members to receive two free cleanings from selected community dentists under a discounted fee structure.

Web Site Addresses

USFHP – www.hopkinsusfhp.org
TRICARE – www.tricare.mil
FORMULARY – https://www.hopkinsusfhp.org/members/my-benefits/pharmacy/

Claims Submission

Johns Hopkins Health Plans
EDI Payor ID #52123
PO Box 830479
Birmingham, AL 35283
Attn: USFHP Claims

Appeals Submission

Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: USFHP Appeals

Network Hospitals

Johns Hopkins Health Plans has contracts with the majority of hospital facilities within Maryland, Pennsylvania, Delaware, Virginia, and Washington, DC. For a complete and up-to-date listing of these hospitals, please refer to the provider search function at HopkinsHealthPlans.org

Member Safety

Providers will be encouraged to participate in plan-sponsored patient safety programs. The plan encourages optimizing patient outcomes and communication through the implementation of a patient safety program that will provide an evidence-based approach utilizing information, people, and resources to achieve the best clinical quality outcomes and the prevention of medical errors and patient harm. The DoD currently uses a comprehensive set of evidence based and field-tested tools and strategies called Team Strategies and Tools to enhance Performance and Patient Safety (TeamSTEPPS™) that are applicable to any health care setting.

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.

Member Eligibility Verification

All TRICARE eligible members listed in the DoD's 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 800-808-7647 or Johns Hopkins Health Plans's secure, online portal, HealthLINK.

SECTION III:
Care Management

Care Management

Care Management is intensive coordination and evaluation of care that is appropriate when a member's health care needs are of high acuity and/or the member is at risk of repeat admissions and emergency room (ER) visits. Care Management programs monitor, evaluate, and coordinate appropriate health care services for USFHP members, ensuring quality care in a cost effective manner.

Care management services are voluntary and are provided at no cost to the member. Our Care Management model promotes prevention skills, performs health risk identification, and encourages member adherence. We help our members to get the right care, in the right place, at the right time. We are here to support all members wherever they are on the health continuum.

Member Identification

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

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

Referrals for Care Management

To refer a patient for Care Management services, call 800-557-6916, Monday through Friday, 8 a.m. to 5 p.m. You can also email caremanagement@jhhp.org.

All referrals must include:

- Referral source name
- Referral source number
- Name of member
- Member's current phone number
- Date of birth
- ID number
- Diagnosis
- Patient needs

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

Service Areas

Behavioral Health

For members living with a mental health condition such as anxiety, depression, substance use disorders, or autism spectrum disorder, we provide Care Management services, which includes access to confidential care coordination support. Behavioral health Care Managers assist members through their treatment needs. Care managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists, and create plans to support self-management.

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

Complex Care

Complex Care Management provides evidence-based interventions for members with high-complexity and/or multiple chronic conditions. Care Managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists, and create plans to support self-management of chronic conditions to minimize exacerbations.

Health Education

Johns Hopkins Health Plans's Health Educators advocate, encourage and teach about healthy lifestyles and living well with a chronic condition. They provide health education classes and activities; develop and distribute health-related newsletters, fact sheets, and brochures; and collaborate with Care Managers in providing member education to reinforce members' treatment plans.

Maternal Child Health

Maternal Child Health Care Management provides support to high-risk prenatal and postpartum members, newborns and children. We offer health education, community resources, care coordination and promote access to quality health care services. We strive to contact and engage with members as soon as possible to address barriers that may be adversely affecting a members' health.

If a baby needs care in the NICU, our care managers work with the parents to ensure their understanding of their baby's care. We also assist the parents in their transition home. Care managers are available for onsite, high-risk clinic sessions to provide the critical resources and services needed. Care managers work closely with the provider and member to improve compliance, coordinate care, and maximize favorable outcomes.

Preventive Care

We provide care and resources for members with health risks to stabilize health and prevent development of significant care need. The Care Management team engages health care providers, closes gaps in care, and promotes self-management of health and wellness.

Transitional Care

Care Managers can provide members with assistance navigating the health care system following a health event such as an emergency room (ER) visit, hospitalization, new diagnosis or significant life event. Care managers work closely with members to address barriers and gaps in care, coordinate care with providers and specialists.

Other Services

Clinical Practice Guidelines

Clinical practice guidelines were developed for our providers, as well as our members, to assist with decisions about appropriate health care under special clinical circumstances.

The use of these guidelines allows for the measurement of their impact on outcomes and may reduce interprovider variation in diagnosis and treatment.

We have incorporated the latest scientific basis and expert opinion into these guidelines. The guidelines are updated or revised at a minimum of every two years. Please refer to our website for the most updated versions at: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines/clinical-practice-guidelines.

SECTION IV:
Quality Improvement

Clinical Quality Management Program

Introduction

The Quality Improvement (QI) department at Johns Hopkins Health Plans (Johns Hopkins Health Plans) is dedicated to ensuring our military beneficiaries and their families to receive the highest quality health care services. The USFHP QI program strategy supports the "patient-centered model of care with focus on prevention"[1] and leverages processes that can be measured, analyzed, improved and controlled to implement this approach.

Mission of the QI Program at Johns Hopkins Health Plans

Johns Hopkins Health Plans is guided by its mission to empower our members and communities on their journey to good health. The vision of Johns Hopkins Health Plans is to be a national leader in provider-sponsored health plans and solutions. The QI program aligns with the mission and vision of Johns Hopkins Health Plans and supports organizational strategic priorities.

QI Program Goals

The QI program goals focus on improving health care outcomes while ensuring USFHP meets the regulatory standards that measure these results. Given the comprehensive nature of the standards, Johns Hopkins Health Plans has defined four core QI objectives to which all of the QI programs and initiatives are aligned:

- Improve Beneficiary Experience
- Improve Safety of Clinical Care
- Improve Quality of Clinical Care
- Enhance Quality of Service

QI Program Objectives

The QI objectives are developed annually based on identified opportunities for prioritizing, improving, and implementing QI activities. Opportunities for improvement and subsequent initiatives are identified throughout various QI workgroups, data analysis, and organizational priorities. The QI department aligns objectives using continuous quality improvement, adhering to regulatory and accreditation bodies, such as the National Committee for Quality Assurance (NCQA). Additional objectives are developed throughout the year as needed and are based upon gap analysis of Healthcare Effectiveness Data and Information Set (HEDIS®), as well as evaluation of Consumer Assessment of Healthcare Providers and Systems (CAHPS®), beneficiary and provider complaints data, and other quality related data.

QI Program Description

The goal of the QI program is to monitor clinical care, service and experience provided to our beneficiaries while proactively identifying opportunities for prioritizing, improving and implementing QI activities. The primary activities of the QI program focus on preventive care and disease management including chronic conditions such as diabetes.

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[1]USFHP and TRICARE. Retrieved from https://www.usfhp.com/ TRICARE is a registered trademark of the Department of Defense (DoD).

The QI program generates various deliverables annually, including a program description, work plan, and program evaluation. The QI work plan includes detailed information including but not limited to a timeline, accountable stakeholders, and milestones for the planned activities among others. Planned activities focus on quality and safety of clinical care, quality of service, and beneficiary experience initiatives for the upcoming year, which are measurable and tracked regularly.

QI Program Evaluation

The annual program evaluation is a formal report summarizing the overall effectiveness of the QI program including activities, initiatives and studies carried out during the calendar year (CY). The program evaluation includes:

- Trending analyses of the measures/metrics and comparison to the established performance thresholds such as the NCQA Quality Compass benchmarks for Commercial plans.
- Trending analyses of HEDIS and CAHPS data to identify improvement and enhancement opportunities.
- Root cause and barrier analyses for areas, where warranted.
- Recommendations for future goals and activities to support QI objectives.

Continuous Quality Improvement (CQI)

CQI in health care is defined as "a structured organizational process for involving people in planning and executing a continuous flow of improvement to provide quality health care that meets or exceeds expectations"[2]. CQI serves critical role in addressing the individual as well as community health and wellness needs thus supporting overall population health improvement goals. The prioritization of QI initiatives within the QI program are guided by the beneficiary needs , which is collected through various modalities such as the MCAHPS and HOS surveys, Quality of Care (QoC) reviews, beneficiaries' complaints and appeals, as well as overall health outcomes measured by HEDIS performance. The QI program uses the CQI process and models to guide the development as well as evaluation of quality initiatives to improve beneficiary health, experience, and QoC.

Quality Improvement Initiatives

Quality initiatives are focused actions taken by the health plan, provider* or practitioner** with the goal of improving the quality of health care services, access to care, and beneficiary health outcomes. QI initiatives identification is driven by activities that include, but are not limited to, the following areas:

- NCQA Quality Compass for Commercial plans measures performance
- HEDIS measures performance
- Beneficiary satisfaction survey performance, such as the CAHPS survey
- Pharmacy measures performance

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[2]McCalman, J., Bailie, R., Bainbridge, R., McPhail-Bell, K., Percival, N., Askew, D., & Tsey, K. (2018). Continuous quality improvement and comprehensive primary health care: a systems framework to improve service quality and health outcomes. Frontiers in public health, 6, 76.

* 29CFR §825.125- Definition of health care provider

** According to 45 CFR 60.3[Title 45 -Public Welfare Subtitle a-Department of Health and Human Services Subchapter a-General Administration -Part 60 -National Practitioner-Data Bank for Adverse Information on Physicians and Other Health Care Practitioners-Subpart a- General Provisions], a health care practitioner means "an individual other than a physician or dentist, who is licensed or otherwise authorized by a State to provide health care services."

- QoC reviews
- Monitoring beneficiary appeals, complaint and grievance data
- Data analysis and reporting for clinical condition management programs and key HEDIS measures
- Utilization Management (UM) data
- Provider quality performance data
- National Quality Forum (NQF) Serious Reportable Events (SREs) data
- Hospital Acquired Conditions (HACs) data
- Hospital Compare data
- Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Data

Accreditation

Johns Hopkins Health Plans has achieved accreditation status with nationally recognized entities for health care quality. Accreditation in health care means the healthcare organization is meeting regulations and standards set by an external accreditation organization. Health care accreditation organizations such as the NCQA create a set of standards with the help of industry experts. NCQA is an independent non-profit organization that works to improve health care quality through the administration of measures, programs, accreditation and evidence-based standards. The standards cover everything from training materials, to data retention, to equipment maintenance. In order for a health care organization to achieve accreditation, they must prove compliance with the standards.

NCQA accreditation represents quality, consistency, and reliability of care for all beneficiaries as it is the most rigorous and comprehensive health insurance accreditation program. Annually, NCQA makes adjustments to its standards to respond to feedback from plans, policy makers, providers, patients and others. To prepare for accreditation, healthcare organizations must do a comprehensive assessment of processes, policies, and procedures, and anything else related to accreditation standards. This allows them to identify any areas where there are gaps in compliance. The QI department is currently working with various Johns Hopkins Health Plans departments to collect documents for the 2023 Renewal Survey.

Clinical Quality Management Program (CQMP)

As part of the contract oversight, USFHP is required to submit an annual written CQMP plan to the Department of Defense (DoD). This plan must include the structural and functional components of the program as noted in the contract data requirements list (CDRL) and in the alignment with the TRICARE operating manual (TOM). CQMP plan is defined as a detailed description of the purpose, methods, proposed goals and objectives designed to meet the intent of the program. Some of the keys elements in CQMP include outcomes reporting on HEDIS and CAHPS measures, outcomes reporting concerning Quality Improvement Initiatives (QIIs), Quality Improvement Projects (QIPs), and Clinical Quality Studies (CQSs).

USFHP is a participating partner in the Clinical Quality Performance, and makes recommendations to the USFHP Board of Directors on key quality indicators, clinical metrics, and measures of clinical outcomes. The committee reviews and assesses industry best practices concerning beneficiary experiences to develop a common approach to identify, implement and report on quality indicators and beneficiary safety metrics.

Healthy People 2030

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 includes a wide range of objectives developed by workgroups made up of subject matter experts in specific topics. Most Healthy People 2030 objectives are core, or measurable, objectives that are associated with targets for the decade. Core objectives reflect high-priority public health issues and are associated with evidence-based interventions. Core objectives have valid, reliable, nationally representative data, including baseline data from no earlier than 2015. If applicable, they have a measure of variability. Data will be provided for core objectives for at least three time periods throughout the decade. For more information about Leading Healthy Indicators (LHI) for Healthy People 2020, visit Healthy People 2030 | health.gov.

HEDIS and CAHPS

HEDIS is a set of more than 90 high-level measures with various sub measures that can provide information about the quality of a health plan. HEDIS measures evaluate performance across preventive and chronic condition management categories as well as readmissions and transition of care.

The Johns Hopkins Health Plans QI department coordinates all QI activities associated with the interventions, collection, validation, and submission of HEDIS data as well as other beneficiary experience data. Johns Hopkins Health Plans has contracted with the NCQA certified vendor to conduct an external HEDIS audit to ensure compliance with the data collection processes and validation of data prior to submission. Johns Hopkins Health Plans has Information Technology (IT) resources with strict security controls enabling confidential transmission of data via Interactive Data Submission System (IDSS) tool to NCQA.

The CAHPS program is a public/private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care in commercial and Medicaid plans. Surveys were developed with the Agency for Healthcare Research and Quality (AHRQ). CAHPS data address areas such as patient ease of obtaining information from a health plan; timeliness of service; and speed and accuracy of claim processing. CAHPS results offer an indication of how well health care organizations meet beneficiary expectations[3].

Beneficiary Safety Program

The beneficiary safety program outlines the QI program's plan for monitoring QoC, disparities of care, and analyzing outcomes of QI initiatives and studies related to beneficiary safety. The QI program also works in collaboration with JHM to promote quality clinical outcomes and prevent harm to beneficiaries. Beneficiary safety activities performed throughout the organization include, but are not limited to, the following:

- QoC reviews (clinical, behavioral, and pharmacy)
- Monitoring of beneficiary complaints/grievances
- Medical record chart audits identified through AHRQ Patient Safety Indicator (PSI) software
- Monitoring for quality and appropriateness of beneficiary care (Care Management)
- Referral of potential adverse events as identified through review of concurrent services for hospitalized beneficiaries (Utilization Management)
- Provider credentialing activities (Credentialing)
- Safety activities associated with regulatory compliance oversight

Role of Providers in the QI Program

Providers play a key role in developing, implementing and monitoring various QI and patient safety activities in collaboration with the health plan. Studies have demonstrated that the health plan-provider joint QI efforts yield better outcomes and improve beneficiary satisfaction when compared to independent QI activities developed by either a provider or a health plan.

This collaborative approach involves sharing provider performance data and participation in health plan led QI initiatives to meet Johns Hopkins Health Plans QI goals and objectives outlined above. Johns Hopkins Health Plans encourages providers to fully know their role in the health plan quality program, which includes the following:

- Review quality opportunity reports and take action to improve clinical outcomes as measured by HEDIS measures
- Collaborate with the health plan to resolve beneficiary complaints regarding access to care, QoC, provider service, or other quality/cost/access issues
- Provide medical records as requested for HEDIS, QoC investigations, or other medical record audits
- Collect and share quality relevant information such as performance data for the purposes of joint quality initiatives
- Participate in beneficiary satisfaction initiatives, including improving access to care

A number of providers are routinely invited to participate in health plan QI committees. The perspectives from participating providers are valuable in evaluating clinical efficacy and improving provider as well as beneficiary satisfaction. In addition, USFHP relies on participating providers to offer feedback on clinical practice guidelines, preventive health guidelines, and medical and pharmacy policy.

Looking Ahead

Delivering quality medical services to our beneficiaries is the hallmark of Johns Hopkins Health Plans, and we rely on our network providers to do this. Johns Hopkins Health Plans's Provider Relations department is dedicated to the partnerships we've established within our provider network and encourages network providers to continue to look for ways to improve outcomes for our beneficiaries. Some outcome improvements include: utilizing best practices, access to care and closing care gaps.

Johns Hopkins Health Plans have set certain expectations in place for our provider network and it is expected that our providers are meeting the expectations, including following policies and procedures. For providers that do excel in meeting expectations, Johns Hopkins Health Plans will re-evaluate performance rates, which may include rate increases. Johns Hopkins Health Plans strives for continued excellence in services provided by our network providers which in return benefits the provider network, Johns Hopkins Health Plans and more importantly, the beneficiaries.

SECTION V:
Utilization Management

Utilization Management

USFHP is committed to maintaining the health and wellness of all our members and through our Utilization Management (UM) department, ensuring that care is provided at the right time and in the right setting. The underlying utilization strategy is that the primary care physician (PCP) is the best individual to determine what care should be provided and to coordinate that care for members. The UM department evaluates requests for services for medical care, behavioral health, and substance abuse treatment based on appropriate benefit provisions, clinical criteria or guidelines, and local health care delivery options. The USFHP pharmacy formulary and pharmacy utilization management procedures are established by the Department of Defense (DoD) Pharmacy and Therapeutics Committee. USFHP members are subject to quantity limits, prior authorization, and step- therapy requirements established by the DoD. *(Refer to the Benefits section)*

Information Used to Make UM Decisions

The Medical Management department will review or may request information relevant to any UM decision for coverage used to determine medical necessity. UM staff gathers pertinent information, which may include any or all of the following:

- The procedure/treatment type, length of stay requested, procedure codes(s) and diagnosis code(s)
- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychological history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services and procedures
- Information from responsible family members
- Individual clinical circumstances and history

The type of service requested determines which medical documentation or criteria will be required. When sufficient information is not available to make a determination, every effort is made to obtain the necessary information within the specified time frame. If our Medical Management department cannot obtain relevant documentation, it must make or recommend a decision to the provider/ health plan based on the material available.

Clinical Review Criteria

USFHP utilizes the Tricare Policy Manual, Tricare Operations Manual, and Tricare Prior Authorization Clinical Criteria to determine benefit coverage and medical necessity. Clinical review criteria that are objective and evidence-based are also used to evaluate the medical necessity of pharmacy, medical, and behavioral health care services and include commercial criteria, InterQual®, as well as internally developed medical and pharmacy policies. The medical criteria used for utilization management decisions are available to providers upon request by calling the UM department.

Utilization management decision making is based only on appropriateness of care and service and existence of coverage. Johns Hopkins Health Plans staff may not participate in the review of any case, in which he/she has professional or personal involvement or where judgment may be compromised. There are no rewards to practitioners, providers, or care management staff to encourage barriers to care and service through the issuance of denials of coverage or requested services. There are no financial incentives for utilization management decision makers to encourage decisions that result in underutilization of services.

Medical Policy

Medical policies are internally developed criteria based on the most current research available at the time of policy development and state whether a medical technology, procedure, drug, or device is medically necessary or investigational. TRICARE Policy and Operations Manuals and specific contract benefits supersede medical policy. Please refer to our website for the most updated version of medical policies at: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/policies/medical-policies.

Accessing Utilization Management

Access to UM Staff is available at least eight hours a day during normal business hours, 8 a.m. to 5 p.m., Monday through Friday, for inbound communications regarding UM inquiries. After 5pm, information can be left on a voice mail box, 844-680-2885, and will be processed the next day. TTY/TDD services are available for anyone with hearing or speech difficulties. Language assistance, in the member's chosen language, is available as needed. On call inpatient utilization review nurses are available after-hours for urgent requests from hospitals, DME, or home health providers by paging 800-307-9730.

Utilization Management fax numbers:

410-424-2603 – Outpatient authorization/medical review

410-424-2603 – Durable medical equipment

410-424-2602 – Inpatient authorization

410-424-4839 – Behavioral health

Preservice, Concurrent, and Postservice Review

Prior authorization is required for inpatient and certain outpatient services and supplies and for specific medications. Requests for admissions and services requiring prior authorization require submission of member information and clinical documentation, which may include:

- Demographics
- Attending physician and facility
- Date of procedure
- Procedure or equipment requested
- Medication requested (see pharmacy prior authorization)
- Diagnosis
- Pertinent clinical data
- Description and duration of symptoms
- Results of diagnostic tests
- Consultation reports

Prior authorization is required for all out-of-network services. All elective inpatient admissions must be approved prior to the admission.

Inpatient Preservice and Concurrent Review

In the inpatient setting, prior authorization through prospective review is required for all acute hospital, sub- acute nursing facility, acute rehabilitation, inpatient hospice, inpatient substance abuse treatment, and mental health admissions. All proposed elective or urgent admissions will be reviewed to determine if the service could be provided in an ambulatory care setting.

Notification of an inpatient admission must be sent within 48 hours of the admission. Inpatient admissions that have not been preauthorized will be reviewed for medical necessity from the date of notification to USFHP through discharge.

Once notification of an admission is received, a utilization review nurse will request clinical information to conduct concurrent review using clinical criteria to evaluate for possible movement to a lower level of care without compromising the plan of care, and to anticipate discharge needs.

If a delay in service, treatment, procedure, or discharge is identified during the process of utilization review for an inpatient stay, and the delay will result in, or is anticipated to result in an overall extended length of stay, the hospital days resulting from the delay in service/treatment/procedure/discharge will be denied.

Outpatient Preservice Review

Outpatient services requiring prior authorization include: certain surgical procedures, imaging studies, and durable medical equipment; home health and hospice care; ambulance transfers; requests for Category III or unlisted CPT codes; and speech therapy. Physical and occupational therapy require authorization after the twelfth visit of each episode of care.

Providers can view prior authorization requirements through the Johns Hopkins Prior Authorization Lookup tool (JPAL), a resource that checks and verifies prior authorization requirements for services and procedures. Located in the HealthLINK portal, JPAL offers a user-friendly way for providers to look up prior authorization requirements.

Providers can simply click on the JPAL link in HealthLINK to access this tool.

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

NOTE: JPAL is a way to **look up prior authorization requirements only;** it does not handle prior authorization requests. Please follow Johns Hopkins Health Plans' policies and procedures as usual to request an authorization:

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

Postservice Review

Retrospective review may be conducted when benefit provisions permit and for utilization review of an inpatient admission when the member's medical condition prevented the hospital from determining the patient's insurance status, or when the identity of a member could not be determined. Postservice review is also conducted of inpatients stays if a member is discharged on a weekend or holiday.

Authorizations and Denials

Requests for prior authorization determinations are made in a timely manner to accommodate the urgency of the members' clinical situation, thereby minimizing disruption and/or delay to the provision of health care services.

TRICARE requires authorization notification within two working days but not to exceed five working days following receipt of the request and all required information. Notification of concurrent inpatient requests are made within 24 hours or up to 72 hours if additional information is required to make the determination.

During the process of utilization review for inpatient and outpatient services, including behavioral health services, if TRICARE benefit criteria are not met an administrative denial will be issued. When medically necessary/clinical criteria are not met, the case is reviewed by a Johns Hopkins Health Plans medical director to determine if coverage will be approved. If denied, providers are notified and given the opportunity for a peer-to-peer conversation to discuss the decision with the Johns Hopkins Health Plans medical director. Written notification of the denial will be sent to the primary care provider, specialist, and member explaining the reason for the denial, information on the appeal process, and information on how to request a copy of the criteria or benefit provision used to make the decision.

Site-of-Service Requirements

The Johns Hopkins Health Plans Medical Policy Advisory Committee (MPAC) periodically updates the Johns Hopkins HealthCare LLC Site of Service Policies for USFHP. Site of service requirements may apply to sleep studies and prenatal obstetrical ultrasounds performed in outpatient hospitals. Site-of-service requirements for outpatient surgical or diagnostic procedures are defined in the Johns Hopkins Health Plans medical policy CMS23 .05 Site of Service – Outpatient Surgical Procedures.

This policy specifies that members should receive certain outpatient diagnostic or surgical procedures in an ambulatory surgery center (ASC) when clinically appropriate. A surgical procedure performed in a hospital setting will require prior authorization and must meet medical necessity criteria for the hospital setting. The outpatient hospital setting, classified by Place of Service 22, is also known as "regulated space" within the state of Maryland.

NOTE: The site of service requirements noted in the medical policy CMS23 .05 Site of Service – Outpatient Surgical Procedures do not apply outside of the state of Maryland. Some procedures may also require medical necessity review using clinical review criteria specific to the procedure in ANY site of service (outpatient hospital setting, ambulatory surgery center or office).

Periodic updates to CMS23 .05 Site of Service – Outpatient Surgical Procedures policy, as well as a detailed listing of affected CPT codes are posted to the Provider Communication Repository located here https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines/provider-communications.

Johns Hopkins Health Plans Medical Policy page is located at: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/policies/medical-policies

Referrals

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

Referrals to Specialists

For covered specialty office visits referred by a participating provider, no referral or authorization is required unless there is an exception listed in JPAL, which is our prior authorization lookup tool located in HealthLINK.

When a PCP refers a USFHP 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.

All procedures performed in ambulatory surgery centers (place of service 24), and outpatient hospital settings (place of service 22) must include the name and NPI number of the referring provider. If these procedures/services require prior authorization, clinical notes are also required to be submitted.

Behavioral Health Referrals

Prior authorization or primary care manager (PCM) referral is not required for outpatient, office-based mental health and substance use disorder visits; however, Partial Hospital (PHP) and Intensive Outpatient Program (IOP) services require a referral from the PCM. USFHP beneficiaries and providers can access the Johns Hopkins Health Plans Utilization Management Behavioral Health Department by calling 410.424.4476 and choosing option #3. Johns Hopkins Health Plans Behavioral Health Department also provides assistance in locating behavioral health appointments. To request assistance in locating available providers and appointments, beneficiaries and providers can call the Locator Line at 410-424-4528.

Referrals to Out-of-Network Providers

All referrals to out-of-network providers must be preauthorized through UM and are limited to services that cannot be provided in the network. Clinical notes must be submitted for all out-of-network requests. USFHP is a managed care plan; to minimize the member's out-of-pocket expenses, it is recommended to provide referrals when needed to in-network participating providers, unless the service cannot be provided within the network.

Out-of-Network Services

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 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 Johns Hopkins Health Plans and the PCP.

Communication with Covered Person

Johns Hopkins Health Plans welcomes all opportunities for the provider community to speak freely with their members or other designated parties connected to this organization. Participating practitioners are encouraged to discuss treatment options with members, regardless of benefit coverage limitations. You should explain the pros and cons of each treatment option so the member can make an informed decision.

Peer-to-Peer Conversation

After a provider receives written notification of a denial, the provider has the right to discuss determinations with the medical director, according to the Johns Hopkins Health Plans policy entitled: UM 48 Clinical Review Process-Secondary Medical Review. For inpatient/concurrent review cases, the peer-to-peer conversation must be requested within two (2) business days of notification of denial, and the peer-to-peer conversation must take place within four (4) business days of notification of denial. For outpatient cases/pre-service requests, the peer-to-peer conversation must be requested within three (3) business days of notification of denial, and the peer-to-peer conversation must take place within five (5) business days of notification of denial.

Authorization Notification

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

Third Party Liability

It is the policy of Johns Hopkins Health Plans to do the following:

- **USFHP 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.
- **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 Defense Health Agency (DHA). 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 prior authorization accordingly, the plan issues the referral or prior authorization and documents the payor dispute in its records.
- **Lack of Payment by Other Health Insurer.** 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 and no member may be balanced billed.
- **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.

- **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.
- **Marketing and Enrollment Limitations**. USFHP does not intentionally market to and enroll Military Health System (MHS) members who have other health insurance (OHI) 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 USFHP after providing proof that they have elected to suspend their FEHBP coverage in accordance with 5 CFR Part 890. MHS members also may join USFHP without suspending their coverage; however, USFHP has a limit to the number of members allowed in the plan who have OHI.
- **Timely Filing.** The timely filing limit for COB claims is 90 days from the date the primary insurance adjudicated the original claim. However, certain providers in the USFHP network may have different filing timelines for claims submission.
- **Court Order.** The Johns Hopkins US Family Health Plan is primary except in circumstances listed above. The plan will dispute any court orders stating otherwise and pay as secondary.

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.

SECTION V:I
Benefits

Summary of Health Care Benefits

USFHP provides a comprehensive range of preventive, diagnostic and treatment services as defined by the DoD in accordance with 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 the 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.

For a summary of the costs and benefits under the USFHP, please visit the website at: https://www.hopkinsusfhp.org/members/my-benefits/.

Pharmacy and Medications

Formulary and Copayments

USFHP utilizes the TRICARE pharmacy formulary. The TRICARE pharmacy formulary is a list of generic and brand prescription drugs that are covered under the TRICARE benefit. USFHP members are responsible for a portion of the cost (copayment) of their medications.

The TRICARE formulary is a tiered, open formulary and includes generic formulary drugs (Tier 1), brand name formulary drugs (Tier 2), and non-formulary drugs (Tier 3). Additional information about the DoD Pharmacy and Therapeutics review and list of formulary drugs as well as related drug tier/copay can be found here: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/pharmacy.

USFHP members are responsible for a portion of the cost of their medications, or copay. Copays and fees are subject to change on January 1 of each year. The TRICARE formulary contains three cost levels for USFHP members. The current cost shares are as follows:

- **Tier 1 (Generic Formulary Drugs):**
  $16.00 for up to a 30-day supply
- **Tier 2 (Brand Name Formulary Drugs):**
  $43.00 for up to a 30-day supply
- **Tier 3 (Non-Formulary Drugs):**
  $76.00 for up to a 30-day supply

For home delivery and pharmacy network retail up to a 90-day supply (maintenance medications only), the copays are as follows:

- $13.00 for Generic Formulary Drugs
- $38.00 for Brand Name Formulary Drugs
- $76.00 for Non-Formulary Drugs

Note: Certain medications may be excluded/not covered per TRICARE pharmacy program.

Providers can view the cost share for a medication using the TRICARE formulary search tool. Providers can also search for lower cost alternative medications to a medication they are currently prescribing.

The USFHP plan allows retail prescription processing at Walgreens pharmacies across the United States. Prescriptions may be filled for up to a 90-day supply. For members who prefer to use a mail order program, Walgreens pharmacy provides this service. The contact information, directions, and request form for mail order prescription fills can be found on the plan's website at https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/pharmacy.

Covered Medications *(not all inclusive)*

This option allows USFHP members to fill prescriptions at any Walgreens pharmacy, without having to submit a claim. You may fill prescriptions for up to a 90-day supply at any network pharmacy. The USFHP pharmacy program provides outpatient coverage to beneficiaries for medications that are approved for marketing by the U.S. Food and Drug Administration (FDA) and that generally require prescriptions. Other covered medications include:

- Compounded medications of which at least one ingredient is a legend drug
- Insulin
- Insulin syringes and needles
- Glucose test strips
- Lancets
- Freestyle Lite & Precision Xtra strips are TRICARE preferred test strips, all other test strips will require prior authorization."

Non-Covered Medications *(not all inclusive)*

Prescription medications used to treat conditions that are not currently covered by USFHP either by statute or regulation are likewise excluded from the pharmacy benefit.

Excluded medications include:

- Drugs prescribed for cosmetic purposes
- Fluoride preparations
- Multivitamins (prenatal vitamins with a prescription are covered)
- Food supplements
- Homeopathic and herbal preparations
- Over-the-counter products (except insulin and diabetic supplies, and smoking cessation products covered under the smoking cessation benefit)
- Certain prescription medications removed from the TRICARE pharmacy benefit program.

Certain prescription medications are not covered through TRICARE pharmacy benefit program. Please visit the USFHP website for a list of non-covered medications and alternatives: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/pharmacy.

Prior Authorization and Medical Necessity

Some medications require prior authorization before they can be dispensed. For a list of prior authorization drugs, please visit the TRICARE formulary search tool.

Prior Authorization Determination Time Frames

For formulary drugs requiring prior authorization, a decision is faxed to the requesting provider within five (5) business days of request. Detail regarding approval or denial and next steps (how to speak with reviewer or how to appeal) are included in the letter that is faxed to the provider.

To initiate a prior authorization: providers must complete and fax the Prior Authorization form along with supporting clinical documentation to the Johns Hopkins Health Plans pharmacy department at 410-424-4037. Download a copy of the Medical Review Drug Code Prior Authorization form here: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/pharmacy.

During the pharmacy prior authorization review process, if TRICARE benefit criteria are not met, an administrative denial will be issued. When medically necessary/clinical criteria are not met, the case is reviewed by a Johns Hopkins Health Plans pharmacist or medical director to determine if coverage will be approved. Written notification of the denial will be sent to the requesting provider and member explaining the reason for the denial, information on the appeal process, and information on how to request a copy of the criteria or benefit provision used to make the decision. Decision and notification time-frames for all non-urgent preservice requests will not exceed five business days.

Quantity Limits

The DoD Pharmacy and Therapeutics Committee has established quantity limits for certain medications.

If a USFHP member's medical condition warrants use of quantities greater than listed quantity limit for their medication, providers may submit a prior authorization request for use of the higher quantity. Providers must provide medical justification for use of the higher quantity. Quantity limits are detailed on the TRICARE formulary search tool.

Step Therapy

Step therapy involves prescribing a safe, clinically effective, and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.

Drugs subject to step therapy will be approved for first-time users only after they have tried one of the preferred agents on the DoD uniform formulary.

Note: If a prescription was filled within 180 days prior to implementation of step-therapy, the member will not be affected by step therapy requirements and will not be required to switch medications.

Generic Drugs Policy

DoD's policy on generic drugs requires the pharmacy to substitute generic medications for brand-name medications when a generic equivalent is available. Brand-name drugs with a generic equivalent may be dispensed only if providers submit a medical necessity request and approval is granted by USFHP. In those cases USFHP members will pay the brand-name copayment. Use the applicable form on the USFHP provider website.

Generic drugs are chemically identical to their branded counterparts. They are made with the same active ingredients and produce the same effects as their brand name equivalents. The FDA requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Also, the FDA requires that all drugs, including generic drugs, be safe and effective.

Specialty Medications

Specialty medications are usually high-cost, self-administered injectable, oral, or infused drugs that treat serious chronic conditions. These drugs typically require special storage and handling, and may not be readily available at a local pharmacy. Specialty medications may also have side effects that require pharmacist and/or provider monitoring.

Specialty Medications – Pharmacy Benefit: Are self-administered and processed through the member's pharmacy benefit. These medications are available at a network retail or specialty pharmacy and may require prior authorization. You may search for the specialty medications covered under pharmacy benefit on the Tricare Formulary. Use the Prior Authorization form to request prior authorization for self-administered specialty medications.

Some medications may not be available to you at Walgreens pharmacy because the medication's manufacturer limits the medication to specific pharmacies through limited distribution practices. When a provider submits a request for use of a limited distribution drug, upon authorization approval, the Johns Hopkins Health Plans USFHP Pharmacy Review department will forward the request to a contracted specialty pharmacy.

The specialty pharmacy will coordinate delivery of the medication to the patient's home or physician's office.

Specialty Medications – Medical Benefit: Are administered by a provider or under supervision of a provider and processed through the member's medical benefit. Providers may supply these medications and bill the health plan for the medication and related administration using HCPCS Codes or J codes.

To find the HCPCS Codes that require medical necessity prior authorization and site-of-service prior authorization, visit https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/pharmacy#specialty

The time frame for pre-service review of provider administered injectable requests is available in Section V/UM under Authorizations & Denials

Mental Health and Substance Abuse

What Is Covered

The plan provides medically and psychologically 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, family, and group therapy)
- Hospitalization (including inpatient professional services) subject to medical review
- Appointment locator

Please refer new or existing members to the Emergency Department (ER) within six hours of notification of a non-life threatening behavioral health situation.

USFHP members may self-refer to a participating mental health provider office-based mental health and substance use disorder treatment. Non-office based mental health and substance use disorder treatment (e.g. intensive outpatient or partial hospitalization) require a PCM referral. All inpatient admissions require a prior authorization. Members also have access to an appointment locator service. By calling 888-309-4573, members can speak to and work with staff that can help them find urgent and routine appointments with mental health and substance abuse professionals.

Treatment for chemical and alcohol dependency at approved inpatient or outpatient treatment facilities is covered when prior authorized by the plan.

Autism Care Demonstration Program

Tricare has updated the Autism Care Demonstration (ACD) program effective March 23, 2021, TRICARE Operations Manual 6010.59-M, April 1, 2015 Chapter 18, Section 4 Department of Defense (DoD) Comprehensive Autism Care Demonstration.

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

Referrals

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

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

Beginning August 1, 2021, the TRICARE Autism Care Demonstration requires outcome measures with initial ABA treatment request and each subsequent reauthorization. TRICARE requires the submittal of outcome scores and relevant data, signature of respondents with identification of relationship to beneficiary, be submitted on the following outcome measures:

Pervasive Developmental Disorder Behavior Inventory (PDDBI, 1.5 years to 18.5 years)

- Due with initial authorization for treatment and with each reauthorization. Parental Stress Index, Fourth Edition, Short Form (PSI-4), (0-12 years) or Parental Stress Index of Adolescents (SIPA, 11 yrs – 19 yrs + 11 mos)
- Due with Initial ABA treatment authorization requests and with each reauthorization. Vineland Adaptive Behavior Scales, 3rd Edition (Vineland II, 0-99 yrs)
- Due with Initial Authorization ABA treatment request, due annually thereafter. Social Responsiveness Scale, 2nd edition (SRS 2, 2.5 yrs -99 yrs)
- Due with initial Authorization ABA treatment request, due annually thereafter.

All beneficiaries must have all outcome measures completed before requesting the initial authorization for treatment. Results must include the full report with scores.

UpLift

USFHP members now have access to behavioral health providers in the UpLift network. UpLift is a virtual behavioral health practice that expands access to providers.

UpLift also allows members to schedule an appointment with a psychiatrist or therapist as soon as the next day, and no further out than two weeks.

UpLift supplements the existing network of quality behavioral health care providers available to members, adding more therapists and psychiatrists. The UpLift platform also makes finding the right care simple by matching a therapist or psychiatrist according to personalized needs and provider specialties, allowing members to filter searches for different results.

While UpLift is primarily virtual, some providers offer in-person appointment options. Member cost shares for UpLift providers are the same as all in-network behavioral health care services.

Members can self-refer or primary care providers can now refer members to UpLift to locate a provider in the UpLift network, in addition to referrals to other network providers. Refer members to joinUpLift.co to learn more and to find a provider.

Behavioral Health Audit

Beginning in 2024, USFHP is conducting an annual statistically valid sample size audit of Behavioral Health (BH) network providers documentation for the following standardized measures:

- Post-Traumatic Stress Disorder (PTSD)
- Anxiety disorders
- Depressive disorders

The audit is across all BH settings (outpatient mental health (MH) and SUD, Opioid Treatment Programs (OTPs), Intensive Outpatient Programs (IOPs), partial hospitalization, psychiatric RTCs, and inpatient/residential Substance Use Disorder Rehabilitation Facilities (SUDRFs)) and when age appropriate. USFHP will report audit results of the Standardized Behavioral Health Measures that complies with the requirements in the TOM Chapter 7, Section 6, Para 8. (CDRL A090)

USFHP is also creating educational materials for behavioral and mental health providers to promote the use of required standardized measure assessments. The materials will be posted on our website: HopkinsHealthPlans.org.

USFHP will use claims data to identify all providers submitting anxiety, depressive disorder, and/or post-traumatic stress syndrome diagnoses, either as primary or secondary.

Direct outreach will be made to diagnosing providers to ensure they are performing the appropriate assessments in accordance with timelines outlined in this requirement. Outreach may be conducted telephonically, electronically, or in-person, depending on volume of claims and members captured in claims review.

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:

- Sexual functioning disorders
- Support services and/or groups not conducted by a licensed professional
- Learning disabilities, including psychological testing for academic and intelligence testing

Other Covered Benefits

Ambulance Service

Benefits are provided for medically necessary, life-sustaining ambulance transport when the use of any other method of transportation is inadvisable. Please refer to the benefits chart for copay information.

Diabetes Programs

USFHP offers programs that meet members where their needs are, whether they are learning how to live with a recent diabetes diagnosis, or are trying to prevent the onset of diabetes.

Diagnostic Services

If authorized by the primary care provider or specialist, the following are covered without an additional copayment when performed by an in-network provider:

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

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) may be covered if deemed medically necessary. DME must be authorized by the PCP, and purchased or rented from a plan provider. Copayments are applied for retirees and their family members who do not carry Medicare Part B. Active duty family members and retirees with current Medicare Part B do not have to pay the copayment for covered durable medical equipment.

Extended Care Health Option (ECHO)

Extended Care Health Options (ECHO) provides financial assistance only for active-duty family members with specific qualifying mental or physical conditions. Some conditions include: (please note this list is not all-inclusive)

- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability
- Extraordinary physical or psychological condition causing the beneficiary to be homebound
- Moderate or severe mental retardation
- Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems)
- Serious physical disability

ECHO Benefits

ECHO benefits, services and supplies are not available through the basic USFHP program. ECHO coverage provides benefits such as:

- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Medical and rehabilitative services
- In-home respite care services (can only be used in a month when at least one other ECHO benefit is being received):
- ECHO respite care—up to 16 hours per month
- EHHC respite care—up to eight hours per day, five days per week for those who qualify
  Note: The EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a skilled nursing facility
- Training to use assistive technology devices
- Institutional care when a residential environment is required
- Special education (which can include applied behavioral analysis)
- Transportation under certain limited circumstances (includes the cost of a medical attendant when needed to safely transport the beneficiary)

ECHO Eligibility Process

For general questions, potential ECHO enrollees or family members may call the USFHP customer service telephone number at 410-424-4528 or 800-808-7347. USFHP also has a dedicated ECHO team. A member of the ECHO team will assist members by answering more detailed questions regarding the eligibility and enrollment process. To enroll in the ECHO program, members must be currently enrolled in USFHP, enrolled in the Exceptional Family Member Program (EFMP) of their branch of service and provide medical documentation that a qualifying condition exists. USFHP will grant provisional ECHO enrollment (for 90 days) while the sponsor completes the EFMP forms. Upon receipt of the application and documentation, members will receive a decision letter with their eligibility status.

ECHO Costs

Active-duty sponsors pay a cost-share that is based on their pay grade and is separate from other USFHP program cost-shares. The monthly cost-share is one fee per sponsor, not per ECHO beneficiary.

Sponsor's Pay Grade	Monthly Cost-Share	Sponsor's Pay Grade	Monthly Cost-Share
E-1 to E-5	$25	WO-5, O-5	$65
E-6	$30	O-6	$75
E-7, O-1	$35	O-7	$100
E-8, O-2	$40	O-8	$150
E-9, W-1, W-2, O-3	$45	O-9	$200
W-3, W-4, O-4	$50	O-10	$250

The maximum government cost-share is $36,000 per beneficiary, per calendar year. Sponsors are responsible for the cost of ECHO benefits that exceed this limit.

Note: The ECHO Home Health Care (EHHC) benefit is not subject to the $36,000 per CY maximum government cost-share. The sponsor's cost-share does not count toward the annual catastrophic cap. ECHO costs cannot be shared between family members.

For more information about ECHO, you can also visit www.tricare.mil (see benefit information) or go to https://usfhp.healthtrioconnect.com/public-app/consumer/provdir/entry.page.

Telemedicine

Telemedicine services are covered by TRICARE/USFHP. The originating site can be the member's home, and the provider can be at a health care office or facility, including an Urgent Care Center. TRICARE policy does not exclude the provider's home as distant site--unless state law prohibits the service from home via telehealth it would be covered.

Telemedicine services include office visits, preventative health screenings, telemental health services (individual psychotherapy, psychiatric diagnostic interviews and exams and medication management) and services for End Stage Renal Disease.

Continuing PT/OT can be covered when performed via telehealth. This benefit is only for continuing therapy, not initial therapy. Speech Therapy via telemedicine can be covered for initial evaluations and continuing therapy.

Please see TRICARE Policy for details on Telemedicine as well as billing guidelines. Providers can also refer to the USFHP-Johns Hopkins Health Plans Telemedicine Policy.

The same authorization requirements and copays apply for telemedicine services and face-to-face visits. Special authorization is not required because a service being delivered via telemedicine.

Emergency and Urgent Care Services

Non-Emergency Urgent Care in the Plan Area

For non-emergency medical conditions requiring prompt attention, members need to contact their PCP before seeking care. If they call after office hours, the PCP after-hours line should provide information and guidance on where they should seek care.

Non-Emergency Urgent Care Outside the Plan Area

If a member becomes ill or injured and requires urgent, but not emergency, care while traveling, the member is required to call their PCP office during regular hours or by using the after-hours service. For advice, plan members may contact the 24-hour nurse line at the number on the back of the member ID card. They must be referred by the PCP prior to seeking care to ensure that their care will be covered by the plan.

To locate an in-network urgent care center, use the Search for a Provider tool:
usfhp.healthtrioconnect.com/public-app/consumer/provdir/entry.page

Choose "Hospital or Facility," then under Specialty, choose "Urgent Care Center."

Urgent Care: Johns Hopkins On Demand

The Johns Hopkins OnDemand Virtual Care service is as an online telemedicine platform for both adult and pediatric patients. JH OnDemand Virtual Care is available to members through mobile app, computer or tablet at https://ondemand.hopkinsmedicine.org.

Providers can diagnose and prescribe medications for common care concerns such as colds and flu, ear infections, sinus and respiratory problems, and more.

The service is not for emergency medical matters. If a patient is experiencing a medical emergency, they should call 911 or go to the nearest emergency room.

No Appointment Needed

Weekdays: 6:00 p.m. to 8:00 a.m.
Weekends: 24 hours

OnDemand Virtual Care Process

The health care provider will join via secure video or telephonically and assess the member's symptoms, make a diagnosis, recommend next steps and answer any questions the member may have.

If medications are necessary, the provider will electronically send prescriptions to the member's Walgreen's pharmacy of choice. Telemedicine providers will refer members back to their Primary Care Physician (PCP) for follow up care.

During normal office hours, USFHP members should connect with their primary care provider. If a member sees a Johns Hopkins Community Physicians provider, they will have access to video visits during normal business hours through Johns Hopkins Medicine.

Emergency Services out of the Country or at Sea

If a member becomes ill or injured while in another country or at sea and requires urgent care, they can go to the nearest emergency room or medical facility to receive the necessary treatment. The hospital or facility may demand immediate payment; if they do, the member needs to ask for treatment information, bills, and receipts. Within seven (7) days of their return, the member will need to submit itemized bills and receipts to the Customer Service department along with an explanation of the services and the identification information from their USFHP identification card.

Hospice Care

Palliative care to manage symptoms at the end of life for terminally ill members is covered. Eligibility determinations are made using established medical criteria. Members should be referred to approved hospice care providers; prior-authorization is required.

National Cancer Institute Clinical Trials

USFHP members have access to National Cancer Institute sponsored clinical trials; prior authorization is required.

Point of Service Benefit

USFHP members have a Point of Service option (POS) should they seek care with an out-of-network provider. Out-of-network care requires prior authorization and must be considered medically necessary. POS benefits are only paid after the individual or family deductible is met. Out-of-network claims are considered for payment at the lesser of either 50 percent of the allowed amount or 50 percent of billed charges. Use of the USFHP's extensive participating provider network is recommended.

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
- 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

Note: This list is not all-inclusive and additional limitations may exist.

SECTION VII:
Claims and Appeals

Claims Submission and Processing

Network providers are required to bill for all services and submit fee-for-service claims on a CMS 1500 form or UB 04 within 180 days of the date of service. Appeals for denied claims or requests for reconsideration for repayment must be submitted within 90 calendar days of the date of the denial.

- Code all services with CPT (Current Procedural Terminology) codes; code all diagnoses with the appropriate ICD-10 codes or DSM-5 codes for psychiatric disorders to the highest level of specificity for the current year
- Routine clean claims are processed within 30 days

Submit the completed claim to:

Johns Hopkins Health Plans
EDI Payor ID #52123.
P.O. Box 830479
Birmingham, AL 35283
Attn: USFHP Claims

Payment Integrity

About the Johns Hopkins Health Plans Payment Integrity Department

Claims must be billed and paid in accordance with laws, regulatory requirements, CMS billing guidelines, provider contracts, and Johns Hopkins Health Plans reimbursement policies. The Johns Hopkins Health Plans Payment Integrity department works to identify, recover and prevent inaccurate, erroneous and/or fraudulent claims payments through numerous activities during the life cycle of a claim. For example, Johns Hopkins Health Plans Payment Integrity engages in subrogation activities, coordination of benefits, activities to detect and identify erroneous payments, improper payments, duplicate payments and/or overpayments, hospital billing audits, data mining in an effort to confirm compliance with enrollment requirements, payment policies, coding/billing rules and/or provider contracts and activities to detect fraud, waste and abuse.

Access HealthLINK for Claims Adjudication Details

Johns Hopkins Health Plans offers details on claims adjudication, including reasons for adjustments, on HealthLINK – our secure, online web portal for Johns Hopkins Health Plans members and their in-network providers. Providers can conveniently access information including status of submitted claims, reasons for adjustments on previously paid claims, and additional details related to claims disposition. This information is also available on the Explanation of Payment supplied to providers.

Recoupment, Offset, and/or Adjustments of Erroneous Payments

The Parties shall comply with applicable laws, regulations, and Payor Program requirements related to the recoupment, offset, refund and/or adjustment of erroneous payments, which includes, but is not limited to, erroneous payments, improper payments, duplicate payments, overpayments due to coordination of benefit, suspected provider fraud, improper coding/billing, eligibility issues and other incorrect payments (collectively "Erroneous Payments"). The timeframes for the recoupment, offset, refund and/or adjustment for any Erroneous Payments are set forth in the chart on the next page:

Reason for Retraction	Duplicate Claims	Coordination of Benefits	Suspected Provider Fraud	Payment Error	Improper Coding/Billing	Eligibility
USFHP	36 months from Date of Payment, or unlimited in cases of suspected fraud.	18 months from Date of Service.	Unlimited.	36 months from Date of Payment.	36 months from Date of Payment, or unlimited in cases of suspected fraud.	Unlimited.

If Provider identifies an Erroneous Payment on its own, then Provider shall voluntarily refund such Erroneous Payments to Johns Hopkins Health Plans within thirty (30) days of Provider's discovery of an Erroneous Payment regardless of the cause of such Erroneous Payment, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful.

If Johns Hopkins Health Plans Payment Integrity identifies an Erroneous Payment, then Johns Hopkins Health Plans Payment Integrity will provide written notice of such Erroneous Payment to Provider. Provider shall refund the Erroneous Payment to Johns Hopkins Health Plans Payment Integrity within thirty (30 days) following the date of Johns Hopkins Health Plans Payment Integrity's written notice to Provider.

If refund of the Erroneous Payment is not received by Johns Hopkins Health Plans Payment Integrity from Provider within the thirty (30) days following the date of Johns Hopkins Health Plans Payment Integrity's notice, then Johns Hopkins Health Plans Payment Integrity shall be entitled to recoup, offset and/or adjust to collect such Erroneous Payment against any claims payments due and payable to Provider under the applicable Payor Program in accordance with applicable laws, regulations and Payor requirements. In such event, Provider agrees that all future claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes.

Should Provider disagree with any determination that Provider has received an Erroneous Payment, Provider shall have the right to dispute such determination under the procedures in the Provider Claims/Payment Dispute Process section of the Provider Manual. Johns Hopkins Health Plans Payment Integrity reserves the right to recoup the Erroneous Payment amount during the dispute process unless prohibited by applicable laws, regulations and/or Payor requirements. Johns Hopkins Health Plans Payment Integrity reserves the right to employ a third party collection agency in the event of non-payment by Provider of an Erroneous Payment.

Provider Claims/Payment Dispute Process

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

- Rejected untimely filing of claim
- Coordination of benefits (EOB of primary carrier required)
- Itemized bill requested

- Invoice attached/MUE denial
- Overpaid/underpaid per contract
- Fee schedule
- Contract rate
- Not duplicate claim
- Authorization on file (authorization number required)
- Referral attached

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

Providers should submit a claim to the primary insurance carrier for each date of service, then submit a claim to USFHP with the primary insurance remittance for the same date of service. The primary insurance remittance must include the denial reason and denial explanation. The claim must be submitted with the primary insurance remittance within 90 calendar days of the primary remittance date.

No action is required by the member. **Payment disputes do not include medical appeals.** Providers will not be penalized for filing a payment dispute. All information will be confidential in accordance with USFHP's policies and/or applicable law or regulation. The Adjustments department will receive, distribute and coordinate all payment disputes. To submit a payment dispute, complete the *Provider Claims/Payment Dispute and Correspondence Submission Form* located online at https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/forms and mail to:

Johns Hopkins Health Plans
Adjustments Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Or fax to 410-424-2800

A web version of the Provider Payment Claims/Payment Dispute can also be found in HealthLINK under the "Administration" tab.

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

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

Timely Filing

Paper and electronic claims, as well as corrected claims, must be filed within 180 calendar days. Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Timely filing requirements are defined in the provider agreement. USFHP will deny claims submitted after the filing deadline. Corrected claims may be submitted electronically, please follow CMS guidelines.

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

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

Other Health Insurance

Under the law, TRICARE benefits are payable only for charges remaining unpaid after all other health coverage, except Medicaid and other programs identified by Defense Health Agency (DHA), have paid benefits. DHA 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
- 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 Johns Hopkins Health Plans fee maximum, whichever is less. Johns Hopkins Health Plans 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, Johns Hopkins Health Plans 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 Johns Hopkins Health Plans 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.

Medicare Leakage

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

Members having coverage under both Medicare and USFHP may only use Medicare benefits for ***non-covered*** USFHP services (End Stage Renal Disease (ESRD) is a covered service, but is considered secondary after Medicare). Providers billing Medicare for services covered by USFHP are subject to termination from the USFHP network. Federal regulations preclude the federal government from paying twice for services.

Appeals

Appeals should be sent to:

Johns Hopkins Health Plans
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: USFHP Appeals
Fax: 410-762-5304

Appeals of 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 calendar days after date of denial. The provider must submit a separate appeal form for each member or claim that is being appealed. Each submission should reflect one member and one inpatient stay or date of service. Each pharmacy and pre-service appeal should address one medication or service.
- Johns Hopkins Health Plans will send written notice of its reconsideration determination within 30 calendar days of receipt of the appeal.

Appeals of Medical Necessity Determinations

If UM denies a service or treatment to a network provider, they have two (2) levels of appeal. To avoid conflict of interest situations, Johns Hopkins Health Plans 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. 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 eligibility
- Network provider/contract disputes
- Provider not authorized
- Ineligible member
- Factual determination (not a covered service or benefit; see benefit plan)

Provider Notification of Appeals

An appeal must be filed within 90 calendar days after notification of a denial. The network provider must file in a timely manner or lose all rights to appeal. The provider will be notified of the determination in writing within three days of receipt of the appeal for expedited requests, and within 30 calendar days for non- expedited appeals. A second or final level of appeal may be filed if the first level appeal results in an adverse determination. These must be filed within 90 calendar days after the participating provider is notified of the first level appeal determination.

Provider Appeal Request Form Process

Clinical Medical Necessity Appeals

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

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

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

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

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

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

Please fill out the *Provider Appeal Request Form-Clinical/Medical Necessity/Administrative Appeals Only* form, which is located online at https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/forms

Provider Complaint Process

USFHP appreciates provider feedback. If you are dissatisfied with personnel, services, or quality of care, please call your Provider Relations representative. You may also call customer service to report a complaint at 410-424-4528 or 800-808-7347 or email usfhpcustomerservice@jhhp.org. We will make every effort to resolve the complaint to your satisfaction during your initial call. If your complaint is not resolved to your satisfaction, please file a written complaint. Your written complaint will then be forwarded to the Provider Relations department for additional investigation.

Written Complaint Procedure

If you wish to file a written complaint, please send it to:

Johns Hopkins Health Plans
Attn: Provider Relations Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Please include a detailed description in your letter, including dates and names of individuals involved.

Resolution Process

If you have any questions or concerns during the process, please feel free to discuss with your Provider Relations representative.

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

Member Assignment to New PCM or Specialist

USFHP providers (PCMs and specialists) have a limited right to request a beneficiary be assigned to a new provider. A provider may request to have a beneficiary moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits
- The beneficiary is disruptive, unruly, threatening, or uncooperative to the extent that member seriously impairs USFHP or the provider's ability to provide services to the beneficiary or to obtain new beneficiaries, and the aforementioned behavior is not caused by a physical or behavioral health condition
- Repeated refusal to comply with office procedures essential to the functioning of the PCM's practice or to accessing benefits under the managed care plan

The provider should make reasonable efforts to address the beneficiary's behavior that has an adverse impact on the patient/physician relationship, through education and counseling, and, if medically indicated, referral to appropriate specialists.

If the beneficiary's behavior cannot be remedied through reasonable efforts and the provider feels the relationship has been irreparably harmed, the provider should notify the USFHP QI department.

USFHP will research the concern and decide if the situation warrants requesting a new provider assignment. If so, USFHP will document all actions taken by the provider and USFHP to resolve the situation. This may include beneficiary education and counseling. A USFHP provider cannot request a disenrollment based on adverse change in a member's health status or utilization of services medically necessary for treatment of a beneficiary's condition.

Procedure

USFHP may take immediate action in accordance with Tricare Operations Manual 6010.59-M, April 1, 2015, Chapter 13, Section "Threats Against Contractor." In all other instances, once USFHP has reviewed the provider's request and determined that the physician/patient relationship has been irreparably harmed, the beneficiary will receive a minimum of thirty (30) days notice that the physician/patient relationship will be ending. Notification must be in writing, sent by certified mail, and USFHP must be copied on the letter sent to the beneficiary. The provider will continue to provide care to the beneficiary during the thirty (30) day period or until the beneficiary selects or is assigned to another provider. USFHP will assist the beneficiary in establishing a relationship with another provider.

The provider will transfer, at no cost, a copy of the medical records of the beneficiary to the new provider and will cooperate with the beneficary's new provider in regard to transitioning care and providing information regarding the beneficiary care needs.

A beneficiary may also request a change in PCM for any reason. The PCM change that is requested by the beneficiary will be effective the first day of the month following the receipt of the request, unless circumstances require an immediate change.

Billing for Non-Covered Services

As outlined in the TRICARE Operations Manual 6010.59-M, April 1, 2015, Chapter 5, Section 1, a network provider may not require payment from beneficiaries for any excluded services that the beneficiary received from the network provider and the beneficiary is "held harmless." Excluded or excludable services include TRICARE statutory exclusions (e.g., cosmetic procedures, certain durable medical equipment items or supplies) or services considered to be unproven or experimental. Providers are required to follow all applicable prior authorization requirements, as Hold Harmless provisions apply. An **Acknowledgment and Financial Responsibility Statement** is available for members to fill out and the form is also listed in the Forms section in the back of this manual.

SECTION VIII:
Compliance

Compliance with Contract, Federal, State, and Local Regulations

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

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

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

Discrimination Against Members

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

In addition, provider will not:

- Make distinctions in the provision of services based on age, sex, disability, race, color, religion, or national origin
- Deny a member any service, benefit or availability of a provider based on age, sex, disability, race, color, religion, or national origin
- Provide a service or benefit that is different, or provide in a different manner or on a different schedule, from any other member for any reason other than medical necessity and/or capacity
- Segregate or separate treatment based on age, sex, disability, race, color, religion, or national origin
- Treat a member differently from others in receiving any covered service or benefit that is offered to other members
- Treat a member differently from others in order to provide a service or benefit
- Assign times or places to obtain services based on age, sex, disability, race, color, religion, or national origin

Medical Record Documentation and Retention

Provider must maintain members' medical record documentation in a manner that is current, detailed, organized, promotes effective and confidential patient care and quality review, and meets generally accepted standards and established goals for medical record keeping. To access and review the plans' Medical Record Documentation Policy in its entirety to which provider is subject with respect to USFHP members, please click on the following hyperlink: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines/clinical-practice-guidelines (See: Medical Record Documentation Standards Policy).

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

Audit Process

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

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

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

Privacy and Release of Member Information and/or Records

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

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

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

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

Member Rights and Responsibilities

We value the members of our USFHP health care family. Our members have certain rights and responsibilities which are communicated to them upon enrollment and annually thereafter. We encourage providers to review the Members' Rights and Responsibilities Statement located on the USFHP member website at the following location: hopkinsusfhp.org.

Standard of Conduct

In order to affect USFHP's commitment to the highest legal and ethical standards, USFHP has adopted the Johns Hopkins Health Plans Code of Conduct. A copy of Johns Hopkins Health Plans' Code of Conduct can be found at: https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/resources-guidelines (see Standard of Conduct). Provider is required to either adopt and abide by the Johns Hopkins Health Plans Code of Conduct or implement a code of conduct that incorporates requirements consistent with Johns Hopkins Health Plans's Code of Conduct.

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

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

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

General Compliance and Fraud, Waste, and Abuse Education

It is strongly recommended that providers and their employees, independent contractors, and subcontractors receive training in the identification and prevention of fraud, waste, and abuse (FWA). Free training is available on CMS' Medicare Learning Network (MLN Provider Compliance website): https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/providercompliance. The Centers for Medicare and Medicaid Services (CMS) Medicare Parts C and D Fraud, Waste, and Abuse and General Compliance training provide a comprehensive overview. In addition, Johns Hopkins Health Plans's provider website contains educational resources for providers.

Fraud

Tricare defines **fraud** using the definition located in 32 CFR 199.2. In this citation fraud is defined as: 1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payments, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRICARE claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence."

Examples of fraud, under TRICARE, include, but are 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
- 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:

- Billing for 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
- 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
- Alteration of patient records and/or claim forms

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)
- An authorized provider billing for services that 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 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

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 "...any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary costs, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term abuse includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim."

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 contractor's access to records related to TRICARE claims
- Billing substantially in excess of customary or reasonable charges unless it is determined by DHA 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 some cases
- Unauthorized use of the term TRICARE in private business

Waste

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

Both fraud and abuse can expose a provider, contractor or subcontractor, to criminal and civil liability. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.Provider is responsible for implementing methods to prevent fraud, waste, and abuse. Listed below are some common prevention techniques. This list is not meant to be all-inclusive.

- Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities[1]
- Validate all member ID cards prior to rendering service
- Ensure accuracy when submitting bills or claims for services rendered
- Submit appropriate referral and treatment forms
- Avoid unnecessary drug prescription and/or medical treatment
- Report lost or stolen prescription pads and/or fraudulent prescriptions

Reporting Fraud, Waste, and Abuse

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

Reports of actual or suspected FWA involving USFHP can be made to Johns Hopkins Health Plans Payment Integrity department. Individuals making a report may do so anonymously using the contact information below. All reports are taken seriously and investigated and to the extent possible kept confidential.

By mail: Payment Integrity Department,
Attention: FWA,
7231 Parkway Drive, Suite 100,
Hanover, MD 21076

Phone: 410-424-4971

Fax: 410-424-2708

Email: FWA@jhhp.org

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

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

Provider is responsible for reporting all incidents of actual and/or suspected FWA. No Johns Hopkins Health Plans employee may threaten, coerce, harass, retaliate, or discriminate against any individual who reports a compliance concern. To support this effort, Johns Hopkins Health Plans has enacted zero-tolerance policies and annually trains all personnel on their obligation to uphold the highest integrity when handling compliance related matters.

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

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

Reporting of Other Compliance Concerns

Provider, and its employees, independent contractors, and subcontractors are required to report concerns about actual, potential, or perceived misconduct to the Johns Hopkins Health Plans Corporate Compliance department at the numbers/addresses noted above.

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

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

For reporting all other issues, contact USFHP Customer Service at 800-808-7347. Immediately below is a list of examples of such reporting. The list is not intended to be all-inclusive.

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

SECTION IX
Plan Initiatives

HealthLINK@Hopkins

HealthLINK@Hopkins is a secure, online portal for USFHP members and their in-network providers.

As a **provider** you can:

- Submit claims and search for existing claims
- Review electronic remittance advice and download onto a PC
- Search for members based on name, member ID, PCP, or DOB run reports such as member rosters
- Check the status of referrals and authorizations
- Directly enter referrals and certain services for prior authorization
- Correspond securely with Customer Service

First-time users must register for an account at HopkinsHealthPlans.org. If at any time you need assistance with registration, contact your network manager directly or Provider Relations at 410-762-5385 or 888-895-4998.

The HealthLINK Quick Reference Guide, which can be found on our website, will help you navigate the portal with ease.

Text4baby

Text4baby provides free weekly text messages to pregnant USFHP mothers, with information to help them through their pregnancy and the baby's first year.

Participating members:

- Get support during their pregnancy.
- Get support throughout baby's first year.
- Receive totally free text messages each week.
- Receive accurate health information and resources in a format that is personal and timely.
- Learn useful tips about prenatal care, labor signs, nutrition, breastfeeding, and more.

If you think your patient would benefit from this service, tell them to text BABY to 511411, or go online to www.text4baby.org to sign up!

Text4baby is a free service of the National Healthy Mothers, Healthy Babies Coalition. This is for informational purposes only. The Text4baby program is not a program of Johns Hopkins Health Plans, USFHP, and we are not responsible for any advice or messages provided by the Text4baby program.

SECTION X
Important Forms

Provider Claims/Payment Dispute Request Form

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/forms

Provider Appeal Request Form

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/forms

Psychological Testing Request Form

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/forms

Acknowledgment and Financial Responsibility Statement

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/our-plans/usfhp/forms

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