CORE
PROVIDER MANUAL

A Publication of Sentara Health Plans' Network Management Department

This version of the Sentara Health Plans Provider Manual was last updated on December 20, 2023. Updates to the provider manual may occur due to the introduction of new programs, changes in contractual and regulatory obligations, and updates to existing policies. The most current information is available on the Sentara Health Plans provider website: Providers | Sentara Health Plans

SENTARA HEALTH PLANS KEY CONTACTS

Please see the Sentara Health Plans Medicaid program provider manual and Medicare (HMO and Special Needs Plan) supplements for contact numbers specific to those programs.

Provider and Member Services

Provider Services Medical
Phone: 800-881-2166
Fax: 1-757-552-7316

Behavioral Health
Phone: 1-800-648-8420
Fax: 1-757-552-7499

Clinical Care Services

Medical Authorizations and Medical Benefit Drugs for Commercial Members
Phone: 1-800-229-5522
Fax: Fax number is indicated on each authorization form

Medical Authorizations and Medical Benefit Drugs for Sentara Health Plans Medicare and Medicaid Products
Phone: 1-888-946-1167
Fax: Fax number is indicated on each authorization form

Authorizations Behavioral Health Providers
Phone: 1-888-946-1168
Fax: Fax number is indicated on each authorization form

After-hours Nurse Advice Line
Phone: 1-833-933-0487

Sentara Health Plans Case Management Services (Direct)
Phone: 1-866-503-2730

Case Management Partners in Pregnancy:
Phone: 1-866-239-0618, option 1

Quality Improvement
Phone: 1-844-620-1015
Fax: 1-844-518-0706

Pharmacy Services

Pharmacy Provider Services - Nonmedical Benefits

Phone: 1-800-229-5522
Fax: 1-800-750-9692

Mail Order Pharmacy (Express Scripts)
Phone: 1-877-728-0179

Specialty Pharmacy (Proprium Pharmacy)
Phone: 1-855-553-3568
Web: propriumpharmacy.com/for-prescribers/

Critical Incidents
Email: CIReporting@sentara.com
Phone: 757-252-8400
Fax Line: 804-200-1962 | Toll Free Fax Line: 1-833-229-8932

Telephone for Deaf and Disabled (TDD)
Phone (Virginia Relay): **711**

Health and Preventive Services
Phone: 1-800-736-8272

Fraud and Abuse
Hotline: 1-866-826-5277
Email: compliancealert@sentara.com
U.S. Mail: Sentara Health Plans
C/o Special Investigations Unit
PO Box 66189
Virginia Beach, VA 23466

Network Management Department Notifications
Email: Send to assigned network educator
Mail: Contract Manager
PO Box 66189
Virginia Beach, VA 23466

Medical Necessity Reconsiderations (Authorization)
Mail: Clinical Care Services
PO Box 66189
Virginia Beach, VA 23466

Claim Payment Reconsiderations
Mail:
Medical Claims
PO Box 8203
Kingston, NY 12402

Behavioral Health Claims
PO Box 8204
Kingson, NY 12402

Overpayments
Phone: 1-800-508-0528
Mail: Sentara Health Plans Provider Receivables
PO Box 61732
Virginia Beach, VA 23466

Provider Appeals
Fax: 1-866-472-3920
Mail: Sentara Health Plans
PO Box 62876
Virginia Beach, VA 23466
Provider Appeals

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INTRODUCTION

As a participating provider, you are an integral member of our team. We thank you for partnering with Sentara Health Plans to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare and the best in customer service to the communities we serve.

Sentara Health Plans Resources for Providers

Sentara Health Plans provides several resources for providers to obtain information regarding membership, products, policies, and procedures:

Provider Manual

This provider manual identifies contacts and resources within Sentara Health Plans and provides basic information for member identification, credentialing procedures, requirements for prior authorization, and claim and reimbursement procedures. The provider manual also offers directions to locate detailed lists, contact information, and policies on the provider website. The provider manual consists of a core document that includes general policies and procedures for all plan types and specific information for Sentara Health Plans commercial plans. It also includes supplements containing information specific to 1) hospitals and ancillary providers; 2) providers participating in the Sentara Health Plans Medicaid program; 3) providers participating in the Medicare Advantage HMO; 4) providers participating in Sentara Community Complete, the Dual-eligible Special Needs Plan (D-SNP); 5) and ARTS Supplement for behavioral health providers who participate with the Sentara Health Plans Medicaid program.

The provider manual was developed to assist providers in understanding the administrative requirements associated with managing a member's healthcare. This provider manual, including all sources that are referenced by and incorporated herein via web-link or otherwise, is a binding extension of your provider agreement and is amended as our operational policies change. Many of the policies and procedures that are referenced by or incorporated into this provider manual are available on the provider website.

Should the terms of the body of the provider agreement or its exhibits (excluding the provider manual exhibit) conflict with this provider manual, then the body of the provider agreement and its exhibits (excluding the provider manual exhibit) controls.

In addition to the provider manual being available online, it is also available in paper form by written request. Providers are responsible for complying with updates to the provider manual, as they are made available from time to time. Sentara Health Plans notifies providers of updates to this manual via email. For these reasons, please keep us updated on changes to your mailing and email addresses, and make sure to check your emails and the provider website regularly.

Online

Up-to-date contacts, policies and procedures, forms, and reference documents are available to providers through the provider website.

Provider Portal

Beginning January 1, 2024, Sentara Health Plans has chosen Availity as our exclusive provider portal. Availity Essentials is a multi-payer portal where providers can check eligibility and benefits, manage claims, and authorizations to streamline their work. Many providers are already using Availity with other payers that they are contracted with and are familiar with its ease of use.

Over the course of 2024, our provider portals, including all features, functionality, and resources, will transition to Availity. This is a phased transition, with access to both our provider portals and the Availity Portal being available, as features and functionality are deployed on Availity's Portal. If a provider is already working in the Availity Essentials portal, the same user ID and password can be used to sign-in to the Essentials account for Sentara Health Plans on January 1, 2024. For providers new to Availity Essentials, the Get Started page has an abundance of resources, including a recorded webinar.

During the transition to Availity providers will need to access the legacy provider portals for capabilities not yet available on Availity. For providers not already registered to our legacy portals, a request for secure access can be submitted by visiting the provider website and completing the online enrollment form. Providers can access the registration process at this link.

In addition, providers can access required and supplemental training at sentarahealthplans.com on the providers tab under provider support.

Provider Training

Providers are required to review the Model of Care Provider Guide (MCPG) within 30 days of their initial orientation date as a newly contracted provider and by January 31 each subsequent year. Attestation is required and will be recorded by provider (practice/facility) name, tax identification number (TIN) and email address. Out-of-network providers must review the MCPG when they sign the requisite Single Case Agreement (SCA). The MCPG and Attestation can be found here.

Providers are encouraged to take Fraud, Waste, and Abuse, Trauma Informed Care, and Cultural Competency training during onboarding and as ongoing training.

Quarterly Webinars

Online educational webinars are held quarterly and allow providers to ask questions, provide Sentara Health Plans updates, and provide refreshers on how to successfully do business with Sentara Health Plans. Providers must register on the Sentara Health Plans provider website by the day before each event. The schedule is listed on the Provider Webinars | Sentara Health Plans | Sentara Health Plans page and in the provider newsletter, along with other educational opportunities.

Mailings and Newsletters

Providers may be notified of updates or changes to policies via targeted mailings or email. We notify providers of news, updates, or changes to our policies via our quarterly provider

newsletter, with an email notification when the newsletter is available on the provider website.

Telephone

Medical and behavioral health providers may contact provider services by phone. In the event an issue or a dispute under the provider agreement cannot be satisfactorily resolved by provider services, providers should contact their assigned network educator.

A complete directory of phone and fax numbers for Sentara Health Plans departments (including contacts for after hours) may be found online on the provider website under "contact us." A listing is also provided in the **"Sentara Health Plans Key Contacts"** section at the top of this manual.

Sentara Health Plans Resources Updates

Notice of changes, amendments, and updates to this provider manual and any sources that are referenced by and incorporated herein, are communicated to you via the Sentara Health Plans website and by email (for providers that have notified Sentara Health Plans of their email address) sixty (60) days before the changes become effective. For this reason, it is critical that you keep your email address current so that you can receive electronic communications with new and updated operational information, including amendments to your provider agreement and the provider manual. It is your responsibility to ensure that the email address that you have provided to us is correct and current. To update your email address and directory information, contact your network educator.

HIPAA Privacy Statement

Sentara Health Plans entities follow this ***Notice of Privacy Practices*** available here.

Sentara Health Plans maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and American Recovery and Reinvestment Act (ARRA). To ensure the protection of confidential information and patient health information, Sentara Health Plans has implemented privacy and security policies and procedures, has developed required forms, has established safeguards to protect patient health information, and conducts HIPAA awareness training.

PRODUCT OVERVIEW

Sentara Health Plans offers several health plans designed to meet the needs of most large and small employer groups as well as individuals and families. In addition, Sentara Health Plans offers plans for Medicare Advantage and managed Medicaid, including plans for dual-eligible members. Product offerings and designs are subject to change and often vary by geographic area.

Plans Sold on the Health Insurance Marketplace

As a qualified health plan (QHP), Sentara Health Plans sells several HMO plans on the Federally Facilitated Marketplace (FFM). The front of the Sentara Health Plans member ID card indicates FFM in the lower left corner of the card.

Product Funding Types

When the bottom of the member ID card shows "Administered by Sentara Health Plans, Inc." on the front or back of the card, it is an indicator that the plan is self-funded. These plans may also have employer-specific logos as well as the Sentara Health Plans name. Because medical costs are funded directly by the employer, employer-directed exceptions are common to these plans. Please check benefits on the provider portal or call Sentara Health Plans provider services to obtain plan specifics.

Commercial Product Information

The following tables show general information for commercial plan types currently offered by Sentara Health Plans. For plans with a deductible, the annual deductible does not apply to preventive care. Plan type offerings may vary by geographic location. Specific benefit information is available via the provider portal or by calling provider services.

HMO PLAN TYPES Underwritten by Sentara Health Plans		
All HMO Plan Types: • No referrals required. • Primary care provider (PCP) selection required. • No out-of-network coverage except emergency care. • Some services require prior authorization.		
Product Name	Description	Features
Sentara Vantage	standard HMO-type plan	• includes copayments with some services requiring coinsurance • may have deductibles

Sentara Vantage Equity/ Sentara Vantage HSA	• High Deductible Health Plan (HDHP) • includes a Health Savings Account (I) with most plans • HSAs administered by HealthEquity • HSAs funded and owned by the employee to help pay patient out- of-pocket expenses • debit card or I remit may indicate HealthEquity	• includes copayments • may have coinsurance • annual deductible
Sentara Vantage Design/ Sentara Vantage HRA	• HDHP • a Health Reimbursement Account (HRA) funded by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• includes coinsurance • some services may require copayments • annual deductible does not apply to preventive care

PPO PLAN TYPES
Underwritten by Sentara Health Plans

All PPO Plan Types:
- in-network and out-of-network coverage
- primary care provider (PCP) selection encouraged but not required
- no referrals required
- some services require prior authorization

Product Name	Description	Features
Sentara Plus	standard PPO	• includes copayments with some services requiring coinsurance • may have deductible

Sentara Plus Design/ Sentara Plus HRA	• High Deductible Health Plan (HDHP) • a Health Reimbursement Account (HRA) funded and owned by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• includes coinsurance • some services may require copayments • annual deductible
Sentara Plus Equity/ Sentara Plus I	• HDHP • a Health Savings Account (I) with most accounts administered by HealthEquity • accounts funded and owned by the employee to help pay patient out-of-pocket expenses • debit card or I remit may indicate HealthEquity	• includes copayments • may have coinsurance • annual deductible
POS (Point of Service) PLAN TYPES Underwritten by Sentara Health Plans		
All POS Plan Types: • no referrals required • primary care provider (PCP) selection required • includes an out-of-network benefit • some services require prior authorization		
Sentara POS	• operates similar to HMO Plans except includes out-of-network coverage at reduced benefit level similar to PPO • offers high deductible options with a Health Savings Account (I) or a Health Reimbursement Account (HRA) similar to HMO plans	• includes copayments with some services requiring coinsurance • may have deductibles
INDIVIDUAL AND FAMILY		

Sentara Individual & Family Health Plans	• healthcare purchased directly or through the health insurance marketplace by individuals
	• Plans are HMO:
	  ○ Sentara Gold
	  ○ Sentara Silver
	  ○ Sentara Bronze
		refer to information for plan purchased

	Cost Share Reduction Plans also available through the health insurance marketplace	
STRUCTURED NETWORKS		
Sentara Select Plans	a plan for individuals and families who live in the Charlottesville and Rockingham areas - Members receive services from a narrow network of facilities and practitioners s consisting of SQCN, VCU, Riverside, CHKD, TPMG, EVMS, and a few other select providers.	services received outside the network not covered except for emergency services
Sentara Direct Plans	a two-tiered network of doctors and providers for Richmond Metropolitan Statistical Area, Charlottesville, Halifax, Hampton Roads, Harrisonburg, Mecklenburg, and Rockingham area residents	members pay lower cost share when choosing provider in Tier 1 for a specific set of benefits

For plan information regarding Sentara Health Plans Medicaid program, Medicare HMO, or Sentara Community Complete, please reference the appropriate provider manual or provider manual supplement.

MEMBER IDENTIFICATION

Member ID Cards

Members receive identification cards for each enrolled member of the family. The card is for identification purposes only and does not verify eligibility or guarantee payment of services. Members should present their identification card at the time of service. The sample cards shown are representative of each of the Sentara Health Plans options. ID cards vary slightly due to specific differences between plans and employer groups.

Access sample member identification cards for Sentara Health Plans here:

Core Commercial Member ID Samples

Core Commercial Member ID Samples (COVA)

Eligibility Verification

Since a member's eligibility status may change, member coverage should be verified at the time of service. Providers may access the provider portal or call the Sentara Health Plans interactive voice response (IVR) system 24 hours a day, 7 days a week for the most current eligibility in Sentara Health Plans systems. Sentara Health Plans verifies coverage based on the most current data available from the employer/payer. Retroactive changes could alter the member's status; therefore, verification of eligibility **is not** a guarantee of payment.

To view eligibility information online, sign into the provider portal > Choose "view eligibility."

To use the IVR system, call provider services and press 2 to verify eligibility.

There are three options available to search for a member:

- Press 1 to enter the member ID number.
- Press 2 to enter Social Security number (SSN).
- Press 3 to enter Medicaid ID number.

The IVR system provides:

- The member ID number if an SSN or Medicaid number is used to search for the member.
- The member ID number if the member is disenrolled.
- The member's "eligible as of" or "terminated as of" date when applicable.
- The member's group number.

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

CREDENTIALING AND RECREDENTIALING

The information below is a summary of the standard Sentara Health Plans credentialing process. Access the complete credentialing and re-credentialing policy and procedures here.

The goals of the Sentara Health Plans credentialing/re-credentialing policy are to promote professional competency and to protect:

- the public from professional incompetence
- the organizations for which professionals work from liability
- the professionals from unfair or arbitrary limits on their professional practices
- the professionals at large from damage to their reputations and from loss of public respect
- the long tradition of the profession regarding self-governance

Scope

Practitioners who require credentialing as a condition of participation with Sentara Health Plans are physicians, optometrists, podiatrists, nurse practitioners, dentists, physician assistants, licensed midwives, psychologists, professional counselors, social workers, licensed behavior analysts, licensed assistant behavior analysts, licensed psychological associates (NC), licensed clinical addictions specialists (NC), and opioid-based treatment providers, as applicable by specialty.

Delegated Credentialing

If you are participating through an organization that has been approved and contracted to perform delegated credentialing, your credentialing process may differ somewhat from the process described in this manual. Please contact your group practice administrator for further information.

ARTS and MHS Organizations Contracting Approval

ARTS and MHS organizations that bill under a Type 2 NPI utilize specific licensures, corrective action plans, and prior audit review (LCAR) contracting approval processes. These organizations do not utilize the practitioner credentialing policy.

Marriage and Family Therapists and Mental Health Counselors

On January 1, 2024, CMS will recognize Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) as a new Medicare provider type. Payment for these services under Part B of the Medicare program will begin January 1, 2024. Contact the Behavioral Health Contract Manager assigned to your practice to determine if your agreement will need to be amended.

LTSS

Contracting and credentialing for LTSS are handled by Centipede/HEOPS. Centipede may be contacted by email at joincentipede@heops.com.

Initiating the Sentara Health Plans Credentialing Process if your practice/organization (tax ID) is out-of-network and is interested in participating with Sentara Health Plans, please complete the Request for Participation" form located here.

The Sentara Health Plans network management department determines if the provider meets minimum participation and/credentialing criteria. Applicants with a felony conviction, Office of Inspector General (OIG) sanction(s) or Excluded Parties List System (EPLS) sanctions will not be accepted.

Access the Sentara Health Plans Credentialing Packet:

- Medical Credentialing Documents
- Behavioral Health Credentialing Packet

Join the Network

- Behavioral health
- Medical

CAQH

The Sentara Health Plans credentialing process uses the Council for Affordable Quality Healthcare (CAQH) application exclusively for provider credentialing. Providers who do not currently have a CAQH application can complete the CAQH ID Request Form on the Provider Data Portal website listed below.

Contact Information for CAQH

Website: proview.caqh.org/Login/Index?ReturnUrl=%2f
CAQH Provider Help Desk: **1-888-599-1771** or email providerhelp@proview.caqh.org

Supporting Documents

In addition to the completed CAQH application, all providers must submit the following supporting documents to Sentara Health Plans or CAQH:

- copy of all current state medical licenses
- copy of DEA certificate
- copy of current malpractice insurance face sheet indicating amount of coverage:
    - In all states except Virginia, the coverage amount required under the applicable state law governing minimum medical malpractice coverage for providers. If the state does not have a requirement for minimum medical malpractice coverage, the provider must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year. Virginia providers must maintain coverage in amounts not less than the medical malpractice caps currently in effect under section 8.01-581 of the **Virginia Code**. Non-prescribing Sentara Health Plans behavioral health providers must

maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.

- copy of curriculum vitae (resume) that includes work history for the past five years
- copy of the Sentara Health Plans Authorization and Release Form. The provider signature/date must be current within 180 days (six months) of submission to Sentara Health Plans
- copy of completed Disclosure of Ownership and Control Interest Statement at the time of contracting/credentialing

Where applicable, providers should also submit:

- letter of explanation for any gaps in malpractice insurance
- letter of explanation for any gaps in work history of six months or longer in the past five years
- psychological testing application for licensed professional counselors
- neuropsychological testing application for licensed clinical psychologists
- copy of ECFMG certificate if foreign medical school graduate with ECFMG number noted in CAQH
- completed cross coverage form from covering provider if not within provider's practice
- copy of completed W-9 form if provider is not in an existing Sentara Health Plans contracted practice
- MHS application, as well as an application submitted through the behavioral health credentialing process, for licensed assistant behavioral analysts (ABAs) who bill via a type 2 organizational NPI

Credentialing Process

The Sentara Health Plans credentials analyst reviews all applications for completion. Incomplete applications will not be processed.

Verifications

The Sentara Health Plans credentialing department verifies with the primary source that the provider meets the Sentara Health Plans credentialing requirements for the following:

- verification of completion at the highest level of education: internship, residency, or fellowships for physicians, and other degrees as applicable, for nonphysicians
- verification of specialty board certification/eligibility
    - Accepted boards are as follows: American Board of Medical Specialties, American Osteopathic Association, American Board of Oral & Maxillofacial Surgery, American Board of Podiatric Surgery, American Board of Podiatric Medicine, the American Board of Dentistry, and the National Chiropractic Board.

Note: Sentara Health Plans may, at its sole discretion, waive the specialty board certification/eligibility requirement for applicants practicing in an area that is under-served in the applicant's specialty.

- verification of current professional liability insurance in amounts required by contracts for the past five years for physicians and two years for ancillary providers
- verification of all current state licensures and past state licensures

- verification of hospital privilege status at a participating hospital, if applicable, or proof of acceptable coverage arrangements with a participating physician
- verification of Medicaid participation in good standing, if applicable
- verification of Medicare participation in good standing, if applicable
- review of the OIG Sanction Report, HIPDB and EPLS for sanctions

After primary source verifications are complete, the application is presented to the Sentara Health Plans medical director for review and submission to the credentialing committee.

The medical director may request additional information or documentation prior to submission of the application to the credentialing committee for discussion and final committee decision. All committee approvals and denials are communicated in writing.

No provider will be denied network participation based upon gender, race, creed, ethnic origin, sexual orientation, age, disability, type of patients treated. Sentara Health Plans will not discriminate against the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. Additionally, providers will not be denied network participation based on their practice serving high-risk populations or specializing in the treatment of costly conditions.

After an application is approved for participation, providers are contacted by their network educator to inform them of the participation effective date. Sentara Health Plans complies with Virginia Law §38.2-3407.10:1 regarding payments to providers during the credentialing process.

Billing While Credentialing Is Pending for Commercial Plans

According to VA Law § 38.2-3407.10:1 of the Code of Virginia, Sentara Health Plans may reimburse providers for services rendered during the period in which their credentialing application is pending. An application is considered pending once the application has been deemed complete/clean by Sentara Health Plans to advance within the credentialing process. Reimbursement for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by Sentara Health Plans Credentialing Committee and subsequent provider record configuration in the Sentara Health Plans claims system. Claims for these services should be submitted to Sentara Health Plans after the provider receives notification that the SHP credentialing and configuration process is complete.

New provider applicants, to submit claims to Sentara Health Plans pursuant to the law, shall provide written or electronic notice to covered members in advance of treatment that they have submitted a credentialing application to Sentara Health Plans stating it is in the process of obtaining approval. More information on the recommendations on what to include in the notice can be found in our Doing Business with Sentara Health Plans Provider Guide or the Sentara Health Plans Credentialing Guide .

Re-credentialing

Practitioners are re-credentialed no less frequently than every 36 months and no more frequently

than every 12 months unless an issue is identified by the credentials committee that necessitates an earlier review. Sentara Health Plans contacts providers at the time of re-credentialing to initiate the process.

Confidentiality and Provider Rights

All credentialing information is maintained in a confidential manner. All parties involved in the Sentara Health Plans credentialing process sign a confidentiality agreement on an annual basis. The confidentiality agreement includes all credentialing documents, reports, and communications relating to practitioners. All credentialing documents are maintained by the credentialing department in a secure, locked environment.

An applicant has the right to review the information submitted in support of their application. The right to review information shall not require Sentara Health Plans to allow the applicant to review references, recommendations, or other information that is peer-review protected under the Health Care Quality Improvement Act.

An applicant has the right to correct erroneous information submitted by another party. In the event that information obtained from other sources varies substantially from that submitted by the applicant, the applicant will be notified of the discrepancies by the credentials analyst within 10 days of receipt of the conflicting information.

The applicant has five business days from the date of notice of the erroneous information to correct such information. Corrections must be submitted (in writing) to the Sentara Health Plans credentials analyst.

Credentialing For Facility and Ancillary Providers

Providers interested in participating with Sentara Health Plans should complete the "Request for Participation" form located here.

Sentara Health Plans Facilities and Ancillary Providers are required to hold certification and/or licensure appropriate to the services offered. The credentialing process begins after a determination has been made by Sentara Health Plans that there is a need for the provider to be added to the Network. At a minimum, the Sentara Health Plans Facility and Ancillary Credentialing and Re-Credentialing processes will:

- Be conducted at least every three years
- Confirm that the Provider is in good standing with state and federal regulatory bodies
- Confirm that the Provider has been reviewed and approved by an acceptable accrediting body
- Implement standards of participation for any Provider that has not been approved by an acceptable accrediting body and the process for assuring review of CMS' site audit.

Facilities and Ancillaries must provide Sentara Health Plans with copies of current accreditation certificates, Medicare certification survey results and state licensures, as applicable to each contracted Facility or Ancillary. In addition, completion of a Disclosure of Ownership and Control

Interest Statement is required.

Any Facility or Ancillary that does not hold the expected certification may be credentialed only after the Sentara Health Plans Quality Improvement department reviews the Certification Survey letter and copy of CMS-2567 (Statement of Deficiencies and Plan of Correction) issued by the applicable State survey organization.

Notice of Suspension Requirement

Any Facility or Ancillary that has its Medicare certification suspended due to cited deficiencies must notify their Sentara Health Plans Contract Manager immediately.

Accreditations and Certifications

Accreditations or certifications accepted by Sentara Health Plans are as follows**:**

Hospitals (Medical and Psychiatric)
- Joint Commission
- DNV Healthcare, Inc.
- HFAP (Healthcare Facilities Accreditation Program)

The only exception made for Hospital accreditation is when a Facility is newly opening. If the Hospital is initially open, documentation of patient safety plans and records from a state or federal regulatory body that has reviewed the Hospital must be forwarded to Sentara Health Plans. Full accreditation must be acquired within three years to continue the contract with Sentara Health Plans.

Home Health Agencies
- Joint Commission
- CHAP (Community Health Accreditation Program)
- ACHC (Accreditation Commission for Health Care)
- Medicare Certification (if not accredited)

Skilled Nursing Facilities/Nursing Facilities
- Joint Commission
- Medicare Certification (if not accredited)

Free Standing Ambulatory Surgery Centers (ASC)
- Joint Commission
- DNV
- AAAHC (Accreditation Association for Ambulatory Health Care)
- Medicare certification (if not accredited)

Sleep Studies Centers
- American Academy of Sleep Medicine (AASM)
- ACHC

All sleep labs must comply with Medicare guidelines and criteria as referenced in the Medicare Program Integrity for Independent Diagnostic Testing Facilities (IDTFs). Physicians must show evidence of proficiency which may be documented either by certification or criteria established by the carrier for the service area in which the IDTF is located.

Sentara Health Plans uses the AASM guidelines and credentials physicians who are board certified or eligible. Sleep technicians supervising sleep studies on Sentara Health Plans Members must be certified or enrolled in an approved program by the Board of Registered Polysomnographic Technologists (BRPT) or other pre-approved certification body. All sleep labs must maintain an appropriate level of patient to technician ratio of 2:1.

Other Provider Types

Please contact your Network Educator for credentialing requirements for any other type of Facility or Ancillary Provider.

Department of Medical Assistance Services (DMAS) ARTS Program (Addiction and Recovery Treatment Programs)

For more information regarding the ARTS Program, please see the Sentara Health Plans Medicaid Program Provider Manual.

DISCIPLINARY ACTION

The Sentara Health Plans credentialing committee is responsible for reviewing potential areas of corrective action and recommending disciplinary or corrective action for practitioners who fail to comply with their practitioner's agreement with Sentara Health Plans policies and procedures. Grounds for corrective action include:

- quality of care below the applicable standards
- a pattern of over/underutilization of services which is significantly higher/lower than other practitioners
- failure to comply with utilization management and quality improvement programs
- violation of the terms of the practitioner's agreement
- disruptive behavior, including but not limited to failure to establish a cooperative working relationship with Sentara Health Plans, making false statements to members or the public which discredit Sentara Health Plans, or abusive or abrasive behavior toward members of Sentara Health Plans or other participating practitioners' office staff
- falsification of information on documents submitted to Sentara Health Plans
- conviction of a felony
- licensure sanctions (including probation, suspension, supervision, and monitoring)
- loss of DEA certification
- sanction or exclusion from government health programs, including Medicare and Medicaid
- failure to maintain required malpractice insurance coverage

The Sentara Health Plans credentialing committee may recommend the following actions as applicable:

- summary suspension
- termination of participation
- probationary participation status
- mandatory attendance at continuing education courses if the quality of care is deficient but not deficient enough to warrant immediate termination
- concurrent review by the Sentara Health Plans medical director or designee of the care rendered by the disciplined practitioner
- other actions as determined by the committee
- summary suspension of the practitioner's clinical privileges may occur without prior investigation or hearing whenever:
    - immediate action is deemed necessary in the interest of patient care or safety or the orderly operation of Sentara Health Plans
    - practitioner is convicted of a felony

The National Practitioner Data Bank (NPDB) and the State Board of Medicine or State Board of Nursing will be notified in accordance with legal requirements regarding any quality issues, limitation in participation, or termination when determined by Sentara Health Plans.

Access the Right to a Fair Hearing and Appellate Review Policies and Procedures found here.

Provider Directory Information

Provider contact and availability information in the Sentara Health Plans online and print directories is the primary source for members to access medical care. It is important to notify Sentara Health Plans of any changes to maintain member access. Centers for Medicare & Medicaid Services (CMS) audits Sentara Health Plans information to confirm that only practice locations where providers routinely see patients and only specialties in which providers are currently taking appointments are listed. Except for emergencies, providers must notify Sentara Health Plans in advance of closing their practice to new patients. Prior notice of termination is required in writing for member notification and in accordance with the terms of the provider agreement. Participation in CMS-mandated directory information audits performed by Sentara Health Plans is required.

Provider Data Accuracy

Sentara Health Plans ensures that data received from providers are accurate and complete by:

- Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments.
- Screening the data for completeness, logic, and consistency.
- Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts.
- Making all collected data available to DMAS and upon request to CMS.

Patient Appointment Access Guidelines

Access to care is recognized as a key component of quality care. As a condition of participation, providers must provide covered services to members on a 24 hour per day, 7 day per week basis, in accordance with Sentara Health Plan's standards for provider accessibility including, if applicable, call coverage or other back-up, or arrange with an in-network provider to cover patients in the provider's absence. Providers may direct the member to go to an emergency department for potentially emergent conditions and this may be done via a recorded message. Appointment access standards for commercial (HMO/POS/PPO) plans:

Service	Sentara Health Plans Commercial Standards
Emergency appointments, including crisis services	Must be made available immediately upon the member's request
Urgent appointments	Must be made within 24 hours of the member's request

Routine primary care	Must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days; or for routine specialty services like dermatology, allergy care, etc.
Maternity care – first trimester	Must be made within seven calendar days of request
Maternity care – second trimester	Must be made within seven calendar days of request
Maternity care – third trimester	Must be made within three business days of requests
Maternity care – high-risk pregnancy	Must be made within three days of high-risk identification, or immediately if an emergency exists
Postpartum	Must be made within 60 days of delivery
Mental health services	Appointment availability must be no more restrictive than for medical conditions
LTSS	Must be made as expeditiously as the member's condition requires and within no more than five business days from Sentara Health Plans' determination that coverage criteria are met

Appointment access standards for Medicare plans:

Service	Sentara Health Plans Medicare Standards
Urgently needed services or emergency	Must be made immediately
Services that are not emergency or urgently needed, but the member requires medical attention	Must be made within seven business days

Routine and preventive care	Must be made within 30 business days

Please see the Sentara Health Plans Medicaid Program Provider Manual for the Medicaid program appointment access standards.

Continuity and Coordination of Care

Sentara Health Plans strives to ensure that all members receive the highest quality of care. Ongoing collaboration between primary care providers (PCPs) and specialists and behavioral health providers, as well as between PCPs and other types of providers, promotes a continuous plan of care that benefits the member. Other types of providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, and may include providers for ARTS, mental health services (MHS) providers, and long-term services and supports (LTSS) providers.
The Sentara Health Plans policy monitors and identifies potential problems with continuity and coordination of care for all of our members. Information on continuity and coordination of care is collected at the time of HEDIS chart reviews. Sentara Health Plans also monitors continuity and coordination through transitions in care (changes in management of care between providers, changes in settings, or other changes in which different providers become active or inactive in providing ongoing care for a patient).
If a provider leaves the provider network, except for cause, the member may have continued access to that provider under the following circumstances:

- Members undergoing active treatment for a chronic or acute medical condition have access to their discontinued provider through the current period of active treatment or up to 90 calendar days, whichever is shorter.
- Members in their second or third trimester of pregnancy have access to their discontinued provider through the postpartum period.
- Members who are receiving care directly related to the treatment of a terminal illness have access to their discontinued provider for the remainder of their life.

If the PCP terminates in a plan that requires a PCP, notice is sent to the member by Sentara Health Plans at least 30 days prior to the PCP termination with the assignment of a new PCP stated in the letter. Members have the option of changing to another PCP if they desire.
Within 15 days of receiving notice that a specialist practice is terminating, Sentara Health Plans sends notification of the pending termination to all members who have been seen by the specialist's practice within the past 12 months.

Culturally Competent Care

Delivery of culturally competent care allows healthcare providers to appropriately care for and address healthcare concerns to include belief and value systems of patients with diverse cultural and linguistic needs. To promote health equity, Sentara Health Plans providers should ensure services are provided in a culturally competent manner to all members, including the following populations:

- members with limited English proficiency or reading skills

- ethnic, cultural, racial, or religious minorities
- members with disabilities
- members identifying as lesbian, gay, bisexual, or other diverse sexual orientation
- members identifying as transgender, nonbinary, or other diverse gender identities
- members living in rural areas and other areas of high levels of deprivation
- members adversely affected by persistent poverty or inequality

Providers are encouraged to:

- build rapport by providing respectful care
- determine if the member needs an interpreter or translation services
- remember that some cultures have specific beliefs surrounding health and wellness
- ensure that the member understands diagnosis, procedures, and follow-up requirements
- offer health education materials in languages that are common to your patient population
- be aware of the tendency to unknowingly stereotype certain cultures
- ensure staff is receiving continued education in providing culturally competent care

Providers are encouraged to complete Cultural Competency Training. Online training is available in the provider support section of the Sentara Health Plans website located here.

Continuing Medical Education (CME) credits are available. Upon completion of the training, providers should complete the Provider Acknowledgement Form for cultural competency to receive credit. The Sentara Health Plans provider directory displays cultural competence as a feature on all provider profiles, informing members which providers have completed the training.

QUALITY IMPROVEMENT

Sentara Health Plans, through its commitment to excellence, has developed a comprehensive program directed toward improving the quality of care, safety, and appropriate utilization of services for our members. The Quality Improvement (QI) program is designed to implement, monitor, evaluate, and improve processes within the scope of our health plan on a continuous basis to improve the health of our members every day**.** Sentara Health Plans providers are required to comply with the QI program.

NCQA Accreditation

As part of our commitment to quality, Sentara Health Plans voluntarily participates in the accreditation process administered by the National Committee for Quality Assurance (NCQA). NCQA is a private, nonprofit organization dedicated to improving healthcare quality. NCQA accredits and certifies a wide range of healthcare organizations. It also recognizes clinicians and practices in key areas of performance. NCQA is committed to providing healthcare quality information for consumers, purchasers, healthcare providers, and researchers.

HEDIS®[1]
Healthcare Effectiveness Data and Information Set (HEDIS) is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer

service. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare healthcare quality. HEDIS performance measures are a part of the NCQA accreditation process. Some of the major areas of performance measured by HEDIS are:

- effectiveness of care
- access/availability of care
- experience of care
- utilization and risk-adjusted utilization
- health plan descriptive information
- measures reported using electronic clinical data systems

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

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are adopted to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. Sentara Health Plans adopts and disseminates CPGs relevant to its membership for the provision of health, acute and chronic medical services, and for preventive and non-preventive behavioral health services. All clinical or preventive health practice guidelines that are adopted or developed are:

- Based on valid and reliable clinical evidence-based practices, or a consensus of healthcare professionals in the respective field.
- Consider the needs of the members.
- Reviewed and updated, at minimum, every two years, as applicable.
- Disseminated to practitioners and members annually.
- Provide a basis for utilization decisions, member education, and service coverage.

Sentara Health Plans ensures network providers utilize appropriate evidenced-based clinical practice guidelines through web technology, use of electronic databases, and manual medical record reviews, as applicable, to evaluate appropriateness of care and documentation. A modified approach to the utilization of clinical practice guidelines and nationally recognized protocols may need to be taken to fit the unique needs of all beneficiaries.

These medical and behavioral health guidelines are based on published national guidelines, literature review, and the expert consensus of clinical practitioners. They reflect current recommendations for screening, diagnostic testing, and treatment. These guidelines are published by Sentara Health Plans as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these guidelines. The Sentara Health Plans guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment. Copies of clinical guidelines are available via mail, email, or fax. To request a printed copy of the health plan's CPGs, please contact the Member Safety department at 757-252-8400 or toll free at 1-844-620-1015. CPGS are also available online via the health plan's website.

Sentara Health Plans Member Safety/Quality Improvement (QI) Program

The goal of the QI Program is to ensure member safety and the delivery of high-quality medical and behavioral healthcare. The QI Program concentrates on evaluating both the quality of care offered and the appropriateness of care provided.

The goal of continuously improving the quality of care provided is to improve the overall health status of our members. The measurement of improvement of health status can be demonstrated by health outcomes. Sentara Health Plans is committed to improving the communities where our members live through participation in public health initiatives on the national, state, and local levels and the achievement of public health goals.

This continuous assessment uses quality improvement methodologies such as Six Sigma, Root Cause Analysis, and Plan, Do, Study, Act (PDSA). The QI Program is a population-based plan that acts as a road map in addressing common medical problems identified within our population. The Sentara Health Plans QI Program activities include the elements of:

- identification of performance goals
- internal and external benchmarks
- data collection and establishment of baseline measurements
- barrier analyses, trending, measuring, and analyzing
- development and implementation of corrective interventions, as needed

The Sentara Health Plans QI Program is designed to monitor, assess, and continuously advance care and the quality of services delivered. The scope of the QI Program is integrated within clinical and non-clinical services provided for the Sentara Health Plans members. The program is designed to monitor, evaluate, and continuously improve the care and services delivered by contracted practitioners and affiliated providers across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient, and transitional settings and is designed to resolve identified areas of concern on an individual and system-wide basis.

The QI Program will reflect the population served in terms of age groups, disease categories, special risk statuses, and diversity. The QI Program includes monitoring of community-focused programs, practitioner availability and accessibility, coordination and continuity of care, and other programs or standards impacting health outcomes and quality of life.

The scope of the QI Program includes oversight of all aspects of clinical and administrative services provided to our members, to include:

- program design and structure
- quality Improvement activities that comply with CMS, NCQA, DMAS, and other regulatory entities
- care management (to include complex case management, behavioral health, care transitions and end of life planning) and chronic care management programs that are member-centric focused and address the healthcare needs of members with complex medical, physical, and mental health conditions, assessments of drug utilization for appropriateness and cost-effectiveness
- utilization management focus on providing the appropriate level of service to members

- grievances and appeals
- high-quality customer service standards and processes
- benchmarks for preventive, chronic, and quality of care measures
- credentialing and re-credentialing of physicians, practitioners, and facilities
- compliance with NCQA accreditation standards
- audits and evaluations of clinical services and processes
- development and implementation of clinical standards and guidelines
- measuring effectiveness
- evidenced-based care delivery
- potential quality of care and safety concerns

Each year, Sentara Health Plans develops a Member Safety Quality Program Description, Annual Evaluation, and Work Plan that outlines efforts to improve clinical care and service to members. Providers may request a copy of the current Quality Program Description and Annual Evaluation by calling the Network Management Department. Information related to QI initiatives is also available on the provider website and in provider newsletters.

The Sentara Health Plans Quality Program Description, Annual Evaluation, and Work Plan is a comprehensive document or a set of documents that serves our culturally diverse membership. It describes, in plain language, the QI program's governance, scope, goals, measurable objectives, structure, responsibilities, annual work plan, and annual evaluation.

The primary objective of Sentara Health Plan's QI Program is to continuously improve the quality of care provided to members to enhance the overall health status of the members. Improvement in health status is measured through HEDIS® information, internal quality studies, and health outcomes data with defined areas of focus. Sentara Health Plans has defined objectives to support each goal in the pursuit of improved outcomes.

The following are identified functions of the QI Program:

- provide the organization with an annual Quality Program Description, Quality Annual Evaluation, and Quality Work Plan
- coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing, and other related functions managed at the plan level or delegated to vendor organizations
- identify and develop opportunities and interventions to improve care and services
- identify and address instances of substandard care including member safety
- monitor, track, and trend the implementation and outcomes of quality interventions
- evaluate effectiveness of improving care and services
- oversee organizational compliance with regulatory and accreditation standards
- improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into the primary care practices
- promote collaboration between the QI and Population Health Programs
- report relationships of QI Department staff and the QI Committee and sub-committee structure
- provide resource and analytical support

- delegate QI activities, as applicable
- collaborate interdepartmentally for QI-related activities
- outline efforts to monitor and improve behavioral healthcare and the role of designated behavioral healthcare practitioners in the QI Program
- define the role of the designated physician within the QI program, which includes participating in or advising the QI Committee or a subcommittee that reports to the QI Committee
- define the role, function, and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities (e.g., clinical subcommittees, ad hoc task forces, or multidisciplinary work groups or subcommittees)
- describe practitioner participation in QI committee and how participating practitioners are representative of the specialties in the organization's network, including those involved in QI subcommittees outline the organization's approach to address the cultural and linguistic needs of its membership
- provide guidance on how to report member critical incidents (inclusive of quality of care, quality of service, and sentinel events)
- provide training materials for providers and organization employees on cultural competency, bias, and/or diversity and inclusion
- utilize performance measure data for continuous quality improvement (CQI) activities

Goals of Quality Improvement Program

One of the primary goals of the Sentara Health Plans Quality Improvement (QI) Program is to achieve a five-star rating from NCQA by ensuring the delivery of high quality culturally competent healthcare, particularly to members with identified healthcare disparities. Our healthcare modalities will emphasize medical, behavioral health, and pharmaceutical services. The QI Program concentrates on evaluating both the quality of care offered and the appropriateness of care provided. These goals allow Sentara Health Plans to:

- reduce healthcare disparities in clinical areas
- improve cultural competency in materials and communications
- improve network adequacy to meet the needs of underserved groups
- improve other areas of needs the organization deems appropriate
- include a dynamic work plan that reflects ongoing progress on QI activities throughout the year
- plan QI activities and objectives for improving quality and safety of clinical care, quality of service, and member experience
- establish time frames for QI activity completion
- determine staff members responsibility for each activity
- monitor previously identified issues
- evaluate effectiveness of the QI Program's Annual Evaluation by comparing performance measure outcomes
- continuously meet organization's mission
- continuously meet regulatory and accreditation requirements
- create a system of improved health outcomes for the populations served
- improve the overall quality of life of members through the continuous enhancement of

comprehensive health management programs including Performance Improvement Projects
- make care safer by reducing variation in practice and enhancing communication across the continuum
- strengthen member and caregiver engagement in achieving improved health outcomes
- ensure culturally competent care delivery through practitioner cultural education including provision of information, training, and tools to staff and practitioners to support culturally competent communication

For hard copies or information about the QI Program, at Sentara Health Plans, please contact the member safety QI department at 757-252-8400 or toll-free 1-844-620-1015.

Critical Incident Reporting

A critical incident is defined as any actual, or alleged, event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of the member. Critical incidents are categorized as either quality of care incidents, sentinel events or other critical Incidents as defined below:

- Quality of care incident is any incident that calls into question the competence or professional conduct of a healthcare provider while providing medical services and has adversely affected, or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as sentinel events.
- Sentinel event is a patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the Member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof. All sentinel events are critical incidents.
- Another critical incident is an event or situation that creates a significant risk to the physical or mental health, safety, or well-being of a member not resulting from a quality-of-care issue and less severe than a sentinel events.

Providers must report critical incidents that occur during:

- the provision of services to members in nursing facilities, inpatient behavioral health or HCBS settings, hospital, PCP, specialist, transportation, or other healthcare setting
- participation in or receipt of mental health services, ARTS, or services in any setting (e.g., adult day care center, a members' home, any other community-based setting)

<u>Reportable Critical Incidents:</u>

- abuse
- attempted suicide
- deviation from standards of care
- exploitation, financial or otherwise
- medical error
- medication discrepancy
- missing person

- neglect
- sentinel death
- serious injury (including falls that require medical evaluation).
- theft
- other

Provider-Preventable Conditions and Services (Never Events)

A provider-preventable condition (PPC) means a condition that meets the definition of a "healthcare-acquired condition" or an "other provider-preventable condition" including, but not limited to:

- wrong surgical or other invasive procedure performed on a patient
- surgical or other invasive procedure on the wrong body part
- surgical or other invasive procedure performed on the wrong patient
- other conditions found to be reasonably preventable through the application of procedures supported by evidence-based guidelines

Serious Reportable Events

Events that are clearly identifiable and measurable, usually preventable, and are serious in their consequences such as resulting in death or loss if a body part, injury more than transient loss of a body function or assault. These events are adverse in nature and represent a clear indication of a healthcare provider's lack of safety systems. Serious reportable events (SREs) focus on the following areas:

Examples of SREs include, but not limited to, the following:

- death (patient suicide, attempted suicide, homicide, and/or self-harm while in a healthcare setting)
- falls (resulting in death or serious injury while being cared for in a healthcare setting)
- pressure ulcers that are unstageable or stage III or IV acquired post admission/presentation to a healthcare setting
- patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- restraint use (physical restraints or bedrails) that results in death, require hospitalization, or result in loss of function
- patient death or serious injury associated with patient elopement (disappearance) while being cared for in a healthcare setting
- abuse/assault on a patient or staff member on healthcare facility grounds

For a comprehensive list of Serious Reportable Events, please visit this link.

Abuse, Neglect, or Exploitation

Mandated reporters are persons who are identified in the Code of Virginia as having a legal responsibility to report suspected abuse, neglect, and exploitation. As defined by the Code of Virginia § 63.2-1606:

- any person licensed, certified, or registered by health regulatory boards listed in Code of Virginia § 54.1-2503, except for persons licensed by the Board of Veterinary Medicine
- any mental health services provider as defined in § 54.1 -2400.1
- any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5
- any guardian or conservator of an adult
- any person employed by, or contracted with, a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity

Procedures/Guidelines

Sentara Health Plans requires all network and/or affiliated providers to report Critical Incidents within 24 hours of discovery. The initial report of an incident may be submitted verbally within the 24-hour period but must be followed-up with a written report within 48 hours. If the Critical Incident includes notifying APS/CPS, the following numbers may be used for either Adult or Child Protective Services:

Adult Protective Services (APS): 1-888-832-3858
Child Protective Services (CPS): 1-800-552-7096

Notify Sentara Health Plans of a Critical Incident either by phone, fax, or email within 24 hours of knowledge of incident. Contact information can be found in the **"Sentara Health Plans Key Contacts"** section.

Sentara Health Plans requires network and/or affiliated providers to report critical incidents via the Critical Incident Reporting form located on the health plan website.

Office Site Reviews

Any complaint regarding physical accessibility, physical appearance, and/or adequacy of waiting and/or examining room space that is received regarding a Sentara Health Plans participating provider is reviewed by the Sentara Health Plans medical director. The network educator schedules a site visit with the office within 60 days of the complaint when the medical director determines that a site visit is appropriate. The office site review tool will be utilized for the review, and a letter with the results of the review will be sent to the provider within 10 calendar days of the site visit. If issues are found during the site visit, a corrective action plan may be initiated, per the Sentara Health Plans site visit policy.

Medical Record Documentation Standards

Sentara Health Plans may request medical records for review. Listed below are the current medical record standards:

- A Current active problem list must be maintained for each member. It should be legible

and updated as appropriate. Significant illnesses and chronic medical conditions must be documented on the problem list. If there are no identified significant problems, there must be some notation in the progress notes stating that this is a well-child/adult visit.

- Allergies and adverse reactions must be prominently displayed. If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record. A sticker or stamp noting allergies/NKA on the cover of the medical record is acceptable.
- Past medical history (for patients seen three or more times) must be easily identified and include family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illnesses.
- Each page of the medical record contains the patient's name or ID number. All entries are dated. Working diagnoses and treatment plans are consistent with medical findings.
- All requested consults must have return reports from the requested consultant or a phone call follow-up must be noted by the PCP in the progress note. Any further follow-up needed or altered treatment plans should be noted in progress notes. Consultations filed in the chart must be initialed by the PCP to signify review. Consultations submitted electronically need to show representation of PCP review.
- Continuity and coordination of care among all providers involved in an episode of care, including PCP and specialty providers, hospitals, home health, skilled nursing facilities, and free-standing surgical centers, etc., must be documented when applicable.
- There should be documentation present in the records of all adult patients (emancipated minors included) that advance directives have been discussed. If the patient does have an advance directive, it should be noted in the medical record. A copy of the advance directive should be present in the record.
- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a nonpublic area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy practices.
- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 years and older. Referrals to a behavioral health specialist should be documented as appropriate.
- Records should indicate that preventive screening services are offered in accordance with Sentara Health Plans' preventive health guidelines. This should be documented in the progress notes for adults 21 years and older.

Behavioral Health Medical Record Documentation Standards

Medical records may be audited according to Sentara Health Plans' behavioral health treatment record documentation guidelines that incorporate accepted standards for medical record documentation as shown below:

- history of present illness
- psychiatric history
- substance use assessment
- mental status examination
- diagnosis (all five axes)
- medical history, including allergies and adverse reactions (physicians only)

- medication management (physicians only)
- allergies and adverse reactions to medications
- treatment planning
- risk assessment
- evidence of continuity of care
  - documentation of collaboration with the member's primary care provider (PCP) in medication and treatment rendered or documentation of the member's refusal to consent to same.
  - after obtaining the patient's informed consent prior to the release of information, the provider is expected to notify the PCP when the member presents for an initial behavioral health evaluation and continued treatment, including significant changes in the patient's condition, changes in medication, and termination of treatment.

Confidentiality of clinical information relevant to the patient under review should be contained in the record or in a secure computer system, stored and accessible in a nonpublic area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy. Patient information should be in chronological or reverse chronological order and in a consistent, logical format.

Medical Record Policies

Participating providers must treat all communications and records pertaining to the member's healthcare as confidential, and no records may be released without the written consent of the member or as otherwise permitted by state or federal law. In the case of an unemancipated minor, the release of information requires the authorization of the legal guardian unless otherwise permitted by law. Healthcare providers are required to accept a photocopy, facsimile, or other copy of the original document signed by the patient providing authority for the requester to obtain the records, as if the copy were an original document. Participating providers must obtain a separate release of Information, or waiver, from those members with certain conditions, such as sexually transmitted diseases. **Providers must fulfill medical record requests as soon as possible but no later than 10 calendar days of the date of the record request.**

Charging for copies of records:

Participating providers **may not** charge Sentara Health Plans for copies of medical records or for the completion of forms. Failure to comply may result in not meeting contractual and regulatory obligations.

Retention of Medical Records:

- Providers must maintain records as required by applicable state or federal law.
- Subject to applicable law, if a provider practice or facility is sold, the medical records go with the sale, but the selling provider must notify its patients in writing that it is selling its facility or practice and must state where the records will be located. Providers must also ask patients if they wish to receive their records.
- If the practice or facility is being closed, medical records must be maintained in accordance with the applicable state statute.
- Providers are advised to contact their malpractice insurance carrier to see if they have any

additional stipulations regarding medical record retention.

Advance Directives

Sentara Health Plans provides members with information related to advance directives, living wills, appointment of a healthcare agent, and organ donation and anatomical gift designation in compliance with the Patient Self-Determination Act and the applicable state law requiring any service provider to inform adult patients about the laws concerning the patient's rights to accept or refuse care and the right to make advance directives about their care.

Access Advance Care Planning information for Virginia and North Carolina providers from the Sentara Center for Healthcare Ethics here.

Additional QI Information

To request a copy of HEDIS Performance Measures for Sentara Health Plans, request a hard copy of our clinical guidelines, or ask questions concerning the QI process, please contact the quality improvement department. Current information on HEDIS measures, clinical guidelines, and preventive health guidelines is available to providers online on the provider website.

OFFICE VISIT/ENCOUNTER PROCEDURES AND MEMBER RESOURCES

Member Visit/Encounter Procedure

- Members should present their member ID card and another form of identity verification (e.g., driver's license).
- The provider's staff should check the card for eligibility and benefits and make a copy of the card for the member's record.
- In an emergency, treatment should proceed without question of eligibility or coverage. Eligibility verification can be obtained as soon as appropriate after treatment.
- The provider's staff should confirm that an authorization has been received if necessary.
- Provider's staff may access the provider portal anytime or call provider services during business hours for verification if a member's status is in question.

Copayments, Coinsurance and Deductibles

- Check the member's ID card to determine if there is a copayment due for the specific service rendered. Copayments vary depending on services provided and the member's plan benefits. Some plans do not have copayments. Collect the appropriate copayment from the member.
- The suggested best practice is for providers to submit the claim to Sentara Health Plans first and utilize the Sentara Health Plans remittance to determine the amount due from the member. This process avoids over collecting from members and the additional paperwork and cost of refunding overpayments.
- The member should not pay more than the contracted rate of the service rendered. If the copayment amount is more than the contracted rate for the service, the member pays the lesser amount of the contracted rate and not the copayment amount.
- A copayment should only be collected for services that are reimbursable under the member's plan.
- Copayments vary depending on services provided and the member's plan benefits. Some plans do not have copayments.
- Members are responsible for the full plan-contracted allowable amount for applicable visits until their deductible is met if their plan has a deductible.
- Once the deductible is met, members that have plans with coinsurance are responsible for the appropriate coinsurance (percentage of the contracted allowable charge for the visit) unless the member's plan has a reimbursement account funded by the employer to help pay out-of-pocket expenses directly to the provider.
- Providers may elect to collect at the time of service when the member has not yet met their deductible. The amount of the deductible and whether the member has met a portion, or all of the deductibles are available through the provider portal or by calling Sentara Health Plans provider services. Member responsibility information will be correct as of the time of an inquiry, but if other claims are received and processed before your claim is received and processed, member responsibility could change.
- Providers must reimburse the member any amount collected more than the member's responsibility within 30 days.

- When Sentara Health Plans is the secondary insurance carrier:
    - Do not collect the copayment if the primary payer does not have a deductible.
    - Do not collect the copayment if the member has met the deductible of the primary payer.
    - Collect the copayment if the member has not met the primary payer's deductible.
- Members are notified when they reach their max out-of-pocket (MOOP) and providers should not collect a copayment or coinsurance. It is the responsibility of the provider to refund the member any coinsurance or copayment paid while the member is in the MOOP. Providers agree to assist Sentara Health Plans to document refunds as part of Sentara Health Plans internal audits, or any audit by a state or federal regulatory body.

Members Rights and Responsibilities

The Member Rights and Responsibilities document assures that all Sentara Health Plans 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. Each Sentara Health Plans product has a specific Member Rights and Responsibilities document that is provided to members at the time of enrollment. The Member Rights and Responsibilities are similar for all Sentara Health Plans products but have slight variations based on variations in the product and the members served by that product. The Member Rights and Responsibilities listed below apply to Sentara Health Plans commercial product members (HMO/POS/PPO/Individual). The specific lists of Member Rights and Responsibilities for the other Sentara Health Plans products (Sentara Medicaid program and Sentara Medicare) are provided in the specific provider manual or provider manual supplement for each product.

Commercial Members

Sentara Health Plans members have the right to:

<u>Timely and Quality of Care</u>

- access to protected health information (PHI), medical records, physicians, and other healthcare professionals and referrals to specialists when medically necessary
- continuity of care and to know in advance the time and location of an appointment as well as the physicians and other healthcare professionals providing care
- receipt of the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- participation with physicians and healthcare professionals in:
    - their condition, regardless of cost or benefit coverage
    - the right to affirm that all practitioners, providers, and employees who make utilization management (UM) decisions
    - discussing their diagnosis, the prognosis of the condition, and instructions required for follow-up care
    - understanding the health problems and assisting to develop mutually agreed-upon goals for treatment
    - decision-making regarding their healthcare and treatment planning
    - a candid discussion of appropriate or medically necessary treatment options for

their base decisions on appropriateness of care, services, and existence of coverage

- the right to affirm that all practitioners, providers, and employees who make utilization management (UM) decisions:
    - are not rewarded for issuing medical denials of coverage
    - do not encourage decisions that result in underutilization through financial incentives

Treatment With Dignity and Respect — Members will:

- be treated with respect, dignity, compassion, and the right to privacy
- 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. Expect this right by both Sentara Health Plans and contracting providers
- expect protection of all oral, written, and electronic information across Sentara Health Plans and information to Sentara Health Plans sponsors and employers
- extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding medical care
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- be able to refuse treatment or to sign a consent form if the member feels they do not clearly understand its purpose, cross out any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent, as well as be informed of the medical consequences of this action

Receive Health Plan Information — Members will:

- receive information about their health plan; its services; its physicians; other healthcare professionals; facilities; clinical guidelines and member rights and responsibilities statements; and the collection, use, and disclosure of PHI
- know by name, title, and organization the physicians, nurses, or other healthcare professionals providing care
- receive information about medications (what they are, how to take them, and possible side effects) and pharmacy benefit information (effective date of formulary change, new drugs available, or recalled medications)
- receive clear information regarding benefits and exclusions of their policy, how medical treatment decisions are made/authorized by the health plan or contracted medical groups, payment structure, and the right to approve the release of information
- be advised if a provider proposes to engage in experimentation affecting care or treatment. The member may have the right to refuse to participate in such research
- be informed of policies regarding advance directives (living wills) as required by state and federal laws

Members Solve Problems in a Timely Manner by:

- presenting questions, concerns, or complaints to a customer service specialist without discrimination and expecting problems to be fairly examined and appropriately addressed
- voicing concerns or complaints to Sentara Health Plans about their health plan if the care provided was inadequate or they feel their rights have been compromised, including the right to appeal an action or denial and the process involved
- making recommendations regarding Sentara Health Plans members' rights and responsibilities

Member Responsibilities

Sentara Health Plans members, in addition to their rights, subscribers and their enrolled dependents will:

- identify themselves and their family members as Sentara Health Plans enrollees and present their identification card(s) when requesting healthcare services
- be on time for appointments and contact the physician or other healthcare personnel at once if there is a need to cancel or if they are going to be late for an appointment
    - If the physician, other healthcare personnel, or facility has a policy assessing charges regarding late cancellations or "no shows," the member will be responsible for such charges.
- provide information about their health to physicians and other healthcare professionals so they may provide appropriate medical care
- actively participate and understand improving their health condition(s) by following the plans and instructions for care and treatment goals that they agreed upon with the physician or healthcare professional
- act in a manner that supports the care provided to other patients and the general functioning of the office or facility
- review the employee handbook and plan documentation:
    - to make sure the services are covered under Sentara Health Plans
    - to approve release of information and have services properly authorized before receiving medical attention
    - to follow proper procedures for illness before and after business hours
    - for materials concerning health benefits (e.g., UM issues) and educate other covered family members
- accept financial responsibility for any copayment or coinsurance associated with services received while under the care of a physician or other healthcare professional or while a patient at a facility
- contact Sentara Health Plans if they have concerns or if they feel their rights have been compromised

Special Needs Members

Sentara Health Plans will use all reasonable means to facilitate healthcare services for members with physical, mental, language, and/or cultural barriers. To ensure the needs of members with physical, mental, language, and/or cultural barriers are properly accommodated, members with special needs should be instructed to call member services at the number on the back of their

member ID card. Members are notified of these services in their member materials (handbook). If a member services representative needs assistance in accommodating the member, the representative may contact clinical care services (CCS) for additional resources and assistance.

Sentara Health Plans provides appropriate auxiliary aids and services, including interpreters and information in alternative formats, to individuals with impaired sensory, manual, or speaking skills where necessary to ensure equal opportunity to benefits. Communication services for Sentara Health Plans members, potential members, and their companions/family members are provided through a contracted vendor.

Providers requesting translation services should contact provider services to arrange for the member to obtain a hard copy of the material in the primary non-English language or alternative format. The material will be provided on a standing basis, unless otherwise indicated by the member.

Providers should handle interpreter services as follows:

Sentara Health Plans Commercial and Medicare Advantage Members:

Providers are responsible for coordination and payment of interpreter services for their patients, if necessary, as directed by the Americans with Disabilities Act (ADA) and the Civil Rights Act of 1964. Providers can contact Sentara Health Plans provider services for assistance in coordinating (but not reimburse for) interpreter services.

Sentara Health Plans Medicaid Program Members:

Providers are to contact Sentara Health Plans provider services for interpreter services. Interpreter services for the Sentara Health Plans Medicaid program for members are coordinated and reimbursed by Sentara Health Plans as required by the Virginia Department of Medical Assistance (DMAS). Auxiliary aids and services are available upon request and at no cost for members with disabilities.

Providers are required to notify Sentara Health Plans of their office(s) ADA accessibility status for every office location for Sentara Health Plans to meet requirements for display of ADA access in provider directories.

Members who require special services (e.g., substance abuse, childbirth classes, smoking cessation) may have these services arranged by Sentara Health Plans to ensure access to such services.

Essential Community Providers

Sentara Health Plans contracts with available essential community providers (ECPs), such as federally qualified health centers, rural health centers, community health centers, and Indian healthcare providers.

PRIMARY CARE PROVIDER (PCP)

Primary Care Provider Panels

Primary care providers (PCPs) are required to accept an average of 350 members across all Sentara Health Plans with which they participate before closing their panels to new members. In addition, providers are required to accept current patients who convert to Sentara Health Plans coverage even if they have reached the 350-member average.

Notification from the provider practice is required for any network panel status change. All changes will become effective 60 days after the receipt of the notice. Any member who selects the PCP prior to the effective date of the panel limitation will be paneled to that PCP.

The provider's office will receive a written response by email or letter acknowledging receipt of the notification, confirming the provider's intentions, and informing the provider of the effective date of the panel status change.

PCP Panel Status Options:

- open and accepting new members
- not accepting new patients; provider will continue to provide services for established patients, siblings, and spouses switching plans
- (pediatrics) provider is not accepting new patients; provider will accept established patients, newborns, and their siblings
- age restriction
- covering provider only

Patients who have seen the provider within the past two years are considered established patients by Sentara Health Plans.

Guidelines for Removing a Member from a PCP Panel

Providers may request that Sentara Health Plans assist members in selection of another PCP when the members demonstrate any of the following behaviors:

- failure to pay required copayments
- abusive behavior
- noncompliance with provider treatment plan
- failure to establish a provider-patient relationship

Upon notification of these behaviors, member services will counsel the member and assist with the selection of a new PCP.

The procedure for removing a member from a providers panel is as follows:

1. Send a certified letter to the member and state the reason for asking him/her to be re-paneled to another provider. State in the letter that the member has 30 days to select a new provider. Inform the member that his/her medical care will continue to be rendered for

the next 30 days on an emergency basis only.
2. Send a copy of the letter to your contract manager in the network management department at Sentara Health Plans by mail or fax.

Providers may not seek or request to have a member terminated from Sentara Health Plans or transferred to another provider due to the member's medical condition or due to the amount, variety, or cost of covered services required by the member.

HEALTH AND PREVENTIVE SERVICES

Purpose

Health and preventive services are dedicated to improving the health and preventing the disease of individuals and populations. The scope of the department encompasses health plan members, providers, employer groups, and our health improvement community partnerships. Members may contact health and preventive services through the member services phone number listed on the back of their member ID card. Information for members is available on the member website.

Member Services

Preventive health services for members include specific interventions to increase preventive health practices and to decrease identified health risks.

The Patient Identification Manager (PIM) reminder system is a computer-based direct mail program designed to reach members and providers every month to promote health. These initiatives support HEDIS improvement requirements. Mailings and communications may include:

- **Birthday cards-** All plan members aged 3 and over receive a birthday card during their birthday month from Sentara Health Plans. Members ages 18 and over receive a bookmarker that serves to remind members of the preventive health guidelines they should follow to achieve their personal best health. The mailing to members ages 3–17 years includes a bookmarker with games and puzzles to remind their family to schedule annual checkups. Teen and adult members who have an email address in their profile will receive an electronic birthday message instead of the paper card that includes health information as well as links to the Sentara Health Plans website.

- **Healthy pregnancy mailings-** Once the health plan learns of a member's pregnancy, the member receives a letter, a voucher for a healthy parenting magazine subscription, and a magnet featuring the childhood immunization schedule and Sentara Health Plans' wishes for a healthy delivery (sent once member is in the seventh month of pregnancy). Additional mailings are sent throughout the course of the pregnancy and include messages related to pre-term labor, stress management, and postpartum check-up reminders.

- **Immunization postcards and letters-** Postcards are mailed to parents for children at 6, 12, and 18 months of age emphasizing the basic immunization schedule.

- **Provider notifications-** Providers receive monthly lists of their patients (our members) who were reminded through the PIM system and are still noncompliant with their immunizations and preventive screenings.

Health and Preventive Services by Sentara Health Plans offers health improvement programs, which include health risk identification and risk reduction strategies. Members may complete an online personal health assessment (PHA) and generate an immediate detailed report with specific risk reduction strategy recommendations. A shorter report that can be taken to their

healthcare provider is also available. Diabetic, asthmatic, and pregnant health plan members are referred to our clinical care services teams.

Health Risk Reduction Programs

Several health risk reduction programs are available free of charge to health plan members on a regular basis throughout the year. A current list of programs is available to members on the member website.

Health Coaching Services

WebMD health coaching is available to members participating through groups that are fully insured and to any self-insured groups that purchase the health coaching option. Through a partnership with WebMD, members are provided health and wellness solutions that are designed and managed by clinical experts and fully integrated with the health plan with an emphasis on improving the health of all members, not just at-risk members. Sentara Health Plans provides this unique resource that includes: a health improvement web site, personalized wellness plans, and access to health coaches.

WebMD's online and telephonic coaching is a powerful resource to help members adopt healthy behaviors, reduce health risks, and lower their lifetime cost of care. This comprehensive health coaching program has telephone-based coaching with strong internet tools and educational resources to support the members in their goal to improve their health. Members complete a personal health assessment that is used to develop an individualized wellness plan.

The program is fully integrated with Sentara Health Plans. Self-reported and claims data combine for better targeting, permitting outreach and interactions that are well coordinated and "member centric" rather than "disease centric." This resource promotes total population health management since members have access to health coaches and receive a personalized wellness plan.

In partnership with Omada Health, Sentara Health Plans offers members who qualify a digital, lifestyle-change program focused on reducing the risk of obesity-related chronic disease. This program combines the latest technology with ongoing support so participants can make changes that matter most to improving their health. The program includes a wireless smart scale, weekly online lessons, professional health coaching, and small online peer groups that offer real-time support. Members can determine if they qualify for the program by visiting Sentara Health Plans | Omada (omadahealth.com) and by completing the online screening tool.

Resources

A comprehensive library of prevention literature and information about Sentara Health Plans print pieces and community resources for patient education is maintained by health and preventive services and is a resource for participating providers. Please contact health and preventive services for specific preventive health educational needs.

Communications

Health and preventive services participate with the Sentara Health Plans physician leadership committee to obtain essential feedback about preventive health practices and recommendations for innovations or revisions in existing services to better meet the needs of health plan members. Health and preventive services contribute news and current preventive health initiatives to the Sentara Health Plans provider newsletter and other Sentara Health Plans publications.

Community Health

Community health improvement partnerships and coalitions contribute to the success of our population preventive health strategies. Departmental representatives are active in city, regional, and state community health improvement organizations.

Awards

Sentara Health Plans received the National Health Information Award for the “Eating for Life” DVD program and the Wellness in the Workplace Award from WELCOA. Additionally, Sentara Health Plans was awarded the C. Everett Koop National Health Award Honorable Mention and the Game Changer Award in Employee Health from the Virginia Health Innovation Network for the employee health improvement program, “Mission Health.”

HEALTHCARE SERVICES

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services.

Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist
- members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara Health Plans

To refer members for healthcare services, you may call provider services and be referred to the appropriate team.

Direct phone numbers for case/care management services are listed in the **"Sentara Health Plans Key Contacts"** section of this manual.

Members are assigned to the healthcare services teams based on their individual medical/behavioral needs and the type of group coverage. The following levels of service are assigned along with goals and outcomes:

- care coordination
- case management
- complex case management: coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services

CLINICAL CARE SERVICES

For all members the following apply:

- PCP referral is not required for members to access health services.
- Providers may not refer to out-of-network providers unless authorized by Sentara Health Plans.
- Providers must obtain prior authorization from Sentara Health Plans **prior** to recommending the member obtain care out-of-network.
- HMO plans will not pay if the services are provided to the member by a nonparticipating provider.
- Providers must receive prior authorization before services are rendered for any services requiring authorization.

Primary care providers (PCPs) or specialists **may not** authorize noncovered benefits or out-of-network services unless it is medically necessary and has received prior authorization by Sentara Health Plans.

Exceptions may apply for emergencies and network accessibility.

Behavioral Health Services Access

PCP referral is not required for members to access behavioral health services.

Provider to Provider Communication

To ensure continuity of care, the specialist is **required** to report medical findings to the PCP. The written report must include:

- diagnosis
- treatment plan
- answers to specific questions as the reason for the referral

Second Opinion

Sentara Health Plans will pay for a second opinion for surgical procedures to determine if the procedure is medically necessary or to explore other treatment options. Members have the option of consulting with any provider at their own expense at any time.

MEDICAL CLINICAL CARE SERVICES: PRIOR AUTHORIZATION

Prior Authorization via the Provider Portal

The preferred method to obtain prior authorization is through the Sentara Health Plans secure provider portal. Providers must register to access the provider portal.

Prior-authorization Fax Forms

All prior-authorization forms are available on the provider website. The fax number varies based on the service requested and the member's Sentara Health Plans product type. Please use the fax number listed on the authorization form for the specific requested service for commercial, Medicare, or Medicaid programs.

Prior authorization is available by phone for medically urgent requests; however, providers are encouraged to use the provider portal whenever possible to expedite the process.

Clinical Care Service Availability

Clinical care service personnel are available to process faxed requests and medically urgent telephone requests between 8 a.m. and 5 p.m., Monday through Friday, Eastern Time. Confidential voicemail is available between the hours of 5 p.m. and 8 a.m., Monday through Friday and 24 hours on weekends and holidays.

Medicaid Program and Medicare Prior Authorization

Sentara Health Plans Medicaid program, Medicare Advantage HMO, and Sentara Community Complete have a dedicated phone number for government programs prior authorization. Please reference the Sentara Health Plans Medicaid Program Provider Manual, Medicare HMO, or Sentara Community Complete provider manual supplements for information specific to the Sentara Health Plans Medicaid program, Medicare HMO, and Sentara Community Complete policies, procedures, and contacts.

Prior-authorization Procedures and Requirements

Prior authorization is based on medical necessity as supported by medical criteria and standards of care. Sentara Health Plans does not provide incentives to influence authorization decisions, to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. Sentara Health Plans follows the National Committee for Quality Assurance guidelines for Timeliness of UM decisions.

Requests for elective admissions must be submitted for prior authorization 14 days prior to scheduling an admission or procedure. Treatment by nonparticipating providers must receive prior authorization from Sentara Health Plans in the same time frame as above.

The requesting provider should receive an authorization for services within 14 days if all the

necessary clinical information is provided with the initial authorization request and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing.

Failure to pre-authorize services will result in the denial of payment, and the provider may be held responsible for the cost of services rendered.

Please note on the form if the authorization is urgent and requires expedited review. The definition for an expedited review is the following:

Failure of an immediate review would result in loss of life or limb or result in permanent injury.

Prior authorization determines medical necessity. It does not determine the level of payment or coverage and therefore does not guarantee payment. Payment decisions are also based on eligibility for services on the procedure date and benefits provided through the member's health plan.

Except in the case of emergency treatment, prior authorization may, at the sole discretion of Sentara Health Plans, be required for:

- all inpatient hospitalizations
- all partial hospitalizations
- all outpatient surgeries/short stays/observations and IV therapy and drug infusions.
- all skilled nursing facility admissions
- all acute rehabilitation
- all Intensive outpatient programs
- all out-of-area services or referrals to nonparticipating providers (prior to scheduling)

All the following services require prior authorization regardless of the place of service:

- commercial plan durable medical equipment (DME) single purchased items greater than $750 and all rentals (for Medicaid and Medicare guidance, please reference the appropriate provider manual or provider manual supplement)
- home health/hospice/IV infusions
- commercial plan orthotics/prosthetics, single purchased items greater than $750, and all rentals, repair, replacement, and duplicates (for Medicaid and Medicare guidance, please reference the appropriate provider manual or provider manual supplement)
- plastic surgery
- all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.)
- therapies (PT, OT, ST)
  - Sentara Health Plans Medicaid program does not require prior authorization unless they are part of home health services
- applied behavioral analysis
- early intervention services (part H certification required)
- OB global notification
- transplant services (also applicable when Sentara Health Plans is not the primary payer)
- human and synthetic tissue
- oral surgery and related services

- advanced imaging studies: PET, CT, CTA, MRI, MRA, MR-CT
- sleep studies performed by a Sentara Health Plans accredited/contracted sleep study provider (requirements may vary for some self-funded groups)
- hyperbaric therapy
- electronic bone stimulator
- any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed
- injectable drugs indicated on the online prior-authorization forms
- genetic testing (if covered by group/plan)
- bone densitometry, if less than 24 months since last study

Please reference the Sentara Health Plans Medicaid Program Provider Manual for information specific to prior-authorization requirements and contact numbers for Sentara Health Plans Medicaid program.

Sentara Health Plans Oncology Program

The Sentara Health Plans oncology program promotes evidence-based, high-value care for members receiving drug regimens and/or radiation therapy for the treatment of cancer. This program is administered through AIM Specialty Health® (AIM). Radiation oncology performed as part of an inpatient admission is not part of this program.

Providers of radiation or medical oncology services are required to contact AIM for pre-review for all cancer treatment and supportive drugs and radiation services listed below:

- 2D conventional and 3D conformal radiation therapy
- brachytherapy
- proton beam therapy
- intensity-modulated radiation therapy (IMRT)
- intraoperative radiation therapy (IORT)
- selective internal radiation therapy (SIRT)
- stereotactic body radiotherapy (SBRT)
- stereotactic radiosurgery (SRS)
- fractionation in bone metastases, non-small cell lung cancer, and breast cancer when requesting external beam radiation therapy (EBRT) and intensity-modulated radiation therapy (IMRT)
- image-guided radiation therapy (IGRT)
- special procedures and consultations associated with treatment planning (CPT® codes 73370 and 77470)

The oncology program applies to all Medicaid programs, Medicare, and fully insured members. Self-insured commercial groups may elect to join the program at the time of their benefit renewal. Medical oncology providers should attempt to obtain an authorization for services on all Sentara Health Plans commercial members. If a self-insured member has not yet been enrolled in the program, a message indicating the member's enrollment status will be transmitted at the time of authorization entry.

To authorize admissions:

- Scheduled inpatient admissions: Complete the online request in the provider portal or fax the completed request form and supportive clinical information to the fax number on the request form.
- Emergent inpatient admission for a member who is currently hospitalized: Complete the online form via the provider portal and indicate that it is an urgent request or call clinical care services.
- Emergent inpatient admission for a member who has not been admitted: Complete the online form via the provider portal and indicate that it is an urgent request or call clinical care services.

Forms for inpatient admissions should be completed online via the provider portal or faxed to the number listed on the prior-authorization form:

The provider or office staff should provide the following information when pre-authorizing a member by form or by telephone:

- attending physician's name
- patient's name and member ID number
- name of admitting hospital
- date of planned admission
- admitting diagnosis, reason for admission/procedures, and any applicable codes
- procedures and procedure code(s) to be performed and date
- treatment plan and prior treatment
- summary of test results (if applicable)

Prior authorization is **not** required for the following:

- blood transfusions
- EEG
- echocardiogram
- EKGs
- PVL
- X-rays
- lab tests
- biopsies
- bone density studies (bone densitometry)
  - Prior authorization is needed if it is performed more than once in 24 months.
- gallium scans
- mammograms
- spinal tap
- commercial plan DME or prosthetic purchased items costing less than $750 per single item, and the rendering provider is a contracted DME provider
- emergency/UCC care
- ultrasound
- colonoscopy
- incontinence supplies

- upper GI
- Sentara Health Plans as a secondary payer (except organ transplant)

Genetic Testing and Counseling

Providers must obtain a prior authorization from Sentara Health Plans **prior** to the member receiving services for all genetic testing except BRCA and NIPT. Testing must be performed at participating specialty laboratories.

Behavioral Health Prior-authorization Requirement

Routine Outpatient Services
Prior authorization is not required before routine outpatient services are rendered.

Psychological and Neuropsychological Testing
Prior authorization is not required for up to seven hours of psychological testing or eight hours or less of neuropsychological testing. All Sentara Health Plans participating providers, except licensed clinical psychologists, are required to complete a supplemental application in addition to the CAQH application at the time of credentialing and be approved for testing privileges by the Sentara Health Plans Behavioral Health Credentialing Committee prior to testing. Psychological and neuropsychological testing privileges applications are available on the provider website.

Prior Authorization Required
Except in the case of emergency treatment, the following behavioral health services require prior authorization:

- inpatient/partial hospitalization
- intensive outpatient program (IOP)
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation (rTMS)
- applied behavior analysis
- eight or more hours of psychological testing

Clinical Care Policies/Criteria

Clinical decisions are based on evidence-based medicine, appropriateness of care, and service and coverage. Sentara Health Plans does not reward denials or provide any financial incentives that could result in underutilization.
Clinical care policies are used to determine medical necessity. Clinical care services develop policies using the following:

- review of MCG
- HAYES Medical Technology Directory
- specialty journals, medical/professional journals, Pub-Med, research studies/outcomes, and articles
- government regulations and requirements, including LCD and NCD
- assistance of appropriate network providers/specialists

- Benefits Committee review
- computer medical search
- local practicing providers

The medical directors of Sentara Health Plans review clinical care services policies. Approved policies are distributed to all appropriate departments, and all policies are available to providers upon request. To request copies of coverage policies and criteria, please call clinical care services.

Pre-services Review

Medical or behavioral health services requiring elective prior authorization should be submitted as soon as possible or at least 14 calendar days prior to scheduling procedures. This enables the nurse reviewers and medical directors time to review all submitted documentation and request other information or test results to make authorization determinations. These elective decisions will be rendered within 14 calendar days from receipt of all requested information. Urgent cases will be completed within 72 hours. Emergency requests due to life-altering situations will be completed within 24 to 48 hours.

Admission Review

Clinical care services hospital-review case managers conduct admission reviews within one working day of the patient's admission. If, at the time of review, there is no record of a pre-admission prior-authorization request, Sentara Health Plans will determine if the admission was medically necessary. If the admission was medically necessary, Sentara Health Plans will pay the claim.

Post-service/Retrospective Review

Any service or admission that was not authorized may be retrospectively reviewed. Reviews and decisions will be completed within 30 business days of receipt of all requested information.

Concurrent Review

Concurrent or continued- stay review is performed daily (Monday–Friday) on all hospitalized members by hospital-review case managers (RNs). Hospital case managers do telephonic review and/or chart reviews via fax to determine whether the hospitalization remains appropriate or whether it should be modified given significant changes in the patient's condition. If medical necessity for continued hospitalization is uncertain, the medical director may discuss the case with the attending physician (peer-to-peer).

Pre-service or Current Request for Reconsideration of an Adverse Decision/Denial

When a denial of authorization for payment/adverse decision is issued by Sentara Health Plans, both the provider and their patient will receive written notification that includes an explanation of the medical necessity or benefits decision and information on the appeal/reconsideration process. If a provider would like to have the request reconsidered, medical directors are available to

discuss the criteria the decision was based on. To request a reconsideration of a denial/adverse decision for payment, utilize the Reconsideration of a Denied Pre-authorization Form. This form with the fax number for submission is available on the provider website in the authorizations section. Government program requirements frequently require program-specific forms and processes for Medicare and Medicaid programs.

A treating provider may request reconsideration of an adverse decision or may appeal an adverse decision. Any reconsideration of an adverse decision may only be requested by the treating provider on behalf of the covered person. A decision on reconsideration will be made by a physician advisor, peer of the treating healthcare provider, or a panel of other appropriate healthcare providers with at least one physician advisor or peer of the treating healthcare provider on the panel.

The treating provider on behalf of the member shall be:

- notified verbally at the time of the determination of the reconsideration of the adverse decision and in writing following the determination of the reconsideration of the adverse decision
- notified verbally at the time of the determination of the reconsideration of the adverse decision of the process for an appeal of the determination and the contact's name, address, and telephone number to file and perfect an appeal

If the treating provider on behalf of the member requests that the adverse decision be reviewed by a peer of the treating provider at any time during the reconsideration process, the request for reconsideration will be vacated and considered an appeal. In such cases, the member will be notified that the reconsideration has been vacated and an appeal initiated, all documentation and information provided or relied upon during the reconsideration process pursuant to this section will be converted to the appeal process, and no additional actions will be required of the treating provider to perfect the appeal.

Any reconsideration will be rendered, and the decision provided to the treating provider and the member in writing within 10 business days of receipt of the request for reconsideration.
The peer-to-peer process outlined above does **not** apply to claim denials. Please refer to the "**Claim Payment Reconsideration"** section and the **"Appeals"** sections of this manual for claim denial reconsiderations.

Inpatient Denials

The following are examples of inpatient denials/adverse decisions:

- If the attending physician continues to hospitalize a member who does not meet the medical necessity criteria, all claims for the hospital from that day forward will be denied for payment. The claim will be denied, "Services not pre-authorized, provider responsible (D26)." The members cannot be billed.
- If the member remains hospitalized because a test ordered by the attending physician is not performed due to hospital- related problems (such as scheduling and pre-testing errors), then all claims from that day forward for the hospital will be denied. The claim will be denied, "Services not pre-authorized, provider responsible (D26)." The member cannot be billed.

- If the family member insists on continued hospitalization (even though both the attending physician and Sentara Health Plans agree that the hospitalization is no longer medically necessary), the claims related to the additional days will be denied. The claims will be denied, “Continued stay not authorized, member responsible.”

For all medically unnecessary dates of service, both the provider and member will receive a letter of denial of payment from Sentara Health Plans. The letter will note which dates of service are to be denied, which claims are affected (hospital and/or attending physician), and who is responsible for the charges.

OBSTETRICAL CARE/PARTNERS IN PREGNANCY

Once a member's pregnancy is confirmed, the obstetrician (OB) must notify Partners in Pregnancy by completing the OB Certification/Psychosocial screen and submitting it to Sentara Health Plans, or the provider may complete the screening and certification process on the provider website.

The certification assures the obstetrician may provide care for the member throughout the entire pregnancy, delivery, and for six weeks postpartum care.

Partners in Pregnancy Program

The Partners in Pregnancy program is available to members enrolled in all Sentara Health Plans products. Partners in Pregnancy program referrals come from provider offices and member self-referrals, as well as administrative data, to ensure as many members can be reached as possible.

Once a referral has been received, the team reaches out to the member by phone to explain the program. When a member elects to participate in the program, a comprehensive assessment, including an obstetrical assessment, is completed to tailor the program to suit the member's individual needs. Risk stratification is conducted using the assessments to allow members to be assigned to the appropriate Partners in Pregnancy team member. Members who stratify as high risk are assigned to a registered nurse, and members who stratify as low risk are assigned to care coordinators. Moderate risk members may have a combination of team member types. The team contacts members at regular intervals during their pregnancy to provide prenatal education and mental health screenings and to answer questions regarding benefits and other available services. The team also includes a licensed clinical social worker who can assist with community resources such as housing, food, etc.

The Partners in Pregnancy team can communicate a member or case manager's concern to a designated person within the provider office to expedite coordination of care. After 60 days postpartum, members who require additional assistance will be referred to other appropriate Sentara Health Plans case management teams for further assistance. The number for Partners in Pregnancy is listed in the **"Sentara Health Plans Key Contacts"** section at the top of this document.

Patient Access Guidelines

For maternity care, appointments to provide initial prenatal care will be made as follows:

- within seven calendar days of the request for pregnant enrollees in their first trimester
- within seven calendar days of the request for pregnant enrollees in their second trimester
- within three business days of the request for pregnant enrollees in their third trimester or for high-risk pregnancies, or immediately if an emergency exists

Home Health Post-Delivery Services

Home health services are available, **if they receive prior authorization,** to assess both the mother and child after discharge. These services include but are not limited to:

- drawing lab studies on the newborn
- providing bili lights and bili blanket therapies
- providing breast feeding education and information for the mother
- checking mother's condition

High-risk Pregnancies

All high-risk pregnancies should be managed by a contracted maternal and fetal medicine specialist (MFM). If you need assistance identifying a contracted MFM specialist, please contact the Partners in Pregnancy case manager.

Dependent OB Coverage

Not all dependents will have OB coverage. Please call provider services to confirm OB coverage for dependents.

GYNECOLOGICAL CARE

Annual Gynecological Exams

Annual OB/GYN exams are covered every 320 days. This allows a 45-day grace period for scheduling appointments. This exam includes routine healthcare services rendered during or because of the annual visit. It includes:

- physical and pelvic exam
- hematocrit or hemoglobin test
- pap smear
- urinalysis
- wet prep
- Depo-Provera
- pregnancy testing if medically indicated
- cholesterol screening
- mammograms:
    - covered under preventive healthcare services at participating ACR-accredited radiology facilities with a physician prescription
    - annual mammograms covered starting at age 40
    - screening/diagnostic mammograms covered for members between the ages of 35 and 40

Vasectomies and Tubal Ligations

Most plans require copayments for vasectomies and tubal ligations. Call provider services for more plan-specific information. Not all plans cover these services. Please see the Sentara Health Plans Medicaid Program Provider Manual for Medicaid program-specific policies.

Infertility Treatment

Some members do not have infertility benefits in their core coverage. Please call provider services to verify coverage. In addition, fertility drugs, in vitro fertilization, services associated with the storage/freezing of sperm, or charges for donor sperm are not covered.

Termination of Pregnancy/Abortions

Most members have benefits for elective abortions in the first 12 weeks of pregnancy. If the PCP or OB/GYN does not wish to refer the member, the member may obtain an authorization by calling the prior-authorization number on the member ID card. Please call the clinical care services medical or government programs phone number for a list of providers contracted to provide this service. Medicaid pregnancy termination policies are listed in the Sentara Health Plans Medicaid Program Provider Manual.

EMERGENCY DEPARTMENT/URGENT CARE CENTERS

Members do not need prior approval from their PCP or Sentara Health Plans before seeking care at the Emergency Department (ED) or urgent care center (UCC). All members are encouraged to contact their PCP or Sentara Health Plans via the After-hours Nurse Advice Line program for instructions on the type of care to receive.

Sentara Health Plans covers any emergency services rendered at a hospital necessary to screen and stabilize members.

All members seeking care at emergency facilities will be subject to the member cost share.

AFTER-HOURS NURSE ADVICE LINE PROGRAM

The After-hours Nurse Advice Line provides an avenue of care for members who need treatment or advice after their provider's office is closed. Registered nurses are available to provide direction and education for patients whose needs range from a sore throat to surgery questions. These nurses follow a set of protocols written and approved by physicians.

Depending on patient's symptoms, the nurse may give instructions (advice) with approved protocols for self-care and further follow-up if symptoms should worsen or reoccur; they may recommend follow-up with a primary care provider (PCP) or may refer patients to a facility for evaluation and treatment of symptoms. Members are informed that the after-hours nurse does not have access to medical records and does not diagnose medical conditions, order lab work, write prescriptions, order home health services, or initiate hospital admissions. If the member disagrees with the nurse's advice for self-care and proceeds to the Emergency Department or an urgent care center, Sentara Health Plans may retrospectively review the visit for payment determination.

Benefits

Providers benefit from the program in several ways:

- The member receives advice after-hours to meet appropriate healthcare needs.
- The program reduces the number of after-hours nonemergency calls you receive.
- The after-hours nurse will contact you if the situation requires it.

Information

Information about the after-hours program and how to use it is available from provider services for offices to distribute to patients.

Telephone Number and Hours

Members may be directed to their member ID cards or the member website for telephone contact numbers. The program is available 24 hours a day, 7 days a week.

MDLIVE

When the member's provider office is closed and the after-hours nurse recommends seeking care other than the provider's office when it reopens, Sentara Health Plans fully insured members, some self-funded groups, and Medicare Advantage and Medicaid program members have access to board-certified physicians through MDLIVE 24 hours a day, 7 days a week by calling **1-866-648-3638** or online.

Members with this benefit can access MDLIVE through online video, by phone, or with secure email for a specific listing of complaints. Sentara Health Plans member ID numbers are required for members to register for MDLIVE.

ADDITIONAL ANCILLARY SERVICES

Depending on the plan, covered ancillary/other services, such as home health, DME, and prosthetic appliances, require prior authorization by the clinical care services (CCS) department. Details are outlined in the information provided below and in product-specific provider manuals or provider manual supplements for the Sentara Health Plans Medicaid program and Medicare Advantage.

Artificial Limb Benefit

Coverage for artificial limbs varies by product and/or employer. Please call provider services to determine coverage and patient cost share for the specific member you are treating, or you may inquire about specific benefit limitations and patient cost share at the time of prior authorization of services. Prior authorization is required.

Audiology Services

Audiology services are covered when authorized by CCS.

Hearing aids are covered under some plans through a rider. Members have access to a value-added hearing aid discount program if they use the discount program provider. This value-added hearing aid discount program can be accessed when the member does not have a hearing aid benefit. Please contact provider services for specific coverage.

Chiropractic Services

Some plans and employer groups have chiropractic benefits. Sentara Health Plans has contracted with a vendor to administer the chiropractic benefits as applicable to all plans. A chiropractic provider search feature and additional provider information for the HMO/POS and PPO chiropractic networks are available on the provider website. For authorization, billing, and reimbursement information, refer to the chiropractic vendor guidelines.

Dental Coverage

Accidental Dental:

Treatment of a dental accident is covered as a medical benefit for some members and is separate and apart from any dental plan or dental rider. Specific coverage information and exclusions are available to providers during business hours by calling provider services. A healthcare professional, such as a nurse or a physician, must document treatment. For injuries that happen on or after the member's effective date of coverage, treatment must be sought within 60 days of the accident. Specialist copayments apply to each visit to a dentist or oral surgeon covered under this benefit.

Dental services performed during an Emergency Department visit immediately after an accidental injury in conjunction with the initial stabilization of the injury are covered. Members are responsible for the Emergency Department copayment or coinsurance.
Dental coverage varies by plan type and/or employer group. Federally Facilitated Marketplace (FFM) plans include dental coverage according to the Affordable Care Act.

Dental Care Discount:
Sentara Health Plans members may receive up to 20% off usual and customary charges for dental services and appliances when receiving services from a participating discount dental care provider. A detailed description of the benefits and exclusions of this program and a listing of discount dental care providers are available on the member website.

Dialysis Services

- A valid written or verbal order from the attending nephrologist is required.
- Dialysis claims must be submitted on a UB 04 claim form.
- Dialysis supplies are only payable in the home setting. Appropriate documentation and J-codes are required to differentiate the medication from pharmacy supplies.
- Dialysis claims must indicate the appropriate revenue, CPT codes, and/or HCPCS codes.
- Nonroutine dialysis lab work must be sent to a participating reference laboratory for processing.

Disposable Medical Supplies

- Commercial plans cover ostomy supplies, diabetic supplies, holding chambers (spacer/aero chamber), and peak flow meters. These items do not require authorization.
- Other disposable medical supplies are **not** covered.
- Spacers (which are different than spacing devices) are included with the medication and are **not** separately reimbursable.
- Insulin pump supplies are **not** included in diabetic supplies and require authorization.

In summary, all **covered** disposable supply items (excluding those supplies listed above) that will be separately billed to Sentara Health Plans must be authorized. All **covered** replacement supply items also require authorization.

Billing and Reimbursement:
If a miscellaneous HCPCS code is billed for an item when a specific HCPCS code exists, the item will be denied with comments stating to resubmit the claim with specific HCPCS codes.

Durable Medical Equipment (DME)

Durable medical equipment (DME) includes equipment or items, which can be purchased or rented, which are able to withstand repeated use, which are medically necessary, and which are typically used in the home. Some supply items that fall under the DME category are covered services and typically require prior authorization. Most products have a calendar year benefit maximum. Contact provider services for specific member benefit information. Utilization Management (UM) will assign authorizations for DME services that require authorization.

Authorizations are issued for medical necessity but do not guarantee payment.

DME Equipment Rental and Purchase Policy

The following applies to commercial and Medicaid program plans:

- Sentara Health Plans clinical care services will determine if equipment being rented should be converted to purchase within the first three months of rental.
- Should accumulated rental payments exceed 110 percent of the purchased price of the equipment, Sentara Health Plans considers the equipment purchased, and all rental payments are stopped.
- If equipment is being rented and subsequently purchased, all accumulated rental payments are offset against the purchase price; only the difference is paid, and the equipment is considered purchased.
- All equipment rentals must be billed in monthly increments (except codes E0935 RR – CPM Machine and E0202 RR – phototherapy blanket rented daily). The appropriate date range and a quantity of 1 (one month's rental) should be indicated on the claim form.
- Sentara Health Plans follows CMS units of measure for all rentals.

Equipment Rental Payment when a Member Becomes Disenrolled

If Sentara Health Plans determines that a member became disenrolled during the period covered in the date range, Sentara Health Plans will process the claim as indicated below:

- The line item billed will be changed to indicate the dates the member was covered by Sentara Health Plans.
- A quantity of one will be shown for the covered days, and the full month's rent will be paid.
- A second line item will be added indicating the dates the member was not covered by Sentara Health Plans.
- A quantity of zero will be shown for the noncovered days and an adjustment code, D28, indicated with a comment: "Member disenrolled on XX date, full month rental payment made."

DME Copayments/Coinsurance

Copayments vary by product and employer. Please contact provider services for details.

DME Authorization

- Commercial plan authorization requirements for DME equipment single purchase are any item > $750.00; however, specific authorization requirements may vary by employer.
- Services must be provided by contracted DME providers.
- All DME **equipment rentals**, regardless of the dollar amount, require an authorization. Services must be provided by contracted DME providers.
- All covered disposable supply items (excluding ostomy and diabetic supplies) that will be

separately billed to Sentara Health Plans must be authorized. All covered replacement supply items also require authorization.
- Providers may fax a completed prior-authorization form to medical care services (MCS) to request an authorization.
- Requested changes in authorizations must be faxed to medical care services within 30 days of the original authorization.

DME Service/Maintenance on Purchased Items
Service/maintenance of purchased items requires prior authorization.

Commercial Lines of Business:
- Providers must bill with the appropriate HCPCS code for the purchased item and append the "MS" modifier.
- Sentara Health Plans allows for reimbursement of maintenance/service once every six months for parts and labor items that are no longer under warranty.

Sentara Health Plans Medicaid program follows DMAS requirements for billing of E1399 with an English description.

DME Miscellaneous Codes
Digital hearing aids, custom and power wheelchairs, and wheelchair accessories with no established allowance will be reimbursed based on invoice. An invoice must be submitted with the claim for the equipment to be reimbursed.

Employee Assistance Program (EAP) Services

All behavioral health providers who participate with Sentara Health Plans commercial products (fully insured, self-insured, commercial, HMO, POS and PPO) are contractually obligated to provide services for the employee assistance program (EAP), per exhibit A-1 of the Sentara Health Plans Behavioral Health Provider Agreement, unless there is a qualified written exception.

A provider's assessment and referral of EAP services include:
- diagnostic assessment
- intervention and/or short-term counseling
- referral to appropriate local resources

Providers will receive EAP referrals from employees of Sentara Health Plans. Appointments should be offered within 48 hours of the referral with a face-to-face assessment at that time unless a later date is requested. Sentara Health Plans EAP will send a detailed provider packet via secure email or fax that includes all forms required for case documentation and reimbursement.

Home Health and IV Therapy

Home health and IV therapy services require prior authorization for all products. To arrange and obtain prior authorization for home health or IV therapy services, fax the completed authorization

form to clinical care services. Change requests for authorizations must be faxed to clinical care services within 30 days of the original authorization.

Home health benefits are not payable for custodial care. Custodial care is defined as "treatment or services designed mainly to help the patient with daily living activities." These activities include helping walking, getting in and out of bed, bathing, preparing meals, acting as companion, etc.

For all products, therapy services (physical, occupational, or speech) provided in the home setting **will** have a copayment applied for each modality provided during the visit as defined by the plan. No supplies or pharmacy items should be billed in conjunction with therapy services.

Standard supplies are included in the skilled nursing visit. Extensive supplies used in conjunction with an authorized skilled nursing visit for wound care services are reimbursable at contracted rates if specifically authorized by clinical care services (CCS).

Hospice Services

Hospice care is available to members who are diagnosed with a terminal illness and have fewer than six months to live. Hospice care services (revenue code 651) include:

- care of the member and the family as a unit
- palliative care (relief of pain) rather than heroic measures
- bereavement counseling
- pastoral services

The members must **elect** the hospice program. Following the member's election, all hospice care must receive prior authorization by clinical care services (CCS).

Medical Transportation Services/Ambulance

Ambulance/stretcher service is covered for most plans when provided by an agency authorized to provide such a service to transport a member. Wheelchair transportation is typically not covered by commercial plans; however, wheelchair transportation may be authorized by clinical care services (CCS) on a case-by-case basis as follows:

- Emergency ambulance/stretcher service is covered from the place where the member was injured to the nearest hospital where treatment can be furnished when medically necessary.
- Ambulance/stretcher transportation from facility to facility must receive prior authorization through CCS. When part of a scheduled transport, ambulance services should receive prior authorization by CCS.
- Members are responsible for copayments each way for ambulance services. This applies to both emergent and nonemergency services.
- Ambulance providers must obtain prior authorization for applicable services whenever possible for all products. In cases requiring services after routine business hours or other circumstances where services were provided in good faith, Sentara Health Plans will not withhold authorization if the patient is a current Sentara Health Plans member, medical necessity warrants the services, and the authorization request is made within 30 days of the service.

Please reference the Sentara Health Plans Medicaid Program Provider Manual for Medicaid program specific transportation policies and procedures.

Nutritional Counseling/Dietician

Coverage is limited to medically necessary conditions that must be managed by nutritional assessment or behavior modification.

These include but are not limited to:

- pregnancy
- diabetes mellitus
- morbid obesity
- heart disease
- hyperlipidemia
- obstructive sleep apnea

All plans will cover diet evaluation and instruction by a contracted dietician or physician. The patient is responsible for office visit copayments each session.

Oxygen Policy

Members may receive oxygen through a durable medical equipment (DME)/respiratory therapy provider. Oxygen services are paid as a **medical benefit** rather than a DME benefit. DME maximum benefit limits do not apply. For all products, oxygen therapy receives prior authorization by clinical care services (CCS) based upon diagnosis and medical necessity. For all products, oxygen services require a physician order and oxygen saturation level meeting medical criteria. All supplies are included in the rental reimbursement.

Continuation of oxygen usage by a member requires the provider to submit yearly oxygen saturation levels to CCS, except for patients with chronic conditions. All oxygen and oxygen equipment must meet the criteria for medical necessity as defined by clinical care services. All pulse oximetry tests require prior authorization.

All requests for liquid oxygen will require the ordering physician to submit the medical necessity ordering form/oxygen and must be approved by Sentara Health Plans' medical director. Initial authorizations will be set up for either three months or one year depending on the episode of illness. Oxygen systems do not fall under the rental to purchase procedure.

Physical and Occupational Therapy

Outpatient physical and occupational therapy are covered services when medically necessary and authorized by clinical care services (CCS). Outpatient physical and occupational therapy may be performed by participating therapy providers meeting Sentara Health Plans' therapy participation criteria. All therapy providers must complete the physical therapy provider participation criteria and licensure/malpractice verification requirements attesting that they meet Sentara Health Plans' therapy criteria and agree to comply with all participation requirements and pass the

Sentara Health Plans self-assessed physical therapy provider office site evaluation. For purposes of this section, the term “therapy provider” includes freestanding and hospital-based therapy centers.

Physical and occupational therapy policies and procedures may vary for the Sentara Health Plans Medicaid program. Please refer to the Sentara Health Plans Medicaid Program Provider Manual for any Medicaid program-specific policies and procedures.

The following therapy guidelines are applicable to all therapy providers:

- Coverage of therapy services varies by plan type and employer. Verification of therapy benefits for a specific member may be obtained by contacting provider services.
- Reevaluations are not covered by Sentara Health Plans.
- Work-hardening programs or functional capacity testing is not covered by any plan.

Ordering and Authorization Process:

- All therapy services must be ordered by a physician. A primary care provider (PCP) or specialist may order therapy services by providing the member with a **written prescription for therapy services to a participating therapy provider.**
- The participating therapy provider or facility can perform the evaluation without an authorization. Following the evaluation, the therapy provider or facility must contact clinical care services to obtain authorization.
- Upon completion of the evaluation, the therapy provider should proceed as follows:
    1. The therapy provider must complete and fax an authorization request for an Outpatient Physical Occupational-Speech Therapies form to CCS for members of commercial plans.
    2. CCS will process and return the authorization request Outpatient Physical Occupational-Speech Therapies form to the therapy provider indicating the authorization number, the number of visits authorized, the modalities, and the time frame. If a treatment was provided in addition to the evaluation during the initial visit, that treatment must be indicated on the authorization request Outpatient Physical Occupational-Speech Therapies form. CCS will then determine if the treatment performed during the initial visit will be covered.
    3. The therapy provider will use the authorization request Outpatient Physical Occupational-Speech Therapies form approved by CCS as the basis for continued therapy services, for the number of visits and time frame indicated.
    4. If the treatment plan changes or additional modalities or visits are needed for a member, the therapy provider must fax an updated authorization request Outpatient Physical Occupational-Speech Therapies form to CCS for appropriate authorization for commercial members.

Please refer to the Sentara Health Plans Medicaid program for Medicaid specific policies and procedures.

Billing and Reimbursement:

- Freestanding therapy providers should submit claims electronically on a CMS 1500 claim form using the appropriate CPT codes, as designated by the current AMA CPT code book.
- Hospital-based therapy providers should submit claims on a UB 04 claim form using the

revenue code 42X for physical therapy and revenue code 43X for occupational therapy. In addition to the revenue code, the appropriate CPT codes, as designated by the current AMA CPT Code book, **must** be included.

- Procedure code 97750 (physical performance measurement, with written report, each 15 minutes) is covered and may be billed by a therapy provider to render an initial evaluation of the member at the initial visit. This code is billable in 15-minute increments.
- Customized splints provided by the therapy provider must receive **specific** prior authorization by CCS for all plans. The customized splint must be billed using the appropriate HCPCS code.
- Therapy codes apply one copayment per visit (date of service) for each modality of therapy provided.

Prosthetic and Orthotics

Prosthetic and orthotics are covered when determined to be medically necessary and appropriately pre-authorized by clinical care services (CCS). Customized and non-customized single orthotics with requested charges equal to or greater than $750.00 must be authorized for commercial plan members. Authorization limit amounts may differ for some self-funded groups. Providers should call provider services to determine authorization requirements for self-funded groups. For Medicaid and Medicare guidance, please reference the appropriate provider manual or provider manual supplement. Coverage for nonsurgical implanted prosthetic and orthotics combined is limited to the member's benefit limit per calendar/contract year and to those conditions resulting from injury or illness while a member is covered. Please contact provider services to determine the member's coverage.

Prosthetic and orthotics are covered as follows:

- purchase of the initial device for conditions resulting from illness or injury while a member is covered
- replacement prosthesis for a growing child up to age 18 (age 21 for Medicaid program members) who may or may not have been continuously covered when the illness or injury occurred and the initial prosthesis was fitted
  - Replacement is covered due to growth and surgical revision of an amputation.
- breast prosthetics
- two prosthetic bras for members with a cancer diagnosis

Coverage does not include:

- repairs to or replacement of a prosthesis that an adult member received prior to enrollment
- replacements due to weight gain or loss or shrinkage of the appendage

Please see the Sentara Health Plans Medicaid Program Provider Manual for coverage variations.

Skilled Nursing Facilities (SNFs)

Placement in a skilled nursing facility requires prior authorization. Clinical care services will make the necessary arrangements with the facility. Case managers are available to make the necessary arrangements to transition the patient home. Please see the Sentara Health Plans Medicaid Program Provider Manual for Medicaid program-specific information.

Sleep Studies

Home sleep studies are the preferred method of testing. Facility-based studies require proof of a failed home sleep study or a medical reason why home sleep study testing is contraindicated.

Speech Therapy

- Speech therapy services require prior authorization by medical care services (MCS) for commercial plans.
- Speech therapy may be performed by participating providers, therapy centers, or hospitals contracted to perform speech therapy.
- Verification of therapy benefits for a specific plan may be obtained by contacting provider services.
- Regardless of place of service, deductibles/coinsurance or copayments are required for therapy services, per visit, per therapy type for commercial plans.

VISION COVERAGE

Preventive Vision Coverage

For most benefit plans, members receive preventive vision benefits through our vision vendor. Preventive vision services are not reimbursed under Sentara Health Plans and should be obtained by members through their vision vendor (or if applicable, other employer-specific) vision benefits.

Vision Benefit

Each covered individual may receive an eye exam (at a plan-specific copayment) every 12 or 24 months, depending on the member's vision benefit.

This includes:

- case history: pertinent health information related to eyes and vision acuity test, unaided and with previous prescription
- screening test: for disease or abnormalities, including glaucoma and cataracts

Diabetic Dilated Eye Exam Exception

For members with diabetes, regardless of benefit plan, dilated retinal eye exams are covered every 12 months without a referral. These screening exams may be obtained through the vision vendor or participating ophthalmologists or optometrists.

Accessing Benefits

Members should first call the member services number on their member ID card for details.

Members should call their vision vendor for an appointment and provide their member ID number for identification. Members may select a provider by going to the member website.

Providers should verify eligibility and coverage by contacting the vision vendor. Please use the member's ID number to obtain eligibility and coverage information.

<u>Exclusions</u>
The following are not covered:

- orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- medical and/or surgical treatment of the eye, eyes, or supporting structures
- corrective eyewear required by an employer as a condition of employment and safety
- eyewear, unless specifically covered under plan
- services provided as a result of any worker's compensation law
- discount is not available on frames where the manufacturer prohibits a discount

Vision Materials Supplement

Groups electing the vision materials supplement coverage have a benefit for expanded

optical care service. The member may be responsible for a plan-specific copayment for the materials in addition to the exam copayment.

Discount Schedule

Members may be able to obtain discounts or exams and vision materials by selecting vision under the portal for more information.

PHARMACY SERVICES

Pharmacists as Providers (For Commercial Plans)

In accordance with the provisions of § 54.1-3303.1, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to Commercial plan members 18 years of age or older with whom the pharmacist has a bona fide pharmacist-patient relationship in accordance with a statewide protocol developed by the Board in collaboration with the Board of Medicine and the Department of Health and set forth in regulations of the Board. Pharmacists who initiate treatment with, dispense, or administer a drug or device in accordance with state law shall counsel members regarding the benefits of establishing a relationship with a primary health care provider.

To provide medical services, Pharmacists must meet Sentara Health Plans contracting and credentialing requirements. Pharmacists acting as providers are also responsible for adherence to following the State Board of Pharmacy protocols. This includes obtaining the appropriate training and maintenance of records. Pharmacists can find additional information on the contracting, credentialing, and billing processes by visiting the Sentara Health Plans provider website, which can be found at this link: Provider Support | Providers | Sentara Health Plans | Sentara Health Plans. Information on the Medicaid requirements for Pharmacists as Providers can be found in the Sentara Health Plans Medicaid Program Provider Manual.

Pharmacy Program

Sentara Health Plans manages the pharmacy program by evaluating the safety, efficacy, and cost-effectiveness of drugs. A Pharmacy and Therapeutics (P&T) Committee, consisting of pharmacists and physicians representing different specialties, review the clinical appropriateness of drugs for inclusion in the formulary. The P&T Committee also reviews and approves the clinical criteria for drugs with utilization management programs such as prior authorization (PA), step therapy (ST), and quantity limits (QL). A team of pharmacists at Sentara Health Plans are responsible for drug coverage and formulary management decisions with the guidance provided by the P&T Committee.

Our formularies are developed with the inclusion of key agents within selected therapeutic classes. These agents offer comparable safety and efficacy yet are more cost-effective than similar agents. Sentara Health Plans formularies are available on our website. Notification of changes to the formulary appears in *providerNEWS* (Sentara Health Plans' provider newsletter) with a link to the formulary changes on the provider website.

Members may enroll in plans that do not include a pharmacy benefit. The member's ID card will identify pharmacy benefits under the "Rx" section, which will include their cost share for covered drugs.

Sentara Health Plans Formularies and Drug List

Sentara Health Plans offers the following prescription formulary programs for our commercial members:

- Sentara Open Formulary for Self Funded, Business*EDGE,* and Large Group Plans
- Sentara Standard Formulary for Self Funded and Large Group Plans
- Sentara Standard Formulary for Small Group Plans
- Sentara Specialty Drug List
- Sentara Equity Preventive Drug List (by preventive class and in alphabetical listing)
- Medical Benefit Oncology Drugs
- Sentara Individual & Family Health Plans Formulary
- City of Suffolk Formulary
- Virginia Commonwealth University Health System Authority Formulary

Sentara Health Plans Open and Sentara Health Plans Standard formularies cover many medications unless there are benefit exclusions. This allows for accessibility of multiple medications within a class and permits members and providers to determine the medication that is best for the individual member.

Sentara Health Plans Small Group plans formulary covers select medications within each therapeutic drug category that has been reviewed by the P&T Committee and meet the state regulatory agency's (such as the Virginia Bureau of Insurance) benchmark. Members may request an exception for a drug that may not be included on the formulary.

Our formularies require generic drug prescription usage whenever possible. These drugs are listed with the generic name on the formularies. If a member requests a brand name drug when a generic drug is available, the member may be responsible for additional charges.

Tier Formulary Copayment Structure (Commercial Plans)

All covered drugs, including specialty drugs, are placed in one of four tiers for our commercial formularies. Copayments are dependent on both the member's pharmacy benefit structure and the tier in which the prescription drug falls. It is important for the member and provider to work together to determine which drug is appropriate.

- **Preferred Generic (Tier 1):** Medications on this tier have the lowest member cost sharing amount and include commonly prescribed generic drugs. Brand drugs may be included in Tier 1 if Sentara Health Plans recognizes that they show documented long-term decreases in illness.
- **Preferred Brand and Nonpreferred Generic (Tier 2):** Includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, which are considered by Sentara Health Plans to be standard therapy.
- **Non-selected Brand (Tier 3):** Includes brand name drugs not included by Sentara Health Plans on Tier 1 and Tier 2.
- **All Other (Tier 4):** Includes those drugs classified by Sentara Health Plans as specialty drugs. Tier 4 also includes covered compound prescription medications. For more information, reference the specialty drug section below.

Utilization Management Program

Sentara Health Plans' clinical staff, along with the P&T Committee, may require utilization

management edits prior to coverage or reimbursement for the drug. Setara Health Plans utilizes prior authorization, step therapy, and/or quantity limits. The formulary, which is available on the provider website, will indicate if a covered drug has any restrictions, or providers can refer to the prior authorization, step edit, and quantity limit drug lists.

- **Step therapy** is a process to ensure that Sentara Health Plans preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment. Sentara Health Plans utilizes claim history for approval of second course treatments at the point-of-sale. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs.
- **Quantity limit** restricts the quantity of a drug that is covered within a given time. This helps ensure the safety of our members by preventing high and/or inappropriate doses of medication at the point of sale. The quantity limits placed on medications are based on recognized standards of care, such as FDA recommendations for use, and may be periodically updated.
- **Prior authorization** requires prescribing physicians to send clinical documentation as part of the medical necessity request. Prior authorizations are placed for selected medications that have specific indication for use, are high in cost, or have increased safety concerns.
- An **exception request** for certain drugs may be obtained by filling out the specific prior-authorization form for the medication. These forms may be completed by an office staff member but must contain an original prescriber signature. For copies of the forms, go to the provider section of the provider website l or call pharmacy authorizations at clinical care services.

An exception request can be made by the provider, on behalf of the member, by either:

- calling the pharmacy provider services
- faxing an exception request form along with clinical evidence to pharmacy provider services

Formulary prior-authorization responses are generally received within two working days of Sentara Health Plans receiving the completed form and information from the provider.

Mail Order Prescription Drug Program

Commercial products and FAMIS members (excluding Medicaid plan and individual plan members) have the option of filling certain medications from a mail-order pharmacy. Our members may purchase a 90-day supply of drugs from Express Scripts mail services.

Members can register for Express Scripts by signing into the member portal.

Physicians can submit the prescription electronically directly to Express Scripts or contact them via phone.

For contact information on the mail order program, please reference the **"Sentara Health Plans Key Contacts"** section at the beginning of this document.

Diabetic Supplies

Diabetic testing supplies may be covered under the member's pharmacy or medical benefits. Most plans cover diabetic testing supplies under the members' pharmacy benefit, which allows members to buy their diabetic supplies from a local, in-network retail pharmacy. The Diabetes Supply Order Form may be found on the provider section of the website, or you may call Edgepark at **1-877-852-3512** or Home Care Delivered at **1-800-565-5644**.

Members should contact their member services department for more information about their diabetic testing supply coverage.

Injectable and Infusion Medications Administered in the Physician's Office

Sentara Health Plans has an agreement with Proprium Pharmacy to fill and deliver injectable and infusion medication orders for administration in the physician office. Proprium Pharmacy is a mail-order specialty pharmacy that provides certain prescription medications and immunizations directly to physician offices. Delivery to the physician's office is generally received within 24 hours of submitting the prescription order.

A 20% coinsurance may apply to certain drugs requiring prior authorization. The prior-authorization requirements also apply when using Proprium Pharmacy. Medications that are administered in the physician's office that require prior authorization are listed on the Sentara Health Plans injectable and infusion medication list on the provider website.

Proprium Pharmacy bills Sentara Health Plans directly for the medication. The physician office should only bill for the administration of the medication and should not collect copayments or coinsurance associated with the medications from patients. **Proprium Pharmacy will bill the member for the coinsurance or copayment amount**. Proprium Pharmacy may be reached by calling **1-855-553-3568**. Specialty forms are available to providers on the provider website. Providers may also bill Sentara Health Plans for pre-authorized injectable and infusion medications obtained from other sources by submitting the appropriate J code. When billing Sentara Health Plans directly for the cost of the medication, providers will be responsible for collecting any coinsurance amount due from the member when the remittance is received.

Limited Distribution Drugs

Manufacturers are increasingly limiting the distribution of specialty drugs to certain pharmacies. Instructions and ordering forms will be distributed to providers by Sentara Health Plans to facilitate continuity of care when this occurs. Sentara Health Plans will notify providers of limitations by mail, email, newsletters, and postings on the provider website.

Specialty Drugs

Specialty drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty drugs generally require unique dosing, administration, and additional education and support from a healthcare professional.
Specialty drugs include the following:

- medications that treat certain patient populations, including those with rare diseases
- medications that require close medical and pharmacy management and monitoring
- medications that require special handling and/or storage
- medications derived from biotechnology and/or blood derived drugs or small molecules
- medications that can be self-injected
- medications that can be delivered via injection, infusion, inhalation, or oral administration

Specialty drugs are only available through the specialty mail order pharmacy, Proprium Pharmacy. Please reference the **"Sentara Health Plans Key Contacts"** section for Proprium Pharmacy contact information.

Pharmacy Coverage Exclusions

The following is a list of products or categories that are not covered for reimbursement under the member pharmacy benefit contract. **Benefits for self-funded plans may vary, and coverage should be verified for self-funded plans.** This list is subject to periodic review by Sentara Health Plans and therefore may not be a complete listing of products.

Prescriptions for the following are **excluded** from coverage:

- Medications that do not meet Sentara Health Plans' criteria for medical necessity are excluded from coverage. If request for pre-authorization is denied, you have the right to file an appeal.
- 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.
- Medications with no approved FDA indications are excluded from coverage.
- Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law) are excluded from coverage except for injectable insulin. This exclusion does not apply to over-the-counter drugs that Sentara Health Plans must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- 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.
- Immunization agents, biological sera, blood, and blood products are excluded from coverage.
- Injectables (other than those self-administered and insulin) are excluded from coverage, unless authorized by the Plan.
- Medication taken by or administered to the member in the physician's office is excluded from coverage.
- Medication taken or administered, in whole or in part, while a member is a patient in a licensed hospital is excluded from coverage.

- Medications for experimental indications and/or dosage regimens determined to be Experimental 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 conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from coverage.
- Drugs with a therapeutic over the counter (OTC) equivalent are excluded from coverage unless required by law.
- Cosmetic health and beauty aids are excluded from coverage.
- Drugs purchased from non-plan providers over the internet are excluded from coverage.
- Drugs purchased through a foreign pharmacy are excluded from coverage unless approved by the Plan for an emergency while traveling out of the country.
- Minerals, fluoride, and vitamins are excluded from coverage unless determined to be medically necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
- Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage unless Covered under the Plan's "Durable Medical Equipment (DME) and Medical Devices, Orthotics, and Prosthetics, and Medical and Surgical Supplies" benefits.
- Raw powders or chemical ingredients are excluded from coverage unless authorized by the Plan or submitted as part of a compounded prescription.
- Infertility drugs are excluded from coverage.
- Prescription or OTC appetite suppressants and any other prescription or OTC medication for weight loss are excluded from coverage.
- Nutritional and/or Dietary Supplements, except as required by law, are not Covered Services. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not Covered Services. This exclusion does not apply to Plan Covered Services under the "Medically Necessary Formula and Enteral Nutrition Products" benefits.
- Member charges that result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from coverage and do not count toward any plan maximum out-of-pocket limit.
- Sentara Health Plans will not cover any additional benefits after benefit limits have been reached. The member will be responsible for payment for all outpatient prescription drugs after a benefit limit has been reached.
- 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.

Additional Pharmacy Policies

- Members may have transition of care benefits for certain medications when they are newly enrolled. Transition of care information is available to members by calling member services.
- Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to

treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration (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 FDA for use in the treatment of cancer on the basis that the drug has not been approved by the 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 FDA for use in the treatment of cancer pain because the dosage is more than the recommended dosage of the pain-relieving agent if the prescription has been prescribed for a person with intractable cancer pain.
- At its sole discretion, the Sentara Health Plans Pharmacy and Therapeutics Committee determines which tier a covered drug is placed in. The 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.
- Amounts the member pays for any outpatient prescription drug after a benefit limit has been reached, or for any outpatient prescription drug that is excluded from coverage, will not count toward any plan maximum out-of-pocket amount.
- 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.
- Sentara Health Plans may approve coverage of limited quantities of an OTC drug. You must have a physician's prescription for the drug, and the drug must be included on Sentara Health Plans' list of covered preferred drugs.
- Insulin, syringes, and needles are covered. 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 prescription drug rider are covered under Sentara Health Plans' medical benefit. Any plan maximum benefit does not apply to physician prescribed diabetic supplies covered under the medical benefit.
- Intrauterine devices (IUDs) and cervical caps and their insertion are covered under Sentara Health Plans' medical benefits.
- Written outpatient drug prescriptions must be executed on tamper-resistant prescription pads.

LABORATORY SERVICES

Laboratory services may only be performed by contracted lab providers. Any entity providing laboratory services must have the appropriate CLIA certificate.

In-office Lab

Sentara Health Plans reimburses providers for certain specific lab tests performed in the provider's office. Access the most current list of services that will be reimbursed by Sentara Health Plans when testing is performed in the provider's office here.

In addition to the in-office lab list, a limited number of specialty specific lab tests may be performed in certain specialty offices. Your network educator will provide you with details for your specialty. These specialties include:

- dermatology
- infectious disease
- ophthalmology
- urology
- endocrinology
- nephrology
- reproductive medicine
- hematology/oncology
- OB/GYN
- rheumatology

The in-office lab list is applicable to medical providers only and does not apply to behavioral health providers.

All other testing must be performed by a participating reference lab. Sentara Health Plans will reimburse providers for the draw fee. Charges from providers for lab tests other than the ones listed above will be denied as a nonallowed lab charge, and the member may not be held responsible.

Sentara Health Plans does not provide additional reimbursement to participating reference labs for the draw/collection.

Certain highly specialized lab tests may be available only from a few labs. Some exceptions apply for providers located in specific geographic areas. Please contact your network educator for guidance in these cases.

In-office Laboratory Services Reimbursement

- The office may bill one venipuncture fee per patient.
- Samples obtained by swab or cup are part of the office visit.
- Sentara Health Plans will not reimburse CPT code 99000 as a handling or draw fee.
- Sentara Health Plans will not reimburse CPT codes billed individually when they are considered part of a bundled CPT code.

Reference Lab Providers

Any lab test not included on the "in-office lab" list must be sent to a participating reference lab. Participating reference laboratory providers are listed on the provider website under the provider

search option.

Laboratory Draw Sites

Providers have the option of sending the patient with orders to a participating reference laboratory draw site. Members and providers may locate the nearest participating laboratory draw site by using the provider search option on the provider website or by calling provider services. Since locations and providers are subject to frequent additions and changes, the most reliable locator for current information is on the provider website.

Pre-operative Lab and X-ray

Members scheduled for surgery at a participating hospital may obtain services through a participating reference lab or may be sent directly to the admitting participating hospital with a prescription for pre-operative testing.

If surgery is scheduled with fewer than three days' notice, the lab testing should be performed by the admitting hospital.

Genetic Testing

All genetic testing requires prior authorization by the ordering physician prior to initiation of the order for tests and must be ordered from a participating genetic testing laboratory.

Toxicology Lab Services and Medication Compliance Testing

Aegis Sciences Corporation provides in-network toxicology lab services for all Sentara Health Plans service areas. In-depth medication compliance services, including pain management and substance abuse testing, are available for Sentara Health Plans medical and behavioral health providers for all Sentara Health Plans products.

REIMBURSEMENT

Sentara Health Plans follows American Medical Association (AMA) coding guidelines (e.g., CPT and HCPCS definitions) and health plan policy, as well as Medicare policies and procedures, to include the most current Correct Coding Initiative (CCI) edits when making claims payment determinations with respect to the following:

- bundling/unbundling
- anesthesia included in surgical procedure
- separate procedure definitions
- most extensive procedure
- sequential procedures
- mutually exclusive procedures
- misuse of component codes with comprehensive codes
- standard preparation/monitoring services
- standards of medical/surgical practice
- laboratory panels

The above list is not meant to be all-inclusive but represents major categories of edits where Sentara Health Plans routinely uses Medicare rules as its basis. Sentara Health Plans may utilize proprietarily purchased software products that incorporate similar coding and compliance rules into Sentara Health Plans' claims processing edits.

Clear Claim Connection (C3) is a web-based code-auditing reference tool that enables Sentara Health Plans to disclose code-auditing rules and associated clinical rationale. Medical providers can enter outpatient claim information using CPT and/or HCPCS codes, obtain audit results, and review recommendations. Clear Claim Connection is available to medical providers through the provider portal on the provider website. 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 and how to go about obtaining those edits.

Provider Fee Schedule

Provider compensation arrangements and rates are detailed in your provider agreement. Information and current policies for developing fee tables and gap filling fees for existing codes or assigning fees to new codes may be obtained by contacting your contract manager.

BILLING AND PAYMENTS

Contracted Amounts/Billing Covered Persons

By entering into a provider agreement, you have agreed to accept payment directly from us. This constitutes payment in full for the covered services you render to 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 between the two amounts.**

Appropriate Service and Coverage

Sentara Health Plans has mechanisms in place to detect and correct potential under and overutilization of services. As such:

- Utilization management (UM) decision-making is based only on appropriateness of care and service.
- The managed care organization does not compensate providers or other individuals conducting utilization review for denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage denials of coverage or service.

Medical Necessity

Sentara Health Plans may deny claims for services deemed medically unnecessary. If the provider does not agree with Sentara Health Plans' determination, the provider may submit medical documentation (chart copies, treatment sheets, consultation reports, etc.) with a request for reconsideration to Sentara Health Plans.
See the Appeals Section in this manual for more detailed information.

Members may not be billed for services determined to be not medically necessary by Sentara Health Plans, unless:

- The member has been informed prior to receiving the services that those services may not be covered under the member's benefit plan.
- The members have agreed in writing to pay for the services at the time or before services are rendered.
- A patient should be billed directly if it cannot be proven that a patient is a member at the time of service. If it is later determined that the patient is indeed a member, you must refund the member any payments he/she made **more than** applicable copayments, coinsurance, or deductibles and file a claim for the service rendered. Please see the "Copayments and Coinsurance**"** section of this manual for more information.

Payment Policies

As of November 1, 2023, Sentara Health Plans payment policies are accessible through the secure provider portal. The policies, stored in Compliance 360, explain acceptable billing and coding practices to equip providers with information for accurate claims submission. Sentara Health Plans will inform providers as new policies are published. To access the policies, providers must have an active provider portal account.

Coding

Sentara Health Plans requires the most current procedure and diagnosis codes based on Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) guidelines for inpatient and outpatient claims. The principal diagnosis is the condition established after study to be chiefly responsible for causing the hospitalization or use of other Hospital services. Each inpatient diagnosis code must indicate in the contiguous field whether symptoms warranting the diagnosis were present on admission.

Sentara Health Plans will group to MS-DRG or APR DRG groupers as appropriate.

Revenue codes must be valid for the Bill Type and should be listed in ascending numeric order. CPT or HCPCS codes are required for ambulatory surgery and outpatient services and NDC numbers are required for drugs.

Appropriate DRG information is required in Field 71 for all Hospital reimbursement methodology. For Hospital claims based on DRG methodology, the claim will be denied "provider error, submit corrected claim, provider responsible" (D95) if the applicable type of DRG information, based on the Provider Agreement, is not indicated.

Please refer to the most current version of the Uniform Bill Editor for a complete and current listing of Revenue Codes, Bill Type, and other Facility claims requirements.

Corrected Claim Submission of a Previously Billed Claim

Bill Type is a key indicator to determine whether a claim has been previously submitted and processed. The first digit of the Bill Type indicates the type of Facility, the second digit indicates the type of care provided and the third digit indicates the frequency of the bill. Bill Type is important for interim billing or a replacement/resubmission bill. Claims submitted for correction require a "7" as the third digit. "Resubmission" should be indicated in block 80 or any unoccupied block of the UB-04 or box 22 of the CMS-1500 form. Enter the original claim number of the claim you are replacing in the right side of item 22.

Inpatient Billing Information

Clinical Care Services (CCS) will assign an authorization number based on Medical Necessity. The authorization number should be included in the UB claim.

Copayments, Deductibles, or Coinsurance may apply to inpatient admissions.
Inpatient claim coding must follow "most current" coding based on the date of discharge. If codes become effective on a date after the Member's admission date but before the Member's

discharge date, Sentara Health Plans recognizes, and processes claims with codes that were valid on the Member's date of discharge. If the Hospital Agreement terms change during the Member's inpatient stay, payment is based on the Hospital Agreement in effect at the date of discharge. If the Member's benefits change during an inpatient stay, payment is based upon the benefit in effect on the date of discharge. If a member's coverage ends during the stay, coverage ends on the date of discharge.

An inpatient stay must be billed with different "from" and "through" dates. The date of discharge does not count as a full confinement day since the Member is normally discharged before noon and therefore, there is no reimbursement.

Pre-Admission Testing

Pre-admission testing may occur up to ten (10) days prior to the ambulatory surgery or inpatient stay. The testing may include chest x-rays, EKG, urinalysis, CBC, etc. The tests should be performed at the same Facility at which the ambulatory surgery or inpatient stay is ordered. The tests should be billed on the inpatient or ambulatory surgery claim. The admission date for ambulatory surgery must be the actual date of surgery and not the date of the pre-admission testing.

- Sentara Health Plans will only pay separately for pre-admission testing if the surgery/ confinement is postponed or canceled.
- If the pre-admission testing is billed separately from the ambulatory surgery or inpatient stay and the surgery was not postponed or canceled, the pre-admission testing will be denied "provider billing error, provider responsible" (D95).

Re-Admissions

Members re-admitted to the Hospital for the same or similar diagnosis will be considered as one admission for billing and payment purposes according to the terms of the Facility Agreement. This protects the Members from having to pay multiple cost-share amounts for related readmissions within a short period of time.

Sentara Health Plans follows the DMAS reimbursement policies for readmissions for the Sentara Health Plans Medicaid program.

Never Events and Provider Preventable Conditions

Sentara Health Plans requires providers to code claims consistent with CMS "Present on Admission" guidelines and follows CMS "Never Events" guidelines.

A "never event" is a clearly identifiable, serious, and preventable adverse event that affects the safety or medical condition of a member and includes provider preventable conditions. Healthcare services furnished by the hospital that result in the occurrence and/or from the occurrence of a "never event" are considered noncovered services.

When an inpatient claim is denied as a "never event," all provider claims associated with that

"never event" will be denied. In accordance with CMS guidelines, any provider in the operating room when the error occurs who could bill individually for their services is not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. The hospital providing the repair will be paid. All "never event" claims are reviewed by the Sentara Health Plans medical director.

Providers are required to report "never events" and "provider preventable conditions" associated with Medicaid program claims for payment or member treatments for which payment would otherwise be made by using the DMAS form on the Sentara Health Plans website.

DMAS requires verbal reporting of incidents within 24 hours.

Furloughs

Furloughs (revenue code 018X) occur when a member is admitted for an inpatient stay, discharged for no more than ten days, and then readmitted under the same authorization. Examples include situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests but cannot begin immediately.

Interim billing

Interim Billing indicates that a series of claims may be received for the same confinement or course of inpatient treatment that spans more than thirty consecutive days. Interim billing may be based on the month's ending date (Medicare) or based on a 30-day cycle from the date that charges begin. The appropriate Bill Type should be indicated for each claim.

Newborn Claims

Claims for newborn members may be sent utilizing the **subscriber's** member ID number, the **newborn's date of birth,** and the newborn's name in field 2 of the CMS-1500 form. Coverage for a newborn child or adopted newborn child of a member will begin at birth if the newborn is added to the plan within 31 days of birth. Sentara Health Plans does not delineate between sick or well newborns, or whether the care is rendered in an inpatient Facility or provider's office. Claims for infants outside of 31 days from the newborn's date of birth will suspend for review of newborn eligibility and will be processed according to the enrollment status of the newborn.

Normal newborn charges for care rendered in the Hospital (while the mother is confined) will be paid whether the newborn is enrolled in Sentara Health Plans or not. One claim should be submitted for the mother and a second claim should be submitted for the newborn.

If the newborn must stay in the Hospital after the mother has been discharged (boarder baby), the newborn must be enrolled, and must have an inpatient prior authorization under the newborn's own Member ID number for the charges to be covered. The "boarder baby's" date of admission should equal the mother's date of discharge.

Please see the Sentara Health Plans Medicaid Program Care Provider Manual for newborn

enrollment information.

Organ Transplants

Sentara Health Plans contracts directly with Optum Health Care Solutions for organ transplantation services. A limited number of direct contracts with local and regional transplant providers are used as part of the Optum Managed Transplant Program. **Prior- authorization is required for transplant services, even if Sentara Health Plans is the secondary payer**.

Prior authorization should be obtained at the time the member is identified and referred for organ transplant evaluation for all plans.

Please see the Sentara Health Plans Medicaid Program Provider Manual for transplant information specific to the Medicaid program.

Skilled Nursing Facility Services

Placement in a Skilled Nursing Facility (SNF) requires prior authorization. Clinical Care Services will make the necessary arrangements for the Facility admission. Case Managers will review SNF services concurrently and authorize a continued stay as appropriate and arrange the Member's transition to home. If a member has exhausted their SNF benefit or has been moved to custodial care, the SNF service is no longer a Covered Benefit.

Sentara Health Plans Medicaid program Skilled Nursing Facility services follow payment methodology as published by the Department of Medical Assistance (DMAS).

Sentara Health Plans Medicaid program requires that a valid screening exists for individuals admitted to a certified Nursing Facility. Screenings must be entered into the electronic preadmission screening (ePAS) system (or approved alternative) prior to an admission to receive reimbursement.

Inpatient Denials/Adverse Decisions

If the attending Physician continues to hospitalize a Member who does not meet the Medical Necessity criteria, or there are Hospital related delays (such as scheduling), all claims for the Hospital from that day forward will be denied for payment. The claim will be denied "services not pre-authorized, Provider responsible (D26)". The Member cannot be billed.

If a family member insists on continued hospitalization (even though both the attending Physician and Sentara Health Plans agree that the hospitalization is no longer Medically Necessary), the claims related to the additional days will be denied. The claims will be denied "continued stay not authorized, Member responsible (D75)".

For all medically unnecessary dates of service, both the Provider and Member will receive a letter of denial of payment from Sentara Health Plans. The letter will note which dates of service are to be denied, which claims are affected (Hospital and/or attending Physician), and the party having responsibility for the charges.

Facility Outpatient Services

Members may receive certain outpatient services (i.e., diagnostic tests, chemotherapy, radiation therapy, dialysis, physical therapy, nutritional counseling, etc.) per their benefit plan. Providers must use UB bill type 131 for outpatient services.

Outpatient Facility services typically have a member cost-share associated with them. Sentara Health Plans assigns certain revenue codes to specific plan benefits. For example, revenue codes 0450-0459 are mapped to Emergency Department services, and further drive the determination of the Member's cost share. The default outpatient benefit is "outpatient diagnostic". Member cost share may be waived if the Member is subsequently admitted.

If no dollar amount is billed on the claim, Sentara Health Plans automatically assigns zero dollars as the Billed Amount. If quantity is not reported, Sentara Health Plans automatically denies the claim and request additional information from the Provider.

Laboratory Services

Sentara Health Plans Reference Lab Providers are required to provide an electronic report each month. That report includes actual test values for selected tests used by Sentara Health Plans in HEDIS reporting and in disease management. Laboratory Provider service standards and reporting requirements are listed in the Reference Laboratory Provider Agreement.

Emergency Department Services

Emergency services are those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a **prudent layperson** who possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual
- Danger of serious impairment of the individual's bodily functions
- Serious dysfunction of any of the individual's bodily functions
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Examples of emergency services include, but are not limited to, heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions.

There are no follow-up days associated with an emergency room visit. Emergency room Providers must direct the Member to the appropriate provider for follow up care**.**

A member liability amount may apply under the Member's benefit plan. If the Member is directly **admitted to the same Hospital** where the ER service was performed, the emergency room Facility charges should be added to the inpatient or ambulatory surgery bill submitted by the Facility. The Member is only responsible for the inpatient or ASC copayment, coinsurance or

deductible as applicable. If the Member is not directly admitted to the same Hospital, the Emergency Department charges are paid separately from the inpatient charges. In this situation, the Member may visit the Emergency Department, return home, and be admitted later in the day (normally within 24 hours).

Member Cost Share

You should expect payment of member copayments at the time of service. If the copayment is more than the charges for the service rendered, the allowed charge amount should be billed to the member instead of the full copayment.

The Sentara Health Plans remittance advice will indicate the "patient responsibility" amount. After receipt of the remittance, you will be able to calculate and bill the member for the amount due for any coinsurance or deductible.

Coordination of Benefits (COB)

Group health plans coordinate benefits with various other payers on either primary or secondary basis to avoid duplication of coverage among payers that have partial liability for the same bill. Work-related claims and similar liability insurance claims are **not** covered by group health plans.

Access detailed Sentara Health Plans Coordination of Benefits Policies found here.

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 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 state agency.

Pursue Letter

On occasion, Sentara Health Plans may be identified as the member's primary insurance in error. If Sentara Health Plans has paid as the primary carrier instead of the secondary carrier, Sentara Health Plans will send a "pursue" letter to the provider stating the member has other primary insurance. If the provider files with the primary insurer, Sentara Health Plans will coordinate as the secondary carrier.

If the provider has not received the EOB from the primary carrier after 30 days of receipt of Sentara Health Plans pursue letter, Sentara Health Plans will retract any claim paid and deny the claim pending receipt of the primary carrier's EOB.

Overpayments

As part of the Sentara Health Plans audit process, Sentara Health Plans and/or its

subcontractors may use statistical sampling and extrapolation of claims in determining the amount of an overpayment made to a provider. The extrapolation methodology utilized by Sentara Health Plans is consistent with the methodology authorized in the Medicare Integrity Manual. In most cases, when a provider is paid in error, Sentara Health Plans automatically executes a retraction with 30 days advance notice to the provider stating the reason for the retraction. If retraction is not reasonable or possible and the provider would prefer to send a refund, please send a copy of the remit, the reason the claim was paid in error, and the payment check within 30 days to the Sentara Health Plans provider receivables address in the **"Sentara Health Plans Key Contacts"** section of this manual.

If the remit is not available, please send a check with the member's name, member ID number, the reason the claim was paid in error, and the date of service to the provider receivables address. Please be sure to make the check payable to the company that sent you the check.

CLAIMS

General Information and Filing Requirements- Rendering and/or Billing Provider

- The preferred method for claim submission to Sentara Health Plans is electronic claim submission. Claims can be submitted through Availity or any clearinghouse that can connect through Availity.
- All claims must be submitted within the guidelines of the product (see the "timely filing" section in this chapter), or they will be denied as a late claim submission.
- Claims submitted must be for participating providers within the practice.
- Submit paper claims on the standard CMS 1500 form for professional providers or UB-04 form for facilities. All claims must be "clean claims."
- In order to process a claim, we require a valid W-9 for the provider tax identification number (TIN) on file with Sentara Health Plans. Claims submitted without a W-9 may be rejected by a clearing house or Sentara Health Plans, or administratively denied. We may require that any claim submitted without a valid W-9 on file be resubmitted in order to be processed.

NPI

All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number and taxonomy code will be rejected or denied.

Completing the CMS 1500 Claim Form

To expedite payment and avoid re-submission of claims, it is important to fill out the CMS 1500 claim form as completely and accurately as possible. Submit claims containing all the data elements and industry-standard coding conventions. The National Uniform Claims Committee (NUCC) provides standard instructions for completing the 1500 form on their website at nucc.org.

The CMS 1500 claim form version 02-12 is required by Sentara Health Plans.

Listed below are some of the fields that cause most payment delays:

- Complete all patient-identifying information in boxes 1–13. The **member's ID** and **group number** should be placed in **boxes 1a and 11**. Paper claims will be accepted when billed under the Sentara Health Plans member ID or the Social Security number.
- The member's name submitted on the claim must match the member's name in box 12.
- Either the patient's signature or the words "signature on file" are required.
- **ICD-10** diagnosis codes are required on all claims, or the claim will be denied for invalid diagnosis code and must be resubmitted for correction within 365 days from the last date of service.
- For unlisted or miscellaneous procedure codes (codes ending in 99), an English description of services or complete list of supplies must be provided.

A "clean claim" will be processed and paid by Sentara Health Plans within 30 days of its

receipt. Processing delays may occur for claims that require coordination of benefits, code review, or medical review.

Paper Claims

All paper claims should be sent to the claim address on the member's ID card.

Common Reasons for Claim Rejection

- There are errors in the member's name.
- Hyphenated last names are submitted incorrectly.
- The birth date submitted doesn't match the birth date associated with the member ID number.

Remittance Advice

A remit is an explanation of reimbursement. The remittance advice details claim adjudication. Providers registered with the provider portal may download their remittance advice.

Negative Vendor Status

This term is used for information purposes for claims that are paid to vendors with negative balances. Vendors can enter a negative status when retractions are greater than positive payments. Retractions are done to correct overpayments. An example of a common overpayment issue is if Sentara Health Plans paid a claim as the member's primary carrier but should have paid as secondary. Reversing the claim to pay as secondary could create a negative balance if the dollar amount for other claims being paid would not cover the reversal. The provider would then be in a negative vendor status and receive no additional payments until new claims are approved for payment or a refund is received by Sentara Health Plans.

Interim Reports

When providers enter a negative vendor status, they begin receiving a negative vendor interim statement rather than a check and a remit. The negative vendor interim statement reports all claims received and processed to that vendor's account for that month. It is to be used for information purposes only and should not be used for posting. When enough claims have been received to balance out the negative amount, or the provider refund check has been received, the provider will receive a remit. Claim payments will resume.

Pending Claims

If a claim needs to be reviewed by claims processing or clinical staff, it will be assigned a "suspend" code. The "suspend" code states the reason for the suspension. The pending claims report is sent with remittance statements. Suspend code descriptions appear at the end of the report.

If a claim has been on your pending report for more than 30 days from the date of the report, call

provider services for medical or behavioral health claim information to resolve its status.

If your claim has not been paid or denied and is not pending for any reason, please call provider services for information. If the claim is confirmed as not received, a second request must be submitted. These claims are subject to the timely filing policy.

Authorization Search

The authorization search program matches newly received authorizations to pending claims. This program finds authorizations entered after claims are pended. The program also checks for additional suspension reasons, such as medical review or coordination of benefits. If none are found, the claims are released.

Timely Filing Policy

All claims are to be submitted within one year, 365 days of the date of service. This includes first time submission claims and claims that have been previously paid or denied (reconsideration).

Sentara Health Plans allows 18 months from the date of service to coordinate benefits.

Late Claim Reconsiderations and Appeals

Requests for waivers to the timely filing requirements due to an exceptional circumstance must be made in writing within the reconsideration filing deadlines and should be submitted to the Sentara Health Plans claims department.

In situations where a provider does not agree with the reconsideration decision on a claim, an appeal should be filed according to the Appeal section in this manual.

Duplicate Claims and Reconsiderations

Duplicate claim submission is one of the biggest obstacles encountered during the claims process. If you are unsure if a claim has been filed, please view claim status on the provider portal, or call provider services to inquire on the status of your claim. Sentara Health Plans checks for duplicate claims by comparing the member number, vendor identification number, date of service, procedure code, and total charges of the current claim to claims that are stored in the member's history. Some service lines may be paid, and other service lines denied as duplicates, or the entire claim may be denied as a duplicate.

A "new claim" is a first submission by the provider. It has not been previously billed or processed and does not reference another claim.

A 're-billed" or "corrected claim" is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service and/or procedures.
A reconsideration is a written notification from the provider indicating their request to review how a claim is processed. No changes to the claim are being made. Please see the "Claim Payment Reconsiderations" section of this manual for detailed information.

Changes in Insurance Information

If a provider receives corrected insurance information from the member and provides supporting documentation (for example, original dated registration, new registration, etc.) the provider may submit a claim to Sentara Health Plans within 90 days of receipt of the new information.

Retroactive Disenrollment

Sentara Health Plans will use reasonable efforts to determine in a timely manner that a member has been disenrolled. Should an employer group retroactively disenroll one of its members, Sentara Health Plans will retract claim payments for that member made for dates of service falling after the effective date of the member's disenrollment. The provider will be given 30 days' notice prior to the retraction of the claim.

Health Insurance Marketplace Three-month Grace Period Mandate

Plans sold on the marketplace have a mandated three-month grace period for individuals who receive an Advance Premium Tax Credit (APTC) when they have paid at least their first month's premium but are delinquent in subsequent premium payments.

In accordance with the mandate, Sentara Health Plans will process claims for service rendered during the first month of the grace period. Claim payment for services received during the second and third month of the grace period will be suspended until the premium is paid in full or the grace period ends, and the member's enrollment is terminated for nonpayment.

If the member fails to pay the full premium balance before the end of the grace period, the member will be disenrolled. At that time, all claims for services during the second and third months will be denied, and the member will be responsible for the payment of these services in full. Sentara Health Plans will not retract claim payments from services rendered during the first month of the grace period.

Providers will receive notification when claims are suspended for nonpayment of premium during the second and third months of the grace period and will be informed of a grace period status when contacting provider services for eligibility verification. Eligibility status is also available 24 hours a day through the provider portal located here. The provider portal will indicate that the member is in the grace period with the dates that claims will be pended.

Claims Denied in Error

The provider's office must follow up with Sentara Health Plans within 365 days of the date of service for claims the provider suspects have been denied in error. If, after researching the claim, Sentara Health Plans discovers that the claim was denied in error, the provider is entitled to payment.

Worker's Compensation

Any claim with an injury diagnosis code for a patient over the age of 16 will be reviewed. Sentara Health Plans communicates with the members to determine if the injury is work-related. We will automatically send a letter to the member requesting information about the injury. The member has 30 days to respond to the request for information.

If a claim is paid under a Sentara Health Plans benefit plan prior to determining that it is a workers' compensation claim, Sentara Health Plans will reverse the payment. The claim should be submitted through the member's employer's workers' compensation plan.

Dispute Resolution

Any dispute between the parties arising out of or relating in any manner to the provider agreement, whether sounding in tort, contract, or under statute (a "dispute"), shall first be addressed by exhausting all policies and procedures applicable to the dispute, including but not limited to claims payments, credentialing, utilization management, adverse benefit determinations, or other programs, including applicable appeals procedures, before either party may seek to resolve the dispute in any other forum or manner. If the dispute is not resolved by the parties via the policies and procedures or is of a type not subject to the policies and procedures, the parties shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The negotiations may be initiated by either party upon written request to the other (the "meeting request notice"), provided such meeting request notice is delivered in accordance with the notice requirements of the provider agreement within 60 days of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the dispute. The negotiations shall occur within 30 calendar days following the day the receiving party receives the meeting request notice, and neither party may seek to resolve the dispute in any other forum or manner unless the dispute is not resolved within 60 days after the meeting request notice.

The deadline for initiating any recovery efforts (including applicable regulatory time frames and or statute of limitations) shall be tolled by the applicable dispute resolution procedures and appeal process(es) set forth in the policies and procedures and herein.

All dispute resolution procedures shall be conducted only between the parties and shall not include any member unless involvement of a member is necessary to the resolution of the dispute, which determination shall be made in the sole discretion of Sentara Health Plans or the payor.

ELECTRONIC CLAIMS AND ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 24 hours after payments are processed. Clean claims are processed and paid for by Sentara Health Plans within an average of seven days when submitted electronically and when payment is made through EFT. Commercial and Medicaid program providers must complete the electronic payment/remittance authorization agreement to enroll.

The form can be accessed here.

For Medicare claims, EFT and ERA will be issued through Payspan. This change will require a Payspan account. For providers that already access Payspan, updates will be required.

New Payspan Users — How to Register:
Contact providersupport@payspan.com or **1-877-331-7154**, option 1, for help obtaining registration codes and assistance with navigating the website. Provider services specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m.

If provider data is not loaded in Sentara Health Plans' new claims platform, or if feedback is received from Payspan that there is no provider entry in the Payspan system, a claim must be submitted to Sentara Heath Plans to receive a paper check. This check will include registration information for Payspan.

For Current Payspan Users:
If providers already have an account, there will be a single registration code that is tied to the pay to entry. If there are multiple pay to entries in Sentara Health Plans' claims platform, providers will have multiple registration codes. To obtain a code, providers can contact Payspan and provide their TIN/NPI.

If there are any questions, please contact a Payspan provider service representative at **1-877-331-7154**.

Filing Claims Electronically

Providers that submit claims to Sentara Health Plans' electronic claims program enjoy several benefits: documentation of claims transmission, faster reimbursement, reduced claim suspensions, and lower administrative costs.

- Claims can be submitted through Availity or any clearinghouse that can connect through Availity.
- The Sentara Health Plans payer ID number is 54154
- Providers who can receive data files in the HIPAA compliant ANSI 835 format may elect to receive EFT/ERA directly from Sentara Health Plans. The 835 transaction contains remittance information as well as the electronic funds transfer.

Inquiries about direct claims submission or EFT/ERA transactions may be submitted by email to EFT_ERA_Inquiry@sentara.com.

- All claims must be submitted within the timely filing policy provisions stated in your agreement or as dictated by plan policy. Please see the "**Timely Filing Policy**" section in the "**Claims"** chapter of this manual.
- Claims submitted electronically will be accepted when billed under the member's Sentara Health Plans member ID, the member's Social Security number, or for the Sentara Health Plans Medicaid program, the member's Medicaid number. Providers should first review their clearinghouse requirements for submission of member identification to confirm that their clearinghouse will accept claims using their chosen option for submission.
- Claims submitted must have charge amounts. Claims for zero charge amounts will be rejected.
- Claims submitted electronically will be received within 24 hours of processing.

Required Claims Information

All information noted in the **"Claims"** chapter of this manual is applicable to claims filed electronically.

Birth Date

Claims submitted with incorrect birth dates (birth date submitted does not match birth date associated with member ID number submitted) will be rejected.

Corrected Claim Submissions

Sentara Health Plans accepts the following corrections electronically:

- patient payment
- service periods/dates
- procedure/service codes
- charges
- units/visits/studies/procedures
- hospitalization dates
- name or ID number of referring provider
- provider ID
- wrong member ID number or birth date

Coordination of Benefits (COB)

Sentara Health Plans accepts secondary and subsequent claims electronically. Your clearinghouse or software vendor is the best resource for you to determine how to submit the necessary data. Please provide:

- full claim allowed amount
- patient responsibility at the claim level
- any additional line information that is available

Status Reports

Provider sites receive “status” or “response” reports that will give the total number of claims transmitted, filed, denied, rejected (invalid), and pended. Pended claims require review. A pended claim does not necessarily mean that the provider has to furnish additional information.

Support for Electronic Claims Filing

The Sentara Health Plans Professional Companion Guide is available here.

The Sentara Health Plans Institutional Companion Guide is available here.

Contact your current EDI vendor for:

- problems with transmission
- level one or level two errors

Contact provider services for:

- consistent rejections of claims, although information is correct
- status of claims received electronically
- questions concerning the adjudication or payment of claims sent electronically

INFORMATION FOR SPECIFIC CLAIM TYPES (A-Z)

Add-on Codes

The CPT code book identifies add-on codes with a + symbol. These codes are to be added to a primary procedure. They cannot be billed alone. Sentara Health Plans adjudicates add-on codes at 100 percent of the allowable fee schedule. They are not subject to multiple surgery discounts or reductions.

After-office Hours Codes

- After-office hours codes can only be billed when the services extend beyond the **posted** hours.
- Two codes are used for billing after-hours care: the appropriate office visit code and the appropriate after-hours code.
- Specialists are not reimbursed for after-hours codes.

Allergy Claims

The office visit copayment applies to allergy injections. The date of each injection must be indicated on the claim. Since allergy benefits vary, please confirm eligibility and specific allergy benefits and authorization requirements by calling provider services and choosing option 2.

Anesthesia

The most current ASA codes should be used when billing anesthesia codes. The claims processing system will automatically add the appropriate base units based on Medicare guidelines. If appropriate, use modifying units such as physical status and qualifying circumstances. Bill for time and modifying unit only, include start and stop times, and use the following guidelines:

- 00–15 minutes 1 unit
- 16–30 minutes 2 units
- 31–45 minutes 3 units
- 46–60 minutes 4 units

Anesthesia Modifiers

According to ASA guidelines, there are specific units associated with the physical status modifiers:

- All P1, P2, and P6 modifiers will not receive any additional payment.
- Claims with modifiers P3, P4, and P5 may require supporting documentation as a prerequisite for payment.

Code 99211

CPT code 99211 is used for an evaluation and management visit that may not require the presence of a physician. Presenting problems are usually minimal, and time spent performing or

supervising services is typically five minutes or less. An appropriate use of this code would include a blood pressure check performed by a nurse where medications were maintained or changed at the time of the visit. This service includes an exam and decision making.

Code 99211 should **not** be used if **only** the following services are being performed on the date of service:

- administration of injections (vitamin B-12, Depo-Provera, etc.)
- administration of medication for an established course of therapy following a protocol that does not require physician input for dosing (chemotherapy, PUVA) when no other services are performed
- routine in-person prescription renewal and telephone prescription renewal
- venipuncture (use code 36415 when no other service is performed)
- allergy injections

Conscious Sedation and Monitored Anesthesia Care

Reimbursement is provided for conscious sedation as part of the non-facility payment when the conscious sedation is administered and monitored by the provider performing in-office diagnostic procedures and surgeries. Monitored anesthesia care that is provided by a qualified participating anesthesiologist or CRNA will receive separate reimbursement in accordance with criteria for medical necessity.

Payments to participating anesthesia providers for in-office monitored anesthesia care are based on an all-inclusive case rate. Participating providers are responsible for any associated payments for services provided in conjunction with diagnostic and surgical services provided in the office setting by nonparticipating providers based on a participating provider referral or subcontract arrangement.

General anesthesia is excluded from coverage in an office setting.

Fluoroscopic Guidance and Contrast

Sentara Health Plans allows the reimbursement of fluoroscopic guidance and, in general, follows CCI guidelines on payment of this procedure. The policy is available upon request.
Sentara Health Plan allows the reimbursement of contrast materials under specific circumstances in accordance with CMS guidelines. The policy is available upon request.

Immunizations and Injections

- Provide the name of the injectable and the appropriate CPT code or J code.
- Provide the amount, strength, dosage, and, when appropriate, the NDC number.
- Provide the charge.

Incident–to Guidelines

Per the Centers for Medicare & Medicaid Services (CMS), national coverage provision for

incident-to services, when nonphysician practitioners (NPPs) render services that are incident-to a physician service, they may bill under the physician when the service is:

- an integral part of the physician's professional service
- commonly rendered without charge or included in the physician's bill
- of the type that is commonly furnished in physician offices or clinics
- furnished by the physician or auxiliary personnel under the physician's direct supervision

CMS defines incident-to services as those performed by an NPP who is under the supervision of a physician and who is employed by or contracted with the physician or the legal entity that employs or contracts with the physician.

There must have been a direct, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician is an incidental part, which means that the physician must see the patient first to initiate the plan of care for the patient. The NPP would follow the physician's plan of care for subsequent services. The physician must perform the initial service for the diagnosis and must remain actively involved during treatment. The physician must perform subsequent services that reflect his or her continued active involvement in the patient's care.

Psychiatric nurse practitioners must be licensed independently and credentialed by Sentara Health Plans. They may not utilize incident-to billing.

Example: If a patient informs the NPP of a new problem while being seen in a subsequent visit for an established problem with an established plan of care, the visit cannot be billed incident-to because the physician has not seen the patient to establish a new plan of care for the new problem. If the NPP is credentialed with Sentara Health Plans and the services are within the NPP's scope of practice, then the NPP should bill the appropriate level of new or established E/M service provided under his or her own provider number.

Per CMS guidelines, "direct supervision in the office setting means the physician must be present in the office suite and immediately available to provide aid and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room with his or her aide."

The only time an NPP can bill a service under a physician is when a physician is in the office suite and directly available to help. **The physician being available by phone is not appropriate and does not constitute direct supervision.** ***More information is available from: CMS. (Revised 2016). Incident-to*** **located here.**

Laboratory Claims

Reference lab providers may submit claims using the CMS 1500 format or UB 04 format.

Modifier 51 Exempt

The CPT code book identifies modifier 51 exempt codes with an "Ø" symbol. Sentara Health Plans adjudicates these exempt codes at 100 percent of the applicable fee schedule and will not

apply multiple surgery discounts or reductions.

Pathology Reports

Pathology reports are required when a skin lesion is excised in the office or an ambulatory surgery facility. Pathology may not be billed as office charges. The physician may bill for excising the lesion. Either the lab or the pathologist may bill for examination of the specimen and for the written report.

Subrogation

Subrogation laws vary by state, and some states' laws do not permit subrogation for certain products. Sentara Health Plans follows the applicable state law.

Surgical Procedures

Miscellaneous surgical codes require operative notes. Failure to submit operative notes with the claim will delay payment.

Unlisted Procedure Codes

"Unlisted" procedure codes are those codes ending in 9. Additional information must always be provided when these codes are billed. They are "special report" codes and do not have fees assigned. Examples of documentation are OP reports for unlisted surgical procedures and specific descriptions of lab tests and their methods. If the documentation is not provided with the claim, processing delays or denials may occur due to insufficient information. If the claim is denied, please provide the additional information, and submit the claim for reconsideration within 365 days of the date of service.

CLAIMS POLICIES– MODIFIERS

AS Modifier – Surgical Assistants

Sentara Health Plans allows reimbursement for surgical assistants under the following conditions:

- A surgical assistant is a physician's assistant or nurse practitioner who provides diagnosis and treatment of patients under the supervision of a surgeon. A surgical assistant is a nonphysician, as opposed to an assistant surgeon who is a physician.
- The physician's assistant or nurse practitioner must be credentialed with Sentara Health Plans and bill with a separate and distinct provider number from the primary surgeon.
- The primary surgeon should bill with the appropriate procedure code and the nurse practitioner or physician's assistant should bill with the same procedure code with an AS modifier.
- Sentara Health Plans does not limit the procedures to which an AS modifier would be allowed.

Surgical assistant reimbursement is 10% of the Sentara Health Plans maximum allowable fee.

24 Modifier – Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

Modifier 24 is required for payment of an evaluation and management service that was performed during a postoperative period for a reason unrelated to the original procedure.

25 Modifier – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

When a preventive examination and a problem-oriented evaluation and management service are reported on the same day for the same patient, the problem-oriented evaluation and management service, appended with modifier 25, is reimbursed at 50% of the allowed amount.

Preventive Medicine Codes:

- 99381–99397 (Preventive Medical Exam)
- G0402 (Preventive Physical Exam)
- G0438–G0439 (Annual Wellness Exam)

Problem-oriented Codes:

- 99201–99215

Per CPT guidelines, modifier 25 (a significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service) is required to be billed in conjunction with the problem-oriented visit evaluation and management code when a preventive medicine service is reported on the same day for the same patient.

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81 Modifier – Professional/Technical Component

Sentara Health Plans follows CMS guidelines for coding and reimbursement of professional, technical, and global procedures. Modifier 26 is appended to the primary procedure code to report and bill for the provision of the professional component (PC) of a procedure. Modifier TC is appended to the primary procedure code to report and bill for the provision of the technical component (TC) of a procedure. Reimbursement of modifier 26 is provided only for codes designated by the CMS national physician fee schedule relative value file as having a separately identifiable and billable technical/professional component.

- **CMS National Physician Fee Schedule Relative Value File, PC/TC Designation of 1 or 6**
  Modifier 26 is applicable for the procedure code. If billed by a professional provider with a facility place of service, the procedure must be billed with modifier 26 or the claim will be denied.
- **CMS National Physician Fee Schedule Relative Value File, All Other PC/TC Designations**
  A separate professional and technical component is not applicable for the procedure code. If billed with a modifier 26 by a professional provider the claim will be denied regardless of the place of service.

Global procedure codes include reimbursement for technical and global components. Modifiers 26 and TC should not be used for global procedures. Global codes billed by a professional provider with a facility place of service will be denied.

51 Modifier – Multiple Surgical Procedures

Multiple procedures are defined as two or more CPT codes (10000–69999) procedures performed at the same time.

A clinical representative will review claims with four or more surgical procedures. However, if all the codes other than the primary code are add-on codes or modifier 51 exempt codes, they will not be sent to clinical for review. Those claims will be paid at 100% of the appropriate maximum allowable fee.

Reimbursement will be determined using the following guidelines:
- The procedure with the highest work relative value unit (RVU) will be paid at 100% of the maximum payment amount.
- The procedure with the second highest work RVU will be paid at 50% of the maximum payment amount.
- The procedure with the third highest work RVU will be paid at 25% of the maximum payment amount, as will all other procedures billed for that member on that date of service. Sentara Health Plans does not limit the number of procedures that may be performed.
- If multiple procedure codes are billed for the same member on the same date of service but do not have a modifier 51 attached, the Sentara Health Plans code review software will determine whether the codes should have been billed with 51 modifiers and will affix the modifier if appropriate. In turn, multiple surgical discounts will apply (as outlined above).

57 Modifier – Decision for Surgery

Modifier 57 should be used only when evaluation and management services that result in the initial decision to perform surgery are performed the day before or the day of the surgery.

59 Modifier/XE/XP/XS/XU – Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Sentara Health Plans code bundling determinations are generally based upon the most current AMA coding guidelines (e.g., CPT and HCPCS definitions), Medicare policies and procedures, and Correct Coding (Initiative (CCI) edits.

Starting with dates of service on January 1, 2015, providers should utilize the newly created CMS modifiers XE, XP, XS, and XU in place of modifier 59 when appropriate. The new modifiers are more specific versions of the 59 modifier; they should not be used on the same line as modifier 59. Modifier 59 should only be used when the new modifiers are not appropriate for the procedure.

Modifiers XE, XP, XS, XU, or 59 do not bypass multiple surgery fee reductions, bilateral fee adjustments, or any other administrative policy other than clinical edits. Documentation should be available in the patient's record to support the distinct or independent identifiable nature of the service and provided in a timely manner for review upon request.

62 Modifier – Two Surgeons

Sentara Health Plans allows the reimbursement of two surgeons under the following conditions:

- Both surgeons must be MDs or Dos.
- Each surgeon must be a participating provider and have a separate and distinct provider number.
- Each surgeon is performing a distinct part of a procedure.
- Both surgeons bill the same procedure code with a modifier 62.
- Operative notes are required.

If the procedures are deemed appropriate, payment is determined by taking the Sentara Health Plans contracted allowable rate, multiplying it by 125%, and dividing it by 50%. This payment is made to each co-surgeon. If there are multiple surgery codes with a 62 modifier, then the multiple surgery discount will apply.

80 and 82 Modifier – Assistant Surgeon

Sentara Health Plans allows reimbursement for assistant surgeons under the following conditions:

- The Assistant surgeon must be an MD or DO.
- The Assistant surgeon must be a participating provider and bill with a separate and distinct provider number from the primary surgeon.
- The Sentara Health Plans list of codes which warrant an assistant surgeon are generally based upon CCI guidelines.
- The primary surgeon should bill with the appropriate procedure code. The assistant surgeon

should bill with the same procedure code with an 80, 81, or 82 modifiers. Assistant surgeon claims are paid at 16% of the Sentara Health Plans fee maximum.

81 Modifier – Minimum Assistant Surgeon

Billing and credentialing requirements are the same for modifier 81 as they are for modifiers 80 and 82. Modifier 81 is reimbursed at 10% of the Sentara Health Plans fee maximum.

CLAIM PAYMENT RECONSIDERATIONS

A “request for reconsideration” is required prior to initiation of the appeals process for commercial products. The reconsideration filing deadline is **365 days** from the **date of service.**
Non-par Medicare providers have 60 days from claim adjudication date to file reconsideration and must also submit “Waiver of Liability” agreeing not to balance bill regardless of reconsideration outcome.

Registered providers may electronically submit claim corrections through the provider portal Providers can make changes or corrections online for the following:

- procedure/service coding
- diagnosis
- billed charges
- quantity
- place of service

This option is not available for hospitals and ancillary claims that would typically use the UB-04 format.

Electronic corrections are accepted in an electronic claim file through a clearinghouse or software vendor. Claims sent through a clearinghouse or software vendor must have a seven-frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guides. If a claim is resubmitted without the resubmit code, the claim will be denied as a duplicate. Contact your software vendor or clearinghouse with questions about how to send this code.
Provider Reconsideration Forms are also available under billing and claims information on the provider website or by calling provider services.

Reconsiderations submitted using the CMS 1500 form should indicate the original claim number. All line items submitted on the original claim should be included. Mail the completed Provider Reconsideration Form and, if necessary, any attached documentation to the claim reconsideration address in the **“Contacts”** section of this manual.

Providers will receive written letters indicating that the denial will be upheld when reconsiderations are submitted without complete information. If the provider is not satisfied with the initial reconsideration outcome based on payment outcome, a second reconsideration may be requested based on the denial reason.

PROVIDER/MEMBER APPEALS AND EXPEDITED APPEALS

Claim Appeals for Commercial Products

Sentara Health Plans attempts to resolve issues presented by providers informally whenever possible. An internal provider appeals process is available to reconcile issues if an issue cannot be resolved informally. An appeal is a formal request to reconsider and change a previous adverse decision when Sentara Health Plans has determined that the original payment was properly adjudicated, and the provider continues to dispute the payment. Sentara Health Plans will not take punitive action against a provider who requests an expedited resolution or supports a member's appeal. Policies and procedures for Medicaid and Medicare program provider and member appeals may be found in the specific program provider manual supplements.

Appealed commercial claims must meet the following criteria:

- An adverse payment decision is made by Sentara Health Plans **after the service has been delivered**.
- The provider has been held **responsible** for reasons such as:
    - disputes regarding coding, capitation, contractual payments, and rates, and/or usual and customary (UCR) charges, etc.
    - denials based upon the provider's failure to obtain prior authorization of services, timely filing, delayed treatment, length of stay, and level of care, etc.
- The claim has already completed the reconsideration process.

Access the Policies for Commercial Product Provider Appeals, Expedited Appeals, and Member Appeals here.

Hold Harmless Policy

For all Sentara Health Plans products, if Sentara Health Plans denies a claim for service due to failure of the contracted providers to follow any rule or procedure or based on retrospective review that the service was not medically necessary, the provider **must** hold the member harmless and not bill the member.

Adverse Benefit Determination – Provider Appeals on Behalf of a Member

Providers may appeal adverse benefit determinations on behalf of the member; however, they must indicate that they are appealing on behalf of the member. These member appeals may be filed pre-service, concurrent to, or following services being rendered. Appeals on behalf of the member are processed according to the member appeal process and must include a completed ***Authorized Designation Form*** signed by the member. Expedited appeals do not require an Authorized Designation Form.

FRAUD, WASTE, AND ABUSE

Sentara Health Plans is responsible for detecting and preventing fraud, waste, and abuse (FWA) in accordance with the Deficit Reduction Act and the False Claims Act.
Sentara Health Plans, through the program integrity unit (PIU), has implemented policies and procedures to detect and prevent all forms of insurance fraud, including fraud involving employees, providers, employer groups, and contractors or agents of Sentara Health Plans. Sentara Health Plans has adopted the Commonwealth of Virginia's definition of fraud, waste, and abuse (FWA) as any "suspicious claims activity," which is any claim that an insurance company has reason to believe, based upon evidence, and may contain one or more material misrepresentations. Sentara Health Plans further defines fraud and abuse as "intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit."

Common types of fraud and/or abuse are as follows:

- unbundling
- split billing
- services not rendered
- upcoding
- falsification of records/bills/enrollment applications
- waiving copayments/deductibles
- duplicate claims submissions
- prescription drug switching or shorting
- dispensing expired or adulterated prescription drugs
- prescription drug seeking behavior, theft, forging, or altering of prescriptions
- identity theft
- improper COB
- over/underutilization

The Sentara Health Plans anti-fraud plan is carried out through the efforts of its PIU (program integrity unit). The PIU is an internal investigative unit, separate from the compliance department, whose responsibility it is to:

- detect and prevent fraud, waste, and abuse
- ensure correct payment of medical, behavioral health, and prescription services, including correct coding, reimbursement, quantity, and quality
- utilize real-time systems that ensure accurate eligibility, benefits, and reimbursement
- reduce or eliminate fraudulent or abusive claims paid
- identify members abusing medical and prescription services
- identify and recommend providers for exclusion from the network as a result of fraudulent or abusive practices
- identify fraud on employer group enrollment applications
- refer potential FWA cases to the appropriate authorities (CMS, MEDIC, MFCU, law enforcement, etc.) and conduct case development and support activities for those investigations
- identify and report illegal activities and assist law enforcement by providing information needed to develop successful prosecutions

Identification of fraud, waste, and abuse is accomplished through:

- referrals from employees or providers
- use of detection software with claims data
- participation in anti-fraud forums with government agencies
- staying current with national industry FWA trends through networking and education

The PIU department may receive referrals through internal communications from employees, the hot line, or the compliance email. The hot line and compliance email are published on Sentara Health Plans websites on the explanation of benefits and included in the employee training manual and can be completely confidential.

If you or someone you know has knowledge of a health insurance claim submitted to Sentara Health Plans that may meet the above definition of a "suspicious claims activity," or suspects any provider, enrollee, or employee of Sentara Health Plans may be committing fraudulent or abusive practices, please forward all the pertinent information to the Sentara Health Plans PIU for further investigation. Your complaint will be investigated, and a thorough follow-up will be undertaken, including possible follow-up with you if additional questions arise. All referrals made to the PIU may remain anonymous. Please be sure to leave your name and number if you wish to be contacted for follow-up. If appropriate, the necessary governmental agency (CMS, OIG, BOI, etc.) will be notified, as required by law.

Upon conclusion of the investigation, Sentara Health Plans will pursue restitution for financial loss where appropriate.

In cases of waste and abuse, provider education may be provided to prevent further incidents. If needed, a corrective action plan may be issued to a provider that will require them to sign and agree to a plan to correct any issues identified within a specified time.

In cases of fraud, waste, and abuse that go uncorrected after education, Sentara Health Plans reserves the right to terminate a provider, broker, or employer group contract. These cases will be brought to the compliance fraud, waste, and abuse subcommittee for review. This committee is headed by the program integrity unit and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.
When a determination of fraud or abuse is made, the case will be reported to the appropriate government agencies, law enforcement, and/or regulatory agency (State Medical Board, State Police, Attorney General's Office, Office of Personnel Management [OPM]/Office of the Inspector General [OIG], Medicaid Fraud Control Unit [MFCU], CMS, FBI, etc.).

All referrals, cases, and supporting documentation are tracked and stored electronically. Supporting documentation may include medical records, letters received and mailed, claims identified, phone call summaries, etc.

Sentara Health Plans requires all employees to complete fraud, waste, and abuse training within 30 days of hire and annually thereafter.

Federal False Claims Act

The Federal False Claims Act's primary use is to combat fraud and abuse in government healthcare programs. The act accomplishes this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $10,000 per false claim.

The False Claims Act prohibits, among other things:

- knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval
- knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
- conspiring to defraud the government by getting a false or fraudulent claim allowed or paid
- knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information, 2) acts in deliberate ignorance of the truth or falsity of the information, 3) and acts in reckless disregard of the truth or falsity of the information.

The False Claims Act also contains a qui tam or "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the applicable state or federal government. The qui tam provision also protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment because of the employee's lawful acts in furtherance of a false claims action.

Providers contracted with Sentara Health Plans will agree to be bound by and comply with all state and federal laws and regulations. Any violation by the practice or by any practice physician is grounds for termination.

Providers contracted with Sentara Health Plans will also comply as follows:

- Provider agrees to comply with all nondiscrimination requirements set forth in the contract.
- Practice agrees to provide access to its premises and to its contracts and/or medical records, to representatives of Sentara Health Plans, as well as duly authorized agents or representatives of the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and the State Medicaid Fraud Unit in accordance with their contract.
- Practice agrees otherwise to preserve the full confidentiality of medical records in accordance with their contract.
- Practice agrees to ensure confidentiality of family planning services in accordance with the contract.

Program Integrity Audit, Reconsiderations, and Appeals Policy and Procedures

As a managed care organization, Sentara Health Plans is required by state and federal entities to audit claims, identify overpayments, and educate all types of providers on program integrity issues.

Sentara Health Plans conducts claim audits either on a prepayment or post-payment basis. Claim audits are conducted to confirm that healthcare services and supplies were delivered in compliance with the member's plan of treatment and/or to confirm that charges were accurately reported in compliance with Sentara Health Plans' policies and procedures, as well as general industry standard guidelines and state and federal regulations.

In addition, Sentara Health Plans continually monitors provider billing practices and conducts investigations for purposes of detecting inappropriate, inaccurate, or abusive billing patterns, medical necessity, as well as patient safety and quality of care. Data on provider services for specified periods are compiled and compared with other providers within the same specialty/provider type and geographic peer groups. Providers are selected for audit based on their utilization and billing patterns, relative to their peers.

Providers who are an outlier may be subject to further analysis, including desk or on-site investigations. Investigations will include a review of the provider's medical records that pertain to the billed services and may employ offset of overpayments or extrapolation methods. Sentara Health Plans has a detailed written policy for the program integrity audit process, including reconsiderations and appeals of audit findings. This policy contains definitions of the terms used, time frames for record request responses, procedures for desk audits and on-site audits, time frames for findings letters to be sent, and time frames for providers to request reconsideration of findings and request an appeal. The policy also includes the Sentara Health Plans medical record documentation standards.

The complete policy can be found here.

Physician Query Requirements

A coding query is defined as "a written question, posed by a coder requesting clarification on documentation in the medical record, which requires further specificity for accurate coding." Sentara Health Plans will accept appropriate, timely, and compliant physician coding queries submitted **as part** of the patient medical record to the extent it provides clarification and is consistent with other medical record documentation. Physician queries are not accepted after an audit has been initiated. Sentara Health Plans follows the Centers for Medicare & Medicaid Services' (CMS) position on query forms, as stated by the director of CMS' quality improvement group.

Additionally, Sentara Health Plans **will not** accept the practice of assumptive coding and will refer for further action any facility found to be practicing assumptive coding. The Office of Inspector General (OIG) defines assumptive coding as "assuming (and coding) from the clinical evidence on the patient's record that the patient has certain diagnoses in the absence of the physician's explicit documentation of the diagnosis." **Assumptive coding is a forbidden practice among**

coders.

Sentara Health Plans will evaluate coding queries as follows:

Clarity and language:
The physician query process involves asking a physician to clarify inconsistent, vague, or otherwise unclear documentation about a patient's diagnosis. The physician query process should only be triggered when there is a problem with documentation quality and there are clinical triggers that act as "clues" to guide the coder in the query process.

Coders' queries to physicians should:

- be initiated only when there is sufficient supporting documentation within the body of the medical record to warrant a query
- present or refer to specific clinical information within the record that prompted the query
- be clear, open-ended questions allowing the physician to render and document his/her clinical interpretation of the diagnosis, condition, and/or procedure, based on the facts of the case
- indicate why the query is required (principal diagnosis is unclear, conflicting documentation, etc.)

Queries which are leading in nature, refer to differences in payment, and/or introduce new information will not be accepted for DRG validation by Sentara Health Plans and may be subject to referral for further action.

Examples as to when a physician query is appropriate:

- Documentation regarding reportable conditions or procedures is conflicting, ambiguous, or is otherwise incomplete.
- Abnormal diagnostic test results indicate the possible addition of a secondary diagnosis or higher specificity of an already documented condition.
- The patient is receiving treatment for a condition that has not been documented.
- Abnormal operative/procedural findings are not documented.
- It is unclear as to whether a condition was ruled out.
- The principal diagnosis (the reason, after study, for admission) is not clearly identified.

Examples of when a physician should not be queried include:

- There is no clinical indication to warrant a query.
- There is a discrepancy between the physician's diagnosis and clinical indicators. (Unless hospital policy requires a query in this circumstance, policy must be submitted).

Legibility:
Illegible documentation cannot be assumed or interpreted and may be a reason to deny payment for services.

Completeness:
Queries must be maintained as part of the medical record and are subject to the same contemporaneous, permanent professional treatment of records as the body of the medical record.

Timeliness:
Queries must be submitted to the physician and returned by the physician **prior** to billing and submitting a UB-04 to Sentara Health Plans. Queries that are not timely **will not** be accepted for reimbursement or for DRG validation purposes.

Authentication:
Physicians must date and sign all query responses. Physicians also need to date and cosign queries documented by other clinicians whose work they are responsible for. This applies, for example, to residents and interns in teaching facilities.

Physician Self-treating

Per the American Medical Association (AMA), "professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered." Physicians' professional relationships with their patients are based on fiduciary responsibility. Family relationships and collegial relationships with same-practice physicians, by contrast, are based on familiarity.

As such, Sentara Health Plans will not reimburse any services rendered by a physician to:

- self
- family member

DEFINITIONS:

The following definitions are important for understanding this policy:

Family Member: For this policy, "family member" means a physician's spouse or partner, parent, child, sibling, grandparent, or grandchild; a parent, child, sibling, grandparent, or grandchild of the physician's spouse or partner; or another individual in relation to whom the physician has personal or emotional involvement that may render the physician unable to exercise objective professional judgment in reaching diagnostic or therapeutic decisions.

Treating: "Treating" encompasses the performance of any controlled act, including ordering and performing tests, making, and communicating a diagnosis, and prescribing medications.

Fraud, Waste, and Abuse Training

Access Fraud, Waste, and Abuse training for providers and office staff here.

PROVIDER RESPONSIBILITIES FOR EXCLUDED ENTITY SCREENING AND REPORTING

The Office of Inspector General imposes exclusions from state and federal healthcare programs under the authority of sections 1128 and 1156 of the Social Security Act. The law requires that no payment is made by any federal healthcare program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal healthcare programs are administered by the Centers for Medicaid & Medicare Services (CMS). This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services, and anyone else who provides services through or under the direction of an excluded person. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Providers are obligated to ensure that Medicaid and Medicare funds are not used to reimburse excluded individuals or entities by taking the following steps:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded. This includes owners with an interest of 5% or more.
2. ***Search the HHS-OIG website*** (oig.hhs.gov/exclusions/) monthly to capture exclusions and reinstatements that have occurred since the last search.
3. Immediately report any exclusion information to Sentara Health Plans in writing.

Civil monetary penalties may be imposed against providers and managed care entities that employ or enter into contracts with excluded individuals or entities to provide services for federal healthcare programs.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Sentara Health Plans requires all provider-disclosing entities to complete a Disclosure of Ownership and Control Interest Statement at initial contracting/credentialing and at re-credentialing as a condition of participation. Disclosure as a participating fee-for-service provider for DMAS meets this requirement for Sentara Health Plans.

SUBCONTRACTOR, VENDOR, AND AGENT COMPLIANCE PROGRAM

Subcontractors, vendors, agents, and consultants who represent the company are expected to adhere to the Sentara Health Plans compliance program. It is the policy of Sentara Health Plans to comply with all local, state, and federal laws governing its operations; to conduct its affairs in keeping with the moral, legal, and ethical standards of our industry; and to support the government's efforts to reduce healthcare fraud and abuse. The Sentara Health Plans compliance program establishes a culture within the organization that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law and federal, state, and private payor healthcare program requirements.

Confidentiality

Information designated as confidential should not be discussed with anyone other than on a "need to know" basis. In addition, agents and vendors have a responsibility to avoid disclosure of nonconfidential internal information about the company, its employees, its clients, and its business associates unless specifically authorized by the company.

Subcontractors must comply with 42 CFR Part 2 that prohibits subcontractors from re-disclosing substance abuse treatment information. Disclosure of substance abuse treatment Information is limited to information necessary for the subcontractor to perform services they are obligated to perform under its agreement.

Business Information

Sentara Health Plans considers its pricing information, pricing policies, terms, market studies, business or strategic plans, and any other similar information to be confidential. The sharing of information with competitors is a highly sensitive matter, particularly where that information could form the basis of a pricing agreement.

All bids or proposals should be accurate, complete, and directly responsive to the prospective customer's request and may not contain any information that is false or intentionally misleading.

Equal Opportunity Employment

Pursuant to Executive Order 11246, Section 503 of the Rehabilitation Act of 1973, as amended, and the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, you are advised that our subcontractors, suppliers, and vendors are obligated to take affirmative action to provide equal employment opportunity without regard to race, religion, sex, national origin, age, genetic information, disability, and/or veteran status.

Conflict of Interest

Sentara Health Plans employees may not accept:

- money or gifts (regardless of monetary value) from customers
- money from vendors or gifts having a monetary value of $25 or more

"Gifts" include any item, favor, discount, entertainment, meal, hospitality, loan, forbearance, personal service, transportation, travel, and lodging, whether provided in-kind, by purchase of a ticket, payment in advance, or reimbursement after the expense has been incurred.

Gifts and Improper Use of Funds

Sentara Health Plans prohibits giving anything of value to government employees who work for customers or potential customers of Sentara Health Plans. There are four permissible exceptions to this rule:

- promotional items of nominal value ($20.00 or less), such as a calendar or coffee mug displaying the company logo

- modest refreshments, such as coffee and donuts, in connection with a business discussion
- a meal on-site to accommodate continuing business meeting with government employees
- food, refreshments, entertainment, and instructional materials at a widely attended event provided the government employee's agency has properly authorized his/her attendance

Nongovernmental personnel may be provided with meals, refreshments, and entertainment with reasonable value, less than $25, in connection with business discussions, provided this does not violate the policies of the recipient's organization. Gifts or other considerations of more than a nominal value ($20 or less) or money of any amount may not be given to a physician or anyone in a position to influence client referrals.

Anti-kickback Act

The federal Anti-kickback Statute requires each prime contractor or subcontractor to promptly report a violation of the kickback laws to the appropriate federal agency, inspector general, or the Department of Justice if the contractor has reasonable grounds to believe that a violation exists.

Business Records

Sentara Health Plans' records are maintained in a manner that provides for an accurate and auditable account of all financial transactions in conformity with generally accepted accounting principles. No false or deceptive entries may be made, and all entries must contain an appropriate description of the underlying transaction. All reports, vouchers, bills, invoices, payroll and service records, time worked, member records, and other essential data must be prepared with care and honesty.

Billing Practices

Sentara Health Plans is committed to accurate billing and submitting claims for services that are medically necessary, reflecting the services and care provided to members, and are justified by documentation. Sentara Health Plans agents and vendors are required to report any potential or suspected improper billing practices or violations of standard billing practices or of company policies and procedures.

False Claims

Federal and state laws and regulations govern billing for services provided to Sentara Health Plans members. Failure to follow claims regulations can lead to exclusion from federal funding, including payments from Medicare and Medicaid, as well as criminal and civil liability. Submission of claims for reimbursement that are false, fraudulent, inaccurate, incomplete, or duplicative or for noncovered services is prohibited.

The federal False Claims Act covers fraud involving any federally funded contract, including Medicare and Medicaid. Liability is established for any person who knowingly presents or causes a false or fraudulent claim for payment by the U.S. government. "Knowingly" is defined as a person having actual knowledge of false claim information and acting in deliberate ignorance or reckless disregard of the information. Healthcare providers violating the federal False Claims Act

can be subject to civil monetary penalties ranging from $13,507 to $27,018 per false claim and three times the amount of the government's damages.

The criminal penalties for acts involving federal healthcare programs provides for felonious criminal penalties and a fine of not more than $25,000 and/or imprisonment for not more than five years for whomever makes false statements or submits false claims.

Any Sentara Health Plans contractor, agent, or vendor who is aware of or suspects any false report or document, false claim, improper billing practices, or violations of company policies and procedures must report their concern to the Sentara Health Plans Compliance Committee or to the Sentara Health Plans' Fraud, Waste, and Abuse Hotline. All reported violations will be investigated.

Fraud and Abuse

"Fraud" is defined as intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or persons. Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to a government healthcare program or other healthcare plan.

The Deficit Reduction Act of 2005 became effective on January 1, 2007, and requires healthcare organizations receiving five million dollars or more in annual Medicaid reimbursement to educate employees, contractors, and agents about fraud and abuse, false claims, and whistleblower protection laws and regulations. The Deficit Reduction Act requires investigation of all potential false claims and fraud/abuse, such as payment coordination, claims payment only for US citizens or qualified aliens, copayment limits compliance, and electronic claims submission by large providers.

Administrative remedies for false claims and statements states any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than $5,000 for each claim and an assessment of not more than twice the amount of the claim. Sentara Health Plans will investigate all potential fraud and abuse violations and will initiate actions to resolve the identified problem.

Whistleblowers

The False Claims Act prohibits a company from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee, vendor, or agent if the individual reports or assists in the investigation of a false claim.

Under no circumstances will Sentara Health Plans take any adverse action or retribution of any kind against any employee, contractor, agent, or vendor because they report a suspected violation of federal or state laws and regulations**.**

Insider Trading

Agents and vendors who have material nonpublic ("insider") information obtained through a relationship with Sentara Health Plans are prohibited from purchasing or selling the security. Agents and vendors may not use insider information for the purpose of communicating such information (“tipping”) to those who trade.

Government Sanctioning

Sentara Health Plans does not contract with individuals or companies sanctioned under government programs. All agents and vendors must:

- notify Sentara Health Plans of any known or suspected violations of law or regulations pertaining to the agent's or vendor's relationship with the company.
- disclose to Sentara Health Plans any government investigations in which the agent or vendor is, was, or may become involved.
- disclose to Sentara Health Plans any persons affiliated with the agent or vendor, including any officer, director, owner, employee, or contractor, who has been disbarred or excluded from participation in any federal or state funded healthcare program.
- immediately disclose to Sentara Health Plans any persons affiliated with the agent or vendor, including any officer, director, owner, employee, or contractor of the agent or vendor, who has been convicted of or pleaded guilty to a felony or other serious offense and who remains in affiliation or employment relationship with the agent or vendor after the conviction or guilty plea.

Maintaining Your Position of Trust

Each agent, vendor, subcontractor, and consultant have an obligation to always act with honesty and decorum because such behavior is morally and legally right and because Sentara Health Plans’ business success and reputation for integrity depends on you.

VIRGINIA ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:
"Carrier," "enrollee" and "provider" shall have the meanings set forth in § *38.2-3407.10*; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ *38.2-5800* et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator, or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.
"Clean claim" means a claim that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.
"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.
"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.
"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.
"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation

of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § *38.2-3407.1* or *38.2-4306.1*, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, down-coding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or down-codes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and down-coding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or email address that a

provider can use to request the specific bundling and down-coding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the provider or to health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized.

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation

of why the claim is being retroactively adjusted.

9. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and

(ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

11. If the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or

otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § *38.2-223*, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

1999, cc. *709*, *739*; 2004, c. *425*; 2005, c. *349*; 2014, cc. *157*, *417*; 2015, c. *709*; 2019, c. *683*.