PROVIDER pulse

Johns Hopkins HealthCare Provider Newsletter

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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

"It is spring again. The earth is like a child that knows poems by heart."

–Rainer Maria Rilke

This has possibly been the most unusual and unsettling spring we've ever seen. Day-to-day life has changed for all of us during this unprecedented time and it will be a while before things go back to normal – whatever "normal" will look like in the age of coronavirus.

If anything reassuring has emerged from the pandemic, it is that we're all in this together.

With our health plans' coverage, requirements and policies rapidly evolving – often daily – we at JHHC are working hard to keep you updated on COVID-19 pandemic information. Visit our **COVID-19 update page** for the latest news on COVID-19 testing and treatment, prescriptions, and telemedicine coverage.

We know the spring of 2020 has been a difficult one, as providers and facilities face the realities of the pandemic and strive to adapt new strategies for care, such as telemedicine. Please know that we are available to help you through this transition to telemedicine for delivery of services, in any way we can.

Now more than ever, JHHC appreciates the effort and dedication our providers bring to offering high-quality care to our members, coming through even under our current challenging circumstances. Thanks for all you do.

–Editor, Provider Pulse

// POLICIES AND PROCEDURES

How to Handle Unlisted Claims Codes

In order to be processed for payment, unlisted codes require documentation (i.e. medical records) to be submitted with the claim. If a provider receives a denial for additional information (denial reason codes NR58 or NR36), please **resubmit the claim** with the applicable information. Providers do not need to submit appeals for unlisted codes.

Outpatient Referral and Preauthorization Guidelines For the Second Quarter

The Outpatient Referral and Preauthorization Guidelines (OPRGs) clearly outline the referral and preauthorization requirements for many outpatient services for our Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners and US Family Health Plan (USFHP) members. These guidelines are updated every quarter and posted to the **Johns Hopkins HealthCare website**.

To ensure the most-up-to-date referral and preauthorization guidelines for outpatient services are being followed, visit www.jhhc.com> For Providers> **Resources and Guidelines**.

Below is a summary of the changes to the Outpatient Referral and Preauthorization Guidelines that went into effect **May 1, 2020:**

Johns Hopkins Advantage MD

- Policies retired to InterQual criteria:
  - Bone marrow and stem cell transplantation
  - Oxygen and oxygen supplies
  - International Normalized Ratio (INR) self-monitoring devices
- No preauthorization required:
  - Pulmonary rehabilitation
- Preauthorization required:
  - Panniculectomy
  - Partial Hospitalization Program (PMP)

Johns Hopkins EHP

- Policies retired to InterQual criteria:
  - Bone marrow and stem cell transplantation
  - Oxygen and oxygen supplies
  - International Normalized Ratio (INR) self-monitoring devices
- No preauthorization required:
  - Radiation

- Abdomen CT
- Brain MRI
- Cervical and lumbar spine MRI
- Chest CT
- Lower extremity MRI
- Pelvis CT
- Sinus cavity CT

» Prostate surgery
» External beam radiation therapy (prostate cancer only)
» Three-dimensional conformal radiation therapy (3D-CRT)
» Intensity modulated radiation therapy (IMRT)
» Stereotactic radiation therapy (SBRT)

- Preauthorization required:
  » Panniculectomy

Priority Partners:

- Policies retired to InterQual criteria:
  » Bone marrow and stem cell transplantation
  » Oxygen and oxygen supplies
  » International Normalized Ratio (INR) self-monitoring devices
- No preauthorization required:
  » Otolaryngology
  » Prostate surgery
  » External beam radiation therapy (prostate cancer only)
  » Three-dimensional conformal radiation therapy (3D-CRT)
  » Intensity modulated radiation therapy (IMRT)
  » Stereotactic radiation therapy (SBRT)
- Preauthorization required:
  » Panniculectomy

Johns Hopkins USFHP:

- Policies retired to InterQual criteria:
  » Bone marrow and stem cell transplantation
  » Oxygen and oxygen supplies
  » International Normalized Ratio (INR) self-monitoring devices
- No preauthorization required:
  » Prostate surgery
  » External beam radiation therapy (prostate cancer only)
  » Three-dimensional conformal radiation therapy (3D-CRT)
  » Intensity modulated radiation therapy (IMRT)
  » Stereotactic radiation therapy (SBRT)
- Preauthorization required:
  » Panniculectomy
  » Breast tomosynthesis < 40 years of age

Introducing the Johns Hopkins Prior Authorization Lookup tool (JPAL): New Provider Lookup Tool for Outpatient Preauthorization Requirements

JHHC has introduced the Johns Hopkins Prior Authorization Lookup tool (JPAL), a new user-friendly resource providers can use to check and verify preauthorization requirements for outpatient services and procedures for Johns Hopkins Advantage MD, EHP, Priority Partners and USFHP health plans.

Providers can simply click on the JPAL link in HealthLINK under the "Administration" tab 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 resource to look up preauthorization requirements **only**. Authorization requests cannot be submitted through JPAL. Please follow JHHC's current policies and procedures to request prior authorization, which are available on the JHHC website.

- Please remember to confirm the authorization requirements of all outpatient procedures before delivery of service.
- If preauthorization status is unclear, submit an authorization request to JHHC Utilization Management.
  » Authorizations are not a guarantee of payment.

Instructions on how to use the JPAL tool are available on the JHHC Provider Education webpage and within HealthLINK.

Reimbursement Policy Reminders

To clear up any confusion our provider network may encounter with JHHC's reimbursement policies, we would like to offer a few policy clarifications.

- **OB Ultrasound.** There are limits for high-risk and low-risk pregnancies: **https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/Policies/Reimbursement_Policies/ob_ultrasound_policy_4.1.17.pdf**
- **Genetic Lab Testing.** This service requires preauthorization: **https://hpo.johnshopkins.edu/healthcare/policies/898/42597/policy_42597.pdf?_=0.080586345805**
- **DME Rent to Own.** Applicable rental codes are capped at 13 months: **https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/Policies/Reimbursement_Policies/DME%20Rent-to-Own%20Policy05.2020.pdf**
- **High Cost Radiology.** Select codes and places of service require preauthorization: **https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/provider_communications/2018/prior-authorization-for-radiology-9.5.18.pdf**

// BENEFITS AND PLAN CHANGES

Breast Pump Benefit Update for EHP Members

Recently, the breast pump benefit has been revised for JHHC employees who are EHP members. Effective March 1, 2020, non-hospital grade pumps are available without preauthorization and prior to delivery.

Online Diabetes Prevention and Management Programs Members Can Do While Staying at Home

Johns Hopkins Advantage MD, JH USFHP, and Priority Partners members can practice self-care for diabetes prevention and management from home with two online programs, DECIDE and act2.

Health care providers can refer JH Advantage MD and USFHP members directly to both programs. Providers can refer Priority Partners members to DECIDE **only**.

DECIDE

DECIDE is a literacy-adapted, self-paced, self-management program that helps adults learn how to change everyday behaviors to manage their type 2 diabetes better. The program – which takes a participant between two-and-a-half and six months to complete – enhances health behavior change, coaches patients online, and improves clinical outcomes. T**his program is intended for patients who struggle with the management of their diabetes.**

act$_2$

act$_2$ is an interactive, online, year-long support and engagement program. The goal is to empower individuals who have been diagnosed with prediabetes to take charge of their health as they work with a personal coach to lose weight gradually (5% to 7% body weight), build physical activity into their daily routine, understand good nutrition and healthy eating habits, develop skills for behavior change, and stay motivated. **This program is intended for patients at high risk of developing type 2 diabetes.**

Referral Process

Members cannot be enrolled in both programs, and they cannot self-refer, though they may be referred by JHHC Care Management or referred by their health care provider.

If your patients would benefit from one of these programs, please refer them to us in one of the following ways:

Phone: 866-809-2073
Email: HopkinsDiabetes@healthy.works
Online: bit.ly/hopkinsdiabetes

For all referrals, please include the following information:

- Patient's name; address; home phone #; mobile phone #; email address
- Referring provider's name; NPI #; office address; office phone #; mobile phone #; email address

For more information on DECIDE and act2, call 866-809-2073.

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, additional charges may apply.

Modification to Limits for Compression Stocking—DME Benefit

Effective June 1, 2020, the DME benefit for compression stockings has been modified for Johns Hopkins Advantage MD, Johns Hopkins Employer Health Programs (EHP), Priority Partners, and Johns Hopkins US Family Health Plan (USFHP) members.

Compression stockings with the code range of A6530-A6541 have a limit of four (4) pairs per 365 days. Previously, these compression stockings may have been limited to four individual stockings per 365 days.

Please contact the JHHC Provider Relations department at 888-895-4998 with any questions or concerns.

// CLAIMS AND BILLING

Claims Adjustments and 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

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 form and mail it 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 a 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 determinations related to coverage, rescissions of coverage or provisions 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 if you have questions about this process. For status inquiries, please call Customer Service; when contacting Advantage MD Customer Service about a payment dispute with or without a request for clinical review, please state that you submitted a payment dispute, not an appeal.

Reminder: Clear Claim Connection™ Web-Based Reference Tool

JHHC offers you an easy way to view edits applied to Johns Hopkins Employer Health Programs (EHP), Priority Partners, and Johns Hopkins US Family Health Plan (USFHP) claims before you submit them. Clear Claim Connection™ is a web-based reference tool on www.jhhc.com where providers can look up the justifications and clinical rationales for claims edits. JHHC's claims processing systems are integrated with McKesson Claim Check 10.0, Knowledge Base 60, which includes Outpatient Code Editor (OCE) and Correct Coding Initiative (CCI) edits version 23.3. The software automatically and carefully audits codes before claims are paid.

To access Clear Claim Connection:

1. Go to **www.jhhc.com**.
2. Select either the EHP/Priority Partners or USFHP portal.
3. Log into HealthLINK.
4. Go to Administration, then click on the correct claims menu item depending on the claim:
   a. EHP Professional Claims
   b. PP Professional Claims
   c. USFHP Professional Claims
   d. EHP Facility Claims
   e. ePP Facility Claims
   f. USFHP Facility Claim
   g. EHP DME Claims
   h. PP DME Claims
   i. USFHP DME Claims
   j. Hospital-Based Claims
5. Read the terms and conditions and click on the "I Have Read and Agree" button.
6. Select the Gender of the member.
7. Enter the member's Date of Birth.
8. Enter the Claim Diagnosis (code).
9. Enter the following:
   a. Procedure Code
   b. Units
   c. Date of Service (Note: This will automatically populate with the current date)
   d. Enter any modifiers (Mod 1, etc.)
   e. Select the "Provider Specialty" from the drop-down menu
   f. Select the "Place of Service" from the drop-down menu
10. Click "Review Claim Audit Results"
    a. If the codes entered in the claim are correct, you will get a screen message telling you that the claim is allowed.

b. If the claim contains information that will cause the claim to deny, a screen message will tell you what is disallowed. Depending on the information entered, it may also tell you what part of the claim will be allowed.

c. Clicking on the red "Disallow" link will show an explanation for why the claim was rejected.

11. Click "Current Claim" to modify the existing claim.
12. Click "New Claim" to enter a brand new claim.

Priority Partners Begins Denial Claims to Individual Providers/Provider Groups Not Enrolled in ePREP Starting May 1, 2020

As of June 1, 2020, Priority Partners will not reimburse claims payments to providers unregistered in ePREP, the state's provider enrollment portal. 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 electronic **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.

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 a 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.

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

Please contact the JHHC Provider Relations department at 888-895-4998 with any questions or concerns.

Have Questions About Authorization Requests From an Acute Inpatient Facility to a Participating Skilled Nursing Facility (SNF)?

Q: Is the expedited SNF authorization process in place for all JHHC plans?

A: As of January 20, 2020, the expedited SNF authorization process was put in place for all JHHC plans: JH Advantage MD (this process was effective 8/27/19 for JH Advantage MD), Priority Partners, JH Employer Health Programs, and Johns Hopkins US Family Health Plan.

Q: Does the Medicare "3 Day Rule" apply to JH Advantage MD members?

A: No, a JH Advantage MD member does not have to be in the hospital for 3 consecutive days/nights for SNF placement to be covered. A JH Advantage MD member can be transferred/admitted to a Skilled Nursing Facility when it is clinically appropriate.

Q: Which authorization form should be used when requesting a SNF authorization?

A: Use the links below and fax the appropriate Authorization Request Form (one form for JH Advantage MD, one form for PP, JH EHP, and JH USFHP) with supporting documentation to 410-424-2703. The authorization request form is mandatory for JHHC to receive all information necessary to process the request, and so the request is routed properly within JHHC.

- **Advantage MD:** https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/amd/amd_prior_authorization.pdf
- **EHP, Priority Partners, USFHP:** https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/pp-ehp-usfhp-authorization-request-form.pdf

Q: How should providers request an authorization for non-emergent ambulance transport to the SNF?

A: Please use the appropriate Authorization Request Form as noted above and fax to 410-424-2703. Include the Physician Certification Statement.

Q: What phone number should I call if I have questions about the SNF authorization process?

A: 410-762-5210

Q: When will I receive a response regarding my SNF authorization request?

A: If JHHC receives the request during our hours of operation, you will get a response the same day as the request.

*__NOTE:__ If the request is for authorization to an out-of-network SNF, the request will be pended for a UM nurse to review.

Q: What are the JHHC hours of operation for the SNF authorization process? What if I have a request after hours?

A: 7:30 a.m. – 4:00 p.m., Monday through Friday. If a request is received after hours, you will receive a response the next business day.

Q: If 5 days at a SNF will be approved initially, why are PT/OT notes and other clinical information required?

A: Even though we are expediting the transfer to SNF with this process, we still require clinical justification as evidence of medical necessity to support any audits.

Q: Is bed level required when submitting an authorization request?

A: Bed level should be provided if available, but if not, JHHC will enter the case at the lowest level.

Q: A valid diagnosis is required – what does that mean?

A: Please include a current, valid ICD-10 diagnosis code for the member with the authorization request.

Q: Will JHHC accept a SNF authorization request from a Skilled Nursing Facility?

A: No, the SNF authorization request must be submitted by the discharging hospital. The hospital has all applicable clinical information, and we do not want to generate multiple authorizations for the same patient, because this would delay the authorization process.

Updated Guidelines for Priority Partners: Routine Labor and Delivery Claims

The state of Maryland has released updated billing guidelines for routine vaginal delivery and cesarean section (C-section) claims that do not require a 3808 or a review from the MDH's Utilization Control Agent (Telligen) for payment. These guidelines went into effect February 1, 2020.

MDH has implemented a new process for billing labor and delivery claims, requiring providers to submit a combination of diagnosis, procedure, and revenue codes when billing for routine labor and delivery claims. Claims submitted on or after must follow the new billing guidelines described below.

New Claims Billing Process:

To receive payment for payment for routine labor and delivery claims, **all** of the following conditions must be met:

	Mothers	Newborns
2 **days** or less (for vaginal delivery)	The claim must include a diagnosis, procedure, and revenue code: 1. Diagnosis codes: Z37.0- Z37.9; AND 2. Procedure codes: 1OD07Z3 - 100 0728 , 1OEOXZZ; **AND** 3. Revenue codes: 0720 - 0722, 0729	The claim must include a diagnosis and revenue code: 1. Diagnosis codes: 238.0, Z38.1-Z38.30, Z38.4-Z38.61, 238.63, 238.65, 238.68, 238.7 - 238.8; **AND** 2. Revenue codes: 0171, 0 172 , 0175 , 0179, 0 723
4 **days** or less (for C-section delivery)	The claim must include a diagnosis, procedure and revenue code: 1. Diagnosis codes: Z37.0-Z37.9; AND 2. Procedure codes: 1000020 -1000022; **AND** 3. Revenue codes: 0720 - 0722, 0729	The claim must include a diagnosis and revenue code: 1. Diagnosis codes: Z38.0 1, Z38.31, Z38.62 , Z38.64, Z38.66, Z38.69; **AND** 2. Revenue codes: 0171, 0172 , 0 175, 0179, 0723

Reason for Change:

This update corrects ongoing claims payment issues caused by outdated Diagnostic Related Groups (DRG) codes programmed in the Maryland Medicaid Information System (MMIS). Outdated DRG codes in MMIS resulted in providers receiving erroneous denials for labor and delivery claims, which were indicated with an error code ("500") for invalid or missing preauthorization number.

For More Information:

Please contact Denise James, Chief of the Division of Hospital Services, by email at **denise.james@maryland.gov** or by phone at 410-767-1939.

// PHARMACY

Reminder: Submit Medical Injectable Prior Authorization Requests to JHHC's Pharmacy Department

To avoid delays in processing prior authorization requests for medical injectables, requests must be sent directly to JHHC's Pharmacy department. Please do not send these requests to the Utilization Management department or any other JHHC departments.

For Priority Partners: Submit medical injectable prior authorization requests for Priority Partners members using the **Medical Injectable Prior Authorization Form** along with clinical supporting documentation, via fax to the **JHHC Pharmacy department at 410-424-2801.**

A **complete list of the HCPCS codes** for all specialty medications that require prior authorization is available on Priority Partners website.

For USFHP: Submit medical injectable prior authorization requests for USFHP members using the **Medical Injectable Prior Authorization Form,** along with clinical supporting documentation, via fax to the **JHHC Pharmacy department at 410-424-2801.**

A **complete list of the HCPCS codes** for all specialty medications that require prior authorization is available on USFHP website.

Understanding Advantage MD Member's Vaccination Coverage

The cost-share for certain vaccinations for Advantage MD members depends on where they receive them. For the most economical cost share, Advantage MD members should get Part B vaccines at their provider's office or the pharmacy. They should get Part D vaccines at the pharmacy instead of the provider's office because they are not covered by the member's medical benefit.

Part B Vaccines: Advantage MD Members Get at Provider's Office or Pharmacy

- Flu vaccine
- Pneumonia vaccine

Part D Vaccines: Advantage MD Members Get at Pharmacy

- Shingles vaccine
- TDAP vaccine
- Travel vaccinations

NOTE: Some vaccines, like those for tetanus, are covered, depending on the situation.

- **For treatment of a wound:** Tetanus vaccine should be given at the provider's office.
- **For prevention of tetanus:** Tetanus vaccines can be received at the pharmacy because it meets the criteria for a Part D drug.

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**

Saving Patients Money with Real-Time Access to Drug Coverage

Help your patients save money on their prescriptions with electronic health record (EHR) access to patient-specific drug coverage and out-of-pocket cost information.

The portion of health care costs shouldered by consumers is rising and cost continues to be a barrier to medication adherence. In a recent survey, 84 percent of Americans said it would be helpful to know their prescription cost before they go to the pharmacy, and 64 percent said they would use prescription cost information to find lower-cost alternatives instead of forgoing treatment.[1]

With the rise of consumerism in health care, and the growth of high deductible health plans, many pharmacy benefit managers (PBMs) and electronic health record system vendors are making patient-specific prescription benefits information available at the point of prescribing.

While the type of information provided by PBMs and the availability of this information across different EHR systems may vary, a truly comprehensive real-time prescription benefits solution should include these key attributes for the prescribing provider:

- Knowing if the drug you want to prescribe is covered under your patient's prescription plan and what they will pay out-of-pocket (OOP) based on where they are in their deductible.
- Seeing a list of clinically appropriate lower-cost brand and generic alternatives that you could consider prescribing to save your patients money.
- Understanding which therapy options require prior authorization (PA) or have other restrictions like step therapy or quantity limits.
- Initiating the PA process directly from your EHR and receiving a near real-time approval decision.

JHHC uses CVS/caremark as its PBM vendor. CVS/caremark's real-time prescription benefits capability is powered by Script Intelligence, the company's proprietary engine and database of clinically mapped therapeutic alternatives.

The database displays up to five clinically appropriate lower-cost brand or generic alternatives with equal or better formulary status on the patient's specific pharmacy benefit design, and the real-time OOP cost for each based on where they are in their deductible. In addition, it displays information on any restrictions, such as whether or not a PA is required.

With real-time prescription benefits information, you have a more complete picture of your patient's actual cost and coverage to help you make more informed prescribing decisions. Additionally, the ability to instantly initiate a PA request, if needed, will help streamline and simplify the prescribing process.

There's no charge for the service; however, you will need the latest version of your EHR.

The following systems and versions are providing real-time prescription benefits:

EHR Systems and Versions Enabled

- AdvancedMD AdvancedEHR
- Allscripts Professional
- Aprima (v2016 – 16.0.1612.2146)
- Cerner Millennium (v2015.01.25)
- ClaimatComtron Medgen HER
- eMedicalNotes (v3.0)
- Enabledoc Enablemypractice
- EHREpic EpicCare (Epic2018)
- MD Office Manager GeeseMed HER
- Medical Office Solutions Adaptamed
- MedNet Medical Solutions emr4MD
- Modernizing Medicine EMA
- MTBC ChartsPro
- Office Ally EHR 24/7
- Practice Fusion
- Quest Quanum HER
- Waiting Room Solutions WRS Health (v5.0)

e-Prescribing Solutions Enabled

- Allscripts ePrescribe
- DrFirst
- eazyScripts (v3.0)
- InstantDx OnCallData (v5.
- 0)MD Toolbox

Specialty Portal/Hub Solutions Enabled

- Asembia
- United Biosource
- VirMedica

If you don't see your EHR vendor or version listed, contact your EHR vendor and tell them that your providers need patient-specific drug benefit and cost information in their e-prescribing workflow. Ask if they have contracted with Surescripts for real-time prescription benefits.

If you are not using the most recent version of your EHR's system, contact your EHR vendor account manager. For Epic users, contact your Epic account manager to confirm your 2020 upgrade go-live date and determine whether additional interfaces are needed. Work with your Surescripts account manager to complete the contract addendum.

Still having trouble accessing real-time prescription benefits? Contact your EHR vendor's help desk support line. For Epic users, work with your Ambulatory and Bridges TS representative and log a ticket with Surescripts.

[1]CVS Health Morning Consult poll, July 23-25, 2018. The Morning Consult poll was conducted from July 23-25, 2018, among a national sample of 2,201 registered voters. The interviews were conducted online and the data were weighted to approximate a target sample of registered voters based on age, race/ethnicity, gender, educational attainment, and region. Results from the full survey have a margin of error of plus or minus 2 percentage points.

// REMINDERS

Mail Forwarding Order Expiration

It's hard to believe it has been more than a year since JHHC moved to our new corporate headquarters in Hanover, Md. Our first anniversary means many things, but one milestone is that the USPS forwarding order for mail expired on April 15, 2020.

This means the post office is no longer forwarding mail addressed to 6704 Curtis Court or 6701 Baymeadow Drive. In addition, the post office will not hold the mail for JHHC to pick up. Any mail sent to our previous addresses (or to 6691 Baymeadow Drive) will be returned to sender, which could delay responses, processing and/or payments.

Please take the time to ensure all correspondence to JHHC reflects our corporate address of 7231 Parkway Drive, Suite 100, Hanover, MD 21076.

Provider Changes Notification Requirements

If there are any demographic changes in your practice or facility, you are required to notify the Johns Hopkins Provider Relations department by email at **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" and then under the Forms section of the "Resources and Guidelines" page) and attach it to the email before sending to JHHC. Information on the form includes changes to telephone numbers, address, suite numbers and email or fax numbers.

Any questions about the provider changes reporting process may be directed to Provider Relations at 888-895-4998.

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):
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

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

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.

PRPULSE10-Spring 2020

PROVIDER pulse

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