PROVIDER pulse

Johns Hopkins Health Plans Provider Newsletter

FALL 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 "-ber" months at Johns Hopkins Health Plans are busy and fruitful. It's the time of year that our health plans go through the annual open enrollment period and all that it entails. We also gather the information and resources necessary to providers and members advance notice of the benefit and process changes that will go into effect at the beginning of 2025 and throughout the year. In this issue of *Provider Pulse,* we want to make you aware of a Pharmacy and Part D changes coming to Advantage MD starting January 1. We also have important updates on our reimbursement policies, code changes and medical policies, as well as some promising results of our diabetes education program, suggested medication management strategies and support for your practice's interpretation services. In this time of being thankful, we appreciate the essential work our providers do day in and day out to provide high-quality, committed care to our members across all our health care plans. Without you, we wouldn't be Johns Hopkins Health Plans.

—Jayne Blanchard, Editor

// POLICIES AND PROCEDURES

Anesthesia Processing Reimbursement Policy Effective Dec. 2, 2024

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

(RPC.007) Anesthesia Processing Guidelines — Updated (Effective Dec. 2, 2024)

Johns Hopkins Health Plans allows reimbursement, of a reasonable cap, on professional neuraxial epidural anesthesia services (CPT 01967), provided in conjunction with labor and delivery as follows:

- One unit of CPT 01967 per 15 minutes for the first hour of anesthesia (4 units total), plus one unit of CPT 01967 per hour after the first hour (5 units) up to the maximum of 360 minutes (9 units), is allowed.
- Providers may submit documentation upon dispute for consideration/reconsideration for additional reimbursement of time in excess of 360 minutes.

"Anesthesia time" means the time in minutes during which the anesthesia provider is both furnishing continuous anesthesia care to a patient **and** must be **physically** present with the patient.

- No payment is provided for any type of physician "standby or monitoring" services without direct hands-on patient contact, even when required by the hospital.

When billing add-on codes (AOCs) CPT 01968 and 01969 along with CPT 01967, Johns Hopkins Health Plans will limit the reporting of these AOCs to the first hour of 01967.

The appropriate and required modifier(s) for anesthesia services must be reported, and in the correct order, or the service will be denied.

Anesthesia services performed for non-covered procedures, including services considered not medically necessary, experimental and/or investigational, will not be reimbursed.

AMD, EHP, USFHP: Consistent with CMS guidance, Johns Hopkins Health Plans does not recognize "Qualifying Circumstances" when CPT codes 99100-99140 are billed for our members.

- Johns Hopkins Health Plans does not allow additional units for physical status modifiers, when applicable.

Priority Partners: In alignment with Maryland Medicaid, Johns Hopkins Health Plans will not make additional payments

for participant risk factors, such as participant age or health status (Physical Status Modifiers or Qualifying Circumstance procedure codes), or for monitored anesthesia care (MAC).

- No separate payment will be made for the medical supervision of a CRNA by a physician.

Policy language updated; Key Definitions, Background, Coding and References sections updated.

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

Changes to Emergency Department Review Policy, Sudden and Serious List

The Johns Hopkins Health Plans Reimbursement and Coding Committee (RAC) approved changes to the Sudden and Serious List, which is a list of ICD-10 codes for which Emergency Department (ED) payment does not require medical review. Several ICD-10 codes were removed. There will be a change in review for payment of ED ancillaries as well. Please see details below.

Please view the current version here: Sudden and Serious Diagnosis Codes List*

NOTE: The current list contains an addendum with codes that were **deleted effective Nov. 1, 2024**. These codes are:

- E03.9 - Hypothyroidism Unspecified
- E11.65 - Type 2 Dm w/hyperglycemia
- G40.909 - Epilepsy Uns Not Intract W/O Se
- G89.18 - Other Acute Postprocedural Pain
- J21.0 - Acute Bronchiolitis Due To RSV
- J21.9 - Acute Bronchiolitis Unspecified
- K29.70 - Gastritis Uns Without Bleeding
- N12 - Tubulo-Interst Nephrit Not Ac/Chrn
- O21.0 - Mild Hyperemesis Gravidarum
- O21.9 - Vomiting Of Pregnancy Unspecified
- R04.0 - Epistaxis
- R11.15 - Cyclicl Vomtng Syn Unreltd Migraine Ed
- R41.82 - Altered Mental Status Unspecified
- S06.0X0A - Concussion Without Loc Initial Enc
- T78.1XXA - Oth Adverse Food Reactions Nec Init
- T78.40XA - Allergy Unspecified Initial Encntr
- Z11.52 - Encount For Screening For COVID-19
- Z86.16 - Personal History Of COVID-19

For claims without a diagnosis on the Sudden and Serious list, Johns Hopkins Health Plans performs a clinical review. This review evaluates each clinical situation in terms of the Prudent Layperson standard (EMTALA law). Historically, Johns Hopkins Health Plans automatically paid for many ancillary tests even when the clinical situation did not meet the Prudent Layperson standard.

Also beginning Nov. 1, 2024, if Johns Hopkins Health Plans determines that a Prudent Layperson would not have sought Emergency Department care in their specific clinical situation, Johns Hopkins Health Plans will also evaluate the medical necessity of each ancillary study accompanying the visit. Ancillaries that are not medically necessary will not be paid.

*To view the full descriptions of policies, please visit the **Johns Hopkins Health Plans website** on or after the effective date or call Provider Relations at 888-895-4998 (Option 4).*

*If the link to this PDF breaks, please visit our ***Communication Repository.***

Did You Remember to Document the Interpreter?

According to Johns Hopkins Health Plans and Johns Hopkins Medicine policies, the interpreter name and/or ID number must be documented on the consent of any patient with a language need.

Per the policy on Interpretation and Translation Services,

- The patient's preferred language for medical discussions must be documented in the medical record.
- If a language other than English is documented for the patient or the consented care partner, then an interpreter must be used for consent.
- You must document the interpreter's (or qualified bilingual staff member's) name and/or ID number on the consent form.
- The consent may also be provided in the patient's language upon request, if available. However, an interpreter should still be used to explain the information.

As a refresher, Johns Hopkins Health Plans provides free tools and services to people who have disabilities to communicate effectively. Johns Hopkins Health Plans also offers 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.

Johns Hopkins Medicine International for assistance.

- Language Assistance
- Language Services

You may also visit registry-search-cmi-2 (memberclicks.net) to locate a credentialed medical interpreter.

// CLAIMS AND BILLING

Alaffia Health to Support Johns Hopkins Health Plans' Payment Integrity Team

Johns Hopkins Health Plans has engaged the services of Alaffia Health (Alaffia) to enhance the efforts of our Payment Integrity team. Alaffia is a technology-focused payment integrity firm with extensive knowledge of Maryland, Washington, D.C. and the health care ecosystem in the surrounding area.

Early in 2025, Alaffia will begin performing post-payment itemized bill (IB) and clinical chart reviews for inpatient and outpatient facility claims for Advantage MD, Employer Health Programs (EHP) and Priority Partners.

If an IB is not already on file with Johns Hopkins Health Plans, Alaffia will contact identified facility contacts via email to request the IB for review. Johns Hopkins Health Plans Provider Relations representatives will be reaching out to obtain the appropriate contacts for Alaffia outreach shortly, before the audits begin.

These reviews will focus on validating the charges submitted on the claim by reviewing the itemized bills and, at times, requesting medical records to determine accuracy and adherence to coding/payment guidelines. If a discrepancy is found, Alaffia will send a findings letter via email notifying the provider of the error(s) and applicable disallowed/overpaid amount. The provider will have 30 days to request clarification or dispute the findings with Alaffia before the overpayment is confirmed and the retraction process commences.

Please note that post-disbursement audits can result in technical denials. A technical denial is when a provider does not respond to a request for documentation within a requested period. A retraction will be performed on these claims. Providers may follow the Johns Hopkins Health Plans payment dispute process once retractions are processed if they would like to dispute the retractions.

Additional information concerning Alaffia Health can be found on their website.

Recent Code Changes for Johns Hopkins Health Plans

Johns Hopkins Health Plans has approved the following changes to Prior Authorization (PA), No Prior Authorization (NPA) and Non-Covered (NC) requirements for the selected procedure codes listed below for Advantage MD, Employer Health Programs (EHP), Priority Partners and US Family Health Plan (USFHP). These requirements affect members of all ages enrolled in these plans.

- All health plans effective Nov. 1, 2024
- USFHP only effective Nov. 16, 2024
- Priority Partners only eviCore lab code changes effective Oct. 24, 2024

Prior authorization process

- Please use our secure online portal, Availity, to submit electronic prior authorization requests for Priority Partners, EHP and Advantage MD.
- Submit USFHP prior authorization requests to the Johns Hopkins Health Plans Utilization Management (UM) department using these dedicated fax numbers: 410-424-2602 or 410-424-2603. The USFHP prior authorization form with applicable fax numbers can be found on the provider website.
- 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. 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 for outpatient services and procedures. Prior authorization requirements are subject to change.

// PHARMACY

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

2025 Changes to Medicare Part D and Plan Prescription: Impact to Advantage MD Members

Effective **Jan. 1, 2025**, several important changes will take effect for Medicare Part D and Advantage MD prescription drug benefits.

Understanding how these changes affect Advantage MD members to whom you prescribe medication will make it easier to anticipate questions and concerns from your patients.

CMS has made the following key changes to Medicare Part D for 2025:

1. **Coverage Gap Phase Is Eliminated.** In previous years, the Coverage Gap (also called the donut hole) was a coverage stage where members' cost shares for generic and brand name drugs increased to 25%. In 2025, the gap is gone. After reaching their out-of-pocket maximum, Advantage MD members with prescription drug coverage will enter the catastrophic coverage phase and will pay nothing for covered Part D medications for rest of the year.
2. **Out-of-Pocket Maximum Reduced to $2,000.** Medicare Part D enrollees will enjoy a reduction of their annual out-of-pocket cost share maximum for their prescription medications to $2,000.
3. **The Medicare Prescription Payment Plan.** Members will have the option to "smooth" their prescription drug costs over the plan year by paying monthly installments rather than having to pay out-of-pocket costs for medications all at once at the pharmacy. This can help members who may be living on lower, fixed monthly income to avoid higher out-of-pocket expenses the first few months of the year.

Advantage MD has made the following changes to its Part D pharmacy benefits in 2025 that may affect members:

1. **Deductible for Certain Medications.** An annual deductible of **$590** will apply for all **Tier 3 through Tier 5** prescription drugs (except D-SNP and HMO Tribute plans).
2. **New Co-Insurance for Tier 3 and Tier 4 Drugs.** After fulfilling the deductible, the 2025 cost share for Tier 3 and Tier 4 drugs is a **25% co-insurance**, a change from the copay members pay in 2024.

For some Advantage MD members, these changes will result in minimal changes or even lower overall costs. For others, the changes may mean higher annual out-of-pocket costs for their prescription medications and/or higher out-of-pocket outlays during the first few months of the year.

Recommendations

Discussing options with Advantage MD members to whom you prescribe medication and helping them understand their

medication tier can help them to prepare for the new benefit year, maintain medication compliance and avoid unanticipated financial impacts:

- When prescribing a Tier 3 or 4 drug, consider an equivalent generic medication in Tier 1 or 2.
- Advantage MD members to whom you prescribe Tier 3 and 4 drugs will likely have higher out-of-pocket expenses the first few months of 2025. These members will benefit by enrolling in the Medicare Prescription Payment Plan so they can pay monthly installments instead of having to pay all their out-of-pocket costs at the beginning of the plan year. **Important:**
  - » Members must enroll in the Medicare Prescription Payment Plan **before** filling their first prescription in 2025 for their out-of-pocket prescription costs to be eligible.
  - » If a member's prescription needs change **after** Jan. 1, 2025, they can still enroll in the program, but they will need to enroll **before** taking delivery of their first new prescription for the cost-share to be eligible.
  - » Members who are informed **at the time they are prescribed** a new higher-cost medication can request rapid enrollment in the program by calling Advantage MD Member Services at:
    - › PPO: **877-293-5325** (TTY: 711)
    - › HMO: **877-293-4998** (TTY: 711)
- Advantage MD members who are currently taking a Tier 3 or 4 medication have the opportunity to save on their out-of-pocket costs in advance of the 2025 pharmacy benefit changes: Members can order a 90-day supply of Tier 3 or Tier 4 medications at only **two** times the 30-day copay* but they must place their order **before** Dec. 31, 2024.
- Advantage MD members who are currently taking a Tier 1 or 2 medication will continue to be able to order a 100-day supply of Tier 1 medications and up to a 90-day supply of Tier 2 medications at only **two** times the 30-day copay*
- Many of the medicines Advantage MD members may be taking on a regular basis can be delivered safely and confidentially by mail at no additional cost, saving members time and travel concerns. They can request prescriptions by mail through their pharmacy.

*Advantage MD D-SNP (HMO) members can fill all prescriptions for 90-day supplies.

// QUALITY IMPROVEMENT UPDATES

Asthma Medication Ratio (AMR) Controller Medication Education

Overview of the AMR

- The AMR measure tracks the proportion of patients ages 5 to 64 with a ratio of controller medication to total asthma medications of 0.50 or greater.
  - » For example, if a patient filled three controller medications and one rescue inhaler, the AMR ratio would be 3/(3+1) = 0.75, meeting the goal of 0.5 or higher.
- A higher ratio indicates better management of asthma, reducing the likelihood of exacerbations, emergency visits and hospitalizations.

Strategies for Improving AMR

- **Promote the use of inhaled corticosteroids (ICS):** Manage inflammation and prevent asthma symptoms with this medication. According to guidelines, ICS-containing treatment should begin promptly after an asthma diagnosis, as short-acting beta-2 agonists alone are not recommended for ongoing treatment.
- **Educate on controller medication adherence:** Provide regular patient education on the importance of adhering to controller medication. Rescue inhalers should be emphasized as "emergency only" and not a substitute for daily management.
- Develop asthma action plans: Educate patients on asthma triggers and provide instructions on how to treat the condition and manage asthma attacks.
- Monitor prescription patterns: Use electronic health records (EHR) to identify patients who are not using inhaled corticosteroids or are over-reliant on rescue inhalers, and ensure controller medication are prescribed.
- Schedule regular follow-ups: Schedule follow-up visits to assess asthma control and adherence to controller medications.
- Collaborate with care teams: Involve pharmacists, nurses and asthma educators to Support patient adherence to controller medications.

Asthma Controller Medications

Description	Prescription
Antibody inhibitors	Omalizumab
Anti-interleukin-4	Dupilumab
Anti-interleukin-5	Benralizumab, Mepolizumab, Reslizumab
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Methylxanthines	Theophylline

Asthma Reliever Medications

Description	Prescriptions
Beta2 adrenergic agonist—corticosteroid combination	albuterol-budesonide (2025 HEDIS change)
Short-acting, inhaled beta-2 agonists	Albuterol, levalbuterol

References

1. National Committee for Quality Assurance. (n.d.) Asthma Medication Ratio (AMR). Retrieved from https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/
2. National Committee for Quality Assurance. (2024). HEDIS MY 2025. Summary of changes. https://www.ncqa.org/wp-content/uploads/HEDIS-MY-2025-Summary-of-Changes.pdf
3. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2024. Updated May 2024. Available from: www.ginasthma.org

End-of-Year Focus: Key Strategies to Close Gaps in Care

As we approach the end of the year, it is crucial to focus on targeted strategies to close gaps in statin therapy, Asthma Medication Ratio (AMR) and Risk of Continued Opioid Use (COU) measures. By addressing these areas, we can work together to enhance patient outcomes and meet performance goals.

1. Statin Therapy for Patients with Diabetes (SPD) and Statin Therapy for Patients with Cardiovascular Disease (SPC)

- **Ensure refills during follow-ups** by confirming patients have filled their last prescription to promote adherence.
- **Transition to 90-day statin prescriptions** to enhance adherence and minimize medication gaps.
- **Address barriers to adherence** by discussing side effects or financial concerns that may prevent patients from taking their medications consistently and provide solutions in collaboration with health plans.
- **Educate on long-term benefits** to reinforce the importance of adherence to statin use for cardiovascular risk reduction, especially for those who may not perceive an immediate benefit.
- **Submit appropriate exclusion** codes as applicable to remove patient and provider from future notifications regarding initiation of statin therapy.
    - » Relevant medical record (progress note) with measure exclusion information can be faxed to **410-424-2709.**
    - » **Exclusion Code**

Muscular Pain	M79.10 –Myalgia, G72.0 – Drug Induced Myopathy, M62.82 – Rhabdomyolysis, G72.9 – Myopathy
Cirrhosis	K74.3 – Primary biliary cirrhosis, K74.4 – Secondary biliary cirrhosis, K74.69 – Other cirrhosis of liver, K70.30 – Alcoholic cirrhosis of liver without ascites, K70.30 – Alcoholic cirrhosis of liver with ascites
ESRD	End Stage Renal Disease, N18.5 – Chronic Kidney Disease, stage 5

    - » For full listing of exclusion codes, visit https://tinyurl.com/3znpusxm.

2. Asthma Medication Ratio (AMR)

- **Ensure refills during follow-ups** by verifying they have recently filled their controller medication prescription.

- **Opt for 90-day supplies for controller medications, such as inhaled corticosteroids,** to improve adherence and reduce reliance on rescue inhalers.
- **Encourage daily use of controller** to prevent asthma attacks, even when symptoms are not present.
- **Utilize asthma action plans** to help patients understand when and how to use their controller vs. rescue medications.
- **Report correct diagnosis codes for the member's condition,** including any codes that may exclude them from this measure.
- **Submit appropriate exclusion codes as applicable.**
    - » Respiratory diagnoses with different treatment approaches than asthma may include chronic respiratory pulmonary disease (COPD), acute respiratory failure, cystic fibrosis, emphysema, obstructive bronchitis and acute respiratory failure

3. Risk of Continued Opioid Use (COU)

- Follow opioid prescribing guidelines
    - » Use **Johns Hopkins and CDC guidelines** to ensure safe opioid prescribing and reduce long-term use.
    - » CDC Opioid Prescribing
- Leverage Prescribing Drug Monitoring Programs (PDMPs)
    - » Use **PDMPs** to monitor patient opioid prescriptions, track patterns and identify patients at risk for extended opioid use early.
- Ensure follow-up with patient shortly after prescribing opioids
- Intervene early
    - » Proactively review patient records once they reach 30 days of opioid use and provide **non-opioid and non-pharmacological alternatives** to prevent them from reaching the 62-day threshold as appropriate.
- Submit exclusion codes
    - » Ensure accurate submission of exclusion codes for injectables, buprenorphine for opioid use disorders (OUD) and fentanyl patches
- Educate patients on risks
    - » **Proactively educate** patients about the risks of long-term opioid use, offering personalized support and alternative pain management strategies.

New Part D Stars Measures in 2025

Two new Part D measures are joining the 2025 measurement year Stars ratings — Managing the Concurrent Use of Opioids and Benzodiazepines (COB) and Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH).

Managing the Concurrent Use of Opioids and Benzodiazepines (COB)

Overview:

- COB monitors the percentage of patients 18 years and older prescribed opioids and benzodiazepines simultaneously.
- This concurrent use increases risks, including respiratory depression, cognitive and motor function impairment, tolerance and dependency and/or death.
- Lower COB rates suggests better care.

Measure Criteria:

- **Eligible Population:** Patients with at least two prescription claims for opioid prescriptions on different dates, accumulating to 15 or more days of medication use
- **Concurrent Use:** Patients with two or more benzodiazepine prescriptions, with at least 30 days of overlapping opioid and benzodiazepine use
- **Exclusions:** Hospice, cancer and sickle cell patients

Improving COB Performance:

- **Offer non-pharmacological therapies,** such as physical or cognitive-behavioral treatments to patients before initiating the combination.
- **Regularly use Prescription Drug Monitoring Programs (PDMPs)** to monitor controlled substance prescriptions.
- **Educate and engage** patients on the dangers of concurrent use of benzodiazepines and opioids, including respiratory depression, overdose, increased sedation, cognitive impairment and memory issues.
- If co-prescribing opioids and benzodiazepines is necessary, after offering non-pharmacological approaches, follow key principles from CMS for safe management:
    - » **Prescribe the lowest effective dose** for a limited duration.
    - » **Discuss treatment goals** in collaboration with the patient.

- » **Taper long-term prescriptions** gradually and/or discontinue whenever possible.
- » **Conduct continuous monitoring** for adverse events and signs of misuse.
- » **Educate** on overdose risks and provide naloxone.

References

1. Pharmacy Quality Alliance. (2024). Measure Overview. https://www.pqaalliance.org/measures-overview#cob
2. Centers for Disease Control and Prevention. 2022. https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)

Overview

- POLY-ACH tracks the percentage of adults aged 65 and older prescribed at least two anticholinergic medications, such as antihistamines, bladder antispasmodics or tricyclic antidepressants, for 30 days or more. These medications can increase risk of adverse drug events, such as cognitive decline, confusion and falls
- Reducing the use of multiple anticholinergics is crucial for improving safety and quality of life in older adults.

Exclusions:

- Patients in hospice care

Recommendations to Improve POLY-ACH Performance

- **Promote non-pharmacological alternatives** to reduce reliance on anticholinergic medications, such as pelvic floor exercises and bladder training for overactive bladder, cognitive behavioral therapy (CBT) and sleep hygiene for insomnia, and mindfulness practices or CBT for anxiety.
- **Engage patients and their caregivers** in discussions about the risks of anticholinergic medications, and involve them in making informed about their treatment options.
- **Implement de-prescribing interventions** to identify unnecessary or potentially harmful medications and taper or discontinue them safely over time.
- **Encourage regular comprehensive medication reviews** to identify and minimize polypharmacy risks, with an emphasis on managing anticholinergic burden.

References

1. Pharmacy Quality Alliance. (2024). Measure Overview. https://www.pqaalliance.org/measures-overview#cob
2. Pharmacy Quality Alliance. (2023). Quality Essentials Review: Strategies for Reducing Polypharmacy to Improve Medication Safety. https://www.pqaalliance.org/index.php?option=com_dailyplanetblog&view=entry&category=quality%20forum&id=282:quality-essentials-review-strategies-for-reducing-polypharmacy-to-improve-medication-safety

New MDH Behavioral Health Vendor Effective Jan. 1

Carelon Behavioral Health will replace MDH's previous Medicaid behavioral health services vendor, Optum Health Maryland, as of Jan. 1, 2025. Please refer to this document for information about the transition to Carelon.

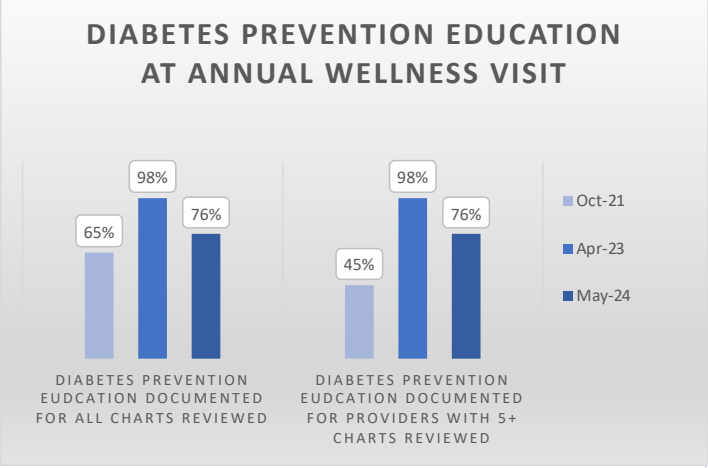
// QUALITY CARE

USFHP Follow-up Results on Goal to Increase Diabetes Prevention Education Documentation for Providers

In 2022 and 2023, US Family Health Plan (USFHP) shared a Provider Toolkit to support providers in improving their rate of documentation of diabetes prevention education, with a goal to increase documentation by 20 percentage points over two years.

We have room for improvement. The rate of documentation improved from 65% to 98% in 2023 and fell to 76% in 2024.

The Quality Improvement (QI) team, on behalf of USFHP, performs retrospective chart reviews of various outpatient standard of care measures annually to assure that beneficiaries are receiving evidence-based care. Interventions using provider input are established to improve care.



Results from the May 2024 chart review find 76% of beneficiaries with a BMI in the overweight or obese range receive patient education during their annual wellness visit. This is an 11 percentage point improvement over the October 2021 chart review.

Members are more likely to continue behaviors that increase the risk of developing diabetes without targeted patient education about lifestyle modifications that can help prevent diabetes.

Providing diabetes prevention education to all patients who are overweight or obese will meet or exceed value-based practice measures. Please continue to provide diabetes education to our members.

The next chart review to look at documentation of diabetes prevention education will be in spring 2024.

No Bones About It — Osteoporosis Affects Quality of Life for Women

Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. A bone disease characterized by low bone mass, osteoporosis leads to bone fragility and increased susceptibility to fractures of the hip, spine and wrist.

Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.

For women ages 67 to 85, it is highly recommended that they receive a Bone Mineral Density (BMD) test or a prescription for a medication to treat osteoporosis within six months a fracture.

Additionally, the U.S. Preventive Services Task Force (USPTF) recommends BMD screening for all women age 65 or older as well as those under age 65 who are at increased risk of osteoporosis. There are many options for how these tests can be completed, and in many cases, patients can complete these tests in mere minutes and at no cost.

Good bone health is vital to overall well-being and independence. Many thanks to our Johns Hopkins Health Plans providers for helping to ensure that your patients stay healthy, happy and in motion.

For more information, please visit OMW - Osteoporosis Management in Women Who Had a Fracture | Johns Hopkins Medicine.

Source: Osteoporosis Management In Women Who Had a Fracture - NCQA

// BENEFITS AND PLAN CHANGES

USFHP Expands Hearing Aid and Hearing Services Benefit

TRICARE® recently updated its policy to expand hearing aid and hearing aid services eligibility*.Hearing aids and hearing aid services and supplies are covered for eligible Active Duty Family Members. Backdated effective Dec. 22, 2023, hearing aids, services and supplies have been extended to child dependents of eligible retirees. Prior authorization is required to confirm eligibility and clinical criteria.

For US Family Health Plan (USFHP) members that do not qualify for coverage under the TRICARE policy, USFHP offers a value-add benefit with Access HEARS*.

Access HEARS

Access HEARS offers **50% off over-the-counter hearing aids and personal amplifiers** to eligible USFHP members. To qualify for this discount, members must meet the following criteria:

- Be a USFHP retiree member or eligible retiree family member
- Have mild to moderate age-related hearing loss

If you treat a patient who meets the above criteria, please let them know about this discount. Eligible individuals can submit an inquiry online**.

Eligible participants will have an initial phone interview to discuss hearing loss, available options and how Access HEARS can help them navigate the process of hearing care. Following a virtual or face-to-face session, participants will enjoy a free, two-week trial period with no obligation to buy and receive ongoing support throughout the first 12 months.

**Access HEARS Inc. is a 501(c)3 nonprofit organization whose mission is to connect individuals with hearing loss to the solutions they need to age well. Founded by physicians and leading hearing experts and entrepreneurs at the Johns Hopkins University, Access HEARS delivers services directly to the community, offering its clients a low-cost, in-person or virtual service delivery, teaching individuals how to use over-the-counter hearing aids and other high-quality listening devices.*

***If you are unable to access the online form, copy and paste this link, bit.ly/JH_USFHP_HearingDevices, into the address bar using Google Chrome as the browser.*

Resources When Responding to Mental Health Crises in the Military Community

The fall months mark the time to raise greater awareness of suicide prevention resources for soldiers, civilians and family members who may need crisis support or want to help someone they know. The theme for suicide prevention efforts in 2024 is "We Are Stronger Together."

We ask that our US Family Health Plan (USFHP) providers consider taking the free, one-hour online training course "Face the Fight: Basics of Veteran Suicide Prevention."

Please share the resources below with your staff and USFHP members to build knowledge and resources for suicide prevention and support during a mental health crisis:

- Defense Suicide Prevention Office (dspo.mil)
- Defense Suicide Prevention Office | Resources & Tools (dspo.mil)
- Suicide Prevention Month: Defense Suicide Prevention Office | SP Month & Recognition (dspo.mil)
- Suicide Prevention Reports: Defense Suicide Prevention Office | Reports (dspo.mil)
- Suicide Prevention Response Independent Review Committee Report Defense Suicide Prevention Office | Suicide Prevention and Response Independent Review Committee (dspo.mil)

Advantage MD Discontinuing Premier (PPO) Plan for 2025

Effective plan year 2025, Advantage MD will no longer offer its Premier (PPO) plan. Coverage for these members will end after Dec. 31, 2024. These members received a notification/letter from Advantage MD on Oct. 2, 2024, advising members of this change and offering options for selecting a new health plan.

Any health care services these members have with you or another provider will be covered through Dec. 31, 2024. As of Jan. 1, 2025, no services, prescriptions or supplies will be covered under the terminated Premier (PPO) plan.

Unless the patient selects new coverage, they will be automatically moved to Original Medicare on Jan. 1, 2025, and their prescription benefit will end.

- **For members with NO Part D Low-Income Subsidy:** If members decide to move to Original Medicare, they will need to select a prescription drug plan by Dec. 31 of this year to maintain prescription drug coverage. That means if they move to Original Medicare and do not choose a prescription drug plan by Dec. 31, they will not have prescription drug coverage in 2025.
- **For members with a Low-Income Subsidy:** Members with a Part D Low-Income Subsidy will be assigned a prescription drug coverage along with being moved to Original Medicare.

Advantage MD has three other PPO plans that these members can choose:

- Advantage MD (PPO)
- Advantage MD Plus (PPO)
- Advantage MD Primary (PPO)

If an Advantage MD member asks you about this change, please advise them to call the Customer Service number on the back of their member ID card.

If a member selects a new Medicare plan, their provider and/or pharmacy network may change. Their new plan may or may not be contracted with you.

Thank you for your understanding as we transition members through this change.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Program Spotlight: STI/HIV Risk Assessment and Lab Testing

The Maryland Healthy Kids/EPSDT Program promotes access to and ensures availability of quality health care for Medical Assistance children, teens and young adults less than 21 years of age.

The program provides appropriate practice-based performance improvement assessments and targeted interventions to enhance the quality of health services delivered by Medicaid providers (such as Priority Partners) to eligible recipients less than 21 years of age.

One of the measures featured in the EPSDT program is the **STI/HIV Risk Assessment and Lab Testing.** The Maryland Department of Health (MDH) requires completion and documentation of all components listed to be listed as "the measure met."

Laboratory Tests/At-Risk Screenings requires evaluation and includes documentation of:

- Sexually transmitted infection/human immunodeficiency virus (STI/HIV) risk assessment beginning at 11 years of age, or younger if indicated, and annually thereafter with appropriate follow-up for positive or at-risk results
- Human immunodeficiency virus (HIV) lab test required between the ages of 15 and 18
- Patients must sign an informed consent form for HIV testing. (Under the age of 18, consent must be provided by the patient's state of Maryland acceptable health care advocate/parent/legal guardian. Unless the patient meets state-defined criteria to sign consent for themselves.)
- Exception [OPT-OUT] must be documented in the patient's chart — as evidence of having refused testing — following provider explanation/information.

The **Maryland Healthy Kids Program Clinical and Administrative Manual** further describes the requirements for Medicaid providers, such as those in the Priority Partners network:

- The Maryland Healthy Kids Program currently requires PCPs to conduct risk assessments for Sexually Transmitted Infections/Human Immunodeficiency Virus (STI/HIV) at each Healthy Kids visit beginning at 11 years of age, or earlier if indicated by the child's history.
  - » The questions for the STI/HIV risk assessment are on the Preventive Screen Questionnaire (Refer to Section 7, Appendix II for the English and Spanish versions).
  - » Document results of the assessment on the questionnaire form or on the visit sheet. Be sure to date and sign off on the questionnaire after review.
  - » A "yes" response to any of the questions indicates a positive risk and the need for further assessment and appropriate testing with results documented in the medical record.
  - » The CDC recommendation is to screen, through opt-out testing, all patients ages 13 to 64 years in all health care settings.
  - » Diagnosis of an STI often requires multiple specific diagnostic tests, and all sexually active adolescents should be counseled and tested for sexually transmitted infections and educated about safe sex and contraception.
  - » Effective contraceptive management is important for the sexually active adolescent, but if the PCP does not perform these services, an appropriate specialty referral is indicated to a gynecologist for female adolescents or adolescent medicine specialist for males and/or females. For more information about contraceptives, refer to the Contraceptive Options subsection of Section 4 of this Manual.
  - » The US Preventive Task Force recommends that Pap smears be deferred until the female adolescent turns 21 years of age. This recommendation is based in part on the very low incidence of invasive cancer and the potential for adverse effects of the follow-up of abnormal cytology screening results. Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting."

Consultant	County Jurisdiction Covered	Phone Number	E-Mail Address
Mary Jo Harris, MSN, RN Division Chief	*Baltimore City, Baltimore County, Carroll,* *Eastern Shore Counties:* Caroline, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester *Delaware*	410-767-4804	maryjo.harris1@maryland.gov
Kimberly "Kim" Boyer, BSN, RN Nurse Consultant	Allegany, Frederick, Garrett, Howard Washington Upper Montgomery Co: Germantown; Gaithersburg & Rockville West Virginia	410-767-1620	Kimberly.boyer1@maryland.gov
Paula Rice, MSN, RN Nurse Consultant	*Anne Arundel; Cecil, Harford* *Southern MD*: Calvert, Charles, St. Mary's Counties Montgomery Co Lower. Prince George's Counties. Washington, DC	410-767-1486	paula.rice@maryland.gov

If a patient/Priority Partners member tests positive for HIV, please reach out to the Priority Partners Rare and Expensive Case Management (REM) program via email at REM_referral@jhhp.org or contact Stephanie Gisriel at 410-582-2415, sgisriel@jhhp.org.

- The REM intake unit at MDH may be reached at 800-565-8190.
- Please note, for HIV diagnosis (ICD 10: B20), the REM eligibility age is 0 to 20 years old.
- Priority Partners providers can also contact MDH's Health Kids Consultants for information and support.

Priority Partners providers can also contact MDH's Health Kids Consultants for information and support.

Priority Partners Providers:

Please share any barriers to compliance with the completion of the MDH EPSDT measure (see below). You may also share contact information for your designated EPSDT support person at:

- Priority Partners — Quality Improvement & Patient Safety
  QIAdverseEvents@jhhp.org
  Fax: 410-424-4035

Resources and References:

1. Medicaid Managed Care Organization Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review Statewide Executive Summary Report Measurement Year 2022. Submitted April 2024. Accessed 10/02/2024 from: https://health.maryland.gov/mmcp/healthchoice/Documents/MY%202022%20EPSDT%20Statewide%20Executive%20Summary%20Report.pdf
2. Maryland Healthy Kids Medical Program Clinical & Administrative Manual. March 2017/12th Edition Updated 2022. Accessed 10/02/2024 from: https://health.maryland.gov/mmcp/epsdt/Documents/FINAL%202022%20Healthy%20Kids%20Provider%20Manual_8.26.2022.pdf
3. Healthy Kids Program Consultants. Accessed 10/02/2024 from: https://health.maryland.gov/mmcp/epsdt/pages/Home.aspx

// REMINDERS

Reminder: 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.

Tips and Information: Navigating MDH's ePREP Portal for Priority Partners

The Maryland Department of Health (MDH) requires all providers delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP).

NOTE: Active enrollment applies to providers (individuals and provider groups).

Both the **rendering provider NPI** and their **billing group NPI** submitted on the claim must be enrolled in ePREP.

Resources/links to register:

- ePREP Login Page
- ePREP Instructions and Training

Please contact the Johns Hopkins Health Plans Provider Relations department at 888-895-4998 or email ePREP@jhhp.org with any questions or concerns.

REMEMBER: Priority Partners provider **claims will be denied** if they are not enrolled in ePREP.

As communicated back in 2020, Priority Partners will not reimburse claims payments to individual providers, provider groups and facilities that are not registered or "Active" in ePREP at the time of billing/claim submission. **This includes the billing AND the rendering provider NPIs.**

- ePREP status is validated on a weekly basis through a file received directly from MDH; if you and your group are registered and listed as ACTIVE for the date of service on your claim, it will be processed as usual.
- If either billing or rendering NPI is not found on the most recent file, or does not have an active status, the claim will deny with a specific denial reason and the Explanation of Payment (EOP) will reflect the reason for claim denial specific to ePREP.

Steps to resolve – If you believe you have received a denial in error please review the following:

1. Use the Maryland Medicaid provider verification service to confirm NPIs submitted on the claim for both **billing group** and **rendering provider** are active in ePREP for the date of service of the denials you are disputing at the time of resubmission.
2. If either NPI is not in ePREP at all: Register for ePREP immediately so future claims won't be denied, as initial ePREP registration can NOT be backdated to cover services provided prior to registration.
3. If your site/individual provider has another NPI (active in ePREP) please resubmit your claim with the correct NPI for adjudication within timely filing deadlines (180 days from date of service).

4. If your site/individual NPI is suspended or showing inactive **in error** in ePREP:
    - Contact ePREP directly to update account.
    - Once account is showing active; resubmit claims for adjudication within timely filing deadlines (180 days from date of service).

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 whether 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.

Reminder: Behavioral Health Services Requirements and Audit Process

Beginning in 2024, US Family Health Plan (USFHP) implemented requirements for behavioral health assessments as well as a process for auditing network behavioral health/mental health providers' documentation of standardized measures in compliance with TOM Chapter 7, Section 6, Para 8. (CDRL A090).

Your participation in this audit process is required per your provider contract with USFHP; see section M. 2 and 7 of the core contract and pages 35, 69 & 70 of the USFHP provider manual for details.

When contacted by the USFHP Quality Improvement department, please send requested medical records timely and securely in order for the audit to be completed per Department of Defense requirements.

For more information about the Behavioral Health requirements and resources for USFHP providers, please visit our dedicated webpage on the Johns Hopkins Health Plans provider website.

Fall Reminders From USFHP

- **Manual edition.** US Family Health Plan (USFHP) follows the guidelines of the 2021 Edition (T-5) TRICARE manuals. Please use this updated version as your source of reference.
- **Claims submission with other health insurance (OHI).** When submitting claims for USFHP members with OHI, please follow these procedures:
    - » USFHP members **under the age of 65** and/or without Medicare should be billed with OHI as primary insurance and USFHP as secondary.
    - » USFHP members **over the age of 65** should bill USFHP first as the primary insurance and any OHI as secondary.
    - » Encourage timely filing to avoid claim denials.
- **Help for veterans.** Consider taking the free, one-hour online training program "Face the Fight: Basics of Veteran Suicide Prevention."

Coding and Whole Health Assessment Form Update

Currently, providers transmit a Whole Health Assessment (WHA) form and include the code G9008 when submitting claims to Johns Hopkins Health Plans. **Effective Jan. 1, 2025, the process will change.**

- Starting Jan. 1, 2025, the reimbursement code G9008 and the current WHA form will be phased out.
- Providers should use the current WHA form and reimbursement code G9008 for **2024 dates of service only** until the program cut-off date in mid to late January 2025.
- Providers should not use the current WHA form and reimbursement code G9008 for claims with dates of service occurring in 2025.
- A new WHA form will be put into place in March 2025 that focuses on the chronic condition history specific to each member.
- In March 2025, the Advantage MD team will contact providers regarding the new WHA forms, explaining how the new forms and program work.

Although these changes will reduce the number of targeted Advantage MD members, most providers will still receive WHA forms to review and then transmit to Johns Hopkins Health Plans. Instead of one blank, generic form per member, Advantage MD providers will use the new WHA form, which is prefilled for each targeted member and includes the specific conditions we are asking to be evaluated.

Please email **WHA@jhhp.org** with any questions about this change and the WHA forms.

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

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.

PRPULSE18-FALL 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