PROVIDER pulse

Johns Hopkins Health Plans Provider Newsletter

SPRING 2024

JOHNS HOPKINS HEALTH PLANS

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

// INTRODUCTION

"The world's favorite season is the spring. All things seem possible in May."

—Edwin Way Teale

Spring has a way of making most anything seem possible. New growth and new opportunities open up as the earth and air grow warmer and more daylight stretches our days into greater possibilities.

Johns Hopkins Health Plans has been spending the spring planting new seeds of change and efficiency. We are streamlining our platforms and procedures so that our providers can access the forms and processes they need to do day-to-day business with us in a more centralized way. As we expand and fine-tune our Availity provider portal, we trust our providers will find an increasingly integrated and unified experience. With the changeover to PNC ECHO for claims payments and remittance services for all lines of business, providers will be able to go to one claims platform for all our health care plans.

Our growth would not be as profuse without the essential contributions and collaborations from our provider network. Thank you for all you do in partnership with Johns Hopkins Health Plans.

—Jayne Blanchard, Editor

// POLICIES AND PROCEDURES

Availity Provider Portal Expansion for Electronic Submission of Prior Authorization Requests Effective May 20, 2024

Johns Hopkins Health Plans **implemented Phase II of Availity,** which allows all Johns Hopkins Health Plan providers to use Availity for submission of electronic prior authorization (PA) requests to Johns Hopkins Health Plans Utilization Management (UM) department for Priority Partners, Employer Health Programs (EHP) and Advantage MD. This will also allow providers to check authorization status in the Availity portal. A couple of key points below:

- Phase II of Availity became effective May 20, 2024. This will include electronic submission of PA requests to Johns Hopkins Health Plans. Supporting clinical attachments can be attached to the PA request upon submission to Availity. Authorization status will be visible through Availity, so providers can track the progress of their authorizations.
- Any PA requests faxed in to Johns Hopkins Heath Plans UM prior to May 20, 2024, will be honored.
  - » If an authorization with a date span beyond May 20, 2024, is approved via fax, you will **not** have to request a new authorization in Availity for dates of service after May 20; a new authorization request for a service authorized via fax would only be needed if you are requesting an extension of that authorization.
  - » Authorization status for faxed requests cannot be checked in Availity; if a PA request was faxed, the sender will receive the decision via fax. Providers can contact customer service to check the status of any pending case that was faxed in to Johns Hopkins Health Plans UM.
- Availity should be used to submit electronic PA requests to John Hopkins Health Plans for Priority Partners, EHP and Advantage MD; faxes for PA requests will be accepted for US Family Health Plans (USFHP) until Availity is implemented for USFHP. The USFHP PA form with applicable fax numbers can be found on the provider website and is **linked here** for your reference.
- If a PA request cannot be submitted through Availity for some reason once implemented, a fax request to Johns Hopkins Health Plans UM team will be accepted for all plans. Fax numbers and PA request submission forms remain the same and can be found on the Johns Hopkins Health Plans provider website or in Availity Payer Spaces application.
- For newborns who do not have a member identification number yet, please fax notification/PA request.
- For an elective surgery that was authorized by Johns Hopkins Health Plans UM prior to May 20, 2024, please fax notification of admission.
- **Reminder:** Electronic submission of PA requests through the Availity portal are for services reviewed by

the Johns Hopkins Health Plans UM department. **PA processes for vendors (eviCore, Novologix, Progeny) are not affected by this change.**

- For health systems on Epic, Payer Platform can also be implemented to submit PA requests electronically for Priority Partners, EHP, Advantage MD and USFHP to the Johns Hopkins Health Plans UM team later in 2024. If Payer Platform is implemented, it will be the primary process for submitting PA requests to Johns Hopkins Health Plans UM department, with Availity and USFHP faxes as a backup. Please let your Provider Relations representative know if you are interested in Payer Platform implementation.
- Linked here is a recorded training session that was held for a pilot group if you would like to review the information.

Other Availity Updates:

- The eviCore portal can be accessed directly through Availity now (without having to log into HealthLINK), and the Novologix portal is directly accessible through Availity.
- The functionality to submit electronic claim payment disputes and medical necessity appeals through Availity for Priority Partners and EHP (without having to log into HealthLINK) is now available.
- For Advantage MD, please continue to fax or mail claim payment or clinical disputes until further notice.
- For USFHP, please continue to use HealthLINK for electronic submission of claim payment disputes and medical necessity appeals, or submit by fax or mail, until further notice.

Recent Code and Prior Authorization Changes

Please note the following Prior Authorization (PA) and No Prior Authorization Required (NPA) changes for the following Johns Hopkins Health Plan codes for Advantage MD, Priority Partners and US Family Health Plan (USFHP).

1. **Advantage MD Diabetes Prevention Program, Change from PA to NPA, effective Jan. 1, 2024:**
    - » G9886-Behavioral counseling for diabetes prevention, in-person, group, 60 minutes. Up to 22 visits combined in a 12-month period allowed. NPA/ NC > 22 visits.
    - » **G9887-**Behavioral counseling for diabetes prevention, distance learning, 60 minutes. Up to 22 visits combined in a 12-month period allowed. NPA/ NC > 22 visits.
    - » **G9888-**Maintenance 5% WL from baseline weight in months 7-12. Up to 6 visits allowed. NPA/NC > 6 visits.
    - » **G9880 & G9881** NPA/NC > 1 visit.
    - » **G9890-Bridge Payment:** A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary. Visit limit added: NPA/ NC > 1 visit.
2. **USFHP J-Codes for Pharmacy, Change from PA to NPA, effective May 15, 2024:**
    - » Please see the USFHP J Codes Effective 5-15-24 list for pertinent codes.

Johns Hopkins Health Plans New Reimbursement Policies Effective June 10, 2024

Johns Hopkins Health Plans has released its notification of updated and new reimbursement policies for Advantage MD, Employer Health Programs (EHP), Priority Partners and US Family Health Plan (USFHP):

(RPC.018) Assistant at Surgery — Updated

- Johns Hopkins Health Plans recognizes the Medicare Physician Fee Schedule (MPFS) status indicators for Assistant-at-Surgery services to determine if the procedure is allowed with the assistance of a second surgeon.
- Assistant surgeons must bill the same procedure codes as the primary surgeon, with the exception of when the primary surgeon bills a global code. In that case, the assistant surgeon must bill the related surgery-only code, as global surgery rules do not apply to assistant-at-surgery services.

- **Priority Partners** — Johns Hopkins Health Plans reimburses Assistant-at-Surgery services in accordance to the Maryland Medicaid Administration Professional Services Provider Manual. Modifiers 80 and 82 will be paid 20% of the contracted rate for the surgical procedure.
- **USFHP** — No payment may be made for an assistant surgeon when co-surgeons are reimbursed.
- Policy language updated; Key Definitions, Background, Coding and References sections updated.

(RPC.019) Discontinued Procedures — Updated

- In alignment with CMS guidance, Modifiers 73 or 74 can only be used on one procedure code, per member, per date of service.
- When Modifier 73 is appended to a procedure code, Johns Hopkins Health Plans will only reimburse the covered service at 50% of the allowed amount. Only the primary intended procedure should be submitted on the claim.
- Consistent with CMS guidance, when another modifier that reduces the fee schedule amount is also applicable, Modifiers 73 and 74 must be reported in the secondary position; Modifier 73 and 74 cannot be reported with Modifier 50.
- Maryland Waiver Providers are required to bill services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations and will be reimbursed under the HSCRC payment methodology.
- Policy language updated; Key Definitions, Background, Coding and References sections updated and included.

(RPC.024) Staged, Related, & Unrelated Procedures — Updated

- Use of an incorrect modifier for a staged, related and/or unrelated procedure may result in denial of the subsequent surgery.
- Modifier 58 is not to be used to report the treatment of a problem that requires a return to the operating room and modifiers 50 and 78 cannot be submitted for the same service.
- Modifier 79 is a pricing modifier and should be reported in the first position and may only be submitted with surgery codes.
- Policy language updated; Key Definitions, Background, Coding and References sections updated and included.

REFERENCES:

- CMS Regulations & Guidance
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CMS MLN9013344-How to Use the PFS Look-Up Tool Booklet
- CMS Medicare Physician Fee Schedule (MPFS)
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 12- Physicians/Nonphysician Practitioners
- Medicare Claims Processing Manual CH. 4- Part B Hospital
- National Provider Identifier Standard (NPI) website
- TRICARE Reimbursement Manual- Chap 1 Sect 17

To view the **Johns Hopkins Health Plans Reimbursement Policies**, please go to: **HopkinsHealthPlans.org > For Providers > Policies > Reimbursement Policies**.

CPT® Codes Requiring Prior Authorization for Advantage MD

Effective April 1, 2024, Johns Hopkins Health Plans requires prior authorization for the selected medical procedure and equipment codes listed below for Advantage MD health plans. This requirement affects members of all ages enrolled in these plans.

Procedure Code	Effective Date	Procedure Description	Advantage MD Prior Auth YES/NO
0439U	4/1/2024	Code identifies proprietary test for a blood-based genetic test designed to evaluate the risk of coronary heart disease using AI algorithms to analyze genetic and epigenetic biomarkers.	YES, per eviCore
0440U	4/1/2024	Code identifies proprietary test for a blood-based genetic test designed to detect coronary heart disease in symptomatic individuals by analyzing genetic and epigenetic biomarkers.	YES, per eviCore
0444U	4/1/2024	Aventa FusionPlus is a comprehensive gene panel test using proprietary technology to identify gene fusions and rearrangements missed by conventional tests.	YES, per eviCore
0448U	4/1/2024	Code for oncoReveal Dx Lung and Colon Cancer Assay, a next generation sequencing test for detection of somatic mutations in DNA from formalin-fixed paraffin-embedded (FFPE) non-small cell lung cancer (NSCLC) and colorectal cancer (CRC) tumor tissue. The test is intended to be used to select patients with NSCLC or CRC that may benefit from treatment with targeted therapies.	YES, per eviCore
0449U	4/1/2024	Unity carrier screening is a single blood test combining maternal carrier screening and fetal aneuploidy NIPT testing for 5 single-gene disorders. Test does not require paternal sample.	YES, per eviCore

eviCore Prior Authorization Process for Advantage MD

- For codes subject to prior authorization through eviCore, providers should submit prior authorization requests via the eviCore portal through **Availity**, the **eviCore portal** directly or, if the portal cannot be accessed, by calling eviCore at 866-220-3071.

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

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

Johns Hopkins Health Plans Utilization Management (UM) Transitions to Epic Platform for Medical Necessity Reviews

In order to more efficiently service the needs of our members and providers, Johns Hopkins Health Plans has moved to a new Utilization Management (UM) platform, Epic, for both inpatient and outpatient reviews.

- The go-live date for US Family Health Plans (USFHP) was Feb. 12, 2024.
- The Priority Partners, Advantage MD and Employer Health Programs (EHP) go-live date was April 22, 2024.
- There are no changes to the fax numbers the providers use for submission, and future enhancements will allow greater portal access for authorization requests.*

Providers may notice some changes in the format of authorization responses with the transition to Epic.

- For example, authorization numbers now start with the letter "E:" **REFERENCE # E00001571**
- Each request for an extension of services or visits will result in a new authorization number.
- A detailed grid is provided in the provider letters to indicate the number of units/visits requested and those approved (including requested codes that do not require prior authorization):

Proc Code	Desc	Status	Start Date	End Date	Req Units/Visits	Appr Units/Visits
99215 (CPT®)	PR OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN	No Authorization Required	4/8/2024	6/7/2024	4	
99205 (CPT®)	PR OFFICE/OUTPATIENT NEW HIGH MDM 60 MINUTES	Authorized	4/8/2024	6/7/2024	2	2

- The Status column (outlined in red) is a new feature. Please note that the Appr Units/Visit column will be empty/blank (outlined in red) if no authorization is required.**
- Johns Hopkins Health Plans UM will manage group codes for outpatient PT/OT authorizations. The codes are 97161 for PT and 97165 for OT. These group codes cover the requested CPT® codes for the multiple modalities used in the treatment of the member. **NOTE:** This is not applicable for reviews managed by eviCore.

*The Johns Hopkins Health Plans process for electronic submission of prior authorization requests for Priority Partners, Advantage MD and EHP will switch over to Availity, starting with a pilot group on April 22, 2024, then with the rest of the network beginning on May 20, 2024. Providers will continue to submit prior authorization requests to Johns Hopkins UM for USFHP via fax until Availity is implemented for USFHP at a later date. If for some reason a provider cannot submit an electronic prior authorization request through Availity, the request can still be faxed.

**Always check JPAL for prior authorization requirements prior to rendering services.

// CLAIMS AND BILLING

PNC Healthcare and ECHO Health Inc. to Provide Claims Payments/Remittance Services for Advantage MD and USFHP Providers

Johns Hopkins Health Plans has engaged PNC Healthcare and ECHO Health Inc. to provide new electronic methods for claims payment and remittances via their Claim Payments & Remittances (CPR) service for Advantage MD and US Family Health Plan (USFHP). The transition from Change Healthcare to this CPR service will take place for Advantage MD first, with USFHP to follow (specific date to be set soon).

Once implemented, payments for Advantage MD and USFHP (Employer Health Programs [EHP] and Priority Partners currently) will *only* be issued using this CPR service. This service will also enable you to log into a website to access a detailed Explanation of Payment (EOP) for each transaction.

If you are already enrolled with PNC/ECHO for EHP and Priority Partners, you do not need to take further action. If you are not enrolled with PNC/ECHO for EHP and Priority Partners, please follow the important instructions below to ensure you receive payment for Advantage MD and USFHP as soon as this new CPR service is available.

We will communicate the effective date for Advantage MD and USFHP as soon as possible, but **we recommend you enroll now,** as the Electronic Funds Transfer (EFT) enrollment process does take 7 to 10 business days once the request is submitted. We also recommend that you call Advantage MD Customer Service at 877-293-5325 or USFHP Customer Service at 800-808-7347, as applicable, to confirm your remittance address and fax number on file, as your first payment after the transition will be sent via fax or mail if you do not complete early enrollment for EFT.

Outlined below are the payment options and any action items needed by your office:

Virtual Card Payments: Your first payment will be issued as a virtual credit card with your EOP. Your office will receive notification by mail or fax for each payment containing a unique virtual credit card number, along with instructions for processing. The steps for processing these payments are similar to how you manually enter patient card payments today. Be sure to enter the full amount of the payment prior to the expiration date on the card. Normal transaction fees apply based on your merchant acquirer relationship. **NO ACTION IS NECESSARY to start receiving virtual card payments**.

EFT Payments: If you are currently enrolled in EFT with Change Healthcare for Advantage MD and USFHP and want to continue receiving electronic payments, you will need to take the following action(s) to ensure a smooth transition to the new CPR service:

- **Early enrollment:** This is only an option if you have a previous/existing relationship with ECHO and the CPR service through another health plan. You will need to provide a check/draft number and payment amount from a payment issued via ECHO Health Inc., as well as your TIN and bank account information.

  To sign up to receive EFT only, or 835/EFT, from Johns Hopkins Health Plans, visit **enrollments.echohealthinc.com/EFTERADirect/JohnsHopkins/**.*

  To sign up to receive EFT only, or 835/EFT, from Johns Hopkins Health Plans and all ECHO Health payers, visit **enrollments.echohealthinc.com**.*
- **Standard enrollment:** If you do not enroll early, your first payment will be a virtual card. Once you receive this first payment via a virtual card, you can enroll with PNC Healthcare and ECHO Health. You will be able to use information from the virtual card (draft number and payment amount), as well as your TIN and bank account information, to enroll in EFT.

  To sign up to receive EFT only, or 835/EFT, from Johns Hopkins Health Plans, visit enrollments.echohealthinc.com/EFTERADirect/JohnsHopkins/.*

  To sign up to receive EFT only, or 835/EFT, from Johns Hopkins Health Plans and all ECHO Health payers, visit **enrollments.echohealthinc.com**.*

If additional assistance is needed, contact ECHO Health at 888-834-3511.

Paper Check: To receive paper checks and paper EOPs, you must elect to opt out of Virtual Card Services by contacting ECHO Customer Service at 888-697-6755 (8 a.m. to 6 p.m. ET). To request to receive a paper check instead of a virtual card, you may also log onto **echovcards.com*** and follow the prompts for opting out of virtual card and requesting a paper check. You will need a copy of a virtual card payment to register. HIPAA verification along with a draft number and amount are required to complete the opt-out process.

835 Electronic Remittance Advice (ERA): Providers who enroll to receive EFT payments will continue to receive the associated ERAs. Since the ERAs will be generated from the ECHO Health system, they will be distributed using the Payer ID 58379. **ACTION NEEDED: Please update your practice management system to accept the new Payer ID 58379.** Retain prior Johns Hopkins Health Plans Payer IDs for historical claims payments and remittances.

We also want to make you aware of another exciting enhancement. You will now be able to log into **providerpayments.com*** to access and download all generated and detailed EOPs for your provider transactions from Johns Hopkins Health Plans and all other PNC Healthcare payers.

We appreciate your support as we roll out these new payment options. If you have additional questions regarding your payment options, please contact ECHO Customer Service at 888-697-6755 (8 a.m. to 6 p.m. ET).

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

New CPT® Codes Requiring Prior Authorization for Advantage MD and USFHP

Effective May 15, 2024, Johns Hopkins Health Plans requires prior authorization for the selected medical procedure and equipment codes listed below for Advantage MD and US Family Health Plan (USFHP) health plans. This requirement affects members of all ages enrolled in these plans.

- **E0468** - Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions
- **E2298** - Complex rehabilitative power wheelchair accessory, power seat elevation system, any type

Prior Authorization Process:

Submit prior authorization requests to the Johns Hopkins Health Plans Utilization Management (UM) department using the dedicated fax numbers below:

- Advantage MD: 855-704-5296
- USFHP: 410-424-2602 or 410-424-2603

This code list is for reference purposes only and may not be all-inclusive. The listing of a code does not imply the service described is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right toreimbursement or guarantee claim payment. Other policies and guidelines may apply. Please refer to the Johns Hopkins Prior Authorization Lookup tool (JPAL), located in the **Availity** and **HealthLINK** portals, to check and verify prior authorization requirements. Prior authorization requirements are subject to change.

// PHARMACY

Improve Member Satisfaction by Using Drugs Covered Through Advantage MD

Johns Hopkins Health Plans strives to help your patients get their prescribed medication(s) in a timely manner to improve care and patient satisfaction as reported in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

We believe writing prescriptions with restrictions, without submitting an exception/medical necessity request or telling the patient that the drug will not be covered immediately, which often results in a patient's dissatisfaction with the plan and their prescribing physician.

Here are some suggestions to work with us to improve patient satisfaction:

- Before prescribing, look up the drug on the **Advantage MD formulary**.
- When a prescribed drug is not immediately available, perhaps because it requires prior authorization or step therapy, or is non-formulary, please either:
  - » Select a formulary alternative, OR
  - » Submit an electronic prior authorization request through either your preferred online portal (CoverMyMeds or SureScripts), your electronic health record (EHR) platform, our website: **tinyurl.com/mps5mfbj** or by fax or phone.
- Please notify the patient that you have submitted the request and that they will be contacted with the exception decision.

Top Ten Prescription Medications That Are Non-Formulary for Advantage MD

Non-Formulary	Formulary Alternative
BUDESONIDE/ FORMOTEROL INH 160-4.5 and 80-4.5	FLUTICASONE/SALMETEROL INH or WIXELA (generic Advair Diskus) Brand Advair HFA Brand Breo Ellipta Brand Dulera
METHOCARBAMOL TAB 500MG and 750MG	Tizanidine tabs, baclofen tabs
INSULIN ASPART PEN 100U/ML	Brand Novolog FlexPen
CICLOPIROX SOL 8%	Terbinafine tabs
SUTAB PACK	Gavilyte-g (generic GOLYTELY) Sod sulfate-pot sulf-mg sulf oral sol (generic SUPREP BOWEL PREP KIT)
HUMALOG KWIK PEN 100U/ML	ADMELOG SOLOSTAR
FLUTICASONE/VILANTEROL INH 200-25 and 100-25	Brand Breo Ellipta
FLUTICASONE/ SALMETEROL INHALER 25 0/50	Brand Advair
FLUTICASONE HFA INHALER 110MCG	Brand Arnuity Ellipta
INSULIN GLARGINE PEN 100U/ML	Brand Lantus Pen or Basaglar Pen

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Pharmacy Formulary Update

A variety of pharmacy information and resources are available to you on the Johns Hopkins Health Plans website and the Priority Partners, Employer Health Programs (EHP), US Family Health Plan (USFHP) and Advantage MD pharmacy pages. 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 Johns Hopkins Health Plans Pharmacy department at 888-819-1043 for questions or concerns for Priority Partners, EHP and USFHP. Call 877-293-5325 (Option 2) for questions or concerns regarding Advantage MD.

Pharmacy websites to bookmark:

- **EHP**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > EHP > **Pharmacy and Formulary**
- **Priority Partners**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > Priority Partners > **Pharmacy and Formulary**
- **USFHP**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > US Family Health Plan > **Pharmacy and Formulary**
- **Advantage MD**
  HopkinsHealthPlans.org > For Providers > Our Health Plans > Advantage MD > **Pharmacy and Formulary**

New Prior Authorization Requirements for Certain Provider-Administered Medications

Effective June 1, 2024, Johns Hopkins Health Plans will require prior authorization to determine medical necessity for several provider-administered medications under Priority Partners, Employer Health Plans (EHP), US Family Health Plan (USFHP) and Advantage MD. These requirements affect members of all ages.

Priority Partners Prior Authorization Requirements June 1

EHP Prior Authorization Requirements June 1

USFHP Prior Authorization Requirements June 1

Advantage MD Prior Authorization Requirements June 1

For certain drug classes, each of our health plans have preferred drug lists. These preferred drugs are indicated on the "Preferred Medical Injectable Drug List" included at the above links. The comprehensive lists of provider-administered medications that require prior authorization for these health plans are also available on the **Johns Hopkins Health Plans website** for your reference.

Submitting Medical Injectable Prior Authorization Requests:

Advantage MD, EHP and Priority Partners

- Providers may submit electronic prior authorization requests through NovoLogix using the **Availity** secure provider portal.
- If Availity is not able to be accessed, providers may contact NovoLogix for assistance by calling 844-345-2803 (EHP and Priority Partners) and 800-932-7013 (Advantage MD).

USFHP:

- Providers may request prior authorization by submitting the **Medical Injectable Prior Authorization Form** along with clinical supporting documentation via fax to 410-424-2801.

// QUALITY CARE

Muscle Issues Associated With Statins: Strategies for Managing Intolerance

Statins have demonstrated effectiveness in atherosclerotic cardiovascular disease prevention; however, muscle-related side effects are frequently reported and cause patients to discontinue statin treatment.

Statin-associated muscle symptoms (SAMS) can include muscle tenderness, weakness, soreness, stiffness, cramping, or fatigue. SAMS are commonly reported in the large muscle areas (e.g., legs and shoulders) symmetrically.

Despite muscle symptoms being the most common statin-related adverse effects, over 70% of patients eventually tolerate statins well.[1]

SAMS management strategies differ based on the patient and include continuous assessment and monitoring. Potential strategies include:

- Discontinue the statin for at least 2 weeks, then reintroduce the medication at the same or a lower dose when asymptomatic.

- Discontinue the statin for at least 2 weeks, then start a different statin at low dose and slowly raise the dosage until the maximum effective dose has been achieved or side effects occur.
    - » Pravastatin, rosuvastatin and fluvastatin have been found to cause less muscle toxicity.[4]
- Consider updating prescription to an alternate-day dosing schedule.
- Consider non-statin treatment if indicated.

There is conflicting data regarding the administration of coenzyme Q10 (CoQ10) for treatment or prevention of SAMS; benefits and risks should be assessed before use.

If your patient is unable to tolerate statin therapy due to SAMS, consider including the appropriate exclusion code in your claim submission:

- G72.0 – Drug Induced Myopathy
- M79.1 – Myalgia

For additional guidance and information, download the American College of Cardiology Statin Intolerance App at **https://www.acc.org/statinintoleranceapp**.

References:

1. Cheeley, Mary Katherine, et al. "NLA Scientific Statement on Statin Intolerance: A New Definition and Key Considerations for ASCVD Risk Reduction in the Statin Intolerant Patient." Journal of Clinical Lipidology, June 2022, https://doi.org/10.1016/j.jacl.2022.05.068.
2. Newman, Connie B., et al. "Statin Safety and Associated Adverse Events: A Scientific Statement from the American Heart Association." Arteriosclerosis, Thrombosis, and Vascular Biology, vol. 39, no. 2, Feb. 2019, https://doi.org/10.1161/atv.0000000000000073.
3. Wiggins, Barbara S., et al. "Statin-Associated Muscle Symptoms—a Review: Individualizing the Approach to Optimize Care." Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy, vol. 42, no. 5, 15 Apr. 2022, pp. 428–438, https://doi.org/10.1002/phar.2681.
4. Jeeyavudeen, Mohammad S, et al. "Statin-Related Muscle Toxicity: An Evidence-Based Review." European Endocrinology, vol. 18, no. 2, 2022, p. 89, https://doi.org/10.17925/ee.2022.18.2.89. Accessed 6 Jan. 2023.
5. "Managing Statin-Associated Muscle Symptoms." American College of Cardiology, www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/05/03/10/43/statin-associated-muscle-symptoms. Accessed 22 Oct. 2020.

Navigating the Path to Safer Pain Management: Understanding the HEDIS® Measure on Continued Opioid Use Risk

Long-term opioid use frequently begins with the treatment of acute pain. A relationship exists between early prescribing patterns and long-term use of opioids. Studies find a consistent link between increasing days' supply of the first prescription with probability of continued opioid use. The rate of opioid use at one year post-initial prescription increases substantially for patients with 31 or more days of opioid therapy. 1

In an effort to assess potentially high-risk opioid analgesic prescribing practices, the HEDIS Risk of Continued Opioid Use (COU) measure is defined as the percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

How you can help:

- Use the lowest dosage of opioids for the shortest length of time possible.
- Use the Prescription Drug Monitoring Program (PDMP) to review prescribing and dispensing of controlled substances.
- Discuss risks of using multiple prescribers with patient.
- Establish and measure goals for pain and function as well as goals for reducing and stopping opioid use.
- Establish follow-up appointments shortly after prescribing opioids to reassess the pain management plan.
- Educate the patient about side effects of medications, including the risk of addiction and what to do if side effects appear.

- Consider alternative pain management methods (cold/heat, acupuncture, topical pain relievers, corticosteroid injections, exercise and weight management, physical therapy, stress reduction, transcutaneous electrical nerve stimulation [TENS], and mind-body techniques such as meditation and yoga, massage therapy, etc.).

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

References:

1. "Risk of Continued Opioid Use (COU)." NCQA, www.ncqa.org/hedis/measures/risk-of-continued-opioid-use.
2. CDC. "CDC Clinical Practice Guideline for Prescribing Opioids for Pain" www.cdc.gov, 26 Sept. 2023, https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html.

// BENEFITS AND PLAN CHANGES

Prescription Copays and Reminders for Priority Partners

There are no pharmacy copays for children under the age of 21, pregnant members, individuals in long-term care facilities, Native Americans, or for family planning. For member groups that are subject to copays, pharmacy copays amounts are:

- $1.00 per prescription for generic drugs and preferred brand name drugs
- $1.00 per prescription for HIV/AIDS drugs
- $3.00 per prescription for non-preferred brand name drugs

As a provider, it is critical to explain the proper use of pharmacy services to Priory Partners members, including the following:

- It is important that members understand that they might need both their Priority Partners' identification card and their regular Medical Assistance ID card when filling a prescription.
- It is important for members to always use the same pharmacy within the Priority Partners network to fill all of their prescriptions. This enables the pharmacist to know about possible problems that may occur when a member is taking more than one medication.
- Members should always present their Priority Partners identification card when they have a prescription filled. They will also need to present their Medical Assistance ID card for drugs prescribed by their mental health provider.

// REMINDERS

Communication Services

Johns Hopkins Health Plans provides free tools and services to people who have disabilities to communicate effectively. Johns Hopkins Health Plans also provides free language services to people whose primary language is not English (e.g., qualified interpreters and information written in other languages). Members can obtain these services by calling the Customer Service number on their member ID card.

You may also contact Johns Hopkins Medicine International for assistance.

- Language Assistance
- Language Services

Provider Education Requirement for Advantage MD D-SNP

Johns Hopkins Health Plans would like to take this opportunity to remind providers in the Advantage MD D-SNP (HMO) plan of the mandatory training requirement.

Providers must take the D-SNP training when initially contracted to participate in the plan network. Then every year, providers in the Advantage MD D-SNP network are required to go through the training and fill out the training attestation form.

- Visit the provider website to sign up for 2024 D-SNP Training Dates.
- The presentation is available on our website's Provider Education page.
- Providers must submit the training attestation form after review of this training presentation. Access the form provided at the end of the presentation or by going to the Forms page on HopkinsHealthPlans.org and clicking on "Model of Care Provider Training Attestation Online Form (D-SNP)" under Advantage MD.

Important D-SNP Notice: Billing and Services

- Per the Advantage MD participating provider agreement, participating providers may not deny services to D-SNP members.

- Providers may not bill D-SNP members for any services covered under the D-SNP plan.
    - » Providers would need to bill Medicaid for the 20% that the D-SNP members would typically be responsible for, or accept the 80% payment from Advantage MD as full payment for the covered services.
- If a provider is not registered with Maryland Medicaid, we recommend they sign up so they can bill for services provided to D-SNP members.
- The D-SNP member may not be billed and is held harmless.
- Balance billing D-SNP members is prohibited.

Expanded Member Referral Form Available for Priority Partners

Recently, Johns Hopkins Health Plans revamped its Member Referral Form that gives expanded options for providers seeking to refer Priority Partners members needing additional services.

The form helps direct providers to the appropriate Johns Hopkins Health Plans department so their Priority Partners patients can receive the necessary services, such as care management, pregnancy services, health education and homeless services.

The form may also be used for member services outreach, such as when a provider needs to disengage a member from the practice. In this case, a certified letter must be sent to the member and a faxed copy provided to Priority Partners with the referral form (COMAR 10.67.05.03).

Providers can find the Member Referral Form on the provider website under the Resources and Guidelines in the Priority Partners forms section.

Reminder to Update Provider Demographic Information

If there are any demographic changes for your practice or facility, you are required to notify the Johns Hopkins Health Plans Provider Maintenance department 30 days prior to the change via:

- Your delegated roster
- If you do not have a delegated credentialing agreement, please use the Provider Information Update form, which can be submitted electronically online, or the PDF can be emailed or faxed.

Please also be sure to include any changes in panel status (accepting new patients or not) as we want to ensure we are reflecting correct access information for our members. In addition, please confirm email addresses, as Johns Hopkins Health Plans communicates provider notices via email.

- **Delegated Rosters:** Follow the established process for submitting notification of any provider changes and confirm if the provider is accepting new patients or not.
- **Digital Submission of the Provider Information Update Form** *(preferred)*: Submit the Online Digital Provider Information Update Form directly from the provider website.
- **Email Submission:** Fill out the Provider Information Update Form* and email it to ProviderChanges@jhhp.org. This mailbox is monitored daily to collect and process all provider changes.
- **Fax Submission**: Use this method **only** if you are using a Social Security Number in place of a Tax ID. Complete the Provider Information Update Form* and fax to 410-762-5302 to ensure identity protection. Do not send digitally or by email.

*This form is located on HopkinsHealthPlans.org, under "For Providers" and then under the Forms section of the"Resources and Guidelines" page.

NOTE: Please submit W-9 requests to w9requests@jhhp.org.

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

Qlarant Survey Season Begins in June for Priority Partners Providers

Qlarant is the Maryland Department of Health's (MDH) designated independent external quality review organization (EQRO) that assists state agencies in meeting federal regulations in assessing managed care organizations (MCOs). Priority Partners provider surveys start in June. We thank you for your participation.

Network Access Standards

Johns Hopkins Health Plans 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 Primary Care Provider (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

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

US Family Health Plan

Service	Appointment Wait Time (Not More Than):
Well-patient	Four (4) weeks
Specialist	Four (4) weeks
Routine	One (1) week
Urgent	Twenty-four (24) hours
Office wait time	Thirty (30) minutes

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	Immediate
Behavioral health emergency	Immediate

// SPECIAL REPORT

CAHPS® Survey Results on Race and Ethnicity for Priority Partners

Overview

Johns Hopkins Health Plans monitors providers who provide primary care, behavioral health care, and specialty care to meet or exceed network availability standards for members as defined by the member's health plan. This report analyzes CAHPS survey results on race and ethnicity, U.S. census data on resident language preference and race distribution, data on member linguistic needs and member complaints.

The comparison between the demographic results of the Priority Partners CAHPS survey respondents (Table 1) and the U.S. census data (Table 2) continues to reflect a similar distribution in the overall service area. The exception to this is the Hispanic group, with the Priority Partners membership for this group lower than the U.S. Census Bureau statistics for the service area.

During the first three quarters of 2023, the Customer Service department (CS) received over 11,608 calls requiring translation support, a 120% percent increase over the same period in 2022. This demonstrates a continuing upward trend, over the last several years. The most requested language continues to be Spanish, followed by Asian (Korean, Mandarin) and Other (Creole and Russian). These results align more with the U.S. census data (Table 2) than the member data (Tables 1 and 4). There were no member complaints about provider ability to meet member ethnic, racial, cultural or linguistic needs.

The 2023 plan level geographic analysis (Table 5) continues to show all required standards being met. A gap analysis at the county level showed no opportunities for improvement, as all areas reported above the 90% geo-access goal. Priority Partners will continue to monitor network adequacy reporting, which is reviewed monthly, at a minimum, for areas of expansion or improvement.

Member Cultural Needs and Preferences

Priority Partners analyzes data about member cultural, ethnic, racial and linguistic needs and preferences every year to determine whether the current provider network is meeting these needs.

Member cultural, ethnic, racial and linguistic needs and preferences are assessed through:

- CAHPS survey results on respondent race and ethnicity
- U.S. census data on resident language preference and race distribution for the health plan's service area
- Data on member linguistic needs based on customer service language translation requests
- Member expressed needs regarding providers who meet their ethnic, racial, cultural or linguistic needs through analysis of member complaints

The U.S. census data can be found at **this web page**.

Table 1

Trended CAHPS Data – Racial and Ethnic Demographics*				
Race/Ethnicity	**2021**	**2022**	**2023**	**Trend**
Respondents total	703	467	584	+117
White	50%	46%	48%	+2
Black or African American	40%	38%	39%	+1
Asian	6%	8%	7%	–1
Native Hawaiian or other Pacific Islander	1%	2%	2%	—
American Indian or Alaska Native	3%	4%	3%	–1
Hispanic or Latino	22%	25%	24%	–1
Other	14%	15%	22%	+7

**The percentages shown are an aggregate of the Adult and Child CAPHS surveys conducted, separately, by the Center for the Study of Services (CSS), on behalf of the Maryland Department of Health.*

Table 2

Service Area Census Data			
Race/Ethnicity	**2021***	**2022**	**2023**
White	67%	67%	65%
Black or African American	27%	27%	28%
Asian	11%	10%	11%
Native Hawaiian or other Pacific Islander	0.1%	0.1%	0.1%
American Indian or Alaska Native	0.6%	0.5%	1%
Hispanic or Latino	16%	16%	15%
Other	9%	8%	14%

**Data is from the 2020 U.S. census, released in 2022, as there were no 2020 estimates released in 2021.*

From January through September 2023, the CS department received 11,608 calls requiring translation support. This is a 120% increase for the same time period last year. The most requested language continues to be Spanish, followed by Asian (Korean, Mandarin) and Other (Creole and Russian). The membership distribution (Table 3) and the U.S. census distribution reported above align with this in that Spanish is the largest group of non-English speakers. The translation requests show higher for the Asian group than the other two data sets.

Table 3 displays the racial/ethnic distribution of the responding providers.

Table 3

Priority Partners Provider Data – Racial and Ethnic Demographics				
Race/Ethnicity	**2021**	**2022**	**2023**	**Trend**
White	58%	53%	51%	–2
Black or African American	7%	7%	7%	—
Asian	13%	13%	10%	–3
Native Hawaiian or other Pacific Islander	0%	0%	0%	—
American Indian or Alaska Native	<1%	<1%	<1%	—
Hispanic or Latino	2%	2%	2%	—
Other	20%	26%	24%	–2

Table 4 displays the proportion of the provider network that reports speaking the predominant languages other than English reported through the credentialing process for the service area. The proportion of the provider network is compared to the proportion of members who report speaking that language to determine whether the provider network can meet member linguistic needs.

Table 4: Priority Partners Language Data

Total Providers That Speak Identified Languages*	Percent of Total Network	Total Members That Speak Identified Languages**	Percent of Total Membership
Asian: 9,709	Asian: 35%	Asian: 9,435	Asian: 3%
Spanish: 5,686	Spanish: 20%	Spanish: 17,385	Spanish: 5%
Other: 9,971	Other: 36%	Other: 18,869	Other: 6%

**Based on language reported on credentialing application.*

***Based on data captured from enrollment files.*

Total providers for Priority Partners is 27,832 and total membership for Priority Partners is 342,886.

Upon comparison of data on providers who speak languages other than English with the proportion of individuals in the service area who speak other languages, the Priority Partners network exceeds the linguistic needs of its members. There were no member complaints about provider ability to meet linguistic needs in 2023.

Table 4 lists the standards, measurement method and measurement frequency for each provider type for whom availability is monitored.

Table 4: Standards and Measurement Methods by Provider Type

Provider Type	Standard	Measurement Method	Measurement Frequency
Primary care providers: Family and general providers	90% of members have at least 2 PCPs within 30 miles	Geo-access	Annually
	At least 1 FP/GP per 500 members	Ratio of member to provider	Annually
Primary care providers: Internal medicine	90% of adult members have at least 2 IM within 30 miles	Geo-access	Annually
	At least 1 IM per 500 adult members	Ratio of member to provider	Annually
Primary care providers: Pediatrics	90% of members have at least 2 PC/PED within 30 miles	Geo-access	Annually
	At least 1 PC/PED per 500 pediatric members (age 22 or younger)	Ratio of member to provider	Annually
High-volume specialty: Obstetrics and gynecology	90% of adult members have at least 1 OB-GYN within 60 miles	Geo-access	Annually
	At least 1 OB-GYN per 500 members (age 12 or older)	Ratio of member to provider	Annually

Table 4: Standards and Measurement Methods by Provider Type

Provider Type	Standard	Measurement Method	Measurement Frequency
High-impact specialty: Oncology	90% of members have at least 1 oncologist within 60 miles. At least 1 oncologist per 500 members.*	Geo-access Ratio of member to provider	Annually Annually
High-impact specialty: Cardiology	90% of members have at least 1 cardiologist within 60 miles. At least 1 cardiologist per 500 members.*	Geo-access Ratio of member to provider	Annually Annually

** NCQA does not require ratios for high-impact specialists, and Behavioral Health is carved out to the State of Maryland.*

Table 5: Measurement Results and Comparison to Performance Goal by Provider Type

Provider Type	Standard	2021	2022	2023	Change (+/-)	Goal Met?
Primary care providers: Family and general practice	90% of members have at least 2 FP/GP within 30 miles	100%	100%	100%	No change	Yes
	At least 1 FP/GP per 500 members	126:1	82:1	96:1	+14	Yes
Primary care providers: Internal medicine	90% of adult members have at least 2 IM within 30 miles	100%	100%	100%	No change	Yes
	At least 1 IM per 500 adult members	199:1	158:1	155:1	–3	Yes

Provider Type	Standard	2021	2022	2023	Change (+/-)	Goal Met?
Primary care providers: Pediatrics	90% of adult members have at least 2 PC/PED within 30 miles	100%	100%	100%	No change	Yes
	At least 1 PC/PED per 500 pediatric members (age 21 or younger)	46:1	64:1	43:1	–21	Yes
High-volume specialty: Obstetrics and Gynecology	90% of adult members have at least 1 OBGYN within 60 miles	100%	100%	100%	No change	Yes
	At least 1 OBGYN per 500 members (age 12 or older)	103:1	84:1	83:1	–1	Yes
High-impact specialty: Oncology	90% of members have at least 1 oncologist within 60 miles	—	—	100%	—	Yes
	At least 1 oncologist per 500 members*	—	—	247:1	—	Yes
High-impact specialty: Cardiology	90% of members have at least 1 cardiologist within 60 miles	100%	100%	100%	No change	Yes
	At least 1 cardiologist per 500 members*	621:1	660:1	443:1	–217	Yes

** NCQA does not require ratios for high-impact specialists. High-Impact Oncology was reinstated in 2023.*

Priority Partners conducts analysis at the county level to identify potential opportunities to improve provider availability and meets weekly to review strategies and outcomes of recruitment activity. The county-level gaps are analyzed in Table 6.

Table 6: County Level Gap Analysis

County	Provider Specialty Gap	Analysis
No gaps were identified		

Barriers and Action Plans (Opportunities for Improvement)

For 2023, with all areas meeting or exceeding the required goals, no barrier or opportunity was identified for improvement. Johns Hopkins Health Plans will continue to monitor network adequacy reporting (reviewed at least monthly) for areas of expansion or improvement.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

—Prepared By: *Melissa Moses, Provider Relations*

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 Johns Hopkins Health Plans Provider Relations department by email at ProviderChanges@jhhp.org or by using the online Provider Information Update Form.

Care Management Referrals
caremanagement@jhhp.org or 800-557-6916

DME (Durable Medical Equipment)
Fax 410-762-5250

Availity Provider Portal
www.availity.com/essentials-for-health-plans
800-282-4528

HealthLINK@Hopkins
www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/healthlink

Johns Hopkins Health Plans Corporate Compliance
410-424-4996
Fax 410-762-1527
compliance@jhhp.org

Fraud, Waste & Abuse
FWA@jhhp.org

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: HopkinsHealthPlans.org
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
Advantage MD
P.O. Box 3537
Scranton, PA 18505

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

Pharmacy Services
877-293-5325

Prior Authorization
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: HopkinsHealthPlans.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 – Delta Dental
800-932-0793

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

Cigna
800-261-2393

***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-health-plans/providers-physicians/our-plans/ehp

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: HopkinsHealthPlans.org
800-654-9728

Customer Service (Provider)
800-654-9728

Dental (Maryland Healthy Smiles Dental Program)
855-934-9812

HealthChoice
800-977-7388

Health Education
800-957-9760

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

Medical Claims Submission
Johns Hopkins Health Plans
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 Disorder 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 disorder professionals.*

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

Health Education
800-957-9760
healtheducation@jhhp.org

Inpatient Utilization Management
Fax 410-424-2602

Outpatient Utilization Management
Fax 410-424-2603

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

Medical Claims Submission
Johns Hopkins Health Plans
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 Disorder 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.

PRPULSE16-SPRING 2024

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

PROVIDER pulse

JOHNS HOPKINS HEALTH PLANS

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