Johns Hopkins HealthCare
Post-Acute Care

Quick Reference Guide

Prior Authorization Program

eviCore healthcare manages Post-Acute Care (PAC) Prior Authorization requests for Johns Hopkins Healthcare (JHHC) members enrolled in the following programs:

• Advantage MD (Medicare)
• Priority Partners (Medicaid)

Prior Authorization is required for member admissions to the following provider types:

- Skilled Nursing Facilities (SNF)
- Inpatient Rehabilitation Facilities (IRF)
- Long Term Acute Care Facilities (LTAC)

Providers should verify member eligibility and benefits on: https://jhhc.healthtrioconnect.com/

Prior Authorization Requirements

To ensure the Prior Authorization (PA) process is as quick and efficient as possible, we highly recommend submitting pertinent clinical information to substantiate medical necessity for the type of service being requested. The information requirements are outlined on our Prior Authorization requests forms. A link to the PA forms is available at: https://www.evicore.com/resources/healthplan/johnshopkinshealthcare

eviCore offers 3 convenient methods to request Prior Authorization reviews:

1. eviCore Web Portal www.evicore.com
2. Fax PA requests to:
   844.216.0198 for initial review
   877.791.4098 for concurrent review (include case number)
3. Telephone: Call **866.220.3071**

Hours of Operation

- Monday through Friday 8 a.m. to 7 p.m. EST
- Saturday 9 a.m. to 5 p.m. EST
- Sunday 9 a.m. to 2 p.m. EST
- Holidays 9 a.m. to 2 p.m. EST

24 hour/7 days on call coverage for urgent needs

Prior Authorization Outcomes

Once all information is submitted to eviCore, a determination is made within 48 hours for standard requests.

Verbal notification is made to the requesting provider and written notification in the form of a letter will be faxed to the requesting provider and mailed to the member. Authorization information can be viewed and printed on demand from the eviCore healthcare Web Portal www.evicore.com

Clinical Consultations

If a request requires further clinical discussion for approval, eviCore offers timely clinical consultations to reduce the occurrence of appeals. To schedule, please call **866-220-3071.**

Authorization Denials

Once a case has been denied, providers are often able to utilize post-decision activity to secure case review for overturn consideration.

The denial letter with the rationale for the decision and appeal rights will be faxed by eviCore to the requesting provider and mailed to the member.

Appeals Process

Appeal requests for **Priority Partners members** must be submitted to eviCore within **60 calendar days** from the initial determination. Instructions are outlined on the denial letter. A written notice of the appeal decision will be mailed to the member and faxed to the ordering provider.

eviCore will not process **Advantage MD member** appeals, please follow the Johns Hopkins Advantage MD appeal process outlines in the denial letter

Urgent Precertification Requests

eviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the customer. Urgent requests can be initiated by phone (recommended) or fax and will be reviewed within 72 hours.

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Convenient Provider Portal

The eviCore online portal is the quickest and most efficient way to request precertification and check precertification status

www.evicore.com

eviCore Portal Assistance:
portal.support@evicore.com
800.646.0418 (option 2)

Call Center: 866.220.3071

Monday – Friday 8 a.m. to 7 p.m. EST
Saturday 9 a.m. to 5 p.m. EST
Sunday 9 a.m. to 2 p.m. EST
Holidays 9 a.m. to 2 p.m. EST
24 hour on call coverage for urgent needs

Fax: 844.216.0198

Provider Resource Page

The eviCore Provider Resource page contains portal registration/submission information, frequently asked question documents, and other important resources that are kept up-to-date for your convenience.

https://www.evicore.com/resources/healthplan/johnshopkinshealthcare

Authorization from eviCore healthcare does not guarantee claim payment. Services must be covered by the health plan and the member must be eligible at the time services are rendered. ***Claims submitted for services may be subject to benefit denial.*** *Please verify the member's benefits and eligibility with the health plan. Regardless of the benefit determination, the final decision regarding any health care services or treatment is between the member and their health care provider.*

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