Provider Manual

Medicare Supplement

This supplement is for providers who participate with Sentara Medicare. Sentara Medicare is a Medicare Advantage HMO product available in select service areas in the Commonwealth of Virginia. Information in this supplement details additional information and exceptions that are specific to Sentara Medicare. Unless otherwise indicated in this supplement, information in the Core Provider Manual applies to Sentara Medicare as well as Sentara Health Plans' commercial plans. Please continue to refer to the Core Provider Manual for policies and procedures not addressed in this supplement and contact your network educator for questions regarding Sentara Medicare.

Sentara Medicare offers Medicare members a physician-led team approach to delivering the care seniors need. Support by a care manager helps coordinate medications, routine health screenings, doctor visits, and treatments. A patient-focused care team enables the patient to get to know their care manager, doctors, and other care providers over the long term.

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Product Overview

Sentara Health Plans offers two Medicare HMO plans in the following counties:

Accomack, Albemarle, Alexandria City, Alleghany, Amelia, Amherst, Appomattox, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Bristol City, Brunswick, Buchanan, Buckingham, Buena Vista City, Campbell, Caroline, Carroll, Charles City, Charlotte, Charlottesville City, Chesapeake City, Chesterfield, Clarke, Colonial Heights, Covington City, Craig, Culpeper, Cumberland, Danville City, Dickenson, Dinwiddie, Emporia City, Essex, Fairfax, Fairfax City, Falls Church City, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Frederick, Galax City, Giles ,Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City, Henrico, Henry, Highland, Hopewell City, Isle of Wight, James City, King George, King William, King and Queen, Lancaster, Lee, Lexington City, Loudoun, Louisa, Lunenburg, Lynchburg City, Madison, Manassas City, Manassas Park City, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Norton City, Nottoway, Orange, Page, Patrick, Petersburg City, Pittsylvania Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford City, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Rockingham, Russell, Salem City, Scott, Shenandoah, Smyth, Southampton, Stafford, Staunton City, Suffolk City, Surry, Sussex, Tazewell, Virginia Beach City, Warren, Washington, Waynesboro City, Westmoreland, Williamsburg City, Winchester City, Wise, Wythe, York.

Sentara Medicare plans are offered by Sentara Health Plans, a Medicare Advantage health maintenance organization (HMO) that contracts with the federal government. Product offerings, designs, and service areas are subject to annual review each calendar year.
The following grid shows general information for Medicare HMO products offered by Sentara Health Plans as of January 2024:

MEDICARE HMO PLAN TYPES **Offered by Sentara Health Plans**		
Sentara Medicare Plan Types: • No referrals required. • Primary care physician (PCP) selection required. • No out-of-network coverage except care provided in an Emergency Department. • Some services require prior authorization.		
Product Name	**Description**	**Features**

Sentara Medicare Value (HMO)	• standard HMO type Medicare Advantage plan • original Medicare benefits plus additional enhanced benefits	• no copayments for primary care services and original Medicare-covered preventive services • includes copayments for specialist services • generally higher copayments than Medicare Prime (HMO) plan

Sentara Medicare Prime (HMO)	• standard HMO type Medicare Advantage plan • original Medicare benefits plus additional enhanced benefits	• no copayments for primary care services and original Medicare-covered preventive services • includes copayments for specialist services • generally lower copayments than Medicare Value plan
Sentara Medicare Salute (HMO)	• standard HMO type Medicare Advantage plan • no Part D coverage • original Medicare benefits plus additional enhanced benefits	• no copayments for primary care services and original Medicare covered preventive services • includes copayments for specialist services • generally higher copayments than Medicare Prime plan

Member Identification and Information

Sentara Medicare Member ID Cards

The Sentara Medicare identification card is for identification purposes only and does not verify eligibility or guarantee payment of covered services. Medicare (HMO) members should present their card at the time of service.

Providers can access a sample Sentara Medicare ID card at the following link.

Eligibility Verification

Medicare members may only change plans during the Medicare annual enrollment period unless they qualify for a special election period (SEP). Sentara Medicare providers may access Provider Connection or call the Sentara Health Plans interactive voice response (IVR) system 24 hours a day, 7 days a week for rapid, up-to-date eligibility verification. To view eligibility information online, sign into the Provider Portal.

To use the IVR system, call provider services at the number on the **"Key Contacts"** page of the Core Provider Manual.

There are two options available to search for a member:

- Press 1: to enter Sentara Health Plans member ID number
- Press 3: to enter HCIN number

The IVR system provides:

- the Sentara Health Plans member ID number if an HCIN number is used to search for the member
- member's "eligible as of" or "terminated as of" date, when applicable
- member's group number
- primary care physician's (PCP) name, when applicable

Specific copayment and benefit information is available 24 hours a day on the provider web portal or by speaking with a provider service representative during business hours.

Sentara Medicare Members' Rights and Responsibilities

Policy Statement:

The Sentara Medicare Member Bill of Rights and Responsibilities assures that all Sentara Medicare members are treated in a manner consistent with the mission, goals, and objectives of Sentara Health Plans and assures that members are aware of their obligations and responsibilities upon joining Sentara Health Plans and throughout their membership with Sentara Health Plans:

Members Have the Right:

- to be treated with respect, dignity, and compassion, and the right to privacy by Sentara Health Plans personnel, network doctors, and healthcare professionals
- to exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care - Members should expect this right by both Sentara Health Plans and contracting physicians.
- to receive information about their health plan, its services, physicians, other healthcare professionals, facilities, and clinical guidelines
- to privacy and confidentiality for treatments, tests, and procedures received
- to voice concerns about the service and care received

- to register complaints and appeals concerning the health plan and the care provided
- to receive timely responses to concerns
- to participate in a candid discussion with doctors and other healthcare professionals in decision-making about medically appropriate treatment options and planning for conditions, regardless of cost or benefit coverage
- to be provided with access to doctors, health professionals, and healthcare facilities
- to receive information about and refuse to participate in any experimental treatment
- to have coverage decisions and claims processed according to regulatory standards, when applicable
- to choose an advance directive to designate the kind of care the member wishes to receive should they become unable to express their wishes
- to have the right to inspect and copy, amend, request an accounting, and request restrictions to medical information that Sentara Health Plans creates
- to make recommendations regarding member rights and responsibilities
- to affirm that practitioners, providers, and employees:
    - make utilization management decisions based on appropriateness of care, services, and existence of coverage
    - do not reward practitioners or other individuals for issuing medical denials of coverage
    - do not encourage decisions that result in underutilization through financial incentives
    - participate in understanding the member's health problems and assist in developing mutually agreed-upon treatment goals

Members Have the Responsibility:

- to know and confirm benefits before receiving treatment
- to contact an appropriate healthcare professional when there is a medical need or concern
- to show their ID card before receiving healthcare services
- to pay any necessary copayment at the time they receive treatment
- to use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- to keep scheduled appointments

- to provide information needed for their care
- to follow agreed-upon instructions and guidelines of physicians and healthcare professionals
- to participate in understanding of health problems and developing mutually agreed-upon treatment goals
- to notify Sentara Health Plans of any changes to personal contact information
- to call member services when there is a question about eligibility, benefits, claims, appeals, etc.
- to read and be aware of all materials distributed by Sentara Health Plans explaining policies and procedures regarding services and benefits

Sentara Medicare Member Services

Medicare HMO member services (**1-800-927-6048**) and the free TTY/TTD phone line (**1-800-828-1140** or **711**) are available to Sentara Medicare members from 8:00 a.m. to 8:00 p.m. ET, seven days a week, from October 1 through March 31; and from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday, April 1 through September 30. On Thanksgiving Day, Christmas Day, and weekends and holidays from February 15 through September 30, only the interactive voice response system is available on the regular member services phone number. These phone numbers are published in the member materials and assist the members in contacting Sentara Health Plans with questions regarding their health plan benefits, eligibility, claims, behavioral health services, or any other questions/information related to their health plan benefit coverage.

Provider Requirements

Medicare Provider Participation Requirement

All Sentara Medicare providers must be enrolled as Medicare providers as a requirement of participation. Any provider who has “opted out” of Medicare is not eligible to participate in Sentara Medicare.

Nonparticipating Providers

Non-Participating Providers must obtain authorization prior to rendering services to a Sentara Health Plans Medicare member in order to be eligible for payment.

Additional/Ancillary Services for Medicare

Acupuncture Services

Acupuncture visits are covered at a maximum of 15 visits a year. An acupuncture provider search feature and additional provider information for the Medicare HMO acupuncture network is available

on the provider website. Sentara Health Plans contracts with American Specialty Health (ASH) for Medicare HMO acupuncture services. For billing and reimbursement information, refer to the ASH guidelines.

Alcohol Misuse Screening

Alcohol misuse screening is covered for adults with Medicare (including pregnant women) who misuse alcohol but are not alcohol dependent. If the screening is positive for alcohol misuse, a qualified primary care physician or practitioner in a primary care setting may provide up to four brief face-to-face counseling sessions per year.

Audiology Services

Medicare HMO benefits for audiology services vary based on the Medicare HMO plan purchased. Prior authorization is required for hearing aids when covered by the Medicare HMO plan. Prior authorization is not required for Medicare-covered diagnostic hearing exams.

Chiropractic Services

Medicare-covered chiropractic visits for manual manipulation of the spine to correct subluxation are covered. A chiropractic provider search feature and additional provider information for the Medicare HMO chiropractic networks are available on the provider web portal. Sentara Health Plans contracts with American Specialty Health (ASH) for Medicare HMO chiropractic services. Prior authorization for chiropractic services is obtained from ASH. For billing and reimbursement information, refer to the ASH guidelines.

Dental Coverage

Dental benefits vary based on the Medicare HMO plan purchased. Sentara Medicare HMO plans include some dental preventive and comprehensive services. Dental services are provided by DentaQuest. Every Medicare Advantage plan has an embedded routine dental benefit. Members must use an in-network dental provider. DentaQuest's provider locator can be found here. Comprehensive services are limited to covered dental codes and may include copays. Members are responsible for the cost of any service over the annual maximum. Treatment of a dental accident is covered as a medical benefit under Medicare guidelines for the Sentara Medicare HMO. The Dental Care Discount program does not apply to Medicare HMO Members.

Disposable Medical Supplies

Medicare-covered disposable medical supplies are covered, according to Medicare guidelines.

Durable Medical Equipment (DME)

Pre-authorization is required for rentals, repairs, and for item charges greater than $750.00. Medical

care services will apply Medicare limitations for DME in the Sentara Medicare plan, except in the case of rental equipment. When it is determined that the member will require long-term use of the equipment, purchase will be authorized, and the total rental amount will apply toward the purchase amount. Medicare HMO members do not have a calendar year benefit maximum.

Gynecological Care

Cervical and vaginal cancer screening is covered for Medicare HMO members once every two years. Women at high risk are covered once a year.

Hospice Services

Sentara Medicare members may receive care from any Medicare-certified hospice program. Original Medicare coverage (rather than Sentara Medicare) pays for the hospice services. Sentara Medicare will continue to cover all other (nonhospice-related) services.

Medical Nutrition

Medical nutrition therapy is covered when services are provided by participating providers. Prior authorization is not required.

Obesity Screening and Therapy

Intensive counseling in a primary care setting is covered for members who have a body mass index of 30 or more. This allows for coordination with the members' comprehensive prevention plan.

Physical Therapy, Occupational Therapy, and Speech Therapy (PT/OT/ST)

Sentara Medicare utilizes Medicare coding and payment methodologies for PT, OT, and ST. Prior authorization is required.

There is no copay for physical therapy, occupational therapy, or speech therapy when provided to Medicare HMO members during an inpatient hospital stay or a home visit. When therapy is provided in an outpatient setting, such as a hospital outpatient department, independent therapist office, or comprehensive outpatient rehabilitation facility, a copayment applies.

Prosthetic Devices Benefit

Medicare-covered devices are covered with copayments, as stipulated by the Medicare HMO plan. Prosthetic devices are covered according to Medicare guidelines when they have received appropriate prior authorization by clinical care services. Prior authorization is required when requested item charges are greater than $750.00.

Smoking and Tobacco Use Cessation

If the Medicare HMO member uses tobacco but does not have a tobacco-related disease, members have coverage for two counseling quit attempts within a 12-month period that includes up to four face-

to-face visits as a preventive service.

If the Medicare HMO member uses tobacco and has a tobacco-related disease or is taking medicine that may be affected by their tobacco use, Sentara Medicare also covers cessation counseling services and provides two counseling quit attempts within a 12-month period, but the member will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.

Therapeutic Massage

Therapeutic massage is covered as part of a non-opioid pain management treatment plan. A massage provider search feature and additional provider information for the Medicare HMO therapeutic massage networks are available on the provider website. Sentara Health contracts with American Specialty Health (ASH) for Medicare HMO therapeutic massage services. A referral is required for coverage of this benefit. For billing and reimbursement information, refer to the ASH guidelines.

Transportation Program

Transportation benefits vary based on the Medicare HMO plan purchased. Sentara Medicare covers nonemergency transportation for eligible members for medical appointments as well as emergency transportation. If a Sentara Medicare member has no other means of transportation, transportation will be provided to and from a medical appointment with a participating provider for a maximum of 48 one-way trips per year.

To schedule a ride a member should call **1-866-381-4860** three days in advance of a medical appointment to have the transportation arranged. The transportation vendor does not cover scheduled ambulance/stretcher transportation. Nonemergency ambulance/stretcher is approved and arranged by Sentara Health Plans clinical care services for Sentara Medicare members.

Vision Coverage

Medicare HMO members receive preventive vision benefits through the vision vendor. Preventive vision services are not reimbursed under the medical plan and should be obtained by members through their vision benefits.

Sentara Medicare members may obtain vision services to diagnose and treat diseases and conditions of the eye through the vision vendor or participating Sentara Health Plans ophthalmologists or optometrists.

Sentara Medicare members also receive an allowance to purchase vision materials using the vision vendor.

Welcome to Medicare Preventive Visit

Sentara Medicare covers the one-time “Welcome to Medicare” preventive visit available to all

Medicare recipients within the first 12 months the member has Medicare Part B.

In addition, Sentara Medicare provides a new member health risk assessment screening for all new Sentara Medicare members. Screenings are most often performed in the primary care office but may also be performed in the member's home during a scheduled face-to-face visit by a Matrix Medical Network clinician. Matrix is a vendor contracted with Sentara Medicare to assist with these screenings. Matrix will communicate any member care management needs directly to the Sentara Health Plans case managers or the primary care physician, as appropriate.

Pharmacy

Formulary

The formulary is called the Sentara Medicare Formulary (List of Covered Drugs).

The formulary:

- provides quantity, form, dosage, and prior-authorization restrictions for certain drugs
- requires generic drug prescription usage whenever possible
  - These drugs are listed with the generic name on the Medicare formulary. If a member requests a brand name drug when a generic drug is available, the member may be responsible for additional charges.
- provides a framework and relative cost information for the management of drug costs

Copies are available on the provider web portal with quarterly updates. Updates also appear in *providerNEWS*, the provider newsletter.

Medicare Part B Prescription Drugs

Members receive coverage for drugs covered under Part B of original Medicare through their Sentara Medicare plan.

Medicare Part D Prescription Drugs

Sentara Medicare plans provide a five-tier copayment structure. Copayments vary depending on the tier in which the prescription drug falls. Tiers include:

- **Tier 1:** preferred generic drugs
- **Tier 2:** nonpreferred generic drugs
- **Tier 3:** preferred brand drugs
- **Tier 4:** nonpreferred brand drugs

- **Tier 5:** specialty drugs

Utilization and Quality Assurance Program Information

Sentara Medicare works with physicians to ensure members get the most appropriate, safe, and cost-effective drugs. Sentara Health Plans' Utilization Management and Quality Assurance program is designed to assure that adverse drug events and drug interactions are avoided and ensure optimum medication use. The Utilization Management and Quality Assurance program is provided at no additional cost to members or providers.

Utilization Management and Quality Assurance programs incorporate tools to encourage appropriate and cost-effective use of Part D drugs. These tools include prior authorization, quantity limits, step therapy, additional charges, and clinical interventions. Other tools may be used if necessary.

- PA = Prior Authorization: Sentara Medicare requires physicians to get prior authorization for certain drugs.
- QL = Quantity Limits: For certain drugs, Sentara Medicare limits the amount of the drug that it will cover. This may be in addition to a standard one-month or three-month supply.
- B/D= Some medications may not be billable under the Part D benefit. Various medications will need a determination on whether they will be considered billable under Medicare Part B or Part D based on:
    - the medical use of the drug
    - situations depending on the drug form (e.g., inhalation, nebulizer, metered dose inhaler)
    - situations depending on the location where medication is administered (e.g., the same drug dispensed by a pharmacy is covered under Part B if provided as part of a service in a provider's office, physician's office, or home)
- ST= Step Therapy: In some cases, Sentara Medicare requires the member to first try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the member's medical condition, we may not cover Drug B unless the member tries Drug A first. If Drug A does not work, Sentara Medicare will then cover Drug B.
- AN = Additional Charge: If Sentara Medicare members obtain a brand name drug when a generic equivalent is available, the member will be required to pay the difference between the cost of the generic drug (which is paid by Sentara Medicare) and the cost of the brand name drug, in addition to the appropriate brand copay.
- NDS = Nonextended Day Supply: Some medications are not available for 90-day supplies. This

means that these medications can only be filled for 30 days or less.

Sentara Medicare's formulary indicates if the drug has prior authorization, step therapy, or quantity limit requirements. The formulary also indicates if additional charges may apply, if the drug requires a B versus D determination, or if the drug cannot be filled for more than a 30-day supply.

The Sentara Medicare product offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). The chart below displays the drugs our plan covers under the enhanced drug coverage. The chart also displays the limitations for each drug and what the member pays when they get a (30-day) supply of the drug.

Drug Name	Limits (QL= Quantity Limit)	Standard retail cost sharing (in-network) (30-day supply)
Sildenafil (25mg, 50mg, 100mg)	QL (6 per 30 days)	$12
Vitamin D2 capsules (50,000 IU)	QL (8 per 28 days)	$0
Folic Acid tablets (1mg)	QL (30 per 30 days)	$0
Benzonatate capsules (100mg, 200mg)	QL (60 per 30 days)	$0
Guaifenesin w/codeine syrup (100/10mg)	QL (120 ML per 30 days)	$0
Cyanocobalamin (Vitamin B-12) 1000MCG/ML	No QL	$12

As part of the Utilization Management and Quality Assurance program, all prescriptions are screened to detect and address the following:

- drug-drug interactions that are clinically significant
- duplication of drugs (taking more than one drug in the same drug class)
- inappropriate drugs
- incorrect drug
- patient-specific drug contraindications
- overutilization of drugs
- underutilization of drugs
- abuse or misuse of drugs

A review of prescriptions is performed before the drug is dispensed. These are concurrent drug reviews and are clinical edits at the point-of-sale (at the pharmacy counter).

Retrospective drug utilization reviews identify inappropriate or medically unnecessary care. Sentara Medicare performs periodic reviews of claims data to evaluate prescribing patterns and drug use that may indicate inappropriate use.

Physicians treating patients who are receiving potentially inappropriate drug therapy will receive provider-specific reports detailing the patient's drug utilization. The providers receive educational materials explaining the report and the intervention it addresses. The reports identify individual patients who may require evaluation, the reason for the report, and options for the provider to consider.

Medication Therapy Management Program Information

Sentara Medicare has a Medication Therapy Management Program (MTMP) that meets the Medicare Modernization Act requirements. Our Medication Therapy Management Program is approved by the Centers for Medicare & Medicaid Services (CMS) for the program year. Members are eligible for Sentara Medicare's Medication Therapy Management Program if they have at least two of the following conditions:

- arthritis (osteoarthritis and rheumatoid arthritis)
- asthma
- chronic heart failure
- chronic obstructive pulmonary disease (COPD)
- depression
- diabetes
- dyslipidemia (high cholesterol)
- hypertension (high blood pressure)

Members must also be taking four or more Part D covered drugs and must be likely to exceed $5,330 in annual costs for medications. Sentara Medicare has a network of Sentara Medicare pharmacists who provide services for members eligible for the MTMP. While this program is not considered a benefit, members eligible for Sentara Medicare's MTMP can receive these services at no cost to them. Members not eligible for the program can also receive the services but must pay the full cost to the participating pharmacy.

Mail Order Prescription Drug Program

Medicare members may purchase a 63–90-day supply of drugs from Express Scripts Mail-Order Program. Physicians need only to call Express Scripts Mail-Order Program at **1-888-899-2653** to

prescribe or ePrescribe.

Members can download and print the order form from the tour website. For more information on the mail order program, members may call Express Scripts toll free at **1-888-899-2653.**

Coverage Exclusions and Limitations

If Medicare does not pay for a drug, it will be excluded from coverage for Sentara Medicare. The member is responsible unless the requested drug is found upon appeal to be a drug that is not excluded under Part D and that Sentara Medicare should have paid for or covered because of the member's specific situation.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- drugs that would be covered under Medicare Part A or Part B
- drugs purchased outside the United States and its territories
- off-label use (usually not covered)
  - "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration (FDA). Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then Sentara Health Plans does not cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- nonprescription drugs (also called over-the-counter drugs)
- drugs when used to promote fertility
- drugs when used for the relief of cough or cold symptoms
- drugs when used for cosmetic purposes or to promote hair growth
- prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- drugs when used for treatment of anorexia, weight loss, or weight gain
- outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, the following is a list of products or categories that are not covered for reimbursement under the Sentara Medicare member pharmacy benefit contract. This list is subject to periodic review by Sentara Health Plans and therefore may not be a complete listing of products.

- Medications that do not meet Sentara Health Plans' criteria for medical necessity are excluded from coverage.
- Copayment and coinsurance are out-of-pocket amounts the member pays directly to the pharmacy provider for a covered prescription drug. A copayment is a flat dollar amount. A coinsurance is a percentage of Sentara Health Plans' allowable charge.
- Prescriptions may be filled at a Sentara Health Plans pharmacy or a nonparticipating pharmacy that has agreed to accept as payment in full reimbursement from Sentara Health Plans at the same level as Sentara Health Plans gives to participating pharmacies.
- All covered outpatient prescription drugs must have been approved by the FDA and require a prescription either by state or federal law. Medications with no approved FDA indications are excluded from coverage.
- Some drugs require prior authorization from Sentara Health Plans to be covered. The physician is responsible for obtaining prior authorization. Benefits for covered services may be reduced or denied for not complying with Sentara Health Plans' prior-authorization requirements.
- At their sole discretion, the Sentara Health Plans Pharmacy and Therapeutics Committee determines in which tier a covered drug is placed. Sentara Health Plans' Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee reviews the medical literature and then evaluates whether to add or remove a drug from the preferred drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications.
- Diaphragms, intrauterine devices (IUDs), and cervical caps and their insertion are covered under Sentara Health Plans' medical benefits.
- All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a physician's authorization by state or federal law are excluded from coverage.
- Nondurable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from coverage.
- Insulin, syringes, and needles are covered under the pharmacy benefit. Diabetic supplies and

equipment and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes, if prescribed by a healthcare professional legally authorized to prescribe such items under law, other than those listed as covered under the pharmacy benefit, are covered under Sentara Health Plans' medical benefit.

- Prescription or over-the-counter appetite suppressants and any other prescription or over-the-counter medication for weight loss are excluded from coverage.
- Immunization agents, biological sera, blood, or blood products are excluded from coverage.
- Injectables (other than those self-administered and insulin) are excluded from the pharmacy benefit.
- Medication taken by or administered to the member in the physician's office is excluded from the pharmacy benefit.
- Medication taken or administered, in whole or in part, while a member is a patient in a licensed hospital is excluded from the pharmacy benefit.
- Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from coverage.
- Medications for experimental indications and/or dosage regimens determined by Sentara Health Plans to be experimental are excluded from coverage.
- Replacement prescriptions resulting from loss, theft, or breakage are excluded from coverage.
- Therapeutic devices or appliances, including but not limited to support stockings and other medical/nonmedical items or substances, regardless of their intended use, are excluded from coverage.
- Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from coverage.
- Infertility drugs are excluded from coverage.
- Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication as long as the drug has been approved by the United States FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

- Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States FDA for use in the treatment of cancer on the basis that the drug has not been approved by the United States FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States FDA for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

Member Transition Process

Sentara Medicare provides a transition process for new members who are taking drugs that are not on the formulary, current members affected by a formulary change from one year to the next, and members who transition to a different level of care. A temporary supply of the nonformulary or coverage-restricted drug may be authorized.

Creams and Ointments

A Medicare HMO member may receive more than one tube of ointment or cream per prescription order or refill as long as it does not exceed a 90-day supply. If a prescription exceeds quantity limitations for a 90-day supply and the claim rejects, the pharmacist should call pharmacy authorizations. A copayment per tube may apply.

Days' Supply Dispensing Limitations

Sentara Medicare members may receive up to a 90-day supply of a prescription at a retail pharmacy. A 90-day supply is interpreted as a consecutive 90-day supply.

Diaphragms

Diaphragms are not a Medicare pharmacy benefit.

Laboratory Services

Laboratory services for Sentara Health Plans members may only be performed by Sentara Medicare contracted lab providers. All laboratories, including physician offices, participating with Sentara Health Plans must have the appropriate CLIA certificate.

Reference Lab Providers

Any lab test not included on the "In-office Lab" list **must** be sent to a participating reference lab. Sentara Medicare participating reference laboratory providers (current as of the printing of this manual) are as follows:

Hampton Roads Area Participating Reference Labs:
Sentara Reference Lab:
Client Services/Lab Results - **757-388-3621**
Scheduling - **757-388-2030**

Chesapeake Regional Medical Center Lab: **757-312-6118**

Hampton Roads Area Specialty Lab:

EVMS: Specialty services only. Call for a list of procedures: **757-446-5972**

Laboratory Draw Sites

Providers have the option of sending the Medicare member with orders to a participating reference laboratory draw site. Members and providers may locate the nearest participating laboratory draw site by using the provider website or by calling Sentara Health Plans provider services.

Reimbursement

Medicare HMO Claim Policies

Sentara Medicare reimbursement and claim policies are based on those currently used by Medicare. Medicare policy and procedural information is available at cms.gov/. The CMS website can give your practice information regarding Medicare's National Correct Coding Initiative (NCCI) edits.

Billing and Payments

Contracted Amounts/Billing Covered Persons

By entering into a provider agreement with Sentara Medicare, you have agreed to accept payment directly from us. This constitutes payment in full for the covered services you render to Medicare members, except for copayments, coinsurance, deductibles, and any other monies listed in the "Patient Responsibility" portion of the remittance advice**. You may not bill members for covered services rendered or balance bill members for the difference between your actual charge and the contracted amount. In cases where the copayment is greater than the allowed amount for services rendered, only the allowed amount for the services should be collected. Should you collect more than the allowed amount, you will be expected to refund the member the difference of the two amounts.**

In order to bill a Medicare HMO member for noncovered services, the member must have been informed in writing prior to receiving the service that the service is not covered under their Medicare

HMO plan and must sign a waiver with Medicare-approved language stating they are willing to pay for the service.

Dual-eligible Members with Both Medicare and Medicaid

If you provide services to a member who is eligible for both Medicare and Medicaid, then you may not bill or hold liable the dual-eligible member for Medicare Parts A and B cost sharing if Virginia Medicaid is liable for such cost sharing. You may either accept the Medicare plan payment as payment in full, or you may bill the appropriate Virginia agency.

Sentara Medicare Coordination of Benefits (COB)

Typically, members enrolled in Sentara Medicare do not have commercial insurance coverage in addition to Medicare. It is possible for a member to have other coverage through their spouse. In the case of other coverage, Sentara Medicare follows original Medicare guidelines for COB.

Electronic Claims Filed with Zero Charge Amounts

Electronic Medicare HMO claims may be submitted with zero charge amounts.

Denied Claim Payment Reconsiderations and Appeals

The standard Sentara Health Plans process for pre-service or current requests for reconsideration of an adverse decision/denial for payment does not apply to Sentara Medicare. The process for Sentara Medicare appeals, including the process for expedited determinations and appeals, is outlined in detail in the Medicare Salute HMO, Medicare Value, and Medicare Value Evidence of Coverage Documents (EOC) here.