

PROVIDER pulse

Johns Hopkins Health Plans Provider Newsletter

SUMMER 2023



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JOHNS HOPKINS
HEALTH PLANS

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

// INTRODUCTION

“When the sun is shining I can do anything; no mountain is too high, no trouble too difficult to overcome.”

—Wilma Rudolph

The bright news this season is that Johns Hopkins HealthCare LLC has rebranded and changed its trade name to **Johns Hopkins Health Plans**. The name change is accompanied by a change in visual identity, including a new brand logo and the discontinuation of logos for the affected health plans. Here are the key points you need to know about the new branding:

- The rebranding does not represent a legal name change. Our legal name is still Johns Hopkins HealthCare LLC. Instead, we have secured a Doing-Business-As (DBA) legal agreement to operate as Johns Hopkins Health Plans. Correspondence with us will be as Johns Hopkins Health Plans.
- Relevant and priority information on the provider section of our website and provider portal(s) has been updated in line with the rebrand.
- There will be NO changes to provider contracts, reimbursements, etc. as a result of the rebranding.
- Only Employer Health Plans (EHP), Advantage MD and US Family Health Plan (USFHP) are included in the rebranding initiative. The brands and visual identities of both Priority Partners and Johns Hopkins HealthCare Solutions remain unchanged.
- Along with a new name, Johns Hopkins Health Plans has a new logo. The individual logos and visual branding of USFHP, EHP and Advantage MD plans have been discontinued. All visual branding going forward will be under Johns Hopkins Health Plans.
- We have a new website domain: HopkinsHealthPlans.org. The website has a new look, and all current web pages have been redirected. You may notice a different

appearance in places, but we have taken care to make only minor modifications with intuitive navigation.

- We will continue to keep you informed with relevant updates and announcements throughout the rebranding transition period.

Aside from any necessary visual identity updates to materials, the only change to impact you, our valued doctors and health care providers and facilities, will be our name change to Johns Hopkins Health Plans. You may need to update some of your internal references to reflect the new name, but please keep in mind that there are NO changes to contracts, reimbursements, etc. as a result of the rebranding.

// POLICIES AND PROCEDURES

New Claims Editing System Launched Aug. 15, 2023 for USFHP

The Claim Edit Portal, Optum CEP, is now active for Johns Hopkins USFHP, beginning August 15, 2023. Optum CEP replaces Change HealthCare's Clear Claim Connection (C3) claim edit transparency tool.

The benefits to you as the health care provider are as follows:

- Equitable reimbursement
- Efficient reimbursement
- Accurate and consistent claims processing and reimbursement

The Optum claim edit portal allows providers to test claims prior to submission. If a claim denies, providers can obtain details about the reason for denial after submission. This portal will be accessible through HealthLINK.

Optum CEP affords USFHP providers a way to test different claim scenarios and identify potential edits without submitting a live claim to CES. Once a claim has been analyzed by CES, the line-by-line edits are returned and displayed in the Optum portal. Providers can:

- Add a new claim

The new claims edit portal lets providers enter both Professional and Facility claims. Optum validates and issues edits on claims with multiple lines, diagnoses, and modifiers. Providers can also make real-time updates to claim lines and submit them to CES for editing.

Please see the [JOB AID: Optum Claim Edit Portal](#) for detailed user instructions and helpful screenshots.

Latest Medical Policy Updates

The Johns Hopkins Health Plans Medical Policy Advisory Committee (MPAC) has approved changes and additions to our medical policies for Advantage MD, Employer Health Programs (EHP), Priority Partners and US Family Health Plan (USFHP)

Changes effective Aug. 1, 2023:

New Medical Policies

- CMS24.07—High Risk Obstetrical Home Care
- CMS24.14—Habilitative Therapy Services

Revised Medical Policies

- CMS23.08—Site of Service Sleep Studies
- CMS14.02—Nutritional Assessment and Management
- CMS02.16—Treatment of the Cornea and Refractive Lenses
- CMS20.03—Gastroesophageal Reflux Disease (GERD) Devices
- CMS16.18—Prosthetic Devices
- CMS20.05—Expanded Access and Compassionate Use
- CMS04.03—Pharmacogenomics
- CMS24.05—Private Duty Nursing
- CMS03.01—Clinical Trials

[View the Medical Policy Updates](#)

Changes effective Aug. 21, 2023:

Revised Medical Policies

- CMS16.02—Treatment for Skin Conditions
- CMS03.12—Cosmetic and Reconstructive Services
- CMS01.00—Medical Policy Introduction

[View the Medical Policy Updates](#)

To view the full descriptions of these policies, please visit the Medical Policies section of the Johns Hopkins Health Plans website on or after the effective date or call Provider Relations at 888-895-4998.

Upgrade to JPAL Prior Authorization Tool for Advantage MD Providers

In order to ensure Johns Hopkins Health Plans prior authorization lookup (JPAL) tool for providers continues to provide accurate prior authorization requirements, JPAL will pull solely from Facets effective Sept. 9, 2023, for Advantage MD.

The JPAL tool will look and work the exact same way, but we want to make you aware in case you notice any changes in JPAL verbiage. The new feed should allow for better, more accurate detail; so we hope you find this update beneficial.

As always, we recommend that you keep screen shots of JPAL on file when authorization requirements are checked, and if there are any questions regarding information seen in JPAL prior to Sept. 9, 2023, and after Sept. 9, 2023, please follow the payment dispute process as documented in the Advantage MD provider manual.

New Multi-Payer Portal, Availity, Launching Oct. 21

As part of our continuing effort to boost efficiency and streamline processes, Johns Hopkins Health Plans is introducing a new provider portal developed in collaboration with our vendor, Availity.

Availity Essentials is a secure, real-time platform that connects providers with payers to help providers manage medical benefits and insurance claims. The portal allows providers to view remittances, validate eligibility and benefits and track claims with ease. The impetus for the switch to Availity Essentials is to lighten administrative burdens while engaging with Johns Hopkins Health Plans, giving providers time back in their day to deliver exceptional patient care.

Johns Hopkins Health Plans will take a phased approach with the new provider portal. At launch, the Availity portal will be implemented for Priority Partners, Advantage MD and Employer Health Programs (EHP). US Family Health Plan will be added to the portal at a later date; in the meantime, providers will continue to use the HealthLINK portal.

Starting Oct. 21, 2023, the following functions will be available for Priority Partners, Advantage MD and EHP providers:

- Member eligibility requests and benefit information
- Electronic claims submission
- Claims status
- Remittance and claims payment information
- Insights into financial and administrative transactions

In addition, the new portal will offer the following resources and capabilities:

- Providers can access commonly used forms, find customer service numbers for our plans, review policies and procedures and more.
- Providers can keep up to date on our communications and provider education presentations.

Please Note: As we transition fully to the new provider portal, our current portal, HealthLINK, will continue to be available so providers can access needed functions and resources.

Information on upcoming Availity training opportunities, how to register for Availity and other topics will be addressed in Provider Updates released in the next few months.

Please contact the Johns Hopkins Health Plans Provider Relations department at 888-895-4998 with any questions or concerns.

// BENEFITS AND PLAN CHANGES

Post-PHE Changes for All Health Plans

The national COVID-19 Public Health Emergency (PHE) ended on May 11, 2023. The following summary pertains to the expiration of the PHE and how it affects Johns Hopkins Health Plans.

All Health Plans:

- **COVID-19 Reimbursement Policy (RPC.029) Retired:** Policy RPC.029, the COVID-19 Testing, Treatment and Vaccination policy, is no longer effective.

To view the Johns Hopkins Health Plans Reimbursement Policies, visit our [provider website](#).

- **Peer-to-Peer Process:** As of May 12, 2023, timeframes for the peer-to-peer review process reverted to the standard timeframes that were applicable prior to the PHE. If the treating physician wants to discuss their case with a physician reviewer, the physician must call the Utilization Management (UM) department at 888-401-3592, weekdays from 8:30 a.m. to 5 p.m., to request a peer-to-peer review. In addition, for Priority Partners and Advantage MD (HMO) members who have in-network benefits only, authorization will not be granted to out-of-network providers unless clinically necessary. For Advantage MD (PPO), USFHP and EHP members with out-of-network plan benefits, those out-of-network benefits will apply to services with out-of-network providers. Upon receipt of the faxed notification of denial, the peer-to-peer review must be requested within:
 - » Two (2) business days for inpatient cases
 - » Three (3) business days for outpatient/preservice cases

After the peer-to-peer review is requested, the review must take place within two (2) business days for both inpatient and outpatient cases.

*Per CMS, a denial cannot be overturned as a result of a peer-to-peer discussion for Advantage MD.

Revised Peer-to-Peer Review Process Timeframe		
Standard Review Process		
	Medical Inpatient Cases	Medical Outpatient Cases
Timeframe to request peer-to-peer review upon receipt of the faxed notification of denial	2 business days	3 business days
Timeframe for peer-to-peer review to take place after request	2 business days	2 business days
TOTAL days allowed for standard peer-to-peer review process	4 business days	5 business days

You can find detailed information about Johns Hopkins Health Plan's peer-to-peer review process in the [Provider Manuals](#).

Review Timeframes for Pharmacy Cases for Priority Partners and USFHP

Johns Hopkins Health Plans' Pharmacy department has amended its timeframe for the post-denial review process for Priority Partners and USFHP.

Priority Partners and USFHP providers submitting self- and non-self-administered pharmaceuticals requests for review by Johns Hopkins Health Plans' Pharmacy department:

Details regarding denial of a request and next steps (how to speak with reviewer or how to appeal) are included in the denial letter that is faxed to the provider.

- The review must be requested within three (3) business days upon receipt of the faxed notification of denial.
- After the review is requested, the review must take place within two (2) business days.

Revised Pharmacy Review Process Timeframe	
Standard Pharmacy Review Process	
Timeframe to request review upon receipt of the faxed notification of denial	3 business days
Timeframe for review to take place after request	2 business days
TOTAL days allowed for standard review process	5 business days

Advantage MD:

- **COVID-19 Lab Testing:** Remains covered with no cost share for members.
- **CPT U0003, U0004, U0005, G2023, G2024:** No longer covered as of 5/12/2023.
- **COVID-19 Over the Counter Tests:** No longer covered for Advantage MD as of 5/12/2023.
- **COVID Vaccines:** Remain covered with no cost share for members.
- **COVID-19 Treatments:**
 - » For HMO members are only covered with in-network provider.
 - » For PPO members are covered with an in-network provider, out-of-network benefits apply when using an out of network provider.
 - » HMO and PPO members have a cost share as of 5/12/2023.
- **Telehealth:** Remains covered, members have a cost share as of 5/12/2023.
 - » Place of Service 02 and 10 are still allowable as of 5/12/2023.
 - » No cost share for telehealth visits with an in network provider for:
 - › Johns Hopkins OnDemand Virtual Care
 - › Home Health
 - › Primary Care
 - › Specialists visits
 - › Outpatient Mental Health and Substance Abuse Treatment
- **CR Modifier, CS Modifier and DR Condition Code:** No longer applicable as of 5/12/2023.

Priority Partners:

- Most of the flexibilities permitted by the Maryland Department of Health (MDH) during the PHE have already ended; please see [COVID-19 Provider Updates](#) for more information.
- **MDH General Provider Transmittal 56-23** addresses the flexibilities and policies that remain in place after Aug. 15, 2021 and supersedes previous guidance.
- Important information to note:
 - » MDH will continue to cover COVID-19 vaccinations, tests, and treatments with no copays for Priority Partners members until at least

Sept. 30, 2024. MDH will provide further guidance on whether copays will be required beginning Oct. 1, 2024.

- » Balance Billing Priority Partners members for Personal Protective Equipment (PPE) is prohibited. Providers must accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for a covered service.
- » Telehealth flexibilities, including coverage of audio-only phone conversations, will continue through at least June 30, 2025. As such, Medicaid will continue to provide coverage for health care services delivered through telehealth regardless of the participant's location at the time services are rendered and to allow a distant-site provider to provide services to a participant from any location at which the services may be delivered through telehealth. Additionally, Medicaid will permit services to be rendered via audio-only telehealth through June 30, 2025.
- » The use of non-HIPAA compliant technology products authorized through the end of the federal PHE at the discretion of the federal Office of Civil Rights (OCR) is also ending. OCR is providing a 90-calendar day transition period for covered health care providers to come into compliance with the HIPAA Rules with respect to their provision of telehealth. The transition period in effect beginning on May 12, 2023 expired at 11:59 p.m. on Aug. 9, 2023.

Employer Health Programs (EHP):

These changes became effective for EHP providers on July 10, 2023. Please see the [EHP Coronavirus \(COVID-19\) \(hopkinsmedicine.org\)](#) page on our website for covered codes and other information pertaining to benefits and covered services.

- **JHU:** COVID-19 lab testing remains covered at 100%. Vaccines: remain covered at 100%; no cost share.
- **The rest of EHP:**
 - » COVID lab testing: and corresponding office visits; cost share reinstated as of 7/10/23.
 - » Over the counter testing/kits: no longer covered as of 7/10/23.
 - » Vaccines: remain covered at 100%; no cost share.

- **Telemedicine:** There are no changes to Telemedicine coverage for all EHP plans.
 - » Claims must be submitted with proper modifier (GT, GQ or 95 in accordance with how administered and in accordance with NCCI edits).
 - » There is no restriction on place of service (POS) of rendered services.
 - » Same authorization requirements apply for telemedicine as for face-to-face visits.
 - » Same copayments/co-insurance apply for telemedicine as for face-to-face visits.
 - » Telemedicine provided by out-of-network providers is covered and payable under member's out-of-network benefits, if applicable.
 - » Telephonic consultation is covered. See [list of covered codes](#).

USFHP:

- Effective April 18, 2023 for USFHP members, the monovalent Moderna and Pfizer-BioNTech COVID-19 vaccines listed below are no longer authorized for use in the U.S.
 - » 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0051A, 0052A, 0053A, 0054A, 0064A, 0071A, 0072A, 0073A, 0074A, 0081A, 0082A, 0083A, 0091A, 0092A, 0093A, 0094A, 0111A, 0112A, 0113A, 91300, 91301, 91305, 91306, 91307, 91308, 91309, 91311.
 - » This means the above-referenced Moderna and Pfizer vaccine codes are not covered by USFHP as of April 18, 2023.
- **New Codes:** The following new codes have been added to the vaccine benefit and require no referral or preauthorization:
 - » 0121A, 0141A, 0142A, 0151A, 0171A, 0172A
- **Telehealth:** All providers must now use HIPAA-compliant telehealth platforms, effective May 12, 2023, the day after the expiration of the Public Health Emergency (PHE).
- **Skilled Nursing Facilities:** Effective Oct. 1, 2023, authorization will be required prior to Skilled Nursing Facility Admission for USFHP. We will no longer be able to provide automatic five-day approvals for skilled

nursing facility admissions. Skilled nursing facility requests will be reviewed for medical necessity and to confirm a three-day qualifying stay has occurred.

As a reminder, the three-day qualifying stay authorized in the [Tricare Reimbursement Manual](#) was reinstated for skilled nursing facility admissions beginning April 10, 2023. The above changes correspond to the conclusion of the public health emergency (PHE) for COVID-19.

- » **SNF process:** Johns Hopkins Health Plans' SNF Fax Line receives all post-acute requests and ambulance requests for authorization. This fax line accepts requests for all post-acute settings listed as follows:
 - › Skilled Nursing Facilities (SNF), Acute Inpatient Rehab (ACIR), Long Term Acute Care (LTAC), and Ambulance requests.
 - › The fax number is **410-424-2703**.
- **Additional Information:** Please see Provider Notice published 4/17/23 for additional changes related to [Transition Information for Providers After Termination of COVID-19 National Emergency and the Public Health Emergency \(PHE\) for Johns Hopkins USFHP](#).

Enhanced Reimbursement for Priority Partners Maternal Health Providers Through MDH Programs: The First Step Is ePREP

Johns Hopkins Health Plans would like to make our Priority Partners providers (OB-GYN, Pediatric, Family Medicine, Midwives, Nurse Practitioners and Doulas) aware of maternal health programs from the Maryland Department of Health (MDH) that offer additional reimbursement opportunities.

IMPORTANT: Both programs require active enrollment in ePREP, Maryland Medicaid's electronic Provider Revalidation and Enrollment Portal (ePREP). Providers are responsible for updating their professional license information prior to license expiration in the ePREP portal. Active enrollment applies to providers (individuals and provider groups). For additional information and to complete your application, please visit health.maryland.gov/ePREP or call 844-4MD-PROV.

Centering Pregnancy Program:

Centering Pregnancy is an evidence-based group prenatal care model for low-risk pregnancies. Facilitators support a cohort of 8 to 10 individuals of similar gestational age through a curriculum

of 10 90- to 120-minute interactive group perinatal care visits that largely consist of discussion sessions covering medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care.

Effective Jan. 1, 2024, a practice (OB-GYN, Pediatric, Family Medicine, Midwives, Nurse Practitioners, Doulas) must be accredited or pending accreditation by the Centering Healthcare Institute (CHI), in addition to being licensed.

- Both the group and each individual rendering provider will need to submit supplemental applications in ePREP to add this new service.
- Groups must update their ePREP account to reflect their CHI licensed status. To update, a group should start a supplemental application in ePREP and attach their CHI approval letter attesting their status, as well as the [Group Centering Pregnancy Addendum](#).
 - » Individual rendering providers will also need to submit an [Individual Centering Pregnancy Addendum](#) with the group's accreditation attached.
- The above steps will enable the group to add the code **99078**, "Group educational services by physician," to up to 10 Centering Pregnancy perinatal visit claims for patients who are enrolled in and receive prenatal care in the Centering Pregnancy program. This code will pay an additional \$50 per participant per visit, for up to 10 group perinatal care visits or \$500.
- Please see MDH Transmittals [PT30-23](#) and [PT61-23](#) and the [MDH Medicaid Centering Pregnancy Provider Information webpage](#) for more information.

HealthySteps Program:

HealthySteps, a ZERO TO THREE program, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children from birth to age 3 and their families are screened and placed into a tiered model of risk-stratified supports, including care coordination and onsite intervention. A HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide successful interventions, referrals and follow-up to the whole family. The HealthySteps Specialist screens all children ages 0 to 3 years and their families to place them into the appropriate tier of services.

To be eligible for additional reimbursement, a group must be currently and actively meeting the HealthySteps National

Office (ZERO TO THREE) fidelity requirements or deemed as on track to fidelity.

- Groups must update their ePREP account to reflect their ZERO TO THREE accreditation status.
 - » To update, a group should initiate a supplemental application in ePREP and attach their ZERO TO THREE accreditation letter attesting their status, as well as the [HealthySteps Group Addendum](#).
 - » Each rendering provider will also need to submit an [Individual Supplemental Addendum](#) with the group's accreditation attached.
- The above steps will allow the group to add the code **H0025**, "Behavioral health prevention education service," to each pediatric E&M or well-child visit encounter that includes HealthySteps services and was provided in the clinic or outpatient setting. This code will pay an additional \$15 per participant per visit, up to age 4. NOTE: While this is an H-code, this code should not be billed to the ASO.
- For more information on Healthy Steps, please visit the [MDH website](#) or refer to Transmittal [PT30-23](#)

Additional information about enrollment into these programs can be found at the [Maryland Medicaid Maternal Child Health Programs webpage](#) and in the latest [Professional Services Provider Manual](#).

Update on Dialysis in Tricare Manual for USFHP Providers

Recently, the TRICARE® Policy Manual was updated for Dialysis. USFHP providers should be aware of the following change:

- **Section 2.2:** The attending or prescribing individual professional provider should document the frequency of dialysis services in the patient's medical record and plan of care.

For more information, please visit the [TRICARE website](#).

MDH's Healthy Babies Equity Act Now Effective for Non-Citizen Pregnant Marylanders

The Maryland Department of Health (MDH) Medical Assistance Program provides comprehensive coverage to non-citizen pregnant Marylanders with income up to 250% of the federal poverty level (FPL) who would otherwise be eligible for Medicaid or Maryland Children's Health Program (MCHP) but for their immigration status, as well as their children up to the

age of 1 year, as required by HB 1080 – Healthy Babies Equity Act (Ch. 28 of the Acts of 2022). This program went into effect July 1, 2023.

MDH estimates approximately 6,000 non-citizen pregnant Marylanders will be eligible for this benefit in the first year. Applicants will apply for coverage through the consumer portal on the [Maryland Health Connection](#). The benefit will provide coverage during the pregnancy and four months of comprehensive coverage during the postpartum period. This postpartum period is defined as the date a pregnancy ends to the last day of the month in which the four-month period ends. Retroactive fee-for-service coverage will be available for up to three months, subject to the limitations outlined below.

The non-citizen pregnant individual (birthing parent) will be eligible for the same benefits package available to other pregnant individuals, including physical and behavioral health services, as well as dental and prescription drug coverage without copays. Participants will be enrolled in a managed care organization, such as Priority Partners, during the prenatal and postpartum periods. Carved-out benefits will be covered on a fee-for-service basis.

Individuals who currently qualify for emergency medical services due to pregnancy (X03 L) will be contacted by MDH to alert them to this new coverage opportunity. These individuals can apply for comprehensive benefits using Maryland Health Connection's consumer portal beginning July 1, 2023.

For more information, please refer to [Maryland Medicaid MCO Transmittal No. 175](#).

// CLAIMS AND BILLING

Changeover From Claims Processing System MC400 to Facets Complete

Johns Hopkins Health Plans would like to notify our Employer Health Programs (EHP) and Priority Partners providers that we have completed our conversion from MC400 to our Facets claims processing system. Since late 2022, we have been paying all new claims with dates of service after the conversion on this new Facets system.

Over the next three to six months, if a provider has any balance in the old MC400 system, we will begin moving those balances into our new Facets system. If you have any balance, it will appear on your future regular remittance.

If you have a balance that appears on your future remittance and you have any questions, please reach out to our Customer Service team. They will be able to confirm the balance was moved

from MC400 or they can direct you to the team that can provide any additional detail you need.

- **EHP Customer Service:** 410-424-4450 or 800-261-2393
- **Priority Partners Customer Service:** 410-424-4500 or 800-654-9728

Selected Procedure Codes Removed From Prior Authorization Requirement

Please note the following Prior Authorization Required (PA) and No Prior Authorization Required (NPA) changes for the following Johns Hopkins Health Plans codes.

NPA needed effective Sept. 1, 2023 for Priority Partners and US Family Health Plan

99341 — Home or residence visit for the evaluation and management of a new patient, requiring a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99342 — Home or residence visit for the evaluation and management of a new patient, requiring a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99344 — Home or residence visit for the evaluation and management of a new patient, requiring a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

99345 — Home or residence visit for the evaluation and management of a new patient, requiring a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

99347 — Home or residence visit for the evaluation and management of an established patient, requiring a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99348 — Home or residence visit for the evaluation and management of an established patient, requiring a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of

the encounter for code selection, 30 minutes must be met or exceeded.

99349 — Home or residence visit for the evaluation and management of established patient, requiring a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99350 — Home or residence visit for the evaluation and management of an established patient, requiring a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

E0445 — Oximeter device for measuring blood oxygen levels noninvasively.

PA and NPA Needed Effective Oct. 14, 2023 for Advantage MD, Employer Health Programs (EHP), US Family Health Plan (USFHP)

This code requires **PA for Advantage MD, EHP and USFHP as of Oct. 14, 2023:**

P9099 — Blood components or product not otherwise classified

These codes requiring **PA as of Oct. 14, 2023 apply to Advantage MD only:**

96130 — Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

96131 — Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour, list separately in addition to code for primary procedure

96132 — Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

96133 — Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour, list separately in addition to code for primary procedure

96136 — Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

96137 — Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes, list separately in addition to code for primary procedure

96138 — Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes)

96139 — Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes. List separately in addition to code for primary procedure

96146 — Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

These codes below are for **Advantage MD only and are NPA as of Oct. 14, 2023**. They are currently set up under the Home Health benefit to require PA for more than 12 visits. Effective Oct. 14, 2023, these codes will be under the Provider Evaluation and Management Visit (E&M) benefit and require NPA.

99341 — Home or residence visit for the E&M of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99342 — Home or residence visit for the E&M of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99344 — Home or residence visit for the E&M of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

99345 — Home or residence visit for the E&M of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

99347 — Home or residence visit for the E&M of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99348 — Home or residence visit for the E&M of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99349 — Home or residence visit for the E&M of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99350 — Home or residence visit for the E&M of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Johns Hopkins Health Plans Updates on Reimbursement Policies

John Hopkins Health Plans has released its new, updated and retired reimbursement policies.

Reimbursement Policies Effective Sept. 15, 2023:

- Anatomic Modifiers (RPC.032) — **NEW**
- Bilateral Procedures (RPC.017) — **NEW**
- Evaluation and Management (RPC.025) — **NEW**
- Injection and Infusion (RPC.027) — **UPDATED**
- Split Care Procedures (RPC.001) — **UPDATED**
- Two Surgeon/Co-Surgeon, Professional (RPC.031) — **UPDATED**
- Non-Reimbursable Codes (RPC.026) — **REMINDER**

View a summary of these [Reimbursement Policy Updates](#).

Reimbursement Policy Effective Oct. 20, 2023:

- Psychotherapy Services Reported with Evaluation and Management (E/M) Services (PRC.033) — **NEW**
 - » This payment policy guidance will apply when Psychotherapy Services are billed on the same day as an Evaluation and Management (E/M) visit is performed by providers (participating and nonparticipating).
 - » When a high-level E/M code is reported on the same date of service with a Psychotherapy Services code, the claim may be pended for further review.

Reimbursement Policy Retired Oct. 10, 2023:

- Obstetrical Ultrasound (RPC.008) — **RETIRED**
 - » Due to the recommendations and formal approval through our Reimbursement Policy Committee, the Obstetrical Ultrasound policy (RPC.008) will be retired as of Oct. 10, 2023, and no longer effective after this date. Please refer to our [Medical Policy](#), CMS16.19 Prenatal Obstetrical Ultrasound, for coverage guidelines.

NOTE: All of the above policies are posted on the [Johns Hopkins Health Plans Reimbursement Policy page](#) on the effective date.

// PHARMACY

Pharmacy Formulary Update

A variety of pharmacy information and resources are available to you on the Johns Hopkins Health Plans website and the Priority Partners, Employer Health Programs (EHP), US Family Health Plan (USFHP) and Advantage MD pharmacy pages. These include information related to the pharmacy formulary, pharmaceutical restrictions or preferences, requesting a benefit exception, step therapy, generic substitution and other pharmacy management procedures.

The pharmacy formularies are specific to each plan and are updated regularly to include new medications and the latest safety information. For additional information on the pharmacy formularies and updates for each plan, use the links listed below. You can also contact the Johns Hopkins Health Plans Pharmacy Department at 888-819-1043 for questions or concerns for

Priority Partners, EHP, and USFHP. Contact 877-293-5325 (option 2) for questions or concerns for Advantage MD.

Pharmacy websites to bookmark:

- **EHP**
HopkinsHealthPlans.org > For Providers > Our Health Plans > EHP > [Pharmacy and Formulary](#)
- **Priority Partners**
HopkinsHealthPlans.org > For Providers > Our Health Plans > Priority Partners > [Pharmacy and Formulary](#)
- **USFHP**
HopkinsHealthPlans.org > For Providers > Our Health Plans > US Family Health Plan > [Pharmacy and Formulary](#)
- **Advantage MD**
HopkinsHealthPlans.org > For Providers > Our Health Plans > Advantage MD > [Pharmacy and Formulary](#)

Priority Partners Formulary Change: New Prior Authorization Requirements for Self-administered Adalimumab Products

Beginning Oct. 1, 2023, Priority Partners will remove Humira® (adalimumab) from the formulary. However, the following biosimilar products, which are direct alternatives to Humira, will be added to the formulary: Hadlima® (adalimumab-bwwd), Adalimumab-fkjp (unbranded version of Hulio®) and Adalimumab-adaz (unbranded version of Hyrimoz®). These preferred biosimilar products will require prior authorization for coverage.

How to submit prior authorization requests:

- An electronic prior authorization (ePA) request may be submitted using the [CoverMyMeds](#)** or [Surescripts](#)** online submission tools.
 - » Helpful step-by-step navigation guides are available for both CoverMyMeds and Surescripts. These ePA assistance tools may be found at the following links:
 - › [CoverMyMeds](#) Walkthrough
 - › [Surescripts](#) Walkthrough
- If a provider is unable to submit an ePA request, a completed Pharmacy Prior Authorization form may be faxed to Priority Partners at the fax number listed on the form.
- Please visit [Priority Partners Forms](#) for a list of available pharmacy prior authorization forms.

- Please provide clinical documentation to support all prior authorization requests that are submitted electronically or by fax.
- Please visit [Priority Partners Pharmacy Benefits](#) for more information.

**This link is from an external website that is not provided or maintained by or in any way affiliated with Johns Hopkins Health Plans. Please note Johns Hopkins Health Plans does not guarantee the accuracy, relevance, timeliness or completeness of any information on this external website.*

New Prior Authorization Requirements for Certain Provider-Administered Medications

Effective Oct. 1, 2023, Johns Hopkins Health Plans will require prior authorization to determine medical necessity for several provider-administered medications under the Priority Partners, Advantage MD, and US Family Health Plan (USFHP) health plans. These requirements affect members of all ages.

[Priority Partners Prior Authorization Requirements](#)
Effective October 1

[Advantage MD Prior Authorization Requirements](#)
Effective October 1

[USFHP Prior Authorization Requirements](#)
Effective October 1

For certain drug classes, Priority Partners, Advantage MD, and USFHP have a preferred drug list. These preferred drugs are indicated on the “Preferred Medical Injectable Drug List” included at the above links. The comprehensive lists of provider-administered medications that require prior authorization for these health plans are also available on the [Johns Hopkins Health Plans website](#) for your reference.

Submitting Medical Injectable Prior Authorization Requests:

Priority Partners:

- Providers may submit electronic prior authorization requests through NovoLogix using the Priority Partners HealthLINK secure provider portal.
- If HealthLINK is not able to be accessed, a completed Medical Injectable Drug-Specific Prior Authorization Form with supportive clinical documentation may be faxed to Priority Partners at 866-212-4756.

Advantage MD:

- Providers may submit electronic prior authorization requests through NovoLogix using the AMD HealthLINK secure provider portal.
- If HealthLINK is not able to be accessed, contact NovoLogix for assistance by calling 800-932-7013.

USFHP:

- Providers may request prior authorization by submitting the [Medical Injectable Prior Authorization Form](#) along with clinical supporting documentation via fax to 410-424-2801.

// REMINDERS

Recent Recommendation Statement for Anxiety Disorders Screening for Members Ages 19 to 64

Anxiety disorders are common mental health conditions. They are often unrecognized in primary care settings, and considerable delays in starting treatment can occur.

The U.S. Preventive Services Task Force (USPSTF) has issued a Recommendation Statement endorsing screening for anxiety disorders in adults ages 19 to 64, including pregnant and postpartum persons, who do not have a diagnosed mental health disorder and are not showing recognized signs or symptoms of anxiety disorders. The task force determined that current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults (aged 65 and older).

The anxiety disorders screening is a covered benefit billed under procedure code 96127.

- Treatment for anxiety disorders in adults can include psychotherapy and/or pharmacotherapy. Clinicians should be aware of the risk factors, signs and symptoms of clinically significant anxiety. Listen to any patient concerns and ensure that persons who need help get it.
- To achieve benefit from screening for anxiety disorders and reduce disparities in anxiety disorder–associated morbidity, it is important that persons who screen positive are evaluated further for diagnosis and, if appropriate, are provided or referred for evidence-based care.

- Providers are encouraged to consider the unique balance between benefits and harms of various treatment options during the perinatal period when deciding the best treatment for anxiety disorders for a pregnant or breastfeeding person.
- The USPSTF found no evidence on how often to screen for anxiety disorders. In the absence of evidence, a pragmatic approach might include screening adults who have not been screened previously and using clinical judgment while considering risk factors, comorbid conditions and life events to determine if and when additional screening of patients at increased risk is needed. Ongoing assessment of risks that may develop during pregnancy and the postpartum period is also a reasonable approach.
- Screenings should take place regardless of risk factors. However, some factors increase risk, making more frequent screenings advisable. These include family history of mental health conditions, presence of other mental health conditions, a history of stressful life events, smoking or alcohol use, and marital status (widowed or divorced). Women and black individuals are also at risk.
- Anxiety and depressive disorders often co-occur.
- In the absence of evidence, health care professionals should use their judgment based on individual patient circumstances when determining whether to screen for anxiety disorders in older adults (65 years or older).

Other relevant recommendations

- Screening for depression and suicide risk in all adults
- Preventive counseling interventions for perinatal depression

Information on mental health recommendations

- [USPSTF](#)
- [The Community Preventive Services Task Force](#) recommends mental health benefits legislation to increase appropriate use of mental health services for persons with mental health conditions
- [The National Institute of Mental Health](#) has information on anxiety disorders
- [Perinatal Psychiatry Access Programs](#) aim to increase access to perinatal mental health care

Reminder: Provider Education Requirement for Advantage MD D-SNP

Johns Hopkins Health Plans would like to take this opportunity to remind providers in the Johns Hopkins Advantage MD D-SNP (HMO) plan of the mandatory training requirement.

Providers must take the D-SNP training when initially contracted to participate in the plan network. Then, every year, providers in the Advantage MD D-SNP network are required to go through the training and fill out the training attestation form.

- The presentation is available on our website's [Provider Education](#) page.
- Providers must submit the training attestation form after review of this training presentation. Access the form provided at the end of the presentation or by going to the [Forms page](#) on [HopkinsHealthPlans.org](#) and clicking on "Model of Care Provider Training Attestation Online Form (D-SNP)" under Advantage MD.

Student Health Program No Longer Enrolled in EHP Effective July 1, 2023

As of July 1, 2023, Student Health Program (SHP) terminated its contract for health care benefits with Employer Health Programs (EHP).

For questions about benefits and eligibility for SHP members, contact Wellfleet.

- Contact information for Wellfleet:
 - » Customer Service: 877-657-5030
 - » Claims address: Cigna P.O. Box 188061
Chattanooga, TN 37422-8061

EHP will continue to process claims and answer customer service questions until June 30, 2024, for health care services provided on dates of service **prior to July 1, 2023**.

Reminder to Update Provider Demographic Information

If there are any demographic changes for your practice or facility, you are required to notify the Johns Hopkins Health Plans Provider Maintenance department 30 days prior to the change via:

- Your delegated roster
- If you do not have a delegated credentialing agreement, please use the Provider Information Update form, which can be submitted electronically online, or the PDF file can be emailed or faxed.

Please also be sure to include any changes in panel status (accepting new patients or not), as we want to ensure we are reflecting correct access information for our members. In addition, please confirm email addresses, as Johns Hopkins Health Plans communicates provider notices via email.

- **Delegated rosters:** follow the established process for submitting notification of any provider changes and confirm if the provider is accepting new patients or not.
- **Digital submission of the Provider Information Update form (preferred):** Submit the [Online Digital Provider Information Update Form](#) directly from the provider website.
- **Email submission:** Fill out the [Provider Information Update Form*](#) and email it to ProviderChanges@jhhp.org. This mailbox is monitored daily to collect and process all provider changes.
- **Fax submission:** Use this method only if you are using a Social Security number in place of a taxpayer identification number. Complete the [Provider Information Update Form*](#) and fax to 410-762-5302 to ensure identity protection. Do not send digitally or by email.

*This form is located on [HopkinsHealthPlans.org](#), under "For Providers," then under the Forms section of the "Resources and Guidelines" page.

NOTE: Please submit W-9 requests to w9requests@jhhp.org.

Please call Provider Relations at 888-895-4998 (option 4) with any questions about the provider changes reporting process.

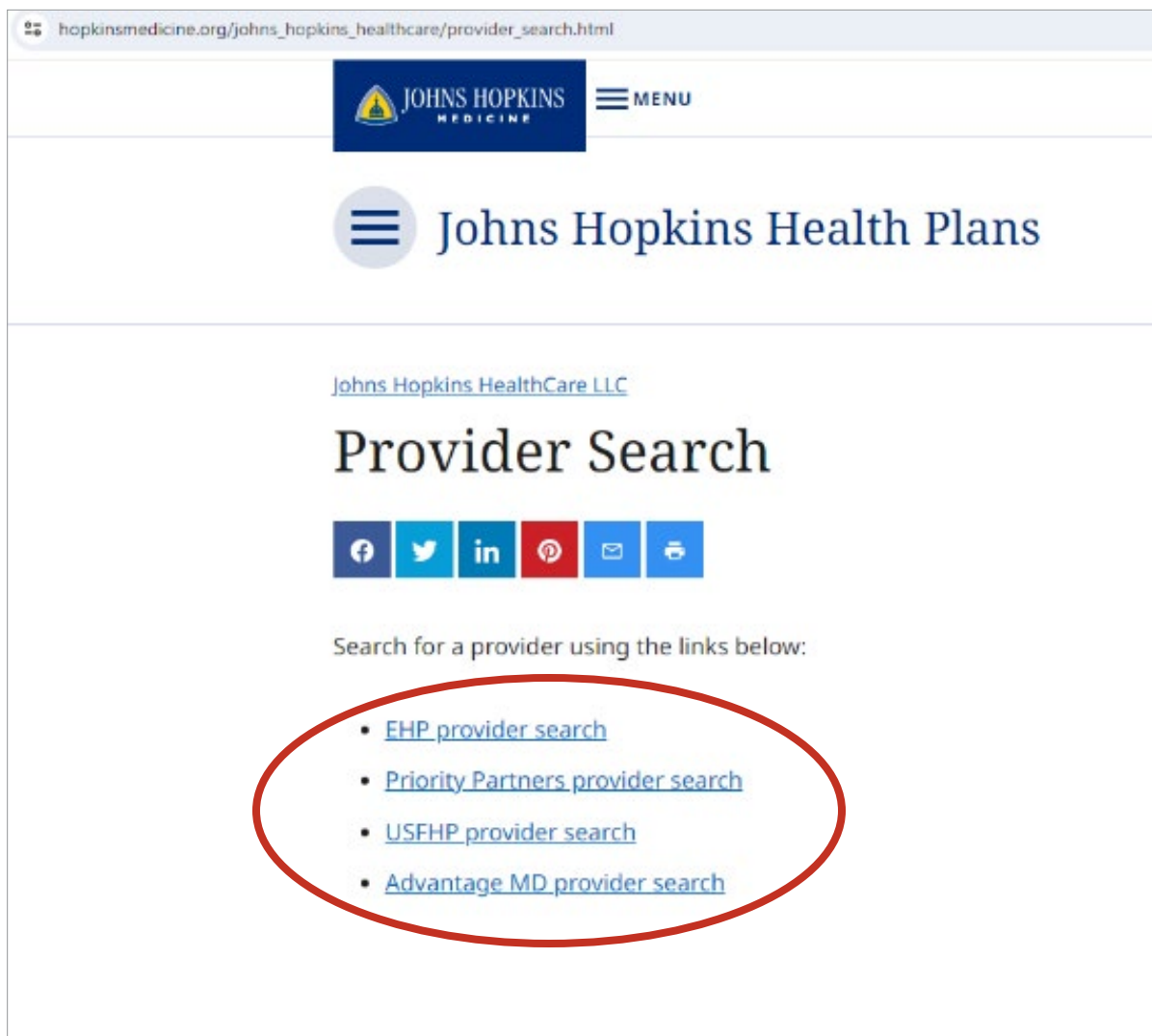
Required Specialist Provider Responsibilities for USFHP Providers

Specialist providers for US Family Health Plan (USFHP) members are responsible for providing all consultation and treatment notes to the primary care provider (PCP) who referred the member for these specialist services. The U.S. Department of Defense requirement states that the PCP should receive an initial report of specialty services and treatment. This initial report 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.

Durable Medical Equipment (DME) Provider Search

The DME Provider Directory is currently being updated and will be posted on the provider and member websites again shortly. As a reminder, DME providers can also be found in the online directories for each plan. When searching for a participating DME provider in the Johns Hopkins Health Plans network, please use the following steps:

1. Go to the applicable [provider directory](#) for Advantage MD, Employer Health Programs (EHP), Priority Partners or US Family Health Plan (USFHP).



hopkinsmedicine.org/johns_hopkins_healthcare/provider_search.html

JOHNS HOPKINS MEDICINE MENU

Johns Hopkins Health Plans

Johns Hopkins HealthCare LLC

Provider Search

Search for a provider using the links below:

- [EHP provider search](#)
- [Priority Partners provider search](#)
- [USFHP provider search](#)
- [Advantage MD provider search](#)

2. Search by location. Scroll down to Service Type, click on “Medical Equipment” and click the yellow Search button.

Provider/Doctor Directory

Quickly find a provider or clinic, hospital or other facility.

ALERT: There may be times where the Captcha feature has been enabled to prevent unusually high volumes of requests. Users may experience problems with the Captcha feature while searching for a provider. Thank you for your patience.

- Please note that members must receive a referral from their Primary Care Manager before seeing a specialist.
- If you are looking for a Vision specialty provider, please search under the provider's specialty (for example, Optometry, Ophthalmology).
- If you are searching for a dentist, follow [this link](#) to find a network Dental Provider in your area.
- Our system is updated every 24 hours; therefore any information populated from your search is only as accurate as the last system update. Doctors may be affiliated with hospitals that are not in the contracted network.
- Search for providers with Sentara Healthcare in the USFHP provider network starting November 1, 2022.

Already have a doctor/facility in mind?

Enter a doctor or facility name

SEARCH

Search in my network

1 LOCATION *

Zip

21210

Distance

25 Miles

OR

State

Maryland

2 SERVICE TYPE *

- Primary Care Specialist/Vendor Hospital or Facility Radiology & Lab
 Behavioral Health Medical Equipment Women's Health
 Telemedicine Services

SEARCH

- Use the gray “Current Search” box on the right to refine your search using the drop-down menus to find specific specialties and areas of interest for DME providers, such as prosthetics, home health care and orthotics.

Medical Equipment Search
Searching near 21210

- To refine or narrow your search results below, type in the providers name, ID, or specialty in the search box below. Or, use the refine search options below to the right.
- Please note some providers have multiple locations.** To make sure a provider is a CCN or Preferred Provider at the location you want to go to, click on the Provider's name, click on the Locations Tab and then "View Provider Details at this Location."
- The online provider directory is updated every 24 hours.

Start New Search View Map Search Tools

Refine results Search Sort by Distance: Nearest

Keyword Search, min. 3 characters

1 - 10 of 80 Page 1

WARRIOR PROSTHETICS AND ORTHOTICS INC 2017 Greening Ave Ste 107 Baltimore, MD 21224-4298 Phone: (410) 664-2192	~ 1.4 mi
CARING TOUCH MEDICAL INC 2017 N Belvidere Ave Baltimore, MD 21218-6216 Phone: (410) 651-4725	~ 1.5 mi
CARING TOUCH MEDICAL INC 2017 N Belvidere Ave Baltimore, MD 21218-6216 Phone: (410) 651-4725	~ 1.5 mi
CONSUMER INC 2017 N Belvidere Ave Ste 107 Baltimore, MD 21218-6217 Phone: (410) 542-6998	~ 1.7 mi

Current Search

Provider Type
Medical Equipment
Zip
21210
Distance
25 miles

Specialty

- Durable Medical Equipment (DME)
- Home Health
- Infusion Services
- Orthotics
- Prosthetics

Areas of Interest

- Prosthetics
- None
- Wigs

Network

None Specified

Network Option

None Specified

Hospital Affiliation

None Specified

Medical Group

None Specified

Gender

Network Access Standards

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

Priority Partners

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

Employer Health Programs (EHP)

Service	Appointment Wait Time (Not More Than):
History & physical exam	Ninety (90) calendar days
Routine health assessment	Thirty (30) days
Non-urgent (symptomatic)	Seven (7) calendar days
Urgent care	Twenty-four (24) hours
Emergency services	Twenty-four (24) hours

US Family Health Plan

Service	Appointment Wait Time (Not More Than):
Well-patient	Four (4) weeks
Specialist	Four (4) weeks
Routine	One (1) week
Urgent	Twenty-four (24) hours
Office wait time	Thirty (30) minutes

Johns Hopkins Advantage MD

Service	Appointment Wait Time (Not More Than):
PCP routine/preventive care	Thirty (30) calendar days
PCP non-urgent (symptomatic)	Seven (7) calendar days
PCP urgent care	Immediate/same day
PCP emergency services	Immediate/same day
Specialist routine	Thirty (30) calendar days
Specialist non-urgent (symptomatic)	Seven (7) calendar days
Office wait time	Thirty (30) minutes

Behavioral Health (all plans)

Service	Appointment Wait Time (Not More Than):
Behavioral health routine initial	Ten (10) business days
Behavioral health routine follow-up	Thirty (30) calendar days
Behavioral health urgent	Forty-eight (48) hours
Behavioral health emergency	Six (6) hours

For Your Reference

Provider Relations

Phone 888-895-4998
410-762-5385
Fax 410-424-4604
Monday through Friday, 8 a.m. to 5 p.m.

Provider Demographic Changes and Updates:

If there are any changes in your practice or facility, you are **required** to notify the Johns Hopkins Health Plans Provider Relations department by email at ProviderChanges@jhhp.org

Care Management Referrals

caremanagement@jhhp.org or 800-557-6916

DME (Durable Medical Equipment)

Fax 410-762-5250

HealthLINK@Hopkins

hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/healthlink
NOTE: First time users must register for an account. If you need assistance with registration, please contact Provider Relations at 888-895-4998.

Johns Hopkins Health Plans Corporate Compliance

410-424-4996
Fax 410-762-1527
compliance@jhhp.org

Fraud, Waste & Abuse

FVA@jhhp.org

Utilization/Care Management

410-424-4480
800-261-2421
Fax 410-424-4603 (Referral not needing medical review)

- Inpatient
Fax 410-424-4894
- Outpatient medical review
Fax 410-762-5205

Advantage MD

Websites

Providers: HopkinsHealthPlans.org
Members: hopkinsmedicare.com

Customer Service (Provider): Eligibility, Claims Status or Provider Payment Dispute

- PPO Products
Phone 877-293-5325
Fax 855-206-9203
TTY 711
- HMO Products
Phone 877-293-4998
Fax 855-206-9203
TTY 711

Dental Services

Dentaquest at: 844-231-8318

Medical Claims Submission

Advantage MD
P.O. Box 3537
Scranton, PA 18505

Medical Payment Disputes

Advantage MD
P.O. Box 3537
Scranton, PA 18505

Pharmacy Services

877-293-5325

Prior Authorization

Medical Management: 855-704-5296
Behavioral Health: 844-363-6772

Silver&Fit®

(Plus and Group Members Only)
877-293-5325

TruHearing

(Plus and Group Members Only)
877-293-5325

Vision Services

Superior Vision at 800-879-6901

EHP

Websites

Members: ehp.org
Providers: HopkinsHealthPlans.org

Customer Service (Provider)

800-261-2393
410-424-4450
Suburban Hospital Customer Service
866-276-7889

Care Management

800-261-2421
410-424-4480
Fax 410-424-4890

Dental – Delta Dental

800-932-0793

Health Education

800-957-9760

Medical Appeals Submission

Attn: Appeals Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-762-5304

Medical Claims Submission

Attn: Adjustments Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-424-2800

Mental Health and Substance Disorder Services

800-261-2429
410-424-4476

Cigna

800-261-2393

*Pharmacy (Mail Order Only)

888-543-4921

Pharmacy Provider Prior Authorization for Medical Necessity

(Fax numbers may vary). Refer to provider website: hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/our_plans/ehp/index.html

Utilization Management

800-261-2421
410-424-4480

**Not applicable to all EHP members. Consult specific schedule of benefits.*

Priority Partners

Websites

Members: ppmco.org
Providers: HopkinsHealthPlans.org
800-654-9728

Customer Service (Provider)

800-654-9728

Dental (Maryland Healthy Smiles Dental Program)

855-934-9812

HealthChoice

800-977-7388

Health Education

800-957-9760

Medical Appeals Submission

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

Medical Claims Submission

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

Mental Health Services

Optum Maryland
800-888-1965
Fax 855-293-5407

Outreach

410-424-4648
888-500-8786

Provider First Line

410-424-4490
888-819-1043

Referrals

866-710-1447
Fax 410-424-4603

Substance Disorder Services

Optum Maryland
800-888-1965
Fax 855-293-5407

USFHP

Websites

USFHP: hopkinsusfhp.org

TRICARE: tricare.mil

FORMULARY: hopkinsusfhp.org

Customer Service (Provider)

(benefit eligibility, claims status)

410-424-4528

800-808-7347

*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

410-762-5206

800-557-6916

Health Education

800-957-9760

healtheducation@jhhp.org

Inpatient Utilization Management

Fax 410-424-2602

Outpatient Utilization Management

Fax 410-424-2603

Medical Appeals Submission

Johns Hopkins Health Plans

7231 Parkway Drive, Suite 100

Hanover, MD 21076

Attn: USFHP Appeals

Medical Claims Submission

Johns Hopkins Health Plans

PO Box 830479

Birmingham, AL 35283

Attn: USFHP Claims

Mail Order Pharmacy

410-235-2128 (Maryland residents)

800-345-1985 (Non-Maryland residents)

Mental Health/Substance

Disorder Services

410-424-4830

888-281-3186

Quality Improvement

410-424-4538

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 dental services from selected community dentists under a discounted fee structure.

PRPULSE14-SUMMER 2023

Important notice:

Please distribute this information to your billing departments.

PROVIDER
pulse



JOHNS HOPKINS
HEALTH PLANS

Johns Hopkins Health Plans
7231 Parkway Dr., Suite 100
Hanover, MD 21076