Virginia Medicaid Program Provider Manual

Medical and Behavioral Health Provider, Facility, and Ancillary

A Publication of Sentara Health Plans' Network Management Department

This version of the Sentara Health Plans Medicaid Program Provider Manual was last updated on June 16, 2025. This version is available to all providers on our Sentara Health Plans **website**. Updates to the provider manual may occur due to the introduction of new programs, changes in contractual and regulatory obligations, and updates to existing policies. The most current information is available on the Sentara Health Plans provider **website**.

Sentara® Health Plans

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Introduction and Welcome

Welcome to Sentara Health Plans. 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.

Easily find information in this Provider Manual using the following steps: Select CTRL+F. Type in the keyword(s). Press Enter.

This Provider Manual covers policies and procedures for providers for the Virginia Medicaid plan administered by Sentara Health Plans.

Providers should refer to the Sentara Health Plans Commercial and Medicare Provider Manual for additional program information.

Within the document, you will find 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 **sentarahealthplans.com**.

The Provider Manual was developed to assist providers 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 or regulatory requirements change. In addition to the Provider Manual being available online, it is also available in printed form by written request. Many of the policies and procedures that are referenced by or incorporated into this provider manual are available on the provider website. Providers are responsible for complying with updates to the provider manual, as they are made available from time to time. Sentara Health Plans notifies providers of updates to this manual via email and website notification 60 days in advance of operational changes that could impact providers doing business with Sentara Health Plans.

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 Sentara Health Plans, or any entity which is controlled by or under common control with Sentara Health Plans, and (b) which Sentara Health Plans has agreed may access services under the Provider Agreement.

Provider Agreement means the participating 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.

Participating Provider means a duly licensed physician or other health and/or mental healthcare professional, as designated at the sole discretion of Sentara Health Plans, who has entered into a contract with Sentara Health Plans 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 Sentara Health Plans' credentialing requirements and the requirements of such contract between the provider and Sentara Health Plans 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 Sentara Health Plans, 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.

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Sentara Health Plans Key Contact Information

Topic	Website Address	Medicaid Program Phone	Information
24-hour Nurse Advice Line	**24/7 Nurse Advice Line**	Phone: **1-833-933-0487**	
Authorizations	**Authorizations**	Medical/Pharmacy Phone: **1-888-946-1167** Behavioral Health Phone: **1-888-946-1168** Behavioral Health Inpatient (IP)/ARTS/Crisis Fax: **1-844-348-3719** Behavioral Health Outpatient (OP) Fax: **1-844-895-3231** Medicaid OP/DME Fax: **1-844-348-3720** Medicaid Urgent Fax: **1-844-857-6409** LTSS UM Authorization Fax: **1-844-828-0600** LTSS UM New Waivers Fax: **1-757-837-4700** 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: **1-833-686-1595** (Toll Free)	
Care Management		Phone: **1-866-546-7924**	Monday through Friday from 8 a.m. to 5 p.m., EST. After 5 p.m., please contact Member Services. Fax: **1-844-552-7508** Medical Reports, etc.

Sentara Health Plans Key Contact Information *(continued)*

Topic	Website Address	Medicaid Program Phone	Information
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**
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 Kingston, NY 12402
Claim Overpayment	**Provider Refund Form**	Phone: **1-800-508-0528**	**Sentara Health Plans Provider Refunds** P.O. Box 61732 Virginia Beach, VA 23465
Claim Reconsiderations	**Provider Reconsideration Form** **Behavioral Health Reconsideration Form**		Mailing address located at the top of each reconsideration form
Contracting	**Join Our Network**	Phone: **1-877-865-9075**	Complete and email the Request for Participation form to: **PrvRecruit@sentara.com**.

Sentara Health Plans Key Contact Information *(continued)*

Topic	Website Address	Medicaid Program Phone	Information
Credentialing		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 Information** **Critical Incident Reporting Form**	Phone: **757-252-8400** option 1 **1-844-620-1015** option 1 Fax: **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 materials
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 Advice (ERA)	**EFT and ERA Instructions**	Zelis Payment Network Customer Service: **1-855-496-1571**	**zelis.com/providers/provider-enrollment/**
Interactive Voice Response System (IVR)		Main Phone Line 24-hour IVR: **1-800-229-8822**	To verify eligibility, providers should utilize the Sentara Health Plans IVR System.
Medical Authorizations, Medical Benefit, Drugs for Medicaid Products		Provider Services Main Phone: **1-800-229-8822** Fax numbers for specific services are located on the authorization fax forms.	Medical benefit questions and pharmacy needs
Medical Records		Phone: **1-844-620-1015** option 2	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

Methods to Reach Sentara Health Plans *(continued)*

Topic	Website Address	Medicaid Program Phone	Information
Member Transportation	**Nonemergency Transportation Benefit**	Phone: **1-877-892-3986**	Members may schedule using the member portal through the contracted transportation vendor.
Network Educators			**contactmyrep@sentara.com**
Participation in Medicaid Fee-for-Service (DMAS)	**DMAS MES Portal**	Virginia Medicaid Provider Enrollment Helpline Phone: **1-888-829-5373**	To review frequently asked questions on the Provider Services Solution (PRSS) portal, please visit the MES website.
Pharmacy Services		Pharmacy Provider Services Phone: **1-844-672-2307** Specialty Pharmacy (Sentara Case Management Pharmacy) Phone: **1-877-349-5242** Web: **sentaracasemanagement.com**	
Program Integrity (Fraud, Waste, and Abuse)	**Fraud, Waste, and Abuse (FWA) Information and Training**	FWA Hotline Phone **757-687-6326** or **1-866-826-5277**	**compliancealert@sentara.com**
Provider Services	**Provider Services**	Phone: **1-800-229-8822**	Contact Sentara Health Plans Medicaid program provider customer service for most concerns
Sentara Health Plans Website	**Sentara Health Plans**		Resource for providers, members, 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 individuals.

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

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, have been phased out and replaced with Cardinal Care Managed Care. This program alignment assists 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 Health Insurance Premium Payment (HIPP) and Family Access to Medical Insurance Security (FAMIS) Select
- managed care eligible populations listed above who are in the hospital at the time of initial Managed Care Organization (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 payor.

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.

Sentara Health Plans has a contracted vendor to administer the transportation program. 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. A nonemergency ambulance/stretcher is approved and arranged by Sentara Health Plans Medical Care Services. For more transportation information, 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 a history of relationships with the providers that have traditionally given the member care. Sentara Health Plans members may access the Member Handbook, which explains the members' healthcare rights and responsibilities.

To obtain copies of the Member Handbook and Member Guides, please visit this **link**. If a member needs the Member Handbook in large print, in other formats or languages, read aloud, or a paper copy, call Sentara Health Plans member services at **1-800-881-2166**.

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 secure provider portal, or call provider services. *Search "Sentara Health Plans Key Contact Information" at the top of this document 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 birth member 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.
- For decisions regarding the medical care of former foster care or Fostering Futures Members, the former foster care or Fostering Futures members are responsible for 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 birth member 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/**

Member ID Cards

Members receive identification cards for each enrolled member. The card is for identification purposes only and does not verify eligibility or guarantee payment of services. Members should present their identification card at the time of service.

Access sample member identification cards for Sentara Health Plans **here**.

Providers can view, download and print individual member identification cards utilizing Availity's Eligibility and Benefit search.

DMAS Contracted Enrollment Broker

The Virginia 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
- provider education and training

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 Resource

Sentara Health Plans encourages our Medicaid providers to visit our provider site **here** to research and explore information such as:

- provider self-service tools
- newsletters
- medical policies at this **link**
- health plan contact numbers
- forms and procedures
- population health programs
- billing and claims resources
- clinical references
- formularies and drug lists
- Healthcare Effectiveness Data and Information Set (HEDIS®) resources
- other resources

Provider Portal

Effective January 1, 2024, Sentara Health Plans selected Availity Essentials (Availity) as our exclusive Provider Portal. Availity Essentials is a multi-payor portal where providers can check eligibility and benefits, manage claims, and authorizations to streamline their work. Many providers are already using Availity with other payors that they are contracted with and are familiar with its ease of use.

Throughout 2024 and 2025, our provider portals, including all features, functionality, and resources, will transition to Availity. This is a phased transition with continued access to the Sentara Health Plans portal. For more information regarding Sentara Health Plans' transition to Availity, click **here**.

If a provider is already working in the Availity portal, the same user ID and password can be used to sign into the Availity account for Sentara Health Plans.

For providers new to Availity, the **Get Started with Availity** page has an abundance of resources, including a recorded webinar.

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 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 who 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 identification number (TIN), 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 the Centers for Medicare & Medicaid Services (CMS)

Locum Tenens Providers

The participating provider must notify Sentara Health Plans of the need for coverage by a Locum Tenens provider by submitting a Provider Update Form on the provider website. In emergency/urgent cases, notification should be made prior to the Locum Tenens provider providing services to Sentara Health Plans members. All services performed by the Locum Tenens provider should be billed with the Locum Tenens provider's NPI number. Since the Locum Tenens provider status is as a covering provider, Locum Tenens providers will not be listed in provider directories, on the provider website, or on listings of participating providers for reporting purposes.

Section II: Provider Processes and Member Benefits

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 simplifies 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 Medicaid providers are required to be screened, enrolled (including signing a Medicaid Provider Participating Agreement), and periodically revalidated in the MES PRSS. The requirement to enroll is included in the Sentara Health Plans Provider Agreement under the Medicaid obligation mandated provision. In accordance with the Affordable Care Act Provider Enrollment and Screening Regulations, all Medicaid Providers are required to revalidate their enrollment information at least every 5 years.

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 before 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**.

Join the Network

To participate in the Sentara Health Plans network, providers must have a contract and be credentialed (as applicable) with Sentara Health Plans. To request a contract with Sentara Health Plans, providers must submit a Request for Participation form to the Sentara Health Plans network management contracting team.

To submit a request to be credentialed with Sentara Health Plans, providers must complete a Provider Update Form on the plan website. Providers must confirm their Council for Affordable Quality Healthcare (CAQH) application is current and attested before submitting a credentialing request. The Provider Update Form is also used to add a provider to an existing (or new/pending) Sentara Health Plans contracted practice/organization.

All providers should review the **Provider Contracting and Credentialing Guide**. Access the complete credentialing program description for Sentara Health Plans **here**.

Credentialing Overview

The information below is a summary of the standard Sentara Health Plans credentialing process.

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

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

Scope

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

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 and may differ somewhat from the process described in this manual. Please contact the organization's administrator for further information.

Organizational Contracting Approval

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

Long-Term Services and Supports (LTSS) Credentialing

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

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 Centipede/HEOPS for provision of LTSS services to Medicaid program members.

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

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

Council for Affordable Quality Healthcare (CAQH)

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

Contact Information for CAQH

Website:
CAQH ProView - Sign In

CAQH Provider Help Desk: **1-888-599-1771** or email **providerhelp@proview.caqh.org**.

Supporting Documents

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

- Current state medical licenses
- DEA certificate
- Current malpractice insurance face sheet indicating the amount of coverage:
    - For the Commonwealth of Virginia, providers must maintain coverage in amounts not less than the medical malpractice cap currently in effect under the **Virginia Code (the "Code")**. Medical Professional Liability (malpractice) insurance in the amount equal to, not less than, the limitation on recovery for certain medical malpractice actions specified in Section 8.01-581.15 of the Code of Virginia, as such Section may be hereafter amended or superseded (currently $2,650,000 per occurrence) and twice that amount (currently $5,300,000) annual aggregate. These limits change year to year, and it is advised that the provider review the Code annually, upon renewal of their policy, to ensure they have the correct limits applied to their current policy. In states other than Virginia, if the state does not have a requirement for minimum medical malpractice coverage, the provider must

maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year. Non-prescribing Sentara Health Plans behavioral health Virginia, individual non-physician providers must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.

- Curriculum vitae (resume) that includes work history for the past five years

Where applicable, providers should also submit:

- Letter of explanation for any gaps in malpractice insurance
- Letter of explanation for any gaps in work history of six months or longer in the past five years
- ECFMG certificate if foreign medical school graduate with ECFMG number noted in CAQH
- Cross coverage forms from covering provider if not within the provider's practice

Credentialing Process

Sentara Health Plans credentialing specialists review all applications for completeness. Incomplete applications will not be processed, and the provider will be notified within 30 days of receipt of the application. Notice shall be provided by electronic mail unless the provider has selected notification by mail.

Verifications

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

- For providers that are not board-certified and for non-physician providers, the verification of completion at the highest level of education will need to be verified: internship, residency, or fellowships for physicians, and other degrees as applicable
- Verification of specialty board certification/eligibility

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

- Verification of current professional liability insurance in amounts required by contracts for the past five years for physicians; two years for ancillary providers
- Verification of all current state licensures and past state licensures
- Verification of hospital privilege status at a participating hospital, if applicable, or proof of acceptable coverage arrangements with a participating physician
- Verification of Medicaid participation in good standing, if applicable
- Verification of Medicare participation in good standing, if applicable
- Review of the OIG Sanction Report, HIPDB and **SAM.gov** for sanctions

After primary source verifications have been completed, the application is presented to the Sentara Health Plans medical director for review and submission to the Credentialing Committee.

The medical director may request additional information or documentation before submission of the application to the Credentialing Committee for discussion and final Committee decision. All Committee approvals and denials are communicated in writing within 90 days after receipt of the additional documentation requested by Sentara Health Plans or, if no additional information is requested, within 120 days after receipt of the completed application.

No provider will be denied network participation based on gender, race, creed, ethnic origin, sexual orientation, age, disability, or type of patient treated (e.g., Medicaid and Medicare). Sentara Health Plans will not discriminate against the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely based on that license or certification. Additionally, providers will not be denied network participation based on their service to high-risk populations or specializing in the treatment of costly conditions.

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

Recredentialing

Practitioners are recredentialed, at minimum, every 36 months and no more frequently than every 12 months unless an issue is identified by the Credentialing Committee that necessitates an earlier review. Sentara Health Plans contacts providers at the time of recredentialing if additional information is required to complete the process.

Confidentiality and Provider Rights

All credentialing information and documents obtained during credentialing, recredentialing and on-going monitoring activities are maintained in a confidential manner. All parties involved in the Sentara Health Plans credentialing process sign a confidentiality agreement on an annual basis. The confidentiality agreement includes all credentialing documents, reports, and communications relating to practitioners. Credentialing applications, data, documents and verifications are only tracked and stored in a secure, electronic credentialing software platform. Sentara Health Plans has documented policies and procedures for managing credentialing system controls and oversight.

Upon receipt of a written request, Sentara Health Plans will provide the applicant with information on the status of their credentialing or recredentialing application. Sentara Health Plans will provide status to the applicant within 10-business days of receiving their request. Practitioners will be advised of the date their application was received, the status of the processing of their application including any missing or outstanding information still needed for their file and the expected timeframe for Medical Director or Credentialing Committee review for participation determination (no peer-review information or details will be disclosed to the Practitioner). Practitioners are informed of this Right through the Credentialing Program Description which is posted publicly on the Sentara Health Plans website. Practitioners are instructed on the Sentara Health Plans website to contact the Credentialing Department at **SHPCredDept@Sentara.com** to request the status of their application.

An applicant may review any documentation submitted by the applicant in support of their application, together with any information received from outside sources such as: malpractice carriers, state licensing agencies or certification boards. Practitioners may not review any peer review information obtained by Sentara Health Plans. Practitioners are informed of this Right through the Credentialing Program Description which is posted publicly on the Sentara Health Plans website. Providers may choose to request to review such information, at any time, by sending a written request, to the Credentialing Department online at **SHPCredDept@Sentara.com** or through the United States Postal Service at:

Sentara Health Plans
Attn: Credentialing Department
1330 Sentara Park
Virginia Beach VA 23464

In the event the credentialing or recredentialing verification process reveals information submitted by the Practitioner that differs from the verification information obtained by Sentara Health Plans, the Practitioner has the right to review information Sentara Health Plans received. Examples of verifications that may produce a variance from information provided by the Practitioner may be licensing actions, malpractice cases and board certification status. The Practitioner is allowed to submit corrections for erroneous information or an explanation for the variation. Practitioners are informed of this Right through the Credentialing Program Description which is posted publicly on the Sentara Health Plans website.

Sentara Health Plans notifies the Practitioner of discrepant information it received during the credentialing and recredentialing process within 30 days of receipt. Sentara Health Plans informs the Practitioner of the discrepancy and requests a written explanation be submitted within 10 days. Practitioners are provided with a copy of the discrepant information to review. The Practitioner is asked to provide a written explanation of correction within 10-business days of receipt. If a correction is needed to the Practitioner's application, they are asked to make the correction on the application page(s) and to sign/date each correction they need to make within the application. When the corrected information is received by Sentara Health Plans, the processing of the Practitioners file will continue to be completed and will follow Sentara Health Plans normal review process for Medical Director or Credentialing Committee participation determination. The Practitioner will be notified of the Medical Director or Credentialing Committee participation decision within 60 days of the determination date.

Ongoing Monitoring

Sentara Health Plans monitors practitioner sanctions, grievances/complaints and quality issues between credentialing cycles and takes action(s) against practitioners when it identifies occurrences of poor quality. Sentara Health Plans acts on important quality and safety issues promptly by reporting such occurrences at monthly credentialing meetings. If an occurrence requires urgent attention, the Medical Director and/or designee will address it immediately; engage the Committee and action(s) will be taken to ensure quality. On an ongoing monitoring basis, Sentara Health Plans collects and takes intervention and/or action by:

- **Collecting and reviewing Medicare and Medicaid sanctions and exclusions**
  Sentara Health Plans will review sanction and exclusion information within 30 calendar days of its release by the official reporting source entity.
- **Collecting and reviewing sanctions or limitations on licensure**
  Sentara Health Plans will review sanction information within 30 calendar days of release. In areas where reporting entities do not publish sanction information on a set schedule, Sentara Health Plans will query this information at least every six months.
- **Collecting and reviewing grievances/complaints** Sentara Health Plans may evaluate both the specific grievance/complaint and the practitioner's history of issues. Evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a trend is identified, a level three (3) rating is assigned, or if a practitioner has a combination thereof, the information will be presented at the next Committee Meeting for discussion.
- **Collecting and reviewing information from identified adverse events**
  Sentara Health Plans monitors adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the adverse event, Sentara Health Plans will implement actions and/or interventions based on its policies and procedures when instances of poor quality are identified.

Credentialing for Facilities and Ancillaries

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

Sentara Health Plans facilities and ancillary providers are required to hold certification and/or licensure appropriate to the services offered. The Sentara Health Plans facility and ancillary credentialing and recredentialing processes will:

- Be conducted at least every 3 years
- Confirm that the provider is in good standing with state and federal regulatory bodies
- Confirm, when applicable based on provider type, 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
- Proof of general and professional liability insurance is required in the amount (at minimum), $1 million per occurrence and $3 million per aggregate.

Facilities and ancillaries must provide Sentara Health Plans with copies of current accreditation certificates (if applicable), or Medicare certification survey results, general and professional liability insurance, and state licensures, as applicable to each contracted facility or ancillary. In addition, completion of a Disclosure of Ownership and Control Interest Statement is required.

Any facility or ancillary provider that does not hold the required certification may be credentialed only after the Sentara Health Plans quality improvement department reviews the Certification Survey letter and copy of CMS-2567 (Statement of Deficiencies and Plan of Correction) issued by the applicable state survey organization.

Notice of Suspension Requirement

Any facility or ancillary that has its Medicare certification suspended due to cited deficiencies must notify their Sentara Health Plans contract manager immediately.

Accreditations and Certifications

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

Accrediting Body	Acronym	Examples of Organizational Provider Types Accredited
Accreditation Association for Ambulatory Health Care	AAHC	Hospitals, Surgery Centers, FQHC, Imaging Center, Urgent Care
Accreditation Commission for Health Care, Inc. (formerly HFAP)	ACHC	Hospitals, Surgery Centers, Behavioral Health, Assisted Living
American Academy of Sleep Medicine	AASM	Sleep Laboratory, DME
American Association for Accreditation for Ambulatory Surgery Facilities	AAASF	Surgery Centers, Rural Health Centers, Physical Therapy Centers
American Association for Laboratory Accreditation	A2LA	Laboratory
American Board for Certification in Orthotics and Prosthetics	ABCOP	Orthotics, Prosthetics
American College of Radiology	ACR	Imaging Centers
American Society for Histocompatibility and Immunogenetics	ASHI	Laboratory
American Speech-Language Hearing Association	ASHA	Hearing Center
Association for the advancement of Blood and Biotherapies	AABB	Blood Collection, Transfusion Services
Board for Orthotist/Prosthesist Certification	BOC	DME, Prosthetics, orthotics, Supplies, Pharmacy, Homecare
Center for Improvement in Healthcare Quality	CIHQ	Hospital, Substance Use Disorder, Free-Standing ER
College of American Pathologists	CAP	Laboratory
Commission for the Accreditation of Birth Centers	CABC	Birth Center
Commission on Accreditation of Ambulance Services	CAAS	Ambulance
Commission on Accreditation of Medical Transport Systems	CAMTS	Air Ambulance
Commission on Accreditation of Rehabilitation Facilities	CARF	Health & Human Service Organizations
Commission on Laboratory Accreditation	COLA	Laboratory
Community Health Accreditation Program	CHAP	Home & Community Based
Council on Accreditation for Children and Family Services, Inc.	COA	Health & Human Service Organizations

Accrediting Body	Acronym	Examples of Organizational Provider Types Accredited
Det Norske Veritas Healthcare, Inc.	DNV	Hospitals
DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc.	DMEPOS	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
Healthcare Organizations (NIAHO)	NIAHO	Hospitals
Healthcare Quality Association on Accreditation	HQAA	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
National Association of Boards of Pharmacy	NABP	Pharmacy
National Children's Alliance Behavioral Health Center of Excellence	BHCOE	Health & Human Service Organizations
National Committee for Quality Assurance	NCQA	Case Management, Specialty Pharmacy, Long Term Services & Supports
National Urgent Care Center Accreditation	NUCCA	Urgent Care Centers
Surgical Review Corporation	SRC	Surgery Centers
The Compliance Team	TCT	DME
The Joint Commission (formerly JCAHO)	TJC	Hospitals, Surgery Center, Nursing Homes, Behavioral Health
Urgent Care Center Accreditations	UCCA	Urgent Care Centers

The only exception made for hospital accreditation is when a facility is newly opened. If the hospital is newly opened, 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 3 years to continue the contract with Sentara Health Plans.

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. However, no services shall be provided to a Sentara Health Plans member until a completed credentialing application has been received by Sentara Health Plans. Claims for these services must be held until the provider has received notification of credentialing approval and the Provider Agreement is signed by Sentara Health Plans. The Provider Agreement must be fully executed for the claims to be processed. If a Sentara Health Plans Provider Agreement is not signed and/or the provider does not meet all credentialing requirements, Sentara Health Plans is not required to reimburse claims as a network provider and the provider should not seek any reimbursement for services provided to the member from the time of application to final notice of the credentialing decision.

To submit claims to Sentara Health Plans pursuant to the law new provider applicants 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**.

If a payment is made by Sentara Health Plans to a new provider applicant or any entity that employs or engages such new provider applicant under this section for a covered service, the patient shall only be responsible for any coinsurance, copayments, or deductibles permitted under the insurance contract with the carrier or participating provider agreement with the physician, mental health professional, or other provider. If the new provider applicant is not credentialed by the carrier, the new provider applicant or any entity that employs or engages such physician, mental health professional, or other provider shall not collect any amount from the patient for health care services or mental health services provided from the date the completed credentialing application was submitted to Sentara Health Plans until the applicant received notification from Sentara Health Plans that credentialing was denied.

Disciplinary Action

The Sentara Health Plans credentialing committee is responsible for reviewing potential areas of corrective action and recommending disciplinary or corrective action for individual practitioners who fail to comply with their Provider Agreement with Sentara Health Plans policies and procedures.

Grounds for corrective action include:

- Quality of care below the applicable standards
- A pattern of over/underutilization of services that is significantly higher/lower than other practitioners
- Failure to comply with utilization management and quality improvement programs
- Violation of the terms of the Provider Agreement
- Disruptive behavior, including but not limited to failure to establish a cooperative working relationship with Sentara Health Plans, making false statements to members or the public that discredit Sentara Health Plans, or abusive or abrasive behavior toward members of Sentara Health Plans or other participating practitioners' office staff
- Falsification of information on documents submitted to Sentara Health Plans
- Conviction of a felony
- Licensure sanctions (including probation, suspension, supervision, and monitoring)
- Loss of DEA certification
- Sanction or exclusion from government health programs, including Medicare and Medicaid
- Failure to maintain required malpractice insurance coverage

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

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

The National Practitioner Data Bank (NPDB) and/or the applicable licensing board of state(s) where the practitioner is providing services will be notified in accordance with applicable law.

Member Benefits

For information regarding the Sentara Health Plans Medicaid program member benefit information, please visit our **website**.

Primary Care Provider Assignment

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. The PCP to member ratio caps may be exceeded only in cases where mid-level practitioners are used to support the PCP's practice or where assignments are made to group practices. 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 them on 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:
1-833-933-0487

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

A provider may bill a member only when the provider has provided advance written notice to the member before rendering services, indicating that Sentara Health Plans Medicaid Program will not pay for the service, and the member has consented. 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.

For covered services, providers must accept Sentara Health Plans payment as payment in full except for patient pay liability amounts for LTSS services as established by the local DSS and must not bill or balance bill a Medicaid program member for Medicaid-covered services.

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 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 non-covered 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. The network is accessed by the 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).

Accommodating Members with Disabilities

Sentara Health Plans ensures that network providers provide physical access, geographic access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. Physical, communication, and/or programmatic barriers must not inhibit individuals with disabilities from obtaining all covered services.

Sentara Health Plans and network providers must comply with all applicable requirements in the Americans with Disabilities Act (ADA) 28 CFR §35.130, and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) to ensure that its programs and services provide as much physical and communication accessibility to members with disabilities as to members without disabilities. Accessibility includes physical accessibility of service sites and medical and diagnostic equipment.

Sentara Health Plans accommodates the needs of members by providing interpreters and translators for members who are deaf or hard of hearing and performing independent site reviews as appropriate, of provider facilities for physical and programmatic accessibility.

Providers should ensure that services are delivered in a manner that accommodates the needs of members by:

- Providing flexibility in scheduling to accommodate the needs of the members;
- Providing interpreters or translators for members who are deaf and hard of hearing;
- Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

- Ensuring safe and appropriate physical and communication access to buildings, services and equipment;
- Ensuring providers allow extra time for members to dress and undress, transfer to examination tables, and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information; and,
- Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical, communication and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

Sentara Health Plans will review compliance of provider accessibility at the time of credentialing and recredentialing of its providers.

Special Needs Members

Sentara Health Plans ensures that network providers provide physical access, geographic access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities Sentara Health Plans Medicaid program members and potential members have access to access to interpretation services free of charge. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English language. 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. Members who require special services (e.g., substance use, childbirth classes, smoking cessation) may have these services arranged by Sentara Health Plans to ensure access to such services.

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

Beginning January 1, 2025, full benefit dual eligible Medicaid enrollees that have elected to enroll in a type of Medicare Advantage (MA) Plan called a Dual Eligible Special Needs Plan (D-SNP) will be assigned to the same health plan for their Medicaid managed care as they selected for their D-SNP.

Full benefit dual eligible enrollees who are in Medicaid managed care and have elected to enroll in a D-SNP will have their health plan enrollment aligned. Full benefit dual eligibles who are excluded from Medicaid managed care (such as those who reside in an excluded facility), are enrolled in Medicare Fee-For-Service or a non-D-SNP MA plan, and partial benefit duals will not be impacted.

DMAS will move any eligible dually enrolled member with unaligned enrollment (enrolled with one health plan for their D-SNP and a different health plan for their Medicaid managed care) to the Medicaid managed care plan that matches their D-SNP choice. (The member's Medicaid managed care enrollment is determined by their choice of D-SNP, as under Medicare rules, beneficiaries must have coverage choice. Virginia Medicaid, on the other hand, requires that most members enroll in managed care.) No dual that elects to enroll in a D-SNP will be allowed to have unaligned enrollment.

Please reference the Sentara Health Plans Dual-eligible Special Needs Plan (D-SNP) Supplement found **here** for more details.

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 using industry standardized guidelines.
- 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 the service is a covered benefit
- Make sure that the chosen provider is in the Sentara Health Plans network
- Evaluate the medical necessity criteria for the service
- Enter the member into Sentara Health Plans' case or disease management program if appropriate

To pre-authorize services, submit a request via the provider portal or contact Sentara Health Plans' 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 the Mental Health Services section 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 UM department for any questions pertaining to prior authorization. For any service that requires prior authorization, requests must be processed prior to services being rendered, except in case of emergency.

Out-of-Network Providers

Out-of-network providers are required to obtain authorization prior to providing services (excluding emergency services and family planning).

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

Out-of-Plan Authorizations

Members may utilize out-of-network (OON) 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 if an in-network provider is unavailable to provide them with care.

The following circumstances may warrant the use of an OON provider:

- Sentara Health Plans has pre-authorized an OON provider:
  - for emergency and family planning services
  - when the member is given emergency treatment by such providers outside of the service area, subject to the terms of the contract between DMAS and Sentara Health Plans
  - when the needed medical services or type of provider, necessary supplementary resources, or services furnished in facilities or by providers outside the Sentara Health Plans network are not available in the Sentara Health Plans network or the in-network physician does not, because of religious or moral objections, provide the service the member needs
  - when Sentara Health Plans does not have the necessary in-network specialist within 30 miles in urban areas or 60 miles in rural areas
  - during the member's continuity of care period when the member's provider is not part of the Sentara Health Plans network, has an existing relationship with the member, and has not accepted an offer to participate in the Sentara Health Plans network
  - when DMAS determines that the circumstance warrants out-of-network treatment
  - when a provider is not part of the Sentara Health Plans network, but is the primary provider of services to the member, provided that
    - the provider is given the opportunity to become a participating provider under the same requirements for participation in the Sentara Health Plans network as other network providers of that type
    - if the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the member will be given the opportunity to transition to a participating provider within 60 days (after being given the opportunity to select a provider who participates)
  - when the member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network
  - 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 Sentara Health Plans network and the service is pre-authorized by Sentara Health Plans.

- All OON 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 Sentara Health Plans, 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.

OON providers will be reimbursed at 100% of the DMAS rate with an approved authorization for services. If a provider requests and is approved for an authorization that is initiated through UM, the provider will be reimbursed at the negotiated rate. If an OON provider has an authorization in the system and accepts the DMAS rates, a Single Case Agreement is not needed and a member of the SCA team does not need to be engaged in this process (unless the provider requests an SCA for documentation purposes).

Authorization Decision Time Frames

Standard Authorization Decisions

For standard authorization decisions, Sentara Health Plans 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
- Sentara Health Plans justifies to the state agency upon request that the need for 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, Sentara Health Plans will make an expedited authorization decision. Sentara Health Plans 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 Plans may extend the 72-hour turnaround time frame by up to 14 calendar days if the member requests an extension or Sentara Health Plans 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	
Urgent – Concurrent or Preservice	72 hours (3 calendar days)
Non-urgent – Preservice (Standard)	14 calendar days
Post Service	30 calendar days
Behavioral Health and ARTS Services	
Urgent Concurrent or Preservice Inpatient Services	72 hours (3 calendar days)
Non-urgent – Preservice (Standard)	14 calendar days
Post Service	30 calendar days

Utilization Management Staff Availability

UM personnel are available to assist you in expediting care for your Sentara Health Plans patient. UM offices are open from 8 a.m. to 5 p.m. 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 Plans 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 Medical Policy and/or Milliman Care Guidelines. The admitting physician or his/her designee will notify Sentara Health Plans' 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 Sentara Health Plans established clinical criteria, the medical directory will review the request for further consideration.
3. Short stays (less than two midnights) may be identified as observation level of care.

Admission / Concurrent Review

All inpatient hospital stays require authorization. At the time of the review for emergency admission, Sentara Health Plans will determine if the admission was medically necessary. Pending the availability of clinical data, determinations will be made within 72 hours (three calendar days) of Sentara Health Plans' notification with subsequent notification to providers within 72 hours (three 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. Sentara Health Plans will send an approval or denial letter, as applicable. For adverse determinations, the letter will 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 DMAS and ASAM criteria 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

To further define, medically necessary services are determined in a manner that:

- Is no more restrictive than the Medicaid fee-for-service Medicaid program criteria, including, but not limited to, quantitative and non-quantitative treatment limits, as indicated in any laws, regulations and interpretations.
- In accordance with § 438.236, Sentara Health Plans' medical necessity guidelines are evidence-based and at a minimum:
  - Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
  - Are adopted in consultation with contracting health care professionals in the service area;
  - Are developed in accordance with standards adopted by national accreditation organizations;
  - Are updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
  - Are applied in a manner that considers the individual health care needs of the member.
  - Are based on ASAM criteria for medical necessity determinations for all Addiction and Recovery Treatment Services (ARTS), and ASAM criteria is made available to any member or contracting provider upon request.

Upon request, individual criteria used in a medical necessity determination will be provided to a member, practitioner and/or facility.

Sentara Health Plans will cover services that address:

- The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.
- The ability for a member to achieve age-appropriate growth and development.
- The ability for a member to attain, maintain, or regain functional capacity.
- In the case of EPSDT, correct, maintain or ameliorate a condition.
- The opportunity for a member receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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).

Sentara Health Plans consults with the requesting provider for medical services when appropriate.

Concurrent Review

Concurrent or continued-stay review is performed on all hospitalized members by utilization review nurses to determine whether the hospitalization remains appropriate or whether it should be modified given changes in the patient's condition. If medical necessity for continued hospitalization is uncertain, the utilization review nurse discusses the case with a Sentara Health Plans medical director to make the continued stay determination. If a continued stay denial is issued, the attending physician may discuss the case with a Sentara Health Plans medical director (peer-to-peer).

Adverse Benefit Determination (ABD)

Sentara Health Plans defines an adverse benefit determination (ABD) as:

a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
b. The reduction, suspension, or termination of a previously authorized service.
c. The denial, in whole or in part, of payment for

a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD.

d. The failure to provide services in a timely manner, as defined by DMAS.

e. The failure of the Sentara Health Plans to act within the timeframes regarding the standard resolution of grievances and appeals.

f. For a resident of a rural area with only one managed care organization, the denial of a member's request to exercise his or her right to obtain services outside the network.

g. The denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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 with 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, can be obtained without service authorization from the PCP. Healthcare services refer to 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 a 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 the pregnancy ends for all eligible members (FAMIS birth members excluded).

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 ACOG, 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.

Members 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 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 after delivery. All pregnant women must be screened for prenatal depression, in accordance with 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. The doula recommendation form should be submitted before services.

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 individuals 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. Medicaid is the primary payor for doula services because commercial insurance does not cover these services.

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 parents 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 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. Coverage for induced abortions is only available in limited circumstances where a physician has found and certified in writing, that, on the basis of his professional judgment, the life of the mother would be substantially endangered if the fetus were carried to term

Sentara Health Plans covers family planning and contraceptive coverage, without the need for authorization, 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 and submit a state-approved waiver 30 days before a procedure for sterilization services. There must be documentation of the member being informed, the member giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed.

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 before enrollment.

Immunizations/Vaccines

Sentara Health Plans covers all immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations. Providers are required to render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current ACIP recommendations, concurrently with the EPSDT screening, and ensure that members are not inappropriately referred to other providers for immunizations. PCPs 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. 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.

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.

All PCPs who administer childhood immunizations are encouraged to enroll in the VVFC, administered by the Virginia Department of Health (VDH). 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 learn more. The Provider Enrollment Form can be accessed **here**.
- 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 that are experienced during the final stages of illness, dying, and bereavement.

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

Sentara Health Plans Oncology Program

The Sentara Health Plans oncology program promotes evidence-based, high-value care for members receiving chemotherapy drug regimens and/or radiation therapy for the treatment of cancer. The program also includes genetic and molecular testing for the diagnosis and management of cancers.

Providers are required to pre-authorize cancer radiation therapy, medical oncology, and genetic/molecular testing services.

The oncology program also provides cancer specific case management at no cost to the health plan members. As part of this program, the members would have access to:

1. 24/7 access to cancer nurses via video, chat, and phone
2. cancer-specific mental health therapists available by appointment
3. personalized nutrition support from registered dietitians specializing in cancer care
4. an extensive library of clinically approved articles, videos, and virtual events

Care Management

Care management is locally and regionally based. Care managers are assigned to individual members to conduct care management activities in every region across Virginia and act as advocates for members and the providers helping members. Using a person-centered and culturally competent integrated delivery model, care managers work closely with members to identify medical and behavioral health needs and member strengths and supports. Care managers also educate members about their condition(s), available benefits and resources, and services that they are receiving. Care managers will ensure appropriate authorizations are in place and resolve barriers to care such as transportation issues and social determinants of health needs. For more information about the Sentara Health Plans care management program, or to refer a member for care management services, please call **1-866-546-7924**.

Direct Access to Specialists

Medicaid program members with special health care needs can directly access a specialist in the provider network. These needs may be determined through an assessment to need a course of treatment or through regular care monitoring. An authorization may be required for the service(s) depending on the member's condition and identified needs. Assigned care managers or member services can assist in locating a specialist.

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
- Other care providers, as applicable

- behavioral health clinician, if indicated
- LTSS provider(s) when the member is receiving LTSS
- Personal care (PC)/PDN provider for Members receiving PC or PDN services under EPSD
- 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
- representative from the Medicare plan, if applicable
- 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 within 30 calendar days after the following:

- HRA reassessments;
- after triggering events requiring significant changes to the member's ICP (e.g., initiation of LTSS, Behavioral Health crisis services, etc.);
- upon readmissions to acute or psychiatric hospitals or nursing facilities, within 30 calendar days of discharge; and
- 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
- permit members, during continuity of care periods, to continue to receive medications and refills authorized by DMAS or another managed care organization
- 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 to a member as currently allowed by Medicaid provider or Sentara Health Plans identifies performance issues that affect member's health or welfare; or
  - provider is excluded under state or federal exclusion requirements.

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 DRG inpatient medical hospitalization from time of admission to discharge while hospitalization remains medically necessary. 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 a participating provider, the claim is paid at the contracted rates. If the service is determined to be nonemergent and the facility provider does not participate with Sentara Health Plans, 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

Sentara Health Plans contracts with licensed mental health providers to provide an array of mental health and substance use services covered under Virginia Medicaid.

For additional details regarding the services outlined in this section, please visit the DMAS website and review the mental health provider manuals located **here**.

Outpatient Mental Health Services (MHS)

Service Names	Procedure/Assessment Code
Mental Health Case Management (MHCM)	H0023
Therapeutic Day Treatment (TDT) School Day for Children	H2016
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 claims submission process

Mental Health Services Authorizations/Registrations

The Sentara Health Plans Medicaid program utilizes the DMAS-defined medical necessity criteria for Mental Health Services (MHS). Members must meet service-specific medical necessity criteria, when applicable, to receive services. Requests are reviewed on an individual basis to determine the length of treatment and units needed based on the member's most current clinical presentation.

MHS requires authorization or registration before initiating services; for a complete listing of services that require/do not require prior authorization, refer to the online **Prior Authorization List**. Authorizations may be submitted via the Sentara Health Plans provider website or faxed to the behavioral health department with a completed service authorization form. Refer to the "Sentara Health Plans Key Contact Information" section for fax numbers. Providers should expect a standard turnaround time on all request(s) of 14 calendar days. Urgent requests can be turned around within three calendar days or 72 hours of receipt.

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 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.

Behavioral Health Resident in Training & Supervisees

Residents in Counseling and Supervisees in Social Work practice under the license of their clinical supervisor. They can work with all populations for which their supervisor is credentialed.

During resident or supervisee sessions, the provider is expected to meet all the requirements of their licensing agency and any educational facility that is providing oversight for the residency program, including documentation, supervising provider participation, review of notes, etc.

Billing for these services would be submitted with the supervising provider's individual NPI listed as the rendering provider.

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

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 fee-for-service (FFS) contractor. Members admitted to a residential treatment facility will be covered by the FFS contractor and not by the members' Medicaid managed care organization (MCO) until the member is discharged from the facility. Members admitted to a therapeutic group home (TGH) are not excluded from the Medicaid program; however, the TGH service is administered through the DMAS service authorization coordinator. While a member remains in a TGH, Sentara Health Plan will work closely with the DMAS FFS contractor to coordinate care and provides coverage for transportation and pharmacy services.

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

Addiction and Recovery Treatment Services (ARTS)

The Addiction and Recovery Treatment Services (ARTS) benefit is an enhanced substance use disorder benefit of the Virginia Medicaid program. The ARTS benefit provides access to addiction treatment services for all enrolled members in the 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 include ensuring that a sufficient continuum of care is available to effectively treat individuals with a substance use disorder.

CPT Code	ASAM Description
H0011	ASAM 4.0 Medically Managed Intensive Inpatient
H2036 HB/HA	ASAM 3.7 Medically Monitored Intensive Inpatient Services
H0010 HB/HA	(Adult) Medically Monitored High-intensity Inpatient Services (Adolescent)
H0010 TG	ASAM 3.5 Clinically Managed High-intensity Residential Services (Adults)/Medium-intensity (Adolescent)
H2034	ASAM 3.3 Clinically Managed Population-specific High-intensity Residential Services (Adults)
S0201	ASAM 3.1 Clinically Managed Low-intensity Residential Services
H0015	ASAM 2.5 Partial Hospitalization Services
See DMAS manual	ASAM 2.1 Intensive Outpatient Services
See DMAS manual	ASAM 1.0 Outpatient Services
See DMAS manual	Opioid Treatment Program (OTP)
See DMAS manual	Office-based Addiction Treatment (OBAT)
H0006 &	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
T1012/	Substance Use Case Management &
S9445	Peer Support Services (individual/group)

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

Sentara Health Plans' ARTS criteria is consistent with the DMAS ARTS Benefit criteria. ARTS providers are responsible for adhering to requirements and regulations outlined in the DMAS ARTS manuals, this Provider Manual Supplement, and their Sentara Health Plans Provider Agreement, as well as state and federal governments. ARTS services must be provided at the ASAM most appropriate level of care.

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, can be found in the DMAS ARTS Manual Chapters 1–9.

Disclosure of Protected Health Information

Federal law (42 CFR Part 2) requires federally assisted alcohol or drug use treatment providers to protect a member's identifying health information. 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 disclosure of protected health information, even for 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 in addition to being enrolled in the Department of Medical Assistance Services (DMAS) PRSS Portal. Providers must be licensed by the Department of Behavioral Health and Developmental Services (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

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. Several services under a member's ARTS benefit may require authorization or registration before the initiation of services. For a complete listing of services that require/do not require prior authorization, refer to the **Prior Authorization List** for coverage and authorization requirements. The provider must obtain prior authorization for services requiring prior authorization prior to providing them. Requests received after initiation/completion of services may result in an adverse determination.

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. These forms are available on the **Sentara Health Plans provider website** and the DMAS website.

Providers submitting ARTS Registration Requests should fax the completed forms to Sentara Health Plans at **1-844-895-3231**. Providers will be notified of approvals/adverse decisions via fax and/or letter. All ARTS requests will be reviewed within 72 hours of receipt. Requests for service authorizations that do not meet the ASAM requirements for the requested level of care will not be approved.

Contracting and Credentialing

All ARTS 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 SHP 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 location 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.

For 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**

If a provider has additional questions or would like further training, provider should contact their network educator at **contactmyrep@sentara.com**.

Billing

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

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

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**.

Continuity of Care

If a member's Medicaid plan changes while receiving services, members may maintain their current MHS provider for up to 30 days (or 60 days for members receiving high intensity care management). 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. DMAS has sole discretion to extend the continuity of care period timeframe.

Out-of-Plan Authorizations

Members may utilize out-of-network MHS or ARTS providers if an in-network provider is unavailable or cannot appropriately address the members' individual needs. Prior authorization is required for all non-emergent services before service is rendered. For an emergent/urgent service, an authorization can be reviewed while the member is receiving services.

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

- emergency and family planning services
- when the member is given emergency treatment by providers outside of the service area
- when the needed services are not available in Sentara Health Plans' network or the in-network physician does not, because of religious or moral objections, provide the service the member needs
- When the needed medical services or type of provider (in terms of training, experience, and specialization), necessary supplementary resources, or services furnished in facilities or by practitioners outside Sentara Health Plans'

network are not available in network

- when Sentara Health Plans cannot provide the needed specialist, within the contract distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas
- during the member's continuity of care period
- when DMAS determines that the circumstance warrants out-of-network treatment
- when a provider is not in-network, but is the primary provider of services to the member, provided that the provider is given the opportunity to join the network (if the provider chooses not to join the network or does not meet necessary qualifications to do join, the member will be given an opportunity to transition to a participating provider within 60 days after being given the opportunity to select a participating provider)
- pursuant to 42 CFR §438.52(b)(2)(ii)(D), the Member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network
- other criteria as defined by DMAS

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 reimbursement via a single case agreement.

Section V: Covered Services

Enhanced Benefits

Enhanced benefits are services offered by Sentara Health Plans to members in excess of the managed care program's covered services. Visit our website for a full list and details of all enhanced benefits.

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 on 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 21 years and older. The benefit includes a $2,000 annual allowance that includes a complete routine hearing exam and evaluation, hearing aid fittings, a three-year supply of batteries, up to 60 batteries per hearing aid per year, and a three year manufacturer's warranty on all hearing instruments. In addition, members will be able to access NationsBenefits, LLC's network of hearing aid providers.

In 2024, Sentara Health Plans made an update that changed which hearing services are reimbursed by the health plan for members ages 21 years and older. Sentara Health Plans will reimburse hearing-related CPT codes. NationsBenefits, LLC will continue to reimburse for the following four CPT codes; 92590, 92591,92592, and 92593, in addition to all hearing aid HCPCS codes for Medicaid members 21 years of age and older. Sentara Health Plans will continue to administer hearing aid services for members under the age of 21. Providers should submit claims for this member population directly to Sentara Health Plans.

Members can access their benefits information by visiting this link or by calling NationsBenefits, LLC at **1-844-376-8637**. Member experience advisors are available 24 hours per day, seven 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.

Chiropractic

Sentara Health Plans only covers chiropractic services when medically necessary in accordance with EPSDT criteria. FAMIS members have coverage for medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.

Dental

Routine 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)

EPSDT is a benefit described in the Social Security Act § 1905(a) and 12VAC30-130-5040 to correct or ameliorate defects and physical and mental illnesses and conditions, including substance use disorder, discovered by the screening. All medically necessary 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.

EPSDT Documentation

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.
- 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 Screenings

EPSDT medical screenings must include:

1. A comprehensive health and developmental history, including assessments of both physical and mental health development to include reimbursement for developmental screens (CPT 96110) rendered by providers other than the primary care provider.
2. A comprehensive unclothed physical examination, including:
   - **a.** Vision and hearing screening;
   - **b.** Dental inspection;
   - **c.** Nutritional assessment;
   - **d.** Height/weight and Body Mass Index (BMI) assessment; and
   - **e.** Pediatric primary care providers must incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings must be documented in the medical record using a standardized screening tool.
3. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations must be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. Sentara Health Plans also covers Covid-19 vaccine counseling visits for children and youth under EPSDT.
4. Appropriate laboratory tests. The following is the recommended sequence of screening laboratory examinations; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and must be obtained as necessary.
   - **a.** Hemoglobin/hematocrit;
   - **b.** Tuberculin test (for high-risk groups); and
   - **c.** Blood lead testing including venous and/or capillary specimen (finger stick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater than five (5) ug/dL obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.

EPSDT Referrals and Treatment

Sentara Health Plans monitors provider compliance with required EPSDT activities. Providers are required to promptly notify Sentara Health Plans in the event a screening for a member eligible for services under EPSDT 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.

When a developmental delay has been identified by a provider for Sentara Health Plans enrolled members under age three, Sentara Health Plans must ensure appropriate referrals are made to the Infant and Toddler Connection of Virginia for early intervention services and documented in the member's records.

Sentara Health Plans will work with DMAS to refer members eligible for EPSDT services for further diagnosis and treatment or follow-up of all conditions uncovered or suspected. Persons outside of the health care system can determine the need for an interperiodic screen.

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.

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
- 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

To access the training, please visit this **link**.

Early Intervention (EI) Services

EI services are covered for children from birth to age three 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 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 three, 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 and Audiology Services

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, SLP, and audiology services. These services are covered, regardless of where they are provided.

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.

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)

Sentara Health Plans covers medically necessary PDN services for children under age 21, consistent with the DMAS criteria described in the DMAS EPSDT Nursing Supplement and for members over age 21 in the technology dependent subgroup who have serious medical conditions and complex health care needs. 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.

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 and adults are covered benefits when recommended as part of an approved intensive rehabilitation program.

Transplants

Transplants for the Medicaid program are covered, according to the Sentara Health Plans contract with DMAS. Necessary procurement/donor services are covered. Transplant services are covered for children under age 21 years of age) per EPSDT guidelines.

Sentara Health Plans Medicaid program coverage for transplants varies depending on the 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 Sentara Health Plans 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 are not covered
- 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.

Authorizations for LTSS must be resubmitted every six months unless the authorization has been previously updated by the care coordinator. Authorization for LTSS will be based on a member's current needs assessment and consistent with the person-centered service plan.

Patient Pay for LTSS

When an individual's income exceeds an allowable amount, the member must contribute toward the cost of their LTSS. This contribution, known as the patient pay amount, is required for individuals who are not covered through MAGI adult (Medicaid expansion) and who reside in a NF (skilled

or custodial) or are enrolled in a home- and community-based waiver. Patient pay is required to be calculated for every individual (including AI/AN) although not every eligible individual will end up having to pay each month.

Waivers

Members 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 Managed Care for their non-waiver services only (e.g., acute, 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.

For more information about enrollment and covered services click this **link**.

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 CCC Plus Waiver services as well as private duty nursing services.

For more information about enrollment and covered services click this **link**.

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 encourages provider education for trauma-informed care via a brief provider training available on the Sentara Health Plans website education page.

Telehealth

Telemedicine is a service delivery model that uses real-time two-way telecommunications to deliver covered physical and behavioral health services for 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 distances.

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 distances. 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 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. Virginia licensed healthcare providers credentialled in the Sentara Health Plans network who provide healthcare services exclusively through telemedicine are not required to maintain a physical presence in the Commonwealth.

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 DMAS 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), Sentara Health Plans and DMAS program requirements. Covered and reimbursed services include:

- synchronous audio-visual telemedicine, including originating site fees approved by Sentara Health Plans
- store-and-forward applications: Sentara

Health Plans shall reimburse for all store-and-forward services covered through the Virginia 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 Virginia 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), including 2024 amendments to Virginia Code § 32.1-325 requiring remote ultrasound procedures and remote fetal non-stress tests
- audio-only services in accordance with the DMAS Telehealth Services Supplement
- 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.

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 by DMAS on a fee-for-service basis:

- dental and related services
- local education agency-based services are covered services rendered by service providers who are employed or contracted by a local education agency, and the local education agency is the billing provider of those services.
- Services provided through tribal clinic providers
- 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)
- Independent Assessment, Certification, and Coordination Team (IACCT)
- psychiatric residential treatment facility services (PRTF)
- therapeutic group home (formerly level A and B group home)

Section VI: Pharmacy

Pharmacists as Providers

In accordance with the provisions of § 54.1-3303.1, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to 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.

Notwithstanding the provisions of § 54.1-3303.1 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. Medicaid Dual-eligible members have pharmacy coverage under a Non-Part D/Over-the-counter (OTC) Wrap listing. This listing covers non-Part D medications as well as OTC coverage. 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 be rejected 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 **1-800-229-8822**, 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**.

OTC medications that are covered on the DMAS PDL 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 be rejected 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 **1-800-229-8822**, 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 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 drugs 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 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 (i.e. fax) 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 and will be reimbursed as covered by Medicaid fee-for-service)
- 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 that include a

DESI drug are not covered

- drugs that 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

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 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 valid 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 UOM field:

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

Coverage of Contraceptives

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 coverage for 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 Virginia Department of Health Professions. More information on the Virginia PMP is available on the Department of Health Professions website at **Virginia Department of Health Professions - Prescription Monitoring Program (PMP)**. 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 **1-800-229-8822**, Monday through Friday, 8 a.m. to 6 p.m.

Section VII: 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 cooperate with QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in Sentara Health Plans QI program. Sentara Health Plans may use provider performance data for quality improvement activities.

Clinical Practice Guidelines

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

- are based on valid and reliable clinical evidence-based practices or a consensus of healthcare professionals in the respective field
- consider the needs of the members
- 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
- do not contradict existing Virginia-promulgated regulations or requirements as published by DSS, DOH, DHP, DBHDS, or other state agencies, as applicable

Sentara Health Plans requires that 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 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 QI Program provides the structure, framework, and governance used to guide the formal and informal processes for evaluating and improving quality focusing on the following aspects:

- Appropriateness of health care services
- Effectiveness of care and care outcomes for the populations served
- Responsible cost and utilization management
- Member experience of care
- Provider experience of service and support

Each year, Sentara Health Plans develops a 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 the 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 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 addressing the cultural and linguistic needs of its membership
- guide 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 the Quality Improvement Program

One of the primary goals of the Sentara Health Plans 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 at **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. PCPs 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, or 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.

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 during a patient care process in a healthcare setting
- restraint use (physical restraints or bed rails) 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 **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 via the approved DMAS **Critical Incident Reporting Form** located on the Sentara Health Plans website. An initial report of an incident may be submitted verbally within 24 hours 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:

APS: **1-888-832-3858**

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 the incident. Sentara Health Plans contact information to report a critical incident is located on the DMAS **Critical Incident Reporting Form** or the **"Sentara Health Plans Key Contact Information"** section at the top of this document.

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 several benefits: documentation of claims transmission, faster reimbursement, reduced claim suspensions, and lower administrative costs.

Claims can be submitted through Availity or any clearinghouse that can connect through Availity.

The Sentara Health Plans Payor ID Number is 54154. Change Healthcare users must only use VAPRM for claims runout for Sentara Health Plans: VP.

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 using the methods above will be deemed received within 24 hours of processing.

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 48 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. For Medicaid program claims, EFT and ERA will be issued through Zelis Payments Network. This will require a Zelis account.

Current Zelis Users
Providers who are enrolled with Zelis should work directly with Zelis to ensure ERAs are routed correctly to avoid payment delays.

New Zelis Users – How to Register:
If not enrolled in the Zelis Payments Network, an enrollment option must be completed to continue receiving electronic payments or payment will be issued by check and sent via U.S. mail. Alternative payment options are also available, including the Automated Clearing House Network (ACH), virtual credit card, and paper check. If you have any questions or want to change your payment method, please call 1-855- 496-1571 or visit **zelis.com/providers/provider-enrollment**/.

Sentara Health Plans ePayment Center
To enroll in the Sentara Health Plans ePayment center, please call **1-855-774-4392**, send an email to **help@epayment.center**, or visit **sentarahealthplans.com**.

Paper Claims

All paper claims should be sent to the claim address on the member's ID card. Handwritten claims are not accepted by Sentara Health Plans.

Common Reasons for Claim Rejection:

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

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 payor 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

Services Being Billed	Primary Insurance	Billing Instructions
Medicaid Program Waiver Only (Medicare Non-Covered Services)	Sentara Health Plans D-SNP	Bill directly to Sentara Health Plans.
	Medicare Fee-for-service	
	Other TPL Coverage	
All Other Services	Sentara Health Plans D-SNP	Submit one claim directly to Sentara Health Plans who will process both the Medicare and Medicaid portion of the claim. No claim submission for secondary claims is required.
	Other TPL Coverage	Bill directly to the primary insurance. Upon receiving the final determination (Remit/EOB) from the primary payer, submit a secondary claim to Sentara Health Plans.
	Medicare Fee-for-service	Bill directly to CMS. Under the Coordination of Benefit Agreement (COBA), CMS will submit the crossover claim directly to Sentara Health Plans. No claim submission for secondary claims is required.

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 DMAS: 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 the bottom of this **link**.

Payment Policies

Sentara Health Plans payment policies are accessible through the Availity provider portal under the resources tab in Payer Spaces. The policies 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 Availity Essentials provider portal account.

Provider Payment Processes

Consistent with the timely processing of claims as Sentara Health Plans will comply with the following standards for all providers:

1. Adjudication (pay or deny) of 90% of all clean claims within 30 calendar days of the date of receipt.
2. Adjudication (pay or deny) of 99% of all clean claims within 90 calendar days of the date of receipt.
3. Adjudication (pay or deny) all other claims within 12 months of the date of receipt (see 42 CFR §447.45 for timeframe exceptions). This requirement must not apply to network providers who are not paid by Sentara Health Plans on a fee-for-service (FFS) basis and will not override any existing negotiated payment scheduled between Sentara Health Plans and its providers.

Overpayments

If a provider receives an overpayment, the provider should complete and return the **Provider Refund Form** to Sentara Health Plans within 60 calendar days after the date on which the overpayment was identified. The form should be completed in its entirety stating the identified problem and the provider should include a refund check. As an alternative, providers that would like to have the overpayment retracted, should complete and return the correct Provider Reconsideration form:

- **Provider Reconsideration Form (medical claims)**
- **Behavioral Health Provider Reconsideration Form (behavioral health claims)**

As part of the Sentara Health Plans audit process, Sentara Health Plans and/or its 99 subcontractors may use statistical sampling and extrapolation of claims in determining the amount of an overpayment made to a provider. Sentara Health Plans automatically executes a retraction with 30 days advance notice to the provider stating the reason for the retraction. If retraction is not possible and the provider would prefer to send a refund, please send a copy of the remit, the reason the claim was paid in error, and the payment check within 30 days to the Sentara Health Plans provider refunds address in the "Sentara Health Plans Key Contact Information" section of this manual.

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

Treatment of Recoveries

In accordance with VA Code § 32.1-325.1:1, Sentara Health Plans must be permitted to retain recoveries of overpayments identified through their own monitoring and investigative efforts. The lookback period for Medicaid is 3 years from the date of payment, however, any overpayments for claims that were paid more than 3 years prior to the date that Sentara Health Plans formally notified DMAS of the overpayment will be retained by DMAS. In addition, if Sentara Health Plans has not recovered an overpayment within 1 year of being authorized to recovery such overpayment, then DMAS is entitled to recoup and retain such overpayment. This does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

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 and Providers have no recourse involving Sentara Health Plans for such situations. Sentara Health Plans will not deny payment due to enrollment processing errors or because the 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 period starts post-adjudication of the Medicare claim by the other payor.

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 includes an Explanation of Benefits (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.

Hospital/Ancillary Billing Information

Sentara Health Plans requires the most appropriate procedure and diagnosis codes based on Current Procedural Terminology (CPT) and International Classification of Diseases (ICD). The principal diagnosis is the condition established after the 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 methodologies. For hospital claims based on DRG methodology, the claim will be denied "provider error, submit a 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.

Corrected Claim Submission of a Previously Billed Claim

UB-04 Claims

- 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.
- The third digit indicates the frequency of the bill.
- Billing type is important for interim billing or a replacement/resubmission bill.
- "Resubmission" should be indicated in block 80 or any other unoccupied block of the UB-04.

CMS-1500 Claims

- Claims submitted for correction require a "7" in box 22.
- Claims that need to be voided require an "8" in box 22.
- Enter the original claim number of the claim you are replacing in the right side of item 22.

Inpatient Billing Information

Clinical care services (CCS) will assign an authorization number based on medical necessity. The authorization number should be included in the UB claim.

Copayments, deductibles, or coinsurance may apply to inpatient admissions.

Inpatient claim coding must follow "most current" coding based on the date of discharge. If codes become effective on a date after the member's admission date but before the member's discharge date, Sentara Health Plans recognizes, and processes claims with codes that were valid on the member's date of discharge. If the Provider Agreement terms change during the member's inpatient stay, payment is based on the Provider 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 before 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 CMS "Present on Admission" guidelines and follow CMS and DMAS "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.

No reduction in payment for a Never Event will be imposed when the condition defined as a Never Event for a member existed prior to the initiation of treatment for that member. Reductions in reimbursement may be limited to the extent that the following apply:

1. The identified provider preventable conditions (I.e., Never Events) would otherwise result in an increase in payment; and
2. Sentara Health Plans can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions

Non-payment of provider preventable conditions must not prevent access to services for members.

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 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) before 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 for "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 the quantity is not reported, Sentara Health Plans automatically denies the claim and requests additional information from the provider.

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 and Post-Stabilization Services

Sentara Health Plans must cover and pay for emergency and post-stabilization care services in accordance with the federal standards at 42 U.S.C. § 1396u-2(b)(2), 42 CFR §438.114, 42 CFR §422.113(c), and Section 1852(d)(2) of the Social Security Act, and in compliance with mental health parity rules per 42 CFR §438.910. Sentara Health Plans must cover emergency services without a service authorization.

Payment of Emergency Services

Sentara Health Plans defines "emergency medical or behavioral health condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part, or
- With respect to a pregnant individual who is having contractions
- That there is inadequate time to affect a safe transfer to another hospital before delivery, or
- That transfer may pose a threat to the health or safety of the pregnant individual or the unborn child.

Sentara Health Plans defines "emergency services" as covered inpatient and outpatient services that are

- Furnished by a provider that is qualified to furnish these services under Title 42.
- Needed to evaluate or stabilize an emergency medical condition.

Sentara Health Plans must cover and pay for emergency medical and behavioral health services and ensure that these services are available twenty-four (24) hours a day and seven (7) days a week, regardless of whether the provider that furnishes emergency services is a network provider or has an authorization.

Sentara Health Plans may not deny payment for treatment obtained if a representative of Sentara Health Plans instructs the member to seek emergency services or a member had an emergency medical or behavioral health condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of "emergency medical condition."

Sentara Health Plans cannot not limit what constitutes an emergency medical condition or behavioral health condition on the basis of lists of diagnoses or symptoms nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCO, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.

A member who has an emergency medical or behavioral health condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. DMAS further requires Sentara Health Plans to ensure that Medicaid and FAMIS MOMS members are not held liable for any charges for emergency services furnished by Sentara Health Plans' network or out-of-network providers. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Sentara Health Plans.

Payment of Post-Stabilization Care Services

Sentara Health Plans defines "post-stabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition.

Sentara Health Plans must cover and pay for post-stabilization care services regardless of whether such services are obtained within or outside the Sentara Health Plans network, if such services are:

- Pre-approved by a network provider or other Sentara Health Plans representative.
- Not pre-approved by a network provider or other Sentara Health Plans representative but administered to maintain the member's stabilized condition within one hour of a request to Sentara Health Plans for pre-approval of further post-stabilization care services.
- Not pre-approved by a network provider or Sentara Health Plans representative, but administered to maintain, improve, or resolve the member's stabilized condition if:
  - Sentara Health Plans does not respond to a request for pre-approval within one hour.
  - Sentara Health Plans cannot be contacted.
  - The Sentara Health Plans representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, Sentara Health Plans must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.

Sentara Health Plans' financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes responsibility for the

member's care through transfer.

- A Sentara Health Plans representative and the treating physician reach an agreement concerning the member's care.
- The member is discharged.

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 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 NPI 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 Health Insurance Portability and Accountability Act of 1996 (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

Subject to the exceptions noted below, any dispute initiated by the provider arising out of or relating in any manner to the Provider Agreement, whether sounding in tort, contract, or under statute (a "Provider Dispute") shall first be addressed by exhausting all Policies and Procedures applicable to the Provider Dispute before a provider may seek to resolve the Provider Dispute in any other forum or manner. Policies and Procedures shall include the following: Program Integrity Audit, Reconsideration and Appeals Policy; Provider Appeals Procedure; Credentialing/Recredentialing Appeals Process; and Appeals of an Adverse Benefit Determination Policy. If the Provider Dispute is of a type not subject to the Policies and Procedures, the provider and Sentara Health Plans shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The provider must initiate negotiations upon written request to SHP (the "Meeting Request Notice") delivered in accordance with the notice requirements in the Provider Agreement within ninety (90) days of the date on which the provider first had, or reasonably should have had, knowledge of the event(s) giving rise to the Provider Dispute. The negotiations shall commence within thirty (30) calendar days after Sentara Health Plans receives the Meeting Request Notice, and the provider may not seek to resolve a Provider Dispute in any other forum or manner unless the Provider Dispute is not resolved within ninety (90) days after Sentara Health Plans' receipt of the Meeting Request Notice. Notwithstanding the foregoing, a provider is not required to engage in Good Faith Negotiations related to a Provider Dispute involving payment for care rendered to a Medicaid member. Sentara Health Plans' and providers' rights to terminate a Provider Agreement pursuant to applicable requirements in the Provider Agreement are not subject to the requirements and processes in this section.

Unless otherwise provided for in the Provider Agreement, Provider shall not commence any action at law or equity against Sentara Health Plans to recover on any legal or equitable claim arising out of their Provider Agreement ("Action") more than one (1) year after the events which gave rise to such Action. The deadline for initiating an Action shall be tolled until ninety (90) days after (1) the completion of any and all applicable Policies and Procedures or (2), for Provider Disputes of a type not subject to Policies and Procedures, receipt by Sentara Health Plans of the Meeting Request Notice set forth above.

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

Section IX: Member Rights and Responsibilities

Privacy Regulations

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

Sentara Healthcare Notice of Privacy Practices is available **here**.

Sentara Health Plans maintains compliance with HIPAA, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the 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

Sentara Health Plans complies with any applicable Federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights.

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, regardless of cost or benefit coverage.
- 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 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.
- Receive information on their rights and responsibilities and exercise their rights without being treated poorly by their providers, Sentara Health Plans, or DMAS.
- 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.
- A right to voice a complaint or appeal about the organization or the care it provides.
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).
- A right to make recommendations regarding Sentara Health Plans member rights and responsibilities policy.
- A right to ask about the Physician Incentive Plans.

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.

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:

An appeal is a request to the health plan that is made by a member, a member's authorized representative or Provider, acting on behalf of the Member and with the Member's written consent, for review of an adverse benefit determination (denial). The internal appeal is the only level of appeal with the health plan and must be exhausted by a member or deemed exhausted before the member may initiate a state fair hearing. An internal appeal may be either standard or expedited. Medicaid program members must contact member services by telephone or in writing within 60 calendar days of the date of the adverse benefit determination indicating that there is 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, in accordance with 42 CFR § 438.408.

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 a member's request for an expedited appeal does not meet the criteria for expedited review, the member will be notified, and the appeal will be processed as a standard appeal. Expedited appeals will be resolved within 72 hours from the initial receipt of the appeal. No punitive action will be taken against a provider who requests an expedited resolution or supports a member's request for an 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, in accordance with 42 CFR § 438.408. 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. If Sentara Health Plans does not reverse its decision, the written notice of Sentara Health Plans' final decision for both standard and expedited appeals will also include a reference to the specific plan provision on which Sentara Health Plans based its determination.

All requests for appeals should be sent to:

Sentara Health Plans
Appeals & Grievances
PO Box 62876
Virginia Beach, VA 23466

Fax: **1-866-472-3920**

Phone: **1-844-434-2916**

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:

- **Online: https://dmas.kepro.com** by clicking the external appeal link.
- **Mail 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. Please see the state fair hearing information below.

State Fair Hearing

If the member disagrees with the internal 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.

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 of the later of: (i) the date Sentara Health Plans sends the notice that the request is denied or that care will change or (ii) 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 the 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.

Provider Notification of Appeals and Grievances Processes

The health plan provides information about the internal appeals, grievances, and state fair hearing processes to all providers, subcontractors, and delegated entities at the time that they enter into a contract. The information includes:

- The member's right to file grievances and appeals.
- The requirements and time frame for filing grievances and appeals.
- The right to a state fair hearing after the health plan has made an adverse appeal decision.
- The availability of assistance in the filling process for grievances and appeals.
- The member's right to continuation of the services that the health plan seeks to reduce or terminate if the member requests continuation of benefits and if the appeal or state fair hearing is filed within the required timeframes.
- The member may be required to pay the cost of services furnished while an appeal or state fair hearing is pending if the final decision is adverse to the member.

Medicaid Program Grievances/Complaints

Grievances 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 from the date Sentara Health Plans receives the grievance/complaint.

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.

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**

Post-Service Claims/Payment Reconsideration Submission Process

A reconsideration is a written notification to dispute the processed claim payment/denial.

No changes to the claim are being made.

A "request for reconsideration" is required prior to initiation of the appeals process. The reconsideration filing deadline is 365 days from the last date of service.

Submit Medicaid reconsideration requests via online submission or by mailing a completed Provider Reconsideration Form.

- For online submissions, the Provider Reconsideration Portal is located **here**.
- For mailed requests, complete a Provider Reconsideration Form. If necessary, include any attached documentation to the claim reconsideration address listed at the top of the provider reconsideration form.
- For mailed requests, complete a Provider Reconsideration Form. If necessary, include any attached documentation to the claim reconsideration address listed at the top of the provider reconsideration form.
  - Provider Reconsideration Forms are available for **medical claims**, **behavioral health claims** or by calling provider services.

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

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 (which includes discrimination on the basis of sexual characteristics, including intersex traits, pregnancy or related conditions, quality of life, or other health conditions, marital status, 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.

Disclosures of Ownership and Control

Sentara Health Plans collects information on ownership and control from its providers upon the provider submitting the provider application, upon the provider executing the provider agreement, upon request of DMAS during the re-validation of enrollment process, and within 35 days after any change in ownership. The disclosure includes:

- The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5% or more interest.
- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
- The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
- The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).
- Information of persons convicted of crimes related to involvement in federally related health care programs.

A nursing facility must disclose upon initial enrollment and revalidation the following information:

- Each member of the governing body of the facility, including the name, title, and period of service for each such member.
- Each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity.
- Each person or entity who is an additional disclosable party of the facility
- The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

The facility is not required to disclose the same information more than once on the same enrollment application submission.

Making Sure Providers Appear in the Directory

Sentara Health Plans Medicaid program members rely on Sentara Health Plans and its network providers to maintain complete and accurate information in our provider directories.

Keeping Sentara Health Plans informed of provider changes and updates is vital to ensure members have access to the most current provider information at all times.

All Sentara Health Plans Medicaid providers must give prior notice using the appropriate **Update Form** for any change of provider information, including but not limited to:

- provider name
- specialty/areas of expertise
- ability to accept new patients
- group affiliations/hospital affiliations
- service locations (street address/phone number(s)/indication if on a public transportation route)
- accommodations for disabilities/ADA accessibility
- cultural and linguistic capabilities
- completion of cultural competence training
- availability of telemedicine services
- website URL, if applicable

In addition, Sentara Health Plans Medicaid network providers are required to respond to quarterly requests for attestation of provider directory data.

Changing an Existing TIN or Adding a Healthcare Provider

If your practice/organization TIN 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 PIU conducts reviews and audits to help ensure compliance with state and federal laws and regulations. Providers are obligated to cooperate with the Sentara Health Plans 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 (DME), prosthetics, orthotics and supplies, rehabilitation services, and home healthcare

Sentara Health Plans may retract payments made to a provider if, in the course of an audit, Sentara Health Plans reasonably concludes any of the following: the provider failed to properly code the service in accordance with the applicable coding requirements; the provider failed to submit documentation for the service in accordance with the Provider Agreement, this Manual, or applicable Sentara Health Plans policies and procedures; or provider submitted incorrect, incomplete, and/or inaccurate documentation for the service.

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.

If an audit reveals an error rate greater than fifty percent (50%), Sentara Health Plans is permitted to use statistical sampling (i.e., extrapolation). In performing an extrapolation, Sentara Health Plans will employ the RAT-STATS software published by the U.S. Department of Health and Human Office of Inspector General.

For requirements related to reconsiderations and appeal rights, please see Policy FWA 0008: Program Integrity Audit, Reconsideration and Appeals.

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 and in no event no later than 60 days from the date on which the overpayment was identified in accordance with 42 CFR § 438.608. Providers must also notify Sentara Health Plans in writing of the reason for overpayment.
- 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 for 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 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.
- 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 Health, Sentara Health Plans entities follow:

Sentara Health Notice of Privacy Practices available **here**.

Provider Availability: Access and After-hours Standards

Access to care is recognized as a key component

of quality care. As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis, in accordance with Sentara Health Plans' standards for provider accessibility. This includes, if applicable, call coverage or other backup, or providers can 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.

The following instructions are considered compliant if provided via live person, recording, or auto-attendant:

- Caller is instructed to dial 911 or go to nearest emergency room
- Caller is instructed to visit urgent care center
- Caller can be connected to a provider, nurse, or after-hours service operator
- Caller can leave name and number for a return call within 30 minutes
- Caller is provided with the phone number of the on-call provider or nurse
- Caller's information is given on call provider or nurse by live person
- Providers can be paged
- Provider answers call
- Nurse triages call
- Caller advised to contact crisis or intervention number

Appointment Timeliness Standards

Sentara Health Plans meets and requires its network providers to meet DMAS standards for timely access to care and services, taking into account the urgency of the need for services. 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 has established mechanisms that will ensure compliance with timely access to care, and the services standards described below. Sentara Health Plans monitors network providers for compliance to these appointment timeliness standards on an ongoing basis, including monitoring Grievances and Appeals data for indications that problems may exist with access to specific providers or provider types. Sentara Health Plans will take corrective action if there is a failure to comply by a network provider.

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

Service Type	Sentara Health Plans Medicaid Standards
Emergency Services, including Crisis Services (medical and behavioral health)	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.
Non-life-threatening Behavioral Health emergency	Within 6 hours or directed to emergency care.
Urgent Appointments (medical and behvioral health)	Within 24 hours of the member's request.
Regular and Routine Primary Care Services	Regular and 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 seven calendar days of request.
Maternity Care – Second Trimester	Within seven calendar days of request.
Maternity Care – Third Trimester	Within three business days of requests.
Maternity Care – High-risk Pregnancy	Within three 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.
Behavioral Health Services (Initial and Follow-up Routine)	Must be made available 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	Must be made available 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 provide services to Medicaid program members in the same manner as they provide to non-Medicaid and non-FAMIS members, including those with limited English proficiency or physical or mental disabilities. Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members and/or FAMIS 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 complete the Cultural Competency Attestation Form found **here** or on the **Provider Update Form** (located under the 'other' checkbox). The provider directory will indicate providers that have completed this training.

Provider Satisfaction Surveys

Sentara Health Plans conducts a provider satisfaction survey in accordance with DMAS contract requirements, at least every two 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

Practitioners and providers furnishing services to Sentara Health Plans members are required to maintain and share, as appropriate, a member health record in accordance with professional standards.

Adequate medical records and documentation relating to the care and services provided to Sentara Health Plans members is required. 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, contracted external quality review organizations, or other DMAS designees. 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 business 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 use 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 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 in addition to requirements for repayment of identified overpayments. 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.

Provider Office Quality of Care/Service Site Visit

A Provider Office Site Visit will be conducted by the Quality Department secondary to a Quality of Care (QOC)/Quality of Service (QOS) event and/or member grievance, or complaint, related to a QOC/QOS event. An office site visit may be conducted as a result of one or more quality concerns including, but not limited to, the following:

- Critical Incidents (QOC/QOS/Sentinel Event)
- Member Complaints/Grievances related to:
  - Quality of care/quality of service
  - Provider office physical accessibility
  - Provider office physical appearance
  - Provider office adequacy of waiting and examining room space
  - Provider office adequacy of medical/treatment record-keeping
  - Provider office equipment accessibility
- Reported member safety concerns from SHP employees

A provider office visit will be conducted as expeditiously as the quality event, or complaint, necessitates, but no later than 30 days of the identified quality concern. All network providers must comply with Sentara Health Plans Quality Department's quality initiatives to investigate such

concerns and must meet a predetermined minimum performance compliance threshold set forth by SHP. If issues are found during the site visit, a Corrective and Preventive Action (CAPA) Plan may be initiated by Sentara Health Plans in its sole discretion. If the quality concern(s) remains unresolved after the specified timeframe, a referral will be made to the appropriate department and/or committee for review via the escalation pathway.

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 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:

- caregiver work references or the documentation of attempts to obtain them
- documentation of any required training and/or certification
- documentation of criminal background checks
- 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 DMAS:

- 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 through electronic communications 60 days before going into effect. Any pertinent changes to policy and protocols are also communicated with an online provider notice posting. To avoid missing any important updates, it is required that providers provide (and update as necessary) a valid email address to Sentara Health Plans.

Quarterly Provider Newsletter

Sentara Health Plans publishes a quarterly provider newsletter, providerNEWS, 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 Leadership Committee (PLC), 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 PLC 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 PLC 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 providers 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, it is important to inform Sentara Health Plans of mailing and email address changes. Check the provider website often for changes and monitor email for provider alerts.

Provider Webinars

Online educational webinars are held and allow Sentara Health Plans the opportunity to answer questions from providers, share updates, and offer ideas 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 of each subsequent year. Attestation is required and will be recorded by provider (practice/facility) name, 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 provides 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 training to support providers in complying with network contracts, if applicable, and policies and procedures. Technical assistance must include activities such as:

1. Supporting providers in the performance member needs assessments;
2. In-person and virtual trainings (e.g., billing, credentialing, service authorizations, etc.);
3. Direct one-on-one support/assistance; and,
4. Facilitating sharing of best practices.

Telephone

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 "Sentara Health Plans Key Contact Information" section at the beginning of this Provider Manual.

Providers may contact provider services by phone with questions regarding member eligibility, benefits information, claims questions for up to five claims, or similar inquiries.

In the event of an issue or question concerning the Provider Agreement, providers should contact their assigned network educator.

Section XIII: Subcontractor, Vendor, and Agent Compliance Program

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

Confidentiality

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

Business Information

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

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

Equal Opportunity Employment

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

Conflict of Interest

Sentara Health Plans employees may not accept:

- Money or gifts (regardless of monetary value) from customers
- Money from vendors or gifts

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

Anti-Kickback Act

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

Business Records

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

Billing Practices

Sentara Health Plans is committed to accurate

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

False Claims

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

The federal False Claims Act covers fraud involving any federally funded contract, including Medicare and Medicaid. Liability is established for any person who knowingly presents or causes a false or fraudulent claim for payment by the U.S. government. "Knowingly" is defined as a person (1) having actual knowledge of false claim information, (2) acting in deliberate ignorance or reckless disregard of the information, or (3) acting in reckless disregard for the truth or falsity of information. The False Claims Act (FCA) provides that any person who knowingly submits or causes to submit false claims to the government is liable for three times the government's damages plus a penalty that is linked to inflation.

The criminal penalties for violations of the False Claims Act include fines and/or imprisonment for more than five years.

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

Fraud and Abuse

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

The Deficit Reduction Act of 2005 became effective on January 1, 2007, and requires healthcare organizations receiving 5 million dollars or more in annual Medicaid reimbursement to educate employees, contractors, and agents about fraud and abuse, false claims, and whistleblower protection laws and regulations. The Deficit Reduction Act requires investigation of all potential false claims and fraud/abuse, such as payment coordination, claims payment only for U.S. citizens or qualified aliens, copayment limits compliance, and electronic claims submission by large providers.

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

Whistleblowers

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

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

Insider Trading

Agents and vendors who have material nonpublic ("insider") information obtained through a relationship with Sentara Health Plans are

prohibited from purchasing or selling the security. Agents and vendors may not use insider information for the purpose of communicating such information ("tipping") to those who trade.

Government Sanctioning

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

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

Maintaining Your Position of Trust

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