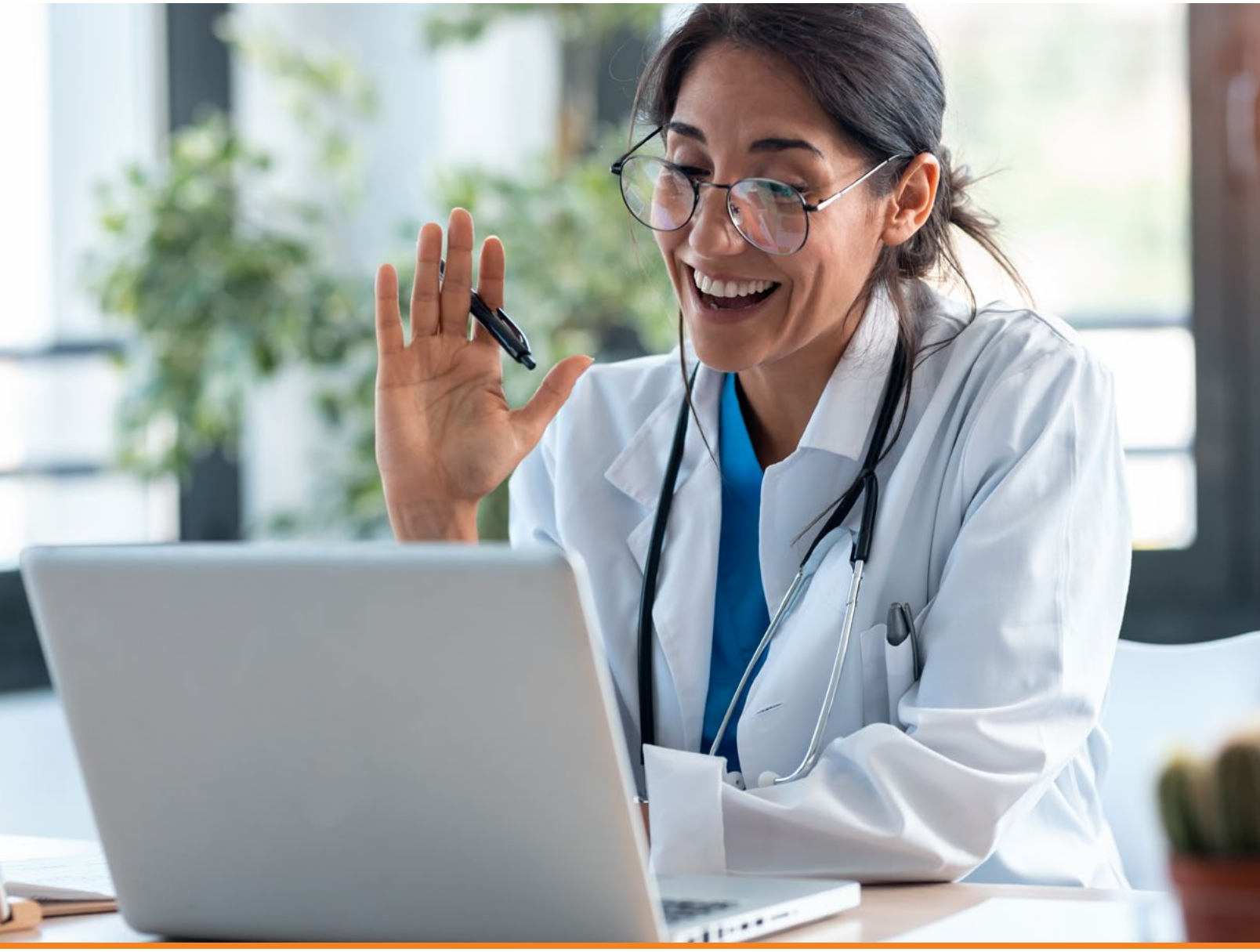
# PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

FALL 2020





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

"Autumn mornings: sunshine and crisp air, birds and calmness, year's end and day's beginnings."
– *Terri Guillemets*

The year unlike any other rolls on throughout the fall months, with crisper weather providing the impetus to dive into new projects and initiatives now that the slower pace of summer has passed.

JHHC continues to deliver consistently high quality health services to our members amid the challenges of the COVID-19 pandemic and we couldn't do it without the partnership and dedication of our providers.

We are busy this season with annual open enrollment periods for our health plans, as well as finalizing and aligning new programs, benefits and procedures. You can learn more about some of these in this newsletter, such as site-of-service initiatives and an introduction to one of our new vendors, eviCore, which provides prior authorization services for High Tech Radiology and Cardiology Advanced Imaging procedures for Johns Hopkins Advantage MD and Priority Partners.

We appreciate your efforts and continued collaboration in this time of uncertainty and always. We give thanks to you for the work you do day in and day out to provide quality, committed care to our members across all of our health care plans. Without you, we wouldn't be JHHC.

–***The editor,*** Provider Pulse

## // POLICIES AND PROCEDURES

### Johns Hopkins US Family Health Plan (USFHP) No Longer Paying Ancillary Fees for Services Provided on Denied Inpatient Days

Johns Hopkins US Family Health Plan (USFHP) will no longer pay ancillary fees for services provided on denied inpatient days effective November 1, 2020. **As previously communicated, this change will not be implemented for Johns Hopkins Advantage MD.**

Hospitals should continue to submit clinical information to JHHC Utilization Management (UM) for all inpatient days for which authorization is being requested. JHHC UM will advise of any denied days based on clinical review.

There will be no change in how hospitals bill for inpatient stays for Johns Hopkins USFHP members. If the billed days exceed the authorized days on an inpatient claim, the claim will be denied and an itemized bill will be requested. The itemized bill can be submitted electronically via the Provider Payment Dispute Web Form on HealthLINK, or submitted on paper and faxed or mailed in with the Provider Claims/Payment Dispute and Correspondence Submission Form.

Room and board and ancillary fees will be processed for services provided on authorized days, and denied for services provided on denied days. All hospital appeal rights remain. There is no member liability for denied inpatient days or services provided on denied inpatient days.

### Medical Policy Updates Effective November 2, 2020

The JHHC Medical Policy Advisory Committee (MPAC)* has approved changes and additions to our medical policies. These changes went into effect November 2, 2020.

The medical policy updates include:

- Telemedicine/Telehealth-CMS00.27
- Hereditary Cancer Testing: High-Penetrance Breast and Ovarian Cancer-CMS02.09 (*Previously titled*: BRCA 1 and BRCA 2 Testing)
- Intradiscal Electrothermal (IDET)-CMS09.04
- Evaluation and Treatment of Pediatric Feeding Disorders and Avoidant, Restrictive Food Intake Disorder-CMS16.15 (*Previously titled:* Evaluation and Treatment of Pediatric Feeding Disorders)

- Blepharoplasty, Brow Ptosis Repair, and Other Surgeries of Eyelid- CMS02.07
- Minimally Invasive Treatment of Varicosities- CMS22.01
- Long Term External Cardiac Event Monitoring (Zio®Patch)- CMS24.02

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.

*MPAC was formerly called SEEPAC (Scientific Evaluation and Policy Advisory Committee).

## Site-of Service Preauthorization Requirements Update Affects Priority Partners and Johns Hopkins USFHP

The JHHC Medical Policy Advisory Committee (MPAC) has approved changes and additions to the JHHC Site-of-Service Medical Policies for Priority Partners and Johns Hopkins US Family Health Plan (USFHP). JHHC is implementing this policy using a staged approach, targeting specific procedures with each phase.

Effective date for changes:

- Priority Partners: Dec. 1, 2020
- USFHP: Jan. 1, 2021

As of these dates, JHHC will require preauthorization to include a site-of-service review for certain Musculoskeletal and Gastrointestinal procedures when performed in an outpatient hospital setting. This requirement affects Priority Partners and USFHP members of all ages. These Musculoskeletal and Gastrointestinal procedures are in addition to the services already requiring site-of-service review and preauthorization when performed in an outpatient hospital setting.

The site-of-service policy specifies that members receive certain outpatient diagnostic or surgical procedures in an ambulatory surgery center (ASC) when clinically appropriate. A surgical procedure performed in a hospital setting will require preauthorization 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). Please refer to Updates to CMS23.05 Site of Service – Outpatient Surgical Procedures for a summary of the criteria changes pertaining to the site-of-service medical policy, as well as a detailed listing of affected CPT codes.

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.

### Preauthorization Process

Submit preauthorization requests to JHHC Utilization Department (UM) only via the fax numbers listed below:

- **Priority Partners** 410-762-5205 or 410-424-4603
- **USFHP** - 410-762-5205 or 410-424-4603

Search our participating providers and freestanding ambulatory surgery centers.

## New Peer-to-Peer Review Timeframes For Inpatient, Outpatient and Pharmacy Cases

Effective Oct. 1, 2020, JHHC has revised the peer-to-peer review process for Johns Hopkins Employer Health Programs (EHP), Priority Partners, Johns Hopkins US Family Health Plan (USFHP), and Johns Hopkins Advantage MD*.

### Inpatient and Outpatient Cases

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.

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.

**COVID-19 Extension:** While Maryland is under a State of Emergency due to COVID-19, we will further extend the timeframe for the peer-to-peer review to take place. During this time, after the peer-to-peer review is requested within the timeframes noted above, the peer-to-peer review must take place within five (5) business days. Once the State of Emergency ends, the allowed timeframe will automatically revert to the standard timeframes listed above.

*Per CMS, a denial cannot be overturned as a result of a peer-to-peer discussion for Johns Hopkins 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** |
| **COVID-19 State of Emergency Extension** | | |
| **Timeframe for peer-to-peer review to take place after request** | 5 business days | 5 business days |
| **TOTAL days allowed for peer-to-peer review process during COVID-19 State of Emergency** | **7 business days** | **8 business days** |

You can find detailed information about JHHC's peer-to-peer review process in the Provider Manuals.

## Pharmacy Cases

JHHC Pharmacy amended its timeframe for the post denial review process for Priority Partners and USFHP beginning October 1, 2020.

**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.

The extensions during the State of Emergency due to COVID-19 (outlined above) also apply for Pharmacy reviews and will revert back to the standard Pharmacy review timeframes when the State of Emergency is over.

| 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** |
| **COVID-19 State of Emergency Extension** | |
| **Timeframe for review to take place after request** | 5 business days |
| **TOTAL days allowed for review process during COVID-19 State of Emergency** | **8 business days** |

## Selected Priority Partners DME Codes for Incontinence Supplies Now Require Preauthorization

Effective September 6, 2020, preauthorization is now required for incontinence supplies offered under Priority Partner's durable medical supplies (DME) benefit.

Providers are encouraged to check preauthorization requirements through the Johns Hopkins Prior Authorization Lookup tool (JPAL). Located in the **HealthLINK** portal, JPAL offers a user-friendly way for providers to look up preauthorization requirements and other details.

The following codes required preauthorization as of September 6, 2020:

**Incontinence Supplies**

| | |
|---|---|
| A4520 | Incontinence garment, any type (e.g. brief, diaper) |
| A4553 | Non-disposable underpads, all sizes |
| A4554 | Disposable underpads, med size (e.g. Chux's) |
| T4521 | Adult sized disposable incontinence product, brief/diaper, small |
| T4522 | Adult sized disposable incontinence product, brief/diaper, medium |
| T4523 | Adult sized disposable incontinence product, brief/diaper, large |
| T4524 | Adult sized disposable incontinence product, brief/diaper, extra large |
| T4525 | Adult sized disposable incontinence product, protective underwr/pull-on, sm |
| T4526 | Adult sized disposable incontinence product, protective underwr/pull-on, med |
| T4527 | Adult sized disposable incontinence product, protective underwr/pull-on, large |
| T4528 | Adult sized disposable incontinence product, protective underwr/pull-on, XL |
| T4529 | Pediatric sized disposable incontinence product, brief/diaper, sm/med |
| T4530 | Pediatric sized disposable incontinence product, brief/diaper, large |
| T4531 | Pediatric sized disposable incont product, protective underwr/pull-on, sm/med |
| T4532 | Pediatric sized disposable incont product, protective underwr/pull-on, large |
| T4533 | Youth sized disposable incontinence product, protective brief/diaper, each |
| T4534 | Youth sized disposable incontinence product, protective underwr/pull-on |
| T4535 | Disposable liner/shield/guard/pad/undergarment, for incontinence, each |
| T4536 | Incontinence product, protective underwear/pull-on, reusable, any size, each |
| T4539 | Incontinence product, diaper/brief, reusable, any size, each |
| T4541 | Incontinence product, disposable underpad, large, each |
| T4542 | Incontinence product, disposable underpad, small, each |
| T4543 | Incontinence product, brief/diaper, bariatric, each |
| T5999 | Supply, not otherwise specified |

## JHHC Adds Weekend, Extended and Holiday Hours to Expedite Authorization Requests to Skilled Nursing Facilities

Authorizations for transfers to Skilled Nursing Facilities (SNF) now may be obtained by a hospital after hours, on weekends, and during holidays. This applies to Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners, and Johns Hopkins US Family Health Plan (USFHP).

- Call the Utilization Management (UM) department's on-call pager at 800-307-9730.
- Extended hours: 8 a.m. to 7 p.m. weekends and holidays and from 5 p.m. to 7 p.m. on business days.
- Regular hours: 8 a.m. to 5 p.m. Monday through Friday

The **SNF Process Job Aid** outlines the expedited SNF authorization process.

## Temporary Waiver of Three-Day Inpatient Stay for SNF Care for Johns Hopkins US Family Health Plan (USFHP)

On September 3, 2020, TRICARE issued its interim final rule regarding temporary modifications to requirements, including its inpatient stay requirement for coverage at a Skilled Nursing Facility (SNF). With this new rule, for the duration of the pandemic, Johns Hopkins USFHP waives the requirement for members to have a 3-day qualifying inpatient stay as a condition of approval for a SNF level of care. Johns Hopkins USFHP members can be transferred or admitted to a SNF when it is clinically appropriate.

For the latest information on the pandemic, please visit our **COVID-19 webpage**.

# // BENEFITS AND PLAN CHANGES

## Blood Pressure Cuff Benefit for EHP Members

Taking ownership of treatment by tracking blood pressure at home can be an effective tool for your patients. To that end, Johns Hopkins Employer Health Programs (EHP) has added a blood pressure cuff monitor benefit to EHP plans that became effective January 1, 2020.

Outreach to members about this benefit includes a **flyer** posted on the EHP member website. Members are encouraged to talk to their doctors about adding home tracking of blood pressure to their treatment plan.

A specific health condition is not required to order a blood pressure monitor for a member. Providers can request devices for their EHP patients through the following process:

- Contact Johns Hopkins Pharmaquip at 410-288-8150 (phone) or 410-282-8455 (fax)
- Request **CPT Code A4670-Automatic Blood Pressure Monitor**

Monitors are available from other DME providers, but EHP has negotiated preferable rates with Johns Hopkins Pharmaquip to reduce plan and member costs.

If the standard model agreed to by EHP and JH Pharmaquip is not available, we will substitute a similarly equipped model. If your patient requires an upgraded model, please contact Johns Hopkins Pharmaquip.

## Change to Continuous Glucose Monitoring Device Benefit for USFHP

Earlier this year, JHHC made changes to the benefit for Continuous Glucose Monitoring (CGM) devices for Johns Hopkins US Family Health Plan (USFHP) members.

CGMs are available to members through the DME benefit. Johns Hopkins Home Care Connections can supply your patients with the CGM device that best suits their needs.

### CGM Devices Covered for USFHP [NOTE: CGMs require preauthorization]:

- **Dexcom G6**
  Available through Johns Hopkins Home Care Connections and Dexcom
  Dexcom Inc
  6340 Sequence Dr
  San Diego, CA 92121
  888-738-3646

  Johns Hopkins Home Care Connections
  5901 Holabird Ave, Ste A
  Baltimore, MD 21224
  800-288-2838
  Fax: 410-367-2053

- **Libre**
  Available through Johns Hopkins Home Care Connections
  **Johns Hopkins Home Care Connections**
  5901 Holabird Ave, Ste A
  Baltimore, MD 21224
  800-288-2838
  Fax: 410-367-2053

## Policy Details

The entire TRICARE policy on **CGM devices** can be accessed via this link. Important information about the CGM benefit is summarized below.

- **4.0 Policy**

U.S. Food and Drug Awdministration (FDA) approved CGMS devices may be cost-shared when used according to FDA approved indications, when:

- it is documented that the recipient has diabetes prior to being prescribed the CGMS,
- a TRICARE authorized provider has examined the beneficiary in person and evaluated the beneficiary's diabetes control within six months prior to ordering the CGMS, and
- a TRICARE authorized provider documents that ALL of the following criteria have been met:
  - » **4.1** Completion of a comprehensive diabetic education program; and
  - » **4.2** Treatment regimen including at least three insulin injections per day or insulin pump therapy, with frequent self-adjustment of insulin doses in the last three months (except for gestational diabetes, which has no time requirement for the self-adjustment of insulin); and
  - » **4.3** Documented blood glucose self-testing on average of at least four times per day prior to initiation of CGMS therapy;
  - » **4.4** And ANY one or more of the following:
    - **4.4.1** Glycosylated hemoglobin level (HBA1c) is greater than 7.0% or less than 4.0%;
    - **4.4.2** History of unexplained large fluctuations in daily glucose values before meals;
    - **4.4.3** History of early morning fasting hyperglycemia ("dawn phenomenon");
    - **4.4.4** History of severe glycemic excursions;
    - **4.4.5** Hypoglycemic unawareness;
    - **4.4.6** History of recurrent, unexplained, severe hypoglycemic events (i.e., blood glucose less than 50 mg/dl);
    - **4.4.7** History of recurrent episodes of ketoacidosis;
    - **4.4.8** Hospitalizations for uncontrolled glucose levels;
    - **4.4.9** Frequent nocturnal hypoglycemia; or
    - **4.4.10** The beneficiary is pregnant and has poorly controlled diabetes or gestational diabetes.
- **5.0 CGM devices and supplies**
  - » **5.1** Therapeutic CGMS is defined as a device that is approved by the FDA for non-adjunctive use (i.e., used as a replacement for fingerstick BGM testing). Therapeutic CGMS devices and all related supplies shall be reported using HCPCS codes K0553 – K0554.
  - » **5.2** Non-therapeutic CGMS is defined as a device that is approved by the FDA for use to complement, not replace, information obtained from fingerstick testing. Non-therapeutic CGMS devices and all related supplies shall be reported using the following HCPCS codes: A9276, A9277 and A9278.
  - » **5.3** Replacement of a CGMS receiver may be cost-shared when BOTH of the following criteria are met:
    - There is documentation confirming that the monitor/component is malfunctioning, is no longer under warranty, and cannot be repaired (See Section 2.1 for additional information on Durable Equipment); and
    - Evidence of an evaluation by a TRICARE-authorized individual professional provider (e.g., physician, nurse practitioner, etc.) managing the diabetes within the last six months that includes a recommendation supporting the continued use of a CGMS.
  - » **5.4** Contractors shall ensure the provisions of 32 CFR 199.9 and the TRICARE Operations Manual (TOM), Chapter 13, are followed to prevent fraud and abuse.
- **8.0 Exclusions**
  - » **8.1** Use of a CGMS device for any condition or indication NOT included above.
  - » **8.2** Use of a CGMS device that is NOT FDA approved or used outside of the FDA labeled indications.

» **8.3** Equipment that does not serve a primarily medical purpose and/or does not meet TRICARE's definition of Durable Medical Equipment (DME), for example, personal computers, smart phones, tablets, smart watches, even if such devices are able to receive data from the CGMS or other DME, and/or are marketed to assist with self-management of diabetes.

» **8.4** Combination devices that include a home blood glucose monitor combined with a cellular telephone or other device not specifically indicated for the management of diabetes mellitus.

» **8.5** Remote glucose monitoring devices (i.e., additional devices that will alarm in a location away from the person wearing the CGMS).

» **8.6** Hypoglycemic wristband alarm (a noninvasive device that does not monitor glucose levels, but measures perspiration and skin temperature).

» **8.7** Equipment, including the CGMS or replacement supplies, which are not medically necessary (e.g., charges for replacement).

## // CLAIMS AND BILLING

# JHHC Announces Partnership with eviCore healthcare for Johns Hopkins Advantage MD and Priority Partners

JHHC is pleased to announce its partnership with the vendor eviCore healthcare (eviCore) to provide prior authorization services for selected procedures (see below) for Johns Hopkins Advantage MD and Priority Partners.

Beginning in early 2021, providers in the Johns Hopkins Advantage MD and Priority Partners networks will be required to use the JHHC-eviCore system to obtain prior authorization for the following services:

- **Phase I:** High Tech Radiology and Cardiology Advanced Imaging
- **Phase II:** Genetic Testing/Lab Management

In both phases, providers will be able to access the JHHC-eviCore provider portal 24/7 for prior authorizations in these categories.

JHHC will offer training for this new process on the JHHC-eviCore portal (details to come) starting in early December 2020. The training includes how to submit a request for prior authorization, how to request a peer-to-peer review, and post-service decisions for appeals. We will provide more details about training in upcoming Provider Updates.

As the JHHC-eviCore partnership develops, we will continue to keep you informed.

# Claims Adjustments, Appeal Processes and Necessary Forms

Just a reminder: JHHC has updated the 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

***Provider Claims/Payment Dispute Form Process on HealthLINK***

The Provider Payment Dispute Form on HealthLINK is available for EHP, Priority Partners and USFHP in-network provider payment disputes only. This enhancement does not apply to JH Advantage MD payment disputes at this time; the current JH Advantage MD Participating Provider Post Service Payment Dispute Submission Form should still be mailed or faxed in to submit JH Advantage MD payment disputes (see the Johns Hopkins Advantage MD section).

The form can be found under "References" on the HealthLINK home page. From the drop-down menu, select the "Provider Payment Dispute Form."

Advantages of the web version of Provider Payment Dispute Form:

- **Fewer steps.** No need to download form, fill it out and then fax it to JHHC. Just complete the web-based form and submit.

- **Ability to submit up to 5 claims on a single web form.** If you want to dispute more than one claim, click on the yellow "Add" button for additional claims data sections.
  - » The maximum claims submitted on a single form is limited to 5.
  - » You can add 5 claims, one at a time, for the same or different dispute reasons.
  - » If you have multiple claims that are being disputed all for the same dispute reason, you can enter one claim into the system and attach an Excel spreadsheet to include the remaining claims as examples or for review.

Instructions on how to use the web version of the Provider Payment Dispute Form for EHP, Priority Partners and USFHP are available on the **JHHC Provider Education webpage** (scroll down to the "HealthLINK Job Aids" section) and within **HealthLINK**.

***The Provider Claims/Payment Dispute Form Process on JHHC.com***

Responses to itemized bill requests, submissions of corrected claims and submissions of COB/third-party liability information should also be sent with the **Provider Claims/Payment Dispute and Correspondence Submission Form.** The form can be found on **jhhc.com** under **Resources and Guidelines** and then under **Forms.**

- 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, and
- a copy of the claim, medical records or contract page.

## Appeals Process

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:

***Payment Disputes***

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, submissions of corrected claims and submissions 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 with any questions you may have.

## Priority Partners Providers and Their Groups Must Be Enrolled in ePREP

Priority Partners will not reimburse claims payments to providers unregistered in ePREP, the state's provider enrollment portal. This requirement became effective May 1, 2020.

Please be aware that the claims denial only applies to providers not yet enrolled in ePREP; if you and your group are registered, claims will be processed as usual.

Maryland Department of Health (MDH) requires all providers delivering services to Maryland Medicaid members to have an active enrollment status in the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal (ePREP) every 5 years. Providers are responsible for updating their professional license information prior to license expiration in the ePREP portal.

### Verification Tool from MDH

The MDH offers the Provider Verification System (PVS), a resource to perform real-time checks of provider fee-for-service enrollment status. Providers can use this link to access their enrollment status and to incorporate these lookups into their enrollment verification workflows: **https://encrypt.emdhealthchoice.org/searchableProv/main.action**

The PVS requires no login from providers. Please note the PVS system is for verification purposes only. The provider and their group (if applicable) still must enroll in ePREP if they have not already done so.

**NOTE:** Active enrollment applies to providers (individuals and provider groups). Both the provider and their group must be enrolled in ePREP.

- MDH's implementation of ePREP went into effect January 1, 2020.
- Priority Partners began validating billing and rendering NPI against a weekly file from MDH on this date.
- If billing or rendering NPI is not found on the most recent file or does not have an active status, claim will deny with this specific denial reason. The claim will deny until the provider corrects the issue in ePREP.
  - » Explanation of payment will reflect the reason for claim denial specific to ePREP:
    "Claim has been denied due to failure to obtain/maintain an active status with the Maryland Medicaid ePrep Program. Please verify your status at **https://eprep.health.maryland.gov/** and resubmit your claim."
  - » Providers can resubmit claims for adjudication within timely filing deadlines (180 days from date of service) once their status has been updated.

For additional information and to complete your application, please visit **health.maryland.gov/ePREP** or call 844-4MD-PROV (844-463-7768).

**NOTE:** Providers contracted with multiple MCOs only need to enroll one time with the state's ePREP system.

## // QUALITY CARE

## Identifying and Referring Priority Partners Members to Behavioral Health Services

Every day, our medical provider community meets patients with serious medical conditions and behavioral health needs. Medical providers are often in a position to first observe signs and answer patient questions about behavioral health problems. Dealing with complex medical issues that are exacerbated by behavioral health conditions is a significant challenge for busy practitioners. Providers need to know how to respond effectively and efficiently to secure proper treatment. We offer the following guidelines to assist medical providers in best responding to patients:

1. **Listen, Reflect and Validate:** Sharing thoughts and symptoms with anyone can be difficult for patients who are aware of the stigma that still exists around mental health. Patients who speak up are being vulnerable. Accordingly, that should be met with welcoming communication that makes patients feel heard, understood and validated by their medical providers.

2. **Language:** Speak to members about behavioral health issues as an important and legitimate part of overall health. Avoid words that may amplify stigma or a patient's sense that they are defective. Educate patients about how prevalent and expected these issues are, especially under pandemic conditions and as a frequent counterpart to serious medical conditions.
3. **Respond to Acuity:** While a full evaluation by a behavioral health clinician may be in order for the patient, if a medical provider becomes aware of a patient's expression of suicidal or homicidal talk or thoughts, or observe that a patient is possibly psychotic, the patient should be diverted to the nearest emergency department. If this is not feasible, the provider office should dial 911.
4. **Understand the PPMCO – Optum Relationship:** JHHC manages the somatic health care of PPMCO members, while Optum manages the behavioral health needs of this membership. To find network treatment providers for PPMCO members, patients or provider offices should call 800-888-1965 and ask for assistance. It is quite common for patients to wait weeks to get an appointment with a psychiatrist. CRNP's are an additional option.
5. **Coordinate Care:** After members have been referred and are in treatment with behavioral health providers, obtain consent for regular, team-oriented communication to coordinate care.

For more information about Optum behavioral health services to PPMCO members, visit: **https://maryland.optum.com/**

## 2020 HEDIS® Measurements: Controlling High Blood Pressure

According to the Centers for Disease Control and Prevention (CDC), about 37 million adults in the United States with uncontrolled hypertension have a blood pressure of 140/90 or greater.[1] It is essential to control hypertension to prevent complications that can have a significant effect on a patient's health and quality of life. These complications include heart disease, stroke, kidney disease, and eye problems. For this reason, the National Committee for Quality Assurance (NCQA) includes Controlling High Blood Pressure (CBP) as one of its HEDIS[a] measures.

### Measure Description:

The CBP measure looks at the percentage of health plan members 18-85 years of age who had a diagnosis of hypertension and whose Blood Pressure (BP) was adequately controlled during the measurement year. **Adequate control is defined as both a systolic < 140 and diastolic < 90.**

### BP Submission Guidelines:

- If a member has an elevated BP > 140/90 at an office visit, it is **important to retake and document the BP during the visit.**
- If multiple BPs are taken at a visit, and Current Procedural Terminology (CPT) II codes are submitted on the claim, the lowest systolic and lowest diastolic values should be used. Example: 150/80, 134/90 - Submit 134/80 making the member compliant with the CBP measure.
- CPT II Codes should be documented consistently throughout the measurement year to include all dates where a blood pressure is taken or recorded in the medical record regardless of results. (See chart below for the systolic and diastolic CPT II codes.)
- Both systolic and diastolic codes must be submitted or the patient will be considered to have uncontrolled blood pressure.
- If no blood pressure is submitted the patient is considered to have uncontrolled blood pressure.
- *NEW* - BP readings may be reported or taken by a member using any digital device and documented by the provider.
- BP readings taken by the member using a non-digital device such as a manual blood pressure cuff and stethoscope are not acceptable.
- Telephone visits, e-visits, and virtual check-ins are acceptable for reporting of BPs.
- Do not submit BPs taken on the same day as a diagnostic test or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure. Example: colonoscopy, dialysis, nebulizer treatment
- **Note:** A patient forgetting to take their regular medications on the day of the procedure is not considered a required change in medication and BPs taken may be submitted.
- Do submit BPs taken on the day of a fasting blood test.
- Do submit BPs taken on the same day that the member receives a common low-intensity or preventive procedure. Examples: injections, wart or mole removal

### Best Practices and Strategies for Improvement:

- Educate office staff on the importance of repeating BPs ≥ 140/90.
- Encourage patients to obtain a digital BP monitor and record BPs regularly.
- Educate patients on the proper size cuff and technique for taking a BP.
- Send out reminders for patients to schedule follow-up visits to have their blood pressure checked.
- Educate patients on the importance of controlling BP and taking blood pressure medications as prescribed.
- Educate patients on lifestyle changes including exercise, healthy diet and smoking cessation.

**Below is a list of CPT II codes that should be used to indicate the member's blood pressure.**

| Blood Pressure Rate | CPT II Code | Definition |
|---|---|---|
| Diastolic 80-89 | 3079F | Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM) |
| Diastolic Greater Than or Equal To 90 | 3080F | Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM) |
| Diastolic Less Than 80 | 3078F | Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) |
| Systolic Greater Than or Equal To 140 | 3077F | Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM) |
| Systolic Less Than 130 | 3074F | Most recent systolic blood pressure less than 130 mm Hg (DM), (HTN, CKD, CAD) |
| Systolic 130-139 | 3075F | Most recent systolic blood pressure 130-139 mm Hg (DM),(HTN, CKD, CAD) |



[1]*CDC. (2020). High Blood Pressure.* **https://www.cdc.gov/bloodpressure/facts.htm#:~:text=About%20half%20of%20adults%20(45,includes%2037%20million%20U.S.%20adults.&text=About%2030%20million%20adults%20who,and%20to%20start%20taking%20it.**

## Quality Assurance: The Substance Use Release of Information (ROI) Process

In the current climate of health care, large amounts of patient information are shared among and between entities working toward comprehensive and coordinated patient care. While this leads to better care and outcomes for members, it is important for providers to adhere to strict guidelines as they pertain to consent for release of information, particularly around substance use issues.

In May of 2018, the US Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC), in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), released two new fact sheets on 42 CFR Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) to assist with the application of the Part 2 provisions across different environments, including through electronic health information exchange (HIE) mechanisms and in provider office settings.

The 42 CFR Part 2 regulations (Part 2) serve to protect patient records created by federally assisted programs for the treatment of substance use disorders (SUD). Part 2 has been revised to further facilitate coordination of care in response to the opioid epidemic while maintaining its confidentiality protections against unauthorized disclosure and use.

Our JHHC providers in the community should thoroughly review the numerous changes to the confidentiality rule. Find them here: **https://www.samhsa.gov/newsroom/press-announcements/202007131330**

The revised rule does not alter the basic framework for confidentiality protection of substance use disorder (SUD) patient records created by federally assisted SUD treatment programs. Part 2 continues to prohibit law enforcement's use of SUD patient records in criminal prosecutions against patients, absent a court order. Part 2 also continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order.

## A Primer on Screening, Intervention, and Referral Programs for Substance Abuse

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the program called Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk for developing these disorders.

SBIRT services are defined as alcohol and/or substance (other than tobacco) abuse structured assessment (for example, Alcohol Use Disorders Identification Test, Drug Abuse Screening Test) and brief intervention. SBIRT was originally developed as a public health model designed to provide universal screening, secondary prevention (detecting risky or hazardous substance use before the onset of abuse or dependence), early intervention, and treatment for people who have problematic or hazardous alcohol problems within primary care and other health care settings. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

### Advantages of SBIRT services

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Especially in these pandemic times when substance abuse situations have increased, it is vital for our provider community to become familiar with the SBIRT approach and process to identify members in need of substance use intervention at any level. Providers can find more information, tools and SBIRT screening procedural codes at **www.samhsa.gov/sbirt.**

*Reference:*
Babor, T., McRee, B., Kassebaum, P., Grimaldi, P., Ahmed, K., Bray, J. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT). Substance Abuse, 28 (3), 7-30.

// 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**

# Quality Assurance Reminder: Demographic Updates

To comply with regulatory requirements, the information we maintain about participating practices, doctors and other health care professionals must be accurate, current and complete. We require that participating providers make appropriate and timely updates to their information on file with us.

Accurate information allows members to locate you and access the care and services they need, other participating providers to locate you for referrals, reduces the potential for delayed/denied payments, and helps ensure that you receive payment and other vital notices in a timely manner.

Johns Hopkins HealthCare (JHHC) conducts a quarterly validation survey of practitioner information in the directories. If during this outreach, your staff identifies a discrepancy, we ask the change to be submitted in writing.

## Submitting a Demographic Update

To request a change to the practice or practitioner information on file, please complete and submit the **Provider Update form**, along with all appropriate supporting documentation, to **ProviderChanges@jhhc.com**. If you have questions, please contact Provider Relations at 888-895-4998.

Updates should:

- Include the name, phone number and email address of the requestor.
- Clearly outline the requested changes/updates.
- Identify the effective date(s) of changes (please provide at least 30 days' advance notice).
- Be accompanied by all appropriate supporting documentation.

Below are some of the important pieces of information (including specific criteria about certain information) that you should ensure are accurate and up-to-date.

| For Practices | For Practitioners |
|---|---|
| • Practice name<br>• Type 2 NPI<br>• Address (including suite number, floor number or building number)<br>• Phone numbers (practice phone numbers should be those numbers that a member would call to schedule an appointment with practitioners at a particular practice location)<br>• Email address<br>• Languages Spoken (other than English)<br>• Office Hours<br>• Billing Information/Billing Company Information<br>• Affiliated Practitioners (Practitioners at a particular practice location) | • Name<br>• Gender<br>• Degree(s)<br>• Type 1 NPI<br>• Specialty<br>• Email address<br>• Board Certification(s)<br>• Office locations at which you practice<br>• Accepting new patients [per practice location(s)]<br>• Languages Spoken (other than English)<br>• Hospital Affiliation(s)<br>• Practice Limitations |

## Approved Forms and Fax Numbers

This is a reminder that you can find approved forms for all JHHC health plans on the Forms page of the JHHC website. The required forms listed on the Forms page are the only ones we accept. Certain approved JHHC forms can also be found on HealthLINK.

The forms should be filled out and faxed **only** to the fax numbers listed on the forms and/or to the general provider fax numbers listed below, if applicable.

- **Provider Relations**
  - » Fax 410-424-4604
- **Utilization/Care Management**
  - » Referral Not Needing Medical Review Fax 410-424-4603
  - » Inpatient Fax 410-424-4894
  - » Initial Inpatient Preauthorization Requests Fax 410-424-2770
  - » Outpatient Medical Review Fax 410-762-5205
- **DME (Durable Medical Equipment)**
  - » Fax 410-762-5250

If you have any suspicions of fraud, waste or abuse, please contact:

JHHC Corporate Compliance Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Telephone: 844-422-6957 or 410-424-4996
Fax: 410-762-1527
Email: compliance@jhhc.com

## JHHC's Access and Availability Standards

Each quarter, we monitor our provider network for adherence to requirements for routine and other care. In the event your office is identified as not meeting the requirements listed in this article, you will be contacted by Provider Relations. Please visit the Provider Manuals page of the website to view all of the access standards described in our manuals.

- OB/GYN – Initial Prenatal Assessments and Family Planning Appointments: Johns Hopkins HealthCare would like to remind our OB/GYN providers of the State COMAR requirement (10.67.05.07) for the initial assessment of pregnant women and those requesting family planning services. Appointments must be offered within 10 business days from request. Providers should remind their staff of these standards and train them to schedule appointments appropriately. You may consider creating a list of relevant conditions to place by the schedulers' phones.
- All providers – Urgent Care Appointments: Urgent care can be described as medically necessary care for an unexpected illness or injury. We remind all providers in our network(s) that EHP and USFHP (TRICARE) require members to be scheduled within 24 hours of request. Priority Partners follows COMAR requirements (10.67.05.07), requiring an urgent appointment within 48 hours of request. If the doctor that sees the member is not available, another doctor in the practice should see the member. If there is no availability, the member should be told why and provided alternative options for care.

## Check and Verify Preauthorization Requirements with JPAL

The Johns Hopkins Prior Authorization Lookup tool (JPAL) is a recently-added provider resource to check and verify preauthorization requirements for services and procedures for Johns Hopkins Advantage MD, EHP, Priority Partners and USFHP health plans. Located in the HealthLINK portal, JPAL offers a user-friendly way for providers to look up preauthorization requirements.

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

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

**NOTE:** JPAL is a means to look up preauthorization requirements **only**; it does not handle preauthorization requests. Please follow JHHC's policies and procedures as usual to request an authorization:

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

Instructions on how to use the JPAL tool are available once you log into **HealthLINK**. There is also a Job Aid for JPAL on the **Provider Education** page on JHHC's provider website.

## Fax Facts from the Utilization Management Team

To reduce bottlenecks and improve the turnaround time for initial inpatient requests, the Utilization Management (UM) department has added a fax line dedicated to initial inpatient requests from providers for Johns Hopkins Employer Health Programs (EHP), Priority Partners and Johns Hopkins US Family Health Plan (USFHP).

The initial inpatient requests fax number is **410-424-2770.**

Please be assured this is an addition to the fax numbers for UM, not a replacement. The UM fax number 410-424-4894 continues to be fully operational and faxes to this number will be processed. However, initial inpatient requests sent to the new dedicated fax number (410-424-2770) may be processed more quickly than similar requests sent to the general UM fax number.

**Reminder:** The UM fax numbers for Johns Hopkins Advantage MD remain the same:

- 844-240-1864 (Inpatient fax for Advantage MD only)
- 855-704-5296 (Outpatient fax for Advantage MD only)

## Network Access Standards

JHCC 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): |
|---|---|
| Health Assessment | 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

**Utilization/Care Management**
410-424-4480
800-261-2421
Fax 410-424-4603 (Referral not needing medical review)

- Inpatient
  Fax 410-424-4894
- Initial Inpatient Preauthorization Requests
  Fax 410-424-2770
- Outpatient Medical Review
  Fax 410-762-5205
  - » Urgent Outpatient Requests
    410-424-2707

## 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

**Fraud & Abuse**
410-424-4996
Fax 410-762-1527
compliance@jhhc.com

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

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

**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.

PRPULSE12-Fall 2020

PROVIDER pulse

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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