PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

FALL 2022

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

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

// INTRODUCTION

"Another fall, another turned page..."

—Wallace Stegner

We're turning over many a new leaf at Johns Hopkins HealthCare (JHHC) on our members' and providers' behalf. As the fall colors blaze and blanket the ground as a vibrant prelude to winter starkness, JHHC is actively finalizing its new claims processing system, Facets, which gives providers a smoother, more efficient and timely experience when submitting claims. In preparation for 2023, we are also briskly carrying out improvements and updates to our processes and portfolio of health plans.

Intentional partnerships with the providers in our ever-expanding network play an essential role in JHHC's commitment to high quality, accessible medical services that improve the overall health of our members. We thank you for all you do every day on behalf of our members.

— *Jayne Blanchard,* Editor

// POLICIES AND PROCEDURES

New Prior Authorization Requirements for Priority Partners and Advantage MD

Johns Hopkins HealthCare (JHHC) requires prior authorization for select medical procedure codes for Priority Partners as of Oct. 6, 2022 and for Johns Hopkins Advantage MD as of Nov. 1, 2022.

- **Advantage MD:** **List of procedure codes requiring prior authorization**
- **Priority Partners:** **List of procedure codes requiring prior authorization**

These lists are provided for reference purposes only and may not be all-inclusive. The prior authorization requirement applies to Advantage MD and Priority Partners members of all ages.

Providers should submit prior authorization requests via the eviCore portal* through **HealthLINK**, the **eviCore portal** directly, or if the portal cannot be accessed, by calling eviCore at 866-220-3071.

The listing of a code does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

Please refer to the Johns Hopkins Prior Authorization Lookup tool (JPAL), located in the **HealthLINK portal**, to check and verify prior authorization requirements for outpatient services and procedures. Note: Prior authorization requirements are subject to change.

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

Expansion of eviCore Musculoskeletal Programs

As previously communicated, beginning on Sept. 1, 2022, providers are now required to obtain prior authorization for physical therapy and occupational therapy from eviCore for Priority Partners and Johns Hopkins Advantage MD members.

Providers should submit prior authorization requests via the eviCore portal* through HealthLINK, the eviCore portal directly, or if the portal cannot be accessed, by calling eviCore at 866-220-3071 (faxes can also be accepted; please see below for details).

Musculoskeletal (MSK)-Therapies

The eviCore MSK-Therapies program encompasses prior authorization of physical therapy and occupational therapy.

- Authorization requirements:
  - » **Authorization is required after the initial PT/OT assessment/visit for Priority Partners members over 21** (therapy for Priority Partners members under 21 is not covered by Priority Partners).
  - » **For Advantage MD,** prior authorization is required after the 12th visit.
  - » If a patient was already in treatment on Sept. 1, 2022, please contact eviCore for prior authorization for additional sessions after Sept. 1, 2022.
- See the list of applicable PT and OT CPT codes for Priority Partners and Advantage MD that require prior authorization through eviCore in the Resources and Guidelines section of the provider website.
- Submit prior authorization requests for PT/OT through the portal, fax to 800-540-2406, or call eviCore at 800-220-3071.
- Please see the eviCore portal for clinical worksheets, which are recommended with submission of prior authorization requests.

Spotlight: How the Medical Policy Team Develops Policies

A recent query from a provider regarding how Johns Hopkins HealthCare's (JHHC) Medical Policy Team develops, adapts and revises our policies has inspired us to present a glimpse into the inner workings of this integral JHHC department.

I. How medical policies are developed:
JHHC medical policies are developed using evidence-based research, guidelines from regulatory bodies and expert organizations and input from practitioners with clinical expertise. The policies are critically reviewed and evaluated by a committee that includes practicing physicians before being approved and published online.

The evaluation and development of medical policies follows a specific protocol. First, a new technology, device or procedure is identified for review through various sources including the utilization management (UM) authorization process, the appeals and claims process, the new CPT/HCPCS code review process, a review of professional literature or new technology reports. Practitioners may also submit requests for medical policies that will be considered for development.

The technology, device or procedure is then investigated through a comprehensive review of the medical literature for sound scientific and clinical evidence to determine if the health service in question is safe, effective and medically necessary.

Additionally, regulatory requirements, industry standards and use of services are reviewed. If necessary, a subject matter expert with relevant clinical expertise is consulted for additional input. A policy may be drafted or updated if the technology, device or procedure meets the following criteria:

1. The technology has final approval from appropriate government bodies.
2. There is sufficient scientific evidence to permit conclusions concerning the effect of the technology on health outcomes.
3. The technology improves the member's net health outcome.
4. The technology is as beneficial as any established alternatives.
5. The improvement is attainable outside the investigational setting.

The drafted policy is presented to the Johns Hopkins Medical Policy Advisory Committee (MPAC). MPAC meets quarterly and comprises participating practitioners who evaluate the technology and policy criteria and vote on policy finalization and coverage decisions.

Policies that are approved by MPAC are implemented on the policy effective date and follow a revision schedule depending on evolving evidence and utilization.

It should be noted that JHHC provides health care products and services for EHP, Priority Partners, Advantage MD and USFHP. Each line of business has its own unique guidelines and should be consulted first to know what benefits are available for coverage. These specific contract benefits, guidelines and policies supersede the information in any of JHHC's online medical policies. Active medical policies for JHHC's four health plans are published on the **JHHC provider website.**

II. Third party entities (InterQual and eviCore): JHHC also uses tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. InterQual provides evidence-based clinical criteria to support clinically appropriate medical utilization decisions.

Similarly, some utilization management decisions are delegated to external vendors like eviCore, an independent medical benefits management company that provides utilization management services. eviCore clinical criteria are available on the **eviCore website.**

A medical policy may be retired when alternative medical necessity criteria, for example, through InterQual or eviCore, is chosen for the technology, service or procedure.

Policies may also be retired for the following reasons:

1. The technology, service or procedure covered by the policy has become standard of care and no longer requires prior authorization if benefits apply.
2. The policy or policies have been combined with or subsumed by another policy.
3. Low or no utilization of the technology, procedure, service, device or supply.
4. Lack business need for a medical policy (e.g., converted to a reimbursement policy).

Medical policy updates including information on new or retiring policies are communicated quarterly and posted on the **JHHC provider website**.

III. Obtaining a copy of clinical review criteria: Practitioners may request a copy of JHHC clinical review criteria by contacting Customer Service at 888-895-4998. Contact the Utilization Management department at 410-424-4480 or 800-261-2421 (for EHP, Priority Partners and USFHP) and 844-580-2856 (for Advantage MD) for request for InterQual criteria.

Medical Policy Updates Effective Nov. 1, 2022

The Johns Hopkins HealthCare (JHHC) Medical Policy Advisory Committee (MPAC) has approved changes and additions to our medical policies. These changes became effective Nov. 1, 2022, for Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners and Johns Hopkins US Family Health Plan (USFHP).

View the Medical Policy Updates

Changes and additions this quarter include:

Revised Medical Policies

- **CMS04.03** Pharmacogenomics
- **CMS16.02** Treatment for Skin Conditions
- **CMS03.01** Clinical Trials
- **CMS20.03** Gastroesophageal Reflux Disease (GERD) Devices
- **CMS01.09** Continuity of Care and Access to Non-Participating Providers
- **CMS14.04** Nutritional Treatment — Medically Necessary Food
- **CMS19.07** Dynamic Splinting for the Treatment of Joint Stiffness and Contracture
- **CMS24.08** Gender Affirming Treatment & Procedures — EHP
- **CMS21.01** Sacral Neuromodulation for Overactive Bladder, Urinary Retention & Fecal Incontinence & Posterior Tibial Nerve Stimulation for Overactive Bladder
- **CMS23.07** Infertility Evaluation and Treatment
- **CMS03.08** Panniculectomy and Body Contouring Procedures

Retired Medical Policies

- **CMS24.04** Cochlear Implants

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

// BENEFITS AND PLAN CHANGES

Contraceptive Services Added to Johns Hopkins USFHP's Preventive Services Benefit

Tricare Policy Manual Change 102 has added medical contraceptive services to the clinical preventive services benefit, effective Nov. 1, 2022.

- Well-woman exams may involve medical contraceptive consultations and services. These medical contraceptive services with no copay include
  - » Injections
  - » Placement and removal of intrauterine devices
  - » Implantable rods
  - » Diaphragm measurements and fittings

Beginning Jan. 1, 2023, no copay applies to tubal ligation procedures. Cost sharing may still apply for tubal ligations performed by out-of-network providers.

Priority Partners: Expansion of Dental Services to Adults

Beginning Jan. 1, 2023, Maryland Medicaid will provide coverage of dental services to adults under the Maryland Healthy Smiles Dental Program (MHSDP).

As a result, all adults who have Medicaid through a managed care organization (MCO), such as Priority Partners, are covered for dental benefits similar to those extended to pregnant women in addition to adults in the Rare and Expensive Case Management program.

The MHSDP program provides comprehensive dental services, which include diagnostic, preventive, restorative, endodontic, periodontic and certain prosthodontic services; oral maxillofacial surgery; and sedation.

The expansion of dental services to adults through Maryland Medicaid means that Priority Partners will no longer offer adults dental benefits through the vendor DentaQuest as of Jan. 1, 2023. Please direct questions about the adult dental coverage expansion to MHSDP at 844-275-8753.

To ensure the continuation of care, we encourage all Priority Partners dental providers to enroll with Maryland Medicaid to participate in MHSDP. To enroll as a Medicaid provider:

- Visit the Electronic Provider Enrollment and Revalidation Portal (ePREP) at **ePREP.health.maryland.gov.**
  - » For more information about Medicaid enrollment, call the ePREP help desk at 844-463-7768.
- **Step-by-step enrollment instructions with tutorial videos** can be found under the prospective provider section of the MHSDP website.

If you are already enrolled in Medicaid, there is nothing additional you need to do.

// CLAIMS AND BILLING

Optum CES Outpatient Code Editor (OCE) Edits

The Optum CES claims editing system replaces McKesson ClaimCheck for Priority Partners, Johns Hopkins US Family Health Plan (USFHP) and Johns Hopkins Employer Health Programs (EHP).

This will be effective for USFHP and Priority Partners on Sept. 1, 2022, and EHP on Dec. 1, 2022. Optum CES edits include CMS' Outpatient Code Editor (OCE) edits.

The OCE is an editing system created and maintained by CMS to process outpatient facility claims. The OCE edits identify incorrect and improper coding of these claims. CMS developed the National Correct Coding Initiative (NCCI or CCI) to promote consistent and correct coding methodologies.

Johns Hopkins HealthCare (JHHC) has adopted a subset of the OCE edits and will use these when processing outpatient facility claims. JHHC's **National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE) reimbursement policy** states that JHHC will not provide reimbursement for services identified through the OCE system as billing/coding errors.

For more information, providers can access the link below to see quarterly updates to the OCE edits for regulated and nonregulated facilities **I/OCE Quarterly Release Files***

Please see the attached list of OCE edits for **Medicaid**** and **TRICARE**** that will be applicable for Priority Partners and USFHP as of Sept. 1. Also, with the implementation of Optum CES, providers should bill according to CMS billing guidelines for bilateral and multiple procedure reductions (modifier 50 and modifier 51).

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

***Please visit our communications repository if the link to this PDF breaks.*

Claims Submission Reminder

Claims or encounter data should be filed on a standard CMS 1500 claim form. Facilities should submit claims on a UB-04 form.

NDC (National Drug Code) is required for payment of Part B medical injectable medication administered by provider. Please include the NDC on the claim form.

Claims must be submitted within 180 days of the date of service to the addresses below:

- Priority Partners
  P.O. Box 4228
  Scranton, PA 18505 (date of service Sept. 1, 2022, or after)
- Johns Hopkins EHP
  P.O. Box 4227
  Scranton, PA 18505 (date of service Dec. 1, 2022, or after)

If you would like to submit claims electronically, email EDI@jhhc.com for additional billing information.

Attachments to a CMS 1500 form or UB-04 form, which may be required, and the circumstances under which they may be requested are:

- A referral or consultant treatment plan
  - Referrals may be required for an appeal of a claim denied for failure to coordinate care with PCP.
  - Treatment plans may be required for certain specialty services such as physical therapy, mental health, substance abuse treatment, etc.
- An explanation of benefits statement from the primary payor
  - Required if JHHC is the secondary payor
- A Medicare Remittance Notice
  - Required if the claim involves Medicare as a primary payor
- A description of the procedure or service, which may include the medical record
  - May be required if a procedure or service rendered has no corresponding CPT or HCPCS code.
- Operative notes
  - May be required if the claim is for multiple surgeries or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82.
- Anesthesia records documenting the time spent on the service
  - May be required if the claim for anesthesia services rendered includes modifiers P4 or P5.
- Documents referenced as contractual requirements in a global contract
  - May be required if there is a global contract between Johns Hopkins HealthCare and a health care practitioner, hospital or person entitled to reimbursement.
- An ambulance trip report
  - May be required if the claim is for ambulance services submitted by an ambulance company licensed by the Maryland Institute for Emergency Medical Services Systems.
- Office visit notes
  - May be required if the claim includes modifier 21 or 22, or an audit of the health care practitioner, hospital or person entitled to reimbursement demonstrated a pattern of fraud, improper billing or improper coding.
- Admitting notes, except in the case of emergency services rendered in accordance with Health General Article §§190701(d) and 19-712.5 Annotated Code of Maryland
  - May be required if the claim for services provided is outside of the time or scope of the authorization, or when there is an authorization in dispute.

// PHARMACY

New Prior Authorization Requirements For Certain Provider-Administered Medications

Prior authorization will be required for the medical injectable drug codes listed on the Johns Hopkins Employer Health Programs (EHP) **Pharmacy page** for EHP-Johns Hopkins University:

- Prior authorization is effective Jan. 16, 2023, for Johns Hopkins University (JHU) groups E00015 and E00151(prior authorization requests may be submitted to Novologix as of Jan. 1, 2023).
- Prior authorization is effective April 17, 2023, for JHU retiree group E0051 (prior authorization requests may be submitted to Novologix as of April 1, 2023).

The process for obtaining prior authorizations for Johns Hopkins EHP will be managed in collaboration with CVS Health-NovoLogix. Providers may submit prior authorization requests electronically using the NovoLogix portal through the **JHHC HealthLINK** portal. The Novologix portal must be accessed through HealthLINK for JHHC prior authorization requests.

Providers may also contact NovoLogix by phone at 844-345-2803.

// QUALITY CARE

Care Management Team Advocates Small Steps, Big Change

Johns Hopkins HealthCare (JHHC) is always looking to improve members' health. No matter where they are on their health journey, we have programs designed to help them get where they want to go. We encourage our members to start small. SMALL STEPS, BIG CHANGE, our approach to member health, helps our members get closer to their best self with the support they need, when they need it.

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.

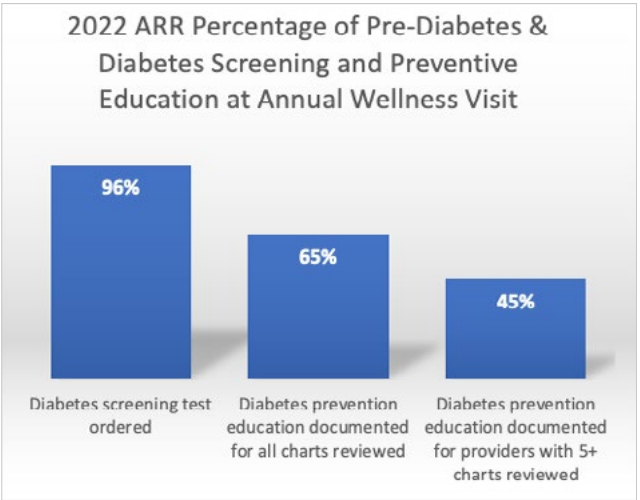
We also offer free health education classes to teach about healthy lifestyles and living well with a chronic condition. Members can register for classes through the member website of their JHHC health plan.

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@jhhc.com.**

Increasing Documentation of Diabetes Prevention Education During Annual Wellness Visits

An internal analysis showed that Johns Hopkins US Family Health Plan beneficiaries are getting screened for prediabetes, but more than half of providers are not documenting diabetes prevention education.

Johns Hopkins USFHP performs retrospective chart reviews of various outpatient standard of care measures annually to assure that beneficiaries are receiving evidence-based care. Recent results showed that 96% of USFHP beneficiaries who qualified for diabetes screening received it during their October 2021 annual wellness visit, but many providers missed documenting patient education. After the results were adjusted to measure the percentage of providers who had five or more eligible charts, only 45% of providers documented diabetes prevention education that could be found in the visit notes or after visit summaries.



Individuals are more likely to continue behaviors that increase the risk of developing diabetes without targeted patient education about lifestyle modifications that can help prevent diabetes.

Providing diabetes prevention education to all patients who are overweight or obese will meet or exceed value-based practice measures.

USFHP wants to better understand the barriers of documenting diabetes prevention education, with a goal to increase documentation by 20% over the next two years.

To accomplish this goal, USFHP is developing a provider toolkit to help support providers in improving their rates of documentation of diabetes prevention education to beneficiaries who are overweight or obese. Collaboration and feedback from clinic administrators, staff, providers and beneficiaries are key to this initiative.

Please complete this short **QIP Diabetes Provider Survey** so we can share the toolkit with providers in early 2023. You can also access the survey with the QR code below:

// REMINDERS

Protect Your Patients This Flu Season

A new flu vaccine is made each fall to protect against the flu viruses predicted to cause outbreaks during that flu season. It's one of the best ways to protect your patients.

For the 2022-2023 flu season, the vaccine is available in different forms. The most common way to get the vaccine is by flu shot. A nasal spray is also available for healthy, non-pregnant people between the ages of 2 and 49. Because COVID-19 is still active, health experts strongly advise that patients get the flu vaccine to protect themselves and others.

Every one of your patients six months and older should get a flu vaccine each year. The season for flu can begin as early as October and most commonly peaks in January of February, but flu seasons are unpredictable.

The flu vaccine is usually recommended to specific groups of people, as well as for anyone who doesn't want to get the flu. It is recommended even for people with egg allergies. People with a history of severe egg allergies are advised to get their vaccine in a medical setting, such as a hospital or outpatient medical clinic overseen by a healthcare provider who can recognize and manage severe allergic reactions. For people 18 and older, an egg-free vaccine may be available. Talk to your patients about which flu vaccine is right for them and where they should get their vaccine.]

Remind them that the flu shot takes about one to two weeks to start working. The Centers for Disease Control and Prevention (CDC) urges that travelers have the flu vaccine at least two weeks before planned travel to allow time to develop immunity.

Now about those rumors

Patients might have qualms about getting the flu vaccine. Reassure them:

- The flu shot cannot give you the flu.
- The flu shot is safe.
- The CDC and U.S. Food and Drug Administration closely watch vaccine safety. Hundreds of millions of flu vaccines have been safely given across the country for decades.

New Overpayments Address for Advantage MD

Providers remitting overpayments for claims paid by Johns Hopkins Advantage MD must send them to the address below:

- Hopkins Health Advantage Inc.
  P.O. Box 419185
  Boston, MA 02241-9185

Failure to send checks to the address identified in this notice may result in delays in application of the payment(s) against your account(s).

NOTE: Please include the claim number(s), applicable dates of service and applicable explanation of benefits (EOB), if possible, with the check when submitting a refund.

Priority Partners Member Health Care Benefits Renewal

The Public Health Emergency (PHE) is scheduled to end on **Jan. 11, 2023**. That means Priority Partners members who were impacted by the extension on redetermination need to

act promptly to renew their health care benefits. Providers are advised to notify Priority Partners members of the termination of the PHE and the reinstated requirement to renew benefits annually. After the PHE ends, the Maryland Health Department will assign them to a new redetermination month. Encourage your Priority Partners members to renew their benefits as soon as they can.

Use Updated Priority Partners Forms for Newborn Notification and Provider Changes

As you are aware, Johns Hopkins HealthCare (JHHC) switched to the Facets claims processing system for Priority Partners on Sept. 1, 2022.

With this change, it was necessary to update certain Priority Partners forms to correctly align with the new system.

Please use these revised forms, which can be found on the Forms page of the JHHC provider website. **The old version of the forms will no longer be accepted and cannot be processed.**

- Priority Partners Newborn Enrollment Notification Form
- Priority Partners Primary Care Provider Change Form
  - » **NOTE:** All Priority Partners members were assigned an individual primary care provider (PCP), not a provider group, as of Sept. 1, 2022.
  - » Please do not submit a Provider Change Form requesting members be assigned back to their former provider group instead of the individual PCP assignment. Priority Partners members can no longer be assigned at the group level.
  - » If members see a PCP in the same group as their assigned PCP, and that PCP bills under the same tax identification number and group NPI number as the assigned PCP, **the claims will pay.**

Network Access Standards

JHHC 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 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

Johns Hopkins US Family Health Plan

Service	Appointment wait time (not more than):
Well patient	Twenty-four (24) hours
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 JHHC Provider Relations department by email at ProviderChanges@jhhc.com.

Care Management Referrals
caremanagement@jhhc.com 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.

JHHC Corporate Compliance
410-424-4996
Fax 410-762-1527
compliance@jhhc.com

Fraud Waste & Abuse
FWA@jhhc.com

Preauthorization Guidelines
hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines

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: jhhc.com
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
Johns Hopkins Advantage MD
P.O. Box 3537
Scranton, PA 18505

Medical Payment Disputes Johns Hopkins Advantage MD
P.O. Box 3537
Scranton, PA 18505

Pharmacy Services
877-293-5325

Preauthorization
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: hopkinsmedicine.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 – United Concordia Companies, Inc.**
866-851-7576

***Health Coaching Services**
800-957-9760
healthcoach@jhhc.com

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 Abuse Services
800-261-2429
410-424-4476

National Provider Network/MultiPlan
866-980-7427

***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: jhhc.com
800-654-9728

Customer Service (Provider)
800-654-9728

Dental (Scion)
855-934-9812

HealthChoice
800-977-7388

Health Education
800-957-9760

Medical Appeals Submission
Johns Hopkins HealthCare LLC
Appeals Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Fax 410-762-5304

Medical Claims Submission
Johns Hopkins HealthCare LLC 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 Abuse 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 abuse professionals.*

Care Management
410-762-5206
800-557-6916

Health Coach Services
800-957-9760
healthcoach@jhhc.com

Health Education
800-957-9760
healtheducation@jhhc.com

Inpatient Utilization Management
Fax 410-424-2602

Outpatient Utilization Management
Fax 410-424-2603

Medical Appeals Submission
Johns Hopkins HealthCare
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Attn: USFHP Appeals

Medical Claims Submission
Johns Hopkins HealthCare
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 Abuse 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.

Important notice:
Please distribute this information to your billing departments.

PRPULSE14-Fall 2022

PROVIDER pulse

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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