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Johns Hopkins Health Plans Provider Newsletter

SUMMER 2024

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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

"Summertime is always the best of what might be."

—*Charles Bowden*

As the long, hot summer of 2024 draws to a close, Johns Hopkins Health Plans reflects on warmer months as a time balanced between the leisure of vacation and the often hectic tempo of our workdays, filled with opportunities and collaboration.

We kept up the pace of growth and rejuvenation throughout spring and summer and look forward to putting in place upgraded and efficient processes and programs that will result in higher levels of service, quality and accuracy.

Our partnerships with providers play a central role in Johns Hopkins Health Plans' commitment to high-quality medical services that are easily accessible to our members and that, in turn, improve overall health and well-being. We thank you for all you do every day on behalf of our members.

—*Jayne Blanchard, Editor*

// POLICIES AND PROCEDURES

Recent Changes and Additions to Reimbursement Policies

Johns Hopkins Health Plans has new and revised reimbursement policies, as follows:

Effective Aug. 1, 2024, for Employer Health Programs (EHP) and US Family Health Plan (USFHP):

- (RPC.029) EHP and USFHP Obstetrical Services, Professional — New
  - » Policy applies only to EHP and USFHP claims for professional, obstetrical services, rendered to our members for maternity care and delivery services, reported to Johns Hopkins Health Plans.

Effective Aug. 15, 2024, for Advantage MD, EHP, Priority Partners and USFHP:

- (RPC.020) Reduced Procedures (Modifier 52) — Updated
  - » If the portion of the procedure that was completed can be represented by another procedure code, Johns Hopkins Health Plans requires the provider to bill for the applicable procedure code instead of billing modifier 52.
- (RPC.035) Inpatient Reimbursement Guidelines, Facility — Updated
  - » New ICD-10-CM Diagnosis Coding Section Added

Effective Sept. 15, 2024, for Advantage MD, EHP, Priority Partners and USFHP:

- (RPC.037) Priority Partners Ambulance and Medical Transportation Services — New
  - » Policy applies only to Priority Partners for ambulance and/or medical transportation claims billed on a CMS-1500, UB-04/CMS-1450, or their electronic equivalent.
- **(RPC.038) Diagnosis Coding Guidelines — New**
  - » Johns Hopkins Health Plans follows the Centers for Medicare & Medicaid Services (CMS), the National Center for Health Statistics (NCHS) and the Department of Health and Human Services (DHHS) direction on the coding and sequencing of diagnosis codes guidelines based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for Coding and Reporting. When ICD-10 codes are reported incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form, Johns Hopkins Health Plans will deny the associated claim line.
- **(RPC.027) Injections and Infusions Policy — Updated**
  - » When injection and infusion services are rendered in an ambulatory infusion center/suite (AIC/AIS), providers are to bill as follows:
    - › Report services in POS 11.
    - › Append modifier SS on the claim line.
    - › Report rending and referring provider.

Effective Oct. 1, 2024, for Priority Partners:

- **(RPC.039) Priority Partners Psychological Testing and Evaluation Services — New**
  - » Policy applies only to Priority Partners claims for psychological testing and evaluation services rendered to Priority Partners members for covered services, billed on a CMS-1500, UB-04/CMS-1450 or their electronic equivalent.

Effective Oct. 18, 2024 for Advantage MD, EHP, Priority Partners and USFHP

- **(RPC.037) Inpatient Reimbursement Guidelines — Updated**
  - » Johns Hopkins Health Plans follows the Centers for Medicare & Medicaid Services (CMS), the National Center for Health Statistics (NCHS) and the Department of Health and Human Services (DHHS) direction on the coding and sequencing of diagnosis codes guidelines based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for Coding and Reporting.
  - » Consistent with ICD-10-CM and the Uniform Hospital Discharge Data Set (UHDDS) Guidance, the circumstances of inpatient admission always govern the selection of principal diagnosis.

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

Changes to Emergency Department Review Policy

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 payment does not require medical review. Several ICD-10 codes were removed.

Please view the current version here: Sudden and Serious Diagnosis Codes List. The current list contains a list of the codes that will be deleted.

Effective Oct. 1, 2024, for Employer Health Programs (EHP), Priority Partners and US Family Health Plan (USFHP), the following codes will be removed from the Sudden and Serious Diagnosis Code List:

- J45.909 – Unspecified Asthma
- E86.0 – Dehydration
- E87.6 – Hypokalemia

Effective Aug. 1, 2024, for EHP and Priority Partners, and Oct. 1, 2024, for USFHP, the following codes will be removed from the Sudden and Serious Diagnosis Code List:

- Z20.822 – Contact with and Suspected Exposure to COVID-19
- U07.1 – COVID-19
- I10 – Essential Primary Hypertension

Policy APL009 describing the Emergency Department Review Process has been updated and includes language that the Sudden and Serious Diagnosis Code List may be updated monthly. Please reference the posted list directly for updates.

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

Recent Prior Authorization Changes Effective Aug. 17, 2024

Johns Hopkins Health Plans approved the following changes to prior authorization status for selected US Family Health Plan services. These changes went into effect Aug. 17, 2024.

Codes Requiring Prior Authorization Effective Aug. 17, 2024:

- **G0160** — Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.
- **G0161** — Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.
- **G0162** — Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home health or hospice setting).

// CLAIMS AND BILLING

Prior Authorization and Coverage Changes for Health Plans

Please note the following No Prior Authorization (NPA) and Prior Authorization (PA) and Not Covered (NC) required changes for the following Johns Hopkins Health Plans codes.

NPA to PA code changes for Advantage MD effective Sept. 15, 2024:

- **93241** — External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
- **93242** — External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
- **93243** — External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report
- **93244** — External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation
- **93245** — External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
- **93246** — External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
- **93247** — External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report
- **93248** — External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation

Employer Health Programs (EHP) codes changing from NPA to PA on Sept. 15, 2024:

- **19499** — Unlisted procedure, breast
- **29999** — Unlisted procedure, arthroscopy
- **41899** — Unlisted procedure, dentoalveolar structures
- **49329** — Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
- **58579** — Unlisted hysteroscopy procedure, uterus
- **64999** — Unlisted procedure, nervous system
- **81479** — Unlisted molecular pathology procedure
- **99199** — Unlisted special service, procedure or report
- **A4641** — Radiopharmaceutical, diagnostic, not otherwise classified
- **C2698** — Brachytherapy source, stranded, not otherwise specified, per source
- **C2699** — Brachytherapy source, nonstranded, not otherwise specified, per source
- **G0235** — PET imaging, any site, not otherwise specified
- **Q4100** — Skin substitute, not otherwise specified
- **S9379** — Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

EHP Codes changing from PA to NPA on Sept. 15, 2024:

- **59899** — Unlisted procedure, maternity care and delivery
- **84999** — Unlisted chemistry procedure
- **88749** — Unlisted in vivo (e.g., transcutaneous) laboratory service
- **96999** — Unlisted special dermatological service or procedure
- **E1229** — Wheelchair, pediatric size, not otherwise specified
- **K0108** — Wheelchair component or accessory, not otherwise specified
- **K0812** — Power operated vehicle, not otherwise classified
- **P9099** — Blood component or product not otherwise classified

NPA to PA code change for US Family Health Plan (USFHP) effective Sept. 6, 2024:

- **64615:** Change to PA required.
  - Per TRICARE® Policy Manual (TPM) Chapter 7* exclusion: Botulinum toxin A used for the treatment of myofascial pain dysfunction syndrome, also known as temporomandibular joint (TMJ) syndrome is unproven.

Not Covered (NC) code change for USFHP effective Oct. 1, 2024:

- **0232T:** Change to NC.
  - » TPM Chapter 4* exclusion: Platelet-Rich Plasma (PRP) is unproven for all indications.

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Proper Billing for USFHP Providers

For members with coverage under both Medicare and US Family Health Plan (USFHP), Medicare cannot be billed for services covered by USFHP. Providers filing Medicare claims, or who have claims filed on their behalf, are in violation of the conditions of participation with USFHP and are subject to disenrollment.

Members having coverage under both Medicare and USFHP may only use Medicare benefits for non-covered USFHP services. End-stage renal disease (ESRD) is a covered service, but is considered secondary after Medicare. Providers billing Medicare for services covered by USFHP are subject to termination from the USFHP network. Federal regulations prohibit the federal government from paying twice for services.

New Claims Mailing Address for USFHP

The mailing address for US Family Health Plan (USFHP) paper claims has changed as of Aug. 1, 2024. Please note the address change and send any **paper claims** to the new address indicated below. It is expected that mail will be forwarded to the new Kansas City, MO, address for a period of time.

There is **no change** to the payer ID number and process for electronic submission of USFHP claims as of Aug. 1.

Old P.O. Box:	New P.O. Box as of Aug. 1, 2024:
P.O. Box 830479 Birmingham, AL 35242	P.O. Box 219960 Kansas City, MO 64121-9960

// 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 web 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

How to Submit NovoLogix® Prior Authorization Requests Through Availity

Since March of this year, Johns Hopkins Health Plans has been using the Availity platform as the secure provider portal to submit electronic prior authorization requests through NovoLogix for certain provider-administered medications under Priority Partners, Employer Health Programs (EHP) and Advantage MD.

For direction about how to access NovoLogix through Availity, please refer to the Accessing NovoLogix & EviCore in Availity Job Aid.

The prior authorization requirements for the identified medications affect members of all ages.

- Priority Partners Prior Authorization Medical Injectable Drug List
- EHP Prior Authorization Medical Injectable Drug List
- Advantage MD Prior Authorization Medical Injectable Drug List

These comprehensive lists of provider-administered medications that require prior authorization are also available on the Johns Hopkins Health Plans website for your reference.

// QUALITY CARE

Improving Health Equity Through Accreditation: Johns Hopkins Health Plans Leads the Way

Johns Hopkins Health Plans is taking an important step toward advancing health equity by applying for health equity accreditation (HEA) from the National Committee for Quality Assurance (NCQA). This prestigious accreditation recognizes health care organizations that meet rigorous standards for delivering culturally and linguistically appropriate services, reducing health care disparities and promoting health equity.

As a leading regional health plan serving Maryland, Johns Hopkins Health Plans' pursuit of this accreditation signals a deep commitment to ensuring all of its members, regardless of their race, ethnicity, language, disability status or other factors, receive high-quality, equitable care.

"At Johns Hopkins Health Plans, we believe that everyone deserves access to affordable, high-quality health care that meets their unique needs," said Dr. Aisha Rahim, Health Equity Co-lead at Johns Hopkins Health Plans.

"Earning NCQA's Health equity Accreditation will validate our efforts to address systemic barriers, promote inclusive practices and empower our members to live their healthiest lives," added Dr. Tina Singh, Health Equity Co-lead at Johns Hopkins Health Plans.

How providers can benefit from Johns Hopkins Health Plans' Health Equity Accreditation:

Johns Hopkins Health Plans' focus on health equity accreditation presents valuable opportunities for the health care providers in its network. Here are a few key ways providers can benefit:

- **Strengthened Partnerships** — As Johns Hopkins Health Plans works to meet NCQA's HEA rigorous standards, it will lean on its provider network to help deliver culturally competent care, gather valuable patient demographic data and identify opportunities to address disparities. This collaborative approach can foster stronger, more rewarding partnerships between Johns Hopkins Health Plans and its providers.
- **Access to Resources and Training** — To achieve and maintain HEA accreditation, Johns Hopkins Health Plans will invest in developing robust cultural competency training programs, language access services and other resources to support its providers in delivering equitable care. Providers can leverage these tools to enhance their own health equity efforts.
- **Enhanced Patient Experiences** — Johns Hopkins Health Plans' HEA accreditation signals to members that the health plan is committed to meeting their diverse needs. This can lead to improved patient satisfaction, trust and engagement — all of which benefit providers through better health outcomes and fewer administrative hassles.
- **Competitive Advantage** — As health equity becomes an increasingly important priority for consumers, employers and regulators, Johns Hopkins Health Plans' HEA accreditation can give its provider network a competitive edge in the market.

By aligning with Johns Hopkins Health Plans' health equity initiatives, providers can differentiate their practices, access valuable resources and ultimately improve the health of the diverse populations they serve. Together, Johns Hopkins Health Plans and its provider network can forge a path toward a more equitable, inclusive health care system.

Statin Measure Exclusion Guidelines Pertaining to Cardiovascular Health

Cardiovascular disease is the leading cause of death in the U.S. People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing atherosclerotic cardiovascular disease (ASCVD).

American College of Cardiology and American Heart Association (ACC/AHA) guidelines state that statins of moderate or high intensity are recommended for adults with established

clinical ASCVD. The American Diabetes Association and ACC/AHA guidelines also recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction in both populations.

The NCQA HEDIS measure, Statin Therapy for Patients with Cardiovascular Disease (SPC), assesses males 21 to 75 years of age and females 40 to 75 years of age who have clinical ASCVD and who received and adhered to statin therapy.

Statin Therapy for Patients with Diabetes (SPD) assesses adults 40 to 75 years of age who have diabetes, and who do not have clinical ASCVD, who received and adhered to statin therapy.

Similarly, the Medicare Stars measure "Statin Use in Persons with Diabetes (SUPD)" measures the percent of Medicare Part D beneficiaries 40 to 75 years old who were dispensed at least two diabetes medication fills on unique dates of service and received a statin medication fill during the measurement period.

Clinically, we know that statins are not appropriate for all patients for a variety of reasons. Each measure has a number of exclusions that, when the exclusion diagnosis code is submitted on the medical claim, will remove the member from the measure. See below for a full listing of measure exclusions.

MEASURE EXCLUSIONS		
SPC	**SPD**	**SUPD**
• Pregnancy • IVF • Estrogen agonist prescription • ESRD diagnosis or dialysis • Cirrhosis • Myalgia, myositis, myopathy or rhabdomyolysis • Hospice enrollment • Palliative care	• Members with MI, CABG, PCI, other revascularization or IVD • Pregnancy • IVF • Estrogen agonist prescription • ESRD diagnosis or dialysis • Cirrhosis • Myalgia, myositis, myopathy or rhabdomyolysis • Hospice enrollment • Palliative care	• Hospice enrollment • ESRD diagnosis or dialysis coverage dates • Rhabdomyolysis and myopathy • Pregnancy • Lactation and fertility • Cirrhosis • Prediabetes • Polycystic ovary syndrome

// BENEFITS AND PLAN CHANGES

Priority Partners Pediatric Provider EPSDT Update

The quality of medical care provided to pediatric and adolescent Medicaid recipients by both providers and managed care organizations (MCOs) is measured by the Maryland Department of Health (MDOH) and reported publicly. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) review assesses the degree to which children enrolled in MCOs are receiving EPSDT services in compliance with the Maryland Healthy Kids Program guidelines.

The external quality review organization (EQRO) for the Maryland Division of HealthChoice Quality Assurance (DHQA) is Qlarant. Qlarant annually evaluates the quality assurance program and activities of each MCO contracting with the State of Maryland to provide care to Maryland Medical Assistance enrollees in the HealthChoice Program. The minimum compliance requirement for the measurement year 2024 EPSDT Medical Review is 80% per component. Qlarant nurses complete medical record reviews and report findings annually (Qlarant, MDOH, 2024).

A detailed narrative report is submitted by Qlarant to DHQA and Priority Partners at the end of the EPSDT review period. This report includes the final scoring results of the EPSDT review

and identifies any areas of concern. The 2022 results of a Priority Partners EPSDT report demonstrated the need for improvement in Priority Partners member's completion and provider documentation of the following measures:

- **Anemia: Patients 1 to 4 years of age**
- **Dyslipidemia: Patients 15 to 20 years of age**
- **Lead Screening: Patients 1 to 4 years of age**
- **HIV: Patients 15 to 18 years of age**

MDOH's Healthy Kids Program Nurse Consultant Services offers participating providers assistance with the following:

- Maintenance of applicable clinical and program manuals/ materials, interpretation of Medicaid health policies and federal/state regulations, orientation and staff training in program standards and procedures
- Assistance with Medicaid billing and MCO encounter data reporting
- Education of providers about MCO and local health department, referral process for outreach and health-related and other applicable topics.
- Contact information by county/jurisdiction can be accessed online.

The 2024 Priority Partners Provider Manual offers reinforcement of the "service delivery" requirements established by Medicaid and the state of Maryland (**health.maryland.gov**, 2016).

In effort to support the MDOH goal for the calendar year 2024 EPSDT medical record review, we request your assistance to get an efficient response when medical records are requested for this purpose. Your staff awareness and commitment to accuracy will support our mutual efforts to improve the health of children and adolescents and, in turn, be reflected in the MDOH published rating of that care. Your compliance with use of standardized screening forms and coding are paramount to your care being reported accurately.

Priority Partners offers providers support in the event a member misses appointments. After attempting to schedule a second appointment within 30 days of the first missed appointment, within 10 days of the child missing the second consecutive appointment. Please call **Priority Partners Member Services at 800-654-9728,** and we will assist in locating and contacting the child's parent, guardian or caretaker.

Priority Partners can assist with member access to nonemergency medical transportation, the 2024 Provider Manual provides a list of the transportation contact numbers for each county. For additional assistance, please call **Priority Partners member services at 800-654-9728.**

Priority Partners offers multidisciplinary care coordination for children and adolescents. Care Management Services are available, including patient engagement and community health worker services.

The 2024 member benefits for EPSDT services for all members under 21 years of age include all well-child services provided in accordance with the EPSDT periodicity schedule by an EPSDT-certified provider. **A PDF copy of the 2024 Maryland Healthy Kids Preventive Health Schedule is available online through the MDOH website.**

Please reach out to your Priority Partners Provider Relations Representative with any questions.

Together we can positively impact the health of children and adolescents in the state of Maryland.

Resources:

Maryland Department of Health (MDOH), 2024. Medicaid Managed Care Organization, EPSDT Medical Record Review, Orientation Manual, Measurement Year 2024. Submitted March 2024. Qlarant.

New Priority Partners Doula Program Strives to Reduce Maternal Mortality Rates for Black Women

Priority Partners announces a new program in collaboration with the digital health solution provider known as Mae Health that focuses on reducing health disparities for Black expectant mothers. Doula services from a state of Maryland-certified doula are a covered benefit available to all Priority Partners members during pregnancy and for one year postpartum.

Mae specializes in culturally competent maternal health care for Black women in Maryland. The Mae program aligns with initiatives to reduce the disparities reported in Black women, while improving health, mental health and birth outcomes. Mae offers participating members a community-led model of doula support along with an online engagement platform that tracks their physical, social and emotional needs during pregnancy and postpartum to inform the guidance and in-person support they receive.

The Pregnancy Experience for Black Women

- Black women are three times more likely to experience a pregnancy-related death than white women.
- Black women are twice as likely to experience a pregnancy-related complication.
- Black women are 49% more likely to give birth prematurely, which impacts the health of their children.

However, an estimated 60% of Black maternal deaths are avoidable.

Interventions and programs, such as the use of doulas, can reduce C-section rates and other complications and drive down rates of preterm birth. Mae was founded on a belief that all women deserve an equal possibility of a safe pregnancy and giving their babies a healthy start.

Launched in 2021 by Chief Executive Officer Maya Hardigan, Mae's model empowers Black expectant mothers through whole-person care, using inclusive tools throughout their pregnancy and postpartum journeys to reduce longstanding inequities in Black maternal health care.

"Existing disparities impact not only the birthing person, but their children, families and broader communities," said Hardigan. The goal of Mae is to "reduce unnecessary maternal morbidity and death across the state, while fundamentally redefining the experience of those we serve."

Doula services, like those included in Mae's provider solution and offered through Priority Partners, are a proven community-based, low-cost approach to improving maternal health. By providing access to doulas and resources to support well-being in pregnancy, Mae will help alleviate systemic inequities in maternal care.

For more information about how Priority Partners is working with Mae, please contact your network manager in Provider Relations.

Maternal Health Resources and Reminders for Priority Partners

Maternal health is the health of women during pregnancy, childbirth and postpartum period. In most cases, maternal health encompasses multiple aspects of health care, including mental health, to ensure a positive, fulfilling experience.

Priority Partners prioritizes maternal health in its benefits, programs and resources. Please take a moment to familiarize yourself with what we offer our members, as well as recent revisions to our obstetrical (OB) services reimbursement policy.

The Importance of Postpartum Depression Screenings

The postpartum period begins soon after the delivery of the baby and usually lasts six to 12 weeks, typically ending when the mother's body has nearly returned to its pre-pregnant state. The postpartum period for a woman and her newborn is very important for both short- and long-term health and well-being — and that includes paying attention to mental health.

- Postpartum depression screening is an essential part of postpartum care.
- Early identification of postpartum depression can prevent long-lasting depression in new mothers as well as improve early childhood development for newborns and young children.
- It is vital to make sure that each member receives appropriate postpartum care, inclusive of a postpartum depression screening, and is connected to care.
- The American College of Obstetrics recommends screening for depression and anxiety during pregnancy and postpartum.
- Electronic postpartum depression screening tools embedded in the electronic health record result in a significant improvement in postpartum depression screenings.
- **NOTE:** Postpartum Depression screening codes are **96127, 96161.**
- Please refer Priority Partners members to Optum for behavioral health care services if it is determined that treatment for postpartum depression is needed. Contact Optum at 800-888-1965 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m.

Reminder: New OB Reimbursement Policy for Priority Partners Providers

(RPC.008) PPMCO Obstetrical Services, Professional

Effective July 15, 2024, the policy applies only to Priority Partners claims for professional OB services rendered to our members for maternity care and delivery services, reported to Johns Hopkins Health Plans.

- Providers must be actively enrolled in ePREP when services are rendered.
- Providers shall not report global obstetric (maternity care) package code(s) or the claim will be denied.

- Johns Hopkins Health Plans considers the postnatal/postpartum period to be 12 weeks (84 days) after delivery.
- Providers are to report the appropriate obstetric abdominal/pelvic ultrasound codes in conjunction with an OB diagnosis or the claim may be denied.
- Doula services are covered in accordance with MDH guidelines, and Johns Hopkins Health Plans will reimburse Doula services in alignment with MDH's reimbursement model.
- Eligible providers may add the code 99078 (group educational services by physician) up to TEN Centering Pregnancy perinatal visit claims for patients who are enrolled in and receive perinatal care.
- Johns Hopkins Health Plans encourages providers to discuss the Priority Partners Pregnancy Support Program with their patients for additional pregnancy support.

// REMINDERS

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 be sure to also 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 at HopkinsHealthPlans.org, under "For Providers," on 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: 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 at 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

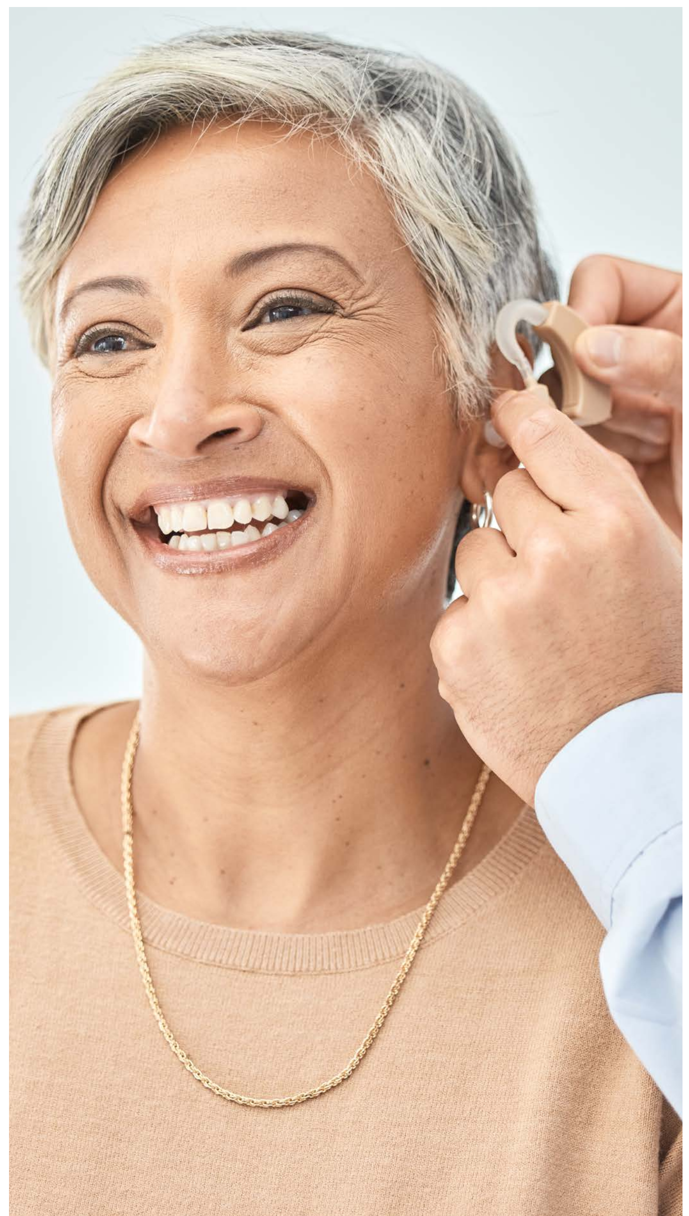
- Per the Advantage MD participating provider agreement, participating providers may not deny services to D-SNP members.
- Providers may not bill D-SNP members for any services covered under the D-SNP plan.

- » Providers would need to bill Medicaid for the 20% that the D-SNP members would typically be responsible for, or they would need to 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.

Timely Reminders for USFHP Providers

- **Out-of-Pocket Expenses.** As we enter the second half of the calendar year, please note there are no additional out-of-pocket expenses after members reach their catastrophic cap. US Family Health Plan (USFHP) tracks the total and adjudicates claims accordingly. Point-of-service charges do not count toward catastrophic cap.
- **TRICARE Manuals.** Just a reminder that USFHP follows the T-5 TRICARE manuals (2021 edition).
- **Access HEARS Program.** If you treat a USFHP member who meets the below criteria, please let them know about this discount. Eligible members can submit an online Access HEARS Inquiry on our website.
  - » Prolonged hearing loss is tied to accelerated cognitive decline, decreased physical mobility, falls and dementia. In addition, hearing loss can cause many people to feel self-conscious, avoid social situations and fall further isolated from daily life.
  - » Johns Hopkins Health Plans recognizes the spectrum of health impacts for people who have hearing loss, so we have contracted with Access HEARS to offer **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
  - » 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 through the first 12 months.

Access HEARS Inc. is a 501(c)3 non-profit 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.



Language Data Compiled for Johns Hopkins Health Plans

Johns Hopkins Health Plans collects reliable data on practitioners who speak languages other than English. The results of this analysis are seen in the following tables, which display the proportion of the practitioner network that reports speaking the predominant languages other than English reported through the credentialing process for the service area. The proportion of the practitioner network is compared to the proportion of members who report speaking that language to determine whether the practitioner network can meet member linguistic needs.

Advantage MD Language Data

Total Providers Who Speak Identified Languages	Percent of Total Network	Total Members Who Speak Identified Languages	Percent of Total Membership
Asian: 8,841	Asian: 36%	Asian: 1,090	Asian: 2%
Spanish: 5,322	Spanish: 22%	Spanish: 1,620	Spanish: 3%
Other: 9,221	Other: 38%	Other: 1,710	Other: 3%

US Family Health Plans Language Data

Total Providers Who Speak Identified Languages	Percent of Total Network	Total Members Who Speak Identified Languages	Percent of Total Membership
Asian: 6,655 (-143)	Asian: 19%	Asian: 1,292 (-44)	Asian: 1%
Spanish: 4,037 (-189)	Spanish: 11%	Spanish: 2,258 (-70)	Spanish: 3%
Other: 6,807 (-515)	Other: 19%	Other: 1,958 (-43)	Other: 2%

Priority Partners Language Data

Total Providers Who Speak Identified Languages	Percent of Total Network	Total Members Who 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%

Employer Health Programs Language Data

Total Providers Who Speak Identified Languages	Percent of Total Network	Total Members Who Speak Identified Languages	Percent of Total Membership
Asian: 11,219	Asian: 33%	Asian: 1,545	Asian: 3%
Spanish: 6,832	Spanish: 20%	Spanish: 2,593	Spanish: 6%
Other: 11,752	Other: 34%	Other: 2,740	Other: 6%

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.

PRPULSE17-SUMMER 2024

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

JOHNS HOPKINS HEALTH PLANS

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