PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

SPRING 2023

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

"Spring is the time of plans and projects."
— Leo Tolstoy

Those Russian writers really knew their stuff. This adage could not be more germane to what's happening at Johns Hopkins HealthCare (JHHC) as the earth warms, the days lengthen and the milder temps spur you to emerge from the isolation of winter and take on new tasks.

Now that the Public Health Emergency (PHE) has officially ended, many policies and procedures have reverted to pre-COVID-19 standards. An article in this issue outlines some of the changes post-PHE. One of the post-PHE and COVID-19 adjustments that affects Priority Partners members is the return of the re-enrollment mandate. Please remind your Priority Partners members that they are required to renew their benefits to avoid losing their health care coverage.

We're also in the middle of the CAHPS® member survey season, and the issue features tips and strategies for some of the major stress points for members when they seek care. The latest code changes and medical policy updates are also highlighted in these pages.

The growth we're experiencing at JHHC would not be possible without your partnership. Thank you for all you do.
—Jayne Blanchard, Editor

// POLICIES AND PROCEDURES

Medical Policy Updates Effective May 1, 2023

The Johns Hopkins HealthCare (JHHC) Medical Policy Advisory Committee has approved changes and additions to our medical policies. These changes went into effect May 1, 2023.

View the Medical Policy Updates

Changes and additions this quarter include:

Revised Medical Policies

- **CMS02.09 —** Testing for Hereditary Breast and Ovarian Cancer Syndromes
- **CMS03.12 —** Cosmetic and Reconstructive Services
- **CMS19.05 —** Solid Organ Transplantation
- **CMS07.05 —** Gender Affirmation Treatment & Procedures
- **CMS01.00 —** Medical Policy Introduction
- **CMS16.19 —** Prenatal Obstetrical Ultrasound
- **CMS23.05 —** Site of Service – Outpatient Surgical Procedures
- **CMS22.01 —** Minimally Invasive Treatment of Varicosities
- **CMS16.15 —** Evaluation and Treatment of Pediatric Feeding Disorders
- **CMS20.04 —** Thermography

Retired Medical Policies

- **CMS02.12 —** Biofeedback
- **CMS01.03 —** Acupuncture

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

Site of Service Medical Policy Changes For Priority Partners and USFHP

The Johns Hopkins HealthCare (JHHC) Medical Policy Advisory Committee has approved changes, deletions and additions to the JHHC Site of Service Medical Policies for Priority Partners and Johns Hopkins US Family Health Plan (USFHP). This requirement affects Priority Partners and USFHP members of all ages.

Please see Updates to the Site of Service Code List for PPMCO and USFHP to view the changes effective May 1, 2023.

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

Some procedures may also require medical necessity review using clinical review criteria specific to the procedure in ANY site of service (outpatient hospital setting, ambulatory surgery center or office).

To view the full description of the site of service policy and important appendices, please visit the **Medical Policies** section of the JHHC website after the policy effective date or call Provider Relations at 888-895-4998 (Option 4).

Prior Authorization Process

Submit prior authorization requests to JHHC Utilization Management department only via the fax numbers listed below:

- **Priority Partners**
  - » Non-urgent Outpatient: 410-762-5205
  - » Urgent Outpatient: 410-424-2707
- **USFHP**
  - » Outpatient: 410-424-2603

JHHC New Reimbursement Policy: Routine Venipuncture and/or Collection of Specimens – Professional

John Hopkins HealthCare (JHHC) has released its new reimbursement policy on Routine Venipuncture and/or Collection of Specimens – Professional. This payment policy applies to Routine Venipuncture and/or Collection of Specimens, professional services that are reported to JHHC on CMS-1500 claim forms or their electronic equivalent from network and non-network physicians, providers and suppliers to the Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs, Priority Partners and Johns Hopkins US Family Health Plan health plans.

This policy makes public JHHC's new policy on the subject matter, with a July 1, 2023, effective date.

- **RPC.015**: Consistent with Centers for Medicare & Medicaid Services (CMS) guidance, JHHC will reimburse venipuncture services and/or collection of specimens when covered under plan benefits and when billing guidelines are met. The appropriate CPT® codes, modifiers and/or Place of Service (POS) must be used when the venipuncture or collection of specimens claims are submitted. Claim(s) that do not follow correct coding and billing guidelines may be denied.
  - » Consistent with CMS, regardless of the number of blood specimens drawn, only one venipuncture collection fee will be allowed per day.
  - » JHHC will deny the venipuncture/specimen collection service when billed with an Evaluation and Management (E/M) services, as these service are considered bundled.
  - » JHHC follows the "first in, first out" logic and will only reimburse one venipuncture service per day, regardless of the number of providers who perform the service.
  - » Consistent with CMS, JHHC considers S9529 to be a non-reimbursable service code and is not eligible for reimbursement.

REFERENCES

- Clinical Laboratory Improvement Amendments (CLIA) CMS*
- CMS Regulations & Guidance*
- COMAR – Maryland Department of Health- Maryland Medicaid Administration*
- CPT® Copyright American Medical Association.
- Medicare Claims Processing Manual Chapter 16 – Laboratory Services*
- NCCI for Medicaid | CMS* and NCCI for Medicare | CMS*
- TRICARE Policy Manual – Administration Chapter 1 Section 12.1, Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes*

To view the JHHC Reimbursement Policies, please go to **JHHC.com > For Providers > Policies > Reimbursement Policies.**

** 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.*

Reminder: Reimbursement for Remote Patient Monitoring Self-Measured Blood Pressure Services for Priority Partners

Remote Patient Monitoring (RPM) is a service that uses digital technologies to collect medical and other forms of health data from individuals and electronically transmits that information securely to health care providers for assessment, recommendations and interventions. Providers should order RPM when it is medically necessary to improve chronic disease control and to reduce potentially preventable hospital admissions.

Originally part of the COVID-19 response, Medicaid has permanently expanded access to RPM services to include participants who qualify based on any conditions and medical histories capable of monitoring via RPM. Additionally, Medicaid has eliminated fee-for-service prior authorization requirements.

In accordance with Senate Bill 244–Maryland Medical Assistance Program - Self-Measured Blood

Pressure Monitoring (Chs. 670 of the 2022 Acts) 2, **effective Jan. 1, 2023,** Medicaid's RPM program covers the monitoring of validated home blood pressure monitors and reimbursement for patient training, patient data transmission, interpretation of readings and reporting, and co-intervention deliveries. Co-intervention deliveries may include educational materials or classes, behavioral change management and medication management.

To receive RPM, participants must be enrolled in a Medicaid plan such as Priority Partners, consent to RPM, have the necessary internet connections and be capable of using the monitoring tools in their homes.

Revenue Code 0581 (for home health agencies) and HCPCS code S9110 (for all other professionals) are reimbursable for RPM. The RPM rate is an all-inclusive rate of $125 per 30 days of monitoring, which covers:

- Equipment installation
- Participant education for using the equipment
- Daily monitoring of the information transmitted for abnormal data measurements

Referrals for RPM may cover an episode of up to 60 days of monitoring. Eligible participants may only receive one unit of RPM per 30-day period and four units within a 365-day period. Physicians or home health agencies can provide RPM; however, the authorization limits apply across programs. Priority Partners will not reimburse for:

- RPM equipment
- Upgrades to RPM equipment
- Internet service for participants

Coverage of blood pressure monitoring equipment as durable medical equipment (DME) has not changed.

Post Public Health Emergency Reminders for Providers

The lifting of the COVID-19 Public Health Emergency (PHE) on May 12, 2023, affects the processes and procedures for all Johns Hopkins HealthCare (JHHC) health plans. Here's a rundown of some of the changes and processes that have reverted to the standards that were in place before the PHE went into effect.

Johns Hopkins Employer Health Programs (EHP), Priority Partners, Johns Hopkins US Family Health Plan (USFHP), Johns Hopkins Advantage MD*

- JHHC's timeframes for the peer-to-peer review process will revert 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 the Centers for Medicare & Medicaid Services (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 JHHC's peer-to-peer review process in the Provider Manuals.

Priority Partners, Johns Hopkins USFHP

- JHHC Pharmacy is amending its timeframe for the post-denial review process for Priority Partners and USFHP when the PHE is lifted on May 12, 2023.
- **Priority Partners and USFHP providers submitting self- and non-self-administered pharmaceuticals requests for review by JHHC 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**

USFHP

- The below policies terminated at the expiration of the President's national emergency for COVID-19.
  - » Temporary Relaxation of State Professional Licensing Requirements (allowing interstate practice) expired **April 10, 2023**. This was authorized in the Tricare Policy Manual. Practitioner must be licensed in the state where the member is receiving care.
  - » Waiver of the skilled nursing facility (SNF) three-day prior hospital stay requirement expired **April 10, 2023**. This was authorized in the Tricare Reimbursement Manual. SNFs continue to require preauthorization — no change to the existing process.
- Effective May 12, 2023, waivers ended for USFHP member copayments and cost-shares for COVID-19-associated evaluations that lead to testing at the provider's office, urgent care and emergency room facilities.
- Visits for detection/diagnosis of COVID-19 and COVID-19 tests are subject to copay beginning May 12, 2023.
  - » The actual COVID-19 test does not have a copay amount (lab tests = $0).
- There is no change to reimbursement for At-Home COVID-19 tests with a provider order: $0 copay.
- Point of Service (POS) charges for out-of-network (OON) visits will apply.

Advantage MD, EHP and Priority Partners

For post-PHE COVID-19 updates applicable to JHHC's other lines of business, please reference the applicable websites:

Advantage MD

- Please reference the CMS.gov Newsroom website for the latest transition information.

EHP

- Please reference the EHP COVID 19 Information Page.

Priority Partners

- Please reference Medicaid Provider Announcements, Orders and Guidance Related to the COVID-19 Outbreak.

Changes and Additions to the Gender Affirming Treatment Medical Policy for EHP

The below listed medical policy been approved by the JHHC Medical Policy Advisory Committee (MPC). Changes and additions became effective June 1, 2023 for Johns Hopkins Employer Health Programs (EHP).

CMS24.08 Gender Affirming Treatment & Procedures – EHP

- Policy updated to align with the World Professional Association for Transgender Health (WPATH) SOC-8 guidelines
- Added revision surgery coverage for detransition/retransition
- Revision of the surgical readiness *letter of referral* criteria.
- Note added on future use of ICD-11 once adopted by the U.S.
- Updated adjunctive treatment/procedures list to include additions and clarifications:
  - » Brow augmentation/brow reduction - added
  - » Rhytidectomy - clarified by adding term for face lift
  - » Hair removal- clarified by adding (electrolysis/laser epilation)
  - » Hair line advancement - added
  - » Augmentation/upper lip shortening - added
  - » Monsplasty/mons reduction – added
- Surgical criteria for adolescents added:
  - » A comprehensive biopsychosocial assessment by qualified licensed mental health AND medical professionals has been completed
  - » Coverage of surgical procedures for adolescents on a case-by-case basis.

// CLAIMS AND BILLING

Reminder: Updated Processes for Claims Submission and Utilization Management (UM) Forms

Johns Hopkins HealthCare (JHHC) now uses optical character recognition (OCR) to scan claims into the system for processing. To avoid claim rejections or delays in processing, please do not submit handwritten claims. Instead, claims should be typed or submitted electronically through **HealthLINK** or a clearinghouse.

Please see the guidelines below for your reference.

- Instructions on the preferred method of submitting claims:
  - » **OCR 1500 Claim Form – Instructions and Helpful Hints (novitas-solutions.com)**
- If you are not registered with HealthLINK, please submit a request via the following link:
  - » **Johns Hopkins – Provider Registration – User Information (healthtrioconnect.com)**
- For more information and HealthLINK job aids, please see the **Overview (hopkinsmedicine.org)** section of the JHHC provider website. Once you are registered, your Network Relations Consultant can provide any necessary training.

Updated UM Team Forms Completion Process

The UM team is asking for your cooperation when completing our prior authorization and referral forms. When submitting a PDF form to UM, please type in all information in the fillable fields. Providers can then fax the printed forms to the appropriate UM fax number (see below for list).

Handwritten responses may take longer to process and may be returned if illegible and/or if all fields are not completely filled out.

NOTE: Please fill out all fields in the UM forms; incomplete forms may not be processed.

UM Fax Numbers:

- **Johns Hopkins Advantage MD**
  - » Inpatient: 844-240-1864
  - » Outpatient: 855-704-5296
- **Priority Partners/Johns Hopkins Employer Health Programs**
  - » Inpatient Initial: 410-424-2770
  - » Inpatient Concurrent: 410-424-4894
  - » Non-urgent Outpatient: 410-762-5205
  - » Urgent Outpatient: 410-424-2707
- **Johns Hopkins US Family Health Plan**
  - » Inpatient: 410-424-2602
  - » Outpatient: 410-424-2603

Proper Billing for USFHP Providers

For members with coverage under both Medicare and Johns Hopkins US Family Health Plan (USFHP), Medicare cannot be

billed for services covered by USFHP. Providers filing Medicare claims, or who have claims filed on their behalf, are in violation of the conditions of participation with USFHP and are subject to disenrollment.

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

Selected Codes Removed from Prior Authorization Requirement

A selection of procedure and service codes will not require prior authorization for the following plans:

Johns Hopkins EHP (EHP), effective June 1, 2023

- A selection of Physical Therapy and Occupational Therapy (PT/OT) codes will not require prior authorization beginning June 1, 2023 for EHP health plans.
- **List of Codes Deleted from Prior Authorization Requirement 6/1/23**

NOTE: All benefit visit limits will remain in effect.

Johns Hopkins Advantage MD, Priority Partners, Johns Hopkins US Family Health Plan, effective June 15, 2023

- **B4102:** Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit
- **B4103:** Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit

These S-codes apply to Priority Partners ONLY, effective July 1, 2023

- **S9330:** Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9331:** Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9338:** Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9342:** Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
- **S9343:** Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
- **S9348:** Home infusion therapy, sympathomimetic/ inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9355:** Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9359:** Home infusion therapy, antitumor necrosis factor intravenous therapy (e.g., Infliximab); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9366:** Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
- **S9367:** Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

- **S9370:** Home therapy, intermittent anti-emetic injection therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9374:** Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9379:** Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
- **S9500:** Home infusion therapy, antibiotic, antiviral or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

// PHARMACY

Pharmacy Formulary Update

A variety of pharmacy information and resources are available to you on the JHHC, Priority Partners, EHP, USFHP and Advantage MD websites. 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 JHHC 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:

- **Johns Hopkins Employer Health Programs (EHP)**
  Jhhc.com > For Providers > Our Health Plans >EHP > **Pharmacy and Formulary**
- **Priority Partners**
  Jhhc.com > For Providers > Our Health Plans > Priority Partners > **Pharmacy and Formulary**
- **Johns Hopkins US Family Health Plan (USFHP)**
  Jhhc.com > For Providers > Our Health Plans > US Family Health Plan > **Pharmacy and Formulary**
- **Johns Hopkins Advantage MD**
  Jhhc.com > For Providers > Our Health Plans > Advantage MD > **Pharmacy and Formulary**

Stay Informed About the Medicare Part D Excluded Drug List

Johns Hopkins Advantage MD follows Medicare Part D regulations on how medications are covered. The following classes of medications are not a covered benefit by Medicare Part D and Advantage MD:

- Over-the-counter (OTC) drugs
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used to promote fertility
- Drugs when used for treatment of anorexia, weight loss or weight gain

Many excluded medications are prescribed for our members and can result in delayed access to treatment and patient dissatisfaction. Below are the top 15 prescriptions written for our members for excluded products (these products are not covered through Advantage MD's Pharmacy Benefit):

Top 15 Excluded Drugs Prescribed by Providers

1. Vitamin D2, 50,000 IU
2. Benzonatate Cap
3. COVID-19 Test Kits
4. Folic Acid
5. Aspirin
6. Cetirizine
7. Sildenafil
8. Tadalafil
9. GG/Codeine Sol
10. Loratadine
11. Docusate
12. Promethazine Sol DM

13. Magnesium Oxide
14. Acetaminophen
15. Ferrous Sulfate

As appropriate, please refer patients to their OTC benefit* or consider asking the patient to purchase the product or a comparable product over the counter. Let them know that the drug is not covered by Medicare Part D and they should expect to pay the full cost of the medication at the pharmacy.

*Advantage MD HMO, D-SNP and PPO Primary members have a quarterly OTC allowance through their OTC benefit.

New Prior Authorization Requirements for Certain Provider-Administered Medications

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

Priority Partners Prior Authorization Requirements Effective May 1

Advantage MD Prior Authorization Requirements Effective May 1

USFHP Prior Authorization Requirements Effective May 1

Additionally, certain medications require site of care prior authorization review under Priority Partners and USFHP as of May 1, 2023. This site of care requirement is noted for the applicable medications in the prior authorization medication lists shown above. These site of care reviews are applicable for new therapy starts, as well as authorization renewals.

The comprehensive lists of provider-administered medications that require prior authorization for these health plans are also available on the **JHHC 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 available, 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 available, call NovoLogix for assistance at 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.

Tell Your Advantage MD Patients About Rx Mail Order Delivery Services

Johns Hopkins Advantage MD members can visit any of the 65,000 pharmacies in our nationwide network. Most pharmacies are in our network and able to fill your patients' prescriptions.

Another option for your Advantage MD patients looking to save money is to fill a 90-day supply of medication on Tier 3 and Tier 4 through CVS Caremark mail order pharmacy. The copay is two times the 30-day copay instead of three times the 30-day copay for a 90-day supply.

- For example, if a member's 30-day supply copay was $47 for a Tier 3 drug, the 90-day supply by mail order would be $94 (two times $47).
- All non-D-SNP members may fill up to a 100-day supply of medication for Tier 1 drugs, up to a 90-day supply for Tier 2-4 drugs and up to a 30-day supply of Tier 5 drugs.
- D-SNP members may fill up to a 90-day supply of all drugs.

There are four easy ways to get your Advantage MD members started on mail order:

1. Send a 90- or 100-day electronic prescription to CVS Caremark Mail Service Pharmacy.
2. Members must then register for an account or sign in to **Caremark.com** and select *Start Rx Delivery by Mail*. Caremark will contact you and begin the process for your Advantage MD patients.
3. Patients can also fill out a Mail Service Order Form on **Caremark.com** and mail it with their 90- or 100-day prescription.

4. Or they can Call CVS Caremark:
    - » Advantage MD (HMO) and (D-SNP) members: **877-293-4998 (TTY: 711)**
    - » Advantage MD (PPO) Members: **877-293-5325 (TTY: 711)**

100-Day Medication Supplies Available to Advantage MD Members

Maximize patient adherence and medication costs by prescribing 100-day supply orders for your patients.

Johns Hopkins Advantage MD members can fill a Tier 1 medication for a 100-day supply instead of 90 days. Tier 1 includes our preferred generic medications including, but not limited to, generic medications to treat diabetes, hypertension and hyperlipidemia.

This will help members in the following ways:

- **Save money:** A 100-day supply costs the same as a 90-day supply.
- **Save time:** With 10 additional days of medication per refill, members make fewer trips to the pharmacy.
- **May improve** medication adherence.

We encourage you to discuss this opportunity with your patients and consider writing 100-day-supply prescriptions for maintenance generic medications.

// QUALITY CARE

CAHPS® Tips

Improving CAHPS scores is a significant motivational factor throughout our teams and departments at Johns Hopkins HealthCare. As part of our efforts, we are emphasizing six key CAHPS measures and offering a few tips for enhancing the member experience, which may result in improved CAHPS scores.

Rating of Personal Doctor and Specialist

Patients are more likely to give high ratings to their doctors if they feel that they are listened to, acknowledged and that their concerns are taken seriously. Take the time to listen to your patients and to provide clear explanations of their diagnosis and treatment plan.

Rating of Health Plan and Health Care

Patients' perception of their overall experience with their health care plan and the care they receive is central. Providers and health care plans can improve this score by communicating effectively with members and making sure they feel heard and understood.

Getting Care Quickly and Easily

Patients value convenience and timely access to care. Ensure patients are able to schedule appointments easily, and offer options for telemedicine and other remote care options.

Coordination of Care

Patients appreciate when their health care providers work together to provide coordinated care. Providers can improve this score by making sure patients receive timely and accurate communication about their care plan and that their care is seamlessly coordinated across different providers and care settings.

Getting Needed Medications Quickly and Easily

Patients who get their needed medications easily and quickly are more likely to be satisfied with their general health care experience. Providing clear instructions for medications, ensuring that patients have access to affordable medications and providing resources for medication management lead to happier patients who may be more likely to respond positively to this measure.

Smoking Cessation

Smoking cessation is an important component of overall health, and patients who successfully quit smoking are more likely to be satisfied with their health care experience. Offer smoking cessation programs and resources, as well as support and encouragement, to patients who are trying to quit.

We hope these guidelines will be helpful in improving your CAHPS scores and overall patient satisfaction.

Guidelines for Lower Back Pain Care

Johns Hopkins HealthCare (JHHC) is committed to improving patient care and outcomes. One measure we focus on is the HEDIS® score for lower back pain. We'd like to share some guidelines with you that can help improve this score and, more importantly, step up the care of your patients.

- **Use evidence-based guidelines for diagnosis and treatment:** Utilize clinical practice guidelines that are based on the latest research and recommendations from reputable organizations such as the American College of Physicians and American Pain Society. These guidelines emphasize conservative, noninvasive approaches to lower back pain management, including physical therapy, exercise and non-opioid pain relievers.

- **Encourage patient engagement and self-management:** Educate patients about their condition, and provide them with tools and resources to manage their pain and prevent future flare-ups. Encourage them to be active participants in their care by setting goals, tracking progress and communicating regularly with their health care team.
- **Consider non-pharmacologic treatments:** Opioid use for chronic lower back pain is associated with increased risks of addiction, overdose and other adverse events. Consider non-pharmacologic treatments such as physical therapy, cognitive behavioral therapy, acupuncture and chiropractic care as first-line options.
- **Monitor opioid use:** When opioids are prescribed, monitor patients closely for signs of misuse or addiction. Follow guidelines for prescribing opioids, such as the Center for Disease Control and Prevention's opioid prescribing guidelines. Consider using prescription drug monitoring programs to identify patients who may be at risk for opioid abuse or diversion.
- **Provide timely follow-up care:** Schedule follow-up visits with patients to assess their progress and adjust treatment as needed. Coordinate care with other providers, such as physical therapists or pain specialists, as appropriate.

By following these guidelines, you can help improve the quality of care for patients with lower back pain.

Help Your Patients Win at Quitting

Providers play a vital role in helping their patients improve their overall health and well-being. One area that can significantly impact a patient's health is their tobacco use. Johns Hopkins HealthCare urges our providers to encourage their patients to kick the tobacco habit for their health's sake.

The importance of smoking cessation cannot be overstated. Smoking is a leading cause of preventable death and can increase the risk of numerous health problems, including cancer, heart disease and respiratory issues. By helping patients quit smoking, you can help them avoid these negative health outcomes and improve their overall quality of life.

Here are some strategies you can use to support smoking cessation:

- **Assess patient readiness to quit smoking:** Start by assessing your patients' readiness to quit smoking. Some patients may be ready to quit immediately, while others may need more time. By assessing their readiness, you can tailor your approach to best suit their needs.
- **Offer counseling and support:** Once you have assessed their readiness, offer counseling and support to help them quit smoking. This may include providing information on the health risks associated with smoking, offering resources for quitting and providing ongoing support throughout the quitting process.
- **Prescribe smoking cessation medications:** In addition to counseling and support, consider prescribing smoking cessation medications, such as nicotine replacement therapy or prescription medications. These medications can help patients manage their cravings and increase their chances of successfully quitting smoking.
- **Follow up regularly:** Following up regularly with your patients is essential to their success in quitting smoking. Check in with them at subsequent appointments, provide additional support as needed and celebrate their successes along the way.

Strategies for Behavioral Health Management

Mental health has moved front and center as our members and provider network find our footing in this post-COVID-19 world.

Understandably, mental health and its impact on overall health has become a priority. That is why Johns Hopkins HealthCare recommends that providers pay close attention to their patients' behavioral health and to take proactive steps to support them in this area.

Mental health and substance use disorders are common among adults in the U.S., with an estimated one in five individuals experiencing some form of mental illness in a given year. It is crucial for health care providers to be vigilant about their patients' behavioral health needs and to take a holistic approach to their care. This includes:

- Screening for mental health and substance use disorders during routine checkups
- Identifying patients who may be at higher risk due to factors such as a family history of mental illness or a history of substance misuse
- Promoting healthy behaviors and supporting patients who may be struggling with behavioral health issues.
    - » This may include recommending lifestyle changes such as regular exercise, healthy eating and stress reduction techniques such as meditation or mindfulness practices.

We also encourage providers to take advantage of technology and telehealth options to ensure that patients have access to the care they need, even if they are unable to come in to the office. Telehealth appointments can be a convenient and effective way for patients to receive counseling or therapy services.

Addressing behavioral health needs is a critical part of providing comprehensive, patient-centered care. By working together, we can ensure that our members receive the support and resources they need to maintain good mental and physical health.

Follow-Up Care Crucial After Hospitalization or ER Visit for Mental Illness and Substance Use Disorders

At Johns Hopkins HealthCare (JHHC), we know that timely and effective follow-up care is critical to ensuring the best possible outcomes for patients with mental illness or substance use disorders. Unfortunately, too often follow-up care after hospitalization or emergency department (ER) visits is inadequate, leading to relapses, complications and readmissions.

Here are a few tips and guidelines to help ensure that our patients receive the follow-up care they need:

- **Develop a comprehensive discharge plan:** Discharge planning should start as soon as possible and involve the patient, family members and caregivers. The plan should include referrals to appropriate resources, medication management and follow-up appointments with a primary care physician or specialist as needed.
- **Schedule follow-up appointments:** Before the patient leaves the hospital or ER, schedule follow-up appointments with appropriate health care providers. This can include a primary care physician, psychiatrist or addiction specialist.
- **Ensure timely medication management:** For patients with mental illness or substance use disorders, timely and appropriate medication management is essential to their recovery. Ensure that patients have access to their prescribed medications and that they understand how to take them correctly.
- **Provide education and support:** Patients and their families may need education and support to manage their conditions effectively. This can include information about healthy coping strategies, stress management and support groups.

By following these guidelines, we can help ensure that JHHC health plans members receive the follow-up care they need to manage their behavioral health conditions effectively and achieve the best possible outcomes.

Refer Patients to Care Management Services

Care managers are licensed clinical staff (e.g., nurses, social workers, etc.) who help Johns Hopkins HealthCare (JHHC) health plans members better understand and manage their physical health and behavioral health conditions. The Care Management team assigns participating members a dedicated care manager to assist with the coordination of care. Care managers work to link members to needed services and community resources, to help them navigate the health care delivery system and to guide them in developing the self-management skills that maintain any gains achieved while participating in Care Management services.

Care Management program areas with dedicated care managers are complex care management (for members with chronic and/or complex conditions and comorbidities), maternal-child health (for high- risk pregnant members and pediatric services) and behavioral health (for members with substance use disorders, depression, anxiety or other mental health conditions). All members participating in Care Management services also get support with transition of care services to assist with movement between treatment settings and between type of treatment (providers), as well as preventive health, which includes referrals to our free and virtual health and wellness education classes.

Coordination of care

Coordination of care is an integral part of the Care Management process, intentionally organizing patient care activities and sharing information among all of the participants concerned with the patient's care to achieve safer and more effective care. Effective coordination of care is beneficial because it:

- Improves patients health, experience and satisfaction
- Improves transition of care
- Lowers the rate of admission and re-admission
- Can prevent emergency department visits
- Increases health service efficiency and reduces costs
- Eliminates care complications and service delays

How to refer members

To refer patients/members to JHHC's Care Management services, please contact us:

- **Email:** caremanagement@jhhc.com
- **Phone:** 800-557-6916, Monday through Friday, 8 a.m. to 5 p.m.

Appropriate Testing for Pharyngitis

Pharyngitis is a common condition that affects patients of all ages. Typically caused by a viral infection, it usually resolves on its own within a week or two. However, in some cases, pharyngitis may be caused by a bacterial infection, such as strep throat, which requires antibiotics for treatment. As health care providers, it is important to test for pharyngitis before prescribing antibiotics to ensure appropriate and effective treatment.

Here are a few tips for effective pharyngitis testing:

1. **Perform a throat culture:** A throat culture is the gold standard for diagnosing strep throat. This involves swabbing the back of the patient's throat and sending the sample to a lab for analysis. Results are typically available within 24 to 48 hours.
2. **Use a rapid antigen test:** Rapid antigen tests are another option for diagnosing strep throat. This test can be done in the office and provides results within minutes. However, it is not as accurate as a throat culture, and a negative result may require further testing.
3. **Consider symptoms and patient history:** In some cases, health care providers may diagnose pharyngitis based on the patient's symptoms and medical history. However, this approach is not as reliable as testing and may lead to overprescribing of antibiotics.

Remember: Not all cases of pharyngitis require antibiotics. In fact, up to 80% of cases are viral and do not respond to antibiotics. Overprescribing antibiotics can lead to the development of antibiotic-resistant bacteria, which is a serious public health concern.

In conclusion, testing for pharyngitis before prescribing antibiotics is essential to ensure appropriate and effective treatment. By performing a throat culture, using a rapid antigen test and considering symptoms and patient history, we can help reduce the overuse of antibiotics and improve outcomes for our patients.

// REMINDERS

Redetermination for Priority Partners Members

The COVID-19 Public Health Emergency (PHE) ended on May 11, 2023. During the period of the declared PHE, Priority Partners members did not need to renew their health care benefits, as they were automatically renewed. Now that the PHE has ended, members will need to renew their benefits again to avoid losing their health care coverage.

Maryland has already started making Medicaid eligibility reviews again. Not everyone is up for renewal at the same time, as these renewals will **take place over 12 months**. The Maryland Department of Health (MDH) and Priority Partners will notify members when it is time to renew their benefits. MDH has provided resources for providers to keep them informed and help them respond to members. Go to **https://health.maryland.gov/mmcp/Pages/MedicaidCheckIn-Providers.aspx** for communication tools, including:

- Office flyers
- Social media tools
- Newsletter blurbs

Priority Partners is communicating to members when it is their turn to renew via postcard, email, text and outbound calls.

- Members who receive a letter or message to reapply for Medicaid will need to:
  - » Call **855-642-8572** and tell them they need to reapply for their Medicaid benefits.

  OR

  - » Go online to **marylandhealthconnection.gov**, log in to their account and use the Change My Information/Renew Coverage button.

  OR

  - » Use the free mobile app, **Enroll MHC**.

Even if the member's information has not changed, they still need to update their application information and renew their coverage. **Members who do not renew on time will lose their MCO coverage.**

Providers who have additional questions can go to the Maryland Medicaid redetermination FAQ sheet at **https://health.maryland.gov/mmcp/Documents/HBX-Redet%20FAQs_FINAL_102015.pdf**

A Refresher on the Transition to PNC Healthcare/ECHO Health, Inc. for Claims Payments and Remittances

Due to a high volume of issues about the transition to PNC Healthcare/ECHO Health, Inc., Johns Hopkins HealthCare (JHHC) offers the following review of the novel process for claim payments and remittances.

- For Priority Partners claims, this change was effective Sept. 1, 2022.
- For Johns Hopkins EHP (EHP) and Johns Hopkins ElderPlus claims, this change was effective Dec. 1, 2022.

NOTE: Johns Hopkins Advantage MD and Johns Hopkins US Family Health Plan (USFHP) still use Change Healthcare for claims payment and remittances.

All initial payments after the transition date for Priority Partners, EHP and ElderPlus were paid via virtual card payment. With that explanation of payment (EOP) information, providers may enroll in electronic fund transfer (EFT) or, if preferred, request paper checks instead.

If you have not received your first payment in a timely manner, please confirm that your remit address on file with JHHC is correct by calling Priority Partners or EHP Customer Service. Payments can be re-issued if a remit address update is necessary. To update your remit address, please submit a Provider Information Change Form to JHHC:
Provider Information Update Form (hopkinsmedicine.org)

Steps to register for EFT and reissue payments as EFT

Go to the JHHC specific enrollment website linked below. This will allow providers to sign up to receive EFT only or 835/EFT from JHHC. Once a request is submitted, standard turnaround time is 7 to 10 business days. You will be notified upon completion.

- Site URL: **https://enrollments.echohealthinc.com/EFTERADirect/JohnsHopkins/**
- This site lists additional information on the registration process and ECHO Health support.
- Since the ERAs will be generated from the ECHO Health system, they will be distributed using the **Payer ID 58379.** Provider will need to update their practice management system to accept the new Payer ID 58379. Please be sure to retain prior JHHC Payer IDs for historical claims payments and remittances.

As a reminder, to validate their account, providers will need to have an ECHO Health draft number and payment amount to allow ECHO to validate the enrollment request. A draft number is listed as the EPC draft number on ECHO Health explanation of payments. If additional assistance is needed, contact ECHO Health at 888-834-3511.

Once EFT registration is complete, provider can contact ECHO Health at 888-834-3511 and have all outstanding payments reissued as EFT. This will include any virtual card payments that have been reissued as a paper check.

NOTE: All virtual card payments are re-sent as a paper check 60 days after original issue date. For example, a virtual card payment issued on 9/30/22 will be re-sent as a paper check on 11/30/22.

How to change payment method to paper check

To receive paper checks instead of virtual cards, log on to **https://echovcards.com** and follow the prompts for opting out of virtual card and requesting a paper check.

Providers will need a copy of a virtual card explanation of payment to register, as indicated above.

Providers can also contact the PNC/ECHO Call Center phone number printed on their virtual card payment to request a paper check.

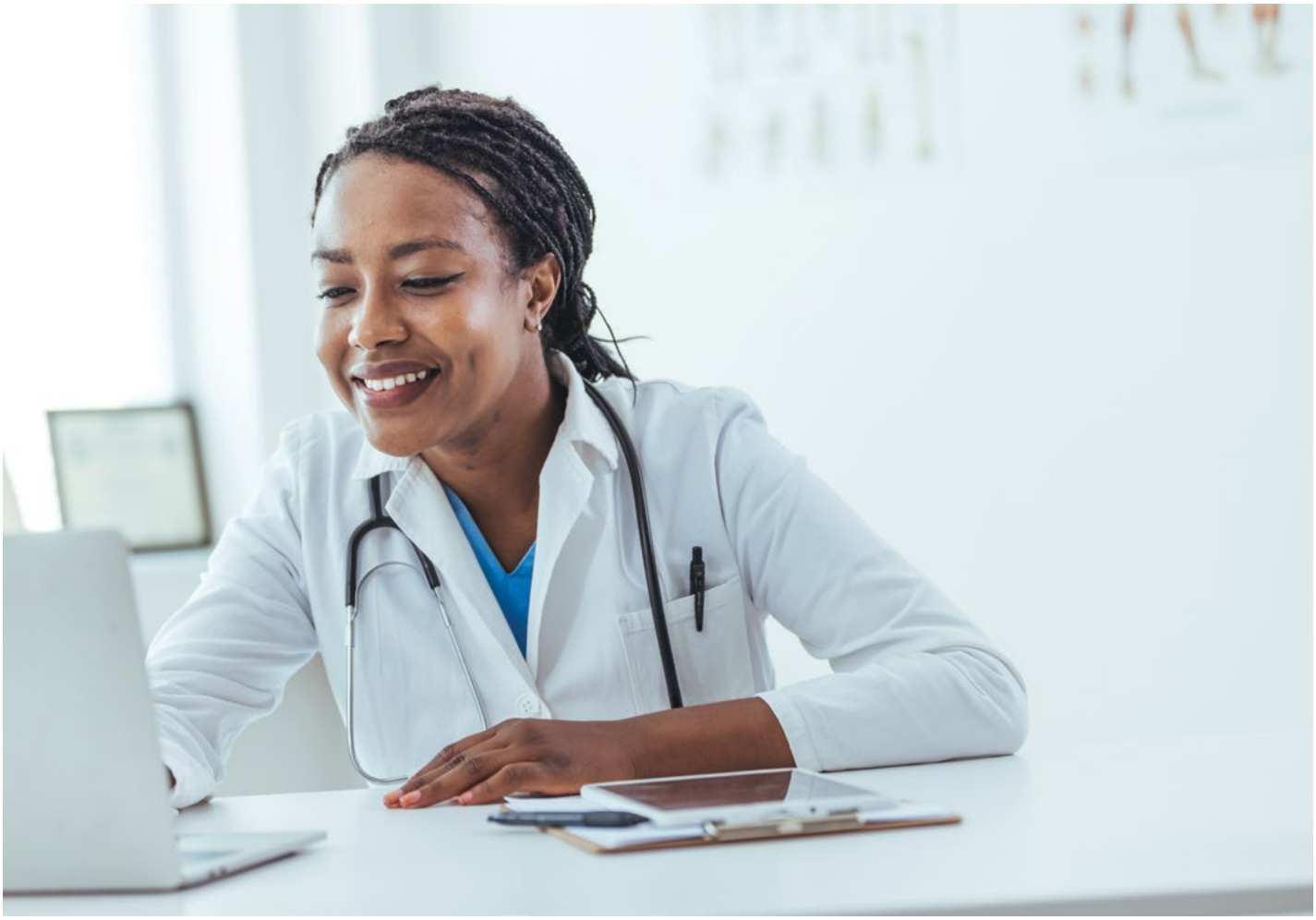
Reminder to Update Provider Demographic Information

If there are any demographic changes for your practice or facility, you are required to notify the Johns Hopkins 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 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 HealthCare 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@jhhc**.com. 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 Tax ID. 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 jhhc.com under "For Providers," and then under the Forms section of the "Resources and Guidelines" page.

NOTE: Please submit W-9 requests to **w9requests@jhhc.com**

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

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.

PRPULSE13-Spring 2023

PROVIDER pulse

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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