PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

SUMMER 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

"And so with the sunshine and the great bursts of leaves growing on the trees, just as things grow in fast movies, I had that familiar conviction that life was beginning over again with the summer."

— F. Scott Fitzgerald

The warm months are a signal to recharge and restore ourselves while sunlight lingers into early evening and days gleam with promise and possibilities.

JHHC takes this time of year to rejuvenate our systems and processes, so when the hurry-up of autumn and the end-of-year arrives, we are ready with expanded and more capable practices and platforms for our providers and members.

Changes are afoot here, largely with the investiture of the new Facets claims system, and all the ancillary vendors and procedures that accompany a transformative upgrade in service, quality and accuracy.

We are in these changes together. Whatever we can do to make these and other improvements understandable and smooth for our provider network, we will work with you.

Our partnerships with providers play a central role in JHHC's commitment to high-quality medical services easily reached by our members that in turn improve overall health and well-being. We thank you for all you do every day on behalf of our members.

— Jayne Blanchard, Editor

// POLICIES AND PROCEDURES

Update on Vision Codes Requiring Prior Authorization

The following vision codes require prior authorization for Priority Partners for services provided under medical benefits as of June 15, 2022.

NOTE: The codes below represent therapeutic contact lenses and scleral lenses that may be considered medically necessary when used for treatment of corneal disorders, severe ocular surface diseases or other medical conditions as described in CMS02.16 Treatment of Cornea medical policy. Prior authorization required. Please contact the member's vision benefit provider (listed on the Priority Partners member ID card) for information about covered services under vision benefits.

HCPCS Code	Code Description
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325
V2627	Scleral cover shell

Preauthorization Process

Submit prior authorization requests to JHHC Utilization Management (UM) department to the dedicated fax number listed below:

- **PPMCO:** 410-762-5205 or 410-424-4603

Please refer to the Johns Hopkins Prior Authorization Lookup tool (JPAL), located in the HealthLINK portal, to check and verify preauthorization requirements for outpatient services and procedures.

No Surprises Act: Mandate for Non-Participating EHP Providers

The federal government enacted The No Surprises Act in December 2020, which became effective on **Jan. 1, 2022**. The No Surprises Act rules allow patients to give consent to waive surprise billing protections in certain circumstances. If a non-participating provider obtains consent from a Johns Hopkins

Employer Health Programs (EHP) member or authorized representative to waive surprise billing protections, the Member Consent Form (see below for link to form template) must be submitted with the claim.

Member Consent Form Submission Methods

- Paper claim, with paper Member Consent Form attached
- Electronic claim, with paper Member Consent Form mailed separately
    - » If submitting a paper Member Consent Form that matches up to an electronic claim, please include the following information to ensure the form will be received and processed correctly:
        1. Member full name
        2. Member date of birth
        3. Member ID number
        4. Date of service
        5. List of services

-OR-

Copy of electronic claim, if possible.

Important Provider Resources

- Member Consent Form template created by the federal government
- Provider requirements under the No Surprises Act

New UM Phone Number for After-Hours and Urgent Authorizations

Johns Hopkins HealthCare (JHHC) offers a new number for all network providers contacting the Utilization Management (UM) department after normal business hours for urgent authorization needs. The UM after-hours number is operational as of Sept. 1, 2022.

The new number for JHHC after-hours voicemail: **844-680-2885**

Examples of urgent authorization needs include:

- Inpatient behavioral health admission through the emergency department
- Urgent skilled nursing facility (SNF) transfer request for **Johns Hopkins Employer Health Programs (EHP) and Johns Hopkins US Family Health Plan (USFHP) members only.** SNF transfer requests for Johns Hopkins Advantage MD and Priority Partners will be handled by eviCore.

Please leave the member's name, ID number, accepting facility and callback information. The voice mailbox will be monitored from 5-9 p.m. Designated on-call staff will address urgent requests within 24 hours of receiving the voicemail at the 844-680-2885 number.

For all non-urgent, standard authorization requests, please contact the UM department during normal business hours (8 a.m. to 5 p.m. EST) for routine clinical follow-up.

UM dedicated fax numbers for routine authorization requests:

- Advantage MD: 855-704-5296
- EHP: 800-261-2421 or 410-424-4480
- Priority Partners: 410-762-5205 or 410-424-4603
- USFHP: 410-424-2602 or 410-424-2603

NOTE: JHHC ensures all authorization reviews will continue to follow operating procedures and regulatory standards for practice.

JHHC Appoints Performant Recovery for Retrospective Payment Audit Services

In a continuing effort to manage and control the cost of health care provided to our members, Johns Hopkins HealthCare (JHHC) has contracted with Performant Recovery Inc. to perform retrospective payment audits. The purpose of the audits is to determine the accuracy of the information submitted for reimbursement purposes and accuracy of payment.

With broad experience in both the commercial and government-sponsored health care markets, Performant currently provides audit and recovery services to national, regional and commercial payers, Medicaid MCOs and Medicare Advantage plans. Under these contracts, Performant identifies and prevents improper payments through the deployment of advanced data mining technology, automated and complex clinical reviews and provider outreach efforts.

Performant uses propriety claims audit technology built through industry and coding standards, LCDS and NCDs, and Performant's experience with Medicare audits. Performant augments this technology with a medical director-led team of registered nurses, coding specialists and analysts that bring their vast health care audit expertise to ensure audits are appropriately performed and tailored in accordance with health plan contracts and policies.

Providers may be contacted by Performant to provide information for the audits. It is important for providers follow the instructions provided in the Performant letters. There is a specific appeals/dispute process handled by Performant with specific timelines outlined in the letters. Performant

will follow the prescribed timelines. Providers ignoring the instructions may risk having their claims adjusted as a provider's "non-response" is considered an agreement with the results of the audit.

Reminder: Expansion of JHHC-eviCore Partnership for Musculoskeletal and Post-Acute Care Programs

Johns Hopkins HealthCare (JHHC) has partnered with eviCore, adopting the Musculoskeletal (MSK) and Post-Acute Care (PAC) programs for utilization management with a focus on delivering improved patient outcomes, efficiencies and value.

What this means for you:

Effective Sept. 1, 2022, providers in the Johns Hopkins Advantage MD and Priority Partners networks will be required to obtain prior authorization for interventional pain management, spine surgery, joint surgery, physical therapy, occupational therapy and post-acute care services from eviCore. 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).

MSK — Advanced Procedures

eviCore's MSK Advanced Procedures program scope includes prior authorization review of 1) **interventional pain procedures** (injection procedures, spinal cord stimulator and implantable drug pumps); 2) **open joint procedures, joint replacements and arthroscopic surgeries of large joints** (hip, knee and shoulder); and 3) **spine surgery** (including decompression, fusion, disc arthroplasty and instrumentation).

Authorization requirements: Medical necessity review and prior authorization will be required for all MSK advanced procedures in scope with eviCore, whether performed in an inpatient or outpatient hospital setting or an ambulatory surgery center. See the list of applicable CPT codes under Resources and Guidelines for Priority Partners and Advantage MD. Prior authorization requests should be submitted through the portal, but can also be submitted by fax at 800-540-2406 or by phone (eviCore) at 866-220-3071.

MSK — Therapies

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

Authorization requirements: Authorization will be required after the initial PT/OT assessment/visit (therapy for Priority Partners members under 21 is not covered by Priority Partners). If a patient is already in treatment, but has not reached their 12th visit and authorization has not been obtained from JHHC, please contact eviCore for prior authorization for additional sessions on or after Sept. 1 2022. Existing authorizations issued by JHHC for patients in treatment as of Sept. 1, 2022, will be honored until the authorization expires. Any additional visits will require authorization through eviCore.

See the list of applicable CPT codes under Resources and Guidelines for Priority Partners and Advantage MD. Prior authorization requests for PT/OT can be submitted through the portal, faxed to 800-540-2406 or by calling eviCore at 800-220-3071. Please see eviCore portal for clinical worksheets.

PAC

eviCore's PAC program includes prior authorization and concurrent review of the following post-acute care settings: skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term acute care hospitals/chronic care hospitals (LTAC).

Authorization requirements: Hospitals will be required to submit prior authorization requests to eviCore for post-acute care. Please submit prior authorization request as soon as discharge status is determined.

- **IRF and LTAC facilities are responsible for submitting the initial prior authorization for members transitioning to a lower level of care, such as an SNF.**
- **PAC facilities (SNF, IRF and LTAC) are responsible for submitting the initial prior authorization requests for members admitted from the community, emergency department or outpatient setting and are responsible for submitting prior authorization for concurrent review requests.**

Prior authorization requests can be submitted through the portal or faxed to eviCore at 844-216-0198 for initial request and 877-791-4098 for concurrent review. For urgent transfers or requests, please call eviCore at 866-220-3071 (preferred) or fax to eviCore at 844-216-0198.

Standard requests are processed within 48 hours **after** receipt of **all** necessary clinical information. Number of prior authorized days at a time are provided according to PAC facility and request type:

Prior authorization	Skilled nursing facility	Inpatient rehab facility	Long-term acute care
Initial	Five (5) calendar days	Five (5) calendar days	Five (5) calendar days
Concurrent	Seven (7) calendar days	Seven (7) calendar days	Seven (7) calendar days

Applicable clinical policies, authorization request forms and clinical worksheets for the MSK and PAC programs will be available on the **eviCore portal** prior to implementation.

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

NOTE: The list of CPT®/HCPCS codes are for informational purposes and may not be all-inclusive. Inclusion or exclusion of a CPT/HCPCS code(s) does not signify or 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's specific benefits 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 of payment. Other policies and coverage determinations may apply.

Recent CPT Codes Requiring Prior Authorization

Johns Hopkins HealthCare (JHHC) requires prior authorization for selected medical procedure codes for the Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners, and Johns Hopkins US Family Health Plan (USFHP). This requirement affects members of all ages enrolled in these plans. These coding changes went into effect July 15, 2022.

Review the **list of procedure codes requiring prior authorization,** effective July 15, 2022.

This list is provided for reference purposes only and may not be all-inclusive. 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 applicablelaws that may require coverage for a specific service. The inclusion of a code does not imply any right toreimbursement or guarantee claim payment. Other policies and guidelines may apply.

Additional codes requiring prior authorization for USFHP, effective Sept. 1, 2022:

Procedure Code	Effective Date	Code Descriptions	USFHP Prior Authorization Yes/No
0101T	9/1/22	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	Yes
0184T	9/1/22	Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEMS), including muscularis propria (i.e., full thickness)	Yes
0232T	9/1/22	Injection(s), platelet-rich plasma, any site, including image guidance, harvesting and preparation when performed	Yes
64628	9/1/22	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies, lumbar or sacral	Yes
64629	9/1/22	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure)	Yes
C1840	9/1/22	Lens, intraocular (telescopic)	Yes
0308T	9/1/22	Insertion of ocular telescope prosthesis, including removal of crystalline lens or intraocular lens prosthesis	Yes
Q2026	9/1/22	Injection, Radiesse®, 0.1 ml (dermal fillers)	Yes
S2152	9/1/22	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency and rehabilitative services, and the number of days of pre- and post-transplant care in the global definition	Yes

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

Prior Authorization Process

Submit prior authorization requests to the JHHC Utilization Management (UM) department using thededicated fax numbers listed below:

- **Advantage MD:** 855-704-5296
- **EHP:** 800-261-2421 or 410-424-4480
- **Priority Partners:** 410-762-5205 or 410-424-4603
- **USFHP:** 410-424-2602 or 410-424-2603

// BENEFITS AND PLAN CHANGES

New Diabetes Prevention and Management Programs from Johns Hopkins Medicine

Two new diabetes programs developed by experts at Johns Hopkins Medicine are now available to eligible plan members of Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners and Johns Hopkins US Family Health Plan (USFHP). Providers can refer members to either program (see referral details below),

1. **Diabetes Prevention Program (DPP**) for Advantage MD and EHP is a standard of care for people with prediabetes or patients at risk of developing diabetes, as recognized by the Centers for Disease Control and Prevention (CDC). It is a 12-month-long, evidence-based curriculum focusing on lifestyle changes with resources and coaching support. The program goals include:
   - Weight loss of greater than or equal to 5%
   - Greater than or equal to 150 minutes of exercise per week
   - HbA1c reduction of greater than or equal to 0.2%

The DPP meets through Zoom in 2022 and may be expanded to an in-person setting based on COVID-19 safety allowances. DPP currently targets Baltimore City residents. There are no out-of-pocket costs for most EHP plan members participating in DPP.

Patients can self-refer by contacting us at brancaticenter@jhmi.edu or by calling us at **410-614-2701**. Information on the provider referral process is listed on the Diabetes Prevention and Education Program website. Providers with EPIC access can also use EPIC order to refer patients. To learn more about the DPP and its benefits for your patients, please visit our website.

2. **Diabetes Self-Management Training (DSMT)** is a standard of care for all Johns Hopkins HealthCare plan members with diabetes. Delivered by certified diabetes care and education specialists (CDCES), it covers a broad range of topics to support patients with diabetes. Self-management and education topics include:
   - Practical and relevant nutrition guidance
   - Physical activity
   - How to interpret and manage glucose levels
   - How to use diabetes technology (continuous glucose monitors, insulin pumps and data sharing with clinics)
   - Medication management (how they work, how to take them, what side effects to look out for)
   - Healthy coping skills
   - Preventing and managing diabetes-related complications

DSMT has been **proven** to:

- Improve hemoglobin A1c levels
- Improve blood pressure and cholesterol levels
- Improve medication adherence
- Decrease severe diabetes-related complications
- Increase healthy lifestyle behaviors such as better nutrition, increased physical activity and use of primary care and preventive services
- Enhance self-efficacy
- Decrease health care costs, including fewer hospital admissions and readmissions

To refer a patient to DSMT, please visit the Diabetes Prevention and Education Program website for instructions. If you have provider access to EPIC, enter an EPIC order for Ambulatory Referral to Diabetic Education (REF20). In the inpatient setting, you will need to enter the referral from the discharge navigator by entering an Additional Outpatient (after discharge) order. To learn more about the DSMT program and its benefits for your patients, please visit our website.

Gender-Affirming Procedures and Treatment Medical Policy Effective for EHP Members

Johns Hopkins HealthCare (JHHC) has released its medical policy on gender-affirming procedures and treatment for Johns Hopkins Employer Health Programs (EHP) members ages 18 and older*, effective July 1, 2022.

- **CMS24.08:** When benefits are provided under the EHP member's contract, JHHC will authorize gender-affirmation treatment and procedures when the diagnostic criteria for Gender Dysphoria, AND the provider qualifications, AND the specific criteria for the requested treatments or procedures have been met.
    - » Refer to Policy Section III for benefit coverage information, including age requirements or limitations, and plan-specific pharmacy formularies.
    - » When a systemic complication such as sepsis, infection, hemorrhage or other serious documented medical complication occurs as a result of any surgical procedure, treatment of the complication is considered medically necessary.
    - » Revision surgery may be considered medically necessary to approximate functional anatomy.
    - » Medically reasonable adjunctive procedures performed to enhance the ability of a member to live aligned with their gender identity will be considered for coverage as defined in the treating provider's treatment plan established in conjunction with the member to relieve gender incongruence.

***Note*:** Particular consideration will be given to whether the proposed procedure(s) advances an individual's ability to properly present and function in the identified gender role, including non-binary role.

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

Prior Authorization Process

Submit prior authorization requests to JHHC Utilization Management (UM) department to the dedicated fax numbers listed below:

- **EHP:** 800-261-2421 or 410-424-4480

*This policy does not pertain to Broadway Services EHP members.

Effective Preventive Health for Children

Priority Partners is dedicated to ensuring its members receive the preventive care they need. This commitment is especially important for the children we serve, and our network health care providers can help.

The Maryland Department of Health manages the Healthy Kids Program, an early and periodic screening, diagnostic and treatment (EPSDT) program to improve early identification and treatment of health problems before they become medically complex and costly to treat. Not only is adhering to these standards the right way to care for our youth, compliance with them is required.

EPSDT Components

To meet these standards, we need to understand them. Here are the EPSDT requirements:

EPSDT laboratory screening tests

- Type: Metabolic screenings (PKU) phenylketonuria
- When: Two screenings, first test completed at birth
- Type: Lead and anemia screenings
- When: Ages 12 and 24 months
- Type: Dyslipidemia screenings
- When: Ages 9 to 11 and 18 to 20 years
- Type: HIV testing
- When: One test, between ages 15 and 18 years

EPSDT risk assessments and screenings

- Type: Tuberculosis
- When: Ages 1 month, 6 months and annually
- Type: Lead
- When: Age 6 months and at every well visit until age 6 years
- Type: Autism
- When: At 18-month and 24- to 30-month visits
- Type: Heart disease
- When: Age 2 years and annually
- Type: Anemia
- When: Age 11 years and annually
- Type: STI/HIV
- When: Age 11 years and annually
- Type: Maternal depression
- When: Child is age 1 month, 2 months, 4 months and 6 months

- Type: Substance abuse
- When: Age 11 (or younger, if indicated) and annually
- Type: Depression
- When: age 11 and annually

We thank you for the tremendous work you do in ensuring your adolescent patients receive this important preventive care. Here are a few additional reminders:

- Update the child's medical record with immunizations, screenings and assessments.
- Ensure the child's vaccine history is updated and completed.
- Provide a documented referral to a dentist starting at age 2 and then annually.
- Enroll in the Vaccines for Children (VFC) program and the Maryland immunization registry (ImmuNet) to update the child's immunization history.

We are in this together. If we can support you in caring for your adolescent patients, please call us at 888-895-4998. To learn more about EPSDT requirements, visit **mmcp.health.maryland.gov/EPSDT.**

Recent Benefits Changes for EHP Members

EHP introduced the following benefit changes effective July 1, 2022:

Broadway Services, Inc.

Superior Vision now administers vision benefits.

- Superior National Network: **SuperiorVision.com***+
- Customer Service Number: 800-507-3800
- Superior Vision Claims Administration
  P.O. Box 967
  Rancho Cordova, CA 95741

Johns Hopkins University Student Health Program

Inpatient hospital co-insurance for facility services coinsurance has changed to 90% after deductible. This change includes the following coverage:

- Hospital inpatient including newborn/nursery care
- Skilled nursing/rehabilitation facility
- Short-term acute rehabilitation
- Maternity/newborn nursery care

Mental Health and Substance Use Disorder inpatient facility coinsurance has changed: The plan will pay 100% for the first 30 days and then 90% for remaining days after deductible.

The lifetime antiretroviral therapy (ART) treatment maximum increases from $20,000 to $100,000.

The limitation on chiropractic services of 20 visits per condition per plan year has been removed.

**Wilmer is in network with Superior Vision for eye exams only.*
+This link is from an external website that is not provided or maintained by or in any way affiliated with Johns Hopkins HealthCare (JHHC). Please note JHHC does not guarantee the accuracy, relevance, timeliness or completeness of any information on this external website.

// CLAIMS AND BILLING

Claims Adjustments and Appeal Processes and Necessary Forms

Just a reminder of JHHC's process for submitting payment disputes and clinical/medical necessity denial reviews.

EHP, Priority Partners and USFHP:

Provider Claims/Payment Dispute

A claims/payment dispute is any dispute between the health care provider and JHHC for reason(s) including but not limited to:

- Corrected claim
- Rejected untimely filing of claim
- Eligible per EVS
- Coordination of benefits (EOB of primary carrier required)
- Itemized bill requested
- Invoice attached/MUE denial
- Overpaid/underpaid per contract
- Fee schedule
- Contract rate/SCA
- Not duplicate claim
- Authorization on file (authorization number required)
- Referral attached

Responses to itemized bill requests, submission of corrected claims and submission of COB/third-party

liability information should also be sent with the **Provider Claims/Payment Dispute and Correspondence Submission Form**

- Use this form for provider claim/payment disputes and claim correspondence only. Complete all fields and submit as noted on the form. Please do not use this form for clinical/medical necessity appeal requests.

- Complete the Provider Claims/Payment Dispute and Correspondence Submission Form and mail to:
  - » **Johns Hopkins HealthCare LLC Adjustments Department**
    7231 Parkway Drive, Suite 100
    Hanover, MD 21076
    Or fax to 410-424-2800

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

Appeals

A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied before services are rendered (preservice) and care denied after services are rendered (postservice), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service.

Clinical/medical necessity appeals must be received within 90 business days of the date on the denial letter. The provider must submit **an appeal letter, including the reason for appeal, and supporting documentation** including medical records. Clinical documentation relevant to the decision will be retrospectively reviewed by a licensed/registered nurse. Established clinical criteria will be applied to the appeal. After retrospective review, the appeal may be approved or forwarded to the plan medical director for further review and resolution.

The appeal letter must be accompanied by the **Provider Appeal Submission Form-Clinical/Medical Necessity Appeals Only.** Use this form when you want to appeal a clinical/medical necessity denial. Complete all fields and submit as noted on the form. The form, letter and other related clinical information should be filled out and mailed to:

- **Johns Hopkins HealthCare LLC**
  Appeals Department
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076
  Or fax to 410-762-5304

Johns Hopkins Advantage MD

There is one form for payment disputes, with or without a request for clinical review. A payment dispute is any dispute between the health care provider and Johns Hopkins Advantage MD for reason(s) including but not limited to:

- Corrected claim
- Rejected untimely filing of claim
- Coordination of benefits (EOB of primary carrier required)
- Itemized bill requested
- Invoice attached/MUE denial
- Overpaid/underpaid per contract
- Clinical review for medical necessity
- Administrative denial (must include documentation of extenuating circumstances to be reviewed)

Responses to itemized bill requests, submission of corrected claims and submission of COB/third-party liability information should also be sent with the **JH Advantage MD Participating Provider Post-Service Payment Dispute Submission Form.** Be sure to complete all fields, submit one form for each request, and mail to:

- **Johns Hopkins Advantage MD**
  Payment Disputes
  P.O. Box 3537 Scranton, PA 18505
  Or fax to 855-206-9206

Please call Provider Relations at 888-895-4998 for assistance and to answer any questions you may have.

Facets, Optum CES and PNC Conversion-Go Live Date for Priority Partners, EHP and ElderPlus

In an effort to transform and improve the efficiency of our processes, Priority Partners, EHP and ElderPlus will convert to Facets, an industry standard claims submission and management system. The Facets system replaces the MC400 system. As previously advised, **September 1, 2022 is the effective date for Priority Partners. We now expect Facets will be operational on December 1, 2022 for EHP and ElderPlus.**

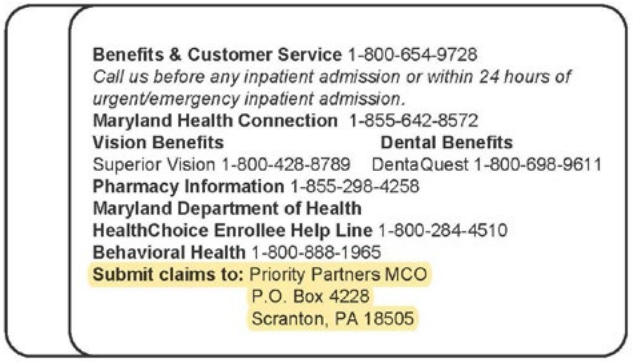
The transition from McKesson ClaimCheck to Optum CES claims editing system is effective on September 1, 2022 for Priority Partners and December 1, 2022 for EHP (Optum will not be implemented for ElderPlus). All claims submitted prior to the effective date for that line of business is not affected.

In addition, the transition from Change HealthCare to PNC Healthcare for electronic claims payments and remittances is effective on September 1, 2022 for PPMCO, and on December 1, 2022 for EHP and ElderPlus. The Explanation of Payment/Remit format will change slightly, as Echo/PNC standard formatting will be used.

New Priority Partners member ID cards will be mailed out to members mid-August, new EHP and Elder Plus member ID cards will be mailed out to members mid-November.

Additional details regarding the Facets transition can be viewed on the **Provider Education** page of the Provider Website under **Facets Migration-Important Information**.

Please see the sample new PPMCO member ID cards. A few things to note:



- Member identification numbers will still have a 9 digit + 2 suffix format, with the 2 digit suffix being the person number.
- Prior to 9/1 PPMCO member identification number starts with 00 and the person number for subscriber is 01; as of 9/1/22 the PPMCO member identification number starts with 10 and the person number for subscriber is 00.
- PCP designation will be individual provider instead of group for Priority Partners (PPMCO).
- Claims address on the back of the PPMCO member identification card will be updated to: P.O. Box 4228, Scranton, PA 18505.

// 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**

Prescribing Mail Service Prescription Medications for Advantage MD Members

Our priority is helping your Johns Hopkins Advantage MD patients get the medication they need when they need it. Please use this guide if you or your patient elect to use mail service and e-prescribe your mail service prescriptions to CVS Caremark Mail Service Pharmacy.

For a seamless Rx experience

Ask your patients if they prefer delivery by mail or pickup at a retail pharmacy.

Work with your patients to confirm and complete all necessary information — such as member ID number and prescription mailing address — before sending your prescriptions to CVS Caremark.
Inform your patients when you send CVS Caremark a prescription so they can expect their medication in the mail.
Write prescriptions for the maximum amount allowed by your patients' plan (usually a 90-day supply).
Explain that it usually takes about five business days to process mail service prescriptions before medications are shipped.
Provide additional information or authorization requests by CVS Caremark by fax in a timely manner.
Tell us how CVS Caremark can contact your office after hours if you don't have an answering service or messaging system; you may receive calls from CVS Caremark seeking resolution for patients.

e-Prescribing information

Complete the mail service prescription fax form. This form is for health professionals only and is available at www.caremark.com/pharmacists-medical-professionals.

- Print and mail to:
  CVS Caremark Mail Service Pharmacy
  NCPDP ID: 0322038
  9501 E. Shea Blvd.
  Scottsdale, AZ 85260

-OR-

- Download and fax to:
  800-378-0323
  Provider Pulse-Summer 2022
  Med Inj-Pharmacy Section

New Prior Authorization Requirements for Certain Provider-Administered Medications

Effective Sept. 1, 2022, Johns Hopkins HealthCare (JHHC) will require prior authorization to determine medical necessity for select provider-administered medications under Johns Hopkins Advantage MD and Johns Hopkins Employer Health Programs (EHP)*. This requirement affects members of all ages.

View the Advantage MD Prior Authorization Requirements effective 9/1/2022
View the EHP Prior Authorization Requirements effective 9/1/2022

Additional information about the comprehensive lists of provider-administered medications that require prior authorization is also available on the JHHC website's Advantage MD and EHP webpages for your reference.

Submitting Medical Injectable Prior Authorization Requests:

- Providers may submit prior authorization requests electronically through NovoLogix using the JHHC HealthLINK secure portal. The NovoLogix portal must be accessed through HealthLINK for JHHC prior authorization requests. This is the preferred and most efficient method of submission.
- However, if HealthLINK cannot be accessed, providers may contact NovoLogix by phone:
  - » EHP: 844-345-2803
  - » Advantage MD: 800-932-7013

*Employees of Johns Hopkins University covered under EHP will be excluded from these prior authorization requirements.

// QUALITY CARE

Prescribing Antipsychotic Medications? Monitor Patients with Care

Antipsychotic medications are effective in treating symptoms of certain mental health illnesses such as schizophrenia and mood disorders. They may also be prescribed for symptomatic relief for a range of other emotional problems. Despite benefits for many, antipsychotics (as well as schizophrenia itself) are associated with a number of potential health problems including:

- Considerable weight gain and obesity-related complications
- Diabetes
- Cardiovascular issues such as hypertension
- Hypercholesterolemia
- Movement disorders
- QT prolongation on EKG

It is important to perform an EKG and metabolic baseline test and ongoing annual testing for all patients (children through adults) who take antipsychotic medications. Metabolic monitoring should include both blood glucose and cholesterol testing annually.

Ensure All Patients Prescribed Antipsychotic Medications Have A Blood Glucose Test And A Cholesterol Test Every Year.	
CPT/CPT II Codes:	HbA1c Tests: 83036, 83037, 3044F, 3046F, 3051F, 3052F Glucose Tests (other): 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 LDL-C Tests: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F Cholesterol Tests: 82465, 83718, 83722, 84478

Before Prescribing

- Conduct a thorough physical exam of your patient.
- Consider risk factors for QT prolongation and need for baseline and follow-up EKG.
- Ensure patients have been appropriately evaluated and diagnosed and that an alternative course of treatment does not exist.
- Collaborate with and refer patients to mental health specialists/providers.
- Monitor for emergency of movement disorders such as tardive dyskinesia.
- If intended as a short-term intervention, note the Stop Date and schedule the follow-up.
- Educate patients about possible side effects such as weight gain, movement disorders, EKG changes and other risks that must be monitored with regular EKG and blood tests.
- Tell patients why it's important to keep appointments with all treating providers and for preventive health care.

Next Steps

Talk with your patient about:

- How to take the medications
- How they work
- Medication benefits, risks and alternatives
- Family planning due to potential risk of antipsychotics during pregnancy
- How long the patient should take them
- Why it's important to keep taking medication even if the patient begins feeling better

We also encourage you to:

- Schedule appointments for continued monitoring and metabolic testing
- Ensure appointment reminders are provided
- Continue to assess for medication side effects
- Educate patients on what to do if they have questions or concerns

Required Cultural Competency Training

Cultural competency training is a requirement for participating providers in the Johns Hopkins HealthCare (JHHC) network: Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners, and Johns Hopkins US Family Health Plan (USFHP).

As a health care provider contracted by JHHC, our expectation is for you and your staff to gain and continually deepen your knowledge of and ability to support the values, beliefs and needs of diverse cultures.

This results in effective care and services for all people by taking into account each person's values, experiences and linguistic needs.

By enhancing the cultural competency of your workforce, together we can

- Improve the quality of patient care delivery and health outcomes.
- Increase member satisfaction.
- Provide greater access to services.

The U.S. Department of Health and Human Services (HHS) offers *A Physician's Practical Guide to Culturally Competent Care,* a free, online educational program accredited for physicians, physician assistants and nurse practitioners. This guide is available at the HHS website (*cccm.thinkculturalhealth.hhs.gov*). The HHS website offers CME/CE credit and equips health care professionals with awareness, knowledge and skills to better treat the increasingly diverse U.S. population they serve.

After completing the training, please fax a copy of your certificate to 410-424-4604.

Unplanned Readmissions: A Costly Indicator of Lower Quality Care

Adult members who follow an inpatient stay with an unnecessary, unplanned hospital readmission for any diagnosis within 30 days not only incur significant costs, but can also indicate low quality care.

Our goal at the Johns Hopkins HealthCare (JHHC) Health Services department is to reduce unplanned hospital readmission and post-discharge emergency department visits, which in turn will help improve the quality of health care for our members.

The increase in readmission stays, and the fact that this is an important National Committee for Quality Assurance (NCQA) measure, informs our commitment to working together with our providers and members to reduce unnecessary readmissions.

Risk factors for unplanned readmission are many. However, they appear to be driven primarily by complications in the patient's health. Taking the appropriate steps to minimize complications will decrease readmissions.

Chronic diseases such as heart failure, chronic obstructive pulmonary disease (COPD), diabetes mellitus, cancer, stroke and/or psychosis, depression and other mental health issues generate the highest risks.

Additional factors that play a role in 30-day unplanned readmissions include:

- Member's health condition at the time of initial hospital discharge
- Level of transitional care planning and care coordination
- Gaps in clinical care
- Insufficient follow-up care
- Limited medication management

Research shows that most unplanned hospital readmissions are avoidable. Medical providers and facilities have a responsibility to keep their patients safe and on the road to recovery after discharge.

The following are reduction strategies to address potential patient complications that result in unplanned hospital readmissions and post-discharge emergency department visits:

Possible Complication	Reduction Strategy
Identifying underlying problem for readmission	Schedule a follow-up with the patient within seven days of discharge
Identifying members likely to readmit to hospital, such as those with potential for postoperative complications, those with chronic conditions, those that have not seen their primary care provider or those nonadherent with prescribed medications.	Review discharge instructions with patient
Lack of early and comprehensive discharge planning	Provide case management services
Need for education on self-management skills	Complete collaborative care with behavioral health provider
No medication management training	Perform medication reconciliation

Appropriate pre- and post-discharge interventions, and arming the patient with knowledge about self-care, will ensure the best overall quality care from their initial hospital stay through the transition to home and maintenance support for their condition. These tactics will decrease the likelihood of unplanned, unnecessary hospital readmissions, which benefits both members and providers.

Women's Wellness Health Measures

Women's preventive care is routine health care that includes screenings and other services to help diagnose and prevent illness, disease or other health problems.

Providers play an essential role in promoting the health of our members. Reinforcing preventive care compliance for Johns Hopkins HealthCare (JHHC) members will ultimately improve their health outcomes.

The screenings and services listed below are annual appointments that are an essential part of women's health care. These preventive visits can detect abnormalities that often may be promptly treated. Annual appointments give our members an opportunity to discuss any issues they may be having and ask questions of their provider. Depending on age, providers can talk about many issues including menstrual difficulties, menopause, hormone therapies, birth control, pregnancy plans and problems with intimacy.

Measure	Best Practice and Measure Tips	Measure Codes
BCS Breast Cancer Screening • Women 50-74 years of age completing at least one mammogram. • Service dates accepted: Oct. 1, 2020, through Dec. 31 2022.	• This measure evaluates preventive screening only. Bilateral or unilateral screening mammograms are acceptable. Biopsies, breast ultrasounds and MRIs are not acceptable. • Documentation of completed screenings in a patient's medical record must include the date of service and type of mammogram (bilateral or unilateral). » For unilateral mammograms, include documentation of a unilateral mastectomy. If the date is unknown, year only is acceptable. • Obtain mammography reports for patient records. Notate the place of service if unable to obtain report. • Submit the appropriate ICD-10 diagnosis code that reflects a patient's history of bilateral mastectomy, Z90.13. • Educate patients on the importance of mammogram screenings for early detection of breast cancer. **Exclusions:** • Palliative care • Hospice • Frailty • Frailty and advanced illness • Living in long-term care	• **Bilateral Mastectomy** » [Z90.13] Acquired absence of bilateral breasts and nipples • **Unilateral Mastectomy** » [Z90.11] Acquired absence of right breast and nipple » [Z90.12] Acquired absence of left breast and nipple

Measure	Best Practice and Measure Tips	Measure Codes
CCS Cervical Cancer Screening Women age 21-64 who were screened for cervical cancer using the following criteria: • Age 21-64 who had cervical cytology performed within the last three years*. • Age 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years**. • Age 30-64 who had cervical cytology/hrHPV co-testing performed within the last five years**. ***Patients must be at least 21 or older at the time of screening occurring within the last three years.** **** Patients must be at least 30 or older at the time of screening occurring within the last five years.**	• Documentation of completed screenings in a patient's medical record must include the date of service and result. • Previous screenings reported by patients are acceptable; date of service and result must be documented in the patient's medical record. • Request results for screenings performed by another provider. • Screenings may be completed during well woman visits, OB/GYN visits and sick visits. • Lab results that indicate sample contained "no endocervical cells" is acceptable if a valid test result is reported. • Educate patients on the importance of preventive screenings for early detection of cervical cancer. **Acceptable Documentation Regarding Hysterectomies:** • Patient no longer requires cervical cancer screening accepted with documentation of hysterectomy. • Date of hysterectomy and "no residual cervix" or "absence of cervix" must be documented in the patient's medical record. **Not Accepted for Completion of a Screening:** • The number of samples returned was not indicated • Lab results that indicate inadequate sample or no cervical cells • Biopsies (diagnostic procedure does not count as a cervical cancer screening) • Referral to OB/GYN provider • hrHPV test: DNA reflex test ordered, test not performed **Exclusions:** • Palliative care • Hospice	• **Cervical Cytology Lab Test** » CPT: 88141-43, 88147-48, 88150, 88152-53, 88164-67, 88174-75 » HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 • **HPV Tests** » CPT: 87624, 87625 » HCPCS: G0476 **Exclusion Codes:** • **Hysterectomy with No Residual Cervix** » CPT: 51925, 56308, 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 59856, 59135 » ICD-10: OUTC0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ • **Absence of Cervix Diagnosis** » ICD-10: Q51.5, Z90.710, Z90.71

Measure	Best Practice and Measure Tips	Measure Codes
COL Colorectal Cancer Screening Patients age 45-75 who received one or more of the following screenings for colorectal cancer: • Colonoscopy/lower endoscopy performed during 2013-2022. • Flexible sigmoidoscopy performed during 2018-2022. • CT colonography (virtual colonoscopy) performed during 2018-2022. • Stool DNA (sDNA) with FIT test (Cologuard®) performed during 2020-2022. • Fecal occult blood test (FOBT) performed during 2022. » FOBT includes two types of tests: gFOBT (guaiac) and FIT/iFOBT (immunochemical). **NOTE: A stool DNA (sDNA) with a FIT test is Cologuard®. A FIT test/iFOBT completed without a stool DNA doesn't equate to completion of a Cologuard® test.**	• Consider the patient's personal and family history when recommending the type colorectal cancer screening a patient should complete. • Documentation of completed screenings in a patient's medical record must include a pathology report that indicates the type of screening and the date of service and place of service (if known). » Documentation of the result is not required if a date of service and pathology report are included in the patient's medical record. • Recommend other available screening options if a patient refuses or can't tolerate a colonoscopy; refusal to complete a colonoscopy doesn't exclude a patient from the measure. **Accepted Documentation:** • It is acceptable if a colonoscopy pathology report indicates "poor bowel prep" or "incomplete exam" if documentation includes the scope advancing past splenic flexure during a colonoscopy or advancing into sigmoid colon during a flexible sigmoidoscopy. • Specific to gFOBT screenings, documentation in the patient's medical record is accepted if: » Three or more samples were returned; » The number of samples returned was not indicated. • Documentation in the patient's medical record of "Colon cancer screening completed in 2021" without notation of type of screening can only be used as evidence of FOBT. **Not Accepted as Completion of a Screening:** • FOBTs performed in an office setting or from any specimen collected during a digital rectal exam • CT scan of the abdomen and pelvis **Exclusions:** • Palliative care • Hospice • Frailty • Frailty and advanced illness • Living in long-term care	• **Colonoscopy** » CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 » HCPCS: G0105, G0121 • **Flexible Sigmoidoscopy** » CPT: 45330-45335, 45337, 45338, 45340-45342, 45346,45347, 45349, 45350 » HCPCS: G0104 • **FOBT Lab Test** » Guaiac Test (gFOBT): CPT: 82270 » FIT Test Immunochemical (iFOBT/FIT): » CPT: 82274 » HCPCS: G0328 • **Computed Tomography (CT) Colonography** » CPT:74261-74263 • **Stool DNA (sDNA) with FIT test** » CPT 81528 This code is specific to the Cologuard® sDNA FIT test » HCPCS: G0464 This code was retired and replaced with CPT code 81528 **Exclusion Codes:** • **Colorectal Cancer** » ICD-10: C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 • **Total Colectomy** » CPT: 44150-44153, 44155-44158, 44210-44212 » ICD10PCS: » [0DTE0ZZ] Resection of Large Intestine, Open Approach » [0DTE4ZZ] Resection of Large Intestine, Percutaneous Endoscopic Approach » [0DTE7ZZ] Resection of Large Intestine,Via Natural or Artificial Opening » [0DTE8ZZ] Resection of Large Intestine,Via Natural or Artificial Opening Endoscopic

Measure	Best Practice and Measure Tips	Measure Codes
PPC Prenatal and Postpartum Care The percentage of live birth deliveries on or between Oct. 8, 2021, and Oct. 7, 2022. For these women, the measure assesses the following: • Timeliness of Prenatal Care: A prenatal care visit in the first trimester or within 42 days of enrollment in the health plan. • Postpartum Care: A postpartum visit on or between 7 and 84 days after delivery. **Provider Specialty:** PCP, OB/GYN, or other prenatal care practitioner. • Live birth applies to a delivery of twins that resulted in one stillborn. • Patients with two separate pregnancies during Oct. 8, 2021, and Oct. 7, 2022, will be applicable to the measure during each pregnancy.	**Prenatal Care:** • Documentation within the patient's medical record must reflect the date of the prenatal visit (telehealth visits accepted) and one of the following: » Documentation indicating or referring to a pregnancy » Physical exam with auscultation for fetal heart tone, obstetric observations or measurement of fundus height » Obstetric panel or TORCH antibody panel alone or rubella antibody test/titer with RH incompatibility (ABO/Rh) blood typing or ultrasound of a pregnant uterus **Not Accepted for Completion of a Prenatal Visit:** • Pap test or colposcopy **Postpartum Care:** • Documentation within the patient's medical record must reflect the date of the postpartum visit (telehealth visits accepted) and one of the following: » Notation of postpartum care » Pelvic exam (Pap smear accepted as completion) » Evaluation of weight, blood pressure, abdomen and breasts (notation of "breastfeeding" accepted for evaluation of breasts) » Perineal or cesarean incision/wound check » Screening of depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders » Glucose screening for women with gestational diabetes » Documentation of the following topics: › Infant care/breastfeeding, resumption of physical activity, intercourse, births spacing or family planning, sleep/fatigue attainment of a healthy weight. **Not Accepted for Completion of a Postpartum Visit:** • Services provided in an acute inpatient setting • Colposcopy **Exclusions:** • Hospice • Pregnancy not resulting in a live birth	• **Bundled Service (codes may be used only if the claim indicates when prenatal care was initiated)** • **Visit for Prenatal Care** » CPT/CPT II: 99500, 0500F-05002F » HCPCS: H1000-04 • **Prenatal Visit** » CPT/CPT II: 99201-05, 99211-15, 99241-45, 99483 » HCPCS: G0463, T1015 » Bundled service - codes may be used only if the claim indicates when PP care was rendered › CPT/CPT II: 59400, 59410, 59425, 59426, 59510, 59515, 59610, 59614, 59618, 59622 › HCPCS: H1005 • **Postpartum Visits** » CPT/CPT II: 57170, 58300, 59430, 99501, 0503F » HCPCS: G0101 » ICD-10 Diagnosis: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 • **Cervical Cytology** » CPT/CPT II: 88141-43, 88147-48, 88150, 88152-53, 88164-67, 88174-75 » HCPCS: G0123-24, G0141, G0143-45, G0147-48, P3000, P3001, Q0091

Measure	Best Practice and Measure Tips	Measure Codes
CHL Chlamydia Screening in Women Women age 16-24 years identified as sexually active completing at least one chlamydia test in 2022.	• Documentation of completed screenings in a patient's medical record must include the date of service and result. • Screenings may be completed via urinalysis or a vaginal swab. » Screening samples must be sent to a lab for analysis. • Educate patients on the importance of safer sex practices and periodic testing for STIs. **Exclusion:** • Hospice	• **Chlamydia Screening Test** » CPT 87110, 87270, 87320, 87490-92, 8781 **Note: Chlamydia screening may not be captured via claims if the service is billed under prenatal and postpartum global billing.**

// REMINDERS

Tips for Addressing Vaccine Hesitancy

The various mutations of COVID-19 circulating this summer have made it clear the pandemic is still very much a major health concern in the U.S.

Despite the persistence of COVID-19, many patients remain unvaccinated or are lax in getting their second or third booster shots.

Internist Marie T. Brown, MD, Director of Practice Redesign at the American Medical Association (AMA), offers these tips to help your patients move from "no vax" to "got vaxxed."

1. **Understand cultural considerations.**
   Patients of African American heritage may be hesitant because of mistrust in the medical community stemming from experiences such as the Tuskegee syphilis study or urban myths of city hospitals kidnapping African Americans for medical experimentation purposes. Patients of Hispanic ethnicity may be reluctant due to general distrust of the government arising from immigration or border-control experiences.
2. **Ask.**
   When a patient says no to the vaccine, simply say, "May I ask why? What have you heard in your community?" It is a less judgmental way to find out what they may be thinking, giving patients the opportunity to speak openly about concerns they may have, while attributing them to others.
3. **Counter misinformation.**
   COVID-19 conspiracy theories and misinformation abound in communities and on social media. Calmly correct any misrepresentations your patient may have for not getting the vaccine.
4. **Know your (trusted) role.**
   Physicians and health care providers are a trusted source for information on the COVID-19 vaccine. Use this authority to get your patients protected against COVID-19 and its variants.
5. **Say it.**
   It may be just as simple as informing your patients they need the vaccine. A major reason many adults say they don't get necessary immunizations is because they claim the doctor hasn't told them to. So tell them.
6. **Tailor your message.**
   To reach people no matter their political view — or whether they believe a vaccine is a personal choice or collective public health responsibility — focus the discussion on how getting a vaccine can help protect a loved one such as a grandparent, a child or someone who is immunocompromised.
7. **Address patients' fears about side effects.**
   Start a conversation by asking a patient how they felt after their last vaccination, such as a flu shot. Ask if they had any side effects or other reaction. Then you can move the conversation to tell them the COVID-19 vaccine is not much different and prepare them for the possible side effects they may experience.

   Preparing patients to expect muscle aches and fatigue if a second dose is required can help prevent them from worrying that the vaccine "gave them the disease," calling

you with concerns and more importantly discouraging their family and friends from getting vaccinated. Hope for the best but prepare them for the worst.

8. **Show your vaccination pride.**
   Everyone in your office who is vaccinated can wear a button or sticker showing they received their COVID-19 shot, reinforcing to patients that the vaccine is safe and that you trust in it.

SOURCE: **https://www.ama-assn.org/delivering-care/public-health/covid-19-vaccine-hesitancy-10-tips-talking-patients.** ©Copyright 1995–2021 American Medical Association. All rights reserved. Accessed July 29, 2022.

Review Your National Provider Identifier Data in the National Plan and Provider Enumeration System

Johns Hopkins HealthCare (JHHC) would like to remind our Johns Hopkins Advantage MD providers to review your National Provider Identifier (NPI) data in the National Plan and Provider Enumeration System (NPPES) as soon as possible and on an ongoing basis to ensure the display of accurate provider data.

As you may be aware, providers are legally required to keep their NPPES data current. The Centers for Medicare & Medicaid Services (CMS) is also encouraging Medicare Advantage organizations such as Advantage MD to use NPPES as a resource for our online provider directories. By using NPPES, we may be able to decrease the frequency by which we contact you for updated directory information and to provide more reliable information to Medicare beneficiaries.

When reviewing your provider data in NPPES, please:

- Update any inaccurate information in modifiable fields including provider name, mailing address, telephone and fax numbers and specialty, to name a few.
- Include all addresses where you practice and *actively* see patients and where a patient can call and make an appointment. Do not include addresses where you *could* see a patient, but do not actively practice.
- Remove any practice locations that are no longer in use. Once you update your information, you will need to confirm it is accurate by certifying it in NPPES.

NOTE: At this time, NPPES has no bearing on billing Medicare Fee-For-Service.

If you have any questions pertaining to NPPES, you may **reference NPPES help**.

How to Submit Provider Information Changes

If there are any demographic changes in your practice or facility, you are **required** to notify the Johns Hopkins HealthCare (JHHC) Provider Relations department:

- Submit digitally via the **Online Digital Provider Information Update Form**.
- Email to **ProviderChanges@jhhc.com**. This email box is monitored daily to collect and process all provider changes. Please fill out the **Provider Information Update Form** (located on **jhhc.com** under "For Providers," then under the Forms section of the "Resources and Guidelines" page) and attach it to the email before sending to JHHC.
- Information on both forms includes changes to telephone numbers, address, suite number and email or fax numbers.
- **Note:** If you are using a Social Security number in place of a tax ID number, the completed update form must be faxed to 410-762-5302 to ensure identity protection. Do not send digitally or by email.
- W-9 requests should be submitted to **w9requests@jhhc.com**.
- Any questions about the provider changes reporting process may be directed to Provider Relations at 888-895-4998.

The Centers for Medicare & Medicaid Services (CMS) requires health plans to validate provider information on a quarterly basis.

Redetermination Period for Priority Partners Members Extended to Dec. 31, 2022

Priority Partners members must renew their health benefits once a year or their Medicaid benefits will be terminated. The termination of benefits due to non-renewal was paused by the Maryland Department of Health (MDH) during the COVID-19 Public Health Emergency (PHE).

Priority Partners is asking our providers to partner with us in reaching out to members to renew their benefits now.

MDH has recently announced that the PHE extension is scheduled to end Dec. 31, 2022. At that point, members will be required to renew their benefits as they have in the past, according to their month of renewal.

There are 3 ways members can renew their benefits:

- Go online to **Maryland Health Connection*** – Log into their account, then click the Change My Information/ Renew Coverage button.
- Call Maryland Health Connection at **855-642-8572.**
- Download and use the free mobile app, Enroll MHC, for **Apple** or **Android**.
- Members can call Priority Partners Member Services at 844-288-9593 for questions or support.

Providers can access a list of impacted members at the same location in **HealthLINK** where providers currently get monthly Redetermination Reports (FTP and FTA).

- The impacted member list is labeled "PPP10101," and the name of the report is "Public Health Emergency."
- The list contains the Priority Partners members who did not complete their Redetermination/Renewal in 2021 and were granted an extension.

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

Special Needs, Interpreter/Language Services Available to Priority Partners Members from In-Network Providers

If your patients need assistance coordinating care, Priority Partners is here to help.

Special Needs/Enhanced Care Management

For assistance in organizing care for a special needs member, contact Priority Partners' special needs coordinator at 410-424-4965 or 800-261-2396 ext. 4906. Providers can also fax a completed Priority Partners Member Referral form to 410-424-4887.

Language Services

Priority Partners also provides free language services to people whose primary language is not English. These services can be obtained by calling the Customer Service number on their member ID card.

Interpreter Services

Interpreter Services are available free of charge to Priority Partners members by calling Customer Service at 800-654-9728 (TTY: 800-201-7165). If a member needs interpreter services for an appointment with a Priority Partners provider, the most efficient tactic is for the member to notify the provider office well in advance of the appointment. This ensures enough time to set up the interpreter service and to avoid a delay in seeking needed medical care. Priority Partners Customer Service may also be able to help coordinate interpreter services for in-network provider appointments.

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-Summer 2022

PROVIDER pulse

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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