

Sentara® Health Plans

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 November 9, 2026. 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.

This version of the Medicaid Program Provider Manual supersedes previous versions. The requirements and obligations in this Manual apply to services rendered from November 9, 2026, until Sentara Health Plans publishes an updated version.

Introduction and Welcome

Welcome to Sentara Health Plans. As a participating provider, you are an essential member of our team. We thank you for making it possible for Sentara Health Plans to maintain health and manage illness and disease by providing access to quality healthcare for 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 caring for members enrolled in the Virginia Medicaid plan administered by Sentara Health Plans.

If a provider is contracted to provide services under Sentara Health Plans' commercial and/or Dual-Eligible Special Needs Plans, the provider should refer to the Sentara Health Plans Commercial and Dual-Eligible Special Needs Plans Provider Manuals for information related to those plans. Providers who provide services solely under Sentara Health Plans Medicaid plans should refer to this manual only.

Within this document, you will find important information to help you with identifying members and products, obtaining authorizations, understanding claims reimbursement policies and procedures, and fulfilling your obligations under the 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 referenced sources, is a binding extension of your Provider Agreement and is updated 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 published. Sentara Health Plans will notify providers of Provider Manual updates via email and website announcements at least 60 days in advance of operational changes that may affect business with Sentara Health Plans.

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

If this Provider Manual conflicts with your Provider Agreement, the terms of your Provider Agreement will take 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.

AI System means any artificial intelligence, machine learning engine, neural network or similar system, including, without limitation, any system falling within such terms as then currently defined by the National Institute of Standards and Technology ("NIST").

Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Provider Agreement means the participating provider agreement, attachments, exhibits, and any amendments.

Member means any individual, whether referred to as "member," "participant," "enrollee," or otherwise, who is eligible, as determined by DMAS, to receive covered services under the Medicaid program and is enrolled in the Sentara Health Plans Medicaid plan.

Participating Provider whether referred to as "provider" or otherwise, 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 or any of its Affiliates 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.

Practitioner means the medical professional that is either employed by or has executed an agreement with Sentara Health Plans, or its subcontractor, to render covered services to Sentara Health Plans members.

Sentara Health Administration, Inc. (SHA) is a corporation that, among other things, contracts with providers for the delivery of healthcare services on behalf of SHA and its Affiliates. It also contracts to administer, arrange, and provide access to these services.

Sentara Health Plans

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Sentara Health Plans Key Contact Information

Topic	Website Address	Medicaid Program Contact Information	Information
24-hour Nurse Advice Line	24/7 Nurse Advice Line	**Phone:** 1-833-933-0487	*No additional information.*
Authorizations	Sentara Health Plans Authorizations	*See Authorization Contacts section.*	The preferred method for submitting authorization requests is through the Availity Essentials secure provider portal. Refer to the Provider Portal section of this manual for additional information.
Behavioral Health Member Crisis Line	*Not applicable*	**Phone:** 1-833-686-1595 (Toll Free)	*No additional information.*
Care Management	*Not applicable*	**Phone:** 1-866-546-7924	**Hours:** Monday through Friday, 8 a.m. to 5 p.m. EST. **After hours:** Contact Member Services. **Fax:** 1-844-552-7508 Medical Reports, Designated Rep Forms, etc.
Claims	Billing Reference Sheets and Claims Submission Guidelines	**Phone:** 1-844-512-3172	**Medical/LTSS 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	*Not applicable*	Mailing address is located at the top of the form.
Contracting	Join Our Network	**Phone:** 1-877-865-9075	Complete and email the Request for Participation form to: PrvRecruit@sentara.com
Credentialing	*Not applicable*	**Phone:**	**Initial credentialing**

		1-877-865-9075	**questions:** SHPInitialCred@sentara.com **Re-credentialing questions:** SHPrecred@sentara.com
Critical Incidents	Critical Incident Reporting Information (under How To…) Provider Critical Incident Form (under Forms)	**Phone:** 757-252-8400, option 1 **Toll Free Phone:** 1-844-620-1015, option 1	**Email:** CIReporting@sentara.com **Toll Free Fax Line:** 1-833-229-8932
Dental (Smiles for Children)	Smiles for Children Program	**Provider Customer Service Phone:** 1-888-912-3456	Resources and training materials for dentists.
DMAS Eligibility Verification	DMAS Eligibility Verification	**Toll Free MediCall Automated System:** 1-800-884-9730 or 1-800-772-9996	Please utilize the MediCall automated system to check claim status, authorizations, and eligibility
Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)	EFT and ERA Instructions Zelis Provider Enrollment	**Zelis Payment Network Customer Service:** 1-855-496-1571	*No additional information.*
Interactive Voice Response System (IVR)	*Not applicable*	**Main Phone Line / 24-hour IVR:** 1-800-229-8822	Use the Sentara Health Plans IVR system to verify member eligibility.
Medical Records	*Not applicable*	**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 may contact Sentara Health Plans for concerns and questions.
Member Transportation	Nonemergency Transportation Benefit	**Phone:** 1-877-892-3986	Members may schedule transportation using the member portal through the contracted transportation vendor.
Network Educators	*Not applicable*	*Not applicable*	contactmyrep@sentara.com

Participation in Medicaid Fee-for-Service (DMAS)	DMAS MES Portal	**Virginia Medicaid Provider Enrollment Helpline:** 1-888-829-5373	Visit the MES website to review frequently asked questions on the Provider Services Solution (PRSS) portal.
Pharmacy Services	Pharmacy Sentara Case Management Pharmacy	**Pharmacy Provider Services Phone:** 1-844-672-2307	*No additional information.*
		Pharmacy Authorizations Phone: 1-800-881-2166	
		Specialty Pharmacy (Sentara Case Management Pharmacy) Phone: 1-877-349-5242	
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 Provider Services for most provider inquiries, including medical authorizations, medical benefit questions, and Medicaid pharmacy-related services.
Sentara Health Plans Website	Sentara Health Plans	*Not applicable*	Resource for providers, members, plan information, and updates.
Telephone for Deaf and Disabled	Telephone for Deaf and Disabled	**VA Relay Phone:** 1-855-687-6260 or 711	For deaf, hard of hearing, and disabled individuals.

Sentara Health Plans

Authorization Contacts

Use the tables below to identify the appropriate phone or fax number for authorization-related requests.

Authorization Phone Numbers

Request Type	Phone Number
Medical and Pharmacy Prior Authorizations	**Phone:** 1-888-946-1167
Behavioral Health Authorizations	**Phone:** 1-888-946-1168

Behavioral Health Authorization Requests

Request Type	Fax Number	Notes
Urgent Behavioral Health Requests	**Fax:** 1-844-348-3719	Includes ARTS, inpatient, crisis, and MH PHP/IOP requests.
Non-Urgent Behavioral Health Outpatient Requests	**Fax:** 1-844-895-3231	Use for all other behavioral health outpatient requests not listed as urgent.

Medical Authorization Requests

Request Type	Fax Number
Outpatient / DME	**Fax:** 1-844-348-3720
Inpatient	**Fax:** 1-844-220-9565
Post-Acute	**Fax:** 1-844-220-9572
Urgent Requests	**Fax:** 1-844-857-6409

LTSS Authorization Requests

Request Type	Fax Number
LTSS UM Authorization Requests	**Fax:** 1-844-828-0600
LTSS UM New Waiver Requests	**Fax:** 1-844-857-6408
LTSS All Other Waiver Requests	**Fax:** 1-844-828-0600

Additional Authorization Requests

Request Type	Fax Number
Government Newborn Enrollment	**Fax:** 1-844-883-6064

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/TDD and American Sign Language are also included.

Providers should contact Sentara Health Plans Medicaid Provider Services at 1-800-229-8822 for interpreter services. 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 on request and at no cost for members with disabilities.

Transportation Program

The Sentara Health Plans Medicaid program provides urgent and emergency transportation. Nonemergency transportation (NEMT) is also covered for eligible members for covered services. NEMT requires scheduling, including air travel and services reimbursed by an out-of-network provider. If a member has no other means of transportation, transportation will be provided to and from medical appointments.

Sentara Health Plans partners with a contracted vendor to administer the transportation program. Members should call 1-877-892-3986 at least five days in advance of a scheduled covered service to arrange transportation. For additional transportation information or assistance, please call 1-877-892-3986 (toll-free).

Sentara Health Plans

Section I: Medicaid Program Overview

Virginia Department of Medical Assistance Services (DMAS) offers Medicaid fee-for-service and managed care programs via a single program—Cardinal Care.

The Medicaid program is designed to better serve individuals receiving Medicaid benefits in Virginia. The goal of the Medicaid program is to improve the lives, satisfaction, and health outcomes of participants by providing a seamless, one-stop system of services/supports.

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.

DMAS Contracted Enrollment Broker

The DMAS and Managed Care Helpline contract with Cover Virginia 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 Cover Virginia website to request an application. Applications are also available at local Department of Social Services offices.

Medicaid Program Enrollment and Assignment 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.

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.

Medicaid Program Eligibility Verification

DMAS has sole responsibility for determining the eligibility of an individual for Medicaid services.

- Providers can verify Medicaid enrollment on the DMAS website or by contacting the toll-free MediCall Automated System at 1-800-772-9996 or 1-800-884-9730. Sentara Health Plans recommends providers verify member eligibility prior to providing services.

- To verify eligibility for Sentara Health Plans, providers should utilize the Sentara Health Plans interactive voice response (IVR) system, Availity Essentials provider portal, or call

Provider Services. *Search "Sentara Health Plans Key Contact Information" at the top of this document for phone numbers.*

Adoption Assistance and Former Foster Care Enrollment and Health Plan Selection

Members enrolled through Former Foster Care (AC070) and in Adoption Assistance (AC072) will be enrolled in the Foster Care Specialty Plan but will have the opportunity to opt out of that plan and enroll in a Cardinal Care Plan at any time.

Sentara Health Plans and network providers comply with the following rules:

- The adoptive parent is responsible for health plan selection, including changes, for children in Adoption Assistance (AC072).
- The Former Foster Care or Fostering Futures Members (AC070) are responsible for their health plan selection and any subsequent health plan changes; and
- Former Foster Care members and Adoption Assistance members may change their health plan at any time and are not restricted to their health plan selection following the initial 90-day MCO 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 the Sentara Health Plans service area.

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 mother or hospital must report the birth. The birth mother 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). The hospital should report the birth by using the DMAS automated method for enrolling newborns. Hospitals should submit newborn enrollment through the Newborn/Newborn E-213 link on the DMAS Medicaid Enterprise System (MES) portal.

Once Medicaid-enrolled, the newborn is enrolled in the birth mother's MCO, effective with the newborn's date of birth.

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 birth member is applying for Medicaid for the newborn. If a newborn claim is filed under the birth member ID number, the claim will be suspended 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 birth member's ID.

To avoid unnecessary delays in claims payment, please encourage the birth member 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 can be processed. Hospitals can make inquiries via the following mailbox after 30 days of submitting the E-213 Enrollment form at: newborn-providers@dmas.virginia.gov.

Member Handbook and Guide

Sentara Health Plans members may access the Member Handbook, which provides information about covered benefits and explains members' rights and responsibilities.

To obtain copies of the Member Handbook and Member Guide, 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 (Hearing Impaired/VA Relay: 711).

Member ID Cards

Members receive an identification card for each enrolled member. Member identification cards are used for identification purposes only and do not verify eligibility or guarantee payment for services. Members should present their identification card at the time of service.

Providers may access sample Sentara Health Plans member identification cards here.

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

Sentara Health Plans Provider Services Team

Contact Sentara Health Plans Provider Services for most needs, including:

- Member eligibility verification
- Benefit information
- Claims status and questions

Sentara Health Plans

Section II: Joining the Network, Credentialing and Provider Directory Processes

Provider Services Solution (PRSS)

DMAS uses the Medicaid Enterprise System (MES). This technology platform includes the Provider Services Solution (PRSS), a module to support both fee-for-service and managed care network providers by managing provider enrollment.

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.

Network providers that are currently enrolled as fee-for-service (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.

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.

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 provider network, providers must have a contract and be credentialed, as applicable, with Sentara Health Plans. Providers interested in joining the network should complete and submit a Request for Participation form to the Sentara Health Plans Network Management Contracting team for review and consideration.

To submit a request to be credentialed with Sentara Health Plans, providers must complete a Provider Update Form on the Sentara Health Plans website. **Providers are required to ensure that their Council for Affordable Quality Healthcare (CAQH) profile is current and attested prior to submitting a credentialing request.** The Provider Update Form is also used to add a practitioner to an existing Sentara Health Plans contracted practice/organization or to a new or pending contracted practice/organization.

All providers should review the Sentara Health Plans Credentialing Guide found under “How To…” on the Sentara Health Plans website. The complete description of the Sentara Health Plans credentialing program is also available 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 ensure quality care and patient safety by utilizing credentialing and recredentialing standards outlined by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), Sentara Health Plans policies and applicable state regulations. Sentara Health Plans will review the education, experience and credentials of all practitioners who care for Sentara Health Plans members at the time of their initial request to participate in the network (credentialing). Sentara Health Plans will at a minimum, recredential all providers every 36 months thereafter. Sentara Health Plans may elect to recredential providers after shorter time intervals based on medical director or credentialing committee requests. No provider shall be included in the Sentara Health Plans network without being credentialed. All providers must maintain current recredentialing status and continue to meet all Sentara Health Plans accreditation, state and federal regulations between credentialing cycles during ongoing monitoring. No practitioner will be denied or terminated from network participation based on their age, sex, race, ethnicity, religion, national origin, or disability.

Practitioners Who Require Credentialing

Practitioners who require credentialing as a condition of participation with Sentara Health Plans are defined as:

- Practitioners who are licensed, certified or registered by the state to practice independently.
- Practitioners who have an independent relationship with Sentara Health Plans. An independent relationship exists when Sentara Health Plans directs its members to see a specific practitioner or group of practitioners, including all practitioners with whom members can select as a Primary Care Provider (PCPs). An independent relationship is not synonymous with an independent contract. Sentara Health Plans does not credential some practitioners with whom it holds independent contracts, however, if a practitioner is listed in the Sentara Health Plans network directory, the practitioner must be credentialed.
- Practitioners may seek approval from Sentara Health Plans to participate as a primary care practitioner and a specialist, provided they meet Sentara Health Plans' participation criteria for all scopes of practice being requested.
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory facilities.
- Practitioners who are hospital-based but who also see Sentara Health Plans members as a result of an independent relationship with the Sentara Health Plans.
- Oral surgeons and dentists who provide care to Sentara Health Plans members under the members' medical benefits.
- Non-physician practitioners who have an independent relationship with Sentara Health Plans and who provide care to members under Sentara Health Plans' medical benefits.
- Telemedicine practitioners.
- Rental networks:
    - That are part of the organization's primary network, and the organization has members who reside in the rental network area.
    - Specifically for out-of-area care, and members may see only those practitioners, or are given an incentive to see rental network practitioners.
- PPO network practitioners if an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network, when they are outside the network, NCQA considers this to be an independent

relationship if information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), or There are incentives for members to see the PPO's practitioners. In this type of contractual arrangement, Sentara Health Plans must credential the practitioners or delegate credentialing to the PPO network.

- Locum Tenens practitioners who work fewer than 60 days or more than 60 calendar days.

Practitioners Who Do Not Need to be Credentialed

The following types of practitioners need not be credentialed:

- Practitioners who do not have an independent relationship with Sentara Health Plans, and meet any of the following:
  - Practitioners who practice exclusively within the inpatient setting, and who provide care for Sentara Health Plans members only because of members being directed to the hospital or other inpatient setting.
  - Practitioners who practice exclusively within free standing facilities and who provide care to Sentara Health Plans members only because of members being directed to the facility.
  - Pharmacists who work in conjunction with a pharmacy benefit management organization to which Sentara Health Plans delegates utilization management functions.
  - Covering practitioners (e.g., Locum Tenens) who do not have an independent relationship with Sentara Health Plans.
  - Practitioners who do not provide care for Sentara Health Plans members (e.g., board certified consultants who may provide a professional opinion to the treating practitioner).
  - Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

- Hospital Based Practitioners (including, but not limited to):
  - Anesthesiologists
  - Emergency medicine practitioners
  - Hospitalists / hospital medicine practitioners
  - Pathologists
  - Radiologists
  - Neonatal / perinatal practitioners
  - Critical care medicine practitioners
  - Trauma medicine practitioners
  - Certified registered nurse anesthetists
  - Any other practitioner specialty practicing exclusively in an inpatient setting

- Non-inpatient facilities in which practitioners may practice exclusively and provide care for members only because of members being directed to the facility may include, but are not limited to:
  - Mammography centers and free-standing radiology centers
  - Urgent care centers
  - Surgery centers
  - Ambulatory behavioral health facilities
  - Psychiatric and substance use disorder clinics

  - School-based clinics

- School-based practitioners
  - School nurses

Organizational Contracting Approval

Organizations that bill under a Type 2 NPI utilize the organizational credentialing policy and procedure.

Long-Term Services and Supports (LTSS) Credentialing

Sentara Health Plans manages the contracting and credentialing process for Long-Term Services and Supports (LTSS) providers.

Sentara Health Plans ensures that LTSS providers are credentialed and recredentialed in accordance with DMAS and Medicaid program requirements and comply with all applicable provisions of the CMS Home and Community-Based Settings Rule.

Practices and organizations (Tax ID) that are not currently participating in the Sentara Health Plans network and are interested in becoming participating providers must complete a Request for Participation form, available here.

The Sentara Health Plans Network Management department evaluates applicants to determine whether minimum participation and credentialing requirements have been met.
Providers with a felony conviction, Office of Inspector General (OIG) sanctions, or Excluded Parties List System (EPLS) sanctions will not be accepted. LTSS Providers shall identify and report all Legally Responsible Individual (LRI) information in accordance with Sentara Health Plan requirements and all applicable state and regulatory guidelines.

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 must complete the CAQH ID Request Form on the Provider Data Portal website listed below.

Contact Information for CAQH

Website:
CAQH ProView
CAQH Provider Help Desk:
Phone : 1-888-599-1771
Email : providerhelp@proview.caqh.org

Supporting Documents

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

- Current state medical licenses.

- Drug Enforcement Administration (DEA) certificate (as applicable).
- 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 $2,750,000 per occurrence) and twice that amount (currently $5,500,000) 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 the correct limits are applied to their current policy.
    - For the Commonwealth of Virginia, Allied Health Practitioners 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 $2,750,000 per occurrence) and twice that amount (currently $5,500,000) 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 the correct limits are 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.
    - Virginia non-prescribing Sentara Health Plans behavioral health, 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.
    - If the Practitioner's malpractice insurance coverage is current and is provided in the CAQH application, it must be current as of the date when the Practitioner signed the attestation and include the amount of coverage the Practitioner has on the date when the attestation was signed. If the Practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.
    - Documentation of malpractice insurance coverage may also be a face sheet, a federal tort letter or employer professional liability policy as an addendum to the CAQH application. The face sheet, federal tort letter or employer professional liability policy must include the insurance effective and expiration dates (the future effective date is acceptable).
    - Evidence of a face sheet must be from the carrier and include the practice name and include a roster of all individuals in the practice who are covered under the policy. The roster may be provided by the carrier or employer.
    - Evidence of federal tort coverage must include effective and expiration dates but is not required to include a roster of all Practitioners who are covered under the policy.
    - Evidence of private malpractice insurance coverage or employer professional liability policy must include a roster of all individuals in the practice who are covered under the policy.

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

Where applicable, practitioners 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.
- Letter of explanation for practitioners who do not have an active DEA or Controlled Dangerous Substances (CDS)/Controlled Substance Registration (CSR) certificate, but who should have one based on their practice. Such practitioners must state the reason for not having a DEA or CDS/CSR certificate and the appropriate covering practitioner who will agree to write prescriptions for their members if applicable.
- As applicable, the practitioner must hold current, unrestricted clinical privileges at a participating Plan hospital:
    - In lieu of clinical privileges, the Practitioner must provide evidence of patient coverage or transfer arrangements with another Plan participating Practitioner to manage their Plan membership hospitalizations; or
    - Have documented admission arrangements with a hospitalist group to a participating Plan hospital.
- Educational Commission for Foreign Medical Graduates (ECFMG) certificate if a foreign medical school graduate with a ECFMG number noted in CAQH.
- Cross coverage forms from covering provider if not within the provider's practice.
- Explanations for malpractice cases.
- Explanations for license sanctions or license limitations.

Practitioners must have acceptable 24-hour coverage, which includes arrangements for alternate care of patients when the practitioner is unavailable through another qualified practitioner consistent with Sentara Health Plans' policies and procedures and/or criteria.

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.

Sentara Health Plans operates an online Credentialing and Recredentialing system. The online system notifies a new Provider applicant that the application has been received. Sentara Health Plans offers a non-electronic based Credentialing and Recredentialing upon request of a Provider. For applications received outside of the online system, Sentara Health Pans will notify the new Provider applicant within 10 days of receiving an application, either by mail or electronic mail, as selected by the applicant, that the application was received.

Verifications

The Sentara Health Plans credentialing department verifies with the primary source that the provider meets the Sentara Health Plans credentialing requirements. Any verifications performed that have an actual expiration date such as a DEA or license, must be verified within

120 days of the credentialing or recredentialing decision and the expiration dates must still be valid on the date the decision is made.

Providers are required to complete an application for initial credentialing and recredentialing. The applications must contain a current, signed and dated attestation statement as to the correctness and completeness of the application. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired, and the disability is documented in the practitioner's file. CAQH has a system that allows the provider to update application information electronically. NCQA accepts the last attestation date generated by this system as the date when the provider signed and dated the application to attest to its completeness and correctness.

If the application and attestation must be updated, only the provider may attest to the update; Sentara Health Plans staff may not. If a copy of an application from an external entity to the Plan is used, it must include an attestation to the correctness and completeness of the application. NCQA does not count the associated attestation elements as present if the provider did not sign the application within the required time frame.

The following verifications are completed for each participating provider:

- Review of the full application to ensure it is fully completed.
- Verification of current valid state licensure (licenses will be verified for all states where the provider provides care to Sentara Health Plans members).
- Verification of current valid DEA/CDS/CSR (if applicable).
- Verification of education and training (if the provider is an individual practitioner).
- Sentara Health Plans verifies the highest of the following levels of education/training obtained by the provider (if the provider is an individual practitioner) as appropriate:
    - Board certification in their practicing specialty(ies).
    - Residency in their practicing specialty(ies).
    - Graduation from medical or professional School.

Sentara Health Plans only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States, the American Osteopathic Association in the United States, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

Note: Verification of Fellowship completion & any future program completion dates do not meet the requirement for verification of education and training.

Note: Verification of board certification does not apply to Nurse Practitioners, Physician Assistants, or other non-physician health care professionals unless the Plan communicates these board certifications to Plan members.

- Work history (minimum relevant work history of the most recent 5 years).

Note: Provider must explain any gaps in work equal to or exceeding six months

- Current professional liability insurance that meets state limit requirements.
- Five Practice-Year malpractice history.
- Medicare and/or Medicaid sanction history.
- State license sanctions or limitations.

- Hospital privileges or acceptable coverage arrangements.
- National Provider Identification (NPI).
- Federal sanction.
- System for Award Management (SAM).
    - Medicare & Medicaid sanctions.
    - Medicare & Medicaid exclusions.

Board Certification Requirements

Sentara Health Plans require all physicians (MD/DO) to be board certified. Sentara Health Plans may, at its sole discretion, waive the specialty board certification requirement for applicants that meet a certain criterion. Non-board-certified physicians must meet one or more of the following requirements:

- They are within 6 years of graduation from their practicing specialty training program;
- They practice in an underserved geographic area classified Rural by the most recent U.S. Census located here.
- They practice a specialty required to fill a geo-access gap for the Plan as determined by Network Management;
- They have been board certified in their practicing specialty for 30 years, have no quality issues and/or malpractice claims (pending or settled) in the last 10 years and have chosen not to renew their board certification.

Sentara Health Plans does not accept boards in the United States that are not members of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Specialty Specific Credentialing Requirements

In addition to the general credentialing requirements applicable to all providers, additional requirements may apply to certain provider types in accordance with Sentara Health Plans' policies and DMAS policies, provider manuals, regulations, and the contract between DMAS and Sentara Health Plans. The provider agrees to furnish information and documentation necessary for Sentara Health Plans to perform credentialing and recredentialing in accordance with such requirements.

A provider's credentialing or recredentialing file is deemed complete and ready for review by the Medical Director or Credentialing Committee once a completed application has been received, all supporting documents and/or responses have been submitted and all verifications, primary source or otherwise have been confirmed. Sentara Health Plans notifies providers within 30 days of receipt of the provider's credentialing application if the application is incomplete. Completed files are reviewed by the credentialing department to ensure the provider's electronic file in Sentara Health Plans' credentialing system has been fully updated and all required tracking information, application, documents and primary source verifications have been obtained and are stored appropriately. Completed files are then assigned a "clean" or "issue" status based on the criteria outlined in the credentialing policy and procedure. Sentara Health Plans medical director has the authority to approve clean files. All "issue" files must be reviewed by the credentialing committee.

Sentara Health Plans does not discriminate, in terms of participation, reimbursement, or otherwise, against any health care professional or facility, who is acting within the scope of their license or certification under state law, based on the license or certification.

Sentara Health Plans does not make credentialing or recredentialing decisions on a practitioner's race, ethnic or national identity, gender, age, sexual orientation or the type of procedure(s) or patient (i.e., Medicaid and Medicare), in which the practitioner specializes. This does not preclude the Plan from including in its network practitioners or facilities who meet certain demographic or specialty needs, for example, cultural needs of Sentara Health Plans members. Sentara Health Plans does not discriminate against practitioners or facilities that serve high-risk member populations or specialize in conditions that may require costly treatment.

Following credentialing or recredentialing decision determinations issued by the medical director or credentialing committee, a letter is sent to the provider advising them of the decision. Unless specific state notification time frames exist, the NCQA notification time frame of sending the decision notification letter within 30 calendar days of approval or denial determination will be followed. In the event a denial decision is issued, the provider is notified in writing within 30 calendar days of the denial reason and if applicable, offered the right to appeal. Please see the Credentialing Appeals Process section found in the Credentialing Program Description for more information.

After an application is approved, providers are contacted by Sentara Health Plans to inform them of the effective date for participation. Sentara Health Plans complies with Virginia Code §38.2-3407.10:1 regarding payments to providers during the credentialing process (see Billing While Credentialing Is Pending).

Recredentialing

Sentara Health Plans recredentials all providers at least every 36 months. Information and documents are obtained and verified according to the credentialing policy and procedure standards. NCQA counts the 36-month cycle to the month, not to the day. The recredentialing process will also include performance-monitoring information on each provider. This review includes review of adverse data from any of the following plan data areas:

- Member grievances and/or complaints.
- Utilization management.
- Quality improvement, performance quality measures, quality deficiencies, and/or trend patterns.
- Site assessment and/or medical record keeping practice/treatment assessment issues.

Confidentiality and Provider Rights

All 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 applicants with information regarding the status of their credentialing or recredentialing application within 10 business days.

Applicants will be informed of the date their application was received, the current status of application processing, any missing or outstanding information required to complete the file, and the anticipated timeframe for Medical Director or Credentialing Committee review and participation determination. Peer review information and related details will not be disclosed.

Providers are informed of this right through the Credentialing Program Description, which is publicly available on the Sentara Health Plans website. To request the status of a credentialing or recredentialing application, providers may contact the Credentialing Department at **SHPCredDept@Sentara.com**.

Applicants also have the right to review information submitted in support of their application, including documentation they provided, and information obtained from external sources such as malpractice insurance carriers, state licensing agencies, and certification boards. However, providers may not review peer review information or references obtained as part of the credentialing process.

This right is described in the Credentialing Program Description posted on the Sentara Health Plans website. Providers may request to review eligible credentialing information at any time by submitting a written request to the Credentialing Department via email at **SHPCredDept@Sentara.com** or by mail 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 provider that differs from the verification information obtained by Sentara Health Plans, the provider has the right to review information Sentara Health Plans received. Examples of verifications that may differ from information provided by the practitioner may be licensing actions, malpractice cases and board certification status. The provider is allowed to submit corrections for erroneous information or an explanation for the variation. Providers are informed of this right through the credentialing program description which is posted publicly on Sentara Health Plan's website.

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

Ongoing Monitoring

Sentara Health Plans monitors provider sanctions, grievances/complaints and quality issues between credentialing cycles and will take action(s) against providers when it identifies occurrences of poor quality. Sentara Health Plans acts on important quality and safety issues promptly by reporting such occurrences to the Credentialing Committee or other designated peer-review body. If an occurrence requires urgent attention, the Medical Director and/or designee will address it immediately, and the Committee and/or Medical Director may take any action(s) reasonably necessary 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 from the OIG and CMS Preclusion list and a NCQA-approved source at least monthly or within 30calendar days of a new alert.
- **Collecting and reviewing sanctions or limitations on licensure**
  Sentara Health Plans will review sanctions and limitations on licensure in all states where the practitioner or facility provides care to Plan members. Licensure sanction and limitation monitoring will be reviewed from a CMS and NCQA-approved source at least monthly or within 30 calendar days of a new alert.
- **Collecting and reviewing grievances/complaints**
  Sentara Health Plan investigates all practitioner-specific member complaints upon receipt and evaluates the practitioner's history of complaints, if applicable. Additionally, evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a trend is identified, a level rating will be assigned. The Credentialing Committee or other designated peer-review body will recommend appropriate interventions based on assigned scoring. When the appropriate interventions are determined, the organization will follow the recommendations to address the issues that were identified, including quality and safety concerns.
- **Collecting and reviewing information from identified adverse events**
  Sentara Health Plans monitors adverse events at least monthly 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 licensures appropriate to the services offered. The ancillary credentialing and recredentialing processes will:

- Reassess the credentials of each participating organizational provider at least every 36 months after initial credentialing.
- 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.
- Conduct a quality assessment of the organization when organizational providers are not accredited.
- Review a copy of a quality review by the Centers for Medicare and Medicaid Services (CMS) or applicable state review board in lieu of Sentara Health Plans conducting its

own quality assessment if the CMS or state assessment is no more than three years old. If the CMS or state assessment is older than three years, Sentara Health Plans is required to perform its own quality assessment.

Note: Sentara Health Plans is not required to conduct a quality assessment if the organizational provider is located in a rural area, as defined by the U.S. Census Bureau at How We Define Rural | HRSA and the state or CMS has not conducted a site review.

- Confirm proof of general and professional liability insurance in the amount of at least $1 million per occurrence and $3 million in the aggregate.
- Validate an active National Provider Identifier (NPI).
- Validate licensure, if applicable.
- Validate the absence of Medicare or Medicaid sanctions and federal exclusions.

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.

Disclosure of Ownership and Control and Control Interest Statement

Sentara Health Plans requires all provider-disclosing entities to complete a Disclosure of Ownership and Control Interest Statement at initial contracting/credentialing and at recredentialing as a condition of participation. Ownership means a direct or indirect ownership interest totaling 5% or more. Disclosure as a participating fee-for-service provider for DMAS meets this requirement for Sentara Health Plans.

Notice of Suspension Requirement

Any facility or ancillary provider 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	AAAHC	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 of Ambulatory Surgery Facilities	AAAASF	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 & Biotherapies	AABB	Blood Collection, Transfusion Services
Board for Orthotist/Prosthetist 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
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 Mgt, 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 Accreditation	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 its patient safety plans and records from a state or federal regulatory body that has reviewed the hospital must be forwarded to Sentara Health Plans.

Billing While Credentialing Is Pending

In accordance with Va. Code § 38.2-3407.10:1, as applicable, Sentara Health Plans will reimburse providers for services rendered during the period in which their credentialing application is pending, provided the claims for such services are clean claims and otherwise meet the criteria for reimbursement, within 40 days of the provider being credentialed and contracted with Sentara Health Plans. Reimbursement for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by the Sentara Health Plans credentialing committee and execution of a provider agreement. 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 fully executed. 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 for services rendered during the credentialing process, new provider applicants must provide written or electronic notice to members in advance of treatment informing members that the provider has submitted a credentialing application to Sentara Health Plans and is in the process of obtaining approval. The notice must include the language at Va. Code § 38.2-3407.10:1(G).

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 member 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 Sentara Health Plans, 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 member 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 warranting corrective action and recommending disciplinary or corrective action for individual practitioners who fail to comply with their provider agreement or with Sentara Health Plans policies and procedures.

Grounds for corrective action include, but are not limited to:

- Quality of care below the applicable standards.
- A pattern of over/underutilization of services that is significantly higher/lower than other practitioners in the same specialty.
- 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 failing to establish a cooperative working relationship with Sentara Health Plans, making misleading 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 and other committees 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.
- Loss of licensure.

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

Provider Data Accuracy

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

- Verifying the accuracy and timeliness of reported data.
- Screening the data for completeness and consistency.
- Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts.
- Making all collected data available to DMAS and, upon request, to the Centers for Medicare & Medicaid Services (CMS).

Practitioner Location Limits

Effective August 1, 2026, newly credentialed practitioners will be limited to a maximum of 10 practice locations per group NPI/tax ID combination. This change is intended to improve the accuracy of the provider directory, reduce member frustration when attempting to schedule at inactive locations, and ensure members are directed to sites where care is truly accessible.

If a practitioner has more than 10 locations, please identify and prioritize up to 10 locations where the practitioner is actively seeing patients, accepting appointments, and available to serve members. If prioritization is not provided, locations will be selected in the following order: primary care, specialty care, then hospital based. All submitted locations must also include accurate days and hours of availability to support successful scheduling.

Please note that this update does not impact the following:

- Currently credentialed practitioners, though location limits may be addressed individually if the thresholds are exceeded.
- Facilities.
- Claims processing and payment.

Updating Your Information

Keeping Sentara Health Plans informed of provider updates is an important step in 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 in accordance with the timeframes set forth in your Sentara Health Plans Provider Agreement of any changes related to your practice, provider roster or location/phone number. 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 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.

Making Sure Providers Appear in the Directory

Sentara Health Plans 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 always have access to the most current provider information.

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

- Provider name, address, and telephone number.
- Office hours (as applicable), including whether provider site is open after 5:00 p.m. (Eastern Time) on weekdays and on weekends.
- Licensing information (e.g., NPI number).
- 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).
- Accommodation for disabilities/ADA accessibility.
- Cultural and linguistic capabilities.
- Completion of cultural competence training.
- Availability of telehealth services.
- Website URL, if applicable.
- For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use.

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

Sentara Health Plans

Section III: Member Information

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 and should adhere to the following ratios:

1. No more than 1,500 Medicaid program members for every 1 full-time equivalent PCP, regardless of specialty type.
2. No more than 1,500 Medicaid program members under the age of 18 for every 1 full-time equivalent.

PCPs may not exceed 1,500 members except in cases where mid-level practitioners are used to support the PCP's practice or where assignments are made to group practices. The provider's panel will not allow additional Medicaid member assignment once the panel limit is reached on the claims platform. Sentara Health Plans may decrease the number of Medicaid program members assigned to a PCP if necessary to meet appointment standards. Any network provider acting as a PCP must indicate to Sentara Health Plans the number of open panel slots available to Medicaid program members. Panel status changes must be communicated to Sentara Health Plans via the Provider Update Form at least 60 days in advance of the change.

PCP Panel Status Options:

- Open and accepting new members.
- Not accepting new patients; providers will continue to provide services for established patients, siblings, and spouses switching plans.
- Pediatrics provider is not accepting new patients; provider will accept established patients, newborns, and their siblings.
- Age restriction.
- Covering provider only patients who have seen the provider within the past two years are considered established patients by Sentara Health Plans.

Please allow up to 30 business days for the requested provider information to be updated in all Sentara Health Plans systems. The requestor will receive a confirmation email when the request has been completed. After 30 days, if a confirmation email has not been received and/or the updated information is not reflected on the provider's profile in the Sentara Health Plans directory, please email an inquiry for status to PUStatus@sentara.com.

Providers are encouraged to check their panel statuses and sizes by accessing the PCP Membership Roster on Sentara Health Plan's Payer Space in Availity.

Guidelines for Removing a Member from a PCP Panel

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

- Abusive behavior.
- Noncompliance with a provider treatment plan.
- Failure to establish a provider-patient relationship.

Upon notification of these behaviors, Member Services will make an outreach to the member and assist with selecting a new PCP.

The procedure for removing a member from a provider's panel is as follows:

1. The provider sends a certified letter to Sentara Health Plans notifying Sentara Health Plans of the reason for asking the member to be repaneled to another provider.
2. The provider sends a letter to the member notifying the member that the provider will no longer be serving as the member's PCP and informing the member that Sentara Health Plans will work with them to find a new PCP. The provider must send a copy of the letter to their contract manager in the network management department at Sentara Health Plans by mail or fax.

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

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 network.

Patient Financial Responsibilities

Per DMAS requirements, members are not subject to cost-sharing (coinsurance, deductibles, and copayments), however, members receiving LTSS services may have patient pay obligations. For more information, please visit this website.

24/7 Nurse Advice Line

Sentara Health Plans provides members with access to a 24/7 Nurse Advice Line. Members may call the 24/7 Nurse Advice Line for support when they experience illness or injury outside of normal business hours or when their provider's office is closed.

Licensed nurses assess the member's symptoms, provide guidance on appropriate levels of care, and offer self-care recommendations when appropriate. Nurses do not have access to the member's medical record and cannot diagnose conditions, prescribe medications, order services, or make treatment decisions. Members may be advised to seek emergency care, urgent care, or follow up with their provider, depending on their symptoms.

24/7 Nurse Advice Line: 1-833-933-0487

When calling the 24/7 Nurse Advice Line, callers should be prepared to provide:

- Member identification information.
- A description of the illness or injury.

- Relevant medical history, including current conditions and medications.

The 24/7 Nurse Advice Line supports members in making informed decisions about their care and does not replace evaluation by a provider. Providers may receive follow-up information, as appropriate, to support continuity of care.

Member Services

Members, providers, 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 member 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 program patient, and the services being provided are the financial responsibility of the member.

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

Second Opinions

Sentara Health Plans will provide coverage for a second opinion when requested by the members to diagnose an illness or confirm a recommended course of treatment. Sentara Health Plans will provide a second opinion from a qualified healthcare professional within the network or, when no such professional exists within the network, arrange for the member to obtain one outside the network at no cost to the member. Authorization may be required for specialty services; however, Sentara Health Plans will not deny a second opinion as a non-covered service.

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. Network adequacy will be assessed

along a number of dimensions, including: whether there are an adequate number of providers in each specialty; hours of operation; whether providers are or are not accepting new patients; accommodations for individuals with physical disabilities (wheelchair access) and barriers to communication (translation services); time in which a member can schedule and receive covered services; and geographic proximity to beneficiaries (provider to members or members to provider).

Provider Accessibility for Individuals with Disabilities and Individuals with Special Needs

Sentara Health Plans require that all network providers provide physical access, geographic access, reasonable accommodations and accessible equipment for members with physical or mental disabilities. Physical, communication, and 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.

Providers are required to submit physical accessibility information for the Sentara Health Plans provider directory to facilitate access for special needs members. This includes, but is not limited to, providing information related to 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 Health Plans providers must 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.
    - Sentara Health Plans Medicaid program members and potential members have 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 languages.
- 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.
    - 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 with provider accessibility requirements at the time of credentialing and recredentialing of its providers. Sentara Health Plans may also review such compliance as necessary to ensure members receive all appropriate and reasonable accommodations.

Cultural Competency

Sentara Health Plans embraces and promotes cultural humility as a foundational approach to the delivery of services, fostering respectful, inclusive, and culturally competent care to all members including individuals with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and sex, which includes, but is not limited to, sex characteristics, (including intersex traits), pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes.

Culturally competent care allows healthcare providers to appropriately care for and address healthcare concerns, including the beliefs and value systems of enrollees with diverse cultural and linguistic needs.

Providers are encouraged to:

- Build rapport by providing respectful and culturally appropriate care.
- Assess the members' needs for interpreter or translation services and provide the appropriate aids and services to meet the members' needs.
- Be mindful of the cultures that may have specific beliefs surrounding health and wellness.
- Ensure that the members understand diagnosis, procedures, and follow-up requirements.
- Offer health education materials in languages that are common to the provider's patient population and/or per member's preferred language.
- Be aware of the tendency to unknowingly stereotype certain cultures.
- Ensure staff receive continued education and training in providing culturally competent and linguistically appropriate care.

Sentara Health Plans requires network 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.

Sentara Community Complete (D-SNP)

Sentara Health Plans offers a Medicare Advantage Dual-eligible Special Needs Plan (D-SNP) to members who qualify for both Medicare and Medicaid. The benefits, provider choices, and drug formularies offered by D-SNPs are designed to best meet the specific needs of its member base, which consists of older adults and people with disabilities who have chronic health conditions. Features of Sentara Health Plan's D-SNP include:

- Integrated Medicare and Medicaid coverage.
- Cost savings for the member.
- Dedicated Care Management.

- Enhanced supplemental benefits.

CMS and DMAS require exclusively aligned enrollment for full benefit dual-eligible Medicaid enrollees that enroll in a D-SNP. Enrollees are required to receive their Medicaid coverage through the same health plan that is selected for their D-SNP coverage. Provider benefits of exclusively aligned enrollment include:

- Unified billing and claims.
- Simplified service authorizations.
- Integrated appeal processes.
- Coordinated care teams.
- Reduced confusion and easier navigation for members.
- Reduced fragmentation of coverage and care.

Full benefit dual eligibles who are excluded from Medicaid managed care are enrolled in Medicare Fee-For-Service or a non-D-SNP Medicare Advantage plan, and partial benefit duals do not require exclusively aligned enrollment.

If you are interested in learning more about our D-SNP, please see the Sentara Health Plans D-SNP Provider Manual for more details.

Sentara Health Plans

Section IV: Utilization Management

Utilization Management

Sentara Health Plans' Utilization Management (UM) program reflects applicable National Committee for Quality Assurance (NCQA) standards:

- UM decision-making is based on the appropriateness of care and service and the existence of coverage, using evidence-based, industry-standard guidelines.
- Sentara Health Plans does not compensate providers or other individuals conducting utilization reviews for denials of coverage or services.
- Sentara Health Plans does not offer financial incentives to UM decision-makers to encourage denials of coverage or services.
- Members have access to covered services in an amount, duration, and scope that is no less than those provided under fee-for-service Medicaid.

Sentara Health Plans has processes in place to monitor and address potential under- and overutilization of services and to support appropriate use of 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 and attestation, available on the Sentara Health Plans Provider Education website.

Service Authorization

Some services require authorization from Sentara Health Plans. The service authorization process supports:

- Verification of member eligibility and benefit coverage.
- Review of medical necessity based on submitted clinical information.
- Coordination of services within the Sentara Health Plans network.
- Identification of members who may benefit from Care Management or disease management programs.

Sentara Health Plans authorizes services in a manner that supports:

- Prevention, diagnosis, and treatment of conditions resulting in health impairment or disability.
- Age-appropriate growth and development.
- The ability to attain, maintain, or regain functional capacity.
- Correction or amelioration of conditions under EPSDT.
- Access to community-based services and person-centered outcomes for members receiving long-term services and supports (LTSS).

To request authorization for medical services or LTSS, providers must submit a request through the Availity Essentials secure provider portal or contact Sentara Health Plans' UM department using the contact information listed in the "Sentara Health Plans Key Contact Information" section of this manual. Failure to obtain the required authorization may result in denial of payment.

Refer to the Behavioral Health and ARTS section of this manual for authorization requirements related to mental health services and ARTS.

Medical Necessity Criteria

Sentara Health Plans uses DMAS criteria and MCG care guidelines health criteria when making medical necessity determinations for medical and surgical services. For DMAS-defined behavioral health services, medical necessity is based on DMAS guidelines and policies outlined in the DMAS Mental Health and Addiction and Recovery Treatment Services (ARTS) Manuals. Additional nationally recognized clinical criteria, including American Society of Addiction Medicine (ASAM) criteria, may be used where applicable to support medical necessity determinations.

Medical necessity criteria are publicly available and accessible electronically via the Sentara Health Plans provider website to support use at the point of care. Providers may access current criteria, policies, and supporting guidelines through this resource.

In addition, Sentara Health Plans will provide, upon request and at no cost, the specific medical necessity criteria used in individual determinations to members, practitioners, or facilities.

If criteria applicable to a specific determination are not available online or if additional details are requested, Sentara Health Plans will furnish the criteria used to the requesting party.

All criteria used in utilization management decision-making are reviewed and applied in accordance with applicable federal and state requirements, including DMAS guidelines.

Coverage decisions are based upon medical necessity and applicable federal and state requirements. Sentara Health Plans:

- Will not deny or reduce the amount, duration, or scope of a covered service solely based on diagnosis, type of illness, or condition.
- May apply appropriate limits based on medical necessity criteria to ensure services are clinically appropriate.
- Ensures services for members with ongoing or chronic conditions, including those receiving long-term services and supports (LTSS), are authorized in a manner that supports the member's needs, functional status, and ability to live in the community.
- Ensures access to family planning services in a manner that supports member choice.

Medical necessity criteria are evidence-based, reviewed at least annually, and applied in a manner that considers the individual needs of the member. Criteria are applied in a manner that is no more restrictive than Medicaid fee-for-service coverage requirements.

Peer-to-Peer Review

A peer-to-peer review may be available following a medical necessity denial for Medicaid plans. Providers should refer to the denial letter to determine whether a peer-to-peer review is available and for instructions on how to request one.

Authorization Decision Timeframes

Standard Authorization Decisions

For standard authorization requests, Sentara Health Plans will provide a decision as expeditiously as the member's condition requires, not to exceed seven calendar days following receipt of the request. This timeframe may be extended by up to 14 calendar days if the member or provider requests an extension, or if additional information is needed in the member's interest.

Expedited Authorization Decisions

Expedited review applies when waiting for a standard decision could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In these cases, Sentara Health Plans will provide a decision as expeditiously as the member's condition requires, but no later than 72 hours after receiving receipt of the request. This timeframe may be extended by up to 14 calendar days if the member requests an extension or if additional information is needed in the member's interest.

Decision Timeframes

Sentara Health Plans comply with applicable federal and state requirements for service authorization decision timeframes. Providers may request expedited review when clinically appropriate. Decision timeframes are not extended due to weekends or holidays. Timeframes for authorization decisions are as follows:

Classification	Type	Timeliness	Extension
Physical/Non-Behavioral Health			
Urgent/Expedited	Concurrent	72 hours	14 calendar days
	Preservice	72 hours	14 calendar days
Non-urgent/ Standard	Preservice	7 calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days
Behavioral Health including Mental Health Services and ARTS Services			
Urgent/Expedited	Concurrent	72 hours	14 calendar days
	Preservice	72 hours	14 calendar days
Non-urgent/ Standard	Preservice	7 calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days

Secondary Payer – Service Authorizations

Sentara Health Plans does not require service authorization when acting as the secondary payer, except in the following circumstances:

- The primary payer does not cover the service, and the service is a covered benefit under Sentara Health Plans.
- The member has exhausted benefits under the primary payer, and the service is covered by Sentara Health Plans.

In these situations, Sentara Health Plans will act as the primary payer. Service authorization is required when applicable to the service.

Transplant services require authorization even when Sentara Health Plans is the secondary payer. See the Transplants Services section of this manual for additional information.

Procedure Codes Requiring Service Authorization

For a complete listing of services, please refer to Sentara Health Plans' Prior Authorization List for coverage and authorization requirements. For the codes on the Prior Authorization List Providers must request authorization prior to rendering services, except in the case of emergency services. For questions regarding authorization requirements, providers should contact the Sentara Health Plans Utilization Management Department.

Out-of-Network Providers

Out-of-network providers must obtain authorization prior to rendering services, except for emergency services and family planning services. Out-of-network providers must ensure that the cost to the member is no greater than it would be if the services were furnished by an in-network provider. Sentara Health Plans may coordinate payment with out-of-network providers in accordance with a completed Single Case Agreement, if applicable.

Out-of-Plan Authorizations

Members may receive services from out-of-network providers when in-network providers are unavailable, do not meet accessibility standards, or cannot meet the member's clinical needs. Sentara Health Plans will authorize and coordinate out-of-network services when authorized or when required under applicable Medicaid requirements.

Out-of-network services may be authorized in the following circumstances:

- When medically necessary services are not available within the network.
- When required specialists are not available within network access standards.
- During an approved continuity of care period.
- When related services must be provided together and are not all available in-network.
- When required, due to provider unavailability related to moral or religious objections.
- When otherwise directed by DMAS.

Payment to out-of-network providers will be made in accordance with applicable rates and authorization terms.

Elective Admissions and Outpatient Procedures

Elective inpatient admissions and outpatient surgical procedures require authorization in accordance with Sentara Health Plans Policies and medical necessity criteria.

Providers must notify Sentara Health Plans prior to a planned admission and submit clinical information to support the request, including the diagnosis, proposed procedure, and expected length of stay.

Short stays may be evaluated for observation level of care based on clinical criteria and expected duration of services.

Inpatient Admissions and Concurrent Reviews

All inpatient admissions require authorization. For emergency admissions, Sentara Health Plans will review the admission for medical necessity based on available clinical information and provide a determination within required timeframes.

Concurrent continued stay reviews are conducted to determine whether an inpatient stay remains medically necessary. Providers must submit clinical information to support continued stays beyond the initially authorized length of stay.

Authorization determinations are based on medical necessity criteria. Providers will be notified of determinations, including written notice for denials with appeal rights. Providers may request discussion of adverse determinations with a qualified clinical reviewer, as appropriate.

Utilization Management Staff Availability

Utilization Management staff are available to assist providers with coordination of care and authorization requests for Sentara Health Plans members. Utilization Management offices are open Monday through Friday from 8 a.m. to 5 p.m. Calls received after hours will be routed to a confidential voicemail system and returned on the next business day.

Sentara Health Plans

Section V: Medical Management/Covered Services

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 both members and their providers. Using a person-centered and culturally competent integrated delivery model, care managers work closely with members to identify medical, behavioral, and social needs and member strengths and support. 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 Sentara Health Plans Care Management program, or to refer a member for Care Management services, please call 1-866-546-7924.

Model of Care

The elements of the Model of Care will:

- Provide the full scope of care coordination services for all members and care management for select populations as defined by DMAS.
- Identify, assess, and stratify members with ongoing, emerging, and changing needs for care management at various intensity levels.
- Include comprehensive HRAs, individualized care planning, and interdisciplinary care team (ICT) involvement for members receiving care management services.
- Integrate physical health, behavioral health, pharmacy, LTSS and social service needs into the approach for the provision of care management services.
- Be responsive to the members' needs and preferences and consider members' health, safety and welfare.
- Include staff and provider training (in conjunction with DMAS whenever possible) on the Model of Care to ensure members receive person-centered, culturally competent care through trained care managers.
- Include processes and systems of care that engage members and family members in person-centered, culturally competent care and ensure seamless transitions between levels of care and care settings, addressing all barriers to accessing appropriate services to support member health.

Assessments and Reassessments

For members engaged in Care Management, Sentara Health Plans' Care Managers conduct comprehensive initial assessments to identify each member's health status, functional needs, strengths, preferences and goals, forming the foundation of the person-centered care plan. Reassessments are conducted at least annually and upon significant triggering events to identify changes in the members' needs or circumstances and to update the care plan accordingly.

Person Centered Individualized Care Plan (ICP)

Sentara Health Plans Care Managers work with members to develop a comprehensive, person-centered Individualized Care Plan (ICP). The ICP is based on the member's health needs,

preferences, and assessment findings and is developed using information from the Health Risk Assessment (HRA) and other relevant clinical and social factors. The ICP is tailored to support the member's medical, behavioral, and social needs. ICP development is based on the member's level of need and is completed within required program timeframes.

Providers may receive copies of the ICP to support coordination of care. Providers should use the ICP as a resource when delivering care and collaborate with the member's Sentara Health Plans Care Manager, as needed, to address the member's needs.

Interdisciplinary Care Team

Sentara Health Plans will establish 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 member of the ICT must have a defined role appropriate to their licensure and relationship with the member. Members are encouraged to identify individuals they want to participate in the ICT. The ICT must be person-centered and built on the member's specific preferences and needs, and must deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

A Sentara Health Plans care manager will lead the ICT. The care manager must ensure that the ICT includes the member and/or their authorized representative(s). The care manager must attempt to include in the ICT all entities rendering care and services as identified in the member's ICP and any of the following participants, at a minimum:

- PCP
- Other treating providers, as applicable
- Behavioral health clinician, as applicable
- LTSS provider(s) when the member is receiving LTSS
- Personal care (PC)/PDN provider for members receiving PC or PDN services under EPSDT
- 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)
- D-SNP or other plan care coordinator, as applicable
- Pharmacist, as applicable

As appropriate, and at the discretion of the member, the ICT also may include any or all the following participants:

- Representative from the Medicare plan, if applicable
- Registered nurse
- Specialist clinician
- PRTF staff providing care to the member when the member is in a PRTF (psychiatric residential treatment facility)
- 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

The member's assigned care manager will attend all ICT meetings. The care manager will provide reasonable and sufficient notice in advance of an ICT meeting to the member and other required attendees to maximize participation for planned ICT meetings. Input will be requested for inclusion in the ICT discussion from ICT members who are unable to attend the ICT in-person or via telephone or videoconference. Within 30 days of each ICT meeting, the care manager must ensure that there is documented evidence in the member's record accessible to all ICT participants summarizing the ICT meeting with the following information:

- Names, titles, and roles of each ICT participant in attendance.
- Names, titles, and roles of invitees that did not attend the meeting.
- Solicited input from required participants who were unable to participate in the ICT meeting and information provided through alternate means.
- Information discussed, outcomes of the ICT meeting and any additional information obtained through alternate means.
- If applicable, the member's refusal to participate in the ICT meeting.
- Review and discussion of the initial ICP, and any updates to it, developed by the care manager with the member.
- Outline of next steps (e.g., referrals or follow-up appointments or any information necessary for the purpose of care coordination or administration of benefits).

The care manager must send the summary of the meeting to the ICT members who were unable to attend the meeting and must ensure the summary is available electronically to the member and treating providers.

For most members assigned to low and moderate intensity care management, ICT meetings will be held at the member's and/or an ICT member's request. For members receiving CCC Plus Waiver services, members in nursing facilities, and members assigned to high intensity care management, ICT meetings will take place within 30 calendar days of:

- Completion of the initial ICP
- HRA reassessments
- Triggering events (as defined in the contract between DMAS and Sentara Health Plans)
    - Inpatient hospitalization or emergency department visit
    - Involuntary treatment episode
    - Use of behavioral health crisis services
    - Law enforcement involvement
    - Pregnancy
    - Transition from a nursing facility or psychiatric residential treatment facility to the community
    - Admission to or discharge from a psychiatric residential treatment facility
    - Loss of informal supports
    - Change in functional status
    - Loss of housing
    - Child welfare, child protective services or adult protective services involvement
    - Foster care involvement
    - Critical incident (as defined in the contract between DMAS and Sentara Health Plans)
- Readmissions to acute hospitals, psychiatric hospitals, or nursing facilities within 30 days of discharge
- Upon member request

Sentara Health Plans

Care Management with Transitions of Care (TOC)

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 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, or 60 calendar days for high-intensity care management and pregnant members.
- Allow members to see and continue seeing their out-of-network providers for the duration of the continuity of care period.
- Not change a member's existing provider before the end of the 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
    - Sentara Health Plans identifies performance issues that affect member's health or welfare.
    - Provider is excluded under state or federal exclusion requirements.
- Make reasonable efforts to contact out-of-network providers who are providing services to members, and provide them with information on becoming credentialed, in-network providers.
- Honor service authorizations issued by DMAS or its contractors for the duration of the service authorization or the duration of the continuity of care period, whichever comes first.
- Permit members, during continuity of care periods, to continue to receive medications and refills authorized by DMAS or another managed care organization.
- Provide coverage for any previously scheduled medical appointments, surgeries, DME, prosthetics, orthotics or other supplies determined to be medically necessary by DMAS and/or the member's previous managed care organization

Onsite transition-of-care staff are available to help with transitions at the following facilities: Sentara Norfolk General, Sentara Virginia Beach General, Sentara Leigh, Sentara Princess Anne, Sentara RMH, and VCU Hospital.

Carved-Out Services

Certain services are excluded from Sentara Health Plans' Medicaid managed care benefit and are reimbursed directly by DMAS on a fee-for-service (FFS) basis. Sentara Health Plans does not authorize or reimburse these services but supports coordination of care and access to related covered services.

Carved-out services include:

- Dental services.
- School-based services billed by local education agencies (LEAs).
- Services provided by tribal clinic providers.
- Developmental Disabilities waiver services, including when covered under EPSDT, such as targeted case management and transportation to/from waiver services (non-waiver services remain covered under Medicaid managed care).
- Independent Assessment, Certification, and Coordination Team (IACCT) services.
- Psychiatric residential treatment facility (PRTF) services, including per diem and required services.
- Therapeutic group home (TGH) services, including when covered under EPSDT.
- Treatment Foster Care Targeted Case Management.

Chiropractic Services

Chiropractic services are not a covered benefit for most adult Medicaid members. For members under 21, services that meet EPSDT medical necessity criteria are covered. FAMIS members have coverage for medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury, up to an annual dollar limit.

Dental Services

Routine dental services must be requested and authorized directly through DMAS.

For more information about dental services and the Smiles for Children program, visit the Cardinal Care Smiles website.

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 identified through an assessment indicating the need for 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.

DRG Inpatient Coverage

If Sentara Health Plans reimburses a facility using a Diagnosis-Related Group (DRG) methodology, coverage includes the full inpatient stay from admission through discharge, provided the hospitalization remains medically necessary. Coverage applies to members who are enrolled on the date of admission, even if enrollment changes during the hospitalization.

Provider services rendered during the inpatient stay are covered for dates when the member is enrolled with Sentara Health Plans.

Emergency Services

Emergency services are covered for all members and do not require prior authorization. Providers must follow applicable requirements for emergency medical conditions and stabilization of the member. Reimbursement is based on participating provider agreements and applicable payment methodologies. Providers must not bill members for covered emergency services.

Enhanced Benefits

Enhanced benefits are services offered by Sentara Health Plans that are in addition to covered Medicaid benefits. These benefits are designed to support members' overall health and well-being beyond the standard state plan services. Refer to the following website for a complete list and detailed description of available enhanced benefits.

Hearing Aid Services

NationsBenefits, LLC administers hearing aid services for eligible Medicaid members aged 21 and older. The benefit includes a $2,000 combined annual hearing aid allowance and access to a network of participating hearing care providers. Covered services include hearing aid evaluations, hearing aid fittings, and hearing aids. Additional benefit features include:

- Three follow-up visits with the original provider during the first year.
- A three-year repair warranty on covered hearing aids.
- Three years of batteries for non-rechargeable hearing aids, limited to up to 60 battery cells per ear, per year.

Coverage does not include implantable or disposable hearing aids. One-time replacement coverage is available for hearing aids that are lost, stolen, or damaged, subject to applicable member cost-sharing requirements.

For Medicaid members aged 21 and older, NationsBenefits, LLC reimburses provider claims for CPT codes 92590, 92591, 92592, and 92593, as well as applicable hearing aid HCPCS codes. Sentara Health Plans reimburses all other hearing-related CPT codes in accordance with plan guidelines. For members under 21, hearing services continue to be administered and reimbursed directly by Sentara Health Plans, and claims should be submitted to Sentara Health Plans.

Members may obtain additional hearing benefit information through NationsBenefits by calling 1-844-376-8637 or accessing hearing benefit resources online. Member support is available seven days a week from 8:00 a.m. to 8:00 p.m. local time. Language assistance services are available at no cost.

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 receive hospice services.

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

Hospital and Outpatient Services

Sentara Health Plans covers inpatient and outpatient hospital services, including services provided by general acute care hospitals, rehabilitation hospitals, rural health clinics, and federally qualified health centers, in accordance with DMAS requirements and Virginia Medicaid benefits. Covered services, consistent with Virginia Medicaid benefits, include preventive, diagnostic, therapeutic, rehabilitative, and palliative services. Authorization is required for inpatient hospital admissions, including acute care and inpatient rehabilitation services.

Immunizations/Vaccines

Sentara Health Plans covers immunizations in accordance with the most current Advisory Committee on Immunization Practices (ACIP) recommendations. Where applicable, Providers must administer immunizations according to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule and ensure that immunizations are reviewed and provided, as appropriate, at the time of the screening visit.

Providers must not routinely refer members to the local health department to receive immunizations and should provide immunizations within their scope of practice whenever possible.

Providers are encouraged to participate in the Virginia Vaccines for Children (VVFC) program administered by the Virginia Department of Health (VDH). For eligible Medicaid members, vaccines are supplied through the VVFC program. (FAMIS members are not eligible for the VVFC program.) For more information about the VVFC program or to enroll as a provider, contact the VVFC program at 1-800-568-1929 or visit the VVFC website.

To the extent possible and as permitted by state requirements, providers should participate in VDH's Virginia Immunization Information System (VIIS). VIIS is a centralized statewide immunization registry used to record and track immunizations, which supports accurate documentation and coordination of care. For more information, visit the VIIS website.

Sentara Health Plans supports efforts to improve immunization rates and works with providers to promote adherence to ACIP recommendations and EPSDT requirements.

Medical Supplies, DME, and Medical Nutrition

Medical supplies, durable medical equipment (DME), and nutritional supplements are covered when prescribed by a qualified practitioner and provided in accordance with DMAS requirements.

DME is covered based on medical necessity. While there are no maximum benefit limits, quantities and duration of use should align with DMAS guidelines. Requests that exceed typical utilization guidelines must include supporting clinical documentation.

Certain items, including specially manufactured equipment, require prior authorization in accordance with DMAS requirements. For service authorization requirements, refer to the Prior Authorization List or the member's benefit plan.

Additional information is available in the DME, Prosthetics, Orthotics and Supplies provider manual, available in the DMAS Provider Manuals Library.

Obstetrics and Gynecologic Services

Sentara Health Plans covers a broad range of obstetric and gynecologic services in accordance with DMAS requirements. Covered services include preventive, diagnostic, and medically necessary treatment services that support reproductive health, pregnancy-related care, and overall well-being.

Members aged 13 or older have direct access to a participating women's health specialist for covered routine and preventive services. This access is available in addition to the member's designated primary care provider, when applicable.

Members do not need a referral to obtain obstetric, gynecologic, or family planning services and may receive family planning services from any qualified provider.

Covered OB/GYN services include, but are not limited to:

- Routine and preventive gynecologic care, including annual exams, mammograms, and cervical cancer screening.
- BRAC genetic screening.
- Prenatal, delivery, and postpartum services.
- Family planning services, including contraceptive methods and sterilization procedures when covered.
- Certified nurse-midwife services.
- Certified and VDH-registered doula services.
- Lactation support; breast pumps and supplies.
- Behavioral health services related to pregnancy and reproductive health.
- Screening and treatment for sexually transmitted infections.
- Medically necessary diagnostic and treatment services related to the reproductive system.

Sentara Health Plans provides members and providers with information on the importance and timing of preventive care and recommended screenings.

Family Planning, Sterilization, and Hysterectomy

Sentara Health Plans covers family planning services that delay or prevent pregnancy. Members may obtain these services from any qualified provider without a referral. Coverage does not include infertility treatment or services intended to promote fertility. Coverage of abortion services is limited to circumstances allowed under Medicaid requirements.

Covered contraceptive methods include but are not limited to:

- Oral contraceptives
- Vaginal rings
- Contraceptive patches
- Long-acting reversible contraceptives (LARCs)

Sterilization procedures are covered for eligible members aged 21 and older in accordance with Medicaid requirements. A state-approved sterilization consent form must be signed at least 30 days before the procedure, and required documentation must be maintained.

A 30-day waiting period does not apply to hysterectomies that are not performed for the purpose of sterilization. Providers must inform the member when the procedure will result in permanent sterility and complete required documentation. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered.

Pregnancy and Postpartum Services

Providers must notify Sentara Health Plans when a member is identified as pregnant or postpartum. Sentara Health Plans covers pregnancy related and postpartum services, services to treat conditions that may complicate pregnancy, and prenatal and infant programs in accordance with coverage requirements.

Sentara Health Plans supports coordination of care for high-risk pregnant members and may provide expanded prenatal services for eligible members, including patient education, nutritional assessment and counseling, homemaker services, and blood glucose monitors when covered. Pregnancy-related and postpartum services are covered for up to 12 months following the end of pregnancy for eligible Medicaid and FAMIS MOMS members. FAMIS Prenatal Coverage provides comprehensive coverage during pregnancy and through 60 days postpartum.

If a member is discharged earlier than 48 hours after delivery, one early discharge follow-up visit is covered when criteria are met and must occur within 48 hours of discharge.

Prenatal and postpartum services do not require prior authorization, except for the Maternal Infant Care Coordination (MICC) program. Members may receive obstetrical care, family planning services, and MICC services from participating providers or qualified non-participating providers, including health departments and Planned Parenthood locations.

Providers should encourage timely postpartum follow-up and screen pregnant and postpartum members for depression. Members who screen positive should receive appropriate referrals, treatment, and follow-up. Participating obstetrical providers are responsible for coordinating care with hospitals and other providers involved in the member’s care and for notifying Sentara Health Plans when support with coordination of care or maternal health program participation is needed.

Services for Pregnant and Postpartum Members

Providers must promptly notify Sentara Health Plans when a member is identified as being pregnant or postpartum. When identified as a pregnant or postpartum member Sentara Health Plans will:

a. Inform the member that for the newborn to be covered, the member must be reported by calling Cover Virginia at (855) 242-8282 or by contacting their local Department of Social Services (DSS) office.
b. Ensure coverage of pregnancy-related and postpartum services, as appropriate based on eligibility, including services to treat conditions that may complicate pregnancy.
c. Cover prenatal and infant programs as required by DMAS.
d. Provide referrals to WIC.
e. Screen for behavioral health needs and coordinate referrals as needed.

Doula Services

Community-based doulas provide non-clinical support during pregnancy, labor and delivery, and the postpartum period. Services may include childbirth education, lactation support, and referrals for health or social services.

To provide covered services, doulas must meet applicable certification and Medicaid enrollment requirements. The current DMAS Doula Care Form must be completed before services begin. Covered doula services do not require prior authorization and are provided in accordance with current visit limits, postpartum timeframes, and billing requirements.

Licensed practitioners who may support access to doula services include physicians, licensed midwives, nurse practitioners, physician assistants, and licensed mental health professionals, in accordance with program requirements.

For more information, see the Doula Program Guide, available on the Sentara Health Plans Provider Orientation website.

Preventive Care

Sentara Health Plans supports the primary care provider (PCP) as the member's central source of care for preventive and routine health services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, physician assistants, nurse practitioners, and other providers who perform primary care functions. Clinics, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and health departments, may also serve as PCPs in accordance with DMAS requirements.

Routine preventive services for members under age 21 are covered under EPSDT.

Prosthetic Devices

Prosthetic devices, including artificial limbs, breast prostheses, and ocular prostheses, are covered when medically necessary in accordance with DMAS requirements. Orthotic devices are covered for members under age 21 and for adults when provided as part of an approved intensive rehabilitation program, in accordance with 12VAC30-60-120.

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, members have access to:

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

Sentara Health Plan's Relationship with the 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. Preauthorization will be required for requests for services from a provider not in network with Sentara Health Plans.

Early Intervention (EI) Services

EI services are covered for children from birth to age three who meet Virginia eligibility criteria, including:

- 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.

Eligibility is determined by the local lead agency, and services are authorized through the Individualized Family Service Plan (IFSP). Service authorization is not required for EI services, which address developmental needs across physical, cognitive, communication, social, emotional, and adaptive domains.

EI services are provided in accordance with the IFSP and delivered by qualified providers in the child's natural environment, such as the home or community-based settings. EI services must be provided by enrolled Sentara Health Plans providers and in accordance with DMAS requirements. Sentara Health Plans covers EI services included in the IFSP and coordinates with the care team to support timely access to services and transition planning, as appropriate.

The child's primary care provider (PCP) must approve the IFSP. A PCP signature on the IFSP, an accompanying letter, or an IFSP summary is required within 30 days of the initial service for reimbursement. If the PCP signature is not obtained within 30 days, reimbursement will begin on the date the signature is received.

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment

EPSDT is a Medicaid benefit for members under age 21 that provides coverage for medically necessary services to correct, ameliorate, or maintain physical and mental health conditions, including substance use disorders, in accordance with the Social Security Act §1905(a) and Virginia Medicaid requirements.

Sentara Health Plans covers all medically necessary EPSDT services, including services that may not otherwise be covered under the standard Medicaid benefit when needed to address a child's condition. Examples of covered services include:

- Behavioral health services
- Nursing and personal care services
- Pharmacy services
- Treatment of obesity
- Neurobehavioral and developmental services
- Other individualized treatments based on clinical need

Medical necessity for EPSDT services is determined on a case-by-case basis using current clinical standards. Services will not be denied when they meet EPSDT criteria solely because they are not covered under the standard benefit package. Services that meet EPSDT medical necessity criteria will not be denied solely as out-of-network, experimental, or noncovered, unless the service is specifically excluded or carved out of the EPSDT benefit.

EPSDT Screenings and Documentation

Providers must conduct EPSDT screenings in accordance with the American Academy of Pediatrics' Bright Futures periodicity schedule and document all screening components in the medical record. EPSDT medical screenings must include:

- Comprehensive health and developmental history, including physical and behavioral health.
- Unclothed physical examination.
- Vision, hearing, and dental screening.
- Nutritional assessment and growth measurements.
- Developmental screening using a standardized tool, as appropriate.
- Immunizations in accordance with guidelines from the CDC's Advisory Committee on Immunization Practices (ACIP) or as directed by DMAS.
- Age-appropriate laboratory testing, including blood lead screening as required.

EPSDT Treatment and Referrals

Providers must refer members for additional evaluation or treatment when a screening identifies a need. If a provider is unable to make an appropriate referral, Sentara Health Plans will assist with coordination of care, including scheduling and transportation when needed.

Referrals for children under age three with identified developmental delays must be made to the Infant and Toddler Connection of Virginia for Early Intervention (EI) services, and the referral must be documented in the medical record.

Sentara Health Plans will coordinate with DMAS, as needed, to ensure access to medically necessary follow-up services.

Former Foster Care Youth and Adoption Assistance Members

Sentara Health Plans covers services for members enrolled in Medicaid under the Former Foster Care Youth (FFCY) and Adoption Assistance (AA) programs. Coverage includes all medically necessary services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Sentara Health Plans provides Care Management and works collaboratively with the Department of Social Services (DSS), members, and caregivers to support coordination of care and access to services. For AA members, Care Management is conducted with the adoptive parent. For FFCY members, Care Management is conducted directly with the member.

Providers should ensure that members receive timely access to care, including a primary care provider (PCP) visit and a dental visit within 30 days of enrollment when appropriate.

Members may change health plans at any time in accordance with program requirements.

Telemedicine and Telehealth

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

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) is defined as the use of digital technologies to collect medical and other forms of health data from patients in one location and electronic transmission of 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 including, but not limited to, weight, blood pressure, pulse, pulse oximetry, blood glucose treatment adherence monitoring, and communication of updates to the care plan with or without digital image upload.

Sentara Health Plans covers telemedicine and telehealth services when medically necessary and ensures they are provided with the same amount, duration, and scope of services covered under the Medicaid fee-for-service program. Sentara Health Plans does not require providers to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

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

Sentara Health Plans encourage the use of telemedicine and telehealth to promote community living and improve access to health services. A health care provider duly licensed by the Commonwealth of Virginia who provides health care services exclusively through telemedicine services is not required to maintain a physical presence in the Commonwealth of Virginia in order to be considered eligible for enrollment as a Medicaid provider. Telemedicine services provider groups with health care providers duly licensed by the Commonwealth are not required to have an in-state service address to be eligible to enroll as a Medicaid vendor or Medicaid provider group.

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) and 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 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 additional store-and-forward applications, including but not limited to, tele-dermatology and tele-radiology.
- Remote patient monitoring (RPM).
- Audio-only services.
- Provider-to-provider consultations as covered by the Medicaid fee-for-service program.
- Virtual check-ins with patients.
- The ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the member's PCP.

DMAS guidance on coverage for the above-listed telehealth services is described in previously published Medicaid memoranda, provider manuals, and regulations and is updated as new authorities and funding are provided to DMAS. Sentara Health Plans will 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 Cardinal Care 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 DMAS model of care requirements.

Therapy Services (PT, OT, SLP, Audiology)

Sentara Health Plans covers physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and audiology services when medically necessary and provided in accordance with DMAS requirements. Services are covered in inpatient, outpatient, rehabilitation, and home health settings and may be provided for acute and non-acute conditions. Comprehensive Outpatient Rehabilitation Facility (CORF) services are covered when provided by appropriately certified facilities. Authorization is required for acute inpatient rehabilitation services.

Coverage is based on medical necessity. While there are no maximum benefit limits, services must align with applicable clinical guidelines and member needs.

Transplant Services

Transplant services are covered in accordance with DMAS requirements, including medically necessary donor procurement services. Coverage varies based on the member's age and the type of organ or transplant service. Transplant services for members under age 21 are covered in accordance with EPSDT requirements.

Members must receive transplant services from approved facilities. Sentara Health Plans coordinates referral to appropriate transplant providers to ensure access to care.

Trauma-Informed Care

Sentara Health Plans supports a trauma-informed approach that recognizes the impact of trauma and adverse experiences on a member's health and well-being. Providers are encouraged to deliver care that is sensitive to trauma, supports individual strengths and resilience, and promotes physical and emotional safety.

Providers are encouraged to complete trauma-informed care training available on the Sentara Health Plans Provider Education website.

Vision Coverage

Each covered individual may receive an eye exam every 12 or 24 months, depending on the member's vision benefit through their vision vendor.

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.

Sentara Health Plans contracts with mobile vision providers, including providers of mobile vision services provided to eligible children on school grounds in localities where local school divisions or schools have written agreements with mobile vision providers. Mobile vision providers will provide comprehensive vision services. Mobile vision services are provided without any service authorization requirements.

Waivers

DMAS operates two types of waivers: the Commonwealth Coordinated Care (CCC) Plus HCBS Waiver and the Developmental Disabilities (DD) Waivers. Sentara Health Plans supports members enrolled in these waivers in accordance with DMAS requirements.

Commonwealth Coordinated Care Plus Waiver

The Commonwealth Coordinated Care (CCC) Plus waiver provides home and community-based services (HCBS) for individuals who are aged, have disabilities, or are technology-dependent and meet nursing facility level of care criteria. These services support members in receiving care in their home or community and help prevent institutionalization.

Sentara Health Plans coordinates covered Medicaid benefits for CCC Plus members, including medical, behavioral health, and long-term services and supports (LTSS), and works with members and providers to support access to medically necessary services, including private duty nursing when applicable.

For more information about CCC Plus waiver enrollment and covered services, refer to the DMAS CCC Plus Waiver website or the CCC Plus Waiver manuals available in the DMAS Provider Manuals Library.

Long-Term Services and Supports

Long-Term Services and Supports (LTSS) are provided to members of all ages with functional limitations and/or chronic conditions to support their ability to live and work in the setting of their choice. Services may be delivered in the home, community, residential settings, or institutional settings.

The LTSS program:

- Uses a person-centered approach to integrate physical health, behavioral health, and social services.
- Supports member choice and rights.

- Engages members and caregivers in care planning.
- Promotes continuity of care across settings and services.

LTSS Eligibility and Service Authorization

Eligibility for LTSS is determined through completion of the Uniform Assessment Instrument (UAI) and other required DMAS forms by designated screening entities in accordance with DMAS requirements. Members must meet level of care criteria and other program requirements to qualify for services.

LTSS services require authorization in accordance with DMAS requirements. Authorizations are based on the member's assessed needs and documented in a person-centered service plan. Continued services require periodic reassessment and authorization updates in accordance with DMAS guidelines.

Required forms are available from the DMAS Forms Library.

Patient Pay for LTSS

Patient pay is the member's financial contribution toward the cost of LTSS when income exceeds allowable limits. Patient pay is determined by the Department of Social Services (DSS). Patient pay is not a copayment, deductible, or coinsurance. Not all members receiving LTSS will have a patient pay obligation.

Private Duty Nursing (PDN)

Sentara Health Plans covers medically necessary private duty nursing (PDN) services for members under age 21 in accordance with DMAS EPSDT Nursing Supplement requirements (see the DMAS Provider Manuals Library). PDN services are also covered for members aged 21 and older who meet criteria for the technology-dependent subgroup and have complex medical needs.

PDN is intended for members who require continuous skilled nursing services that cannot be met through home health services. PDN differs from home health nursing, which provides short-term, intermittent care focused on treatment and caregiver education. PDN services require a level of need that includes ongoing nursing assessment, monitoring, and skilled interventions.

Nursing Facility Services

Sentara Health Plans covers skilled and intermediate nursing facility (NF) services for Medicaid members, including members dually eligible for Medicaid and Medicare after Medicare-covered benefits are exhausted. Sentara Health Plans reimburses NFs directly for covered services.

Sentara Health Plans works with NFs to support quality care by:

- Supporting efforts to reduce avoidable hospitalizations
- Ensuring members have access to medically necessary medical and behavioral health services

NFs must work with Sentara Health Plans to support care planning and coordination for members receiving NF services, including participation in care plan meetings when requested.

Developmental Disability Waivers

DMAS operates three Developmental Disabilities (DD) waivers: Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS). Individuals enrolled in one of these DD Waivers receive waiver services through Medicaid fee-for-service, as these services are carved out of managed care.

Sentara Health Plans covers and coordinates non-waiver services for these members, including acute care, behavioral health, pharmacy, and non-waiver transportation services. Sentara Health Plans works with members, waiver service coordinators, and providers to support continuity of care across covered services.

For more information about DD waiver enrollment and covered services, refer to the DMAS DD Waivers website or the DD Waiver manuals available in the DMAS Provider Manuals Library.

Sentara Health Plans

Section VI: Behavioral Health and ARTS

Sentara Health Plans contracts with licensed behavioral health providers to provide an array of behavioral health and substance use services covered by Virginia Medicaid. For additional details regarding the services outlined in this section, please visit the following sources:

- Sentara Health Plans Behavioral Health Provider Resources website.
- The Behavioral Health Information for Providers page of the DMAS website.
- The following Provider Manuals, available in the DMAS Provider Manuals Library:
  - Mental Health Services.
  - Psychiatric Services.
  - Residential Treatment Services.
  - Addiction and Recovery Treatment Services (ARTS).

The chart below provides a partial listing of Outpatient Behavioral Health Services. For a comprehensive and up-to-date list, please refer to the relevant Provider Manual and the Behavioral Health Information and Provider Map page of the DMAS website.

Service Names	Procedure/Assessment Code and Modifiers*
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
Mental Health Skill-building (MHSS) Assessment	H0032 U8
Intensive In-home (IIH)	H2012
Intensive In-home (IIH) Assessment	H0031
Psychosocial Rehabilitation	H2017
Psychosocial Rehabilitation Assessment	H0032 U6
Mental Health Peer Support Services – Individual	H0024
Mental Health Peer Support Services – Group	H0025
Mental Health Intensive Outpatient (MH-IOP)	S9480
Mental Health Partial Hospitalization Program (MH-PHP) – Community-Based Clinic Program and Hospital Based	H0035
Mobile Crisis Response	H2011, Multiple modifiers
Community Stabilization	S9482, Multiple modifiers
23-hour Crisis Stabilization (not under EDO or TDO)	S9485
Residential Crisis Stabilization (not under ECO or TDO)	H2018
Multisystemic Therapy (MST)	H2033, Multiple modifiers
Functional Family Therapy (FFT)	H0036, Multiple modifiers
Applied Behavior Analysis (ABA)	97151-97158, Multiple modifiers
ABA Behavior Identification Supporting Assessment	0362T, Multiple modifiers
ABA Adaptive Behavior Treatment with Protocol Modification	0373T, Multiple modifiers

*Modifiers should **only** be applied during the claim submission process

Behavioral 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. To determine if a service requires authorization, please refer to Sentara Health Plans' searchable Prior Authorization List. Authorizations may be submitted via the Sentara Health Plan provider website or faxed to the Behavioral Health department with a completed service authorization form. In this manual, refer to the "Sentara Health Plans Key Contact Information" section for Behavioral Health fax numbers, and the Service Authorization Decision Timeframes for the Medicaid Program section for turnaround times on service requests.

Providers must obtain 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 from the Sentara Health Plans Behavioral Health Prior Authorization Forms for Government Plans website and the Behavioral Health Provider Resources page of the DMAS website.

Behavioral Health Residents in Training and Supervisees

Residents in counseling and supervisees in social work practice under the supervision of a licensed clinical supervisor and pursuant to a board-approved supervisory agreement. They may work with populations within the scope for which their supervisor is licensed and credentialed. The supervisor shall assume full responsibility for the clinical activities of the resident or supervisee as defined in the supervisory contract, regardless of whether the supervisor is on-site or off-site.

During resident or supervisee sessions, providers must comply with all requirements of their applicable licensing agency and any educational facility or training program providing oversight for the residency program, including requirements related to documentation, supervision, review of clinical records, etc.

Billing for services provided under supervision must be submitted in accordance with Medicaid requirements, with the supervising provider's individual NPI listed as the rendering provider.

Residential Treatment Services

Residential treatment services include Psychiatric Residential Treatment Facility (PRTF) services (Level C) and Therapeutic Group Home (TGH) services (Levels A and B). These services are administered by DMAS' behavioral fee-for-service (FFS) contractor.

Youth who are admitted to a PRTF remain enrolled with their Medicaid Managed Care Organization (MCO), such as Sentara Health Plans, during their stay. While the PRTF per diem is paid by DMAS through the FFS program, ancillary services outside the per diem—such as physician services, dental and pharmacy services—are covered by the member's MCO.

Youth in PRTFs will have an assigned Sentara Health Plans Care Manager who assists with coordination of non-PRTF services as well as Behavioral Health services at discharge. The PRTF retains primary responsibility for arranging necessary services included in the per diem, as well as care coordination within the facility and discharging planning, in coordination with the Sentara Health Plans Care Manager. Service authorization and Independent Assessment Certification and Coordination Team (IACCT) assessments for PRTF services continue to be managed by the DMAS FFS contractor.

Members admitted to a therapeutic group home (TGH) are not excluded from the Medicaid managed care program. TGH services are authorized through the DMAS service authorization contractor. While a member resides in a TGH, Sentara Health Plans is responsible for covering and coordinating Medicaid-covered services, including transportation and pharmacy services, and providers must coordinate care with Sentara Health Plans.

For members admitted to residential treatment centers for substance use disorder (SUD), all services remain covered under the Medicaid MCO program. Providers must coordinate with Sentara Health Plans for authorization, service delivery, and billing of both residential and ancillary services.

Addiction and Recovery Treatment Services

The Addiction and Recovery Treatment Services (ARTS) benefit is an enhanced substance use disorder (SUD) benefit of the Virginia Medicaid program. The ARTS benefit provides access to addiction treatment services for enrolled members, including community-based services, inpatient detoxification, and residential SUD treatment. The ARTS benefit is designed to ensure access to sufficient continuum of care to support effective treatment and recovery.

The chart below provides a partial listing of ARTS. For a comprehensive and up-to-date list, please refer to the relevant Provider Manual and the Behavioral Health Information and Provider Map page of the DMAS website.

ASAM Description	ASAM Level	CPT Code (with Modifier*)
Medically managed intensive inpatient services	4.0	H0011 Rev 1002
Clinically managed high-intensity residential services: Adult	3.7	H2036 Rev 1002 (HB)
Clinically managed medium-intensity residential services, Adolescent	3.7	H2036 Rev 1002 (HA)
Clinically managed high-intensity residential services: Adult	3.5	H0010 Rev 1002 (HB)
Clinically managed medium-intensity residential services: Adolescent	3.5	H0010 Rev 1002 (HA)
Clinically managed population-specific high-intensity residential services	3.3	H0010 Rev 1002 (TG)
Clinically managed low-intensity residential services	3.1	H2034
Partial Hospitalization services	2.5	S0201 or Rev 0913 with S0201

Intensive Outpatient Services	2.1	H0015 or Rev 0906 with H0015
Outpatient Services	1.0	See DMAS manual
Opioid Treatment Program (OTP)	N/A	See DMAS manual
Office-based Addiction Treatment (OBAT)	N/A	See DMAS manual
Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	N/A	See DMAS manual
Substance Use Disorder Case Management	N/A	H0006
Peer Support Services, Individual/Group	N/A	T1012 / S9445

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

Sentara Health Plans' ARTS criteria are consistent with the DMAS ARTS benefit requirements. ARTS providers are responsible for complying with applicable requirements outlined in the DMAS ARTS manual, this Provider Manual, their Sentara Health Plans Provider Agreement, and all applicable state and federal regulations. ARTS services must be delivered at the most appropriate level of care in accordance with ASAM criteria.

Additional information regarding ARTS services, including authorization requirements, provider qualifications, covered services, Utilization Management, and service limitations, can be found in the DMAS ARTS Manual available in the DMAS Provider Manuals Library.

Disclosure of Protected Health Information

Providers must ensure compliance with applicable confidentiality and redisclosure requirements. Federal law (42 CFR Part 2) provides additional protection for records related to substance use disorder (SUD) treatment, including those records identifying a member as having SUD or receiving treatment. In most cases, patient consent is required to disclose Part 2-protected information. Current regulations permit consent for use and disclosure for treatment, payment, and healthcare operations, consistent with federal requirements.

Providers should consult their legal counsel for guidance regarding these requirements.

Provider Participation Requirements

ARTS providers must meet applicable requirements outlined in the ASAM Criteria (Third Edition or most current version, as adopted by DMAS), DMAS regulations, and the current DMAS ARTS Provider Manual, available in the DMAS Provider Manuals Library.

To participate with Sentara Health Plans, providers must:

- Be enrolled with DMAS, including registration in the PRSS Portal, as applicable.
- Be credentialed and contracted with Sentara Health Plans.
- Hold appropriate licensure through the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and, where applicable, registration or licensure through the Virginia Department of Health Professions (DHP).

ARTS provider types include:

- Opioid treatment programs (OTP)
- Office-based opioid treatment (OBOT)
- Case management
- Peer recovery support services
- Inpatient detoxification
- Residential treatment
- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)

ARTS Service Authorization and Registration

Providers must verify member eligibility and benefits prior to initiating services. Certain ARTS services require authorization or registration before services are provided. Providers should refer to the Sentara Health Plans Prior Authorization List for current requirements.

Authorization must be obtained for applicable services prior to initiation. Requests submitted after services have been rendered may result in an adverse determination.

Service authorization and extension requests must support the requested ASAM level of care. Requests that do not meet medical necessity criteria will not be approved.

ARTS authorization and registration requests must be submitted using the appropriate forms and processes for Government plans outlined on the Sentara Health Plans Behavioral Health Provider Resources website. Additional information may also be found on the ARTS Authorization and Registration page of the DMAS website.

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 Sentara Health Plans 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. Sentara Health Plans performs an annual review on all providers to assure that the health care professionals under contract with each provider are qualified to provide ARTS and that the services are being provided in accordance with the Cardinal contract, ASAM criteria, 12 VAC

30-130-5000, and the DMAS ARTS Provider Manual, Sentara Health Plans requirements, and DBHDS licensing requirements for ASAM Levels of Care.

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

Refer to the applicable Provider Manual from the DMAS Provider Manuals Library and Sentara Health Plans Manuals for billing instructions, claims submission, and units of service requirements.

Providers may submit paper or electronic claims, including through Availity or any clearinghouse that connects to Sentara Health Plans.

Telehealth Services

Telehealth services are covered under specific criteria for both behavioral health and ARTS when provided in accordance with applicable DMAS and Sentara Health Plans policies, including the most current version of the Telehealth Services Supplement. Providers should refer to the DMAS Telehealth Services webpage and Sentara Health Plans resources for service-specific requirements.

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT) to behavioral health and ARTS is a covered benefit. Providers should refer members to the designated transportation vendor at 1-877-892-3986 or to the member's Sentara Health Plans Care Manager to arrange services or for assistance with scheduling.

Continuity of Care

If a member's Medicaid MCO changes while receiving services, the member may continue with their current behavioral health provider for up to 30 days (or up to 60 days in certain circumstances, as determined by Sentara Health Plans). Service authorizations in place prior to enrollment with Sentara Health Plans will be honored for their approved duration or through the continuity of care period, whichever occurs first. Authorizations may be extended, as appropriate, to support a safe and effective transition to a qualified in-network provider. DMAS may extend continuity of care timeframes at its discretion.

Behavioral Health Out-of-Plan Authorizations

Members may receive services from out-of-network behavioral health or ARTS providers when Sentara Health Plans in-network providers are unavailable or unable to meet the member's needs. Service authorization is required for all non-emergent out-of-network services prior to initiation. For emergent or urgent services, authorization may be requested while services are being provided. See the "Out-of-Plan Authorizations" section of this manual for additional information.

Sentara Health Plans

Section VII: Health and Preventive Services

Member Services

Specific interventions are available to members so they can increase preventive health practices and decrease identified health risks.

The patient identification manager (PIM) reminder system is a computer-based direct mail program designed to reach members and providers monthly to promote health. These initiatives support HEDIS improvement requirements. Mailings and communications may include:

- **Birthday Cards** – Plan members who have an email on file will receive a birthday e-card during their birth month from Sentara Health Plans. Their birthday message encourages them to complete preventive health screenings that are applicable to their gender and age.
- **Healthy Pregnancy Mailings** - Once the health plan learns of a member's pregnancy, the member receives communication from the health plan. Our messages include pregnancy resources and tips for mothers-to-be.

Health and preventive services by Sentara Health Plans offer health improvement programs, which include health risk identification and risk reduction strategies. Members may complete an online personal health assessment (PHA) and generate an immediate detailed report with specific risk-reduction strategy recommendations. A shorter report that can be taken to their healthcare provider is also available. Diabetic, asthmatic, those with cardiovascular disease, and pregnant health plan members are also referred to our clinical care services teams.

Health Risk Reduction Programs

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

Digital Lunch-and-Learn Webinars/Podcasts

As part of our ongoing effort to address relevant and timely risk-reduction education, our team of health educators hosts free, monthly webinars on a range of well-being topics. Available here, this series is open to all members. Past webinars are archived for viewing anytime topics include Tobacco Use and Cholesterol and Blood Pressure; Probiotics and Gut Health; Planting Your Money Tree; The Importance of Water Intake; Becoming Mindful, Not Mind Full; and Sleep Deprivation and Heart Health.

Individual Self-Paced Programs

Our unique, self-paced, and award-winning individual wellness programs are offered at no cost to all Sentara Health Plans members. Members can visit the Prevention and Wellness page to view programs on demand. The programs use a variety of media to engage the member in learning about the risks and benefits of their behavior and offer tools for the member to take charge and make healthy changes including:

- Healthy Heart Yoga: Yoga programs include stretching and strengthening exercises to help improve flexibility, strength, and cardiovascular health. Chair yoga is also available.
- Eating for Life: This award-winning educational program helps participants develop healthy eating and exercise habits.
- Guided Meditation – A Journey Toward Health: This program invites listeners to experience a calm, peaceful retreat from everyday stressors.
- Qigong: This program helps your body to relax mentally and physically. The movements of this ancient practice enhance blood flow, release muscle tension, and improve balance.
- Stay Smokeless for Life: This education and support program helps people who want to quit using tobacco.
- MoveAbout: This program focuses on increasing regular activity. It includes information to incorporate movement into daily activities.
- Healthy Habits, Healthy You: This educational program offers helpful ways to prevent Type 2 diabetes and heart disease by making healthy food choices, managing body weight, exercising, and finding ways to relax and get more sleep.

Health Education and Coaching Services

MyLife MyPlan Connection (powered in partnership with WebMD)

Through a partnership with WebMD® Health Services, we offer our members flexible programs, expert guidance, and inspiration to take charge of their health—whether they are continuing healthy behaviors or making a change to improve their health. Sentarahealthplans.com and the Sentara Health Plans mobile app provide direct connection to each member's personalized WebMD Health Services online portal, streamlining how members can access the tools and education they need to sustain healthy behaviors. It all begins when the member completes a personal health assessment, which creates the foundation for their health record and coaching program. The online portal also offers a comprehensive activities tool known as Daily Habits. The Daily Habits tool delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy behaviors in a fun way.

Personal Health Assessments (PHA)

The PHA is an advanced health profiling/risk assessment tool that scores an individual's health status, calculates risk levels, and provides recommendations for health improvement and behavior change. It takes approximately 12 minutes and is conveniently available for desktops, laptop, tablet, and mobile. Features include simple language for easy reading, gaming technology to drive engagement, and helpful "coach-like" notes.

The assessment analyzes different health risk factors that affect an individual's health and well-being. These factors fall into personal health status and lifestyle choices and habits. Based on an individual's responses, they receive a personalized score on 11 modifiable risk factors and the likelihood they will develop certain medical conditions.

A results summary screen with the participant's score, personalized steps to improve health, and risk and condition reports are the first thing the member sees upon completing their health assessment. Program recommendations include other wellness services such as telephonic or digital health coaching or referral to one of our disease management programs. The objective is to guide individuals to the appropriate programs and resources and serve as the foundation for

overarching health and benefits management strategy. All reports are available for printing, including a physician-specific report that the member can take to their annual physician visit.

Member Dashboard with Personalized Risk Education

A member's wellness portal dashboards feature a dynamic display highlighting articles, resources, and personalized recommendations based on the information the member has provided. For instance, if the member has identified a goal or issue related to stress, they will see content related to stress management, or if the member indicated a high BMI on their health assessment, they would see content related to losing weight.

Fitness Device Integration

Our wellness portal offers the ability to integrate a variety of biometric device brands, including (but not limited to) Adidas, Apple Health, Fitbit, Garmin, Google Health, iHealth, Jawbone, Life Fitness, Medisana, Microsoft, Misfit, Moveable, Nokia, Oura, Polar, Suunto, Sync, Telcare, TomTom, Under Armour, Withings, and YOO. The portal also offers integration with many fitness apps such as Adidas, Daily Mile, Garmin, iHealth, Jawbone, MapMyFitness, Moves, Nokia Healthmate, RunKeeper, Strava, Suunto, and Withings. When a device is linked to the WebMD portal, the information collected on the device flows seamlessly into various programs in the well-being platform.

Diabetes Prevention Program

Available to Sentara Health Plans members, our health coaching model is a participant-centered, whole-person approach to behavior change. The program was developed to improve member health using motivational interviewing and solution-focused goal setting. By setting reasonable, attainable goals, the program helps participants take a systematic approach to increasing and incorporating healthy behaviors into their daily lives.

Available at various levels—as determined by the outcome of the member's health assessment—our health coaching covers low, moderate, and high-risk individuals and has options for more intensive tobacco cessation and weight management coaching modules.

CoachConnect is an email-based communication tool that allows members to communicate at a time convenient to them. Telephonic health coaching provides an additional avenue for members to engage in coaching services for our fully insured groups.

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

In partnership with Omada Health, Sentara Health Plans offers members who qualify a digital, lifestyle-change program focused on reducing the risk of obesity-related chronic disease. This program combines the latest technology with ongoing support so participants can make changes that matter most to improve their health. The program includes a wireless smart scale, weekly online lessons, professional health coaching, and small online peer groups that offer

real-time support. Members can determine if they qualify for the program by visiting Omada and completing the online screening tool.

Resources

Sentara Health Plans offers several resource libraries that host up-to-date information to help answer members' health and medication questions. With thousands of articles and helpful tools, such as health education videos, recipes, and quizzes, members can easily find trusted answers through our wellness portal.

Communications

Health and preventive services contribute health information and current preventive health initiatives to the Sentara Health Plans provider newsletter and other Sentara Health Plans publications.

Sentara Health Plans

Section VIII: Pharmacy

Pharmacists as Providers

In accordance with Virginia Code § 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 of Pharmacy in collaboration with the Board of Medicine and the Department of Health and set forth in Board of Medicine regulations.

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 regulations and protocols. This includes, but is not limited to, obtaining the appropriate training and properly maintaining 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 those drugs with Food and Drug Administration (FDA) approval, and their manufacturer participates in the Medicaid Drug Rebate Program (MDRP).

Sentara Health Plans require 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 by 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 FIDE SNP members who have a pharmacy benefit covered by a Medicare Part D plan. Medicaid Dual-eligible FIDE SNP members have additional pharmacy coverage under a non-Part D/over-the-counter (OTC) listing. This list covers non-Part D medications as well as some select OTC coverage. The DMAS PDL is not an all-inclusive list of drugs.

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.

Over-the-Counter (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 service authorizations, step-edits, and quantity limits. These drugs may be rejected at the pharmacy without a service authorization in the system. Service 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. Service 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 here.

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.

Service Authorization Process

In the event a drug has restrictions, and no substitution can be made, a service authorization is required.

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 is 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 receipt of a request for service authorization.

If the decision results in a denial, a Notice of Action will be issued to the prescriber and the member within 24 hours of the denial. The Notice of Action includes appeal rights and instructions for submitting an appeal in accordance with the requirements described in the DMAS Medicaid 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, if the pharmacist, in his/her professional judgment consistent with the current standards of practice, determines that the member's health would be compromised without the benefit of the drug. 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. For unit-of-use drugs (i.e., inhalers, eye drops, insulin, etc.), the entire unit should be dispensed for the 72-hour supply.

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 HCPCS 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 five 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. Use of LARCs should be encouraged and barriers such as service authorization or quantity limits must not be required for approval

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 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.

Medication Therapy Management

Sentara Health Plans Medicaid members may be offered participation in the Medication Therapy Management (MTM) program, which is designed to enhance medication adherence, safety, and effectiveness. The program promotes collaboration among providers, pharmacists, and members to ensure that prescribed medications are used appropriately. Eligible members receive written information about the program and have the opportunity to opt out. The MTM program is delegated to Sentara Health Plans' Pharmacy Benefit Manager (PBM), who administers it through an external vendor under PBM oversight.

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 service 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 Behavioral Health and ARTS section of this provider manual.

Specialty Drugs

Sentara Health Plans

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.

Sentara Health Plans

Section IX: Quality Improvement

Overview

Through its commitment to excellence, Sentara Health Plans has developed an ongoing comprehensive program directed toward improving the quality of care and services, safety, access, transition of care, health disparities, timeliness, 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 to continuously improve the health of our members.

Sentara Health Plans' network and affiliated providers are required to comply with the health plan's QI Program and actively participate in QI initiatives that support improvements in quality of care and services, access and availability of care, and member experience and satisfaction. Providers' contracts require cooperation with the organization's QI activities to enhance care quality, service delivery, and the member experience. This cooperation includes the collection and evaluation of data, as well as participation in the organization's QI programs and initiatives.

National Committee for Quality Assurance (NCQA) Accreditation

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

Healthcare Effectiveness Data and Information Set (HEDIS®)

Healthcare Effectiveness Data and Information Set (HEDIS) is the measurement tool used by health plans to evaluate their performance in terms of clinical quality and customer service. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare healthcare quality.

HEDIS performance measures are a part of the NCQA accreditation process. Some of the major areas of performance measured by HEDIS are:

- Effectiveness of care.
- Access/Availability of care.
- Experience of care.
- Utilization and risk-adjusted utilization.
- Health plan descriptive information.
- Measures reported using electronic clinical data systems.

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

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are adopted to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. Sentara Health Plans adopts and disseminates CPGs relevant to its membership for the provision of preventative, acute and chronic medical and 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 fields.
- Consider the needs of the members.
- Are reviewed and updated, at a minimum, every two years, or more often, as appropriate.
- Are adopted in consultation with contracted health care professionals.
- Are disseminated to practitioners and members upon adoption, revision and request.
- Are used to provide a basis for utilization decisions, member education, and service coverage.
- Do not contradict existing Virginia-promulgated regulations or requirements as published by the Department of Social Services (DSS), Department of Health (DOH), Department of Health Professions (DHP), Department of Behavioral Health and Development Services (DBHDS), or other state agencies, as applicable.

Sentara Health Plans requires that network providers utilize appropriate evidence-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 meet 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 and treatment decisions are always to be made by the practitioner based on their best medical judgement considering each patient's clinical situation. The Sentara Health Plans guidelines 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 Quality Improvement and Member Safety Team at 757-252-8400, Option 1, or toll-free at 1-844-620-1015. CPGs are also available online via the Sentara Health Plans website.

Sentara Health Plans Quality Improvement 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.

With the application of Continuous Quality Improvement (CQI) principles, Sentara Health Plans aims to provide high-quality cost-effective care that enables members to remain healthy, manage chronic illnesses and/or disabilities, and maintain or improve members' quality of life. Improvement in health status can be demonstrated by measurable 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, Define-Measure-Analyze-Improve-Control (DMAIC), Root Cause Analysis (RCA), and Plan, Do, Study, Act (PDSA). The QI Program is a population-based plan that acts as a road map in addressing common physical and behavioral health conditions identified within our population.

The Sentara Health Plans QI Program activities include:

- Identifying performance goals.
- Establishing internal and external benchmarks.
- Collecting data and establishing baseline measurements.
- Analyzing outcomes for barrier identification for performance improvement.
- Developing and implementing written remedial/corrective action, as needed.

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 reflects the population served in terms of factors including, but not limited to, 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.

The QI Program uses the Institute for Healthcare Improvement (IHI) Quintuple Aim, DMAS Quality Strategy, CMS guidelines, State and Federal Mandates, Bureau of Insurance (BOI), and NCQA Standards as guiding principles to shape the QI Program efforts and provide the highest quality of care to better serve Sentara Health Plans' members and the community. The scope of the QI Program includes oversight of all aspects of clinical and administrative services provided to Sentara Health Plans members, including:

- Program design and structure.
- Quality improvement activities that comply with CMS, NCQA, DMAS, and other regulatory entities, including contractual and regulatory reporting requirements.
- Care Management (to include Complex Case Management, Behavioral Health, Care Transitions, and End of Life Planning) and Chronic Care Management programs that are member-centric and address the healthcare needs of members with complex medical, physical, and mental health conditions, assessments of drug utilization for appropriateness and cost-effectiveness.

- Utilization Management focuses on providing the appropriate level of service to members.
- Grievances and appeals.
- High-quality customer service standards and processes.
- Benchmarks for preventive, chronic, and quality of care measures.
- Credentialing and re-credentialing of physicians, practitioners, and facilities.
- Compliance with NCQA accreditation standards.
- Audits and evaluations of clinical services and processes.
- Development and implementation of clinical standards and guidelines.
- Measuring effectiveness.
- Evidenced-based care delivery.
- Potential quality of care and safety concerns.

Each year, Sentara Health Plans develops a QI Program Description, Quality Annual Evaluation, and Work Plan that outlines efforts to improve clinical care and service to members.

The Sentara Health Plans QI Program Description, Annual Evaluation, and Work Plan is a comprehensive set of documents that serve 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. Providers may request a copy of the current QI 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 primary objective of Sentara Health Plans' QI Program is to continuously improve the quality of care provided to enhance the members' overall health statuses. Improvement in health status is measured through Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure data, 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 annual QI 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 quality of care concerns.
- 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.
- Report relationships between QI department staff and the QI committee and subcommittee structure.
- Provide resource and analytical support.

- 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 Quality Improvement Committee (QIC) or a subcommittee that reports to the QIC.
- 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 the QI committee and how participating practitioners are representative of the specialties in the organization's network, including those involved in QIC subcommittees.
- Outline Sentara Health Plans' approach to addressing the cultural and linguistic needs of its membership.
- Provide guidance on how to report member critical incidents (inclusive of quality of care, quality of service, and sentinel events).
- Provide training materials for providers and Sentara Health Plans employees on cultural competency, bias, and/or diversity and inclusion.
- Coordinate performance measure monitoring for improvement and sustainability.
- Utilize performance measure data for continuous quality improvement (CQI) activities.

Data Sharing for Quality Improvement

Providers, including behavioral health providers, are expected to support timely, accurate data sharing with the health plan to support quality improvement activities, care coordination, regulatory and accreditation requirements, and HEDIS measure reporting. Data sharing may include clinical, claims, pharmacy, encounter, admission/discharge/transfer, readmission, follow-up care, screening, and treatment-related information needed to evaluate member access, continuity of care, outcomes, and performance improvement opportunities.

Data sharing supports evaluation and reporting for behavioral health and non-behavioral health related HEDIS measures, including, but not limited to:

- Follow-up after hospitalization for mental illness.
- Initiation and engagement of alcohol and other drug abuse or dependence treatment.
- Pharmacotherapy for opioid use disorder.
- Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults.
- Adherence to antipsychotic medications for individuals with schizophrenia.
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.
- Plan all-cause readmissions.
- Follow-up after emergency department visit for substance use.
- Follow-up after high-intensity care for substance use disorder.
- Follow-up after emergency department visit for mental illness.
- Diabetes monitoring for people with diabetes and schizophrenia.
- Cardiovascular monitoring for people with diabetes and schizophrenia.
- Metabolic monitoring for children and adolescents on antipsychotics.
- Use of first-line psychosocial care for children and adolescents on antipsychotics.
- Prenatal and postpartum care—prenatal rate.

- Prenatal and postpartum care—postpartum rate.
- Eye exams for patients with diabetes.

Providers, including behavioral health providers, must cooperate with reasonable requests from Sentara Health Plans and DMAS for data and documentation, including information needed to confirm services rendered, member follow-up, treatment engagement, medication management, screenings, monitoring results, transitions of care, and other quality-related activities. Shared data must be complete, accurate, and submitted within requested timeframes and in accordance with applicable privacy, security, contractual, and regulatory requirements.

The health plan, provider, practitioner, or behavioral health care organization will jointly determine the applicable measures, data elements, data exchange format and methodology, frequency of exchange, and intended recipients. Data may be shared through approved mechanisms, including secure file transfer, reports, encounter or claims submissions, pharmacy data, admission/discharge/transfer feeds, readmission reports, medical record documentation, or other mutually agreed-upon methods.

Data sharing involves the transmission of member information from the health plan to the provider, practitioner, or care delivery organization responsible for delivering services, programs, or care to the member. The organization will determine the entities with which data is shared (e.g., practitioners, providers, and care delivery organizations) and the scope of information exchanged for each relationship.

Goals of the Quality Improvement Program

One of the primary goals of the Sentara Health Plans' QI Program is to achieve a 5-star rating from NCQA and CMS, respectively, by ensuring the delivery of high-quality culturally competent healthcare, particularly to members with identified healthcare disparities. Our care service delivery modalities emphasize primary medical and specialty healthcare services, behavioral health, long-term services and supports, care coordination, and pharmaceutical services. The QI Program concentrates on evaluating both the quality of care offered and the appropriateness of care provided. This approach allows 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.
- Monitor previously identified issues.
- Evaluate effectiveness of the QI Program's annual evaluation by analyzing performance measure outcomes.
- 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 (PIPs) and other quality improvement projects.

- Make care safer by reducing variation in practice and enhancing communication across the continuum of care.
- Strengthen member and caregiver engagement in achieving improved health outcomes.
- Ensure culturally competent care delivery through practitioner cultural education including the 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 quality improvement and member safety team at 757-252-8400, Option 1 or toll-free at 1-844-620-1015, Option 1.

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

Critical Incident Reporting

A critical incident is defined as any actual or alleged event or situation that threatens or impacts the physical, psychological, or emotional 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. Serious injury specifically includes loss of limb or function that leads to permanent or severe temporary harm. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. **All sentinel events are critical incidents.**
- Other critical incidents refer to 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 incident and less severe than a sentinel event.

Providers must report critical incidents that occur during:

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

Examples of 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 "other provider preventable condition" pursuant to 42 CFR § 447.26(b) and/or a hospital acquired condition or a condition occurring in any health care setting that has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the member, and is auditable. Never events include, but are 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)

Serious reportable events (SREs) are events that are clearly identifiable and measurable, usually preventable, and are serious in their consequences, such as resulting in death or loss of a body part, injury more than transient loss of a body function, or assault. These are severely significant adverse events that should never occur.

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

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

Abuse, Neglect, or Exploitation

Mandated reporters are individuals 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.
- Mental health services provider as defined in § 54.1 -2400.1.
- Emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the suspected abuse, neglect or exploitation directly to the attending physician at the hospital to which the adult is transported, who shall make such report forthwith.
- Guardian or conservator of an adult.
- 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.
- Any person providing full, intermittent or occasional care to an adult for compensation, including, but not limited to, companion, chore, homemaker, and personal care workers.
- Any law enforcement officer.
- Any person who engages in the practice of behavioral analysis, as defined in § 54.1-2900.

Procedures/Guidelines

Sentara Health Plans requires all network and affiliated providers to report critical incidents within 24 hours of discovery via the approved Provider Critical Incident Reporting Form located under “Forms” 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 the incident. Sentara Health Plans contact information to report a critical incident is located on the DMAS Provider Critical Incident Reporting Form located under “Forms” or the “Sentara Health Plans Key Contact Information” section at the top of this document.

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 due to 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 Sentara Health Plans 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 initiatives to investigate such concerns and must meet a predetermined minimum performance compliance threshold set forth by Sentara Health Plans. 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.

Failure To Comply with Review Programs

Failure to comply with utilization management and quality improvement programs may be grounds for corrective action in addition to requirements for repayment of identified overpayments and/or being removed from the network. The failure of the provider to follow the policies and procedures of Sentara Health Plans' 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.

Quality Management Review Waiver Services

In accordance with federal regulations, specifically Title 42 of the Code of Federal Regulations (CFR), Parts 455 and 456, DMAS is mandated to conduct ongoing reviews and evaluations of Medicaid-funded care and services. These Quality Management Reviews (QMRs) are essential to ensure that services provided to waiver members are medically necessary, appropriately delivered, and compliant with DMAS Waiver Program's policies, procedures, and regulatory standards. QMRs may be conducted directly by DMAS or by its designated agents.

At the direction of DMAS, Sentara Health Plans must conduct QMRs. The scope of these reviews includes, but is not limited to:

- Utilization Review: Assessing the appropriateness, efficiency, and necessity of services rendered by providers and received by members.
- Compliance Verification: Ensuring provider adherence to State regulations, including documentation standards, service authorization requirements, and provider qualifications.
- Financial Review (Referral to Program Integrity Unit): Validating claims for reimbursement and identifying potential overpayments or billing discrepancies.

Providers found to be noncompliant may be subject to one or more of the following actions:

- Corrective Action Plan (CAP): A formal request for the provider to address and rectify identified deficiencies. See section "Program Integrity" for more information.
- Technical Assistance: Guidance and support offered to help providers meet compliance standards.
- Referral to the Program Integrity Unit (PIU): For further investigation and potential financial recovery, including retractions of payments for services not meeting DMAS requirements or for confirmed instances of fraud, waste, or abuse.

As part of the QMR and compliance oversight process, Sentara Health Plans' Quality Improvement Coordinator will assess provider adherence to Medicaid Waiver Program participation requirements, with particular emphasis on staff qualifications and regulatory compliance. During these reviews, the following documentation will be requested for all staff who provided services, including but not limited to Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), and other health professionals:

- Verification of professional licensure (e.g., RN, LPN, CNA).
- Caregiver work references.
- Evidence of required training and/or certifications.
- Criminal background checks.
- Any additional staffing documentation required by DMAS or the Department of Behavioral Health and Developmental Services (DBHDS) regulations and policies.

Providers are responsible for ensuring that all agency staff meet the minimum qualifications and regulatory requirements at the time of hire and throughout their employment. This includes maintaining up-to-date credentials and compliance with all applicable training and background check standards. For consumer-directed services, the Employer of Record (EOR) holds the responsibility for ensuring that all attendants meet the required qualifications and documentation standards prior to and during service delivery.

In alignment with the DMAS guidelines, QMRs will evaluate provider performance across the following six domains:

1. Level of Care – Ensuring services are appropriate to the member's assessed needs.
2. Service Plans – Verifying that individualized service plans are person-centered, current, and implemented as written.
3. Qualified Providers – Confirming that all staff meet licensure, training, and background check requirements.
4. Health and Welfare – Assessing safeguards in place to protect the safety and well-being of members.
5. Financial Accountability – Reviewing billing practices for accuracy, compliance, and potential overpayments.
6. Administrative Authority – Evaluating the provider's internal systems for oversight, documentation, and regulatory compliance

Participation in the Virginia Medicaid program obligates providers to cooperate fully with QMR activities, including granting access to records and facilities to Sentara Health Plans employees, DMAS representatives, the Office of the Attorney General, and authorized federal personnel upon reasonable request.

Sentara Health Plans

Section X: Claims Procedures and Coordination of Benefits

Timely Filing

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

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

Filing Claims Electronically

Providers who 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

Electronic Funds Transfer (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 Electronic Remittance Advice (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 a provider is 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 this website.

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.

Remittance Advice

A remittance advice (remit) is an explanation of reimbursement. The remit details claim adjudication. Providers registered with the Availity Essentials secure provider portal may download their remit by clicking on *Claims & Payments and selecting Remittance Viewer*.

Coordination of Benefits

Sentara Health Plans Medicaid program members who are covered by employer-sponsored health plans may be enrolled in a Medicaid-managed care plan. If a Sentara Health Plans program member is identified as having a commercial product, the provider must send the initial claim to the commercial plan for payment. Similarly, if a member is identified as having Medicare coverage, the provider must send the initial claim to Medicare before sending to Sentara Health Plans for Medicaid reimbursement. Medicaid is always the payor of last resort, with the exception of doula services. Sentara Health Plans does 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:

1. Services that are federally required to be provided at public expense.
    a. Assessment/EI evaluation.
    b. Development or review of the Individual Family Service Plan (IFSP).
    c. Targeted case management/service coordination.
2. Developmental services.
3. Any covered early intervention services where the family has declined access to their private health/medical insurance.

In accordance with federal regulations, early intervention providers must notify DMAS when a family declines to use private health/medical insurance for covered early intervention services. To meet this requirement:

- Complete the **Family Declining to Bill Private Insurance** form and submit it with the claim to the Sentara Health Plans Medicaid program. The form can be accessed at the bottom of this link.

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 payor, 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.

Payment Policies

Sentara Health Plans' payment policies are accessible through the Availity Essentials secure provider portal under the Resources tab in Payer Spaces. These policies outline acceptable billing and coding practices designed to equip providers with information for accurate claims submission. Sentara Health Plans will notify providers when new payment policies are implemented or when existing policies are updated. To access the policies, providers must have an active Availity Essentials secure provider portal account.

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 Provider Reconsideration form.

As part of the Sentara Health Plans audit process, Sentara Health Plans and/or its subcontractors may use statistical sampling and extrapolation of claims in determining the amount of an overpayment made to a provider. The extrapolation methodology utilized by Sentara Health Plans is consistent with the methodology authorized in the Medicare Program Integrity Manual. Sentara Health Plans automatically executes a retraction by way of offsetting with 35 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 and the reason the claim was paid in error 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.

Prepay Reviews

Upon notice to a provider, Sentara Health Plans may conduct prepayment reviews of claims before processing such claims. In the event of a prepayment review, a provider must submit the corresponding medical record and other documentation, when requested by Sentara Health Plans, to substantiate the services for which the claim is being submitted.

Treatment of Recoveries

Sentara Health Plans has the right to recoup overpayments identified through its own monitoring and investigative efforts. The lookback period for Medicaid is three years from the date of payment. This does not apply to any amount of 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, and Doula Claim Payments

Clean claims from nursing facilities, LTSS (including when LTSS services are covered under ESPDT), community behavioral health, ARTS, and early intervention, and doula 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.

Providers can verify claim status through the Availity Essentials secure provider portal or by calling Provider Services found in the "Sentara Health Plans Key Contact Information" section of this manual. Failure to comply with DMAS requirements may result in retraction of Medicaid payments.

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 claim submission when the service is known to be non-covered service 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. 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 MS-DRG or APR DRG diagnosis codes 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 (Replacement of Prior Claim)

A corrected claim is a complete replacement of a previously submitted claim that requires changes such as updates to diagnosis codes, procedure codes, modifiers, charges, member information, or provider information. Corrected claims must include all services provided.

If multiple corrected claims are submitted and services are split across those claims, only the services billed on the most recent corrected claim will be considered. Upon receipt of a corrected claim, Sentara Health Plans will reverse the original claim and replace it with the corrected submission.

Corrected claims must be submitted within the original timely filing limit.

To avoid denial as a duplicate claim, all corrected claims must include the required indicators or codes identifying the submission as a correction or replacement of a prior claim. Below are the required elements to identify a corrected claim (by claim type):

Electronic Claim Submission (Preferred)

- Billing Frequency Code (also referred to as the "frequency type"): This code tells Sentara Health Plans the claim is a correction of a previously adjudicated claim.

Claim Type	Corrected Claim Code	Description
Professional (837P)	7	Replacement of Prior Claim
Institutional (837I)	0XX7	Replacement of Prior Claim

Note: Claims sent through a clearinghouse or software vendor must have the frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guides. Providers should contact their software vendor or clearinghouse with questions about how to send this code.

- Payer Control Number (ICN/DCN): The claim number of the latest adjudicated claim (usually the original claim number but could be an adjustment claim number if a correction is being requested for an adjusted claim) assigned by Sentara Health Plans must be included as the Payer Control Number. This links the corrected claim to the original. This number can be found on the 835 ERA or Remittance Advice, which can be accessed in Availity Essentials by selecting *Claims & Payments* and then *Remittance Viewer*.

Paper Claim Submission

UB-04 Claims

- Type of Bill (TOB) – Field 4

  Bill type is a key indicator used to determine whether a claim has been previously submitted and processed. The fourth digit indicates the frequency of the bill submission

and indicates to Sentara Health Plans that the claim is a correction of a previously adjudicated claim.

Field	Requirement	Description
Field 4	0XX7	Replacement of Prior Claim

- Document Control Number (DCN) – Field 64
- Providers must include the claim number of the most recently adjudicated claim (usually the original claim number but could be an adjustment claim number if a correction is being requested for an adjusted claim) assigned by Sentara Health Plans. This links the corrected claim to the original claim. This number can be found on the Remittance Advice, which can be accessed in Availity Essentials by selecting *Claims & Payments* and then *Remittance Viewer*.
- Field 80: "Resubmission" should be indicated in field 80 or any other unoccupied block of the UB-04.

CMS-1500 Claims

- Resubmission Code – Field 22: This code identifies the claim as a correction of a previously adjudicated claim.

Field	Requirement	Description
Field 22	7	Replacement of Prior Claim

- Original Claim Number – Right Side of Field 22: Providers must include the claim number of the most recently adjudicated claim (usually the original claim number but could be an adjustment claim number if a correction is being requested for an adjusted claim) assigned by Sentara Health Plans. This links the corrected claim to the original. This number can be found on the Remittance Advice, which can be accessed in Availity Essentials by selecting *Claims & Payments* and then *Remittance Viewer*.

Duplicate Claims

Duplicate claim submissions are a common occurrence during the claims adjudication process. If a provider is uncertain if a claim has been filed, they should view claim status on the Availity provider portal or call Provider Services to inquire about the status of the claim. Some service lines may be paid, and other service lines denied as duplicates, or the entire claim may be denied as a duplicate.

An "original claim" is the initial submission of a claim by a provider. It has not been previously billed or processed and does not reference another claim.

A "corrected claim" is a resubmission of a previously adjudicated claim to correct or update information. Corrected claims should be submitted with the appropriate indicator or bill type to avoid being denied as duplicate. See section “Corrected Claim Submission of a Previously Billed Claim (Replacement of Prior Claim)” for more information.

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.

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.

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

Pre-admission Testing

Pre-admission testing may occur up to 10 days prior to the ambulatory surgery or inpatient stay. The testing may include chest X-rays, EKG, urinalysis, CBC, etc. The tests should be performed at the same facility at which the ambulatory surgery or inpatient stay is ordered. The tests should be billed on the inpatient or ambulatory surgery claim.

The admission date for ambulatory surgery must be the actual date of surgery and not the date of the pre-admission testing.

Sentara Health Plans will only pay separately for pre-admission testing if the surgery/confinement is postponed or canceled.

If the pre-admission testing is billed separately from the ambulatory surgery or inpatient stay and the surgery was not postponed or canceled, the pre-admission testing will be denied "provider billing error, provider responsible" (D95).

Readmissions

Hospital readmissions include cases where members are readmitted to the hospital for the same or similar diagnosis within 30 days of discharge (excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the member was originally discharged against medical advice).

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 existed prior to the initiation of treatment for the member. Reductions in reimbursement may be limited to situations in which the identified provider-preventable condition (i.e., never event) would otherwise result in an increase in payment and Sentara Health Plans can reasonably isolate the portion of the payment directly related to the treatment of the provider-preventable condition.

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 an 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 service 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 for the members transition 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 valid screening exists for individuals admitted to a certified skilled nursing facility. To receive reimbursement, screenings must be entered into the electronic pre-admission screening (ePAS) system (or approved alternative) before an admission.

Inpatient Denials/Adverse Decisions

If the attending physician continues to hospitalize a member who does not meet the medical necessity criteria, or there are hospital-related delays (such as scheduling), all claims for the hospital from that day forward will be denied for payment. The claim will be denied for “services not pre-authorized, provider responsible (D26)”. The member cannot be billed.

If the member remains hospitalized because a test ordered by the attending physician is not performed due to hospital-related issues (such as scheduling and pretesting errors), then all claims from that day forward for the hospital will be denied. The claim will be denied, “Services not pre-authorized, provider responsible (D26).” The member cannot be billed.

If a family member insists on continued hospitalization (even though both the attending physician and Sentara Health Plans agree that the hospitalization is no longer medically necessary), the claims related to the additional days will be denied. The claims will be denied “continued stay not authorized, member responsible (D75)”. The member cannot be billed.

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

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. 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.”

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 “an 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 use disorder) 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.
- With respect to a pregnant individual having contractions.
- That there is inadequate time for safe transfer to another hospital before delivery.
- A 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:

- Rendered by a provider that is qualified to furnish these services; and
- Needed to evaluate or stabilize an emergency medical condition pursuant to 42 CFR § 438.114.

Sentara Health Plans must cover and pay for emergency medical and behavioral health services and ensure that these services are available 24 hours a day and seven 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 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, Sentara Health Plans, or applicable state entity of the

member's screening and treatment within ten 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 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 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; or
    - 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 Sentara Health Plans 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 §422.114(e) is met.

Sentara Health Plans financial responsibility for post-stabilization care services that has not been 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; or
- 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

In accordance with the Cures Act requirement for Home Health Care Services (HHCS), Virginia utilizes EVV. The following data elements are required to meet EVV compliance:

- Type of service(s) performed
- Individual receiving the service(s)
- Date of the service(s) performed
- 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.

All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number and taxonomy code are not Clean Claims and will be rejected or denied.

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. The following provisions apply:

- 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 Sentara Health Plans (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.

Sentara Health Plans

Section XI: Member Appeals, Grievances & Complaints

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.

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 attorney, or 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 Sentara Health Plans 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, the member’s attorney, or the member’s 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 if Sentara Health Plans provides evidence satisfactory to DMAS that there is a need for additional documentation and that an extension would be in the member’s interest, in accordance with 42 CFR § 438.408.

For any extension not requested by the member, Sentara Health Plans must make reasonable efforts to give the member prompt oral notice of the delay; written notice within two calendar days to the member of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Sentara Health Plans will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

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 if Sentara Health Plans provides evidence satisfactory to DMAS that there is a need for additional documentation and that an extension would be in the member's interest, in accordance with 42 CFR § 438.408. For any extension not requested by the member, Sentara Health Plans must make reasonable efforts to give the member prompt oral notice of the delay; written notice within two calendar days to the member of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. Sentara Health Plans will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 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.

The appeal process described above applies to appeals related to authorization denials for which an adverse benefit determination has been issued.

Note for providers: If a provider has received an adverse benefit determination and rendered services, the provider can submit a provider reconsideration with Sentara Health Plans following the steps outlined in the Provider Reconsiderations section below. The provider must reference on its request that it is pursuing a provider reconsideration and that the services have already been rendered (in whole or in part). Provider reconsiderations where the services have already been rendered do not need written authorization from the member.

Information about contesting a claim can be found in the Provider Reconsiderations section below.

All requests for member appeals should be sent to:

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

Phone: 1-800-881-2166

FAMIS Members Only

If the FAMIS member is not in agreement with the Sentara Health Plans appeal resolution, the member may request an optional external review by an 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 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 deadline to ask for an appeal with DMAS is 120 calendar days from when Sentara Health Plans issues its final internal appeal decision. DMAS will notify the member of the date, time, and location of the scheduled hearing. Most hearings will occur by telephone unless the appellant requests otherwise.

There are multiple ways to request an appeal with DMAS.

1. Online at DMAS 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 that does not qualify as expedited will be issued within 90 days for Medicaid program members. The deadline may be extended for delays not caused by DMAS. Appeals to DMAS that qualify as Expedited Appeals must be resolved within 72 hours or as expeditiously as the member's condition requires. If the Medicaid program member disagrees with DMAS' decision, they may appeal the decision to circuit court.

Continuation of benefits: The member will be able to continue the services that are scheduled to end or be reduced if they request an appeal on or before the later of: (i) within 10 days of the date Sentara Health Plans sends 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.

Processes Related to Reversal of 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 but no later than 72 hours from receipt of notice from the state reversing the denial. If the decision reverses the denied authorization of services and the disputed services 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 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 Sentara Health Plans has made an adverse appeal decision.
- The availability of assistance in the filing process for grievances and appeals.
- The member's right to the 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.

Member Grievances/Complaints

Grievances may involve Sentara Health Plan's Medicaid program benefits, the delivery of services, or Sentara Health Plans' operation. This procedure includes both medical and non-medical (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 members have the right to express a complaint 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

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

Provider Reconsiderations

When services have already been rendered and a denial or audit determination has been issued, providers may utilize the reconsideration process with Sentara Health Plans.

Filing a Reconsideration
The Provider Reconsideration Form can be found here or by calling provider services.

Mail the completed Provider Reconsideration Form and, if necessary, any attached documentation to the reconsideration address found at the top of the form.

Medical Reconsiderations: PO Box 8203, Kingston, NY 12402-8203
Behavioral Health Reconsiderations: PO Box 8204, Kingston, NY 12402-8204

Service Authorization Reconsiderations
If a provider has rendered services (in whole or in part) and received an adverse benefit determination, the provider can submit a reconsideration by following the provider appeal rights included in the Adverse Benefit Determination. The timeframe to file a reconsideration of these actions is 60 calendar days from the date of the Adverse Benefit Determination.

Claim Reconsiderations
A claim reconsideration—distinct from a claim correction—is a written request submitted by the provider seeking a review of how a claim was processed. It is important to note that a reconsideration does not involve any changes to the original claim. The claim reconsideration filing deadline is 365 days from the last date of service. Requests for waivers to the timely filing requirements due to an exceptional circumstance must be made in writing and should be submitted to the Sentara Health Plans claims department.

Initial Decision & Second Level Reconsiderations

Sentara will notify the provider in writing of the reconsideration decision. If the provider is not satisfied with the initial reconsideration outcome, a second reconsideration may be requested based on the uphold reason within 60 days from the date on the determination letter.

Appeals to the Department of Medical Assistance Services (DMAS)

If a provider wishes to further appeal after a second uphold decision, they must file a written notice of appeal with the Appeals Division of the Department of Medical Assistance Services within 30 calendar days of receipt of the second level letter. The provider appeal process is governed by Virginia Code Section 32.1-325.1 and regulations at 12 VAC 30-20-500 *et seq*.

Effective November 5, 2026, providers will be required to request DMAS appeals through the DMAS Appeals Division's online portal, the Appeals Information Management System (AIMS). Providers must have an AIMS account to request an appeal through AIMS.

Provider registration requests must be reviewed before the account is created. As a result, providers will not have an AIMS account immediately after registering. Providers are encouraged to register for AIMS even if they do not need to file an appeal.

Providers can visit https://www.dmas.virginia.gov/appeals/ to register for AIMS, access AIMS, and find more information about the appeal process.

Claim Reconsideration Request Submittal

Claim reconsideration requests should be submitted through the following methods:

Portal

Providers may submit Medicare and Medicaid claim reconsideration requests through the link below until further notice:

Sentara Health Plans Claim Reconsideration Portal | Login

Note: Due to licensing limitations, the portal may be unavailable when too many users are logged in at the same time.

Sentara Health Plans will be replacing the Reconsideration Portal with functionality in the Availity Essentials provider portal beginning in January of 2027. Information will be provided on the website when this feature becomes available.

Sentara Health Plans

Section XII: Rights and Responsibilities

Member Rights and Responsibilities

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.

Sentara Health Plans Medicaid Program members have specific Member Rights and Responsibilities. Members are mailed information on where to locate their Rights and Responsibilities at the time of enrollment.

General Member Rights

General member rights can be found on the Sentara Health Plans website located here.

Members have the right to:

- 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 such records be changed or corrected in accordance with state and federal law.
- Have their medical records and treatment kept confidential. Sentara Health Plans will only release their information if it is allowed under federal or state law, or if disclosure 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 request 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

General member responsibilities can be found on the Sentara Health Plans website located here.

Member responsibilities include:

- 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 DMAS.
- Report suspected fraud, waste, and abuse.

Common Provider Responsibilities

Notice of Nondiscrimination and the Civil Rights Act

Sentara Health Plans providers shall 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 a 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 the request of DMAS during the re-validation of enrollment process, and within 35 days after any change in ownership. Required 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 revalidate 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 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.

Provider Responsibilities for Excluded Entity Screening and Reporting

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

applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

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

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded. This includes owners with a direct or indirect interest of 5% or more.
2. Search The Office of Inspector General website monthly to capture exclusions and reinstatements that have occurred since the last search.
3. Immediately report any exclusion information to Sentara Health Plans in writing.

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

Sentara Health Plans

Section XIII: Medical Records

Practitioners and providers delivering services to Sentara Health Plans members are expected to maintain and appropriately share member health records in accordance with established professional and legal standards.

Practitioners are required to maintain comprehensive and accurate medical records documenting the care and services provided to Sentara Health Plans members. All communications and records related to a member's healthcare must be treated with strict confidentiality. Records may not be released without the member's written consent, or, in the case of a minor, the consent of their legal guardian (unless the records relate to services for which the minor has consented for themselves in accordance with Virginia law), except where permitted by applicable law.

Members are not required to complete an additional medical release form for Sentara Health Plans to obtain records. Sentara Health Plans may request member records for quality assurance purposes in accordance with state and federal regulations and accreditation standards.

Medical records are essential tools for preserving the continuity, accuracy, and integrity of clinical information. As the primary source of data related to patient care, medical records support not only the treating provider, but also other healthcare professionals involved in coordinating and delivering comprehensive care.

Confidentiality

Any personal information about a member received by the provider from Sentara Health Plans must be treated as confidential and securely maintained within the United States.

Confidentiality of medical records must be upheld through the following practices:

- Secure Storage: Medical records must be stored in a secure manner, whether in a confidential filing system or electronically, with appropriate safeguards to ensure that only authorized personnel have access.
- Confidentiality Training: Staff must receive periodic training on the confidentiality of member information, including Sentara Health Plans medical record documentation standards, and additional training as needed.

Providers and all provider staff are required to comply with the HIPAA Privacy and Security Rules.

Providers rendering substance use disorder treatment services that are subject to 42 CFR Part 2 must comply with the confidentiality provisions set forth in 42 CFR Part 2.

Providers must promptly notify Sentara Health Plans in the event of a breach of protected health information, as those terms are defined by HIPAA, affecting Sentara Health Plans Medicaid members.

Medical Record Documentation Standards

Sentara Health Plans

Medical records may be audited in accordance with Sentara Health Plans' physical and behavioral health treatment record documentation guidelines (which reflect accepted standards for medical record documentation) as well as DMAS standards and guidelines, as applicable.

Each medical record must include, at a minimum, the following elements:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history.
- Documentation of allergies and adverse reactions to medications.
- Problem list.
- Medications management & reconciliation.
- Clinical findings and evaluations documented for each visit.
- Preventive services and risk screenings.
- Diagnoses, including documentation for behavioral health.
- Substance use assessment.
- Mental status examination.
- Treatment planning.
- Evidence of continuity of care, including:
    - Documentation of collaboration with the member's primary care provider (PCP) regarding medications and treatment, or documentation of the member's refusal to consent.
    - Upon obtaining consent for the release of information, the BH provider must notify the member's PCP when the member presents for an initial behavioral health evaluation and for ongoing treatment. This includes communication about significant changes in the member's condition, medication adjustments, and termination of treatment. This applies to all specialty providers.

Medical records must be organized and securely stored in a non-public area that allows for efficient retrieval. Providers are responsible for maintaining well-structured records for all members receiving care and services, ensuring they are readily accessible for review or audit by Sentara Health Plans and designated state, federal, and accrediting entities. Records must be comprehensive and contain sufficient detail to support seamless transfer procedures, promoting continuity of care when members are treated by multiple providers. Patient information should be arranged in a consistent, logical format, either chronological or reverse chronological order, to facilitate clarity and ease of use.

Requests for Medical Records

Sentara Health Plans requires participating providers to make medical records available to the health plan, members, and/or their authorized representatives within 10 business days of receiving a request.

Fees for Medical Records

Participating providers shall not charge Sentara Health Plans or its members for copies of medical records or for the completion of related forms.

Medical Record Retention and Continuity of Care

Sentara Health Plans

Participating providers must retain medical records for Sentara Health Plans members for a minimum of 10 years from the last date of service, or longer if required by applicable Virginia and federal regulations. Primary care providers are responsible for obtaining and integrating medical records from both participating and nonparticipating providers to whom they refer members, ensuring continuity and coordination of care.

Medical Record Review and Corrective Action

Providers who do not meet Sentara Health Plans' medical record documentation standards will be required to develop and implement a corrective action plan within a specified timeframe. Each identified deficiency will be monitored at least every six months following the initial review until compliance is achieved. If deficiencies remain unresolved after six months, the matter will be escalated to the Senior Medical Director and/or Credentialing Committee for further review and potential sanctions.

Practice Closure or Sale

Subject to applicable laws, if a provider practice or facility is sold or closed, the provider must notify patients and Sentara Health Plans in writing, indicating the change and the location where patients' medical records will be maintained and stored. Providers must also offer patients the opportunity to obtain copies of their records. In the event of closure, medical records must be retained in accordance with applicable law.

Monitoring the Quality of Care

Sentara Health Plans collaborates with contracted network and affiliated providers to inspect, audit, review, and obtain copies of medical records related to covered services rendered under the Provider Agreement. These reviews may be conducted for purposes including, but not limited to, benefit determinations, payment decisions, member grievances, quality of care (QOC) reviews, sentinel events, member surveys, internal reports, credentialing monitoring, and other quality improvement initiatives.

To support these activities, Sentara Health Plans and its authorized representatives may request documentation, primarily patient medical records. Providers are expected to submit this information electronically if using an electronic health record (EHR) system, or as paper copies when applicable.

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.

Medical Record Maintenance Standards

Participating providers must maintain office policies and procedures for medical record documentation that align with applicable law. At a minimum, records must be:

- accurate and legible.
- securely stored to prevent loss, destruction, or unauthorized access (e.g., in restricted non-public areas).

- organized and accessible for review by the health plan and/or state or federal regulatory entities or external quality review organization (EQRO).
- available to Sentara Health Plans' staff, as appropriate, to support quality and utilization management activities.
- comprehensive with sufficient detail to ensure continuity of care when multiple providers are involved.

Medical Record Coordination and Continuity of Care Standards

To promote effective communication, coordination, and continuity of care, the following standards must be met:

- A current, legible problem list must be maintained and updated as appropriate. If no significant issues are present, this must be noted (e.g., well-child/adult preventive care visit).
- Allergies and adverse reactions must be clearly documented. If none exist, this must be noted (e.g., sticker or stamp noting allergies or no known allergies (NKA) is acceptable).
- Past medical history must be easily identifiable for all patients, and include family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), this includes prenatal care, birth history, surgical history, immunizations, and childhood illnesses.
- Medication records must include drug names, dosages, frequencies, and dates of prescriptions or refills.
- Each page of the medical record must include the patient's name or ID number, and all entries must be dated.
- Entries must be signed and dated by the rendering practitioner (a valid signature includes the practitioner's credentials).
- Working diagnoses and treatment plans must align with clinical findings.
- Consultation reports must be present, with documentation of PCP review and follow-up and a follow-up phone call must be noted in the MD progress note. Electronic consults must show evidence of PCP acknowledgment. Any further follow-up needed or altered treatment plans should be noted in progress notes.
- Continuity and coordination of care must be documented across all providers involved in the member's care, including PCP and specialty providers, hospitals, home health, skilled nursing facilities, and free-standing surgical centers, etc., must be documented when applicable.
- Advance care planning and advance directives discussions must be documented for all adult patients and emancipated minors. If the patient does have an advance directive, it should be noted, and a copy should be present in the medical record.
- Confidentiality must be maintained in accordance with HIPAA. Records must be stored in secure, non-public areas and accessible only to authorized personnel or health plan staff and state/federal regulatory entities.
- Substance use assessments (smoking, alcohol, drugs etc.) must be documented for patients aged 12 and older, with referrals to behavioral health specialists noted as appropriate.
- Preventive screenings must be offered and documented in accordance with Sentara Health Plans' Preventive Health Guidelines and American Academy of Pediatrics and Bright Futures, as applicable, and documented in the progress notes and/or appropriate screening tool.

Advance Directives

Sentara Health Plans provides members with information regarding advance directives, including living wills, healthcare power of attorney designations, and organ donation and anatomical gift preferences. This is done in compliance with the Patient Self-Determination Act and applicable state laws, which require healthcare providers to inform adult patients of their rights to accept or refuse medical treatment and to create advance directives concerning their care.

Access Advance Care Planning information from the Sentara Center for Healthcare Ethics is located here.

Additional Guidance

Providers are encouraged to consult their malpractice insurance carrier for any additional requirements or recommendations regarding medical record retention policies.

Sentara Health Plans

Section XIV: Artificial Intelligence

Provider Use of Artificial Intelligence

Providers shall not, and shall ensure their subcontractors do not, input into any AI System confidential or proprietary information belonging to Sentara Health Plans, except as otherwise permitted under the Provider Agreement and this Manual. Provider shall ensure all AI Systems used in connection with the Provider Agreement meet industry standards and are safe, accurate, and unbiased. Providers shall maintain a list of all AI Systems they use for a period of five years from the date last utilized under the Provider Agreement and shall make such list available for review by Sentara Health Plans upon request (this obligation survives termination of the Provider Agreement).

Providers shall inform and obtain written consent from Members (or their legal guardians, as applicable) whose care will be recorded and/or facilitated by an AI System, and providers shall ensure the use of such AI System complies with HIPAA, all applicable state and federal privacy laws, and all applicable state and federal laws governing the use of AI Systems. Additionally, providers shall inform and obtain written consent from each Member whose personal information will be used to train or improve an AI System operated by a provider.

Providers shall retain all records created by an AI System that relate to services rendered under the Provider Agreement, in accordance with the record retention policies set forth in the Provider Agreement.

Each provider retains ultimate responsibility for all clinical decisions involving care provided to Members, notwithstanding a provider's use of an AI System to assist the provider in rendering such care.

Providers shall allow Sentara Health Plans access to AI Systems used for treatment or billing and to inspect and make copies of records generated by AI Systems for purposes of performing audits related to fraud, waste, and abuse.

AI Use in Telephone Calls and Electronic Communication

The requirements in this section apply to (1) a provider's use, if any, of AI Systems to contact Sentara Health Plans via telephone (using interactive voice response or otherwise) and (2) a provider's use, if any, of AI Systems to contact Sentara Health Plans via electronic communications, including without limitation, secure messaging and texting.

Sentara Health Plans will only interact with "Verified AI Callers" and "Verified AI Messengers." Verified AI Callers are those callers that call from a phone number which the provider has provided to Sentara Health Plans in advance in writing designating that the caller has authority to act on the provider's behalf. Verified AI Messengers are those that message from an address or number which the provider has provided to Sentara Health Plans in advance in writing designating that the messenger has authority to act on the provider's behalf. Sentara Health Plans has the right to disconnect or refuse to answer calls or respond to messages from AI callers and AI messengers, as the case may be (even if they are Verified AI Callers or Verified AI Messengers) if Sentara Health Plans determines that the caller or messenger does not have authority to act on behalf of the provider, is in any way violating the requirements of this Provider Manual, or is not cooperating with the requests of Sentara Health Plans call center staff.

Sentara Health Plans

Provider shall not use AI Systems to call or message Sentara Health Plans for any purpose other than allowing the provider to fulfill its obligations under the Provider Agreement. Without limiting the foregoing, providers will not use calls or messages by AI Systems operated by the provider to Sentara Health Plans to train or improve AI Systems. Additionally, Provider shall bear full responsibility for ensuring the accuracy of information relayed by an AI System to Sentara Health Plans. Sentara Health Plans will not bear any responsibility for action taken in reliance on inaccurate or incomplete information relayed on a provider's behalf by an AI System.

Information received by an AI System on a phone call or message exchange with Sentara Health Plans remains subject to all applicable confidentiality obligations, including without limitation, obligations arising from HIPAA and the Provider Agreement. Providers shall not allow any information transmitted from Sentara Health Plans to a Verified AI Caller or Verified AI Messenger to be inputted into a model or system for any purpose other than fulfilling the provider's obligation to render covered services under the Provider Agreement.

For the avoidance of doubt, any failure of a provider to comply with the requirements in this Section is subject to the indemnification obligations set forth in the Provider Agreement.

Section XV: Provider Communications, Resources, and Appointment Standards

Sentara Health Plans Provider Website

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

- Provider self-service tools
- Medical policies
- Health plan contact numbers
- Billing and claims resources
- Clinical references
- Formularies and drug lists
- Healthcare Effectiveness Data and Information Set (HEDIS®) resources
- Provider update and other forms
- Provider manuals
- Educational materials, such as newsletters and provider announcements
- Access to the Availity provider portal and other secure provider portals

Sentara Health Plans Network Management

The Network Management Department is responsible for keeping providers up to date on services and resources, including:

- How to become an in-network provider and contract with Sentara Health Plans.
- How to update provider demographic information.
- Directly address any provider special needs, concerns, or complex situations, services, and other requirements.
- Provider education and training.

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.

Provider Portal

Sentara Health Plans has selected Availity Essentials (Availity) as our exclusive provider portal. Availity 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 2026, 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 and the ability to register your organization.

Provider Notifications

Sentara Health Plans routinely distributes timely notifications via email to provide updates such as:

- 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

Sentara Health Plans notify providers of any planned policy changes through electronic communications 60 days before the effective date of such policy change. Any pertinent changes to policy and protocols are also communicated with an online provider notice posting. To avoid missing any important updates, providers are required to provide (and update as necessary) a valid email address to Sentara Health Plans via the Provider Update Form or during meetings with the assigned Network Educator.

Provider Newsletters

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

Providers 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 Medicaid regulations, Sentara Health Plans maintains a provider advisory committee. The committee includes external network providers representative of the specialties in the network, including providers with experience serving Medicaid members and individuals with complex or special needs, as well as Sentara Health Plans clinical and network management staff.

The committee meets at least quarterly and serves as an advisory body to support provider engagement and feedback. The committee provides input on preventive health practices and makes recommendations to inform quality improvement activities, as well as guideline, policy, and operational changes. The overall goal of the committee is to support ongoing collaboration

between Sentara Health Plans and network providers to improve care delivery and member outcomes.

Changes to the Provider Manual

Sentara Health Plans provides notice of changes, amendments, and updates to this Provider Manual and any sources that are referenced by and incorporated herein are communicated to providers at least 60 calendar days before the effective date. Notifications are distributed through the Sentara Health Plans provider website and via email to providers who have supplied a valid email address. Providers are responsible for keeping their contact information current by submitting a Provider Update Form to report any changes to mailing or email addresses. Providers should regularly review the provider website and monitor email communications for updates.

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. The events are announced here and in the provider alert email, along with other educational opportunities.

Education and Training

Providers can access both required and encouraged trainings here.

All providers within a provider practice or organization are required to review Sentara Health Plan's Model of Care Provider Guide (MCPG). The MCPG includes important information about the Medicare Special Needs Plans Model of Care. Upon completion of the MCPG training, an attestation must be completed and submitted to Sentara Health Plans. The attestation can be obtained by accessing this link. Only one attestation is required per Tax ID, so if there are multiple providers in a Provider practice or organization only one needs to be submitted. The attestation must be received and verified by Sentara Health Plans. Once Sentara Health Plans receives the attestation, the training requirement is considered complete for the remainder of the calendar year.

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.

Provider Training, Technical Assistance and Education

Sentara Health Plans provides adequate resources 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 and use of member needs assessments.
2. In-person and virtual trainings (e.g., billing, credentialing, service authorizations, etc.).
3. Scheduled visits to provider sites, as circumstances dictate.

4. Direct one-on-one support/assistance.
5. Facilitating sharing of best practices.

Mental Health Services Provider Training

Sentara Health Plans staff will conduct ongoing education via scheduled webinars and direct provider engagement with mental health service providers. Training and technical assistance topics will include model of care elements, person-centered treatment planning, culturally competent care, evidence-based service planning/treatment methods and service provision, effective care coordination in an integrated care service delivery model, effective discharge planning, and strengths-based treatment goal selection. Training will include the appointment availability standards required by line of business and discharge planning expectations and resources for members, particularly for members that have utilized behavioral health crisis services.

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 educational material 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 educational material, please visit this link.

Cultural Competency Training

All providers are encouraged to complete cultural competency training. A link to Think Cultural Health – prepared by the U.S. Departmental of Health & Human Services training is available on the education page of the Sentara Health Plans website. Providers may complete the course of

their choice and 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 at least once every two years in accordance with DMAS contract requirements. The purpose of the survey is to assess provider satisfaction with Sentara Health Plans' services and to identify opportunities for improvement. Provider participation in these surveys is strongly encouraged, as feedback is highly valued and plays a critical role in driving initiatives.

Contact Information

Contact information 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, or similar inquiries. In order to assist as many providers as possible, inquiries will be limited to five per caller. Provider Services will offer self-service options or Network Educator support to address additional inquiries.

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

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 must make arrangements to refer members seeking care after regular business hours to an appropriate provider. Providers may direct the member to go to an emergency department for potentially emergent conditions, and this may be done via a recorded message.

After-Hours Availability Standards

After-Hours Standards (Live answer or automated system)	**Standards (Appropriate responses)**
Emergency instructions provided	Caller is directed to hang up and dial 911 or go to the nearest emergency room for life-threatening emergencies.
Process to reach physician	• Directly connects or forwards caller to the physician/on-call physician or appropriate medical professional.

	• Caller can select an option on their telephone to be directly connected to the physician/on-call physician or appropriate medical professional. • Pages the medical professional; call returned within 30 minutes to the physician/on-call physician or appropriate medical professional. • Answering machines allows caller to leave message; call returned within 30 minutes by the physician/on-call physician or appropriate medical professional. • Call forwarding automatically - call is automatically forwarded to the physician/on-call physician or medical professional.

Appointment Timeliness Standards

Sentara Health Plans meets, and requires its network providers to meet, DMAS standards for timely access to care and services, considering 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 a system to monitor its provider network to ensure compliance with applicable access standards and appointment timeliness standards. Sentara Health Plans regularly monitors network provider compliance with these appointment timeliness standards, including monitoring Grievances and Appeals data for indications that problems may exist with access to specific providers or provider types. When noncompliance with applicable standards is identified, Sentara Health Plans will take appropriate corrective action. Corrective action for a network provider's failure to comply may include implementation of a corrective action plan or other sanctions, as applicable and in accordance with the Provider Agreement and Sentara Health Plans policies and procedures.

Participating providers must adhere to the following appointment timeliness standards established for Sentara Health Plans Medicaid program members:

Service Type	Sentara Health Plans Medicaid Standards
Emergency Services, including Medical and Behavioral Health Crisis Services	1) Emergency appointments and services, including crisis services, must be made available immediately upon the member's request. 2) 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 Services	Within 6 hours or directed to emergency care

Urgent Care Services, including Medical and Behavioral Health	Within 24 hours of the member's request
Routine Primary Care Services	1) Regular and routine, primary care service appointments must be made within 30 calendar days of the member's request. 2) 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 business days, or for routine specialty services like dermatology, allergy care, etc.
Maternity Care – First Trimester Services	Within 7 calendar days of request
Maternity Care – Second Trimester Services	Within 7 calendar days of request
Maternity Care – Third Trimester Services	Within 3 business days of request
Maternity Care – High-risk Pregnancy Services	Within 3 business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists
Postpartum Care Services	Within 60 business days of delivery
Behavioral Health Routine Services (Initial and Follow-up)	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.

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. Except 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.

Physician Assistants and Nurse Practitioners

Physician Assistants, Advanced Practice Registered Nurses (including Licensed Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives and Certified Nurse Anesthetists) may contract with Sentara Health Plans to provide covered services in accordance with the state law applicable to advance practice providers.

Nurse Practitioners and Physician Assistants will be reimbursed for services provided to Sentara Health Plans members provided:

- They are participating with Sentara Health Plans under an active Provider Agreement (either directly or from a group affiliation)
- They are operating within their license – for example, if their license requires them to be supervised, they meet criteria for supervision
- The services they provide are covered and proper authorizations are in place

Nurse Practitioners as PCPs

Nurse Practitioners who are willing and able to meet the Primary Care Provider requirements and obligations stated in the Sentara Health Plans Provider Agreement may, upon request, provide primary care services to members that are assigned directly to them as their Primary Care Provider for Sentara Health Plans Medicaid program. This does not apply to Medical and Behavioral Health Nurse Practitioners who only provide specialty care services.

For new practices or existing practices, a Provider Update Form must be submitted to credential the Nurse Practitioner as a PCP with assigned members.

Nurse Practitioners that are approved by Credentialing as PCPs will be set up with an open panel status to be eligible for incentives available to PCPs based on their attributed members. They will be set up to appear in provider directories as PCPs.

If the Nurse Practitioner is working under a Practice Agreement in collaboration with a licensed patient care team physician, the Nurse Practitioner’s participation cannot be effective prior to the licensed patient care team physician’s effective date of participation.

Sentara Health Plans

Section XVI: Compliance/Ethics

Privacy Regulations

As affiliates of Sentara Health, Sentara Health Plans entities follow Sentara Health's Notice of Privacy Practices which can be found here.

Sentara Health Plans maintains compliance with HIPAA, 42 CFR Part 2, 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.

Program Integrity

Sentara Health Plan's Program Integrity Unit (PIU) plays a critical role in maintaining the integrity of Sentara Health Plans. The PIU is a dedicated team that focuses on detecting, resolving, and preventing potential fraud, waste, and abuse (FWA) by analyzing claims data, monitoring trends, and conducting in-depth investigations to uncover suspicious activities and unusual patterns of potential abusive behavior. The PIU's efforts not only help safeguard financial resources but also ensure that care and coverage remain accessible to those who truly need them.

The PIU has documented its efforts to detect, resolve, prevent, and report potential FWA by implementing an Anti-fraud Plan to ensure compliance with state and federal regulations. Providers may read more about Sentara Health Plan's Anti-Fraud Plan.

Upon completion of an investigation or audit, Sentara Health Plans will send a provider a letter outlining the PIU's final findings with respect to such investigation or audit. Where appropriate, as determined in the sole discretion of Sentara Health Plans, the PIU will include with the final findings a corrective action plan (CAP) that is binding on the provider. Providers acknowledge and agree to comply with all CAPs issued by Sentara Health Plans and, further, that failure to comply with the terms of a CAP shall constitute a material breach of the Provider Agreement. A provider's acceptance of a CAP does not constitute an admission of any disputed finding and does not waive any contractual or legal reconsideration, dispute, or appeal right, including without limitation, appeals with DMAS. However, a provider shall adhere to the terms of a CAP during any dispute or appeal process, unless Sentara Health Plans states otherwise in writing. Issuance of a CAP does not prevent Sentara Health Plans from recouping an overpayment or taking any other action permitted under the Provider Agreement.

To report possible fraud, waste or abuse, please utilize the following options:

Hotline:

- (757) 687-6326 or (866) 826-5277
    - Available 24 hours a day, 7 days a week. This is a voicemail service only; someone will contact you within 48 hours.

Email:

- compliancealert@sentara.com

All referrals made to the PIU may remain anonymous. Please be sure to leave your name and number if you wish to be contacted to follow up.

Confidentiality

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

Equal Opportunity Employment

Pursuant to 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 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 and lodging, whether provided in-kind, by purchase of a ticket, payment in advance, or reimbursement after the expense has been incurred.

Anti-Kickback Statute

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, The Office of Inspector General, or the Department of Justice if the contractor has reasonable grounds to believe that a violation exists.

Business Records

Sentara Health Plan’s provider 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 providers are 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.

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 person 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 person 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.

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.

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

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.