MEDICAID PROGRAM
PROVIDER MANUAL

This version of the Sentara Health Plans Medicaid Program Provider Manual was last updated on March 1, 2024. This version is available to all providers on our Sentara Health Plans website. Updates to the Provider Manual occur as policies are reviewed and updated, new programs are introduced, and contractual/regulatory obligations change.

INTRODUCTION AND WELCOME

Welcome to the Sentara Health Plans Medicaid program. Thank you for your participation with Sentara Health Plan, Inc. (SHP), a division of Sentara Healthcare. As a participating provider, you are an integral member of our team. We thank you for making it possible for Sentara Health Plans to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare to the communities we serve.

This Provider Manual is effective January 1, 2024, and covers policies and procedures for providers for Medicaid plans administered by Sentara Health Plans.
Easily find information in this Provider Manual using the following steps: Select CTRL+F.
Type in the keyword. Press Enter.

The Provider Manual contains important information to assist you with member and product identification, authorizations, claims reimbursement policies/procedures, and provider obligations under your Provider Agreement. You will also find useful information such as contact names, phone numbers, addresses, and direct weblinks to policies and forms. Additional information and tools are available at Sentara Health Plans.

The Provider Manual was developed to assist you in understanding the administrative requirements associated with managing a member's healthcare. The Provider Manual, including all sources that are referenced by and incorporated herein, via weblink or otherwise, is a binding extension of your Provider Agreement and is amended as our operational policies change. In addition to the Provider Manual being available online, it is also available in paper form by written request.

If there is a conflict with any state law, federal law, or regulatory requirement and this Provider Manual, the law or regulation takes precedence.

Should this Provider Manual conflict with your Provider Agreement, your Provider Agreement takes precedence.

The following terms are used throughout this Provider Manual:

Affiliate means any entity (a) that is owned or controlled, directly or indirectly, through a parent or subsidiary entity, by SHP, or any entity which is controlled by or under common control with SHP, and (b) which SHP has agreed may access services under the Provider Agreement.

Agreement means the Provider Agreement, attachments, and any amendments, including Exhibits.

Member means any individual, or eligible dependent of such individual, whether referred to as "insured," "subscriber," "member," "participant," "enrollee," "dependent," or otherwise, who is eligible, as determined by a payor, to receive covered services under a health benefit plan. Members specifically include, but are not limited to, individuals enrolled in self-funded employee benefit plans which engage SHP or an affiliate as a third-party administrator, and individuals enrolled in fully insured plans with an affiliate.

Participating Provider means a duly licensed physician or other health and/or mental healthcare professional, as designated at the sole discretion of SHP, who has entered into a contract with SHP either as an individual or as a member of a group practice and who has been approved to provide covered services under a health benefit plan(s) in accordance with SHP's credentialing requirements and the requirements of such contract between the provider and SHP at the time such covered services are rendered. Participating providers shall include, but not be limited to, licensed professional

counselors, marriage and family counselors, certified behavioral analysts, nurse midwives, nurse practitioners, nurse anesthetists, physician assistants, participating hospitals, and other health and/or mental healthcare professionals, as may be designated by SHP, in its sole discretion, from time to time.

Sentara Health Administration, Inc. is a corporation organized for the purpose of contracting with providers for the provision of healthcare services pursuant to health insurance benefit plans, as well as for benefit plan administration to provide, insure, arrange for, or administer the provision of healthcare services.

TABLE OF CONTENTS

Methods to Reach Sentara Health Plans

Topic	Website Address	Medicaid Program Phone	Information
After Hours Program	Nurse Advice Line	Phone: 833-933-0487	24-hour Nurse Advice Line
Authorizations	Authorizations	Medical/Pharmacy Phone: 1-888-946-1167 Behavioral Health Phone: 1-800-881-2166 Behavioral Health Inpatient/ARTS/Crisis Fax: 1-844-348-3719 Behavioral Health Outpatient Fax: 1-844-895-3231 Medicaid OP/DME Fax: 1-844-348-3720 Medicaid Urgent Fax: 1-844-857-6409 Medicaid Drugs Fax: 1-844-305-2331 LTSS UM Auths Fax: 1-844-828-0600 LTSS UM New Waivers Fax: 1-844-857-6408 Medicaid IP Fax: 1-844-220-9565 Medicaid POSTACUTE Fax: 1-844-220-9572 Govt Newborn Enrollment Fax: 1-844-883-6064	The preferred method to obtain pre-authorization is through the Sentara Health Plans secure provider portal

Behavioral Health Member Crisis Line	Behavioral Health Provider Resources	Phone: 757-552-8383 (local) 833-686-1595 (Toll Free)	
Care Coordination	Not Applicable	Phone: 1-866-546-7924	Monday through Friday from 8:00 a.m. to 5:00 p.m., EST. After 5:00 p.m., please contact member services at the number on the back of your member ID card. Fax: 1-844-552-7508 Medical Reports, etc.
Centipede/HEOPS (LTSS Providers)	Centipede	Phone: 1-855-359-5391	Fax: 1-866-421-4135 Centipede Credentialing: CENTIPEDE Health P.O. Box 291707 Nashville, TN 37229 Email: joincentipede@heops.com
Claim Overpayment	Provider Reconsideration Form	Phone: 1-800-508-0528	Sentara Health Plans Provider Refunds P.O. Box 61732 Virginia Beach, VA 23466
Claims	Billing Reference Sheets and Claims Submission Guidelines	Phone: 1-844-512-3172	**Medical Claims** PO Box 8203 Kingston, NY 12402 **Behavioral Health Claims** PO Box 8204 Kingson, NY 12402
Contracting	Join Our Network	Phone: 1-877-865-9075	Complete and email the Request for Participation form to: PrvRecruit@sentara.com

Credentialing	Not Applicable	Phone: 1-877-865-9075	For Initial Credentialing Questions email: SHPInitialCred@sentara.com For General Credentialing Questions email: SHPCredDept@sentara.com
Critical Incidents	Critical Incident Reporting	Phone: 1-757-252-8400 Fax: 1-804-200-1962 Toll Free Fax Line: 1-833-229-8932	CIReporting@sentara.com
Dental (Smiles for Children)	Smiles for Children Program	Provider Customer Service Phone: 1-888-912-3456	For dentists: resources and training material
DMAS Eligibility Verification	DMAS Eligibility Verification	Toll-free MediCall Automated System at 1-800-772-9996 or 1-800-884-9730	Phone resource for eligibility review
Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERA)	EFT and ERA Instructions		Electronic claims, submission questions, and concerns Call provider customer service for more information.
Interactive Voice Response System	Not Applicable	Main Phone Line 24-hour Interactive Voice Response: 800-881-2166	To verify eligibility, providers should utilize the Sentara Health Plans Interactive Voice Response System (IVR)
Medical Authorizations, Medical Benefit, Drugs for Medicaid Products	Not Applicable	Provider Services Main Phone: 800-881-2166 Fax numbers for specific services are located on the authorization fax form.	Medical benefit questions, and pharmacy needs

Medical Records	Not Applicable	Phone: 1-844-620-1015	Email for medical record requests: SHP_quality@sentara.com
Member Services	Sentara Health Plans Members	Phone: 1-800-881-2166 (Hearing Impaired/VA Relay: 711)	Members can contact Sentara Health Plans for various concerns and questions
Member Transportation	Nonemergency Transportation Benefit	Phone: 1-877-892-3986	Members may schedule using the member portal through the contracted transportation vendor.
Network Educators	Not Applicable		contactmyrep@sentara.com
Participation in Medicaid Fee-for-Service (DMAS)	DMAS MES Portal	Virginia Medicaid Provider Enrollment Helpline Phone: 1-888-829-5373	For a list of common questions and answers for providers on the Provider Services Solution (PRSS) portal, please visit the MES website.
Program Integrity (Fraud, Waste, and Abuse)	Fraud, Waste and Abuse Information and Training	FWA Hotline Phone 1-757-687-6326 or 1-866-826-5277	compliancealert@sentara.com
Provider Services	Provider Services	Phone: 1-800-881-2166	Contact Sentara Health Plans Medicaid program provider customer service for most concerns
Sentara Health Plans Website	Sentara Health Plans		Sentara Health Plans web access as a resource for provider, member, and plan information and updates.
Telephone for Deaf and Disabled	Telephone for Deaf and Disabled	Phone: VA Relay 1-855-687-6260 or 711	For deaf, hard of hearing, and disabled persons

Interpreter Services

Sentara Health Plans makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages. Use of auxiliary aids such as TTY/TDY and American Sign Language are also included.

Providers are to contact Sentara Health Plans provider customer service for interpreter services: 1-855-687-6260. Interpreter services for Medicaid program members are coordinated and reimbursed by Sentara Health Plans, as required by the Virginia Department of Medical Assistance Services (DMAS). Auxiliary aids and services are available upon request and at no cost for members with disabilities.

SECTION I: MEDICAID PROGRAM OVERVIEW

Effective January 1, 2023, the Virginia Department of Medical Assistance Services (DMAS) has rebranded Medicaid fee-for-service and managed care programs into a single program—Cardinal Care. The previous program names, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0, will be phased out and replaced with Cardinal Care Managed Care. This program alignment will assist individuals as their needs change across the continuum of care.

The Medicaid program is designed to better serve individuals who are receiving Medicaid services in Virginia. The goal of the program is to improve the lives, satisfaction, and health outcomes of participants by providing a seamless, one-stop system of services/supports and assisting with navigating the complex- service environment. By integrating medical and social models of care, supporting seamless transitions between service settings, and facilitating communication between providers, Sentara Health Plans will ensure members receive person-centered care driven by individual choice and rights.

Medicaid Program Members
The Cardinal Care population is composed of the following population groups:

- former Medallion 4.0 populations, including low-income families and children covered populations
- former Commonwealth Coordinated Care Plus populations, including aged, blind, or disabled (ABD); medically complex MAGI adults; and LTSS covered populations
- managed care eligible populations listed above who have other third-party liability insurance (TPL), except coverage purchased through HIPP and FAMIS Select
- managed care eligible populations listed above who are in the hospital at the time of initial MCO enrollment

Transportation Program
Our Medicaid program provides urgent and emergency transportation. Nonemergency transportation (NEMT) for covered services **requires scheduling**, including air travel and services reimbursed by an out-of-network payer.

The Sentara Health Plans Medicaid program covers nonemergency transportation for eligible members for covered services as well as emergency transportation. If a Medicaid program member has no other means of transportation, transportation will be provided to and from medical appointments. FAMIS members currently have a limited transportation benefit through social determinants of health (SDOH). FAMIS members are eligible for round-trip rides to grocery stores, etc. Questions regarding FAMIS member transportation should be directed to the contracted transportation vendor at 1-877-892-3986.

Sentara Health Plans has a contracted vendor to administer the transportation program (taxi and wheelchair). The member is expected to call 1-877-892-3986 five days in advance of a scheduled-covered service to have transportation arranged. The transportation vendor does not cover scheduled ambulance/stretcher transportation. Nonemergency ambulance/stretcher is approved and arranged by Sentara Health Plans Medical Care Services. For more information regarding transportation, please call 1-877-892-3986 (toll-free).

Where To Begin the Enrollment and Eligibility Process
All members who would like to enroll in Sentara Health Plans Medicaid programs must be enrolled in

Virginia Medicaid first. Members will either choose or be assigned to an MCO per the DMAS assignment algorithm.

New Member Information
DMAS uses an assignment algorithm to assign Medicaid members to their respective MCOs, often utilizing history of relationships with the providers that have traditionally given the member care. During enrollment, Sentara Health Plans members will receive a New Member Handbook, which explains the members' healthcare rights and responsibilities.

To obtain copies of the member guides, please visit this location.

Medicaid Program Enrollment and Assignment Process
DMAS has sole responsibility for determining the eligibility of an individual for Medicaid-funded services.

- Providers can verify Medicaid enrollment on the DMAS website at login.vamedicaid.dmas.virginia.gov/ or by contacting the toll-free MediCall Automated System at 1-800-772-9996 or 1-800-884-9730

- To verify eligibility for Sentara Health Plans, providers should utilize the Sentara Health Plans interactive voice response (IVR) system, the Sentara Health Plans secure provider portal, or call provider services. *See Methods to Reach Sentara Health Plans for phone numbers.*

Enrollment Process for Newborns
When a Medicaid program member gives birth during enrollment, the newborn's related birth and subsequent charges are covered by Sentara Health Plans through the Medicaid program. For the newborn to be covered, the mother/parent/guardian must report the birth of the child by calling the Cover Virginia Call Center at 1-855-242-8282 or by contacting the member's local Department of Social Services (DSS). Once Medicaid-enrolled, the newborn is enrolled in the birth member's MCO, effective with the newborn's date of birth.

Enrollment Process for Foster Care and Adoption Assistance Children
The Sentara Health Plans Medicaid program provides services for children enrolled in foster care and adoption assistance (designation codes 070, 076, and 072, respectively). Sentara Health Plans and network providers are required to comply with the following rules:

- The social worker is responsible for health plan selection and changes for foster care children.
- The adoptive parent is responsible for health plan selection and changes for adoption assistance children.
- The former foster care or Fostering Futures members are responsible for their health plan selection and any subsequent health plan changes.
- Members in foster care and adoptions assistance may change their health plan at any time and are not restricted to their health plan selection following the initial 90- day health plan enrollment period.
- Coverage extends to all medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or required evaluation and treatment services of the foster care program. Sentara Health Plans and network providers work with DMAS in all areas of care coordination. Sentara Health Plans provides covered services until DMAS disenrolls the child from Sentara Health Plans. This includes circumstances where a child moves out of our service area.

Newborn Eligibility and Claim Submission for Sentara Health Plans Medicaid Program

Any newborn whose mother is enrolled in Sentara Health Plans Medicaid program shall also be enrolled from their date of birth up to three months (birth month plus two months). Continued eligibility is determined by DMAS. For the Sentara Health Plans Medicaid program, please submit claims for newborns under the child's member ID number if the number is available. A provider can use the temporary member ID to file a claim for the newborn, while the subscriber is applying for Medicaid for the newborn. If a newborn claim is filed under the subscriber's member ID number, the claim will suspend for assignment of the newborn's name and member ID number as Sentara Health Plans Medicaid program requires the use of the newborn's member ID, rather than the subscriber's member ID.

To avoid unnecessary delays in claims payment, please encourage the subscriber of the newborn patient to call member services with the newborn's name as soon as possible so a member ID number may be assigned, and the claims processed. Hospitals should submit newborn enrollment via the streamlined online enrollment process through the DMAS web portal at: login.vamedicaid.dmas.virginia.gov/

Medicaid Program Member ID Card
The member ID card is for identification purposes only and does not verify eligibility or guarantee payment of services. Members should present their ID card at the time of service. To access sample Member ID Cards for Sentara Health Plans, visit this link.

DMAS Contracted Enrollment Broker
The Virginia Department of Medical Assistance Services (DMAS) and the Managed Care Helpline (DMAS-contracted enrollment broker) provide enrollment services for Medicaid program members. DMAS contracts with CoverVA to provide enrollment services for Medicaid program enrollees. Eligible recipients interested in enrolling may call Cover Virginia at 1-855-242-8282 or visit the CoverVA website at coverva.dmas.virginia.gov/ to request an application. Applications are also available at local DSS offices.

Sentara Health Plans Network Management
The network management department is responsible for keeping our providers up to date on our services and resources, including:

- how to get in-network and contract with Sentara Health Plans
- how to update provider demographic information
- directly address any provider special needs, concerns, or complex situations, credentialing, services, and other requirements

Our network educators are assigned to specific providers to directly help navigate product, policy, process, and service updates. The network education team can be reached at contactmyrep@sentara.com.

The Web as a Place of Service
Up-to-date contacts, policies and procedures, forms, and reference documents are available to providers through the provider website. Sentara Health Plans encourages our Medicaid providers to visit here to research and process information such as self-service tools and

newsletters. Providers can also access medical policies at this link.

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 into the Essentials account for Sentara Health Plans on January 1, 2024.

For providers new to Availity Essentials, the Get Started with Availity 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.

Sentara Health Plans Customer Service Team
Contact Sentara Health Plans Customer Relations for most needs, including:

- member eligibility
- benefits information
- claims questions (limited per customer service guidelines)

Updating Your Information with Sentara Health Plans Medicaid Program
Keeping Sentara Health Plans informed of provider updates is an important step to ensuring accurate claims payment, correct provider directories, and member satisfaction. It is important that we have up-to-date information about your practice and provider data. Please notify Sentara Health Plans as soon as possible of any changes related to your practice's operations or provider roster. Sentara Health Plans offers electronic submission for your provider update requests! Please use the link below to access, complete, and submit a Provider Update Form for your request. Allow 30 calendar days for the requested provider information to be updated in all Sentara Health Plans systems (60 days for new providers/credentialing requests).

The Provider Update Form is intended for providers that are currently contracted with Sentara Health Plans or are in the contracting process. To access the Provider Update Form, visit this link.

Please note: Tax ID, legal business name, product/reimbursement changes, or other changes affecting your Provider Agreement (contract) cannot be submitted on the Provider Update Form; these requests should be submitted directly to your Sentara Health Plans contract manager. Please contact the network contracting team at 1-877-865-9075 for these requests.

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.

SECTION II: PROVIDER PROCESSES AND MEMBER BENEFITS

LTSS Provider Credentialing
Sentara Health Plans delegates and provides oversight for credentialing and re-credentialing of Medicaid program LTSS providers to HEOPS-Centipede. Sentara Health Plans ensures that HEOPS-Centipede credentials and re-credentials providers per DMAS and Medicaid program requirements and ensures that all providers comply with provisions of the CMS Home and Community-based Settings Rule.

Providers already contracted and credentialed with Sentara Health Plans for provision of medical services that also provide LTSS services must also contract with HEOPS-Centipede for provision of LTSS services to Medicaid program members.

Credentialing for Facilities and Ancillaries
Providers interested in participating with Sentara Health Plans should contact the Sentara Health Plans network educator assigned to their geographic region. 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 Sentara Health Plans determines 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.

Delegated Credentialing
For hospital-based providers and providers participating through an entity that has been approved and contracted to perform delegated credentialing, credentialing is covered under the agreement with that organization. Please contact the organization's administrator for further information.

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 opened. If the hospital is initially opening, 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). Practitioners 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 practitioners 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 preapproved 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.

Billing While Credentialing Is Pending

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.

Member Benefits
For information regarding the Sentara Health Plans Medicaid program member benefit information, please visit the following link.

Member PCP Matching
Medicaid members enrolled in Sentara Health Plans are encouraged to select their primary care provider (PCP). The PCP should be enrolled as a Sentara Health Plans Medicaid program provider. Providers should have no more than 1,500 members on their Medicaid patient rosters for the Medicaid program. Providers are encouraged to check their panel statuses and sizes by visiting the secure provider portal.

The Member Choice for Primary Care Provider
Sentara Health Plans Medicaid members have the right to take part in decisions about their healthcare, including their right to choose their providers from the Sentara Health Plans Medicaid program network.

Patient-financial Responsibilities
Per DMAS requirements, members are no longer subject to cost-sharing (coinsurance, deductibles, and copayments), effective July 1, 2022. However, members receiving LTSS services may have patient-pay obligations. For more information, please visit dmas.virginia.gov.

After-hours Nurse Advice Line
When illnesses or injuries occur after hours or when the provider 's office is closed, Sentara Health Plans members can access the 24/7 Nurse Advice Line. Calling the 24/7 Nurse Advice Line gives access to a professional nurse who can assess our members' medical situations, advise our members as to where to seek care, and, if possible, suggest self-care options until the member can see their provider.

Call the 24/7 Nurse Advice Line:	833-933-0487

Please note: the advice line nurse will not have access to patient medical records and cannot diagnose medical conditions, order lab work, write prescriptions, order home health services, or initiate hospital admissions. Any time the Nurse Advice Line is contacted, please have the following information readily available:

- the member ID number of the person who is ill or has been injured - this number is on the front of the member ID card

- detailed information regarding the illness or injury
- any other relevant medical information about the patient, such as other medical conditions or prescriptions

The advice line nurse will advise our members regarding whether to proceed to the nearest emergency room or urgent care center. The advice line nurse may suggest appropriate home treatments. Our members may be advised to see their provider on the next business day. If a visit to the emergency room is authorized by the advice line nurse, the visit will automatically be covered following Sentara Health Plans guidelines without retrospective review. The PCP will receive a follow-up report about the call so that medical records can be kept up to date.

Member Services

Members, providers, their family members, caregivers, or representatives may contact member services through the phone number listed on the back of their member ID card. Member services representatives are available to respond to various member concerns, health crises, inquiries (e.g., covered services, provider network), complaints, and questions regarding the Medicaid program. Information for members is also available on the member website.

Continuity of Care for New Members

Sentara Health Plans will provide or arrange for all medically necessary services during care transitions for new members to prevent interrupted or discontinued services throughout the transition.

Billing a Medicaid Program Member for Noncovered Services

A provider may bill a member only when the provider has provided advanced written notice to the member prior to rendering services, indicating that Sentara Health Plans Medicaid Program will not pay for the service. The notice must also state that, should the individual decide to accept services that have been denied payment by the Sentara Health Plans Medicaid Program, the provider is accepting the member as a private pay patient, not as a Medicaid patient, and the services being provided are the financial responsibility of the patient.

Second Opinion

When requested by the members, Sentara Health Plans shall provide coverage for a second opinion for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. Sentara Health Plans will provide for a second opinion from a qualified healthcare professional within the network or, when necessary, arrange for the member to obtain one outside the network at no cost to the member. Sentara Health Plans may require an authorization to receive specialty care from an appropriate provider; however, Sentara Health Plans cannot deny a second opinion request as a noncovered service.

Member Access to Care

Sentara Health Plans Medicaid program network adequacy is an important component of quality care and is assessed on an ongoing and recurring basis along several dimensions, including number of providers, mix of providers, hours of operation, accommodations for individuals with disabilities, cultural and linguistic needs, and geographic proximity to beneficiaries (provider to members or members to provider).

-

Sentara Community Complete (D-SNP)

Sentara Health Plans offers a Medicare Advantage Dual-eligible Special Needs Plan (D-SNP). Among the most important features of the D-SNP are:

- a team of doctors, specialists, and care managers working together for the D-SNP member
- a Model of Care (MOC) that calls for individual care plans for members

- the same member rights available to Medicare and Medicaid recipients

Dual-eligible members enrolled in the Sentara Health Plans Medicaid program may receive their Medicare benefits from Sentara Health Plans' companion D-SNP, Medicare fee-for-service, or through another Medicare Advantage (MA) Plan. Please reference the Sentara Health Plans Dual-eligible Special Needs Plan (D-SNP) Supplement for details regarding this plan. Sentara Community Complete is the Medicare Advantage Dual-eligible Special Needs Plan (MA D-SNP) administered by Sentara Health Plans. Sentara Community Complete provides Medicare Part A, B, and D benefits for members who are also eligible for full Medicaid benefits.

More details about the program can be found here.

SECTION III: MEDICAL MANAGEMENT

Utilization Management
The utilization management (UM) program reflects the UM standards from the most current National Committee for Quality Assurance (NCQA) accreditation standards:

- UM decision-making is based only on appropriateness of care and service.
- Sentara Health Plans does not compensate practitioners 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.
- Members have access to all covered services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under FFS Medicaid.

Sentara Health Plans has mechanisms in place to detect and correct potential under and overutilization of services, including provider profiles. Processes include:

- analytics reports based on provider performance and accurate billing
- active committee review of clinical services and cost data
- authorizations based on evidenced-based criteria for clinical services

Providers rendering care to Sentara Health Plans Medicaid program members, regardless of network status, are required to complete annual Model of Care training. Training can be accessed here.

Prior Authorization
Some services require pre-authorization from Sentara Health Plans. The prior authorization process allows the plan to:

- Verify the member's eligibility
- Determine whether or not the service is a covered benefit
- Make sure that the chosen provider is in the SHP network
- Evaluate the medical necessity criteria for the service
- Enter the member into SHP's Case or Disease Management program if appropriate

To pre-authorize services, contact SHP's UM Department at the number listed for the service area. Failure to pre-authorize services will result in denial of payment and the provider may be held responsible for the services.
Please see Mental Health Services for clarification of authorization requirements.

Procedure Codes Requiring Prior Authorization
For a complete listing of services, please refer to the online Prior Authorization List for coverage and authorization requirements.. Providers can contact the Utilization Management Department for any questions pertaining to prior authorization. For any service that requires prior authorization, requests must be processed prior to services being rendered.

Non-Participating Providers
Out-of-network providers are required to obtain authorization prior to providing services (excluding emergency services).
Out-of-network providers are prohibited from causing the cost to the member to be greater than it would be if the services were furnished within the network. If an out-of-network provider delivers services to a member, SHP will coordinate with the provider to ensure the cost to the member is appropriate.

Out-of-Plan Authorizations
Members may utilize out-of-network providers if an in-network provider is unavailable, does not meet accessibility standards, or does not meet the individual member's needs. Sentara Health Plans will adequately and timely cover, pay for, and coordinate the care as long as an in-network provider is unavailable to provide them with care.

The following circumstances may warrant the use of an out-of-network provider:

- SHP has pre-authorized an out-of-network provider
    - Emergency and family planning services
    - When the member is given emergency treatment by such providers outside of the service area
    - When the needed medical services are not available in SHP's network or the in-network physician does not, because of religious or moral objections, provide the service the member needs
    - When SHP does not have an in-network provider within 30 miles in urban areas and 60 miles in rural areas
    - During the member's continuity of care period
    - When DMAS determines that the circumstance warrants out-of-network treatment
    - Other criteria as defined by DMAS

  Referrals to non-participating specialists are permitted in certain circumstances if the required specialty service is not available through the SHP network and the service is pre-authorized by the Plan.

- All out-of-network referrals must receive advance approval by the UM Department representative, or the Medical Director as indicated with the exception of emergent services and family planning. Authorization must be obtained before a claim is submitted by the non-participating specialist or the claim will be denied.
- The PCP or requesting provider should call/fax the UM department to request approval for out-of-network services.
- The UM Staff will review the request. If the out-of-network authorization request is appropriate, the nurse may approve. If the service can be provided in-network, the authorization request will be sent to the Medical Director for determination.
- The PCP or requesting provider will obtain an authorization number from the UM Department, if approved.
- If the request is not approved by SHP, the requesting provider will be notified and provided with alternative recommendations. The PCP or requesting provider has the right to appeal the denial and may discuss medical indications with the Medical Director.

Sentara Health Plans will ensure the cost of such care will be no greater to the member than it would be if the services were furnished within the network.

Sentara Health Plans requires out-of-network providers to coordinate with the plan for payment and will reimburse the out-of-network practitioner/provider per the Single Case Agreement.

Authorization Decision Time Frames

Standard Authorization Decisions
For standard authorization decisions, SHP shall provide the decision notice as expeditiously as the member's health condition requires and within state-established timeframes described in the table below, with a possible extension of up to 14 additional calendar days, if:

- The member or the provider requests extension; or
- SHP justifies to the state agency upon request that the need for the additional information is in the member's interest.

Expedited Authorization Decisions
For cases in which a provider indicates, or Sentara Health Plan determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, SHP will make an expedited authorization decision. SHP will provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.
Sentara Health Plan may extend the 72-hour turnaround time frame by up to 14 calendar days if the member requests an extension or SHP justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.

Service Authorization Decision Timeframes for the Medicaid Program (See above description for extensions.)	**Turnaround Times**
Physical Health	
Concurrent Inpatient	3 calendar days
Outpatient / EPSDT Outpatient (Standard)	14 calendar days
Inpatient and Outpatient (Expedited)	No later than 72 hours from receipt of request (or as expeditiously as the member's condition requires)
Long Term Services and Supports to include - CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Respite, Personal Care, Long Stay Hospital, etc. (Standard)	14 calendar days
Long Term Services and Supports to include CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Respite, Personal Care, Long Stay Hospital, etc. (Expedited)	No later than 72 hours from receipt of request (or as expeditiously as the member's condition requires)
Behavioral Health	

Concurrent Inpatient	3 calendar days
Outpatient / EPSDT Outpatient (Standard)	14 calendar days
Inpatient and Outpatient (Expedited)	No later than 72 hours from receipt of request (or as expeditiously as the member's condition requires)

Utilization Management Staff Availability
UM personnel are available to assist you in expediting care for your Sentara Health Plan patient. UM Offices are open from 8:00 am to 5:00 pm daily. If you call after hours or on a weekend, a confidential voice response system will receive your call. Please leave detailed information and a Sentara Health Plan representative will respond to your call on the next business day.

Hospital Admissions: Elective Admissions
Inpatient and elective hospital admissions, and outpatient ambulatory surgical procedures must be pre-authorized using the following guidelines (left justify this) The admitting physician or his/her designee will notify Sentara Health Plan's UM Department of the planned admission where eligibility will be verified, and baseline information will be obtained including but not limited to:

- Demographic profile
- Requested admission date
- Requested procedure date, if applicable and/or different from admission date
- Hospital or outpatient facility
- Admitting physician
- Diagnosis
- Procedure, if applicable
- Expected length of stay (LOS)

The UM Department will review the request based upon clinical information obtained.

1. If authorized, an authorization number will be given to the physician. All hospital stay extensions beyond the originally authorized length of stay will require additional review.
2. If the reported information does not meet with Sentara Health Plan established clinical criteria, the Medical Directory will review the request for further consideration.

Admission / Concurrent Review
All inpatient hospital stays require authorization. At the time of the review for emergency admission, Sentara Health Plan will determine if the admission was medically necessary. Pending availability of clinical data, determinations will be made within 72 hours or 3 calendar days of Sentara Health Plan's notification with subsequent notification to providers within 72 hours or 3 calendar days of making the decision.

Concurrent or continued stay reviews are performed on all non-DRG hospitalized patients and DRG admissions. Medical Records will be reviewed to determine if an admission meets the criteria for a continued stay. Continued stay decisions will be communicated by fax or telephone to the requesting facility. Approvals or Denial Letters are generated for approvals and adverse determinations which include instructions on submitting an appeal. The facility, attending physician and member are notified in writing of the decision by the expiration date of the authorization.

Medical Necessity Criteria
Sentara Health Plans uses Milliman Care Guidelines (MCG) in making medical necessity determinations. Coverage decisions are based upon medical necessity and are in accordance with 42 CFR §438.210. Sentara Health Plans:

- will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member
- may place appropriate limits on a service based on medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose
- will ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that fully supports the member's ongoing need for such services and supports and considers the member's functional limitations by providing services and supports to promote independence and enhance the member's ability to live in the community
- will ensure that coverage decisions for family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used, consistent with 42 CFR §441.20
- will ensure that services are authorized in a manner that supports the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder, health impairments, and/or disability
- ability for a member to achieve age-appropriate growth and development
- ability for a member to attain, maintain, or regain functional capacity
- correction, maintenance, or amelioration of a condition (in the case of EPSDT)
- opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice

Upon request, individual criteria used in a medical necessity determination will be provided to a member, practitioner and/or facility.
For all the DMAS defined behavioral health services, medical necessity is based on the DMAS guidelines and policies outlined in the DMAS Mental Health Manuals. The ASAM criteria is utilized in determining medical necessity criteria for services under the DMAS Addiction and Recovery Treatment Services (ARTS).

Women's Health Services
Sentara Health Plans covers a full spectrum of women's health services, as provided under its contract with DMAS, including those for prevention and treatment, to meet the members' healthcare needs. These services include but are not limited to:

- mammograms
- pap smears
- cervical cancer screening
- genetic testing (BRAC)

- annual physicals and lab tests
- prenatal and postpartum services for all pregnant members
- routine and medically necessary obstetric and gynecologic services
- reconstructive breast surgery
- certified nurse-midwife services
- family planning, including sterilizations and hysterectomies
- mental health and substance misuse care
- screening and treatment for sexually transmitted diseases
- counseling services
- smoking cessation and weight management
- immunizations
- lactation services and breast-feeding pump/supplies
- nutritional assessments
- homemaker services
- blood glucose monitors pre and postpartum

Sentara Health Plans does not require referrals or authorizations for preventive or obstetrical services.

Sentara Health Plans routinely provides members and providers information about the importance of receiving preventive care, including the time frames for receiving this care. Members receive both written and telephonic information periodically regarding receiving appropriate health screenings and medical services**.**

Gynecological Care
Obstetrician/gynecologists qualify as primary care providers. Any female member of age 13 or older has direct access to a participating women's health care specialist for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.

Annual examinations and routine healthcare services, including pap smears, without service authorization from the PCP. Healthcare services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of, or related to, the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists (ACOG).

Obstetrical Services
Prenatal and postpartum services for pregnant members are covered services. Sentara Health Plans does not require the members to obtain a referral prior to choosing a provider for family planning services. Members are permitted to select any qualified family planning provider without referral.

Sentara Health Plans Medicaid program covers case management services for its high-risk pregnant women. Sentara Health Plans provides, to qualified members, expanded prenatal care services, including patient education; nutritional assessment, counseling, and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. Services are covered for 12 months after pregnancy ends for all eligible members.

In cases in which the mother is discharged earlier than 48 hours after the day of delivery, at least one early discharge follow-up visit, indicated by the guidelines developed by the American College of Obstetricians and Gynecologists, is covered. The early discharge follow-up visit is provided to all mothers who meet DMAS criteria, and the follow-up visit must be provided within 48 hours of discharge and meet minimum requirements.

Prenatal care and postpartum services do not require pre-authorization, except for the Maternal Infant Care Coordination (MICC) program.

Member may seek the following services at any participating health department or Planned Parenthood location or nonparticipating provider:

- obstetrical care
- family planning
- Maternal Infant Care Coordination program (including needs assessments, homemaker services, and nutritional assessments)

Sentara Health Plans reimburses for these services and pays providers s billing for deliveries separately. The fee-for-service reimbursement is based on the contractually determined rates or Sentara Health Plans Medicaid program fee schedule.

Providers should promote member receipt of postpartum services as medically necessary throughout the postpartum period and within 60 calendar days of delivery. All pregnant women must be screened for prenatal depression, in accordance with the American College of Obstetricians and Gynecologists (AGOG) standards. Women who screen positive must receive referrals and/or treatment, as appropriate, and follow-up monitoring.

OB/GYNs are responsible for coordinating services with participating hospitals and specialists for OB related care. The participating OB/GYN is responsible for notifying Sentara Health Plans Case Management Department for assistance with prenatal care and enrollment in the maternal health program.

Doula Services

Doulas are individuals based in the community who offer a broad set of nonclinical pregnancy-related services centered on continuous support to pregnant women throughout pregnancy and in the postpartum period.

Emotional, physical, and informational support provided by doulas include:

- childbirth education
- lactation support
- referrals for health or social services

Like other community health workers, doulas provide culturally congruent support to pregnant and postpartum women through their grounding within the unique cultures, languages, and value systems of the populations they serve.

To enroll as a doula with Sentara Health Plans, providers must meet DMAS criteria and follow the DMAS Provider Services Solution (PRSS) enrollment process.

Postpartum Coverage

Eligible members can maintain their coverage for 12 months following pregnancy. The 12-month coverage went into effect on July 1, 2022. This extension of benefits allows new moms to seek additional supportive services such as primary care, dental, and behavioral health services for one year to optimize health and health outcomes. The coverage extension does not include FAMIS Prenatal MOMS.

Medicaid Program Family planning

Sentara Health Plans covers family planning services, which are defined as those services that delay or prevent pregnancy. Coverage of such services does not include services to treat infertility or services to promote fertility. Family planning services do not cover payment for abortion services, and no funds will be used to perform, assist, encourage, or make direct referrals for abortions.

Sentara Health Plans provides family planning and contraceptive coverage for members for all methods, including but not limited to:

- barrier methods
- oral contraceptives
- vaginal rings
- contraceptive patches
- long-acting reversible contraceptives (LARCs)

Sterilization Program
Sentara Health Plans Medicaid program covers these procedures at 100% for members over the age of 21. Medicaid program members must sign a state-approved waiver 30 days prior to a procedure for sterilization services.

Foster Care and Adoption Assistance
The Sentara Health Plans Medicaid program covers services for managed care enrolled foster care and adoption assistance children. Coverage extends to all medically necessary EPSDT or required evaluation and treatment services of the foster care program. Sentara Health Plans works with DSS and the foster parent(s) or adoptive parents in all areas of coordination. Foster care and adoption assistance children are evaluated within a 60-day time frame. Children should receive a PCP visit within 30 days of enrollment if a provider has not been seen within 90 days prior to enrollment.

Immunizations/Vaccines
Providers are required to render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) recommendations, concurrently with the EPSDT screening and ensure that members are not inappropriately referred to other providers for immunizations. Primary care providers are not permitted to routinely refer members to the local health department to receive vaccines.

To the extent possible, and as permitted by Virginia statute and regulations, providers must participate in the statewide immunization registry database.

Medicaid program members, as appropriate to their age, are covered under the Virginia Vaccines for Children (VVFC) program. All PCPs who administer childhood immunizations are encouraged to enroll in the VVFC, administered by the Virginia Department of Health (VDH). The VVFC program supplies vaccines to providers at no charge. The Sentara Health Plans Medicaid program will reimburse providers for administration of the vaccine if the vaccine code is billed. ***FAMIS does not participate with VVFC***. Immunizations provided to FAMIS members and eligible Medicaid program subpopulations should be billed using the appropriate CPT code to Sentara Health Plans. There is no copayment for immunizations provided to FAMIS members.

For eligible Medicaid program members, vaccines are provided free of charge through age 18. Sentara Health Plans will reimburse providers at the contracted rate for the administration of the vaccine only and an office visit, if billed, based on the provider's submission of the appropriate vaccine code.

Medicaid program members 19 years of age or older are not eligible for the VVFC program. If vaccines

are administered, reimbursement will be at the contracted fee.

The listing of vaccines provided through VVFC is subject to changes by VVFC. Coverage for specific vaccines (e.g., influenza) is subject to VVFC eligibility criteria, and special-order vaccines require VVFC approval.

The process for VVFC provider enrollment is:

- Call the VVFC program at 1-800-568-1929 or 804-864-8055 to receive an Enrollment Packet, or go to vdh.virginia.gov/immunization/vvfc/vfcenroll/ to print an Enrollment Form.
- Complete the VVFC Enrollment Form. Keep a copy and mail the original to the VVFC office.
- It will take five business days for VVFC to process your enrollment and assign your practice a VVFC Practice Identification Number (PIN). You will use your PIN to identify your practice when communicating with the VVFC office.
- Once your enrollment is processed, a VVFC consultant will contact you, and VVFC will schedule an enrollment visit to introduce the program to you.

Hospice
Hospice utilizes a medically directed interdisciplinary team. A hospice program provides care to meet the physical, psychological, social, spiritual, and other special needs which are experienced during the final stages of illness and during dying and bereavement.

Individuals receiving hospice at time of enrollment will be excluded from Sentara Health Plans Medicaid program participation. Sentara Health Plans Medicaid program members who elect hospice will remain enrolled in the program. A member may be in a waiver and be receiving hospice services in an inpatient setting (hospital, nursing facility) or at home.

All services associated with the provision of hospice services are covered services. Hospice care must be available 24 hours a day, 7 days a week.

Model of Care
The elements of the Model of Care include:

- specific biopsychosocial approaches for subpopulations
- staff and provider training
- provider networks with specialized expertise and use of clinical practice guidelines and protocols
- comprehensive assessments
- interdisciplinary care teams
- individualized care plans
- care management transition programs
- member and caregiver education
- gap closure for Healthcare Effectiveness Data and Information Set (HEDIS®) and other clinical quality measures

The LTSS program:

- provides for comprehensive care management that integrates the medical, behavioral health, and social models of care through a person-centered approach
- promotes member choice and rights

- engages the member and family members throughout the process
- prioritizes continuity of care and seamless transitions, for members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits.

Care Management
Care management is locally and regionally based. Care managers are assigned to individual members to conduct care coordination activities in every region across Virginia and act as advocates for members and the providers helping members. The care manager works closely with the member as a point of contact to identify medical and behavioral health needs and member strengths and supports. The care manager also works with the member to develop an understanding of the services they are receiving, ensure appropriate authorizations are in place, and resolve barriers to care such as transportation issues and social determinants of health needs.

Sentara Health Plans and Associating with Our Medicaid Provider Community
Sentara Health Plans care managers are the foundation for the members' care delivery. When enrolled, eligible Medicaid program subpopulations will be assigned a care manager who facilitates services with contracted providers within the Medicaid provider network. Pre-authorization will be required for requests for services from a provider not in network with Sentara Health Plans.

Person-centered Care Planning
One of the core areas of focus driving program effectiveness and efficiency is Sentara Health Plans' approach to best practices for person-centered care planning and effective care transitions and for measuring quality improvement to support people living optimally in their preferred setting. Sentara Health Plans is committed to delivering efficient, effective, person-centered care that meets members' needs, helps keep people in their preferred setting, and aligns with state requirements.

Person-centered Individualized Care Plan (ICP)
The care manager works with the members to develop a comprehensive individualized care plan (ICP). Our Medicaid program uses a health risk assessment (HRA) as a tool to develop the member's person-centered ICP. The ICP is tailored to the member's needs and preferences and is based on the results of the program's risk stratification analysis. The Health Risk Assessment (HRA) must be completed and the ICP developed prior to the end of the member's service authorization and within 30 days of HRA completion.

Interdisciplinary Care Team
Sentara Health Plans will arrange the operation of an interdisciplinary care team (ICT) for each eligible Medicaid program subpopulation member in a manner that respects the needs and preferences of the member. Each eligible Medicaid program member's care (e.g., medical, behavioral health, substance use, LTSS, early intervention, and social needs) must be integrated and coordinated within the framework of an ICT, and each ICT member must have a defined role appropriate to their licensure and relationship with the member. The Medicaid program members are encouraged to identify individuals they want to participate in the ICT. The ICT must be person-centered; built on the member's specific preferences and needs; and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

A Sentara Health Plans care manager will lead the ICT. The ICT must include the member and/or their authorized representative(s) and may include the following, as appropriate:

- PCP/specialist
- behavioral health clinician, if indicated

- LTSS provider(s) when the member is receiving LTSS
- targeted case manager (TCM), if applicable (TCM includes ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high-risk prenatal and infant case management services)
- pharmacist, if indicated
- registered nurse
- specialist clinician
- other professional and support disciplines, including social workers, community health workers, and qualified peers
- family members
- other informal caregivers or supports
- advocates
- state agency or other case managers

Reassessments
The Sentara Health Plans care manager will conduct reassessments to identify any changes in the specialized needs of Medicaid program members. Reassessments will be conducted pursuant to routine time frames and upon triggering events.

The ICT must be convened in conjunction with all routine reassessments, within 30 calendar days, and in the following circumstances:

- after triggering events requiring significant changes to the member's ICP (e.g., initiation of LTSS, BH crisis services, etc.)
- upon readmissions to acute or psychiatric hospitals or nursing facilities, within 30 calendar days of discharge
- upon member request

Care Management with Transitions of Care
The Sentara Health Plans Medicaid program provides transition coordination services to include: the development of a transition plan; the provision of information about services that may be needed prior to the discharge date and during and after transition; the coordination of community-based services with the care manager; and linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation.

Transition support services will be provided to:

- Medicaid program members who are transitioning from a nursing facility to the community
- Medicaid program members who are transitioning between levels of care
- children in foster care who are transitioning out of the child welfare system
- a child/youth who was adopted
- a youth who is transitioning to independence

To ensure continuity of care, Sentara Health Plans will:

- conduct risk stratification to determine if a member may benefit from care management
- observe the continuity of care period for the first 30 calendar days of member's enrollment, 60 calendar days for High-intensity Care Management and pregnant members
- allow members to see out-of-network providers

- not change a member's existing provider before end of continuity of care period, except in the following circumstances:
    - member requests change
    - provider chooses to discontinue providing services
    - provider or Sentara Health Plans identifies performance issues that affect member's health or welfare

Hospital/Ancillary
Inpatient stays in general acute care and rehabilitation hospitals for all Medicaid program members are covered. The Sentara Health Plans Medicaid program also covers preventive, diagnostic, therapeutic, rehabilitative, or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. Pre-authorization is required for inpatient acute care and rehabilitation hospitals.

Hospital Payment Using Diagnosis Relative Grouping (DRG) Methodology
If Sentara Health Plans has a contract with a facility to reimburse the facility for services rendered to its members based on a diagnosis-relative group (DRG) payment methodology, Sentara Health Plans will cover 100% of the full inpatient medical hospitalization from time of admission to discharge. This is effective for any actively enrolled member on the date of admission, regardless of whether the member is disenrolled during the inpatient hospitalization.

Sentara Health Plans covers payment of practitioner services rendered during the hospitalization for any dates in which the Sentara Health Plans Medicaid member was enrolled with Sentara Health Plans.

Emergency Room
If the service is determined to be emergent and the facility provider is participating, the claim is paid at the contracted rates. If the service is determined to be nonemergent and the facility provider is participating, the claim is paid with a triage fee. If the facility is paid a triage fee, the provider may not balance bill the member. Facilities paid using Enhanced Ambulatory Patient Groups (EAPG) methodology will be paid the appropriate EAPG, regardless of whether the service is emergent or nonemergent, and there is no triage fee to the facility.

SECTION IV: BEHAVIORAL HEALTH SERVICES

Mental health services (MHS) covered in the DMAS Mental Health Services Manual include Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health Services (EBH), and Mental Health Case Management (MHCM). CMHRS and MHCM medical necessity and program descriptions are in the DMAS Mental Health Services Manual appendices. EBH medical necessity and program descriptions are in the appendices of the Mental Health Services Manual.

Mental Health Services	Procedure/Assessment Code
Mental Health Case Management (MHCM)	H0023
Therapeutic Day Treatment (TDT) School Day for Children	H2016 license updated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to require one license for all levels of TDT
Assertive Community Treatment (ACT)	H0040 Modifiers U1–U5
Mental Health Skill-building Services (MHSS)	H0046/H0032 U8
Intensive In-home (IIH)	H2012/H0031
Psychosocial Rehabilitation (PSR)	H2017/H0032 U6
Mental Health Peer Support Services – Individual	H0025
Mental Health Peer Support Services – Group	H0024
Mental Health Intensive Outpatient (MH-IOP) for Youth and Adults	S9480
Mental Health Partial Hospitalization Program (MH-PHP)	H0035
Mobile Crisis Response	H2011
Community Stabilization	S9482
23-hour Crisis Stabilization	S9485
Residential Crisis Stabilization Unit	H2018
Multisystemic Therapy (MST)	H2033
Functional Family Therapy (FFT)	H0036
Applied Behavior Analysis (ABA)	97151–97158, 0362T, and 0373T

*Modifiers should be applied during the claim's submission process

MHS Provider Training

Sentara Health Plans staff will conduct ongoing education via scheduled webinars and direct provider engagement with mental health service providers. Training and technical assistance topics will include Model of Care elements, person-centered treatment planning, culturally competent care, evidence-based service planning/treatment methods and service provision, effective care coordination in an integrated care service delivery model, effective discharge planning, and

strengths-based treatment goal selection. Training also includes the appointment availability standards and discharge planning expectations and resources for members, particularly for members that have utilized behavioral health crisis services.

Credentialing

All MHS providers are contracted as an organization (agency) type, and all services are billed under the organization's NPI. MHS organizational providers are required to submit the following documents:

- a completed OBH MHS application
- a completed W-9
- clinical staff roster (must include last name, first name, DOB, NPI if applicable, and services provided)
- a copy of the DBHDS license and Licensed Services Addendum - each service/location on the application requires verification by DBHDS
- copies of all other licensure and/or certifications held by the organization
- a copy of their general and professional liability Certificate of Insurance (face sheet)
- additional locations forms

Facilities offering intensive outpatient programs, partial hospitalization programs, inpatient detoxification, and inpatient and/or residential treatment programs specializing in addiction treatment for Sentara Health Plans Medicaid program members must complete DMAS certification and ARTS attestation documents as well as DMAS credentialing for those services.

Detailed instructions and forms are available on the Sentara Health Plans website.

Continuity of Care

Members may maintain their current MHS provider for up to 30 days. Service authorizations issued prior to Sentara Health Plans Medicaid program enrollment will remain for the service authorization or duration of the 30-day continuity of care period, whichever comes first. Authorizations will be extended as necessary to ensure a safe and effective transition to a qualified in-network provider.

Mental Health Services Authorizations/Registrations

All MHS require authorizations or registrations. The Sentara Health Plans Medicaid program utilizes the DMAS-defined medical necessity criteria for MHS. Members must meet service-specific medical necessity criteria. Requests are reviewed on an individual basis to determine the length of treatment and service limits based on the member's most current clinical presentation.

Authorizations may be submitted to the Sentara Health Plans provider website or faxed to the Behavioral Health Department. Please refer to the Methods to Reach Sentara Health Plans section for fax numbers. Providers should expect a standard turnaround time on all request(s) at 14 calendar days, urgent requests can be turned around in 3 calendar days.

The provider must obtain prior authorization for services before providing them. Requests received after initiation/completion of services may result in an adverse determination.

The Medicaid program uses the following DMAS standardized MHS Authorization/Registration forms. These forms are specific to the service provided. They are available on the Sentara Health Plans

provider website and the DMAS website.

MHS Service	Code	Initial Request	Continued Stay Request
Mental Health Case Management	H0023	Registration	Registration
Mental Health Peer Support Services - Individual	H0025	Registration	Registration
Mental Health Peer Support Services - Group	H0024	Registration	Registration
Assertive Community Treatment (ACT)	H0040	*See below	*See below
Intensive In-home (IIH)	H2012	Authorization	Authorization
Therapeutic Day Treatment (TDT)	H2016U7	Authorization	Authorization
Partial Hospitalization	H0035	Authorization	Authorization
Mental Health Intensive Outpatient for Youth and Adults (MH-IOP)	S9480	Authorization	Authorization
Mental Health Skill-building Services (MHSS)	H0046	Authorization	Authorization
Psychosocial Rehab (PSR)	H2017	Authorization	Authorization
Mobile Crisis Response	H2011	Registration	N/A
Community Stabilization	S9482	Authorization	Authorization
23-hour Crisis Stabilization	S9485	Registration	N/A
Residential Crisis Stabilization Unit	H2018	Registration	Authorization
Multisystemic Therapy (MST)	H2033	*See below	*See below
Functional Family Therapy (FFT)	H0036	*See below	*See below
Applied Behavior Analysis (ABA)	97155 97153 – 97158 and 0373T	Authorization	Authorization

* For ACT/MST/FFT services starting 1/1/24, no authorization is required for Sentara Health Plan members. If services started prior to 1/1/24, authorization is required.

MHS Service Descriptions

Applied Behavior Analysis (CPT 97151-97158, 0362T, and 0373T)
The practice of behavior analysis is established by the Virginia Board of Medicine in §54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. This includes direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorization is required for all non-assessment codes. All requested dates and units may be requested under a single CPT code, 97155, which will allow for billing on any CPT code 97151–97158 for the NPI listed on the authorization.

Additional program description and medical necessity criteria are in Appendix D, Intensive Community Based Support – Youth, of the DMAS Mental Health Services Manual.

Assertive Community Treatment (H0040)
Assertive Community Treatment (ACT) is a highly coordinated set of services offered by a group of medical, behavioral health, peer support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of an individual's needs and is oriented around an individual's personal goals. A fundamental charge of ACT is to be the first line (and sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.
If services started 1/1/24 or later, no authorization is required. If services started prior to 1/1/24, authorization is required.

Additional program description and medical necessity criteria are in Appendix E, Intensive Community Based Support, of the DMAS Mental Health Services Manual.

Mobile Crisis Response (H2011)
Mobile Crisis Response provides rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. It is provided 24 hours a day, 7 days a week. This service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety to prevent the need for a higher level of care. Mobile Crisis Response is the mechanism by which pre-admission screening for hospitalization may be performed by DBHDS pre-admission screening clinicians.

Mobile Crisis Response is designed to:

- provide rapid response to a member experiencing a mental health crisis
- meet the member in an environment where they are comfortable to engage to facilitate quick resolution of that crisis
- provide appropriate care/support/supervision to maintain safety while avoiding unnecessary law enforcement involvement, emergency room utilization, and/or hospitalization
- refer and link to all medically necessary behavioral health services and supports
- coordinate with behavioral health providers
- deploy in real time to the location of an individual in crisis, ideally utilizing a two-person team for safety

Registration is required.

Mobile Crisis Response providers must:

- Be licensed by DBHDS as a provider of Outpatient Crisis Stabilization services and be enrolled as a provider with DMAS.
- Follow all general Medicaid provider requirements
- Have an active, DBHDS approved Memorandum of Understanding (MOU) with the regional crisis hubs prior to providing mobile crisis response services. (Mental Health Services Manual Appendix G).

- Mobile Crisis Response providers that have signed MOU's with their regional HUB must complete and pass DBHDS required Mobile Crisis Response (MCR) training.

Additional information and training requirements for Mobile Crisis services can be obtained by visiting the DBHDS website.

Crisis Call Centers
Beginning December 15, 2023, members may call 988 if they are experiencing a mental health crisis to get immediate help from a trained crisis worker. The 988 Call Center, regional crisis hub, or their contractors will assess each call to determine if a Mobile Crisis Response is indicated. Mobile Crisis Response will not be reimbursable unless the referral came from the 988-call center or regional crisis hub, and the Virginia Crisis Connect platform will not generate a reference number for providers (unless the referral comes from the 988 Call Center or mobile regional crisis hub).

Additional program description and medical necessity criteria are in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

Community Stabilization (S9482)
Community Stabilization is a short-term service designed to support a member in their natural environment following contact with an initial crisis-response service. Services provide referral and linkage to other community-based services at the appropriate level of care. Interventions include brief therapeutic and skill-building, engagement of natural supports to de-escalate and stabilize the crisis, and coordination of follow-up services.
The goal of Community Stabilization is to continue to stabilize the member within their community and support both them and their support system during the period between either 1) an initial Mobile Crisis Response and entry into an established follow-up service **or** 2) a transitional step-down from a higher level of care if the next level of care identified as needed is not immediately available for access.
Authorization is required.

Additional program description and medical necessity criteria are in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

23-hour Crisis Stabilization (S9485)
23-hour Crisis Stabilization provides up to 23 hours in a community-based facility that provides assessment and stabilization to members experiencing an acute behavioral health crisis. This service is for members who require a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit is necessary. This service is appropriate for individuals who have immediate significant emotional dysregulation, disordered thought processes, substance use and intoxication, and environmentally destabilizing events that require a multi-disciplinary crisis intervention team to observe and stabilize the immediate crisis while determining the next appropriate step in the plan of care.
This service is provided in a community-based facility that has referral relationships with both outpatient and inpatient level of care as next level of care options.
Registration is required.

Additional program description and medical necessity criteria are in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

Residential Crisis Stabilization Unit (H2018)
Residential Crisis Stabilization Units (RCSUs) are a diversion from inpatient hospitalization. They provide short-term, 24/7, facility-based psychiatric and substance-related crisis evaluation and brief intervention.

Registration/Authorization is required.

Additional program description and medical necessity criteria are in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

Functional Family Therapy (H0036)
Functional Family Therapy (FFT) is a short-term, evidenced-based treatment program for youth (ages 11–18) who have received referral for treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. FFT is mainly home-based and addresses both symptoms of emotional disturbance in the youth and parenting/caregiving practices and/or caregiver challenges that affect the family. FFT is rehabilitative in nature and serves as a step-down and diversion from higher levels of care. It seeks to understand and intervene with the youth within their network of systems, including family, peers, school, and neighborhood/community.
If services started 1/1/24 or later, no authorization is required. If services started prior to 1/1/24, authorization is required.

Additional program description and medical necessity criteria are in Appendix D, Intensive Community Base Support - Youth, of the DMAS Mental Health Services Manual.

Intensive In-home Services for Children/Adolescents (H2012)
Intensive In-home Services for Children/Adolescents under age 21 are time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. Providers must be licensed as a provider of Intensive In-home Services through DBHDS. The assessment must document the eligibility and medical necessity for the service. Assessment code H0031 or H0032 must be billed before the service code H2012 is billed. Authorization is required.

Additional program description and medical necessity criteria are in Chapter 13: Appendix H (CMHRS), Covered Services and Limitations, of the DMAS Mental Health Services Manual.

Mental Health Skill-building Services (MHSS) (H0046)
Mental Health Skill-building Services are goal-directed training and supports to enable restoration of an individual to the highest level of baseline functioning while achieving and maintaining community stability and independence in the most appropriate, least restrictive environment. MHSS provides face-to-face activities, instruction, and interventions in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals toward self-monitoring and self-regulation of all these activities. The member must have a prior history of qualifying mental health treatment such as a psychiatric hospitalization, comprehensive crisis services, Program of Assertive Community Treatment (PACT), ICT/ACT services, RTC-level C placement, or a TDO evaluation due to mental health decompensation.

Authorization is required.

Additional program description and medical necessity criteria are in Chapter 13: Appendix H (CMHRS), Covered Services and Limitations, of the DMAS Mental Health Services Manual

Mental Health Case Management (MHCM) (H0023)
Mental Health Case Management is defined as a service to assist individuals, eligible under the state plan who reside in a community setting, in gaining access to needed medical, social, educational, and

other services.

Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, if the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the assessment, the Individualized Service Plan (ISP), and the progress notes. Mental Health Case Management services assist individual children and adults in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Providers must be credentialed with a Community Services Board (CSB) and licensed by DBHDS.
Registration is requested.

Additional program description and medical necessity criteria are in Chapter 14: Appendix I (Case Management), Covered Services and Limitations, of the DMAS Mental Health Services Manual

Mental Health Intensive Outpatient Services (MH-IOP) (S9480)
Mental Health Intensive Outpatient Services (MH-IOP) are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time-limited treatment programs that integrate evidence-based practices for youth (ages 6–17 years) and adults (18 years and older). MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated, and individualized service plan that uses multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention, and reducing the need for a more acute level of care. MH-IOP services are appropriate when an individual requires at least six hours of clinical services a week (for youth ages 6–17), or nine hours of clinical services a week (for adults 18 years and older) over several days a week and totaling a maximum of 19 hours per week. An MH-IOP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule.
Authorization is required.

Additional program description and medical necessity criteria are in Chapter 11 Appendix F, Intensive Clinic Based Support, of the DMAS Mental Health Services Manual.

Mental Health Partial Hospitalization Program (MH-PHP) (H0035)
Mental Health Partial Hospitalization Program (MH-PHP) is a highly structured clinical program designed to provide an intensive combination of interventions and services like an inpatient program, but available on a less than 24-hour basis. MH-PHP is an active, focused, and time-limited treatment intended to stabilize acute symptoms. The average length of stay may be four to six weeks, though length of stay should reflect individual symptoms, severity, needs, goals, and medical necessity. MH-PHP can serve as a step-down program from inpatient psychiatric admission or a diversion from an inpatient admission. Members would require inpatient psychiatric hospitalization without this service. MH-PHP requires at least four hours of clinical services per day over several days a week and totaling a minimum of 20 hours per week.
Authorization is required.

Additional program description and medical necessity criteria are in Chapter 11: Appendix F, Intensive Clinic Based Support, of the DMAS Mental Health Services Manual.

Multisystemic Therapy (H2033)
Multisystemic Therapy (MST) is an intensive, evidence-based treatment program provided in the home and/or community settings for youth (11–17 years old) who have been referred by the juvenile justice, behavioral health, school, or child welfare systems. MST is appropriate for members with significant clinical impairment. It emphasizes engagement with the family, caregivers, and natural support. MST is a short-term and rehabilitative service that serves as a step-down and diversion from higher levels of care.

If services started 1/1/24 or later, no authorization is required. If services started prior to 1/1/24, authorization is required.

Additional program description and medical necessity criteria are in Chapter 9: Appendix D, Intensive Community Base Support - Youth, of the DMAS Mental Health Services Manual.

Psychosocial Rehabilitation (H2017)
Psychosocial Rehabilitation is provided in sessions of two (2) or more consecutive hours per day to groups of individuals in a nonresidential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, and opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature.

Authorization is required.

Additional program description and medical necessity criteria are in Chapter 13: Appendix H (CMHRS), Covered Services and Limitations, of the DMAS Mental Health Services Manual.

Therapeutic Day Treatment Services (TDT) (H2016)
Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities. TDT is provided during the school day or to supplement the school day or year. The service includes assessment; assistance with medication management; interventions to build daily living skills or enhance social skills; and individual, group, and/or family counseling and care coordination. These services are provided for two or more hours per day. Youth receiving TDT must have the functional capacity to understand and benefit from the required activities and counseling of the service. TDT is rehabilitative and intended to improve the youth's functioning. Assessment code H0031 or H0032 must be billed before the service code H2016 will pay.

Authorization is required.

Additional program description and medical necessity criteria are in Chapter 13: Appendix H (CMHRS), Covered Services and Limitations, of the DMAS Mental Health Services Manual.

Mental Health Peer Support Services or Family Support Partners – Individual (H0024), Group Mental Health Peer Support (H0025)
These services are nonclinical, peer-to-peer activities that empower individuals to improve their health, recovery, resiliency, and wellness. Services are person-centered and provided by a registered peer recovery specialist who has lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders and has been trained to offer support and assistance in helping others in their recovery. Peer support is designed to promote empowerment,

self-determination, upstanding, and coping skills through mentoring and service coordination support, as well as to assist members in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

Registration/Authorization required.

Additional program description and medical necessity criteria are in Chapter 17: The Peer Recovery Support Services Supplement, of the DMAS Mental Health Services Manual.

Billing
Please reference DMAS MHS Chapter 5, Billing Instructions, and appendices for specific service with questions on billings and provision of units.

All MHS services may be billed using the CMS-1500 claim form for outpatient services. In addition, 23-hour Crisis Stabilization, Residential Crisis Stabilization Units, Mental Health Intensive Outpatient Programs, and Mental Health Hospitalization providers may also utilize the UB-04 Claim Form for hospitals/facilities, as appropriate.

Providers may submit paper or electronic claims. MHS providers may submit electronic claims through Availity, or any clearinghouse that can connect through Availity.

Residential Treatment Services
Residential treatment services include psychiatric residential treatment facility services (level C) and therapeutic group home services (TGH) (levels A and B) and are administered by the DMAS behavioral FFS (fee-for-service) contractor (Magellan of Virginia). Members admitted to a residential treatment facility service will be covered by the fee-for-service (FFS) contractor, temporarily excluded from the Medicaid program, until they are discharged. Members admitted to a therapeutic group home (TGH) are not excluded from the Medicaid program, and any professional medical service rendered to members in a TGH are provided through the Sentara Health Plans Medicaid program. The Sentara Health Plans Medicaid program works closely with Magellan to coordinate care and provides coverage for transportation and pharmacy services for these carved out services.

Members admitted to a residential treatment center for substance use disorder are not excluded from the Sentara Health Plans Medicaid program, and all services continue to be provided through the Medicaid program.

Addiction and Recovery Treatment Services (ARTS)
The Addiction and Recovery Treatment Services (ARTS) benefit is an enhanced substance use disorder treatment benefit of the Virginia Medicaid program. The ARTS benefit provides access to addiction treatment services for all enrolled members in Medicaid program. This treatment includes community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment. Goals for the ARTS benefit and delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with a substance use disorder.

Sentara Health Plans' ARTS criteria are consistent with the American Society for Addiction Medicine (ASAM) criteria as well as DMAS's criteria for the ARTS benefit. ARTS providers are responsible for adhering to requirements and regulations from ARTS, this Provider Manual Supplement, and their Sentara Health Plans Provider Agreement, as well as state and federal governments.

Sentara Health Plans applies the treatment criteria for addictive, substance-related conditions

published by the ASAM (Third Edition) for the ARTS program. The ASAM provides criteria for many levels and types of care for addiction and substance-related conditions. It also establishes clinical guidelines for making the most appropriate treatment and placement recommendations for members who demonstrate specific signs, symptoms, and behaviors of addiction.

Providers requesting assistance with ARTS care coordination for Sentara Health Plans Medicaid members can call 1-800-881-2166.

Additional information for ARTS services, including authorizations, provider requirements, covered services and utilization review, and controls, is in the DMAS ARTS Manual Chapters 1–9.

Disclosure of Protected Health Information
Federal law requires federally assisted alcohol or drug abuse treatment providers to protect a member's identifying health information, whether direct or indirect. This is to protect members from being identified as having a current or past drug or alcohol problem or as being a participant in a covered program without their written consent. With limited exceptions, this law requires a patient's consent for disclosures of protected health information, even for the purposes of treatment, payment, or healthcare operations.
Providers can consult their legal counsel for more information regarding this requirement.

Provider Participation Requirements
Addiction and Recovery Treatment Services (ARTS) providers must be qualified as defined in the ASAM Criteria; Treatment Criteria for Addictive, Substance-related, and Co-occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine. For providers to participate in the Sentara Health Plans Medicaid program, the provider must be credentialed and contracted by DMAS and Sentara Health Plans. Providers must be licensed by DBHDS and registered with the Department of Health Professions (DHP). These providers include:

- opioid treatment programs
- office-based opioid treatment
- case management
- peer recovery supports
- inpatient detox
- residential treatment
- partial hospitalization
- intensive outpatient programs

Contracting and Credentialing
For ARTS contracting and credentialing options and provider-specific information, please visit this link or call:

- Contracting: 1-877-865-9075 x 4 or email PrvRecruit@sentara.com
- Credentialing: Cred_Org_Apps@sentara.com

ARTS Service Authorization and Registration
Providers need to verify the member's benefit eligibility before providing services to ensure the service being requested is covered. For initial requests, providers should complete the ARTS Service Authorization Review Form.

To request an extension for the same ASAM level, they should complete the ARTS Service

Authorization Extension Review Form.
All ARTS authorization/registration request(s) forms can be found on the provider website.

- ARTS DMAS Provider Attestation Form (ASAM Levels 2.1 to 3.7)
- ARTS Peers Registration Request
- ARTS Peers Service Authorization Guidelines
- ARTS Service Authorization Review - Extensions
- ARTS Service Authorization Review - Initial Request
- ARTS Substance Use Case Management Registration

The provider must obtain prior authorization for services prior to providing them. Requests received after initiation/completion of services may result in an adverse determination.

Providers submitting ARTS Registration Requests should fax the completed forms to Sentara Health Plans at 844-895-3231. Providers will be notified of Approvals/Denials via fax and/or letter. All ARTS requests will be turned around within 3 calendar days. Requests for service authorizations that do not meet the ASAM requirements for the requested Level of Care will not be approved.
Note: for denials, a letter will be sent by the managed care organization (MCO) to both the provider and member, in accordance with National Committee Quality Assurance (NCQA) requirements.

For questions concerning the authorization/registration process, please contact:

Sentara Health Plans
(Behavioral Health)
1-800-881-2166

ARTS Questions
ARTS Helpline number:
804-593-2453
Email:
SUD@dmas.Virginia.gov

ARTS Service Authorization Requirements are detailed in the following table:

ASAM Level of Care	CPT Code	ASAM Description	Service Authorization Required
4.0	H0011	Medically Managed Intensive Inpatient	Yes
3.7	H2036	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-intensity Inpatient Services (Adolescent)	Yes
3.5	H0010	Clinically Managed High-intensity Residential Services (Adults)/Medium-intensity (Adolescent)	Yes
3.3	H0010	Clinically Managed Population-specific High-intensity Residential Services (Adults)	Yes
3.1	H2034	Clinically Managed Low-intensity Residential Services	Yes

2.5	S0201	Partial Hospitalization Services	Yes
2.1	H0015	Intensive Outpatient Services	Yes
1.0	See DMAS manual	Outpatient Services	No
OTS	See DMAS manual	Opioid Treatment Program (OTP)	No
OTS	See DMAS manual	Office-based Addiction Treatment (OBAT)	No
0.5	See DMAS manual	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	No
n/a	H0006 T1012 S9445	Substance Use Case Management Peer Support Services (individual/group)	Registration Required

ARTS Service Descriptions

Residential Substance Use Treatment (H2034, H0010, H2036) ASAM Levels 3.1–4.0
Services are for members with serious substance use problems who require a residential level of care for the purposes of improving the member's overall health, treating the substance use disorder, strengthening supportive relationships, and achieving and maintaining a sober and substance-free lifestyle. The enrollee must agree to actively participate in care. Services provided are development education, symptom and behavior management, and personal healthcare training. Authorization for this service is required.

Substance Use Partial Hospitalization Services (S0201) ASAM Level 2.5
Services of two or more consecutive hours per day may be scheduled multiple times per week and provided to groups of individuals in a nonresidential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week. Substance use day treatment may not be provided concurrently with intensive outpatient or opioid treatment services. Authorization is required.

ARTS Intensive Outpatient (H0015) ASAM Level 2.1
Intensive outpatient services (ASAM Level 2.1) are a structured program of skilled treatment service for adults, children, and adolescents delivering a minimum of three service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents. Intensive outpatient services require a service authorization.

Services of two or more consecutive hours per day may be scheduled multiple times per week and provided to groups of individuals in a nonresidential setting. The maximum number of service hours is 19 hours per week. This service should be provided to those members who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment services. Authorization is required.

Substance Use Traditional Outpatient Therapy ASAM Levels 1.0 and 0.5
ASAM Levels 1.0 and 0.5 are traditional outpatient therapy or Screening, Brief Intervention, and Referral to Treatment (SBIRT) where the primary diagnosis and focus of treatment is on the substance use disorder. Providers practice within the scope of their license and bill appropriate outpatient CPT codes. No authorization is required for in-network providers.

Opioid Treatment Programs/Office-based Addiction Treatment (OTP/OBAT)
OTP/OBATs are medication-assisted treatment programs that incorporate methadone, buprenorphine, or naltrexone along with psychotherapy and psychosocial treatment services. These programs are licensed by DBHDS; OBAT programs must obtain additional credentialing from DMAS. For additional information regarding program requirements, service components, limitations, and billing, please review the Preferred Office-based Addiction Treatment and Opioid Treatment Programs Supplement found on the DMAS website. No authorization is required.

Substance Abuse Case Management (H0006)
These services assist members and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the member's basic needs. Registration is required.

Peer Support Specialist T1012 ARTS Individual; S9445 ARTS Group
This includes services that are nonclinical, peer-to-peer activities that empower individuals to improve their health, recovery, resiliency, and wellness. Services are person-centered and provided by a registered peer recovery specialist who has lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders and has been trained to offer support and assistance in helping others in their recovery. Peer support is designed to promote empowerment, self-determination, upstanding, and coping skills through mentoring and service coordination support, as well as to assist members in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.
Registration for the initial and concurrent services is required.

Additional program description and medical necessity criteria are in the Peer Recovery Support Services Supplement of the DMAS Mental Health Services Manual.
Additional information for ARTS services, including authorizations, provider requirements, covered services, and utilization review and controls, is in the DMAS ARTS Manual, chapters 1–9.

Note: crisis services are covered for both ARTS and/or mental health crises through the MHS program for all eligible members.

Billing
Please reference DMAS ARTS Chapter 5, Billing Instructions, and appendices for specific service with questions on billings and provision of units.

Providers may submit paper or electronic claims. ARTS providers may submit electronic claims through Availity or any clearinghouse that can connect through Availity.

To find ARTS Reimbursement Structure for billing codes and units for ARTS services, visit the DMAS Information and Provider Map

Telemedicine

Telemedicine services are covered under specific criteria for both MHS and ARTS services and in accordance with the most current version of DMAS Telehealth Services Supplement. Providers should contact provider customer service with questions or for specific policies and requirements.

Transportation
Transportation to nonemergency MHS and ARTS covered services is a covered benefit. For specific questions or to coordinate transportation services for members, please contact the transportation vendor at 1-877-892-3986.

SECTION V: COVERED SERVICES

Covered services include care management and benefits that are not generally covered through Medicaid fee-for-service, including:

- smoking cessation
- assistive devices
- adult vision
- wellness rewards
- home-delivered meals after inpatient hospital stay
- weight management
- memory alarms and devices
- free cell phones
- nonmedical transportation (up to three round trips every three months)

All enhanced benefits are coordinated through the member's assigned care manager.

Audiology
Audiology services are provided as inpatient or outpatient hospital services or by outpatient rehabilitation agencies, or home health services. Benefits include coverage for acute and nonacute conditions and are limited based upon medical necessity. There are no maximum benefit limits on audiology services.

Hearing Aid Services
NationsBenefits, LLC will administer hearing aid services for all eligible Medicaid program members ages 22 and older. The benefit includes a $2,000 annual allowance that includes a complete routine hearing exam and evaluation, hearing aid fittings, a three (3) year supply of batteries, up to sixty (60) batteries per hearing aid per year, and a three (3) year manufacturer's warranty on all hearing instruments. In addition, members will be able to access NationsBenefits, LLC's network of hearing aid providers.
Note: Effective October 1, 2022, Sentara Health Plan will administer hearing aid services for pediatric members 21 years of age and younger. Providers can bill Sentara Health Plan directly for this age range.

Members can access their benefits information by visiting this link or by calling NationsBenefits, LLC at 844-376-8637. Member Experience Advisors are available 24 hours per day, 7 days per week, 365 days per year. Language support services are available free of charge.

Brain Injury Services (BIS) Case Management
BIS case management services are activities designed to assist individuals, 18 years or older, in accessing and maintaining needed medical, behavioral health, social, educational, employment, residential, and other supports essential for living in the community and in developing his or her desired lifestyle. To provide BIS case management services, providers must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and must meet PRSS enrollment requirements. For billing guidance, Providers should refer to the DMAS Brain Injury Services Manual.

Behavioral Health Services
Behavioral health services are covered and include treatment for both mental health and substance use disorders. Services range from outpatient counseling or community-based treatment programs to inpatient or residential based treatment facilities. Urgent and emergent issues can also be addressed

through crisis services.

Chiropractic
Chiropractic services are not Medicaid-covered services. However, Sentara Health Plans does cover chiropractic services when medically necessary for spinal manipulation, illness, injury, and in accordance with EPSDT criteria.

Dental
Dental services should be requested and authorized directly through DMAS.

Learn more about Smiles for Children Medicaid General Dentistry services: dmas.virginia.gov/for-providers/dental/

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
All EPSDT services for members under age 21 are covered. Sentara Health Plans complies with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct, ameliorate, or maintain health status.

Where it is determined that otherwise excluded services/benefits for a child are medically necessary services that will correct, improve, or are needed to maintain the child's medical condition, Sentara Health Plans will provide coverage through EPSDT for medically necessary benefits for children outside the basic Medicaid benefit package, including, but not limited to:

- extended behavioral health benefits
- nursing care (including private duty)
- personal care
- pharmacy services
- treatment of obesity
- neurobehavioral treatment
- other individualized treatments specific to developmental issues

Per EPSDT guidelines, Sentara Health Plans covers medical services for children if it is determined that the treatment or item would be effective to address the child's condition. The determination of whether a service is experimental will be reasonable and based on the latest scientific information available.

Providers are encouraged to contact care coordinators to explore alternative services, therapies, and resources for members when necessary. No service provided to a child under EPSDT will be denied as "out-of-network" and/or "experimental" or noncovered," unless specifically noted as noncovered or carved out of this program.

Documentation of EPSDT Screenings
EPSDT services are subject to health plan documentation requirements for network provider services and to the following additional documentation requirements:

- The medical record must indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT-related services, whether provided by the PCP or another provider.
- Providers must make appropriate EPSDT referrals and document said referrals in the member's medical record.

- Documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized.
- The medical record must indicate when a developmental delay has been identified by the provider and an appropriate referral has been made.

EPSDT Referrals and Treatment
Sentara Health Plans will monitor provider compliance with required EPSDT activities. Sentara Health Plans requires that network providers promptly notify Sentara Health Plans in the event a screening for a member eligible for EPDST services reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability of a provider to make an appropriate referral for EPSDT services, Sentara Health Plans will secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation.

EPSDT Provider Training
Sentara Health Plans educates providers on the EPSDT program and goals, required EPSDT screening components, including oral health screening requirements, and qualified EPSDT screening providers. Sentara Health Plans will also educate network providers about proper coding for diagnoses and evaluation and management for EPSDT services.

The comprehensive plan ensures that all providers qualified to provide EPSDT services have access to proper education and training regarding the EPSDT benefit.

The training includes the following topics:

- overview of the EPSDT benefit
- eligibility criteria
- EPSDT screenings
- proper coding
- diagnostic services
- treatment services, including EPSDT Specialized Services
- referrals
- clinical trials
- required services to support access
- beneficiary outreach and communication
- medical necessity
- service authorization
- utilization controls
- secondary review
- intersection of EPSDT and HCBS waivers
- notice and appeals
- provider manuals

For more information, please visit this link.

Early Intervention Services
Early Intervention (EI) services are covered for children from birth to age 3 who have:

- a 25% developmental delay in one or more areas of development
- atypical development
- a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay

EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social, emotional, or adaptive).

Children are first evaluated by the local lead agency to determine if they meet requirements. If they are determined eligible, the local lead agency enters the data in the Infant and Toddler Online Tracking System (ITOTS). Based upon ITOTS information, DBHDS staff enter the EI level of care (LOC) in the DMAS system.

Once the LOC is entered, the EI services are billable based upon the provider's order on the Individualized Family Service Plan (IFSP). All EI service providers must be enrolled with Sentara Health Plans prior to billing. Service authorization is not required.

EI services are provided in accordance with the child's IFSP and developed by the multidisciplinary team, including the care manager and EI service team. The multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family-centered treatment. EI services are performed by EI-certified providers in the child's natural environment, to the maximum extent appropriate. Natural environments can include the child's home or a community-based setting in which children without disabilities also participate.

Sentara Health Plans provides coverage for EI services as described in the member's IFSP developed by the local lead agency. Sentara Health Plans works collaboratively as part of the member's multidisciplinary team to:

- ensure the member receives the necessary EI services timely and in accordance with federal and state guidelines
- coordinate other services needed by the member
- transition the member to appropriate services

The child's primary care provider (PCP) approves the IFSP. The PCP signature on the IFSP, a letter accompanying the IFSP, or an IFSP summary letter is required within 30 days of the first visit for the IFSP service for reimbursement of those IFSP services. If PCP certification is delayed, services are reimbursed beginning the date of the PCP signature.

When a developmental delay has been identified for children under age 3, Sentara Health Plans will collaborate with the provider to ensure appropriate referrals are made to the Infant and Toddler Connection and documented in the members' records. Sentara Health Plans will work with DMAS to refer members for further diagnosis and treatment, or follow-up of all uncovered or suspected abnormalities. If the family requests assistance with transportation and scheduling to receive services for early intervention, Sentara Health Plans will provide this assistance.

The Sentara Health Plans EI policies and procedures, including credentialing, follow federal and state EI regulations and coverage and reimbursement rules in the DMAS Early Intervention Services Manual.

Medical Supplies and Medical Nutrition
Medical supplies and equipment are covered to the extent allowed by DMAS. Durable medical

equipment (DME) benefits are limited based upon medical necessity. There are no maximum benefit limits on DME. Nutritional supplements and supplies are covered benefits. The Sentara Health Plans Medicaid program covers specially manufactured DME equipment that was pre-authorized, per DMAS requirements. Please review the current Summary of Benefits or contact member services for prior authorization requirements. Additional information can be found in the Durable Medical Equipment and Supplies Provider Manual available on the DMAS web portal found here.

Physical Therapy/Occupational Therapy/Speech Pathology
Sentara Health Plans Medicaid program covers physical therapy (PT), occupational therapy (OT), and speech pathology (SLP) services that are provided as an inpatient or outpatient hospital service, by outpatient rehabilitation agencies, or home health service. Benefits include coverage for acute and nonacute conditions and are limited based upon medical necessity. There is no maximum benefit limit on PT, OT, and SLP services. These services are covered, regardless of where they are provided. Pre-authorization for these services is not required unless they are part of home health services.

All medically necessary, intensive physical rehabilitation services in facilities that are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs) are also covered. Pre-authorization is required for acute inpatient rehabilitation.

Policies and procedures for speech therapy may vary by enrolled Medicaid program members.

Special Needs Members
Sentara Health Plans Medicaid program members who have been identified as hearing impaired and/or speak limited or no English and/or require interpreter services may have these services arranged by Sentara Health Plans, as directed by the DMAS contract. Provider offices should aid when hand-to-hand transportation is required for the special needs member. In addition to the provider requirements for special needs members from the DMAS contract, providers are required to submit physical accessibility information for provider directories to facilitate access for special needs members such as wide entry, wheelchair access, accessible exam rooms, tables, lifts, scales, bathroom stalls, grab bars, or other accessibility equipment.

Preventive Care
The Sentara Health Plans Medicaid program encourages and supports the PCP relationship as the Medicaid member's provider "health home." This strategy will promote one provider having knowledge of the member's healthcare needs, whether disease-specific or preventive in nature.

PCPs may include pediatricians; family and general practitioners; internists; OB/GYNs, physician assistants, nurse practitioners, and specialists who perform primary care functions; and clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Care Providers, and other providers approved by DMAS.

Routine physicals for children up to age 21 are covered benefits under EPSDT.

Private Duty Nursing (PDN)
Medically necessary PDN services for children under age 21, in accordance with DMAS criteria described in the DMAS EPSDT Manual, are covered benefits. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing, which provides for short-term, intermittent care where the emphasis is on member or caregiver teaching. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including but not limited to nursing level assessment, monitoring, and skilled interventions. Pre-authorization is required.

Prosthetic Devices
Prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) are covered benefits, to the extent that they are covered under Medicaid. Medically necessary orthotics for children under age 21 and for adults and children are covered benefits when recommended as part of an approved intensive rehabilitation program. Custom orthotics over $1,000 for a single item require pre-authorization.

Transplants
Transplants for the Medicaid program is covered, according to the contract with DMAS. Necessary procurement/donor services are covered. Children under 21 years of age are covered for transplants, per EPSDT guidelines. Pre-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.

Sentara Health Plans Medicaid program coverage for transplant varies depending on recipient age and organ. Sentara Health Plans uses the Optum Health Care Solutions Centers of Excellence Network and certain local and regional transplant providers for organ transplants. Members will be directed to an appropriate transplant facility for care.

Vision Coverage
Preventive vision services are not reimbursed under the medical plan and should be obtained by members through the vision vendor.

Each covered individual may receive an eye exam 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.

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

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 (note: these services are not considered routine services and would not be covered under routine vision vendor coverage, but they are covered by Sentara Health Plans when medical necessity criteria are met).
- Corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under plan.
- Services provided because of any worker's compensation law.
- A discount is not available on frames where the manufacturer prohibits a discount.

Long-term Services and Supports

Long-term Services and Supports (LTSS) are a variety of services and supports that assist individuals with health or personal needs and activities, activities of daily living, and instrumental activities of daily living over a period. Long-term Services and Supports can be provided at home, in the community, or in various types of facilities, including nursing facilities.

LTSS Service Authorization
All LTSS services require a pre-authorization/notification number. The appropriate DMAS form should be attached to the pre-authorization form. Forms are available on the DMAS website and also here.

Authorizations for LTSS must be resubmitted every six months unless the authorization has been previously updated by the care coordinator.

Patient Pay for LTSS
When a Medicaid program member's income exceeds an allowable amount, they must contribute toward the cost of their LTSS. This contribution is known as the patient pay amount. The local DSS will identify Medicaid program members who are required to pay a patient pay amount and the amount of the obligation as part of the monthly transition report.

The following are examples of services that qualify for patient pay:

- nursing facility
- private duty nursing
- adult day care
- personal care
- respite care

Waivers
Individuals enrolled in the Commonwealth Coordinated Care Plus Waiver receive waiver services furnished by the Sentara Health Plans Medicaid program providers as well as medically necessary nonwaiver services. Individuals enrolled in the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers are covered only for their medically necessary nonwaiver services:

- acute and primary healthcare
- behavioral health
- pharmacy
- non-LTSS waiver transportation services

Developmental Disability (DD) Waiver
Individuals enrolled in one of DMAS's Developmental Disability (DD) waivers (the Building Independence [BI], Community Living [CL], and Family and Individual Supports [FIS] waivers) will be enrolled in the Medicaid program for their nonwaiver services (e.g., acute and primary healthcare, behavioral health, pharmacy, and non-LTSS waiver transportation services). DD waiver services (including when covered under EPSDT), targeted case management, and transportation to the waiver services are paid through Medicaid fee-for-service as "carved-out" services.

Services are based on assessed needs and are included in a person-centered Individual Care Plan (ICP). Individuals receiving home and community-based services through one of these waivers have a variety of choices of both types of services and providers.

The Sentara Health Plans Medicaid program manages members who are enrolled in the BI, CL, or FIS

waivers, in addition to all individuals with a diagnosis of a developmental disability.
Sentara Health Plans collaborates with providers to coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services by working with the member's interdisciplinary care team (ICT) and residential provider, as applicable, to support the individual's health and well-being.

Commonwealth Coordinated Care (CCC) Plus Waiver
The CCC Plus Waiver covers a range of community support services for individuals who are aged, have a disability, or are technology-dependent individuals who rely on a device for medical or nutritional support (e.g., ventilator, feeding tube, or tracheostomy). Home and Community-based Services allow members to receive care in their home or community and prevent institutionalization. LTSS are provided through the 1915(c) Home and Community-based Services (HCBS) Waiver. Individuals who are technology-dependent, chronically ill, or severely impaired (having experienced loss of a vital body function) and require substantial and ongoing skilled nursing care to avert death or further disability are eligible to receive all CCC Plus Waiver serves as well as private duty nursing services.

To be enrolled in the CCC Plus Waiver, an individual must meet the level of care (LOC) required for a nursing facility. Enrollment into the CCC Plus Waiver requires a pre-admission screening (PAS) performed by an approved LTSS Screening team. As part of the PAS, individuals who are technology-dependent must also receive an age appropriate DMAS Technology Adult Referral form (DMAS 108) or Technology Pediatric Referral form (DMAS 109). The CCC Plus Waiver is offered to individuals who meet the criteria. The individual must choose to receive services through the CCC Plus Waiver in lieu of facility placement. The PAS includes:

- Uniform Assessment Instrument (UAI)
- DMAS-95 MI/DD/RC (and DMAS-95 MI-ID/RC Supplement Form, Level II, if applicable) for individuals who select nursing facility placement
- DMAS-96 (Medicaid-funded Long-term Care Service Authorization Form)
- DMAS-97 (Individual Choice – Home and Community-based Services or Institutional Care or Waiver Services Form)
- DMAS 108 (Adults) or DMAS 109 (Children) for individuals who are technology dependent and need private duty nursing

All individuals requesting community-based or nursing facility LTSS must receive a screening to determine if they meet the LOC needed for nursing facility services. DMAS has contracts with the Virginia Department of Health (VDH), Virginia Department of Social Services (VDSS), hospitals, and nursing facilities to conduct screenings for individuals. In the community, screeners are members of the local health departments (LHD) who may include physicians and nurses along with social workers and family services specialists within the local departments of social services (LDSS). Community screenings for children (up to age 18) are contracted to a department designee, currently VDH, through the local health departments in the jurisdiction where the child resides. Acute care hospitals utilize persons designated by the hospital to complete the screening. The nursing facility LTSS Screening team may complete the LTSS Screening for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid after discharge from an acute care hospital when the individual was not a Medicaid enrollee upon admission to the nursing facility. Details about the screening process and the criteria for meeting the LOC required for eligibility for LTSS can be found in the department's Screening Manual for Medicaid-funded Long-term Services and Supports (LTSS) on the Virginia Medicaid provider portal.

For members enrolled in the CCC Plus Waiver, Sentara Health Plans covers all services that provide members with an alternative to institutional placement. This includes:

- adult day healthcare
- personal care (agency-directed and/or consumer-directed)
- skilled private duty nursing
- personal emergency response systems and medication monitoring
- respite care (agency-directed and/or consumer-directed) or skilled private duty respite care (agency-directed)
- assistive technology
- environmental modifications
- transition services (for those members meeting criteria who are transitioning back to the community from a nursing facility or long-stay hospital)

Waiver services may be agency-directed (AD) or consumer-directed (CD). CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants. For both AD and CD care, the member must have a viable backup plan (e.g., a family member, neighbor, or friend willing and available to assist the member, etc.) in case the personal care aide or CD attendant or nurse is unable to work as expected or terminates employment without prior notice. The identification of a backup plan is the responsibility of the member and family and must be identified and documented on the ICP. The backup plan may be the primary caregiver when the primary caregiver is not a paid attendant for the member. Members who do not have viable backup plans are not eligible for services until viable backup plans have been developed. For AD care, the provider must make a reasonable attempt to send a substitute personal care aide. If this is not possible, the member must have someone available to perform the services needed.

The Medicaid program covers CCC Plus Waiver services: when the member is present, in accordance with an approved person-centered Individualized Care Plan, when the services are authorized, and when a qualified provider is providing the services to the member. Services rendered to or for the convenience of other individuals in the household (e.g., cleaning rooms, cooking meals, washing dishes, doing laundry, etc., for the family) are not covered.

Adult Day Health Care (ADHC)
The Sentara Health Plans Medicaid program covers long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility. The program must be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC).

Personal Care Services
Assistance with Activities of Daily Living (ADL) include eating, bathing, dressing, transferring, toileting, medication monitoring, and monitoring of health status and physical condition. This service does not include skilled nursing services except for skilled nursing tasks that may be delegated. When specified in the individual service plan, personal care services may include assistance with instrumental activities of daily living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves and/or supervision.

The Sentara Health Plans Medicaid program provides coverage for personal care services for work-related or post-secondary school-related personal assistance when medically necessary. This allows the personal care provider to help and support individuals in the workplace and those individuals attending post-secondary educational institutions. This service is only available to individuals who require personal care services to meet their ADLs. Workplace or school supports through the CCC

Plus Waiver are not provided if they are offered by the Department for Aging and Rehabilitative Services, required under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

Individuals are afforded the opportunity to act as the employer in the self-direction of personal care services. This involves hiring, training, supervision, and termination of self-directed personal care assistants. For consumer-directed services, as defined by the Code of Virginia, “any person performing state or federally funded healthcare tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks” is exempted from the Nurse Practice Act and nurse delegation requirements.

Personal care hours are limited by medical necessity. The Sentara Health Plans Medicaid program manages requests in accordance with criteria listed in 12VAC30-120–927 and contract standards.

Personal care is not a replacement for private duty nursing (PDN) services, and the two must not be provided concurrently. Personal care cannot be used for ADL/IADL tasks expected to be provided during PDN hours by the RN/LPN. Trained caregivers must always be present to perform any skilled tasks not delegated.

State and federal laws and regulations require prospective personal care assistants to pass background checks. Background checks include Virginia State Police Criminal Background checks; Virginia Department of Social Services Child Abuse and Neglect Central Registry checks when the member is under the age of 18; the Federal list of Excluded Individuals and Entities (LEIE) database checks; and employment eligibility checks.

Respite Care Services
Respite care services are provided to members who are unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those primary, unpaid caregivers who normally provide care. Respite care services may be provided in the member’s home or place of residence or children’s residential facility. Respite services include skilled nursing respite and unskilled respite.

Individuals may choose to use agency-directed (AD), consumer-directed (CD), or a combination of these models of service delivery. CD respite is only available to members requiring unskilled respite care services. Unskilled respite is not available to individuals who have 24-hour skilled nursing needs.

Respite care services are limited to 480 hours per individual per state fiscal year (July 1 through June 30).

Consumer Direction
Eligible CCC Plus Waiver members may choose the consumer-directed model of service delivery for their personal care and respite services. Through consumer direction, the member, or someone designated by the member, employs attendants, and directs their care. The members will receive financial management support in their role as employer by Sentara Health Plans’ contracted fiscal/employer agent (F/EA).

Services Facilitation (SF)
SF is a function that assists the member (or the member’s family or representative, as appropriate) when consumer- directed services are chosen. The SF provider serves as the agent of the individual or family, and the service is available to assist in identifying immediate and long-term needs,

developing options to meet those needs, accessing identified supports and services, and training the member/family to be the employer. Practical skills training is offered to enable families and members to independently direct and manage their waiver services.

Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem solving. The services include providing information to ensure that members understand the responsibilities involved with directing their services.

Environmental Modifications (EM)
Environmental modifications are not covered under Medicaid's state plan durable medical equipment benefit but may be covered under the CCC Plus Waiver. Modifications may be made to a member's primary residence or primary vehicle and must be of a remedial nature or medical benefit to enable the member to function with greater independence. EM services must not be duplicative in homes where multiple waiver individuals reside. EM may not be used for general maintenance or repairs to a home, to increase the square footage of a home, or to purchase or repair a vehicle; however, it may be used for the repair of an accessibility feature (i.e., repair of a ramp or a van lift).
EM must be provided in conjunction with at least one other CCC Plus Waiver service. EM is covered up to a maximum of $5,000 per member per calendar year. Costs for EM cannot be carried over from one calendar year to the next.

Assistive Technology (AT)
Assistive Technology (AT) provided outside of the Medicaid state plan durable medical equipment benefit may be covered under the CCC Plus Waiver. AT is covered for members who have a demonstrated need for equipment for remedial or direct medical benefit primarily in the member's residence to specifically increase their ability to perform ADLs/IADLs or to perceive, control, or communicate with the environment in which they live.

AT is considered a portable device, control, or appliance, which may be covered up to a maximum of $5,000 per member per fiscal year. The costs for AT cannot be carried over from one fiscal year to the next. When two or more members live in the same home (congregate living arrangement), the AT must be shared to the extent practicable, consistent with the type of AT.

AT must be provided in conjunction with at least one other CCC Plus Waiver service. All AT requires an independent evaluation by a qualified professional who is knowledgeable of the recommended item before authorization of the device. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers, or rehabilitation specialists.

Personal Electronic Response System (PERS)
PERS is an electronic device that enables members to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to members who live alone or who are alone for significant parts of the day and have no regular caregivers for extended periods of time. PERS services are also limited to those individuals ages 14 and older. When medically appropriate, the PERS device can be combined with a medication-monitoring system to monitor medication compliance. PERS must be provided in conjunction with at least one other qualifying CCC Plus Waiver service.

Skilled Private Duty Nursing (PDN)
Skilled PDN includes nursing services ordered by a physician in the plan of care and provided by a licensed registered nurse (RN) or by a licensed practical nurse (LPN). This service is provided to

individuals in the technology-dependent subgroup who have serious medical conditions and complex healthcare needs. Skilled PDN is used as hands-on member care, training, consultation, and oversight of direct care staff, as appropriate. Examples of members who may qualify for skilled PDN coverage include, but are not limited to, those with health conditions requiring mechanical ventilation, tracheostomies, prolonged intravenous administration of nutritional substances (TPN/IL) or drugs, peritoneal dialysis, continuous oxygen support, and/or continuous tube feedings.

PDN hours are determined by the scores on the appropriate objective assessment based on the member's age. The pediatric assessment is utilized for a member less than 21 years of age. PDN hours for adult members are determined by medical necessity.

All members receiving PDN services must have a trained primary caregiver who must ensure that all hours not provided by an RN or LPN will be provided and must be documented in the provider's records along with a backup plan.

Transition Services
The Sentara Health Plans Medicaid program covers transition services, meaning setup expenses, for Medicaid program members who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, which may include an adult foster home, where the person is directly responsible for his or her own living expenses. These services could include:

- security deposits
- utility deposits
- essential/basic household furnishings (furniture, appliances, window coverings, bath/bed lines, or clothing)
- items necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy
- fees to obtain a copy of a birth certificate or an identification card or driver's license
- other reasonable one-time expenses incurred as part of a transition

Transition services are furnished only to the extent that they are reasonable and necessary as determined through the transition plan development process, are clearly identified in the transition plan and the person is unable to meet such expense, or when the services cannot be obtained from another source.

Nursing Facility and Long-stay Hospital Services
The Sentara Health Plans Medicaid program covers skilled and intermediate nursing facility (NF) care for Medicaid program members, including for dual-eligible members after the member exhausts their Medicare-covered days. Sentara Health Plans will pay NFs directly for services rendered.

Sentara Health Plans works with NFs to:

- Adopt evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services.
- Ensure that individuals in nursing facilities are assessed for, have access to, and receive medically necessary services for medical and behavioral health conditions.

NFs must cooperate with the Sentara Health Plans Medicaid program for Sentara Health Plans representatives to attend (either in person or via teleconference) all care plan meetings for Medicaid

program members who are receiving NF services. Attendance at the care plan meetings will ensure that the NF is current with the care needs of the members and will provide access to Sentara Health Plans to discuss service options.

Trauma-informed Care

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood experiences have played in their lives. This approach builds on member resiliency and strengths to address the physical and emotional well-being of the individual. Sentara Health Plans requires provider education for trauma-informed care via a brief provider training that is available on the Sentara Health Plans website education page. The provider directory will indicate providers that have completed this training.

Telehealth

Telemedicine is a service delivery model that uses real-time two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment (see temporary exception for audio-only telecommunications in this section) to link the member to an enrolled provider approved to provide telemedicine services at the distant (remote) site.

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.

Telehealth is different from telemedicine because it refers to the broader scope of remote healthcare services used to inform health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, remote patient-monitoring devices, and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) is defined as the use of digital technologies to collect medical and other forms of health data from patients in one location and electronically transmit that information securely to health providers in a different location for analysis, interpretation, recommendation, and management of a patient with a chronic or acute health illness or condition. These services include monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data; treatment adherence monitoring; and interactive video conferencing with or without digital image upload.

Sentara Health Plans provides coverage for telemedicine and telehealth services as medically necessary and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. Sentara Health Plans provides telemedicine and telehealth services regardless of the originating site and regardless of whether the patient is accompanied by a healthcare provider at the time such services are provided.

Sentara Health Plans cannot require providers to use proprietary technology or applications to be reimbursed for providing telemedicine services.

Sentara Health Plans allows the prescribing of controlled substances via telemedicine and requires such scripts to comply with the requirements of § 54.1-3303 and all applicable federal law.

Sentara Health Plans encourages the use of telemedicine and telehealth to promote community living

and improve access to health services. Licensed healthcare providers who provide healthcare services exclusively through telemedicine are not required to maintain a physical presence in the commonwealth. More information can be found on dmas.virginia.gov/.

DMAS Medicaid manuals and memos on telemedicine specify the types of providers that may provide Medicaid-covered telemedicine and telehealth services. Sentara Health Plans may propose additional provider types for the department to approve for use.

The decision to participate in a telemedicine or telehealth encounter will be at the discretion of the member and/or their authorized representative(s), for which informed consent must be provided, and all telemedicine and telehealth activities shall be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and DMAS program requirements. Covered and reimbursed services include:

- synchronous audio-visual telemedicine, including originating site fees
- store-and-forward applications: Sentara Health Plans shall reimburse for all store-and-forward services covered through the Medicaid fee-for-service program, including, but not limited to tele retinal screening for diabetic retinopathy in a way that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program. Sentara Health Plans cannot be more restrictive and cannot require additional fields or photos not required by the Medicaid fee-for-service program. Sentara Health Plans may also reimburse for additional store-and-forward applications, including but not limited to, tele-dermatology and tele-radiology.
- remote patient monitoring (RPM)
- audio-only services
- provider-to-provider consultations as covered by the Medicaid fee-for-service program
- virtual check-ins with patients the ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the member's PCP

DMAS guidance on coverage for the above-listed telehealth services is described in previously published Medicaid memoranda, provider manuals, and regulations and is updated as new authorities and funding are provided to DMAS. Sentara Health Plans will be required to provide coverage for the above-listed telehealth services in a manner that is no more restrictive than, and is at least equal in amount, duration, and scope as is available through, the Medicaid fee-for-service program.

All telemedicine and telehealth services must be provided in a manner that meets the needs of members and is consistent with Model of Care requirements.

In addition to the above requirements, services delivered via telehealth will be eligible for reimbursement when all the following conditions are met:

- The provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth.
- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code, as defined by the American Medical Association (AMA).
- The service provided via telehealth meets all state and federal laws regarding confidentiality of healthcare information and a patient's right to his or her medical information.
- Services delivered via telehealth meet all applicable state laws, regulations, and licensure requirements on the practice of telehealth.
- DMAS deems the service eligible via telehealth through Medicaid program published fee

schedule.
- To be reimbursed for services using telehealth that are provided to MCO-enrolled individuals, providers must follow their respective contract with Sentara Health Plans.

Additional information about the Medicaid MCO programs can be found at dmas.virginia.gov/for-providers/cardinal-care-transition/

The Sentara Health Plans Medicaid program also provides coverage for telemedicine services for our members. Telemedicine is defined as the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

Physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed, and professional counselors are permitted for telemedicine services and require one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and state laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities must be compliant with HIPAA requirements. Telemedicine services can be provided in the home or another location if agreeable with the member.

Carved Out Services
The following services are carved out of the contract between Sentara Health Plans and DMAS. These services are reimbursed directly to providers under the DMAS fee-for-service program:

- dental and related services
- local education agency-based services and school health services (covered services rendered by service providers who are employed or contracted by the local education agency, and the local education agency is the billing provider of the services)
- tribal clinic provider types
- Developmental Disabilities (DD) Waiver services such as Building Independence Waiver, Family and Individual Support Waiver, Community-living Waiver, targeted case management, and transportation to/from DD Waiver services (nonwaiver services are included in the Medicaid program)
- pre-admission screening for nursing facilities
- Independent Assessment, Certification, and Coordination Team (IACCT)
- psychiatric residential treatment facility services (PRTF)
- therapeutic group home (formerly level A and B group home)
- treatment foster care - case management

SECTION VI: PHARMACY

Pharmacists as Providers

In accordance with the provisions of § 54.1-3303, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to Medicaid program 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.

The following will become effective upon expiration of the provisions of the federal Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 related to the vaccination and COVID-19 testing of minors.

Notwithstanding the provisions of § 54.1-3303 of the Code of Virginia, a pharmacist may initiate treatment with, dispense, or administer the following drugs and devices to persons three years of age or older:

1. Vaccines included on the Immunization Scheduled published by the Centers for Disease Control and Prevention and vaccines for COVID-19
2. Tests for COVID-19 and other coronaviruses.

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 PRSS enrollment requirements in addition to meeting Sentara Health Plans contracting and credentialing requirements. Pharmacists acting as providers are also responsible for adherence to 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.

Prescription Drug Coverage

Sentara Health Plans covers Food and Drug Administration (FDA) approved drugs for Sentara Health Plans Medicaid program members. Drugs for which federal financial participation is not available are not covered.

Sentara Health Plans requires that prescribers have a valid and active National Provider Identifier (NPI). Prescriptions from prescribers who do not have a valid NPI will be rejected at point of sale.

In most cases, Sentara Health Plans will pay for prescriptions only if they are filled at Sentara Health Plans' network pharmacies. To find a network pharmacy, visit our Sentara Health Plans website.

Preferred Drug List (PDL) for the Medicaid Program

The Medicaid program has adopted the DMAS Preferred Drug List (PDL) for all members. Note that the PDL does not apply to dual-eligible members who have a pharmacy benefit covered by a Medicare Part D plan. The DMAS PDL is not an all-inclusive list of drugs. The Medicaid program will cover all medically necessary, clinically appropriate, and cost-effective drugs that are federally reimbursable.

Drugs not listed on the PDL may reject at the pharmacy unless Sentara Health Plans has approved a medical necessity request, and an override is put into the system. Sentara Health Plans' Medical Necessity Request Form is available on the provider website or by contacting the pharmacy department by phone at 1-844-672-2307, Monday through Friday, 8 a.m. to 6 p.m. Medical Necessity Request Forms should be faxed to the pharmacy department at 1-800-750-9692.

Over the counter (OTC) medications that are covered on the DMAS Preferred Drug List will require a prescription to process at the pharmacy.

Drugs on the PDL may be subject to edits such as prior authorizations, step-edits, and quantity limits. These drugs may reject at the pharmacy without a prior authorization in the system. Prior authorization forms are available on the provider website or by contacting pharmacy authorizations by phone at 1-844-672-2307, Monday through Friday, 8 a.m. to 6 p.m. Prior Authorization Request Forms should be faxed to the pharmacy department at 1-800-750-9692.

All members enrolled in the FAMIS program will utilize a closed formulary pharmacy benefit.

For a complete list of covered drugs, please access Sentara Health Plans Prescription Drug Authorizations located at this website.

Day Supply Dispensing Limitations

Medicaid program members may receive up to a 34-day supply of a prescription drug at a retail or specialty pharmacy. A 34-day supply shall be interpreted as a consecutive 34-day supply. Members may receive a ninety (90) day supply per prescription of select maintenance drugs identified on the DMAS 90-day Medication Maintenance List. To be eligible for a 90-day supply, members must first receive two 34-day or shorter duration fills. The list of covered dugs for DMAS 90-day Medication Maintenance List can be located at:

virginiamedicaidpharmacyservices.com/provider/documents/

Members may receive up to a 12-month supply of contraceptives, including all oral tablets, patches, vaginal rings, and injections, that are used on a routine basis when dispensed from a pharmacy.

Prior Authorization Process

In the event a drug has restrictions, and no substitution can be made, a prior authorization process will need to be requested.

Coverage decisions are made on a case-by-case basis based upon the specifics of the member's situation and in conjunction with the terms and conditions of their benefit plan. Please note that approved pharmacy service authorizations will not exceed one year in duration.

All requests will be processed, and a response provided within 24 hours of receipt of the complete request. A response will be provided by telephone or other telecommunication device within 24 hours of a request for prior authorization.

If the decision results in a denial, a Notice of Action will be issued within 24 hours of the denial to the prescriber and the member. The Notice of Action includes appeal rights and instructions for submitting an appeal in accordance with the requirements described in the Grievances/Complaints and Appeals section of the Medicaid Program Contract.

Emergency Supply
Members will be eligible for a 72-hour emergency supply of a prescribed medication in an instance where the medication requires a service authorization, or the prescribing provider cannot readily provide an authorization. This process provides a short-term supply of the prescribed medication to provide time for the provider to submit an authorization request for the prescribed medication. Requests for an emergency supply will be evaluated on a case-by-case basis to ensure continuity of care.

Benefit Exclusions
Medicaid program excludes coverage for the following:

- drugs used for anorexia or weight gain
- drugs used to promote fertility
- agents whose primary purpose is cosmetic, including but not limited to hair growth (agents used in the treatment of covered gender dysphoria services are not primarily cosmetic)
- agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction for which the agents have been approved by the FDA
- all Drug Efficacy Study Implementation (DESI) drugs as defined by the FDA to be less than effective - compound prescriptions which include a DESI drug are not covered
- drugs which have been recalled
- experimental drugs or non-FDA-approved drugs, except for children and youth covered by EPSDT
- any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

Long-acting Reversible Contraception (LARC)
Medicaid program provides coverage for members for all methods of family planning, including but not limited to:

- barrier methods
- oral contraceptives
- vaginal rings
- contraceptive patches
- long-acting reversible contraceptives (LARCs) - members are free to choose the method of family planning

Patient Utilization Management and Safety Program
The purpose of the Sentara Health Plans Patient Utilization Management and Safety (PUMS) program is to develop, implement, monitor, evaluate, and refine a comprehensive integrated process to reduce the inappropriate use of controlled substances.

To ensure the delivery of high-quality, cost-effective healthcare in a manner consistent with ethical and fiscal responsibility, pharmacy care services and clinical care services (CCS) collaborate to assure that each member accesses care in an appropriate manner and consistent with their Individualized Care Plan (ICP). PUMS accomplishes this by limiting the opportunity for members to continue to misuse or abuse multiple medical resources and by referring members to care/services appropriate to the member's unique situation.

PUMS restricts members whose utilization of medical services is documented as being excessive or potentially unsafe to access prescription refills and certain clinical services to limited sites chosen by or for the member.

In addition to focusing on misuse or abuse of the Medicaid prescription benefit, the PUMS program also focuses on patient safety and further ascribes limits regarding sites of care that can be reimbursed for members in the program.

PUMS is designed to ensure medical and pharmacy benefits are received at an appropriate frequency and are medically necessary. PUMS is also used to assist providers in monitoring potential abuse or inappropriate utilization of controlled prescription medications by Sentara Health Plans members.

If a member is chosen for PUMS, they may be restricted to or locked into only using one pharmacy or one provider to get certain types of medicines.

Members who are enrolled in PUMS will receive a letter from Sentara Health Plans that provides additional information on PUMS, including:

- a brief explanation of the PUMS program
- a statement explaining the reason for placement in the PUMS program
- information on how to appeal to Sentara Health Plans if placed in the PUMS program
- information regarding how to request a State Fair Hearing after first exhausting the Sentara Health Plans appeals process
- information on any special rules to follow for obtaining services, including for emergency or after-hours services
- information on how to choose a PUMS provider

  Member services or the member's care coordinator should be contacted with any questions about the PUMS program.

Prescription Monitoring Program
The Prescription Monitoring Program (PMP) is an electronic system to monitor the dispensing of Schedule II, III, IV, and V controlled substance prescription drugs. It is established, maintained, and administered by the Department of Health Professions. More information on the Virginia PMP is available on the Department of Health Professions website at dhp.virginia.gov.

The PMP may be accessed to determine information about specific members when completing prior authorization forms and to manage care of members participating in the PUMS program.

Opioid Treatment Management

Opioid treatment (including individual, group counseling, family therapy, and medication administration) is a covered benefit. For additional details regarding opioid treatment, please refer to the ARTS section of this Provider Manual.

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

Specialty drugs may include:

- 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 delivered via injection, infusion, inhalation, or oral administration

For more information on how to obtain specialty drugs for your patients, please call pharmacy services at 1-844-672-2307, Monday through Friday, 8 a.m. to 6 p.m.

SECTION VII: MEMBER SAFETY/QUALITY IMPROVEMENT

Through its commitment to excellence, Sentara Health Plans 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 requires providers to comply with the QI program.

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-preventative 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
- are reviewed and updated, at minimum, every two years, as applicable
- are 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 Sentara Health Plans' 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 Sentara Health Plans 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 nonclinical 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 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 outline 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 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 Plans' 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 Healthcare Effectiveness Data and Information Set (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 subcommittee 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.

NCQA's website, ncqa.org, contains information to help consumers, employers, and others make more informed health decisions.

DMAS Performance Withhold Program (PWP)
The PWP is a value-based program developed by DMAS for the purposes of aligning provider quality incentive payments in exchange for addressing gaps in care that will improve the quality of life and achieve population health management for eligible Medicaid program members. Primary care providers will be afforded financial incentives for successful participation in the program as it is designed by DMAS and administered by Sentara Health Plans. Participation in this program requires additional contracting commitments—if interested in more information, please reach out to network management.

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 event.

Providers must report critical incidents that occur during:

- the provision of Medicaid-funded 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 waiver services in any setting (e.g., adult day care center, a member's home, any other community-

based setting)

Reportable Critical Incidents:

- 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 (SREs)
SREs are events that are clearly identifiable and measurable, usually preventable, and are serious in their consequences, such as resulting in death or loss of 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.

Examples of SREs include, but are 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, requires hospitalization, or results 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:
www.qualityforum.org/Topics/SREs/List_of_SREs.aspx#sre4

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, a mandated reporter is:

- 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 Adult Protective Services (APS) or Child Protective Services (CPS), the following numbers may be used:

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. See Methods to Reach Sentara Health Plans for contact information.

Sentara Health Plans requires network and/or affiliated providers to report critical incidents via the approved DMAS Critical Incident Reporting Form located on the Sentara Health Plans website.

SECTION VIII: CLAIMS AND COORDINATION OF BENEFITS

Timely Filing
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.

Filing Claims Electronically
Providers that submit electronic claims to Sentara Health Plans enjoy a number of 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. Change Healthcare users must only use VAPRM for claims runout for Optima Group: VP.

Providers who can receive data files in the HIPAA-compliant ANSI 835 format may elect to receive EFT/ERA. The 835 transaction contains the 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.

Claims submitted electronically will be accepted when billed under the member's Sentara Health Plans member ID or 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 for processing.

Coordination of Benefits (COB)
Sentara Health Plans Medicaid program members who are covered by employer-sponsored health plans may be enrolled in a Medicaid managed care plan. It is also important that if a Sentara Health Plans program member is identified as having a commercial product, that initial claim should be sent to the commercial plan for payment. Medicaid is always the payer of last resort. Sentara Health Plans will coordinate benefits.

For children with commercial insurance coverage, providers must bill the commercial insurance plan first for covered early intervention services, except for the following services that are federally required to be provided at public expense:

- assessment/EI evaluation
- development or review of the Individual Family Service Plan (IFSP)
- targeted case management/service coordination

- developmental services
- any covered early intervention services where the family has declined access to their private health/medical insurance

Under these circumstances, and in following with federal regulations, the Sentara Health Plans Medicaid program requires the early intervention provider to complete the Notification to the Department of Medical Assistance Services: Family Declining To Bill Private Insurance form and submit it with the bill to the Sentara Health Plans Medicaid program. The form can be accessed at this link.

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.

EFT and ERA will be issued through Payspan, which requires 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 the 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 Health 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 is multiple pay to entries in the 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.

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.

Provider Payment Processes
Consistent with the claims processing requirements defined in 42 CFR §447.45, Sentara Health Plans will comply with the following standards regarding timely claims processing for all providers:

1. Within 5 business days of receipt of a claim, Sentara Health Plans will perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.
2. Sentara Health Plans will process and pay or deny, as appropriate, 90 percent of all Clean Claims submitted within 30 calendar days of the date of receipt.
3. Sentara Health Plans will pay or deny, as appropriate, 99 percent of all Clean Claims submitted within 90 calendar days of the date of receipt.
4. For certain types of providers and Covered Services, Sentara Health Plans will comply with prompter pay requirements as described in DMAS Contract Section 12.2.4 Nursing Facility (NF)/LTSS, ARTS, MHS, Early Intervention, and Doula Payments.
5. Adjudication (pay or deny) all other claims within 12 months of the date of receipt (see 42 CFR §447.45 for timeframe exceptions).

Sentara Health Plans has procedures available to providers in written and web form for the acceptance of claim submissions which include:

1. The process for documenting the date of actual receipt of non-electronic claims and date and time of receipt of electronic claims;
2. The process for reviewing claims for accuracy and acceptability in accordance with 42 C.F.R. §438.242(b)(3);
3. The process for prevention of loss of such claims; and
4. The process for reviewing claims for determination as to whether claims are accepted as Clean Claims

Ineligible Members
Sentara Health Plans may retract provider payments made during a period when the member was not eligible. Providers will be instructed to invoice DMAS for payment. Reimbursement by DMAS for services rendered during a retroactive period is contingent upon the member meeting DMAS eligibility and coverage criteria requirements. Sentara Health Plans will not deny payment due to enrollment processing errors or because payment was not reflected in the DMAS 820 Payment Report.

Payment Coordination with Medicare
In accordance with 42 CFR §438.3(t), Sentara Health Plans Medicaid program has entered a Coordination of Benefits Agreement (COBA) with Medicare and participates in the automated claims crossover process for claims processing for its members who are dually eligible for Medicaid and Medicare.

Nursing Facility, LTSS, ARTS, Community Behavioral Health, and Early Intervention Claim Payments
Clean claims from nursing facilities, LTSS (including when LTSS services are covered under ESPDT), community behavioral health, ARTS, and early intervention providers are processed within 14 calendar days of receipt, as an exception to payment within 30 calendar days of receipt for other services. If the service is covered under Medicare other than by Sentara Health Plans, the 14-day time period starts post adjudication of the Medicare claim by the other payer.

Specific claim payment information can be found on the secure provider portal on the Sentara

Health Plans provider website or by calling provider customer service.

Bypass Claims for Third-Party Liability (TPL)
Sentara Health Plans Medicaid Program does not require a provider to bill the primary carrier and include an EOB with the claim submission when the service is known to be non-covered under Medicare or commercial insurance. Examples of these services include, but are not limited to, Medicaid waiver services such as respite and personal care, over-the-counter medications, and certain behavioral health services, including Substance Use Disorder (SUD) services. For a listing of codes that are known to be non-covered and would be considered bypass claims, please refer to the latest DMAS guidelines.

NDC Number
Sentara Health Plans requires a National Drug Code (NDC) number and drug quantity and unit of measure (UOM) on claims that include a billed amount for drugs. The NDC number is required in addition to the appropriate HCPC code. This requirement applies to both UB and HCFA claims. The most current NDC numbers are available from the FDA's NDC Directory or from the RJ Health Systems listing.

NDC Number Requirements:

- the NDC number field - 11 digits are required for this field
- the NDC number cannot be inactive
- the NDC number must be valid for any specific drug, HCPCS, or CPT code billed
- the NDC number must be a valid NDC number if a miscellaneous/unlisted drug code is billed
- the most current NDC numbers are available from the FDA's NDC Directory

Quantity:

- the quantity is the "metric decimal units/measurement" (dosage) administered to the member
- the smallest NDC quantity that the MMIS can accept is .0005
- the "metric decimal units/measurement" is **not** the same quantity found in field 46 on the UB04 or field 24G on the CMS 1500 form

Unit of Measurement: There are four valid qualifiers for the Unit of Measurement (UOM) field:

- F2: International units
- ML: Milliliter
- ME: Milligram
- GR: Gram
- UN: Unit

Hospital/Ancillary Billing Information
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 Billing Editor for a complete and current listing of revenue codes, bill type, and other facility claims requirements.

Reconsideration 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 reconsideration require a "7" as the third digit. "Resubmission" should be indicated in block 80 or any unoccupied block of the UB-04.

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 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).

Readmissions
Members readmitted 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 Centers for Medicare & Medicaid Services (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 Events are reviewed by the Sentara Health Plans medical director.

Providers are required to report Never Events and provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made.

Furloughs
Furloughs (revenue code 018X) occur when a member is admitted for an inpatient stay, discharged for no more than 10 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 30 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.

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 SNF services follow payment methodology as published by DMAS.

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

Inpatient Denials/Adverse Decisions
If the attending practitioner 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 practitioner 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 practitioner), and the party responsible 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 requests additional information from the provider.

Outpatient Billing Guidelines

Providers must bill with the appropriate revenue code and associated CPT/HCPCS code. The following matrix identifies specific outpatient facility services (A–Z), how these services should be billed, and related payment information.

Laboratory Services
Sentara Health Plans reference lab providers are required to provide an electronic report each month. This 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 healthcare 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 ambulatory surgery center 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).

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

Electronic Visit Verification (EVV) for Home Health Provider
To comply with the Cures Act requirement for Home Health Care Services (HHCS), Virginia implemented Electronic Visit Verification (EVV) on July 1, 2023. The following data elements are required to meet EVV compliance:

- type of service(s) performed
- individual receiving the service(s)

- date of the service
- location of the service delivery (can either be in an individual's home or community setting)
- worker providing the service
- time the service begins and ends

The electronic 837P (professional) claim record was modified previously to accept these additional fields for personal care. The electronic 837I (institutional) claim record is being modified for HHCS. Since Virginia Medicaid requires home health providers to use revenue codes, the following 10 revenue codes will require EVV information:

- 0550 Skilled Nursing Assessment
- 0551 Skilled Nursing Care, Follow-up Care
- 0559 Skilled Nursing Care, Comprehensive Visit
- 0571 Home Health Aide Visit (no PA required)
- 0424 Physical Therapy, Home Health Assessment
- 0421 Physical Therapy, Home Health Follow-up Visit
- 0434 Occupational Therapy, Home Health Assessment
- 0431 Occupational Therapy, Home Health Follow-up Visit
- 0444 Speech-language Services, Home Health Assessment
- 0441 Speech-language Services, Home Health Follow-up Visit

For more information regarding Sentara Health Plans and its EVV program, please visit the DMAS website.

National Provider Identification Number
All Medicaid program providers are required to register and attain their National Provider Identification number before conducting business with Sentara Health Plans.

EDI General Overview
All Sentara Health Plans Companion Guides are to be used with the HIPAA-AS Implementation Guide. The HIPAA implementation guides provide comprehensive information needed to create each ANSI transaction set. The Sentara Health Plans Companion Guide is used in conjunction with the HIPAA Implementation Guide: it is intended to clarify issues where the HIPAA Implementation Guide provides options or choices to be made. The HIPAA Implementation Guide is available from the Washington Publishing Company.

EDI Business Use
Each EDI vendor will have to sign a Trading Partner Agreement, which includes the Network Access Agreement and the Business Associate Agreement:

- Each transaction set will be used to expedite the execution of electronic information and accelerate the processing and payment of a claim or encounter.
- The 837 transactions may be sent daily, with a disposition report available the next business day. The disposition report replaces the 997 Acknowledgement File.
- The 835-transaction file consists of a separate remittance file (ERA) and a separate electronic funds file (EFT).

Sentara Health Plans providers may elect to receive an EFT/ERA from Sentara Health Plans directly if they can receive data files in the HIPAA-compliant ANSI 835 format.

340B Registered Entities
A UD modifier must be billed by providers enrolled as 340B providers for all 340B-eligible drugs to identify them as 340B purchased drugs and prevent duplicate discounts from the manufacturer. NDC numbers and quantities are still required.

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 SHP or Payor.

SECTION IX: MEMBER RIGHTS AND RESPONSIBILITIES

Privacy Regulations
As affiliates of Sentara Healthcare, Sentara Health Plans entities follow the Sentara Healthcare Notice of Privacy.

Sentara Healthcare Notice of Privacy Practices are 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.

Sentara Health Plans Medicaid Program Member Rights and Responsibilities

General Member Rights

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability.
- Be treated with respect and consideration for their privacy and dignity.
- Get information about their health plan, provider, coverage, and benefits.
- Get information in a way they can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access healthcare and services in a timely, coordinated, and culturally competent way.
- Get information from their provider and health plan about treatment choices.
- Participate in all decisions about their healthcare, including the right to say “no” to any treatment offered.
- Ask Sentara Health Plans for help if their provider does not offer a service because of moral or religious reasons.
- Get a copy of their medical records and ask that they be changed or corrected in accordance with state and federal law.
- Have their medical records and treatment be confidential and private.
- Sentara Health Plans will only release their information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse.
- Live safely in the setting of their choice. If the member or someone they know is being abused, neglected, or financially taken advantage of, they can call their local DSS or Virginia DSS at 1-888-832-3858. This call is free.
- Receive information on their rights and responsibilities and exercise their rights without being treated poorly by their providers, Sentara Health Plans, or the Department.
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- File appeals and complaints and ask for a State Fair Hearing.
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).
- Be provided information on physician incentive plans.

General Member Responsibilities

- Follow the Member Handbook, understand their rights, and ask questions when they do not understand or want to learn more.
- Treat their providers, Sentara Health Plans staff, and other members with respect and dignity.
- Choose their PCP and, if needed, change their PCP.
- Be on time for appointments and call their provider's office as soon as possible if they need to cancel or if they are going to be late.
- Show their member ID card whenever they get care and services.
- Provide (to the best of their ability) complete and accurate information about their medical history and symptoms.
- Understand their health problems and talk to their providers about treatment goals, when possible.
- Work with their care manager and care team to create and follow a care plan that is best for them.
- Invite people to their care team who will be helpful and supportive to be included in their treatment.
- Tell Sentara Health Plans when they need to change their care plan.
- Get covered services from Sentara Health Plans' network, when possible.
- Get approval from Sentara Health Plans for services that require service authorization.
- Use the emergency room for emergencies only.
- Pay for services they get that are not covered by Sentara Health Plans or the department.
- Report suspected fraud, waste, and abuse.

Member Appeals and Grievances/Complaints

Medicaid Program Member Standard and Expedited Appeal Procedure

The member appeal process for Medicaid program members is as follows for standard and expedited appeals:

Medicaid program members must contact member services by telephone or in writing within 60 calendar days of the original notification of a reduced, terminated, or denied request for service. Members may continue to receive services that were denied during the review process if an appeal is submitted within 10 days of the denial or the change in services or by the date the change in services is scheduled to occur. Medicaid program members may have to pay for continued benefits if the appeal results in another denial.

Appeals may be requested verbally or in writing by the member or their authorized representative. Written consent from the member is required to appoint an authorized representative. Following receipt of an appeal request, the member will receive written notice of receipt of their standard appeal along with the opportunity to submit any additional information for appeal review. Clinical appeals will be reviewed by qualified health professionals with appropriate clinical expertise who were not involved in the initial decision. Members or their authorized representatives may obtain copies of all documents related to appeals. Standard appeals will receive a decision within 30 calendar days, and the member and provider will receive a written appeal decision notice. The review time frame may be extended by up to 14 calendar days if the extension was requested by the member or an extension would be in the best interests of the member.

The member, member's attorney, or member's authorized representative may request an expedited appeal if the provider believes that the time expended in a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If additional information is required, the member will be notified within two days. If an appeal does not meet the criteria for expedited review, the appeal will be processed as a standard appeal. Expedited appeals will be resolved within 72 hours from the initial receipt of the appeal. The review time frame may be extended by up to 14 calendar days if the extension was requested by the member or an extension

would be in the best interests of the member. A written appeal decision notice will be sent to the member and provider, and Sentara Health Plans will also attempt to notify the member of the appeal decision by phone.
All requests for appeals should be sent to:

Sentara Health Plans
Appeals & Grievances
PO Box 62876
Virginia Beach, VA 23466
Phone: 844-434-2916
Fax: 866-472-3920

Members or their authorized representatives must exhaust appeals with Sentara Health Plans before appealing to the Department of Medical Assistance Services Appeals Division (DMAS). A DMAS State Fair Hearing may be requested in any of the following ways:

- Electronically. Online at www.dmas.virginia.gov/appeals or by email to appeals@dmas.virginia.gov
- By fax. Fax your appeal request to DMAS at 804-452-5454
- By mail or in person. Send or bring your appeal request to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, VA 23219

- By phone. Call DMAS at 804-371-8488 (TTY: 1-800-828-1120)

FAMIS Member Appeal Procedure
FAMIS members must contact Sentara Health Plans within 60 days of the original notification of a reduced, terminated, or denied request for service to file an appeal. Appeals from FAMIS members or their authorized representatives must be submitted first to the Sentara Health Plans appeals department for resolution. Internal appeal requests from FAMIS members or their authorized representative should be sent in one of the following ways:

Mail or delivery service:
Sentara Health Plans
Attention: Appeals
PO Box 62876
Virginia Beach, VA 23466

Fax: 1-866-472-3920

Phone: 1-844-434-2916 (TTY: 711)

If the FAMIS member is not in agreement with the Sentara Health Plans appeal resolution, the member may request an optional external review by the independent external quality review organization within 30 days of the final internal appeal decision. External review requests from FAMIS members or their authorized representative should be sent in one of the following ways:

- **Electronically**. Online at https://dmas.kepro.com by clicking the external appeal link.

- **By mail.** Send to:
  Acentra/KEPRO External Review
  6802 Paragon Place, Suite 440
  Richmond, VA 23230

The FAMIS member may also request a State Fair Hearing from DMAS within 120 days of the final internal appeal decision. The FAMIS member or their authorized representative can file the State Fair Hearing request in any of the following ways:

- **Electronically.** Online at https://www.dmas.virginia.gov/appeals or by email to appeals@dmas.virginia.gov
- **By fax.** Fax your appeal request to DMAS at 804-452-5454
- **By mail or in person.** Send or bring your appeal request to:
  Appeals Division
  Department of Medical Assistance Services
  600 E. Broad Street
  Richmond, VA 23219
- **By phone.** Call DMAS at 804-371-8488 (TTY: 1-800-828-1120)

State Fair Hearing
If the member disagrees with the appeal decision, they may appeal directly to DMAS by submitting a request for a State Fair Hearing. The appeals process above must be exhausted before the member, member's attorney, or member's authorized representative may submit a request for a State Fair Hearing. DMAS will resolve a standard request within 90 days and an expedited request within 72 hours. The State Fair Hearing Request may be submitted by internet, mail, fax, email, telephone, in person, or by other electronic means. To appeal to DMAS, the member should contact DMAS appeals department at 804-371-8488 or send a written request within 120 calendar days of receipt of a notice of adverse action/denial to:

Department of Medical Assistance Services Appeals Division
600 East Broad Street
Richmond, VA 23219
Fax: 804-452-5454
Phone: 804-371-8488 (Standard and Expedited Appeals)

The deadline to ask for an appeal with DMAS is 120 calendar days from when Sentara Health Plans issues the final MCO internal appeal decision. DMAS will notify the member of the date, time, and location of the scheduled hearing. Most hearings will occur by telephone.

There are a few ways to ask for an appeal with DMAS.

1. electronically: online at dmas.virginia.gov/appeals/
2. emailing appeals@dmas.virginia.gov
3. faxing appeal requests to DMAS at 1-804-452-5454.
4. by mail or in person - send or bring appeal requests to:

   Appeals Division, Department of Medical Assistance Services
   600 E. Broad Street, Richmond, VA 23219

5. by phone: call DMAS at 804-371-8488 (TTY: 1-800-828-1120)

A decision to uphold or reverse the decision will be issued within 90 days for Medicaid program members. If the Medicaid program member is not in agreement with the resolution by DMAS, they may appeal such a decision to the circuit court.

For provider appeals where Sentara Health Plans does not reverse its decision, the written notice of Sentara Health Plans' final decision will also include a reference to the specific plan provision on which Sentara Health Plans based its determination. Notification of the provider's right to request a DMAS informal or formal hearing and how to do so will be provided.

Continuation of benefits: The member may be able to continue the services that are scheduled to end or be reduced if they ask for an appeal within 10 days from being told that the request is denied, or care is changing or by the date the change in services is scheduled to occur. If the appeal results in another denial, the member may have to pay for the cost of any continued benefits that they received if the services were previously solely because of the requirement.

If the State Fair Hearing decision is to reverse the denial, the Sentara Health Plans Medicaid program will authorize or provide the services as quickly as the condition requires but no later than 72 hours from receipt of notice from the state reversing the denial. If services were denied during the appeal, the Sentara Health Plans Medicaid program will pay for those services.

Processes Related to Reversal of Our Initial Decision
If the State Fair Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, Sentara Health Plans will authorize or provide the disputed services as quickly as the member's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, Sentara Health Plans pays for those services as specified in policy and/or regulation.

Medicaid Program Grievances/Complaints
Disputes may involve Sentara Health Plans Medicaid program benefits, the delivery of services, or Sentara Health Plans' operation. This procedure includes both medical and nonmedical (dissatisfaction with the plan of care, quality of member services, appointment availability, or other concerns not directly related to a denial based on medical necessity) issues. A complaint, by phone or in writing, can usually be resolved by contacting member services.

The grievance/complaint procedure is available to all providers; timely resolution will be executed within 90 days.

A Medicaid program member or the member's authorized representative (provider, family member, etc.) acting on behalf of the member, may file a grievance/complaint either orally or in writing at any time.

Medicaid Program Member Grievance/Complaint Procedure
Medicaid program members have the right to express a complaint about service or clinical issues at any time. Members may register an internal complaint by calling member services during business hours or by submitting a complaint in writing to:

Sentara Health Plans Appeals & Grievances
P.O. Box 62876
Virginia Beach, VA 23466-2876

Sentara Health Plans shall resolve a grievance/complaint and provide notice as expeditiously as the member's health condition requires, within state established time frames not to exceed 90 calendar days from the date Sentara Health Plans receives the grievance/complaint. Sentara Health Plans may extend

this time frame by up to an additional 14 calendar days if the member requests the extension or if Sentara Health Plans provides evidence satisfactory to DMAS that there is need for additional information and that a delay in rendering the decision is in the member's interest.

Members may also register a complaint externally to the:

DMAS Helpline:	1-844-374-9159 TDD 1-800-817-6608
U.S. Department of Health and Human Services Office for Civil Rights:	hhs.gov/ocr
Office of the State Long-term Care Ombudsman:	elderrightsva.org

SECTION X: PROVIDER PRINCIPLES

Common Provider Responsibilities

Notice of Nondiscrimination and the Civil Rights Act
Sentara Health Plans providers will not differentiate or discriminate in the treatment of any member because of age, sex, marital status, sexual orientation, gender identity, race, color, religion, ancestry, national origin, disability, handicap, health status or need for health services, source of healthcare coverage/payment, utilization of medical or mental health services or supplies, or other unlawful basis, including, without limitation, the filing by any member of any complaint, grievance or legal action against provider or the applicable health benefit plan.

Immediate Termination
Sentara Health Plans may immediately terminate the Provider Agreement at any time for the following reasons:

- insolvency
- dissolution
- failure to comply with review programs
- termination of provider's insurance
- loss of provider license
- conviction of a crime
- material breach
- harm to member
- exclusions
- false statements and omissions
- provider representations
- failure to provide notice
- termination for merger or acquisition
- termination for breach
- termination with notice
- termination of individual practice providers
- notice to members

Provider Services Solution (PRSS)
On April 4, 2022, DMAS launched the Medicaid Enterprise System (MES). This new technology platform includes the Provider Services Solution (PRSS), a module to support both fee-for-service and managed care network providers. Fee-for-service (FFS) providers and those dually enrolled in fee-for-service and managed care networks are already using PRSS to manage enrollment and maintenance processes.

PRSS will simplify provider enrollment tasks, such as updates to licenses, certifications, and submission of documents through the secure portal. All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act. All providers are required to be screened, enrolled (including signing a department Medicaid Provider Participating Agreement), and periodically revalidated in the department's MES PRSS. The requirement to enroll is included in the Sentara Health Plans Provider Agreement under the Medicaid obligation mandated provision.

Network providers that are currently enrolled as FFS in Medicaid do not have to reenroll in PRSS. However, all new MCO-only providers must first enroll with PRSS prior to requesting credentialing with

Sentara Health Plans.

For a list of common questions and answers for providers on the PRSS portal, please visit the MES website.

Making Sure Providers Appear in the Directory
Sentara Health Plans serves members of all socioeconomic and cultural backgrounds. Sentara Health Plans Medicaid program members rely on Sentara Health Plans and the providers to deliver complete and accurate information in our directories at all times.

Changing an Existing TIN or Adding a Healthcare Provider
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.

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, prevent, and recover dollars from all forms of insurance fraud, including fraud involving employees, providers, employer groups, and contractors or agents of Sentara Health Plans.

Sentara Health Plans is required to refer suspected fraud, waste, and abuse to law enforcement and regulatory agencies. We also cooperate with law enforcement and regulatory agencies to fight against fraud, waste, and abuse. Sentara Health Plans has a fiduciary responsibility to protect the integrity of the company, its employees, members, providers, government programs, and the public.

Sentara Health Plans understands that health plans are at risk for fraud, waste, and abuse. Sentara Health Plans uses risk analysis to focus our efforts on the needs of our programs. The Program Integrity Unit conducts reviews and audits to help ensure compliance with state and federal laws and regulations. Providers are contractually obligated to cooperate with the company and government entities.
Claim reviews and/or audits are conducted either on a prepayment or post-payment basis. Claim reviews/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.

To conduct reviews and audits, Sentara Health Plans and its designees will request documentation, mostly in the form of patient medical records. Providers may not charge Sentara Health Plans or plan members for copies of medical records or for the completion of forms. Sentara Health Plans will accept other documentation in addition to the medical record from the provider or facility that substantiates the treatment or service. The documentation may be the provider's or facility's established internal policies, professional licensure standards that reference standards of care, or business practices justifying the service. The provider or facility must review, approve, and document all such internal policies and procedures as required by applicable accreditation bodies.

Upon request from Sentara Health Plans or its designee, facilities are required to submit additional documentation for claims identified for prepayment review or post-payment review/audit. Applicable types of claims include, but are not limited to:

- claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
- claims being reviewed to validate items and services billed - documented in the medical record for

hospital bill audits (also known as hospital charge audits)
- claims with unlisted or miscellaneous codes
- claims for services requiring clinical review
- claims for services found to possibly conflict with covered benefits
- claims for services found to possibly conflict with medical necessity
- claims being reviewed for potential fraud, waste, and/or abuse or demonstrated patterns of billing/coding inconsistencies
- other documentation required by other entities such as the Centers for Medicare & Medicaid Services (CMS) and state or federal regulation
- documentation for such services as the provision of durable medical equipment, prosthetics, orthotics and supplies, rehabilitation services, and home healthcare

Sentara Health Plans or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment review/audit:

- Upon confirmation of provider's or facility's address, an original letter of request for supporting
- documentation will be sent.
- When a response is not received within 30 business days of the date of the initial request, a second request letter will be sent.
- When a response is not received within 15 business days of the date of the final request (45 days total):

    - Sentara Health Plans will initiate claims denials for claims identified as prepayment review claims as provider or facility failed to submit the required documentation. The member shall be held harmless for such payment denials

    OR

    - Sentara Health Plans will initiate claim retractions for claims identified as post payment audit claims as provider or facility failed to submit the required documentation. The member shall be held harmless for such payment retractions.

The Deficit Reduction Act (DRA) has provisions reforming Medicaid and Medicare and reducing fraud, waste, and abuse within the federal healthcare programs. All entities receiving at least five million in annual Medicaid payments must have written policies for their employees and contractors. The policies must provide detailed information about the false claims, false statements, and whistleblower protections. As a contracted provider with Sentara Health Plans, you and your staff are subject to these laws and regulations.

Code of Conduct
Sentara Health Plans requires employees and affiliates to conduct business and personal activities in a manner that is ethically and legally responsible. The Code of Conduct outlines this commitment:

- Treat members with respect and dignity.
- Deal openly and honestly with fellow employees, members, providers, representatives, agents, governmental entities, and others.
- Adhere to federal and state laws, regulations, and Sentara Health Plans policies and procedures in all business and personal dealings, whether at work or outside of work.
- Exercise discretion in the processing of claims, regardless of provider, practitioner, and vendor source.

- Notify and return overpayments to Sentara Health Plans immediately upon receipt of such payments.
- Notify Sentara Health Plans' compliance officer of any instances of noncompliance and cooperate with all investigational efforts by Sentara Health Plans and other state and federal agencies.
- Use supplies and services in an efficient manner to reduce costs to Sentara Health Plans.
- Do not misuse Sentara Health Plans' resources nor influence in such a way as to discredit the reputation of Sentara Health Plans.
- Maintain high standards of business and ethical conduct in accordance with regulatory and accredited agencies to include standards of business to address fraud, waste, and abuse.
- Practice good faith in transactions occurring during the course of business.
- Conduct business dealings in a manner that the organization shall be the beneficiary of such dealings.
- Preserve patient confidentiality, unless there is written permission to divulge information, except as required by law.
- Refuse any illegal offers, solicitations, payment, or other enumeration to induce referrals of the members we serve for an item of service reimbursable by a third party.
- Disclose financial interest/affiliations with outside entities to Sentara Health Plans, as required by the Conflict of Interest Statement.
- Hold all contracted parties to the same Standards of Professional Conduct as part of their dealings with Sentara Health Plans.
- Notify Sentara Health Plans' compliance officer of any instances of noncompliance and cooperate with all investigation efforts by Sentara Health Plans and other state and federal agencies.
- Providers providing services to CCC Plus Waiver members shall comply with the provider requirements, as established in the DMAS provider manuals available at vamedicaid.dmas.virginia.gov/provider/faq and the following regulations: 12 VAC 30-120-900 through 12 VAC 30-120-995.
- Providers of CCC Plus Waiver services (including adult day healthcare) shall maintain compliance with the provisions of the CMS Home and Community-based Settings Rule, as detailed in 42 CFR §441.301(c)(4) and (5).

HIPAA Privacy Statement
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. As affiliates of Sentara Healthcare, Sentara Health Plans entities follow:

Sentara Healthcare Notice of Privacy Practices available here.

Medicaid Program Provider Availability: Access and After-hours Standards

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 Standards

Sentara Health Plans providers must arrange to provide care as expeditiously as the member's health condition requires. Members cannot be billed for missed appointments. Sentara Health Plans will ensure that appointment timeliness standards are met for services described below for enrolled members. Sentara Health Plans monitors network provider for compliance to these appointment timeliness standards on an ongoing basis, including monitoring appeals data, for indications that problems may exist with access to specific providers or provider types.

Participating providers must comply with the following access standards for Sentara Health Plan's Medicaid program members:

Service	Sentara Health Plans Medicaid Standards
Emergency Appointments, including crisis services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request Follow up to crisis services must be made within 24 hours of Sentara Health Plans being notified of the crisis services utilization.
Routine Primary Care Services	Routine, primary care service appointments 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	Within 7 calendar days of request
Maternity Care – Second Trimester	Within 7 calendar days of request
Maternity Care – Third Trimester	Within 3 business days of requests
Maternity Care – High-risk Pregnancy	Within 3 business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists
Postpartum	Within 60 days of delivery

Mental Health Services	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met
LTSS	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met

Providers must offer hours of operation that are no less than the hours of operation offered to Medicaid fee-for-service (if the provider serves only Medicaid members).

Cultural Competency
Sentara Health Plans Medicaid program promotes cultural humility and the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Culturally competent care and cultural humility 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. Providers are encouraged to:

- build rapport by providing respectful and culturally appropriate 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

The Sentara Health Plans Medicaid program requires providers to demonstrate cultural competency in all forms of communication and ensure that cultural differences between providers and members do not impede access and quality healthcare.

All providers are encouraged to complete Cultural Competency training. Training is available on the education page of the Sentara Health Plans website. Providers may complete the course of their choice as well as attest at this location. The provider directory will indicate providers that have completed this training.

Provider Satisfaction Surveys
Sentara Health Plans conducts Provider Satisfaction surveys in accordance with DMAS contract requirements, at least every 2 years, to monitor and measure provider satisfaction with Sentara Health Plans services and identify areas for improvement. Participation in these surveys is highly encouraged as provider feedback is very important. Sentara Health Plans informs providers of the results and plans for improvement through newsletters, meetings, or training sessions.

SECTION XI: MEDICAL RECORDS

Participating providers are required to maintain adequate medical records and documentation relating to the care and services provided to Sentara Health Plans members. All communications and records pertaining to our members' healthcare must be treated as confidential. No records may be released without the written consent of the member, or in the case of a minor child, their legal guardian. The member is not required to complete an additional medical release form for Sentara Health Plans. Sentara Health Plans may request member records for the purposes of quality assurance per DMAS, NCQA, and CMS regulations. Medical records provide the mechanism that creates, maintains, and ensures the continuity, accuracy, and integrity of clinical data. The medical record serves as the primary resource for information related to patient treatment, not only for the participating provider but also for other health professionals who assist in patient care.

Medical Record-keeping Requirements
Confidentiality of medical records must be maintained by:

- medical records being stored securely (i.e., confidential filing system, etc.)
- only authorized personnel having access to medical records
- conducting training on confidentiality related to member information periodically and as needed - medical record documentation standards will be utilized.

Each medical record must include the following:

- history and physical
- allergies and adverse reactions
- problem list
- medications
- documentation of clinical findings and evaluation for each visit
- preventive services/risk screening

Medical records must be organized and stored in a manner that allows for easy retrieval. Providers must maintain records in an organized fashion for all members receiving care and services and be accessible for review and audit by DMAS or contracted external quality review organizations. Medical records must be comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider.

Requests for Medical Records
Sentara Health Plans requires participating providers to make medical records available to members and their authorized representatives within no more than 10 days of receiving a request.

Retention and Transfer of Records
Participating providers are required to maintain all records on Sentara Health Plans members for 10 years or longer, if required under applicable state law, or as required per DMAS Provider Participation Guidelines. Additionally, PCPs are responsible for obtaining copies of medical records from both participating and nonparticipating providers to whom they make referrals, to ensure continuity of care and integrated medical records.

Providers who do not meet Sentara Health Plans' medical record standard performance threshold will be expected to document and implement a corrective action plan within a specified time frame.

At least every six months after the initial review, each deficiency will be monitored for progress until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the senior medical director and/or the Credentialing Committee to begin a review and sanctioning process with the provider.

Monitoring the Quality of Care

Sentara Health Plans will collaborate with our providers to inspect, audit, review, and make copies of medical records maintained by our provider community and those that relate to covered services rendered to members under the Provider Agreement. Sentara Health Plans may, at times, request to obtain patient information from providers to make benefit determinations, payment decisions, member grievances, quality of care (QOC) indicators, sentinel events, practice-specific member surveys, reports from Sentara Health Plans employees, credentialing department ongoing monitoring process, and other quality initiatives.

To conduct reviews and audits, Sentara Health Plans and its authorized representatives will request documentation, primarily in the form of patient medical records. The provider agrees to provide Sentara Health Plans with such patient information electronically, if provider maintains an electronic health recording system, or copies of "paper" documentation, if applicable.

At a minimum, participating providers are expected to have office policies and procedures for medical record documentation and maintenance which follow NCQA standards and ensure the following:

- accurate and legible
- safeguarded against loss, destruction, or unauthorized use - this includes keeping medical records in a restricted area and locked file cabinet
- maintained in an organized fashion for all members receiving care and services and accessible for review and audit by DMAS or contracted external quality review organizations
- readily available for Sentara Health Plans' medical management staff with adequate clinical data to support quality and utilization management activities
- comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider

Medical record standards have been established to facilitate communication, coordination, and continuity of care and to promote efficient and effective treatment. Listed below are the current medical record standards:

- A current active problem list must be maintained for each member.
- 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.
- Prescribed medications, including dosages and dates of initial or refill prescriptions, are recorded.

- 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 initiated by the PCP to signify the review.
- Consults submitted electronically need to show the 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 care planning/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 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 old and older. Referrals to a behavioral health specialist should be documented as appropriate.
- Records should indicate that preventive screening services are offered per Sentara Health Plans' Preventive Health Guidelines. This should be documented in the progress notes for adults 21 years and older.
- Sentara Health Plans will oversee and review the quality of care administered to members. Providers are encouraged to maintain best practices when documenting a member's medical records.

Confidentiality
All medical records are considered Protected Health Information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]), and any other personal information about a member received by the provider from Sentara Health Plans shall be maintained within the United States of America and shall be treated as confidential.

Additionally, the provider must maintain the confidentiality of medical records by:

- storing medical records securely (i.e., confidential filing system, etc.) - if records are electronic, have appropriate security measures in place for access; only authorized personnel have access to medical records
- conducting training on confidentiality related to member information periodically, and as needed

Charging for Copies of Records
Providers **may not** charge Sentara Health Plans or plan members for copies of medical records or the completion of forms.

Failure To Comply with Review Programs
Failure to comply with utilization management and quality improvement programs could be grounds for corrective action. The failure of the provider to follow the policies and procedures of our credential verification, quality assurance, risk, or utilization management programs regulations can

lead to exclusion from federal funding, including payments from Medicare and Medicaid, as well as criminal and civil liability.

Office Site Reviews
Providers agree to allow authorized Sentara Health Plans representatives access to conduct office site reviews, with appropriate access to members' medical records. Additionally, the provider agrees to preserve the full confidentiality of all medical records as stated in their contract. Site visit assessments may be conducted as the result of one or more of the following quality concerns:

- member grievances/complaints
- quality of care (QOC) indicators
- sentinel events
- practice-specific member surveys
- reports from Sentara Health Plans employees
- credentialing department's ongoing monitoring process
- other quality-related initiatives

The purpose of the review is to ensure practitioners meet our regulatory and accreditation site standards for quality, safety, and accessibility. Sentara Health Plans will assess the following during an office site visit:

- facility accessibility, appearance, and adequacy
- safety
- adequacy of medical supplies and practices
- medical record-keeping practices
- availability of appointments

Practitioners who do not meet our site visit assessment performance threshold will be expected to document and implement a corrective action plan within a specified time frame. At least every six months after the initial review, each deficiency will be monitored for progress until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the chief medical officer and/or credentialing to begin a review process with the practitioner.

Quality Management Review (QMR) Waiver Services
Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456, and may be conducted by DMAS or its designated agent. A QMR includes a review of the provision of services to ensure that services are being provided per DMAS regulations, policies, and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, or referral to the Division of Program Integrity for determination of retractions.

As a designated agent, Sentara Health Plans may conduct a QMR. During QMR and compliance reviews, staff will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications. The Sentara Health Plans quality improvement coordinator will request registered nurses' (RNs') and other health professionals' licenses, including those of licensed practical nurses (LPNs), certified nursing assistants (CNAs), and others who have provided services. The following documentation will also be requested for

review:

1. caregiver work references or the documentation of attempts to obtain them
2. documentation of any required training and/or certification
3. documentation of criminal background checks
4. any other staffing requirements, as identified in DMAS and DBHDS regulations and policies

The provider is responsible for ensuring that all staff of the provider agency meet the minimum requirements and qualifications at the start of employment. For consumer-directed services, the employer of record (EOR) is responsible for ensuring that all stated requirements are met in the hiring and employment of attendants providing consumer-directed services.

Audits focus on the following domains, as issued by the Department of Medical Assistance Services:

- level of care
- service plans
- qualified providers
- health and welfare
- financial accountability
- administrative authority

SECTION XII: PROVIDER COMMUNICATIONS

The Sentara Health Plans provider website delivers up-to-date information to Medicaid program providers. The website gives providers access to items such as:

- pre-authorization forms
- provider manuals
- clinical practice guidelines and medical policies
- secure provider portal
- electronic data interchange information
- quality and utilization information
- educational materials, such as newsletters and provider announcements
- provider service updates
- other resources and information

Network Provider Alerts
Sentara Health Plans routinely distributes Provider Alerts via email to notify providers of updates, including:

- changes to policies and protocols
- changes to medical policies
- changes to the provider manual
- publication of the quarterly provider newsletter
- details about upcoming educational sessions
- patient education initiatives
- quality improvement efforts
- health plan campaigns
- other important news and information

We notify providers of any planned policy changes 60 days before going into effect. Any pertinent changes to policy and protocols are also communicated with an online provider notice posting. Avoid missing any important updates by providing a valid email address to Sentara Health Plans and notifying us of any changes to your contact information.

Quarterly Provider Newsletter
We publish a quarterly provider newsletter to keep providers informed about Sentara Health Plans news, important state and federal updates, changes to medical or payment policies, quality improvement guidance, details about our preventive health or patient education initiatives, and more. Each issue of the newsletter is published on our website, and providers are notified via email when a new issue is available.

Medical Policy Updates
You will be notified via newsletter of any changes to medical policies. For more information, providers can go to the following website.

Provider Collaboration
In accordance with NCQA requirements, Sentara Health Plans maintains a Provider Advisory Council (PAC), which includes external network providers that are representative of the specialties in the network and Sentara Health Plans Clinical and Network Management members. At least two

providers on the committee must maintain practices that predominantly serve Medicaid members and other indigent populations, in addition to at least one other participating provider on the committee who has experience and expertise in serving members with special needs. The Sentara Health Plans PAC meets bimonthly to function as an advisory body, assist in obtaining essential feedback about preventive health practices, and make recommendations for innovations or revisions in existing services to better meet the needs of Sentara Health Plans members. Recommendations from the PAC inform and direct our quality improvement activities as well as guidelines, policy, and operational changes.

Changes to the Provider Manual
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) 60 days before the changes become effective. For these reasons, keep us updated on changes to your mailing and email addresses, and make sure to check your emails and the provider website often.

Provider Quarterly Webinars
Online educational webinars are held quarterly and give us the opportunity to answer questions from providers, share Sentara Health Plans updates, and offer 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 events are announced here and in the Provider Alert email, along with other educational opportunities.

Provider Trainings
Providers can access required and encouraged trainings here.

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 located here.

Providers are encouraged to review Fraud, Waste, and Abuse, Trauma-informed Care, Critical Incident Reporting, and Cultural Competency trainings at both onboarding and ongoing as needed.

Sentara Health Plans provide adequate resources to support a provider relations function to effectively communicate with existing and potential network providers. Sentara Health Plans conducts ongoing provider education and trainings to support providers in complying with network contracts, if applicable, and applicable policies and procedures. Technical assistance must include activities such as:

1. Supporting providers in the performance and use of member needs assessments;
2. In-person and virtual trainings (e.g., billing, credentialing, service authorizations, etc.);
3. Regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate, including but not limited to assistance on the Contractor's systems and billing practices;

4. Direct one-on-one support/assistance; and,
5. Facilitating sharing of best practices related to Cardinal Care and Sentara Health Plans

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

A directory of phone and fax numbers for Sentara Health Plans departments (including contacts for after hours) can be found online on the provider website under “Contact Us.” A listing is also provided in the “Methods to Reach Sentara Health Plans” section in the front of this Provider Manual.